

Copyright is owned by the Author of the thesis. Permission is given for a copy to be downloaded by an individual for the purpose of research and private study only. The thesis may not be reproduced elsewhere without the permission of the Author.

**COMMUNITY PARTICIPATION IN THE  
ESTABLISHMENT OF A PRIMARY HEALTH  
ORGANISATION IN THE HOROWHENUA: A  
LONGITUDINAL CASE STUDY**

**A thesis presented in partial fulfilment of the requirements for the  
degree of**

**Doctor of Philosophy  
in Management**

**at Massey University, Turitea, Palmerston North,  
New Zealand**

**JANET ELIZABETH LOCKETT-KAY  
2005**



## ABSTRACT

In February 2001 the Minister of Health, in announcing the Primary Health Care Strategy (King, 2001), identified Primary Health Organisations as the vehicles for planning, funding and coordinating primary health care services throughout New Zealand. The requirement that communities be involved in their planning and development was integral to this strategy implementation.

Investigation of the Horowhenua Primary Health Organisation establishment process from the inception of planning to the formation of a Primary Health Organisation provided an excellent opportunity to analyse the determinants of genuine community participation. This case study extended over a nine-month period. Data collected from multiple sources provided the basis for investigating the complex notion of community participation and the attributes which are essential for sustainable community engagement.

The Horowhenua Primary Health Organisation Steering Committee comprised community representatives, iwi and local health professionals. This group along with the two external stakeholder groups - namely the District Health Board Funding Division and the District Health Board Primary Health Care Reference Group – were central to the analysis.

The events recorded and observations made throughout the planning period formed the basis of identifying essential determinants of community participation. These included knowledge of the community and its unique “ways of doing”, the dynamic interdependencies both within the Horowhenua community and with stakeholders external to the Horowhenua, changing power relationships, managing material resourcing and accessibility to essential information. These all influenced how this rural community engaged in Primary Health Organisation planning.

One common theme which emerges in the literature is the synergy between community participation and community development. A community development approach is a commonly agreed way of engaging communities in health service

planning which is genuine, inclusive, self-reliant, and self-determining. This research demonstrated that the New Zealand context, where implementation of the primary health care strategy must be nationally consistent and comply with prescriptive, central government-determined criteria - as well as involving communities in a meaningful way - requires an alternative approach. The thesis presents a way of addressing power discrepancies, promoting interdependencies between stakeholders and achieving inclusiveness in all decision-making where “expert” stakeholders and community bring to the partnership a set of attributes and knowledge which collectively informs the entire planning process.

## ACKNOWLEDGEMENTS

Approval for the research described in this thesis was obtained from the Massey University Campus Human Ethics Committee: Palmerston North and the Manawatu Whanganui Ethics Committee (accredited by the Health Research Council of New Zealand).

Completion of this thesis would not have been possible without the guidance and support of a number of people. I extend to my supervisors, Professor Antonios Vitalis and Professor Emeritus Nancy Kinross, my gratitude for their critique, their strong intellectual focus and their encouragement at every stage of my learning journey.

Special thanks go to the members of the Horowhenua Primary Health Organisation Steering Committee, who welcomed me into their group and gave me the freedom to be part of their unique experience. I am appreciative of all stakeholders who gave of their time so willingly for interviews and the many informal discussions which provided me with essential insights and understandings.

Lastly, thanks must go to my husband, Colin Kay, and our sons Peter, and Grant, for their unfailing encouragement and moral support. Colin actively supported the research in so many ways – preparing meals, providing computer expertise, giving me space to focus, and being so understanding of the time commitment.

## TABLE OF CONTENTS

<i>Abstract</i>	<i>i</i>
<i>Acknowledgements</i>	<i>iii</i>
<i>Table of Contents</i>	<i>iv</i>
<i>List of Tables</i>	<i>ix</i>
<i>List of Figures</i>	<i>x</i>
<i>Glossary and Abbreviations</i>	<i>xii</i>

### **CHAPTER ONE INTRODUCTION 1**

---

### **CHAPTER TWO**

#### **COMMUNITY PARTICIPATION: THE LITERATURE**

<b>2.1 DETERMINING THE LITERATURE TO BE REVIEWED</b>	<b>5</b>
<b>2.2 COMMUNITY PARTICIPATION</b>	<b>7</b>
<b>2.3 COMMUNITY PARTICIPATION AND CONTEXT</b>	<b>13</b>
<b>2.4 BUILDING COMMUNITY CAPACITY</b>	<b>14</b>
<b>2.4.1 Primary Health Care and Community Development</b>	<b>16</b>
<b>2.5 COMMUNITY PARTICIPATION: ISSUES FOR POLICY IMPLEMENTATION</b>	<b>18</b>
<b>2.6 CONCLUDING COMMENTS</b>	<b>21</b>

---

### **CHAPTER THREE**

#### **NEW ZEALAND HEALTH SERVICES: SETTING THE CONTEXT**

<b>3.1 INTRODUCTION</b>	<b>22</b>
<b>3.2 REPORTS AND REVIEWS: 1975 TO THE 1980s</b>	<b>22</b>
<b>3.3 THE EMERGENCE OF COLLABORATIVE PLANNING: THE AREA HEALTH BOARD ERA</b>	<b>24</b>
<b>3.3.1 The Special Advisory Committee on Health Services Organisation</b>	<b>24</b>
<b>3.4 PREPARATIONS FOR THE QUASI-MARKET ERA</b>	<b>27</b>
<b>3.4.1 The Health Benefits Review – 1986</b>	<b>28</b>

3.4.2	Report of the Hospital and Related Services Taskforce – 1988	28
3.5	CROWN HEALTH ENTERPRISES: THE QUASI-MARKET ERA	29
3.6	THE NEW MELLENNIUM: FURTHER RESTRUCTURING	35
3.7	PRIMARY HEALTH CARE STRATEGY: BACKGROUND	36
3.7.1	Population-Based Funding	37
3.8	NEW ZEALAND PRIMARY HEALTH CARE STRATEGY: IMPLEMENTATION	40
3.9	CHOOSING A LOCATION FOR DATA COLLECTION	41
3.10	MIDCENTRAL DHB: BACKGROUND	43
3.11	MIDCENTRAL DHB COMMENCES PLANNING FOR PHC STRATEGY IMPLEMENTATION	45
3.11.1	MidCentral DHB Primary Health Care Reference Group	45
3.11.2	MidCentral DHB's Primary Health Care Strategy	46
3.12	HOROWHENUA/OTAKI HEALTH SERVICES: BACKGROUND	47
3.13	CONCLUDING COMMENTS	48

---

## CHAPTER FOUR

### METHODOLOGY

4.1	INTRODUCTION	50
4.2	ENGAGING IN RESEARCH	50
4.3	THE RESEARCH APPROACH	51
4.4	THE RESEARCH STRATEGY IS PLANNED	53
4.5	ONTOLOGY AND EPISTEMOLOGY	54
4.5.1	The Nature of Reality	54
4.5.2	The Nature of Knowledge	54
4.6	THEORETICAL PERSPECTIVE	57
4.7	METHODOLOGY: A LONGITUDINAL CASE STUDY	58
4.8	METHODS	60
4.8.1	Snowball Sampling	60
4.8.2	Document Review	61
4.8.3	Media Releases	61
4.8.4	Observation	61
4.8.5	Semi-Structured Interviews	63
4.9	ANALYSIS	64
4.10	RESEARCHER AS PARTICIPANT	66
4.10.1	Reflexivity	69
4.11	DATA QUALITY	70

<b>4.12</b>	<b>ETHICAL REVIEW</b>	<b>70</b>
<b>4.13</b>	<b>CONCLUDING COMMENTS</b>	<b>71</b>

---

## **CHAPTER FIVE**

### **FINDINGS: PART 1: PHO ESTABLISHMENT PROCESS**

<b>5.1</b>	<b>INTRODUCTION</b>	<b>72</b>
<b>5.2</b>	<b>THE STEERING COMMITTEE IS ESTABLISHED</b>	<b>74</b>
	5.2.1 Membership	77
	5.2.2 Meeting Times	79
<b>5.3</b>	<b>CRITICAL PLANNING TASKS</b>	<b>79</b>
	5.3.1 Application to MidCentral DHB to form a PHO	80
	5.3.2 Maintaining a Local Planning Focus	85
	5.3.3 Ministry of Health and DHB Establishment Requirements	87
<b>5.4</b>	<b>DISTRICT HEALTH BOARD FUNDING DIVISION</b>	<b>88</b>
	5.4.1 The Horowhenua and Kere Kere Establishment Groups Combine	91
<b>5.5</b>	<b>THE DHB PRIMARY HEALTH CARE REFERENCE GROUP</b>	<b>93</b>
<b>5.6</b>	<b>BEING A PARTICIPANT OBSERVER</b>	<b>95</b>
<b>5.7</b>	<b>CONCLUDING COMMENTS</b>	<b>97</b>

---

## **CHAPTER SIX**

### **FINDINGS: PART II – THE VOICES**

<b>6.1</b>	<b>INTRODUCTION</b>	<b>99</b>
<b>6.2</b>	<b>WHY DID THE STEERING COMMITTEE MEMBERS MAKE THIS COMMITMENT?</b>	<b>101</b>
<b>6.3</b>	<b>HOW DID THE STEERING COMMITTEE GET STARTED?</b>	<b>103</b>
<b>6.4</b>	<b>WHOM DID THE STEERING COMMITTEE REPRESENT?</b>	<b>106</b>
<b>6.5</b>	<b>WHAT WAS THEIR STRATEGY FOR ACHIEVING TASKS?</b>	<b>110</b>
<b>6.6</b>	<b>WHAT CONTACTS DID THE STEERING COMMITTEE MAKE?</b>	<b>113</b>
<b>6.7</b>	<b>HOW WAS THE STEERING COMMITTEE RESOURCED?</b>	<b>116</b>
<b>6.8</b>	<b>WHAT SKILLS AND KNOWLEDGE WERE REQUIRED AND HOW WAS INFORMATION ACCESSED?</b>	<b>119</b>
<b>6.9</b>	<b>CONCLUDING COMMENTS</b>	<b>123</b>

---

## **CHAPTER SEVEN**

### **COMMUNITY PARTICIPATION: DETERMINANTS**

<b>7.1</b>	<b>INTRODUCTION</b>	<b>124</b>
<b>7.2</b>	<b>CONTEXTUAL UNIQUENESS</b>	<b>125</b>
	7.2.1 Community Infrastructure	125
	7.2.2 Grass-roots Community Participation	129
	7.2.3 Historical Influences	130
	7.2.4 Steering Committee Representation	132
<b>7.3</b>	<b>RELATIONSHIPS</b>	<b>133</b>
	7.3.1 Relationships within the Steering Committee	135
	7.3.2 MIPA's Relationship with the Steering Committee	138
	7.3.3 DHB Funding Division's Relationship with the Steering Committee	139
	7.3.4 The DHB Reference Group's Relationship with the Steering Committee	141
<b>7.4</b>	<b>THE STEERING COMMITTEE'S INFLUENCE OVER PROCESS</b>	<b>143</b>
	7.4.1 The Influence of the Grafton Consulting Group and the MIPA	143
	7.4.2 Steering Committee Self-Determination	145
<b>7.5</b>	<b>THE EXPERIENCE OF PARTICIPATING</b>	<b>147</b>
	7.5.1 Knowledge, Skill and Access to Information	147
	7.5.2 Resourcing the Project	149
	7.5.3 Community Leadership	149
<b>7.6</b>	<b>KEY DETERMINANTS OF COMMUNITY PARTICIPATION</b>	<b>152</b>
<b>7.7</b>	<b>CONCLUDING COMMENTS</b>	<b>157</b>

---

## **CHAPTER EIGHT**

<b>CONCLUSION</b>	<b>158</b>
-------------------	------------

---

<b>REFERENCES</b>	<b>164</b>
-------------------	------------

---

<b>APPENDIX A</b>	<b>Terms of Reference: - Community Health Advisory Committee. - MidCentral District Health Board Primary Health Care Reference Group.</b>	<b>179</b>
-------------------	---	------------

<b>APPENDIX B</b>	<b>Information Sheet and Consent Form</b>	<b>181</b>
-------------------	---	------------

<b>APPENDIX C</b>	<b>Template for Recording Observations</b>	<b>184</b>
<b>APPENDIX D</b>	<b>Participants</b>	<b>185</b>
<b>APPENDIX E</b>	<b>Semi-Structured Interview Questions</b>	<b>186</b>
<b>APPENDIX F</b>	<b>Ethics Approval Correspondence</b>	<b>190</b>
<b>APPENDIX G</b>	<b>Funding Arrangements</b>	<b>197</b>

## LIST OF TABLES

---

<b>Table 2.1</b>	<b>Interests in Participation</b>	<b>20</b>
<b>Table 3.1</b>	<b>Differences with the New Primary Health Care Approach</b>	<b>41</b>
<b>Table 4.1</b>	<b>Subjectivist – Objectivist Continuum</b>	<b>55</b>
<b>Table 4.2</b>	<b>Research Strategy</b>	<b>60</b>
<b>Table 4.3</b>	<b>Meetings Attended and Data Collected</b>	<b>63</b>
<b>Table 4.4</b>	<b>Realignment of Themes</b>	<b>66</b>
<b>Table 4.5</b>	<b>Researcher Participation</b>	<b>67</b>
<b>Table 5.1</b>	<b>Key Milestones – Horowhenua PHO Establishment Period</b>	<b>73</b>
<b>Table 5.2</b>	<b>Horowhenua PHO Steering Committee Representation</b>	<b>77</b>
<b>Table 5.3</b>	<b>Critical Tasks Required by the Ministry of Health and DHB for the Horowhenua PHO Establishment</b>	<b>88</b>
<b>Table 5.4</b>	<b>Funding Division Attendance at Steering Committee Meetings. Focus: Compliance</b>	<b>89</b>
<b>Table 5.5</b>	<b>Funding Division Attendance at Steering Committee Meetings. Focus: Guidance and Support</b>	<b>90</b>
<b>Table 6.1</b>	<b>Identification of Voices from Steering Committee Meetings and Interviews</b>	<b>100</b>
<b>Table 7.1</b>	<b>Approach to Analysis</b>	<b>124</b>
<b>Table 7.2</b>	<b>Significant Events Supporting PHO Self-determination</b>	<b>146</b>
<b>Table 7.3</b>	<b>Labonte’s (1997) Model of Partnership Development and Laverack’s (2004) Domains of Capacity Building</b>	<b>155</b>
<b>Table 7.4</b>	<b>Strengthening Partnerships: Knowing the Community and Facilitating Full Participation</b>	<b>156</b>

## **LIST OF FIGURES**

---

<b>Figure 2.1</b>	<b>Eight Levels of Citizen Participation</b>	<b>11</b>
<b>Figure 3.1</b>	<b>MidCentral District Health Board Region</b>	<b>44</b>
<b>Figure 4.1</b>	<b>Philosophies and Fieldwork Conduct</b>	<b>56</b>
<b>Figure 5.1</b>	<b>Horowhenua PHO Catchment Area</b>	<b>75</b>
<b>Figure 7.1</b>	<b>Steering Committee Relationships with Stakeholders</b>	<b>134</b>

## GLOSSARY AND ABBREVIATIONS

Care Plus	Service which targets high use consumers with significant chronic illnesses
HealthPac	Section of Ministry of Health whose responsibility includes processing contract payments
Iwi	Tribe
Kaumātua	Elder
Kuia	Old woman, grandmother
Māori	Indigenous people of New Zealand
Marae	Traditional Māori gathering place
Whānau	Māori customary extended family

---

AHB	Area Health Board
CBF	Capitation Based Funding
CHE	Crown Health Enterprise
CIC	Capitation Information Cleansing
CPHAC	Community & Public Health Advisory Committee
CSC	Community Services Card
DHB	District Health Board
GP	General Practitioner
HFA	Health Funding Authority
HUHC	High User Health Card
IPA	Independent Practitioners Association
LMG	Local Management Group
MIPA	Manawatu Independent Practitioners Association
NHI	National Health Index
PHC	Primary Health Care
PHO	Primary Health Organisation
RHA	Regional Health Authority
SACHSO	Special Advisory Committee on Health Services Organisation
SDG	Service Development Group
SIA	Services to Improve Access



# CHAPTER ONE

## INTRODUCTION

Over the last three decades the New Zealand public health sector has undergone continued review and change. The very nature of health service delivery ensures that it is politicised and of high public interest. Changes in health policy and strategy, health service structure, delivery configurations and changing relationships between the various stakeholders have been well documented in a number of New Zealand publications (Blank, 1994; Bloom, 2000; Davis and Ashton, 2001; Davis and Dew, 1999; Barnett and Barnett, 2005; Gauld 2001; Gauld, 2003) and has been the focus of considerable research attention. The complexities of endeavouring to provide a publicly funded health service which is affordable, accessible and addresses the inequalities in health have been the underlying focus of this policy and strategy development and research attention. The most recent reforms occurred with the passing of the New Zealand Public Health and Disability Act 2000. Among the significant policy changes articulated in the Act was the requirement of the public health service funders, District Health Boards (hereafter DHBs), and their contracted providers, to give local communities input into the planning and development of their health and disability services.

The change to an inclusive collaborative approach to planning is not unique to the health sector. Primary and secondary education in New Zealand adopted similar strategies some years previously and local governments are following a similar trend. The Local Government Act 2000 provides a similar direction for community involvement in local government planning.

The literature highlights the complexities of community participation especially in circumstances where communities are endeavouring to combine their own needs with governmental policy requirements. The literature focuses on a range of issues including the degree of autonomy in decision-making, power relationships, resourcing in terms of new knowledge and skill acquisition as well as consideration of material resources, and the dimensions of community capacity, leadership and representation.

The requirement for community participation to be embedded within future health service developments in New Zealand provided an opportunity to explore this notion and provide some explanation about the key attributes for successful and sustainable community participation. The clearly observable mechanisms for communities to participate have been in governance yet the health policy implied an expectation that the community's contribution went beyond this important role and that there be other mechanisms and opportunities for involvement which would further enhance communities' contribution to achieving the government's goals and vision for the New Zealand public health service.

I wanted to understand how this notion of community participation would develop beyond the clearly observable measures such as community representation in governance and established consultation processes. In 2001 the Minister of Health had released *The Primary Health Care Strategy* (King, 2001). This provided the vision and direction for addressing inequalities in health care. The requirement for communities to be part of local primary health care services was in line with New Zealand policy direction and some international trends in primary health care. One significant event in the history of primary health care, the Alma-Ata Declaration (World Health Organisation, 1978), continued to be a major influencing factor in primary health care strategy development. This declaration, made in the USSR at a 1978 World Health Organisation-funded international conference, identified that communities' full participation was central to achieving socially acceptable, universally accessible, affordable and sustainable primary health care services (King, 2001). The definition of primary health care developed at this conference is the definition of primary health care adopted for the New Zealand primary health care strategy. Primary Health Organisations (hereafter PHOs) were to be the organisational structure which would provide the mechanism for achieving the goals and vision of the primary health care strategy.

Twelve months after the release of the primary health care strategy, and at the time I commenced this doctoral research, PHOs were being established throughout New Zealand. This provided an excellent opportunity to further investigate the notion of community

participation and locate my data collection in a community which was embarking on the preparations for PHO establishment. As a starting point I posed the following questions:

1. What are the key elements of community engagement as determined by the literature?
2. How does a community engage in the preparations for Primary Health Organisation establishment?

I would then be in the position to ask the final question;

3. What key determinants for sustainable and meaningful community participation in the planning for, and establishment of, the Horowhenua PHO emerged from this investigation?

It was important to identify a location where there was evidence of a community commitment to be actively involved in the planning process and a commitment on the part of the DHB funder to work with this community in achieving local community goals as well as meeting the requirements for primary health care strategy implementation.

The research strategy needed to capture the array of events and processes. The point of my engagement would be the participants' reality. I concluded that the preferred strategy for achieving my research goals was to align myself as close as possible to the community participants and stakeholders for the duration of a PHO planning process. A single case study, where I was a participant observer, over an extended period of time would provide me with opportunity to gather data from an array of sources and allow the sequence of events which occurred as a result of the community's planning process to determine the pathway for my data collection. Data collected from multiple sources would provide the basis for investigating the complex notion of community participation and the key attributes which were essential for sustainable community participation for the chosen community.

Having chosen the Horowhenua, a small rural community in the lower North Island of New Zealand, as the location for data collection I set about collecting data over a nine-month period from 22 September 2003 until the last PHO Steering Committee meeting on 21 June 2004.

The thesis is presented in eight chapters. I begin with a review of selected literature in Chapter Two. Definitions of community participation are discussed along with the impact of context on the participation of communities in the planning and delivery of health services. The notion of community capacity is then presented illustrating that primary health care initiatives both provide opportunity for, and benefit from, community capacity building effort. Finally, consideration is given to process issues associated with implementing policy initiatives where communities contribute to planning and decision-making. Chapter Three provides an overview of health service reforms in New Zealand in the 25 years preceding the passing of the New Zealand Public Health and Disability Act 2000 to illustrate the varying opportunities afforded to communities to be involved in meaningful decision-making about health services during that time. The national primary health care strategy is then discussed and details how the MidCentral DHB commenced PHO planning. This chapter also provides an historical account of health service provision in the Horowhenua to ensure that readers are informed of some of the contextual issues which influenced PHO formation in this region. Justification of the research strategy and identification of the rationale for the choice of location for data collection are presented in Chapter Four. The findings are documented in two chapters. Chapter Five presents the sequence of events which occurred over the nine-month data collection period, from September 2003 until June 2004. Chapter Six presents the “Voices” of the community participants and key stakeholders. The Voices capture the rich tapestry of relationships, events, expectations, frustrations and the complex array of contextual influences which led to the establishment of initial themes. Chapter Seven presents the analysis and the determinants of community participation which emerge from the analysis. The thesis concludes with a chapter in which the contribution this research makes to developing the body of knowledge relating to community participation is discussed, along with suggestions for future research.

## CHAPTER TWO

### COMMUNITY PARTICIPATION: THE LITERATURE

The idea of citizen participation is a little like eating spinach: no one is against it in principle because it is good for you.

Arnstein, 1969, p. 216.

#### 2.1 DETERMINING THE LITERATURE TO BE REVIEWED

Crotty (1998) suggests one way of planning research is to begin with the real life issue that requires investigation by giving consideration of the issues, problems and questions. This should occur before identifying the aim and objectives of the research. It is only then that the research strategy can be planned. Stake (2005) promotes the value of case study research to advance understanding of an issue or interest.

The case still is looked at in depth, its contexts scrutinised and its ordinary activities detailed, but all because this helps us pursue an external interest. .... Here the choice of case is made to advance understanding of that other interest.

p. 445

This inductive approach was the chosen option for this research of a unique and real life issue. The analysis of context and process would illuminate the theoretical issues to be addressed. It was, therefore, important that I did not establish a theoretical position in advance of data collection – rather that I be familiar with the literature across a number of theoretical fields. The following sections in this chapter review the literature that is specifically relevant to this investigative research on the notion of community participation. The initial review of literature included an extensive cover of material on stakeholder theory. Consideration was also given to literature on accountability and volunteerism along with the various approaches to collaboration and capacity building.

The stakeholder concept emerged in the 1960s in response to recognition that the focus on business shareholders needed to extend to a variety of stakeholders without whose support an organisation would cease to exist. Jones, Wicks and Freeman (2002) propose that

stakeholder theory has two basic premises. Firstly, if managers are to perform well, they need to pay attention to the vast array of stakeholders, both within their organisation and external to it. Secondly, managers have obligations to stakeholders which go well beyond their responsibilities to shareholders. Stoney and Winstanley describe stakeholders as “Any group or individual who can affect or is affected by the achievement of the organisation’s objectives.” (2001, p.604). Much of the current literature focuses on attempts to reconcile the emerging conceptual issues associated with stakeholder theory development. Freeman’s seminal book, *Strategic Management: A Stakeholder Approach (1984)* is acknowledged as having initiated the dialogue (Davenport, 2000; Donaldson & Preston, 1995; Freeman & McVea, 2001; Rowley, 1997). The issue of corporate social responsibility, business ethics and the inclusion of stakeholder considerations in developing business strategy has a dominant presence in the literature.

Central to the debate on stakeholder theory is the underlying assumption that the relationship business entities form with stakeholders is determined by the needs of the organisation and determined largely by the individuals within the organisation. For this reason, stakeholder theory *per se* would not contribute to creating an in-depth understanding of the parameters of community participation. However, acknowledgement is made in the research of the importance of community stakeholders in the planning and development of the new Horowhenua PHO.

Accountability, like stakeholder theory, takes a position that individuals have a predetermined relationship with others. Accountability implies:

..... some actors have the right to hold other actors to a set of standards, to judge whether they have fulfilled their responsibilities in the light of these standards, and to impose sanctions if they determine that these standards have not been met.

Grant and Keohane, 2005. p. 29

Weber (1999) provides a number of conceptualisations of accountability which are determined by the type of business/organisation and roles of individuals within the entity. There is acknowledgement that power relationships which influence decision making are not equally shared. For this reason it was decided that the literature on accountability, while

having some relevance would not enhance an in-depth understanding of the notion of community participation.

Both stakeholder theory and accountability requires consideration of power relationships which are positioned within organisations. In order to fully understand the notion of community participation within the context of establishing a new health service it was important that my approach was from a grassroots community perspective.

Finally, brief comment must be made about volunteerism. The literature focuses on a range of issues: motivational determinants and styles of volunteering (Hustinx & Lammertyn, 2003; Ramirez-Valles & Brown, 2003), volunteer satisfaction (Boraas, 2003, Green & Chalip, 2003) paths of volunteer commitment (Berridge, 2003) and volunteer and paid staff relationships (Netting, Nelson, Borders & Huber, 2004). There were clearly issues in this research relating to community representatives giving of their time and personal resources to the project. However, as the data collection progressed, contextual and infrastructural influences that emerged provided the opportunity to address the issues of “volunteer input”. As the research aims related to the notion of community participation, rather than the effect of community participation on community representatives the challenges and opportunities accorded to community participants were addressed within the context of capacity building, collaboration and participation.

The literature relating to collaboration, consultation, empowerment and partnership has been incorporated into sections on community participation and building capacity.

## **2.2 COMMUNITY PARTICIPATION**

The term *community* has a multitude of interpretations; its usage over time has become so persuasive that its meaning is overlaid with a vast range of associations (Hawtin, Hughes & Percy-Smith, 1994). Howe (1994) provides a summary of approaches to defining a community. She firstly describes community using a demographic approach where characteristics of the population, such as gender and age, are central to the definition. Her second approach is geographically determined where actual locations or specific settings

are identified. Illustrations used by Hawe include workplaces, schools and hospitals - but could also include the actual physical boundaries of a particular community (rivers, mountains, local government boundaries). The third approach she presents is the commonly used community development or issues approach which describes a community as a social system, having a “.... capacity to work towards solutions to its own community identified problems.” (ibid, p. 201). Gilchrist (2004) takes a similar approach and uses relationships and networks as the basis for identifying a community. She argues that the informal networks that exist between individuals, groups and organisations which are integral to people’s lives are central to the meaning of community. The community development model, she proposes, plays a central role in assisting people to connect with one another so as to empower individuals and groups to overcome or renegotiate obstacles which prevent them from communicating and working together. Communities are “actively constructed by their members” (ibid., p.2). Barnes (1997) proposes that while the definition of community in terms of location has been the most common usage of the term in the past, she, like Gilchrist (2004), presents a definition based on identity of people who share significant characteristics and experiences, adding that this better reflects the plurality of contemporary society. Rifkin, Muller, and Bichmann (1988) would concur. They use the community development definition of community to focus on specific populations and “at risk” groups such as the poor.

This definition is rooted in the epidemiological view of community. In PHC [primary health care], in terms of equity, effectiveness and efficiency, groups of people need to be identified so that resources can be allocated to the greatest effect. It is therefore important to take into account this aspect of health concerns in seeking a realistic definition.

ibid., p. 933

Barnes (1997) acknowledges the way in which local authority boundaries define responsibilities of local health and other social service organisations and reinforces a locality definition. In the Horowhenua, the boundaries for the PHO are determined on this basis. Interestingly, local iwi, as a “community of identity” are not confined to geographical boundaries and therefore do not fit into the PHO geographically determined community.

Wood and Judikis (2002) identify essential process elements of a community to include a sense of common purpose or interest, an acknowledgement of interconnectedness, respect for individual differences and a commitment to the well-being of members of the community. “Communities are stronger when individual members with diverse strengths and talents share in the community vision, purpose, interests and intended outcomes.” (ibid., p.15). Wood and Judikis identify five different categories of community; nuclear (for example, family), tribal (racial, gender or social class), geopolitical (defined by geographic boundaries), life (contacts across a lifetime) and collaborative communities. A collaborative community exists to serve a specific purpose or address an identified need. This all-encompassing approach to describing communities fits well with the parameters of “community” identified in this research. There are a number of quite diverse communities all working towards achievement of the same goal - that is - PHO establishment in the Horowhenua. Process considerations therefore need to include shared goals, vested interests, preferred ways of doing, power relationships and capturing the benefits of diversity.

Laverack (2004) acknowledges that there is considerable overlap between community participation, community development, community empowerment and community capacity building. *Participation*, like *community*, has a wide range of meanings. Labonte (1997) describes participation as the attempt to bring together different stakeholders for the purposes of problem-solving and decision-making. Rifkin et al. (1988) provide an expanded definition, incorporating a notion of community and the social processes which contribute to determining and addressing need:

Community participation is a social process whereby specific groups with shared needs living in a defined geographic area actively pursue identification of their needs, take decisions and establish mechanisms to meet these needs.

p. 933

Campbell and Jochelovitch (2000) agree that it is the *process* of participation that allows social representation to be expressed, reaffirmed and renegotiated, and provides a platform for dialogue between different representations. Morgan (2001) presents a number of approaches to participation. The utilitarian approach sees external agencies inviting

communities to participate in a pre-determined project. This approach would be aligned with people's understanding of the notion of consultation. While Morgan argues that this approach is often used to off-set costs, Irvin and Stansbury (2004) hold the view that this participatory approach can be more expensive than decisions made by a single agency, even if the participants' time costs are ignored. The second approach identified by Morgan (2001) is that of empowerment. Empowering local communities and creating social change to improve health outcomes and reduce inequalities are central to this approach. Interestingly, the Minister of Health, in presenting the New Zealand Primary Health Care Strategy (2001) emphasised the importance of communities having a voice in the planning and delivery of services thus ensuring increased involvement with influencing health inequalities and access issues. This is supportive of an empowerment approach to participation. On the other hand, the Ministry of Health, in determining the *process* for strategy implementation posed a number of requirements and milestones which necessitated a prescriptive approach to managing PHO implementation. Guareschi and Jovchelovitch sum it up: "In real settings participation is messy, takes time and escapes neat definitions." (2004, p, 313).

Labonte (1997) places emphasis on the importance of relationships in underpinning participation. Participation is a process "that continuously changes and unfolds as individual actors (and their varying group or organizational constituencies) negotiate the terms of their relationships." (p. 43). An added dimension is one of commitment and responsibility across the spectrum from needs identification through to evaluation of established health services. Zakus and Lysack propose that participation is:

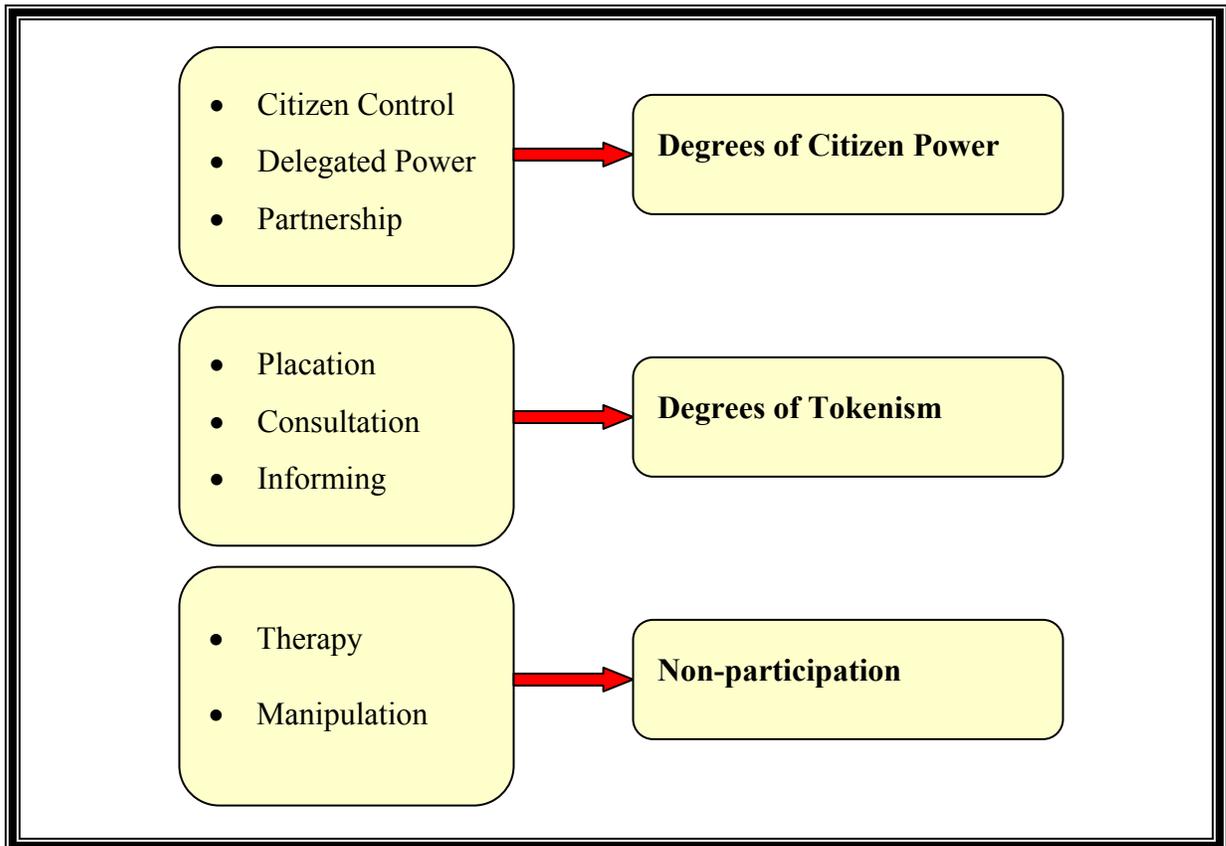
...the process by which members of the community, either individually or collectively and with varying degrees of commitment: (a) develop the capacity to assume greater responsibility for assessing their health needs and problems; (b) plan and then act to implement their solutions; (c) create and maintain organizations in support of these efforts; and (d) evaluate the effects and bring about the necessary adjustments in goals and programmes on an on-going basis.

1998. p. 2.

Rifkin et al. (1988) take a similar approach by identifying the factors which contribute to effective participation as being needs assessment, leadership, organisation, resource

mobilisation and management. Rifkin et al. suggest that these factors (with the exception of the last) present themselves at different places on a continuum: extending from wide to narrow participation depending on the nature of the project. This approach, they propose, provides opportunity to examine process rather than just the impact of community participation.

Arnstein’s (1969) “Ladder of Citizen Participation” has withstood the years of academic debate and discussion and continues to be a frequently cited typology of citizen participation (Harrison, Dowswell & Milewa, 2002; Laverack, 2001; Milewa, Valentine & Calan, 1999; Neuwelt & Crampton, 2005; Wandersman & Florin, 2000).



Modified from: Arnstein, 1969, p. 217

Figure 2.1: Eight Levels of Citizen Participation

*Citizen control* describes situations where community organisations have total and direct control, while *delegated power* occurs when citizens have majority representation in decision-making processes. *Partnerships* imply that citizens do not necessarily hold the

majority, however, there is real negotiation and direct accountability to the communities they serve. Labonte (1997) provides a similar continuum. Participation occurs when there is shared decision-making authority, full stakeholder identification and an allocation of resources for participation. Stakeholder accountability is to the group which the participants represent. *Involvement*, he proposes, describes situations when the terms of engagement are determined by the agency sponsor and the community structure is largely advisory, while *consultation* occurs when information is sought from the community but there are no structures for ongoing engagement.

Wandersman and Florin (1999) pose the question of why people choose to participate, and conclude that doing one's duty and acting on a sense of responsibility could be motivators for such involvement rather than self-interest and personal gain. Lindsey, Stajduhar, and McGuinness (2001) view community participation as a philosophical orientation of engagement rather than as a method which communities are required to adhere to: "... when people are given opportunity to work out their own problems, they find solutions that have a more lasting effect than when they are not involved in such problem solving." (p. 829). Campbell and Jovchelovitch (2000) argue that it cannot be assumed that communities will participate in a similar way, and challenge the assumption that grassroots participation is central to the construction of communities and improved health outcomes. Labonte (1997) warns against confusing participation with other forms of relationships between governments, institutions and communities. He proposes that there is considerable evidence of tokenism in programme development and policy work where communities are involved but have no authority. He contests that invariably in these situations decision-making occurs within clearly determined parameters and rarely includes substantial control over economic resources. There is an assumption that meaningful participation is not achievable if individuals or groups do not share a common power base. Research which informs and develops mechanisms which enable community participation within the context of individuals experiencing varied positions of power has not been reported.

### 2.3 COMMUNITY PARTICIPATION AND CONTEXT

Campbell and Jovchlovitch (2000) highlight the influence of context in producing knowledge, expertise and determining practices. They propose that shared views which emerge from collective activity organise and guide the relationship communities have amongst themselves and with others. “These knowledges are never detached from the concrete social and historical contexts from which they emerge.” (p. 265). They also include cultural and material conditions as influencers of local knowledge. The authors do, however, offer a word of caution. While it is important to recognise this local knowledge care must be taken to ensure they are not idealised. Another consideration, as Rifkin (1990) points out, is that of leadership which she proposes is historically and culturally determined: “If these patterns are not recognized or are deliberately or unwittingly ignored, experience suggests that programmes have little chance of being accepted or utilized at any level in the community.” (p. 29). In her experience, successful health service programmes, where communities have participated, have had the support of local leaders.

Simpson, Wood, and Daws (2003) pay attention to the effect on community of having new projects imposed by funding bodies where there is the expectation for the community to participate in the establishment of a new initiative. They argue that there needs to be careful consideration of the short- and long-term impacts that may result for a community and the impact of a new project on existing social networks. Any new initiative, they propose, has the potential to place demand on a share of already limited stocks of time and energy, and the resulting impact may be that the community’s social infrastructure may shift as individuals are forced to make choices about where to direct their energies.

If insufficient account is taken of the complex inter-relationships that already exist in the community, community development projects can create a dislocation in local networks and place pressure on finite individual and community resources such as money, time, energy, by assuming them to be constantly renewable. Community capacity can be depleted rather than fostered, as the community holds itself responsible for failure.

The challenge for government is how to enable processes of capacity building, participation and community ownership without creating unreasonable pressures on time, personal energy and finances of residents of rural communities.

ibid., p. 284.

Simpson et al. (2003) add that failure to give consideration to the impact of such initiatives on the community can result in “..... rifts that go beyond the boundaries of a particular project and affect the self-image and future viability of the community.” (p. 283).

Empowering communities takes considerable time (Laverack & Labonte, 2000), and may not even occur until well after the completion of a health programme. Rappaport (1987) argues that the historical context is an important influence on the outcomes of a programme. He maintains that there is a need to understand the prevailing conditions “before the beginning” and “after the end” of a project (p. 140).

## **2.4 BUILDING COMMUNITY CAPACITY**

Capacity building, like community development, community empowerment and social cohesion, has been used with varied meanings (Labonte & Laverack, 2001). Labonte (1999) describes the dimensions of community capacity to include: “... skills and knowledge, leadership, a sense of efficacy, norms of trust and reciprocity, social networks and a culture of openness and learning ...” (p. 430). Laverack (2004) identified nine organisational areas which influence community capacity. He proposes that capacity building is not only the means to the end of increasing sustainability, but also that the programme activities become a means for growing community capacity. The operational domains - participation, leadership, organisational structures, problem assessment, ‘asking why’, resource mobilisation, links with others, the role of outside agents and programme management - represent aspects of community empowerment that allow individuals and groups to organise themselves towards social change. Central to empowering communities to participate is the establishment of relationships between stakeholders.

The nine organisational domains which influence community participation (Laverack, 2004) do not address issues associated with stakeholder power relationships. Power is closely associated with participation (Ansari, Phillips, & Hammick, 2001; Campbell & Jovchelovitch, 2000). Laverack (2004) supports the view that the Alma-Ata Declaration (World Health Organisation, 1978) has helped define the “new” health promotion by allowing people to increase control and determine the preferred strategy for improving their

health. Community development strategies, he proposes, are based on collaboration and proceed from the formation of partnerships.

Labonte (1997, p. 100-104) presents the notion of partnership as essential for empowering communities. He describes partnerships as beginning when an issue or problem is to be addressed and for which, without a partnership, there is insufficient knowledge, resource or power to address the issues. The components which he presents for partnership development are:

- creating a Partnership vision which includes determining the roles of the partners,
- defining the shared mutual goal,
- identifying the partners,
- managing the context,
- managing the process which includes decision-making processes, commitments from group members and managing power relationships,
- making time and resource commitments,
- empowering full participation,
- evaluating from the start,
- building in sustainability.

Laverack (2004) supports the notion of “partnerships” and proposes that:

Partnerships demonstrate the ability of a community to develop relationships with different groups and organizations based on recognition of overlapping or mutual interests, and interpersonal and inter-organizational respect. Partnerships also demonstrate the ability to network, collaborate, co-operate and to develop relationships that promote heightened inter-dependency amongst its members.

p. 95

Laverack and Wallerstein’s (2001) position reinforces this argument by proposing that empowering and participatory approaches:

... redefine the role relationship between the secondary and primary stakeholders. The role of the outside agent has been traditionally viewed as one of ‘expert’ or ‘professional’ or as an evaluator ...

p. 183

They propose that this role changes to one of facilitating and enabling within an empowering and participatory approach (ibid.). Laverack and Labonte (2000) concur,

acknowledging that empowering a community takes time and may in fact not occur before the completion of a particular project.

#### **2.4.1 Primary Health Care and Community Development**

There has been abundant literature examining the roles, complexities and obstacles of participatory processes in reducing health inequalities and improving the health status of the disadvantaged populations (Campbell & Jovchelovitch, 2000). The World Health Organisation's commitment to improving the health of all people has had a major influence in the way in which nations have engaged communities in the planning and development of primary health care services (Starfield, 1998).

In 1977 the World Health Assembly declared the main social target for member countries as being "... the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life" (subsequently commonly referred to as "*Health for All by the Year 2000*") (World Health Organisation, 1978) The sequence of events following this declaration brought into focus the notion of primary health care as a means for achieving this goal. At the first international conference on primary health care held in Alma-Ata, USSR, primary health care was defined as:

...essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community, through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in a spirit of self-reliance and self-determination.

ibid., p.3

The Alma-Ata Declaration set the stage for community participation in health service planning and development to be an integral component of policy development (Neuwelt & Crampton, 2005). The five principles of primary health care derived from this definition included essential health care needs, acceptable and appropriate methods and technology, accessibility, full client participation and intersectoral collaboration (WHO, 1978). "Primary health care occurs when all principles are implemented simultaneously." (MacIntosh & McCormack, 2001, p.548). Lindsey et al (2001) identify the four approaches

to achieving these principles as citizen action, voluntary participation which is collaborative and focused on problem solving, empowerment and a focus on achieving holistic, community wide outcomes. The resulting cooperative community identity, they argue, is more likely to result in equitable power relationships, thus a sense of individual and community empowerment. Milewa, Dawswell and Harrison, (2002) stress the added benefit of all parties working together thus providing the opportunity for new relationships and partnerships to challenge and modify established networks and structures. Gilchrist (2004) describes the three traditions of community development. The first is the informal self-help and solidarity groups which characterise small-scale social organisations. The second is the more organised form of mutual aid, where formal arrangements are made to share resources across specific groups. The third tradition is the voluntary or philanthropic services which target specific groups which are considered “less fortunate”. At various periods throughout history community development has been strongly influenced by more radical models which saw community activism attempt to address issues associated with the class struggle, poverty and alienation.

Neuwelt and Crampton (2005) point out that while the Alma-Ata Declaration has been widely quoted in health literature, the application of its principles internationally has been patchy and slow:

Twenty-five years later, the language of the declaration has made its way into New Zealand health policy, but how the language of community participation will translate into practice remains unclear.

p. 196

Within the context of the formulation of the most recent primary health care strategy in New Zealand the requirement for primary health care to be universally accessible, and requiring communities to participate has been central to policy formulation.

Evidence from a review of overseas and New Zealand literature is that community-based intersectoral initiatives are effective in achieving health and other welfare objectives, and that they appear to have worked well for disadvantaged population groups also. Local solutions emerge in response to the community’s interest in addressing a particular issue. They do, however, require support at all levels.

Ministry of Health, 2002, p. 3

Investigation of how community participation translates into practice in the New Zealand context is central to this research.

Laverack and Labonte (2000) take the position that the bureaucratic response to realising the Ottawa Charter<sup>1</sup> has contributed to one of the major tensions in health promotion today:

...many health promoters continue to exert power over the community through 'top-down' programmes whilst at the same time using the emancipatory discourse of the Ottawa Charter. This tension between discourse and practice continues because there has been little clarification of how to make the concept of empowerment operational in the more conventional, or top-down, programme context within which many health promoters still work.

p. 255

The problem of disparities in power and control as they relate to community participation are well articulated, however, apart from emerging models of partnership and capacity building, there is a need to enhance understanding of practical mechanisms which would enable meaningful community participation across different power structures. Labonte (1997, p. 45) challenges readers to “*bury the myth of community self-sufficiency*” where a community group is able to function fully independent from others. He proposes that partnerships and intersectoral cooperation should lead to the fostering of equitable and effective interdependencies rather than promote autonomy.

## **2.5 COMMUNITY PARTICIPATION: ISSUES FOR POLICY IMPLEMENTATION**

Arguments in support of involving communities in the implementation of new policy are universally supported as one means for improving health and health care delivery (Guareschi & Jovchelovitch, 2004). Proponents support the belief that communities involved in the implementation of policy initiatives are more likely to embrace change, there will be improved acceptance of strategy expectations placed on communities by external agencies, participation will more likely produce better decisions and communities

---

<sup>1</sup> The 1986 World Health Organisation Ottawa Charter for health promotion identified a number of conditions essential for improvement of health. These include education, shelter, food, income, sustainable resources, social justice and equity. This Charter expanded the outcomes of health promotion beyond the absence of disease or healthy lifestyles (Laverack, 2004).

will have a better appreciation of issues and rationale for change (Arnstein, 1969; Beierle, 1999; Box, 1998; Irvin & Stansbury, 2004; King, Feltey & O'Neill Susel, 1998; Oldfield, 1990; Stivers, 1990). Irvin and Stansbury (2004) highlight an important long term benefit. This is the opportunity accorded to community participants and agency personnel alike to learn from and inform one another. They propose that policies are more likely to be grounded in citizens' preferences and the public are more likely to become sympathetic to tough agency decisions if participation is seen to be genuine. In addition, if citizens have regular contact with agency decision makers they may act as advocates for government policy positions in their communities and government agencies can obtain important support for change which may otherwise be challenged if imposed unilaterally. In support of this King and Stivers (1998) propose that improved participation can strengthen trust between bureaucrats and communities. The overall benefit could see participation as a transformative tool for social change (Nelson & Wright, 1995).

Engaging communities in decision-making is not without its challenges and risks. Irvin and Stansbury (2004) identify disadvantages to include the time consuming nature of the process and the risk of such opportunities having a de-motivating effect on participants if community input is ignored. The potential for decisions to be heavily influenced by opposing interest groups is also highlighted as a potential negative outcome along with the possibility of losing decision-making control and having no alternative but to accept what the agency consider to be a less favourable outcome (ibid.).

Thomas (1995) takes a more pragmatic view to the benefits of community participation. He proposes that a key desired outcome for agency staff is to seek a more co-operative, compliant public. Pretty (1995) concurs:

The term "participation" has been used to justify the extension of control of the state as well as to build local capacity and self reliance: it has been used to justify external decisions as well as to devolve power and decision-making away from external agencies; ...

p.1252

White (1996) places these issues within the political context. She suggests that participation is political and proposes that the “non-politics” must be addressed. She presents three steps in this process. The first is to agree that participation is in fact a political process where there will always be tensions relating to who is involved, how and on whose terms. The second step is to analyse the interests represented in the participatory process. To assist she presents a framework which extends beyond the *who* and *level* of participation to the *interests* of participation.

Table 2.1 Interests in Participation

<b>Form</b>	<b>Top-Down<sup>2</sup></b>	<b>Bottom-Up<sup>3</sup></b>	<b>Function</b>
Nominal	Legitimation	Inclusion	Display
Instrumental	Efficiency	Cost	Means
Representative	Sustainability	Leverage	Voice
Transformative	Empowerment	Empowerment	Means / Ends

From: White, 1996, p.7

White states that while participation “... has the potential to challenge patterns of dominance [it] may also be the means through which existing power relations are entrenched and reproduced.” (ibid., p.14). The final step recommended by White is acknowledgement that participation and non-participation, while always reflecting interests, may not do so in an open arena.

Both people’s perception of their interests and their judgement as to whether they can express them, reflect power relationships. People’s non-participation, or participation on other people’s terms, can ultimately reproduce their subordination.  
 ibid., p. 15.

<sup>2</sup> Interests of those who design & implement programmes - agency

<sup>3</sup> Interests of community participants

## 2.6 CONCLUDING COMMENTS

The literature, while reflecting a range of approaches to defining *community* and *participation*, has an implied agreement that it is a complex construct influenced by many factors including context, relationships and power issues. Over time definitions of community have moved from an emphasis on tangible aspects such as geographical location and ethnicity to consideration of the more dynamic and complex interrelationships, networks, process elements and diversity. One common theme emerging from the literature on participation is the importance of power sharing for sustainability. Debate is continuing about the degree of success being experienced internationally in operationalising the emancipatory discourse of the WHO declarations.

A number of frameworks to facilitate community engagement have been presented in this chapter representing different approaches to managing structural issues, imbalances of power, skill acquisition and interdependencies. The reality of implementing policy which requires communities to be meaningfully engaged also has risks. Careful consideration of these risks, the literature suggests, will ensure the likelihood of disempowerment, project failure, conflict and disillusionment be minimised.

In Chapter Three an overview of the New Zealand health reforms for the twenty-five year period immediately preceding the passing of the New Zealand Public Health and Disability Act 2000 is presented, highlighting the fluctuations in opportunity for New Zealanders to contribute in a meaningful way to the planning and implementation of health services. The New Zealand primary health care strategy is then presented followed by an overview of strategy implementation in the MidCentral DHB region.

## **CHAPTER THREE**

### **NEW ZEALAND HEALTH SERVICES: SETTING THE CONTEXT**

#### **3.1 INTRODUCTION**

As in most developed countries the health service in New Zealand has been subject to major restructuring over time (Davis & Ashton, 2001; Gauld, 2001). This chapter provides an overview of the sequence of events over the twenty-five-year period immediately prior to the health reforms which took place following the passing of the New Zealand Public Health and Disability Act 2000. Particular attention has been given to how successive restructurings impacted on the opportunities for “community” to contribute to the planning, and delivery of health services and the changes that occurred to primary health care services over this period. This will set the context for further expansion of the current primary health care strategy and how the MidCentral DHB approached its implementation. The chapter concludes with an overview of the historical events in the Horowhenua region.

#### **3.2 REPORTS AND REVIEWS: 1975 TO THE 1980s**

From the mid-1970s the health sector was subject to successive reviews, each concluding that there was a need for change (Barnett & Barnett, 2005). *The White Paper; A Health Service for New Zealand* (McGuigan, 1975) - the first of these reviews - heralded an important milestone in the development of health policy in New Zealand (Martin & Salmond, 2001). In this Paper integration of services was sought. A focus on preventative medicine and the establishment of a system in which access to health care was determined by need rather than ability to pay was proposed (Gauld, 2001). This plan included the establishment of a Health Authority to replace the Department of Health, with responsibility for planning strategy and setting national priorities and targets. The Health Authority’s role in planning strategy and setting national priorities brought with it new accountabilities to the Ministry of Health. For the first time the Crown required that health service performance be monitored and evaluated. Fourteen regional health authorities, with a mix of elected and appointed board members, would have a broader function than hospital boards and be required to undertake operational planning to ensure the national

policies were implemented to best meet the needs of the population in the region. Coordination from primary through to tertiary care was to be strengthened (ibid.).

While the plan for decentralisation and improved coordination across the continuum of services was seen as desirable, the proposed reforms antagonised a number of key supporters, particularly the medical profession, hospital boards, private hospitals and the voluntary sector. (Bassett, 1976; Gauld, 2001; Martin & Salmond, 2001; Raffel, 1976). The assumptions underpinning the White Paper emulated from the fundamental principle of the State's responsibility to provide free health care to all people of New Zealand (Brunton, 2000). Particularly unpalatable for general practitioners was the contentious issue of replacing general practitioner (hereafter GP) fees-for-services with capitation funding arrangements. Stakeholders across the health sector believed that the Department of Health was, through the proposed planning process, attempting to dominate the policy-making activity thus increasing centralist control (Bassett, 1976; Gauld, 2001; Raffel, 1976).

As Gauld, (2001) concludes:

The White Paper provides an interesting case study in health policy-making per se. It demonstrated that policy is not just about producing plans, it is as much about gaining support for those plans and the momentum to see them put in place. This support must come from the health sector, the general public and from within government itself .....

p. 34

Raffel (1976) places emphasis on the influence of stakeholder perceptions and historical events on stakeholders' readiness to embrace change:

Pervading the analysis of the White Paper, however, was a deep-seated suspicion of the Department of Health, a suspicion born of the language and attitudes in the White Paper viewed in the light of the Department's historical image as an authoritarian agency which subjects subordinate units and voluntary groups to arbitrary decisions and interminable delays. The current leadership in the Department must – whether it likes it or not – live with the burden of this interpretation of its past behaviour.

p. 17

Brunton (2000) describes the White Paper as a political disaster, having been written for health workers rather than the public – a tactical error in his view. It failed to address issues of service fragmentation, mal-distribution of general practitioners and access to services (ibid.). The subsequent response by stakeholders to the White Paper was a contributing factor to the demise of the Labour Government (Brunton, 2000; Gauld, 2001). The recommendations were not implemented, however subsequent reforms, as illustrated later in this chapter, had some resemblance to those contained in the 1975 White Paper.

### **3.3 THE EMERGENCE OF COLLABORATIVE PLANNING: THE AREA HEALTH BOARD ERA**

With the lessons learnt from the preceding Labour government the newly elected National Government adopted a consultative approach, particularly with the medical profession. The government set in place a process which gave opportunity for the sector to have meaningful input into policy formulation.

#### **3.3.1 The Special Advisory Committee on Health Services Organisation**

The Special Advisory Committee on Health Services Organisation (hereafter SACHSO) was established with the task of reporting to the Minister of Health on the preferred options for the future organisation of the health sector. While the recommended overall structure of the health services resembled those in the 1975 White Paper, the planned process for implementation clearly illustrated that consideration had been given to the shortcomings of previous attempts (Gauld, 2001). Consultation was emphasised as an integral component of the planning. Service Development Groups (hereafter SDGs), made up of key health professional and service delivery groups from public, private and voluntary sectors were established. Fourteen Area Health Boards (hereafter AHBs) were proposed, amalgamating hospital boards and the Department of Health's district offices. Rather than implement changes nation-wide, Wellington and Northland regions were to be piloted as AHBs before consideration would be given to further implementation.

The SACHSO recommended that while AHBs should oversee a range of services, they need not necessarily provide them all but should rather be “...the machinery for co-ordination ...” (Department of Health, 1982, p. 8)

The SACHSO’s recommendations identified the change in direction and included:

- 1 *A transparent, open and inclusive approach to policy development and organisational change.* The process required that plans for transition to an AHB from a hospital/district office structure had to be drawn up by parties directly involved. For the first time private and voluntary sectors and the community were to share in the planning processes for the regions. Government’s requirements included guidelines for health board membership and consultation expectations.
- 2 *A vibrant public, private and voluntary sector working in cooperation.* Central to the AHB concept was their co-ordinating function where boards were to work with voluntary organisations, the private sector and all public authorities to plan services to meet the identified needs. SDGs were to be the means for identifying community need through consulting with community groups and District Health Committees<sup>4</sup>. The legislation included provision for ensuring that AHBs were active in supporting voluntary organisations, and that these, in turn, co-operated and actively contributed to the planning and maintenance of health services in their respective regions. The SACHSO recognised the real advantage of a strong voluntary and private sector presence and acknowledged that they added a “richness” to the service mix. This, they argued, positively reflected the complex diversity of the communities they served (Dow, 1995).
- 3 *Decentralisation and Integration:* One of the key recommendations of the SACHSO proposal was the need for priorities to be set at the local level. It

---

<sup>4</sup> District Health Committees, made up of community representatives, provided input to AHBs on local service needs.

was argued that eliminating duplication of services and better integration between primary and secondary services would clearly be of benefit to the consumers of AHB services.

- 4 *Strengthened Consumer Focus*: The very nature of the planning process required that input be sought from consumers and the community. District Health Committees, made mandatory in the legislation, guaranteed the community a voice in the identification of priorities.
- 5 *Population-based Funding Formula*: The remnants of the historical arrangements of funding based on previous financial years' expenditure was finally addressed. This capitation formula sought to allocate and control funds using formulae which reflected the size of the population served with weightings for age, sex, ethnic mix and other criteria. This, it was hoped, would also provide some incentive to shift the focus of health priority from hospital-based services to preventative and health promotion activities (Gauld, 2001).

In 1981 the Minister of Health received reports on the pilots from the Northland and Wellington Health Services Advisory Committees. It was not until 1983 that the Area Health Boards Act was passed and even then, in keeping with the agreed inclusive and consultative approach to change, formation of AHBs was not mandatory. The reluctance of some of the smaller boards to amalgamate slowed the transition process.

A Labour Government was re-elected in 1984 and chose to continue with the AHB concept. During this time positive improvements in data gathering, analysis and sharing of information were noted along with improved networking and consultation amongst stakeholders (Martin & Salmond, 2001). However, soon after the Labour Government took office in 1984 Ministers "became impatient with the accepted consultative and incremental approach to health sector decision-making." (ibid., p.47). Barriers to access remained, health status continued to deteriorate, and spending in hospital services continued to increase (Scott, Fougere, & Marwick, 1986). Issues associated with efficiency, equity and

accountability remained and the new political environment signalled a future where ongoing consultation with both internal and external stakeholders was uncertain (ibid.). New Zealand's public sector was about to undergo considerable structural, organisational and management change. There was a liberalisation of the markets, privatisation of state entities, substantial cuts to various government programmes, and a much sharper focus on accountability and performance outcomes (Boston, 1987; Davis & Ashton, 2000; Gauld, 2001).

The World Health Organisation launched its *Healthy Cities*<sup>5</sup> programme in 1986. This approach acknowledged that people's health was affected by their environment as well as by the quality of health care services (Randle & Hutt, 1997). The first Healthy Cities and Healthy Communities programme was established in New Zealand in 1988 and received varying levels of support from government agencies, local government and the health sector (ibid.). This was an example of the promotion of intersectoral cooperation along with community involvement in an effort to influence improved health status. The full potential of this initiative in strengthening intersectoral cooperation and community capability was not fully realised. The quasi-market era was to impact dramatically on opportunity for community-driven innovation.

### **3.4 PREPARATIONS FOR THE QUASI-MARKET ERA**

Two reviews were conducted, signalling a potential change in direction. The first was the *Choices for Health Care; Report of the Health Benefits Review* (Scott et al., 1986) in 1986, followed by *Unshackling the Hospitals - The Hospital and Related Services Taskforce* (Gibbs, Fraser, & Scott) in 1988.

---

<sup>5</sup> The World Health Organisation Healthy Cities programme engaged local governments in health development through a process of community capacity building and policy development which focused on, for example, health inequalities and poverty.

### **3.4.1 The Health Benefits Review – 1986**

The Review Team had the tasks of reporting on the State's role in the delivery of health care and to recommending broad principles and direction for reform (Scott et al., 1986). A number of issues were addressed. These included the continuing rising costs of health care, the lack of improvement in health status of populations, the ongoing strengthening of the “power bases” within various health professional groups (especially the medical profession), rising consumer expectations and the lack of useful information generated by, and for, health services to assist with future planning (ibid.).

The reviewers invited submissions and engaged in extensive consultation resulting in a report that facilitated new thinking about how the health sector might be organised (Davis & Ashton, 2000). The Report used the concepts equity and efficiency to analyse how the roles and performances of funders and providers might be enhanced. The discussion about the distribution of primary health services highlighted the mal-distribution of general practitioner services and the barriers to access.

The Report offered five options, each reflecting different points on a continuum of state involvement. The preferred option was that the state should continue to be the major funder, but the report acknowledged that a reduction in its provider role may enhance equity and efficiency. A mix of state-provided services and contracting was seen as preferable, illustrating that competition and cooperation could co-exist.

A year later the government commissioned a second independent review. *Unshackling the Hospitals - The Hospital and Related Services Taskforce* was to develop proposals for the overall structure of services provided by hospital boards.

### **3.4.2 Report of the Hospital and Related Services Taskforce - 1988**

*Unshackling the Hospitals – Report of the Hospital and Related Services Taskforce* (Gibbs et al., 1988), frequently referred to as “The Gibbs Report” focused further on the funder-provider split in the provision of health services and competition between providers. The

Report recommended that regional health authorities be established as purchasers, AHBs be retained as providers of health care, and modified competition be introduced between hospitals. As with the majority of reviews previously published, the Gibbs Report did not result in immediate change to health service delivery, but clearly set the scene for the reforms of the 1990s.

In the same year the newly appointed Minister of Health, David Caygill, published Labour's proposals for reforming the health services; *Health: A Prescription for Change* (1988). Of significance was that AHBs were to become responsible for the provision and funding of primary health care. Before the changes were implemented, Helen Clark was appointed Minister of Health and soon after published *A New Relationship: Introducing the New Interface Between Government and the Public Sector* (1989). The State Sector Act 1988 and the Public Finance Act 1989 required that chairpersons of the boards were accountable to the Minister for the boards' outputs, signalling a new accountability and transparency for health sector governance. This was to resemble proposals put forward in the 1975 White Paper. In addition, the Minister of Health defined goals and targets for the next ten years that were designed to improve the health status of all New Zealanders (Department of Health, 1989).

These two reports signalled the beginning of an era where independent external reviewers and consultants became integral to health policy and planning. While both reports were commissioned by the Labour Government, they provided a platform for the incoming National Government from which to prepare for further reform. As Blank (1994) concluded, changes in government create opportunities for "rapid and comprehensive shifts in policy." (p. 132). Another major restructuring was about to occur.

### **3.5 CROWN HEALTH ENTERPRISES: THE QUASI-MARKET ERA**

The National Government's health policy *Your Health and the Public Health* (Upton), popularly referred to as the Green and White Paper, was released on 1 July 1991 as part of the Government's annual budget. The prime objective for these reforms was the desire to control and curtail health expenditure and improve operational efficiency (Gauld, 2001;

Poutasi, 2000; Salmond, Mooney & Laugesen, 1994; Somjen, 2000, Treasury, 2000). “Dissatisfied with previous incremental efforts to improve the performances of the health sector, they chose to jolt the system into a fundamentally different mode of operation.” (Salmond, et al., 1994, p. 2). Other contributing factors for this change included deterioration of hospital buildings, ageing equipment, the politicisation of decision-making processes, disease prevention and health promotion programmes falling victim to cost-saving measures, long waiting times, fragmented funding arrangements and problems of access to services, especially for low income families (Upton, 1991). In addition to these drivers was the motivation to increase individual responsibility for health:

The basic goal of the Government’s health policy is to ensure that everyone has access to an acceptable level of health services on fair terms. It is likely that the Government will continue to be principal funder of health services. Therefore, it has a continuing direct interest in ensuring that individuals’ responsibility for their own health is recognised and fostered.

Upton, 1991. p. 137

The plans for these reforms were closely aligned to the recommendations made in the Gibbs Report (Gibbs, 1988) where it was proposed, over time, that the new structure would give society (and individual users) “greater control of its [health service] evolution.” (ibid., p. 27)

To achieve the desired changes as they were relevant to primary health care and involving communities the Government proposed to:

➤ *Intergrate funding for primary and secondary care services.*

Regional Health Authorities (hereafter RHAs) would have responsibility for funding total health services for their populations, thus encouraging improved integration for the management of primary and secondary services. Individual consumers of health services would have the choice of taking their entitlement for total health care to alternative providers. According to Upton (1991), alternative Health Care Plans would allow consumers “the ultimate sanction against RHAs which fail to respond to their concerns: the ability to take their custom elsewhere.” (ibid., p. 62). This would have a twofold effect. Firstly it would “cap” the annual allocation of individual health service expenditure and secondly it would give

individuals choice and by its very nature encourage increased self-responsibility and careful decision-making about which services best served their needs. It would also provide another mechanism for competition between providers of health services. The Health Care Plan concept did not eventuate and so the RHAs' accountability to consumers within a competitive purchasing environment was not tested.

- *Separate the Funder, Purchaser and Provider.* This was to be the separation of the funder (Minister of Health), purchasers (four Regional Health Authorities) and providers (23 Crown Health Enterprises). Key to this change was the positioning of the Regional Health Authorities (hereafter RHAs) between the government and the provider of services. RHAs were charged with addressing the needs of the communities they served, yet they needed to maintain a degree of “distance” from the providers to maintain the integrity of the competitive contracting process. This created a new and different relationship with communities; the purchaser needed to identify community need and consult with interest groups while the provider had no obligation to have this type of relationship with the people for whom it provided services for. The consultation and community-interest group input into health services was separated from those with whom the consumer had direct contact; the provider.
  
- *Establish a Parallel Funder, Purchaser, Provider Structure for Public Health.* An important element in the policy was the separation of the funding, purchasing and provision of population-based public health services from personal services. A newly established Public Health Commission would co-ordinate and contract services and the Public Health Agency would provide the regionally based public health services. In defence of setting up a separate, parallel funding, purchasing and provider structure to the RHAs, Upton argued that this ensured allocated funds were not “captured” by more visible services (for example, acute hospital services) as may be the case if RHAs purchased Public Health Services.
  
- *Redefine Consultation and Community Participation:* The Health Reforms Directorate managed the reforms from within the Department of Prime Minister and

Cabinet rather than from within the Ministry of Health. The holder of the newly created position of Minister of Crown Health Enterprises was responsible for the ownership role of the public providers for the secondary services, while the Minister of Health represented the owners' interests. Consultation and community participation were dramatically reduced simply because of the nature of the competitive environment in which the state entities existed.

During this period the primary care sector expanded its role. The issue of GP access was longstanding, partly reflecting the fee-for-service model (Barnett & Barnett, 2005). In addition to creating barriers to patient access, the fee-for-service provided little incentive for collaborative approaches between GPs and linkages with other health services (ibid.). In response to the opportunities and threats resulting from these reforms general practices underwent a fundamental reorganisation. At this time Independent Practice Associations (hereafter IPAs) emerged as professional collectives and entered into contractual relationships with the RHAs. In addition alternative providers such as Māori, community mental health services and primary care trusts established their collective power and formed contractual relationships with the RHA as funder. Central to primary care trust establishment was their non-governmental, not-for-profit status. These entities, while dependent on the government for funding, were able to incorporate consumer and provider interests into their business and service delivery models and address high need populations specifically. The first union health centres were established in 1987 in South Auckland and Newtown, Wellington (Crampton, Dowell, & Bowen, 2000). Iwi-owned health services also emerged during this period using the same model. During this period considerable capability was developed in establishing population-based, targeted services for populations of high need. This was an important milestone and prepared the way for the establishment of PHOs post-2000.

The formation of the Independent Practitioners' Association Council of New Zealand in 2001 provided a single voice for organised general practice (ibid.). The infrastructure that IPAs afforded GPs created opportunity for "budget holding" arrangements which resulted in the emergence of new models of primary health care delivery. Central to these developments was the opportunity to:

... organise primary care at a level beyond the individual practitioner or practice, enabling general practitioners to express their views on matters of local service delivery and health issues as a coherent body, and allowing other players to work with many local GPs as a single entity.

Love, 2003, p. 69

Both the IPAs and the primary care trusts continued to develop and grow and, over time, have been opportunistic in negotiating contracts with funders to provide a range of innovative population health services. This was a significant development for the later reforms and introduction of PHOs.

A ministerially appointed Board of Directors governed both the RHAs and the Crown Health Enterprises (hereafter CHEs). CHEs were charged with competing for health dollars to provide services and ultimately returning a profit to their shareholding Minister. Cooperation and collaboration between CHEs and other health service providers was greatly impeded because of the contestability of the contracting process. There was no opportunity for board members to be elected by their communities.

Interestingly, despite Upton's (1991) policy document being called a green<sup>6</sup> and white<sup>7</sup> paper there were just two proposals for discussion. The first was the opportunity to comment on the options for financing core health services including the extent to which user part charges should apply. The intention was to extend user-part charges to include hospital inpatient and outpatient services, laboratory tests and higher charges on pharmaceuticals in addition to primary health care services. Upton argued: "There is overwhelming evidence that user charges play a vital role in encouraging consumers to consider costs of health services, and economise in their use." (ibid., 1991, p 94). The introduction of user-part charges created ill feeling amongst the public in general but more specifically amongst the health professionals and added fuel to the speculation to Government's agenda around privatisation (Gauld, 2001).

---

<sup>6</sup> Contains proposals for discussion

<sup>7</sup> Contains policy statements.

The second opportunity for the public to have input was in determining the core health services that would be publicly funded. The National Advisory Committee on Core Health and Disability Support Services was to:

...consult the public, ... about the services currently provided and their distribution, and seek views on which services the government should ensure are purchased and on any desired changes in distribution of services or their terms of access.

National Advisory Committee on Core Health Services, 1993, p. 5

Within the first seven months the Committee abandoned the notion of an explicitly defined core. Instead, they prepared guidelines and information to assist purchasing decisions and to promote best practices among providers (Gauld, 2001).

Opportunities for communities to have input into planning and delivery of health services were minimal. Communities were invited to set up as trusts and take over the control and management of community hospitals and other local facilities. The Government would identify which facilities would be suitable. Trusts would be free to contract with RHAs to provide certain services to their local community: “The establishment of trusts will enable local communities to become more involved in the running of their health services.” (Upton, 1991, p. 36). This notion of community involvement required that the community take responsibility for the associated business risk thus providing a new dimension to the relationship the government had with communities. At a political level, this community involvement provided the government with another mechanism to strengthen the competitive model inherent in this policy.

A focus on a competitive market model did not foster the previously established networking arrangements or mechanisms for engaging communities. Opportunity for community involvement was linked to formalised funder – provider relationships in the form of community trusts. Unique also to the quasi-market era was the lack of a

“relationship” between the provider and the user of services. The user, from a policy perspective, was aligned to the funder.

By 1996 concern was mounting about the impact of the market ideology in health services (Barnett & Barnett, 2005). The recently elected centre-right coalition government made some adjustment by replacing the four RHAs with a single Health Funding Authority and the CHEs became Hospital and Health Services. The requirement to return a surplus was removed and community input at governance level was strengthened (ibid.). The phases of hospital sector restructuring up until the 1999 reforms represent successive attempts to deal with structural weaknesses (Barnett & Barnett, 2005). The area health board era featured a managerialist approach within a public sector framework where general management and accountability for performance was introduced. The National Government’s commercial model (Upton, 1991) required private rather than public solutions and emulation of a “business” rather than a “public service” culture (Barnett and Barnett, 2005).

### **3.6 THE NEW MELLENNIUM: FURTHER RESTRUCTURING**

The new Labour Government elected in 1999 brought with it another cycle of substantial policy and structural changes to the health service along with the promise to restore both local control and a population perspective (Gauld, 2003). The passage of the New Zealand Public Health and Disability Act 2000 paved the way for twenty-one District Health Boards (DHBs) to replace the central purchasing agencies and CHEs. An expanded Ministry of Health now has responsibility for policy advice, funding and monitoring health and disability sectors and reporting to the Minister of Health on progress in achieving health goals. The Minister of Health has full accountability for national policy development, and the setting of funding levels. The purchaser – provider split is managed within the single DHB entity. Cooperation and collaboration with communities have become priorities and are reflected in the governance structure of DHBs; the majority of board members are elected directly by the public. *The New Zealand Health Strategy*, (King, 2000), *The Primary Health Care Strategy* (King, 2001), *The New Zealand Disability Strategy* (Ministry of Health, 2001) and *He Korowai Oranga: Māori Health Strategy* (King and Turia, 2002) are the four principal policy documents which provide policy direction.

Central to the New Zealand Public Health and Disability Act 2000 are the requirements:

- to foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services [Section 22,(1),(h)],
- to ...develop co-operative and collaborative arrangements with persons in the health and disability sector or in any other sector ... [Section 23(1)(b)], and,
- to establish and maintain processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement [Section 23(1)(d)].

Like the proposal in the 1975 White Paper (McGuigan) DHB members are both elected and ministerially appointed. They are directly responsible to the Minister of Health; elected board members do not have accountabilities to their electorate. Adam (2003) points out a potential for conflict for elected members who may feel a responsibility to their electorate, especially at times of difficult financial circumstances. Adam also alerts readers to a potential conflict now that the DHB is both the funder and provider of health services. While the DHB is required to maintain its funding and purchasing activities from the range of public and other health services, the DHBs need to maintain and maximise throughput in their facilities in order to reduce capital and capacity costs. This has the potential to compromise opportunities for the most appropriate provider being funded for service provision.

### **3.7 THE PRIMARY HEALTH CARE STRATEGY: BACKGROUND**

The primary health care strategy had as its key objectives improved health outcomes, better access to low cost primary care and greater coordination of services. In summary the new primary health care services would:

- work with local communities and enrolled populations,
- identify and remove health inequalities,
- offer access to comprehensive services to improve, maintain and restore people's health,
- coordinate care across service areas,
- develop the primary health care workforce,

- continuously improve quality using good information.

King, 2001, p. 6

Funding arrangements and organisational structure were considered central to the new model for delivery of primary health care. Capitation funding based on a defined population and the establishment of PHOs as not-for-profit, non-DHB entities which would be fully and openly accountable for all public funds received were central to this new strategy (ibid.). Communities, iwi and health professionals would be involved in governance and decision-making of primary health care services. The government provided a strong policy direction which supported a trust structure rather than the IPA model of primary health care. In promulgating PHOs the government has taken a more multi-professional and community-inclusive approach along the lines of the community trust model established in the 1990s. This structure supports the policy direction of coordinating primary health care across a range of service areas. The ownership structure of PHOs – that is, “community” ownership – has sent a strong signal about the government’s commitment to community participation in the planning and delivery of primary health care services. Crampton and Starfield (2004) argue that community governed practice with a non-profit entity plays an essential role for facilitation of community self-determination, catering for minority populations and experimenting with new policy options.

### **3.7.1 Population-Based Funding**

The National Advisory Committee on Health and Disability, a committee established to provide independent advice to the Minister of Health, advocated that a population-based approach to funding replace the fee-for-service arrangement. This, they argued, would allow an organised response to promoting and protecting the health of identified groups and reducing inequalities between groups.

It is explicit in acknowledging that socioeconomic conditions are key factors in determining people’s health and that social inequalities produce a gradient in health status, with the most disadvantaged individuals and groups experiencing the worst health outcomes. National Health Committee, 2000, p. 15

Surprisingly, the developments in primary health care services during the quasi-market era of the 1990s provided a platform for current reform; “It is unlikely that New Zealand policy

makers could have promoted the development of such organisations [PHOs] earlier because the development of networks of primary care providers during the 1990s provided a basis for future change.” (Cumming & Mays, 1999, p.2). The Primary Health Care Strategy (King, 2001) evolved out of the development of primary care organisations established in the 1990s. This development has been driven by clinical leadership rather than imposed by Government (Malcolm, 2003).

In an effort to establish a fair and reasonable method for funding PHOs, GP registers were to be the basis for establishing the initial funding level. Funding levels reflected the Minister’s desire to target specific high need populations. The Access formula was targeted at high needs, and the Interim formula was available to all other groups<sup>8</sup>. Over time, PHOs on the Interim formula would receive increased funding to bring them in line with those on the Access formula. In 2005, \$17.2 million additional funding has been allocated as part of the \$2.2 billion the Government is spending over seven years from 2002/03 for the primary health care strategy (Ministry of Health, 2005a).

Patients were expected to enrol with a PHO of their choice. Funding would not be dependent on the type of practitioners or number of services, thus encouraging adoption of innovative models for care delivery and opportunity for health professionals to work together across traditional disciplinary boundaries. The Strategy envisaged that using funding arrangements to target high need populations would provide incentives for primary health care providers to develop services to meet specific community need. Most of the new primary health care funding was to go through PHOs in order to support strategy implementation (King, 2001).

The Strategy acknowledged that the full benefit of capitation-based funding would not be realised while a large percentage of providers’ revenue was generated through user part charges. The Minister of Health was firm in her view that fees-for-services nature of user part charges encouraged the continuation of episodic treatment. (ibid p. 14). The National Health Committee (2000, p. 17) emphasised that good relationships and an understanding of communities takes time to develop. “A history of community participation and

---

<sup>8</sup> See Appendix G for explanation of Access and Interim funding formulae.

collaboration over a number of years would increase effectiveness of participation in health-related activities.”

The Strategy emphasised the importance of each DHB region’s having a thorough understanding of the health status of their populations, the factors influencing health and the strategies most likely to effectively meet specific and unique regional needs. This community development approach, the Minister of Health claimed, would assist in finding the right solutions for disadvantaged and high need groups rather than simply responding to those individuals who actively seek care.

PHOs would be required to include members of the community on their governing bodies thus providing a vehicle for meaningful participation in identifying need and influencing the organisation’s decisions. GPs, it was anticipated, would dominate board proceedings initially, but this would change as non-clinical board members developed into their role. However, it was acknowledged that community representatives on boards would need to be well-informed and capable (New Zealand Institute of Economic Research, 2003). The Ministry of Health would need to give clear guidance on etiquette around cross-directorships (between PHOs and DHBs) and other potential conflicts of interest (ibid.). It was anticipated that as PHOs strengthened their relationships with communities, public health and primary care providers they would share ownership of outcomes. Participation on PHO boards would give Māori and other consumer and community representatives a voice and some leverage over performance.

The Strategy required participation by communities in the planning and ongoing development of primary health care services. This would more likely reflect needs and priorities of consumers and their communities. The Strategy acknowledged that this may require different approaches to different groups. For example, PHOs which had significant numbers of Māori or Pacific people among their enrolled population would, where possible, establish specific services for these people. Examples could include services on marae and mobile clinics. To address the lag in health status of Māori and Pacific people it was expected that these groups would have increased involvement in meaningful decision-

making in mainstream services as well as in Māori and Pacific provider developments. (King 2001, p. 10)

### **3.8 NEW ZEALAND PRIMARY HEALTH CARE STRATEGY: IMPLEMENTATION**

Previously priorities for primary health care had been driven by secondary and tertiary interests rather than the needs of the community (Malcolm & Mays, 1999). Implementation of the primary health care strategy would require significant culture change and different ways of working in the sector (King, 2001). The Minister of Health described the implementation process as “one of evolutionary change over the next few years” (ibid., p. iii) which would not to be fully realised for five to ten years from initial implementation (ibid.). July 2002 marked the commencement of PHO establishment nationally with two commencing operations within the Counties Manukau DHB region. The first PHO was established in July 2002. As at 1 July 2005 there were 79 PHOs with approximately 3.8 million New Zealanders enrolled (Ministry of Health, 2005b).

While performance indicators would be prescriptive and centrally controlled, PHOs could follow a variety of models. Some would evolve from existing organisations (e.g. iwi health services, IPAs), some would be new organisations and others would be a network of existing organisations. These reforms in primary health care would be starting from a primary care sector where GP-delivered services are central. However, change over time can be expected as the medical model of primary health care delivery is brought together with more holistic, social models of health care.

Table 3.1: Differences with the New Primary Health Care Approach

<b>Old</b>	<b>New</b>
Focuses on individuals	Looks at health of populations as well
Provider focused	Community and people-focused
Emphasis on treatment	Education and prevention important too
Doctors are principal providers	Teamwork – nursing and community outreach crucial
Fee-for-service	Needs-based funding for population care
Service delivery is mono-cultural	Attention paid to cultural competence
Providers tend to work alone	Connected to other health and non-health agencies

King, 2001, p. 6

### 3.9 CHOOSING A LOCATION FOR DATA COLLECTION

Love (2003) notes that there are no rules about community involvement in the formation and management of PHOs. The primary health care strategy requires that communities, iwi and health professionals are included in the governance and decision-making of primary health care services through the PHOs (King, 2001). Love (2003) acknowledges that this allows a great deal of flexibility for individual PHOs and communities to arrive at arrangements that meet the need of local contexts. What is acceptable, Love proposes, is influenced to some degree by the interpretation by the DHB which oversees PHO development.

It could be argued that the legal requirement for community engagement and participation is one of the most significant inclusions to the New Zealand Public Health and Disability Act 2000, and the least understood. Identification of an emerging new health service that could be investigated from inception of planning to operationalisation would provide an excellent platform for gaining increased understanding of the key elements of community engagement and participation.

Implementation of the primary health care strategy provided me with an excellent opportunity to investigate the notion of community participation in the planning and establishment of a new health service. In preparation for determining the location for this research I reviewed all DHB plans for future PHO establishment. The key criterion for my selection were that the planning was yet to commence and that there was some certainty that community representatives would be actively involved in the process. The focus of my research was not *whether* communities would be participating, but rather *how* they would be participating in PHO establishment.

There were a number of DHBs anticipating PHO establishment planning to commence at a time that would suit my data collection timeframe. PHOs in the Bay of Plenty, Waikato, Hawkes Bay and MidCentral DHBs were considered. Geographical proximity reduced my choice to Hawkes Bay and MidCentral regions. The Hawkes Bay DHB was planning to establish one PHO for the entire region, excluding Wairoa. Discussions with the Chief Executive in April 2003 confirmed that the process for engaging communities would be largely facilitated by the DHB and the timeframe for planning was expected to be no longer than six months (anticipated establishment date October 2003). In the MidCentral region registrations of interest from communities had been sought from the DHB and groups in the Horowhenua and Otaki region had responded favourably. MidCentral DHB appeared to be fostering a community driven process. I therefore decided to locate my data collection within the Horowhenua region.

The MidCentral DHB had signalled that PHO establishment would be an evolutionary process (Community and Public Health Advisory Committee Minutes, 5 March 2002) and at the time of my initial planning (February to May 2003) the DHB had confirmed the process which would be used (refer section 3.1.1). In addition the DHB Primary Health Care Reference Group (refer section 3.11.1) had just been formed to support the process. The Tararua PHO, being the first PHO to be established in the MidCentral DHB region, was nearing its start date of 1 July 2003. My brief investigation of this planning process confirmed that the MidCentral DHB facilitated inclusion of communities.

In the Horowhenua region the Horowhenua/Otaki Health Services Review Steering Committee, a group of local community representatives, had been working with the MidCentral DHB and an independent consultancy firm, Grafton Consulting Group Ltd., in the review of local health services and the preparation of a Business Case for a capital development programme. The Ministry of Health required, as part of the Business Case for the local health services, that consideration be given to how primary health care generally, and PHO establishment specifically, would be incorporated into local health service organisation. This Steering Committee identified the need for the community to commence planning for PHO establishment. As the Horowhenua PHO establishment programme suited the needs of this research I commenced preparations for obtaining ethical approval in anticipation of locating my data collection in this region.

### **3.10 MIDCENTRAL DHB: BACKGROUND**

MidCentral District Health Board is the funder and provider of Health and Disability services in the Horowhenua/Otaki, Tararua, Manawatu regions and Palmerston North city. The Board serves a population of 160,8000 (MidCentral DHB, 2004a). The DHB offers the full continuum of health and disability services which include secondary and lower tertiary medical and surgical health services, Māori Health, Mental Health, Public Health and Disability Support services.



Source: MidCentral Health DHB (n.d.). Retrieved May 11, 2004.

Figure 3.1 MidCentral District Health Board Region

The District Health Board has seven elected and four appointed members (as at October 2005). There are eight committees of the Board (MidCentral DHB, 2004a) which report directly to the Board, one of which is the Community and Public Health Advisory Committee (CPHAC)<sup>9</sup>, which has responsibility for recommending to the DHB approval of PHO establishment plans. Meetings of the Board and Advisory Committees are open to the public unless their exclusion is clearly justified as outlined in the New Zealand Public Health and Disability Act 2000 (schedule 3, section 32). The Funding Division of the DHB takes responsibility for making all health service purchasing recommendations to the MidCentral DHB Board.

<sup>9</sup> Refer to Appendix A for Terms of Reference.

### **3.11 MIDCENTRAL DHB COMMENCES PLANNING FOR PHC STRATEGY IMPLEMENTATION**

In March 2002 the CPHAC, a subcommittee of the District Health Board, moved that "... the Committee supports, in principle, an evolutionary approach to the development of PHOs based on geographic areas." (CPHAC Minutes, 5 March 2002).

In December 2002 a report was presented to the CPHAC which had the express purpose of providing:

- An overview of the government's strategic approach to primary health care development and the roles and responsibilities which would be assumed by PHOs.
- A report on the Registration of Interest process undertaken by MidCentral DHB and identification of a potential early partner for the District's first PHO development.
- Recommendations for ongoing implementation of the strategy.

MidCentral DHB, 2002.

A formal process earlier in the year requesting registrations of interest for PHO establishment resulted in eleven responses. Proposals were required to be built around existing providers of primary care services. (MidCentral DHB, 2002). One registration of interest, Tararua, had progressed its planning to a stage where the Funding Division's recommendation to the December 2002 CPHAC Meeting was that this proposal be supported to the next stage of development, which required the preparation of an Establishment Plan (Business Case).

#### **3.11.1 DHB Primary Health Care Reference Group**

In October 2002 the DHB Funding Division called together a group of experts from various primary health care services and health professional groups, along with iwi representatives, with the view of forming the DHB Primary Health Care Reference Group (hereafter, the

Reference Group). At their initial meetings they agreed that the Group's functions would include: "to recommend an appropriate consultation process; to secure an appropriate share of the establishment dollars; to monitor and report on developments ensuring alignment." (Reference Group Minutes, 29 October 2002)

The Statement of Intent for the Reference Group, as identified in the Report to the CPHAC Committee in December 2002 included:

The group is committed to fostering strong partnerships and governance which is inclusive of all health workers, service providers and communities. This will ensure Primary Health Organizations in this area take a proactive approach to achieving optimum health for their enrolled population, including the provision of essential first contact services from a range of practitioners.

MidCentral District Health Board, 2002, p. 15

Members of the Group would come from health professional groups, iwi and the community. It was agreed that members were expert advisors and did not represent any particular group or organisation (ibid.).

The first task for the Reference Group was to assist the Funding Division in establishing a process and assessing the Registrations of Interest from communities to establish a PHO. Other tasks included preparation of the DHB primary health care strategy and the provision of advice to the Funding Division on PHO establishment plans.<sup>10</sup>

### **3.11.2 MidCentral DHB's Primary Health Care Strategy**

One of the Reference Group's Terms of Reference required that they; "... assist in the development of MidCentral's Strategic Plan for Primary Health Care." (MidCentral DHB, 2002, p. 15). A draft primary health care strategy document, prepared by the Reference Group, was released for community consultation in September 2003. In addition to meetings held throughout the DHB region (Palmerston North, Manawatu, Tararua and Horowhenua Districts) the public was given the opportunity to make verbal and/or written submissions. The final document outlining the DHB's primary health care strategy was

---

<sup>10</sup> See Appendix A for Terms of Reference for PHC Reference Group.

released in April 2004 (MidCentral DHB, 2004b) and, along with the national strategy document, provides the blueprint for implementation of the government strategy and PHO implementation in the region.

### **3.12 HOROWHENUA /OTAKI HEALTH SERVICES: BACKGROUND**

Before focusing on the actual planning process for the Horowhenua PHO it is important to reflect on the sequence of events that had occurred over the previous 50 years in this small rural community as various community groups worked tirelessly toward securing a health service which provided primary, secondary and tertiary services.

In 1959 the Horowhenua Hospital Promotion Association was established for the sole purpose of campaigning for a general hospital. (Grafton Group Ltd., 2003). Stage one, a 50-bed aged care facility, was completed in 1969. The second stage, - 30 additional aged care beds, 30 medical beds, nurses home, superintendent's residence, occupational therapy unit, X-Ray department and physiotherapy facility - was officially opened in 1973. The final stage was completed in 1979. However, the then Palmerston North Hospital Board had not received the commissioning grants necessary to make the facility fully operational, and as late as 1989 many of the new services had still not been commissioned (ibid.).

The realisation of this new facility was evidence of the determination and absolute commitment of the Horowhenua community to have local primary, secondary and tertiary services. Throughout this period successive health authorities, central government and some health professionals in the district were not as committed as the community. "The doctors stated that any advantages to the local community of having a public hospital in the area were largely illusory unless the hospital could be adequately equipped and staffed to handle almost all medical and surgical problems." (Grafton Group Ltd., 2003, Part B, 1.0 Report, section 3). The reality of funding constraints left this community with the hospital buildings completed, yet expectations about service provision remained unmet; while a base hospital had been built it never became fully operational. In 1998/99 the Health Funding Authority agreed to subsidise services. With the formation of DHBs in 2001, the newly formed MidCentral DHB took over responsibility for the funding and provision of

health services in the region. A \$850,000 disability support services subsidy paid by the Ministry of Health was discontinued from the commencement of the 2000/01 financial year. Continuation of the services was not sustainable (ibid.).

In 2001, MidCentral DHB established a project to review health service delivery in the Horowhenua/Otaki region. In line with the DHB's desire to involve the community in the review process a community steering group, the Horowhenua/Otaki Health Services Review Steering Committee (hereafter the Health Services Review Steering Committee), was established to contribute to the review and provide feedback at all stages. In March 2002 the Grafton Group Ltd., an independent consultancy company, was appointed by MidCentral DHB to work with the DHB and the community in developing a new plan for the delivery of health services in the region. A Business Case proposal for Horowhenua/Otaki Health Services prepared by the Grafton Group was submitted to the Ministry of Health in June 2003. Approval of funding for this project was announced by the Minister of Health in December 2004. The Ministry of Health required, as part of this proposal, evidence that a PHO would be co-located in the proposed new health service facility and demonstration of a commitment to primary/secondary service integration as part of the new regional development. (DHB Minutes, 16 March 2004). This provided the backdrop to the initial plans to form a PHO in the Horowhenua region.

### **3.13 CONCLUDING COMMENTS**

From 1975 through to 2000 the New Zealand health service underwent successive restructurings. While the 1975 White Paper (McGuigan) was not implemented it provided a number of strategies for subsequent reform. The AHB era required, for the first time, a systematic assessment of community health need as part of the process for service planning. District Health Committees provided formalised opportunities for communities to have a voice in planning. The fact that AHB establishment was not mandatory, in part, led to the demise of this consultative and community inclusive era; officials became frustrated with the time demands for consultative processes which were central to these reforms.

Despite the quasi-market era dramatically diminishing opportunity for communities to participate in the development and planning of health services, the formation of primary

care trusts laid the foundation for the 2002 primary health care reform. During this period capability was established in population based contracting with outcomes firmly focussed on improving access and health status of disadvantaged and minority groups.

The New Zealand primary health care strategy implementation plan in the MidCentral DHB provides an illustration of how a DHB established process for working with local communities and enrolled populations in preparing for PHO establishment.

Chapter Four will outline the research strategy. The findings will then be presented in Chapters Five and Six.

# **CHAPTER FOUR**

## **METHODOLOGY**

### **4.1 INTRODUCTION**

This chapter begins with identification of the intrinsic values which I as the researcher brought to the research. The philosophical and theoretical underpinnings are discussed, followed by a detailed description of the methodology and methods chosen along with justification of the methods used at the various stages of the research. Finally, consideration of issues relating to quality of the data and ethical review will be presented.

### **4.2 ENGAGING IN RESEARCH**

Preparing to undertake this research required a level of intellectual and emotional commitment which I had not previously experienced. With a professional background in senior management within the health and tertiary education sectors I came to this project with a view that theory played an important role in informing practice and practice in turn would, through increased understanding and enlightenment, contribute to identifying future research priority and thus – indirectly - contribute to ongoing theory development. Closely associated to this, and reflected in my research strategy, was the value placed on the opportunity for the research to inform current practices and the potential to contribute to best practice initiatives. These intrinsic values were in addition to the contribution this research would make to the developing body of knowledge relating to community participation.

At the outset my task was to ensure that the research strategy provided the necessary discipline and focus to achieve its stated aims. Not only did the project need the robustness illustrative of excellent academic endeavour but also it was essential that it reflected the uniqueness of the subject being investigated. I had accountability to the participants as well as to the academic community to ensure that the findings and conclusions drawn from the research provided meaningful, insightful and relevant knowledge.

### 4.3 THE RESEARCH APPROACH

Denzin and Lincoln (2000) describe qualitative research as a set of interpretive practices where no single methodology is more important than another. Rossman and Rallis (2003) describe qualitative research as taking place in the natural world, using multiple methods that are interactive and humanistic, emergent rather than prefigured and fundamentally interpretive. They describe the qualitative researcher as someone who views social phenomena holistically, is able to systematically reflect on who s/he is in the inquiry, who is sensitive to how s/he shapes the study and uses complex reasoning that is multifaceted and iterative (ibid.).

Lincoln and Guba (2000) identify three issues when giving consideration to methodological approach. The first is the ontological nature of the phenomena being investigated. The focus here is the form and nature of reality and what is known about it. If a “real world” is assumed, then what can be known about it is how things really are and how they will work. This “reality” therefore becomes the focus of research activity. The second issue focuses on the epistemological nature of the world in which the research is to be conducted. Here the focus is on the nature of the relationship between the knower and what can be known. Guba and Lincoln (1994) argue that the answer to this question is constrained by the answer already given to the ontological question because not just *any* relationship can now be postulated. The third issue, the methodology, centres on how the inquirer goes about finding out whatever s/he believes can be known. Again, this is constrained by the answers given to the first two questions.

Crotty (1998) provides a strategy for consideration of the total research process by posing four questions:

- What methods do we propose to use?
- What methodology governs our choice and use of methods?
- What theoretical perspective lies behind the methodology in question?
- What epistemology informs this theoretical perspective?

p. 2

Crotty (ibid.) suggests that research planning should begin with identifying a real life issue or problem that requires investigation. Consideration of associated issues, problems and questions should precede identification of the aim and objectives of the research. It is only then that the research strategy can be planned. This is the path I took, using as a guide Crotty's four questions and Lincoln and Guba's (2000) three issues relating to which paradigm position I would adopt for this research.

In line with Crotty's (1998) recommendation about initial research planning I established three central aims to this research. The first was to identify the existing knowledge and understandings of the notion of community engagement and participation in the planning and establishment of health services. The second aim was to explore how the community at large and individual community stakeholders in the Horowhenua contributed to the PHO planning process. From this it was expected that essential attributes which would contribute to sustainable and meaningful community participation in the planning of health services would be identified.

The research questions that emerged were:

- What are the key elements of community engagement as determined by the literature?
- How did the Horowhenua community engage in the preparations for Primary Health Organisation establishment?

I would then be in the position to ask the final question;

- What key determinants for sustainable and meaningful community participation in the planning for, and establishment of, the Horowhenua PHO emerged from this investigation?

#### 4.4 THE RESEARCH STRATEGY IS PLANNED

To capture all information necessary to gain an in-depth understanding of how the communities of the Horowhenua would be involved in PHO planning I needed to give consideration to the following research issues:

- How do I capture all the information necessary to fully understand the notion of community participation?
- What are the parameters of this research in terms of time and location?
- As the researcher, what will be my relationship with the subjects?
- How can I ensure that I capture the impact and implications of context?

At the outset two key assumptions were considered important. Firstly, it was assumed that participants in the research process would be individuals and groups that were actively involved in the establishment of this new health service organisation. They would bring to this role their realities, knowledge of their community's health needs, knowledge of the history of the health services in the area, their perceptions which had been formed by their lived experiences in this community, life experiences and/or professional knowledge, and for the DHB personnel, as external stakeholders, understandings of accountabilities and expectations of the funding and policy agencies. From this perspective they were, collectively, "experts" in identifying need, priority and process. As the likely source of much of the data, participants would ensure that the research was context-relevant by their very involvement in the project. A second assumption, closely associated to the first, was that taking a "snapshot" view of activities and perspectives could not capture the dimensions of community participation and engagement. An in-depth investigation over a period of time would provide understanding. These two assumptions had a major influence on determining the epistemological and methodological approaches to this research.

I returned to Crotty's (1998, p. 2) four questions.

- What methods do we propose to use?
- What methodology governs our choice and use of methods?
- What theoretical perspective lies behind the methodology in question?
- What epistemology informs this theoretical perspective?

For ease of justification of my approach I will address Crotty's questions in reverse order. I will then comment on my role as researcher before giving consideration to ethical issues and matters relating to quality of the data.

## **4.5 ONTOLOGY AND EPISTEMOLOGY**

The very nature of the research questions for this project implied that I was unlikely to find a clear, already determined process or pathway for engaging communities in PHO establishment. The research would focus on the investigation of emerging phenomena. There was no objective truth waiting to be discovered, but rather meaning would emerge as a result of the community's engagement in the process of PHO establishment. Therefore "meanings" would be constructed as part of the process of community engagement and be brought together in a wide range of constructions of reality. In selecting a research approach I needed to ensure that there was understanding of the way in which individuals and groups create, modify and interpret their reality.

### **4.5.1 The Nature of Reality**

When considering the nature of reality Preissle and Grant (2004) discuss a continuum from realism to idealism. At the realism end of the continuum assumptions about life are set in concrete reality: "... one that is uniform and that exists beyond the minds of the researchers" (p. 167). Idealism describes reality as a creation of the human mind and "... consequently is unstable, configured internally and variable according to the mind apprehending it." (ibid., p. 169). Social situations are fluid and changeable (ibid.).

### **4.5.2 The Nature of Knowledge**

One approach to understanding the construction of knowledge in social science can be consideration of the role and value of the objectivist and subjectivist assumptions about research. Preissle and Grant (2004) describe *objectivism* as the position where meaning is independent of any consciousness and things have intrinsic meanings to be discovered or revealed by inquiry. In contrast they describe *subjectivism* as the position where the knower imposes meaning on the known.

Rather than seeking a single meaning or interpretation, researchers explore the multiple, contradictory, and multilayered meanings inherent in a setting or an event. The meaning of any report derives not from the account itself, but from the interpretations placed on it by audiences or readers. ibid. p. 175

Easterby-Smith, Thorpe and Lowe (2002) point out that the two extremes of these approaches have been elevated to opposing stereotypes by some authors. Rather than make judgments about the merits of either approach it is important to give consideration to the assumptions and methodological implications these perspectives provide for the chosen area of research.

Rossmann and Rallis (2003) take a subjectivist – objectivist continuum approach to describing assumptions about social science.

Table 4.1 - Subjectivist – Objectivist Continuum

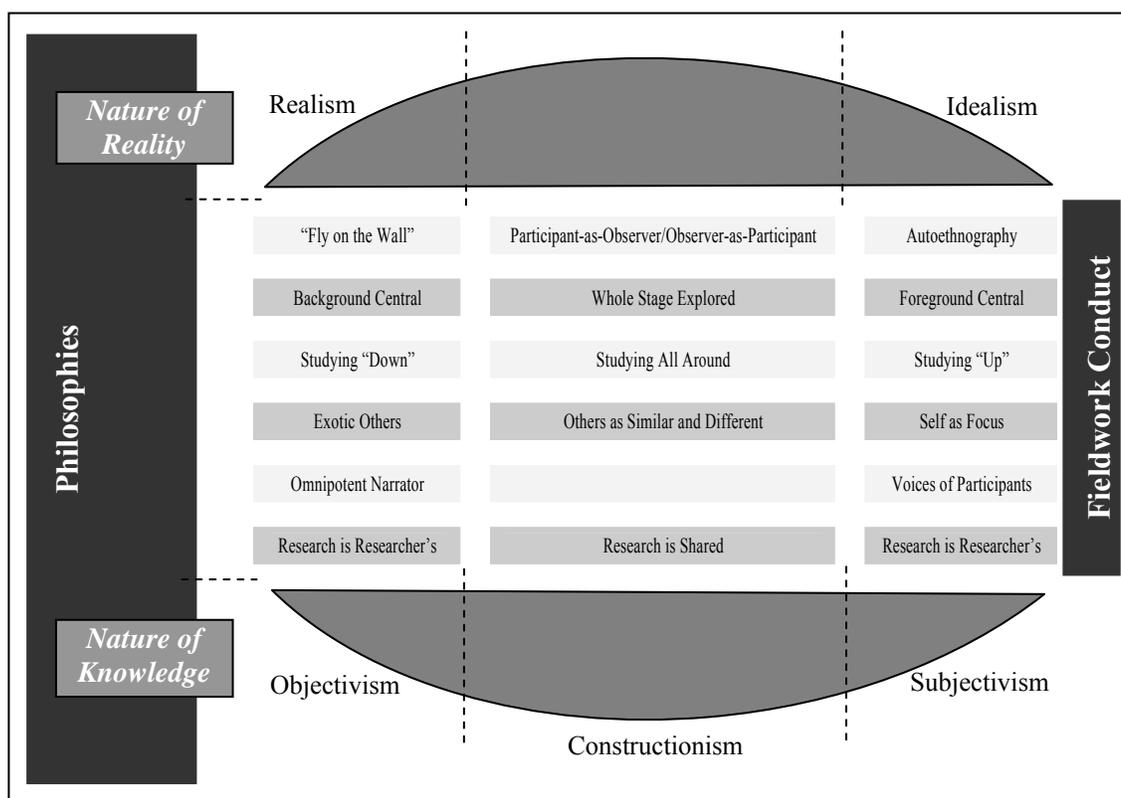
<b>Subjectivist Assumptions</b>	<b>Objectivist Assumptions</b>
Contextual dependency	Generalising tendency
“Working understandings”	“Universal verities” or laws
Getting close to the participants	Systematic protocol and technique
Focus on understanding subjective experience	Focus on testing hypothesis
Comparative logic	Logic of probabilities
Case study designs	Experimental designs
Researcher as “instrument”	Reliable instrumentation
Interpretive analysis of data	Statistical analysis of data
Data in the form of words	Data in the form of numbers

p. 39

Crotty (1998) claims that most current fieldwork is done from the middle position of constructionism. Constructionism, according to Crotty is an epistemological position which takes the view that truth and meaning comes into existence in and out of our engagement with the realities of our world:

... all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context. ibid. p. 42

Preissle and Grant (2004) present a summary of epistemological and ontological approaches which illustrate the realism – idealism continuum and the objectivism-subjectivism continuum.



From Preissle & Grant (2004, p. 168)

Figure 4.1 – Philosophies and Fieldwork Conduct

The constructionist epistemology sits within the anti-positivist epistemology where the nature of knowledge is based on experience and insight. Positioning this research at the centre of the objectivism-subjectivism continuum allows the events occurring during the PHO establishment period to determine the pathway for data collection. Preissle and Grant's elements of constructionism (Figure 4.1) meet the research need, with the addition of one subjectivist element – the inclusion of voices of participants.

#### 4.6 THEORETICAL PERSPECTIVE

The 1970s and early 1980s were described as being the period of “blurred genres” (Denzin & Lincoln, 2000; Locke, 2000). The notions of social realism and objectivist knowledge were challenged, as many qualitative researchers accepted the position that knowledge-making was largely interpretation. It was at this time that qualitative research took its interpretative turn, highlighting - among other things - the role played by culture and context. Guba and Lincoln (1994, p. 107) define a paradigm as a set of basic beliefs. “It represents a worldview that defines, for its holder, the nature of the ‘world’, the individual’s place in it, and the range of possible relationships to that world and its parts ...” As Guba and Lincoln point out, these beliefs are basic in the sense that they must be accepted simply on faith, however well argued; there is no way to establish their ultimate truthfulness.

This research required the “how”, “when” and “where” questions to be answered as well as the “why” questions. The theoretical approach to these two components of the research drew on different assumptions and therefore different but complementary basic beliefs about reality. Central to the inquiry of the “how”, “when”, “where” questions was the desire to understand the nature of the social world as it is experienced by the human beings interacting in it, capturing the sequence of subjective experiences of those people involved in the PHO planning.

An interpretivist approach would provide theoretical basis for capturing the array of situations within which people constructed and gave meaning to the “how”, “when” and “where” questions. An interpretivist approach assumes that interacting individuals approach their reality from a set of values, attitudes and beliefs that reflect their life experiences and the political, economic and moral structures of the reality they have experienced (Denzin & Lincoln, 2000). Morgan (1983) holds the view that the researcher can make meaningful interpretations of human experience only if s/he is totally immersed in the phenomenon under investigation.

The “why” questions focus more on understanding the everyday world of interacting individuals and motive, intention and emotion which determines the experiences when interaction takes place. Constructionists attest that human beings are introduced directly into a whole world of meaning (Schwandt, 2000). The cultures and subcultures of which one becomes part provide human beings with those meanings and continue to influence realities through the process of enculturation (Crotty, 1998).

#### **4.7 METHODOLOGY: A LONGITUDINAL CASE STUDY**

Crotty’s (1998, p. 2) next question is “What methodology governs our choice and use of methods?” Guba and Lincoln (1994), when describing methodology, pose the question: “How can the inquirer (would-be knower) go about finding out whatever ... can be known?” (p. 108).

Data for this research would need to be collected over a period of time, from a variety of sources. It is assumed that context would be critical to the findings. Previous events and the current environment in which people live and work would influence their behaviours and how they approach PHO planning. It was expected that there would be a range of simultaneous activities occurring which would contribute to the planning process. A longitudinal case study approach would enable both the descriptive and investigative components to be fully researched.

Case study is not a methodology but rather a choice of object to be studied. (Stake, 1995). Hartley (2004) also holds the view that case study is not a method but rather a strategy.

Case study research consists of a detailed investigation, often with data collected over a period of time, of phenomena, within a context. The aim is to provide an analysis of the context and process which illuminate the theoretical issues being studied. The phenomenon is not isolated from context (as in, say, laboratory research) but is of interest precisely because the aim is to understand how behaviour and/or processes are influenced by, and influence context.

ibid., p. 323

An advantage of a case study approach is that it would provide opportunity for a holistic view of the process. Yin (2002) identifies the key advantage of the case study approach as

being the ability to study many dimensions of an entity using multiple sources of data over a period of time. This approach, he argues, is ideally suited for asking the how and why questions and focuses on phenomena in a real life context. Zikmund (2003) supports a case study approach:

.. the primary advantage of the case study is that an entire organisation or entity can be investigated in depth and with meticulous attention to detail. This highly focused attention enables the researchers to carefully study the order of events as they occur or to concentrate on identifying the relationships among functions, individuals or entities.”

p. 116

Chetty (1996) identifies the opportunity to investigate the reasons why certain decisions are made, how they are implemented and with what result as being a strength of the case study approach. The influence of context is an important consideration. Yin (2003) describes the case study as the preferred choice when the phenomenon under study is not readily distinguishable from its context. Stake (2000) contends that a project is invariably a complex entity positioned in a number of contexts or backgrounds. Historical, cultural, physical, social and political contexts are among the range of considerations which contribute to making relationships and realities understandable.

In summary, the research strategy used in this research is detailed in Table 4.2

Table 4.2 Research Strategy



Modified from Crotty (1998, p. 4)

## 4.8 METHODS

Methods are the specific activities the researcher engages in to gather and analyse the data. The distinction between quantitative and qualitative research occurs at this level (Crotty, 1998). A number of data gathering methods were employed for this research.

### 4.8.1 Snowball Sampling

Snowball sampling is a process where potential subjects are located through referral networks. Initial contacts lead to additional potential informants being identified. (Cooper and Schindler, 2003). As well as making contact with individuals who had been recommended to me I scanned the local newspapers and attended public meetings of the Horowhenua/Otaki Health Services Review Project<sup>11</sup>. This gave me the opportunity to identify people in the community who were likely to have involvement in the PHO establishment planning. It also provided me with insights into the likely structure and process which would be used and relationships between stakeholders. I was able to identify all members of two local infrastructures, the Horowhenua/Otaki Health Services Review

---

<sup>11</sup> Refer to section 3.12

Steering Committee and the Horowhenua District Council Joint Transport and Health Services Subcommittee<sup>12</sup> along with personnel from the MidCentral DHB who would be involved in PHO development. In addition to identifying specific people who were to be involved with the Horowhenua PHO planning I met informally with staff from two DHBs, the Tararua PHO and personnel from the Ministry of Health, to discuss the primary health care strategy implementation in an effort to gain a broader perspective.

#### **4.8.2 Documentation Review**

Review of a range of documents was considered an important source of data. My initial focus was the Ministry of Health website where guidelines and a range of resource material were available. Documents from MidCentral DHB included the Annual District Plan, Primary Health Care Strategy documents and Minutes from the Primary Health Care Reference Group, the Community and Public Health Advisory Committee and Board meetings. Correspondence to the Horowhenua PHO Steering Committee from a range of sources was also made available for the purposes of this research.

#### **4.8.3 Media Releases**

Library databases Newzindex and Newztext Plus were used to ensure all press releases were captured. In addition I reviewed all *Horowhenua-Kapiti Chronicle* and *Manawatu Standard* newspapers from 1 May 2003 to 30 June 2004. *Primarily*, a Ministry of Health publication, also provided anecdotal information about PHOs development throughout New Zealand.

#### **4.8.4 Observation**

Observation as a data collection tool entails listening to and watching events first-hand in their natural setting (Ghuri & Grønhaug, 2005). This method provides opportunity to

---

<sup>12</sup> The Joint Transport and Health Services Subcommittee reports through the Horowhenua District Council's Development Committee to the Horowhenua District Council. It comprises both Council representatives and selected public members and deals with predominantly local health and transport issues. It does not have established Terms of Reference.

capture dynamics of behaviour and understand attitudes and situational influences as well as providing rich contextual data for exploratory components of the research.

Meetings of the Horowhenua PHO Steering Committee were the only meetings during which I made notes. At the outset members received an explanation of my research, were provided with an Information Sheet and asked to sign the Consent Form<sup>13</sup>. There was unanimous agreement from the Committee that the Chairperson sign a Consent Form on behalf of the Committee members. Three new members joined the Steering Committee during the time of my observations. They were individually approached and given a verbal explanation of the research, an Information Sheet and Consent Form. All new members were satisfied with the arrangement that the Chairperson had signed the Consent Form on the Committee's behalf. There were two Steering Committee meetings which I attended but did not record my observations. This was when the Kere Kere Healthy Communities Network joined the Horowhenua PHO Steering Committee (refer section 5.4.1). On the first occasion the Kere Kere Healthy Communities Network representatives attended the Horowhenua PHO Steering Committee Meeting I spoke with the Chairperson of that group, provided him with the Information Sheet and Consent Form and requested an invitation be offered to me to attend one of their separate meetings to provide an explanation about the research and obtain consent. He preferred to speak to the Kere Kere Group and the following week gave consent on behalf of all members for me to continue recording my observations at the combined Steering Committee meetings. Table 4.3 provides a summary of sources of data collected from observations.

---

<sup>13</sup> Refer to Appendix B for Information Sheet and Consent Form.

Table 4.3: Meetings Attended and Data Collected

<b>Location</b>	<b>Data collected</b>
Horowhenua PHO Steering Committee	Recorded my observations and made detailed notes of discussion <sup>14</sup> Minutes Supporting documentation Correspondence
Horowhenua / Otaki Health Services Project Steering Committee Public Meetings	Minutes
MidCentral DHB CPHAC Meetings	Minutes Made notes of Board Members' discussion after meetings
MidCentral DHB Meetings	Minutes Made notes of Board Members' discussion after meetings
Public Information Sharing Days	No record made
Provider Information Sharing Meeting	No record made
Joint Transport and Health Services Subcommittee Meetings	Minutes

#### 4.8.5 Semi-Structured Interviews

King (2004, p. 11) identifies the goal of any qualitative research interview as seeing the research topic "...from the perspective of the interviewee, and to understand how and why they come to have this particular perspective." Fontana and Frey (2000) propose that structured interviews capture precise data while semi-structured interviews place greater emphasis on understanding the complexities of behaviour and realities of members of society without imposing any categorisation.

Six semi-structured interviews were conducted at the conclusion of the nine-month observation period<sup>15</sup>. The purpose for conducting interviews was two-fold. Firstly, it provided opportunity to validate perceptions and understandings I had formed during the nine-month period when I attended meetings and observed the range of activities which contributed to the planning process. The second reason for conducting interviews was to gain increased understanding of the emerging determinants for community participation in this unique Horowhenua context. To obtain the best representative sample I interviewed

<sup>14</sup> Refer to Appendix C for template used for this record.

<sup>15</sup> See Appendix D for details of personnel interviewed.

three members of the Steering Committee; a community representative, an iwi representative and a GP representative. The three stakeholders' groups external to the Steering Committee which were central to the planning process were the Community and Public Health Advisory Committee, the DHB Funding Division and the DHB Primary Health Care Reference Group. I therefore asked one representative from each of these groups. This made the total of six people interviewed.

At the time of the initial approach to prospective interview participants I provided a verbal overview of the research and an indication of the amount of time the interview would take. All interviews took place at a setting of the participant's choice. Prior to commencing the interview sufficient time was given to the participant to read the Information Sheet and have any questions answered<sup>16</sup>. They received a copy of the prepared interview questions. However, they also understood that these were a guide only, and that there were likely to be further questions based on matters raised during the interview<sup>17</sup>. A Consent Form was signed and all participants agreed to the interview being tape recorded. At the conclusion of the interview they understood that I would be transcribing the tape and that they would receive either an electronic or a hard copy of the transcript (their preference) to which they could make alterations before I used it for analysis.

#### **4.9 ANALYSIS**

For a nine-month period, from 22 August 2003 to 21 June 2004 primary and secondary data were gathered from a range of sources. The central unit for analysis was the Horowhenua PHO Steering Committee. Closely associated with this Committee's activities were the Funding Division of the MidCentral DHB and the Reference Group. The Horowhenua District Council Health and Transport Subcommittee influenced process but more indirectly. In addition to obtaining data from minutes and/or observations from these committees, data were also sourced from public meetings, media reports, the Ministry of Health Web-site and publications and MidCentral DHB publications. It is acknowledged

---

<sup>16</sup> See Appendix B for Consent Form and Information Sheet.

<sup>17</sup> See Appendix E for semi-structured interview questions.

that the approach to this research was not to investigate or evaluate the extent to which the community was engaged in the planning of how best to prepare for PHO establishment. Members of the Health Services Review Committee determined that the process for PHO establishment be the formation of a Steering Committee to complete all preparations. This committee also determined the constituency representation of the Steering Committee – that is, the number of GP, Practice Nurse, pharmacy, iwi and community representatives to be appointed onto the committee. The community representatives on the Health Services Review Committee opted to select the community representatives and this was agreed by the Committee. This research did not include as one of its objectives evaluation of the merits of these community representatives' decision. I did not approach the community-at-large or health professionals working in the region. I was assured – based on the perspectives provided by all the Steering Committee Members (community representatives included) and information received from the public during the information sharing day (February 2004) and from health professionals at their information evening (January 2004) – that the community had minimal knowledge of the primary health care strategy and its implementation and minimal interest in participation in the PHO establishment planning. The decision made by the community to manage the establishment process in this way was not influenced by external stakeholders – for example, the Funding Division.

Early in the data collection phase themes began to emerge. As a preliminary step in collation, the data were coded using this initial choice of themes. This process was not intended to set in place a firm approach to analysis but rather to begin to provide some structure upon which to establish an approach to the analysis. Over the data collection period the number of themes increased. At its conclusion seven themes were identified:

1. Nature of relationships
2. Volunteer role
3. Constituency representation
4. Resources
5. Knowledge and information
6. Autonomy versus control
7. Impact / influence of other supporting infrastructures in the community

It became apparent that several common elements were emerging which crossed a number of the seven themes. Ensuring I did not lose any of these elements, the final themes arrived at were:

- The origins of the Horowhenua PHO Steering Committee,
- Relationships Steering Committee members had with each other, their community and stakeholders,
- The Steering Committee members' experience of participating in this PHO development, and,
- Steering Committee and stakeholder perceptions of community readiness to participate.

Table 4.4 Realignment of Themes

<b>Refined theme</b>	<b>Original Theme</b>
The origins of the Horowhenua PHO Steering Committee	➤ Constituency representation
Relationships Steering Committee members had with each other, their community and stakeholders	<ul style="list-style-type: none"> <li>➤ Nature of relationships</li> <li>➤ Impact / influence of other supporting infrastructures in the community</li> </ul>
The Steering Committee members' experience of participating in this PHO development	<ul style="list-style-type: none"> <li>➤ Volunteer role</li> <li>➤ Resources</li> <li>➤ Knowledge and information</li> </ul>
Steering Committee and stakeholder perceptions of community readiness to participate	➤ Autonomy versus control

These refined themes provided the framework for in-depth analysis.

#### **4.10 RESEARCHER AS PARTICIPANT**

Waddington (2004) describes the participant observer as someone who studies first-hand the day-to-day experience and behaviour of subjects in particular settings and where, if necessary, s/he talks to the subjects about their feelings and interpretations. He proposes that participant observations are an inductive strategy where the researcher uses his/her initial observations as the starting point of the research process. Gans (1999) identifies three

roles of participant–observation. The first is *total participant* where the researcher is completely involved emotionally in the social situation and becomes the researcher only after the event. The second role is that of *researcher-participant* where the researcher partially participates in the social situation so as to ensure he/she is able to function as a researcher. The third role is *total researcher*, where observation occurs without personal involvement. Rossman and Rallis (1998) present a continuum for participation and propose that the researcher’s position may change:

Co-participation ← immersion – limited participation → spectator

.... we do not spend time considering whether to be a participant observer or a non-participant observer. Instead, we consider the level and type of our participation and how that participation is portrayed to the members of the setting.  
ibid. p. 96

Table 4.5 illustrates the level of participation in each data collection situation.

Table 4.5: Researcher Participation

Situation / Activity	Position on Rossman and Rallis’s (1998) Continuum	Details of Activity
Attendance at Horowhenua PHO Steering Committee Meetings	Limited participation to immersion	Sat alongside members at meetings Identified in minutes as “Present” Occasional interaction when meeting is in progress Took notes throughout meeting Had informal conversations before and after meetings
Attendance at the CPHAC Meetings	Spectator	Sat in “Public Gallery” Took notes No interaction with Committee
Attendance at Public Information Sharing Day	Immersion	Distributed PHO information sheets Provided information to the public about primary health care Referred enquiries that related specifically to the PHO to a Steering Committee Member
Attendance at Provider Meeting	Limited Participation	Observed (no notes taken) Contributed to discussion when attendees broke up into discussion groups Assisted with serving supper
Public Meetings	Limited Participation	Observed (no notes taken)

Rossmann and Rallis (ibid.) propose that the greater the amount of time a researcher spends collecting data as a participant observer the less likelihood there is that the researcher's presence will influence participant's behaviour: "Usually, the more familiar the participants are with the researcher, the more they trust him and are willing to share their feelings and knowledge." (ibid., p. 97).

At the first PHO Steering Committee meeting which I attended, in addition to the describing parameters of the research and attending to ethical issues my focus was to begin building sound researcher-participant relationships. This first meeting provided me with the opportunity to introduce myself and outline my professional background as well as my research goals. From the outset I sensed a level of trust and at no time throughout the data collection period did I feel that my presence was impinging on the Committee's discussion or decision-making. While all Committee members understood that they could ask me to leave a meeting at any time, this did not occur in the nine-month period. When taking notes I was particular to ensure that I ceased writing when matters not pertaining to my research focus were being discussed. To illustrate, one such situation occurred when the appointment process for the Project Manager was being addressed.

There was one occasion when a Steering Committee meeting was called at short notice to deal with an urgent item. I deliberately did not attend this meeting. While the matters being discussed were relevant to my research, non-attendance did not compromise the data and in view of the sensitivities surrounding the issues I considered the benefits for the ongoing researcher-participant relationship outweighed any advantages of my attendance at the meeting. In making my decision I also knew that I would receive minutes of the meeting. This incident highlighted the complexities associated with being a participant observer and the importance of ensuring my focus went beyond that of simply data collection, to understanding the context and respecting the needs of the people working within it.

On another occasion, within the first month of commencing data collection a reporter from the local newspaper, *Horowhenua-Kapiti Chronicle*, requested (and was declined) an interview about my research. This request was made when there was considerable media attention being directed at the plans to establish a PHO and at the time when the community

was awaiting a decision from the Ministry of Health and Treasury about the Horowhenua/Otaki Health Services Review. This reinforced the importance of having a sound appreciation of the wider contextual issues in which my research was being conducted.

#### **4.10.1 Reflexivity**

The researcher's background and position will affect how s/he approaches a research project, the methods chosen and how the findings and conclusions are presented (Johnson & Waterfield, 2004; Malterud, 2001). Rather than endeavouring to maintain objective distance from the research, reflexivity seeks to recognise and value the researcher's participation in shaping the data and analysis (Augen, 2000). The participant's experience is lived amidst a host of social and historical experiences and meanings. Reflexivity does not aim to demonstrate neutrality and objectivity, but rather makes explicit the researcher's contribution to the interpretive research process (ibid.). Guareschi and Jovchelovitch (2004) propose that reflexivity is linked to the basic assumption that reality holds a range of possibilities. Rather than describing these realities, they argue, the task of knowledge is to identify critically which alternatives can transform it: "Critical reflexivity develops in communication and social praxis as social actors engage in the task of translating into interlocutors, perceptions, experiences, observations and practices about the everyday." (ibid., p. 317). This, they argue, leads to an awareness of the socio-economic, political and cultural contradictions which shape people's lives and who they are. "No knowledge is closed and perfect in itself: knowledge grows out of challenge and critical reflexivity, as does local knowledges" (ibid., p. 317).

The issue of validity of findings is dependent on the researcher demonstrating transparency in recording the research process and the documentation of research process. Malterud (2001) stresses the importance of the researcher acknowledging that s/he enters the field of research with certain opinions and perceptions. The reflexive process begins with the identification of these perceptions, acknowledgement of personal and professional experiences and pre-research beliefs about what is to be investigated. If reflexivity is maintained, personal issues can be valuable resources for the research. Malterud (ibid.)

warns against confusing the knowledge intuitively present with the knowledge emerging from the enquiry.

Throughout the data collection period I was mindful of the various ways that the data could be influenced by my presence, the relationship I had with participants and the pre-determined perspectives I brought to the research process.

#### **4.11 DATA QUALITY**

Lancaster (2005) identifies three dimensions of data quality; validity, reliability and generalisability. He raises questions relevant to inductive research:

Validity:	Has the researcher gained full access to the knowledge and meanings of informants?
Reliability:	Will similar observations be made by different researchers on different occasions?
Generalisability:	How likely is it that ideas and theories generated in one setting will also apply in other settings? <span style="float: right;">ibid., p. 73</span>

Bowling (1997, p. 180) argues that “No research method is without bias.” Data triangulation describes the use of data from a number of sources or a number of accounts of the same event/s. Hays (2004) argues that the use of multiple methods and multiple sources as forms of triangulation makes case study findings more comprehensive. Burgess (1991) describes time triangulation as being the use of cross-sectional or longitudinal research design to illustrate the influence of time. The use of multiple sources of data during the PHO establishment period, the length of time over which data were collected and the conducting of semi-structured interviews to conclude data collection minimised the risk of compromising the quality of the data.

#### **4.12 ETHICAL REVIEW**

Tolich and Davidson (1999) consider five principles of ethical conduct for social science researchers; doing no harm, voluntary participation, informed consent, avoiding deceit, and confidentiality. As the research strategy involved collecting data from human subjects within the health sector, I was required to submit a proposal to the Massey University

Human Ethics Committee and the Manawatu / Whanganui Ethics Committee<sup>18</sup>. The Manawatu / Whanganui Ethics Committee is a Ministry of Health Ethics Committee accredited by the Health Research Council of New Zealand. Approval was granted from both committees following alterations being made to the Information Sheet and Consent Form and further clarification of some points made in the application. Incorporated into the approval process was the commitment made that data will be stored in a secure, locked cabinet and destroyed by an independent person after a five-year period. On completion of the thesis all participants will receive a prepared summary of findings and be informed about how they may access a copy of the thesis. In addition to providing a written summary I will seek from the Horowhenua PHO Board an invitation to report the findings in person.

#### **4.13 CONCLUDING COMMENTS**

The longitudinal case study approach provided an excellent platform from which to gather data about the way in which this small rural community prepared for PHO establishment. I was dependent on the stakeholders of the Horowhenua community to allow me to observe, participate and question. Throughout the process I was aware of the unique relationship I had, especially with members of the Steering Committee and the obligation I also had to ensure that their “stories” truly reflected the goals, aspirations and the realities of this lengthy and complex planning project.

The findings will be presented in two Chapters. Chapter Five will document the sequence of events that occurred over the nine month period of PHO establishment for which I was a participant observer. Chapter Six, using the voices of selected stakeholders, draws out the elements which were central to determining relationship, skill, knowledge motivational and planning issues which contributed to the final outcome of the project.

---

<sup>18</sup> See Appendix F for Ethics Approval correspondence.

## **CHAPTER FIVE**

### **FINDINGS - PART I: PHO ESTABLISHMENT PROCESS**

We never arrive where we want to be. We only journey closer to it, and journey better with experience.

Labonte, 1999, p.432

#### **5.1 INTRODUCTION**

Data collected over the duration of this case study are presented in two chapters. Chapter Five provides an historical presentation of events during the nine-month establishment phase for the Horowhenua PHO. Chapter Six will focus on the Voices which provide insights into a range of aspects which contributed to and influenced community participation during the Horowhenua establishment period. These two chapters will then provide the basis for the analysis and discussion, as presented in Chapter Seven.

The path chosen by the Horowhenua community for PHO establishment was that of a working group (the PHO Steering Committee) made up of community representatives and health professionals. The community at large was not involved in determining this approach. Community representatives on the Health Services Review Committee who made this decision held the view that the PHO needed to be established within a minimum timeframe so that their community could benefit from the additional funding available through PHOs. The findings therefore reflect the actual events and processes which took place rather than the extent and effectiveness of community participation. The Horowhenua PHO Steering Committee (hereafter the Steering Committee) was central to the data collection. Presentation of findings in this chapter begins with a description of the Steering Committee membership and the way in which it achieved required goals. Critical tasks over the planning period are then described. These include the completion of the Application to the DHB to establish a PHO and achieve the Ministry of Health and DHB compliance requirements, while also ensuring that a local focus was maintained throughout the planning process. There are numerous stakeholder groups who had influence and input into the planning processes, however, I have identified the MidCentral DHB Funding Division

(hereafter the Funding Division) and the Reference Group as being two stakeholder groups which were central to the Steering Committee’s achieving its goal of PHO establishment. I have recorded my observations of these groups’ interactions with the Steering Committee in an effort to understand the dynamics and contextual issues which influenced events, perceptions and planning.

To assist with understanding the sequence of events over the planning period, Table 5.1 provides an overview of events and their relationship to one another in terms of timing.

Table 5.1 Key Milestones – Horowhenua PHO Establishment Period<sup>19</sup>

Horowhenua/Otaki Health Services Project PHO Steering Committee	
March 2003	Called meeting to discuss way forward for PHO establishment.
April 2003	Grafton Consulting Group presented a proposal for PHO establishment to the community.
May 2003	Kere Kere <sup>20</sup> and Otaki signalled their intention to establish their own PHOs. Horowhenua PHO Steering Committee established.
June 2003	Horowhenua PHO Steering Committee members identified.

	Horowhenua PHO Steering Committee	DHB PHC Reference Group
July 2003	First meeting of the Horowhenua PHO Steering Committee.	
September 2003	Application to establish a PHO submitted to DHB.	Draft MidCentral Primary Health Care Strategy document released.
October 2003		Community consultation for Primary Health Care Strategy.
November 2003	Initial feedback received from DHB. Revised application re-submitted.	Initiated combined meeting with Otaki, Horowhenua and Kere Kere PHO working groups.
December 2003	Approval given by DHB for planning to proceed.	A second combined meeting with Otaki, Horowhenua and Kere Kere PHO working groups. Endorsed Horowhenua PHO’s Application.
January 2004	Meeting with health providers.	
February 2004	Public Information Sharing Days.	
April 2004	Establishment funding approved - \$75,000.	DHB Primary Health Care Strategy Released.
July 2004	1 July PHO “Goes Live”.	

<sup>19</sup> The Funding Division played a key role at all stages with all groups identified.

<sup>20</sup> Kere Kere refers to Foxton and surrounding area.

## 5.2 THE STEERING COMMITTEE IS ESTABLISHED

In March 2003 a meeting was called by the Health Services Review Steering Committee<sup>21</sup> to discuss PHO development in the Horowhenua/Otaki area. In the preceding three months the Funding Division had presented their proposal to the CPHAC for PHO development throughout the DHB region<sup>22</sup> and a member of the Health Services Review Steering Committee had been appointed as a community representative to the Reference Group<sup>23</sup>. The Health Services Review Steering Committee identified the need to begin planning for PHO establishment, acknowledging that this task was beyond the scope of their committee. On 23 March 2003 a representative from the neighbouring Kapiti Community Health Group Trust outlined the pathway used in that community for PHO establishment at a meeting of community representatives from the Horowhenua, Otaki and Kere Kere communities. The Portfolio Manager, Funding Division, outlined the MidCentral DHB's vision for PHO establishment. It was to be an evolutionary process where the focus was on local solutions for local issues, and services that reflected provider, iwi and community input into planning. At a public meeting three weeks later (10 April 2003) the Auckland-based consultancy firm, Grafton Group Ltd. presented, on behalf of the DHB, a pathway forward for PHO development in the Kere Kere, Horowhenua and Otaki regions. The DHB asked the Grafton Group to make this presentation because of their previous experience in facilitating PHO establishment in other DHB regions. This consultancy group was involved in the local health and disability services review and thus familiar with the Horowhenua locality. The proposal put forward by the Grafton Group, which was supported by the DHB, recommended that a 17-member working party be established made up of community, iwi, Pacific and health professional representatives from the Horowhenua, Otaki and Kere Kere communities which would prepare for the formation of one PHO for the three communities. Soon after, at another public meeting (8 May 2003), a clear signal was conveyed by community representatives to the Grafton Group and the DHB that one PHO was not the preferred option. Representatives from Kere Kere and Otaki intimated their community's desire to establish a PHO in each of their two respective localities.

---

<sup>21</sup> The Health Services Review Steering Committee was established in 2001 to provide MidCentral DHB with review and feedback from the community on the Business Case Proposal for the development of health and disability services in the Horowhenua/Otaki region. Refer to Section 3.12.

<sup>22</sup> Refer to Section 3.11.

<sup>23</sup> Refer to Section 3.11.1.



Source: Horowhenua District Council (n.d.). Retrieved May 11, 2004.

Figure 5.1 Horowhenua PHO Catchment Area<sup>24</sup>

At a Health Services Review Steering Committee Meeting 24 hours later members agreed that a Horowhenua PHO Steering Committee be established (Minutes, 9 May 2003) and within a month members of this newly established committee were named. This signalled the commencement of the planning process for PHO establishment for the Horowhenua region: leaving the Otaki and Kere Kere communities to formulate their own PHO establishment plans.

In the course of this initial planning period the communities of Otaki, Horowhenua and Kere Kere accepted the mandate from the DHB; that the PHO planning processes be evolutionary, where local solutions would be provided for local issues. It was the preference of the DHB and the Horowhenua PHO Steering Committee that one PHO be established to cover all three communities. Otaki and Kere Kere communities stood firm on

<sup>24</sup> Kere Kere covers the Foxton, Foxton Beach and Himatangi communities. Otaki is in the Kapiti District Council region and is south of Manukau.

their desire to proceed with separate developments, signalling that they did not consider a single PHO to be in the best interests of their communities. The DHB, having embraced a process of community self-determination at this early planning stage, accepted the decisions of the various groups and proceeded to work with them on their individual initiatives.

The Health Services Review Steering Committee determined the membership of the Steering Committee and offered an option for progressing PHO planning in the Horowhenua. The Health Services Review Steering Committee asked the Grafton Group to submit a proposal to the Steering Committee for professional services to manage the establishment process. It was the prerogative of the newly established Steering Committee to agree on a process and, after considering the proposal from the Grafton Group, the Committee opted for a local solution. The desire by the membership to have control over process influenced their decision to undertake this project themselves and use the Manawatu Independent Practitioners Association (hereafter the MIPA) for administrative support and advice. It could be argued that members were influenced by observations made of the Health Services Review, where the Grafton Group used a project management approach which, by its very nature, placed the consultancy firm central to determining the planning and decision-making processes. The Grafton Group was seen by this community to be closely aligned to the DHB, as evidenced by the process used to prepare the Business Case Proposal for the re-configuration of the local health services. As the Chairperson of the Steering Committee explained: “The guts of it was that I felt it [establishing a PHO] was about building relationships and relationships can’t be formed from outside.” (From interview, 18 August, 2004). While not explicitly stated it could be assumed that the agreed arrangement for PHO planning was also seen to placate GPs, all of whom were members of the MIPA. Many GPs in the region were ambivalent about PHO establishment and the MIPA input would provide assurance that GP vested interests would be incorporated into the planning process.

### 5.2.1 Membership

The Steering Committee membership was based on representation and agreed upon at the June 2003 meeting of the Health Services Review Steering Committee. The Health Services Review Steering Committee recommended that community representatives be co-opted rather than seeking expressions of interest through the media; “ ... a lack of community knowledge about PHOs may hinder the process.” (Health Services Review Steering Committee Minutes, 20 June 2003). Consideration of desired skill mix was raised at the June 2003 Health Services Review Steering Committee meeting when it was suggested that a solicitor be included in the membership. Committee members present agreed that legal and other expert advice was best obtained as required rather than to have expertise on the committee.

The first meeting of the PHO Steering Committee was convened on 29 July 2003. Membership is outlined in Table 5.2.

Table 5.2: Horowhenua PHO Steering Committee Representation

<b>Representation</b>	<b>Number of Representatives</b>
Community # *	2
Ngati Raukawa **	2
General Practitioners ##	3
Muaupoko Tribal Authority	1
Pacific	1
Horowhenua District Council	2
Practice Nurse	1
Pharmacy	1

# - Chairperson of the Steering Committee and member of the MidCentral DHB Primary Health Care Reference Group.  
\* - A second representative was co-opted in March 2004.  
\*\* A second Ngati Raukawa (iwi) Representative joined the PHO Steering Committee in May 2004 in preparation for one of the two representatives becoming the Iwi Provider Representative on the inaugural PHO Board.  
## - Two GPs from Levin. A Foxton GP joined May 2004.

Health professional, iwi and Pacific representatives had clearly identifiable constituencies. The nomination process for these representatives was the prerogative of the groups they represented. The way in which community representatives were elected and whom they actually represented were less clear. Before giving consideration to the process used for these community appointments on the Steering Committee it is important to reflect on previous efforts made by this community to be involved in health service planning processes. The Horowhenua/Otaki region had witnessed an extended period (up to fifty years) of planned community effort to secure a health service to meet local expectations (refer section 3.12). The work of the Health Services Review Steering Committee and the working groups that preceded this committee provided the community at large with evidence that individuals in the community were prepared and able to sustain this commitment over an extended period of time in an attempt to achieve goals for what they would describe as “public good”.

The Horowhenua district fought a long battle, spearheaded by the Horowhenua Hospital Promotion Association, to secure services in successive environments in which health and funding priorities and needs regularly changed, health structures altered and financial pressures increased.

Grafton Group Ltd., 2003, Part B, S9

These working groups forged a “way of doing” which had evolved over time. Therefore, it could be assumed that as a result of these efforts the current Health Services Review Steering Committee felt that they had a community mandate to determine the processes for planning initiatives, including determining representation on the PHO Steering Committee. Initially there was just one community representative on the Steering Committee. This person was nominated by the membership to be the Chairperson. She had significant networks and formalised relationships within the Horowhenua community and external to the community. She was a member of the Horowhenua Transport and Health Services Committee<sup>25</sup> and the Health Services Review Committee. The second community representative was asked by the Chairperson to join the Committee in March 2004. This

---

<sup>25</sup> The Joint Transport and Health Services Subcommittee reports through the Horowhenua District Council’s Development Committee to the Horowhenua District Council. It comprises both Council representatives and selected public members and deals with predominantly local health and transport issues. It has no formally ratified Terms of Reference.

community representative had a long involvement in the Horowhenua community and, in the Chairperson's view, had a good appreciation of health issues along with strong community networks. The two Horowhenua District Council members elected by their constituencies were also considered by the Steering Committee to be community representatives. In effect seven of the thirteen members represented the local community. All health professionals on the Steering Committee had lived in the region in excess of ten years and had community networks that went beyond that of their health professional associations.

### **5.2.2 Meeting Times**

While a PHO would have a direct impact on the work of some Steering Committee members when established, the planning phase was not considered by any member on the Committee to be part of his/her employment/work commitment. All but one Steering Committee member was in paid employment. The Steering Committee met at the workplace of one of the Committee members. Meetings were held in the evening commencing, on the majority of occasions, at 7.30p.m. and lasting from one and a half hours to three hours. The Chairperson, a community representative, and the Secretary, a Practice Nurse, were elected by the Committee at the initial meeting. Frequency of meetings varied and was determined by tasks to be achieved. Meetings were generally convened on a fortnightly basis with the exception of July to November 2003. During this period, while the Steering Committee was awaiting a response from the Funding Division on their application for establishment, they met on just three occasions. From April to June 2004, when Kere Kere and Horowhenua began working towards establishing a combined PHO, there were nine meetings over an eight-week period (refer to section 5.4.1). I attended a total of twenty-two meetings between 22 September 2003 and 21 June 2004 - the last Steering Committee meeting before the PHO was formed on 1 July 2004. Frequency of meetings was determined by the required tasks to be undertaken (refer to section 5.3.3).

## **5.3 CRITICAL PLANNING TASKS**

Tasks to be undertaken by the Steering Committee over the establishment period fell into three general categories. Firstly, before planning could progress an application to establish

a PHO in the Horowhenua region needed to be made and accepted by the DHB. This would be in the form of an Establishment Plan. The second task was to ensure that local provider and community relationships continued to develop and strengthen, that networks were maintained and expanded, and communities informed of the changes and new opportunities which would be created by the establishment of the PHO. Local primary health care service issues were central to the Steering Committee planning process. The third task required of the Steering Committee was to meet all Ministry of Health and DHB establishment requirements. Most matters related to preparations necessary for transition from subsidy to capitation-based funding. This was the focus of the Steering Committee's attention for the three months immediately prior to the PHO being established.

### **5.3.1 Application to MidCentral DHB to form a PHO**

The first task for the Steering Committee was preparation of the Establishment Plan, which would be the application to MidCentral DHB to form a PHO in the Horowhenua District. It was agreed that the MIPA should prepare the Plan which would then be considered by the Steering Committee. The Plan was in essence a Business Case for the PHO, incorporating the DHB and Ministry requirements as well as identification of the unique needs of the local community. In line with national primary health care strategy requirements the document included identification of priority populations in the region with emphasis on Māori, Pacific people and people of a lower socio-economic status. A needs assessment was presented along with key local issues which incorporated the health professional workforce, after-hours medical care, primary health care service access, transport, consideration of the impact of the local health services review and the deinstitutionalisation of residents from Kimberley Centre (local facility for people with intellectual disability). The vision agreed to by the Steering Committee was:

#### **Working together for better health in a healthier community**

That in 10 years' time the peoples of the varying Horowhenua PHO community will utilise their health services proactively, seeking wellness and pursuing healthy lifestyles thus improving their quality of life and that of the community."

Horowhenua PHO, November 2003, p. 6

The proposed legal entity was identified along with the governance structure. While the Chairperson circulated background information about the legal entity options, there was no discussion at Steering Committee meetings as to which option would best suit the needs of the Horowhenua PHO and expert independent advice was not sought by the Committee to assist in making a decision about a preferred legal identity. The MIPA Advisor presented a draft constitution for a limited liability company with charitable status in April 2004 as a *fait accompli*. All GPs who would be joining the PHO at the outset had an existing contractual arrangement with the MIPA for the administration of general practice service delivery. The Minister of Health's expectation that PHOs adopt a community trust ownership model which would facilitate innovative multi-professional primary health care service delivery and community inclusiveness in decision-making was not achieved for the Horowhenua PHO. While the legal entity would have charitable status, the limited liability company provided the MIPA with the mechanism to maintain the traditional GP model of primary care service delivery and opportunity in the future to determine which health professional groups would be contracted as providers for new primary health care services. "This arrangement will continue so that providers who are, or may become, members of MIPA will be contracted to the PHO through the MIPA" (*ibid.* p. 28). The MIPA would then contract to the PHO for service provision. The impact of this type of legal entity on the community's ability to have meaningful input into service planning was reduced, however community representation on the PHO Board was a mandatory requirement.

It was proposed in the Plan that six board members be appointed by the provider stakeholders. These would include a practice nurse, a pharmacy representative, an iwi provider and three GPs. Two representatives would come from the local iwi and two representatives from the community. Unlike the Steering Committee membership where community representatives formed the majority, the inaugural PHO Board would have a majority of health professionals. There was opportunity to appoint up to three additional directors to achieve the required skill mix. Local Management Groups (LMGs) would provide the link between the PHO Board and their communities. It was anticipated that these LMGs would meet quarterly and through a formal process provide feedback and comment to the Board (*ibid.*, p. 14). The MIPA would provide management and administrative support to the PHO on a contractual basis. The LMG terms of reference

were not identified at this early planning stage. It was anticipated that these groups would have an advisory and feedback role to the Board along with the responsibility of electing the community representatives to the PHO Board: “These advisory groups would meet quarterly and will serve as a conduit for the PHO Board to receive information from the community, iwi and provider stakeholders and to consult formally with these groups.” (ibid., p.14). This governance and advisory structure heavily supported the continuation of the health professional (and particularly the GP) decision-making power-base with community input being limited to minority membership on the Board and an advisory mechanism to the Board. In the Establishment Plan community participation was considered to be an ethical right; which would be essential for a positive influence on health outcomes, service responsiveness and quality and safety of the service (ibid., p. 15). Apart from representation at governance level and on the LMCs, the Plan did not articulate how community participation would be facilitated. It was acknowledged that community representatives on the Board, along with other Board members, would need to be supported in their governance role through appropriate education and training.

In the Establishment Plan it was estimated that 35.9% of the population in the Levin area fitted within Decile 9-10%<sup>26</sup>. This estimation was based on 2001 Census data and did not factor in the number of local people who sought primary health care services outside the region and those from surrounding areas who sought primary health care services from Levin GPs. The Establishment Plan estimated that approximately 1,500 people from the Foxton area accessed services in Levin and when this was factored into the Levin calculation the percentage of total population in the Decile 9-10% range increased to 49.3% (ibid., p.20). Consequently, the application requested that the DHB support a recommendation to the Ministry of Health for Access funding.

The Application to form a PHO was submitted to the DHB Funding Division in September 2003. The Steering Committee did not consider any tasks over and above the DHB establishment requirements to be part of their brief. As members of the Steering Committee did not perceive any further work could be done until the Establishment Plan had been approved by the DHB, they did not reconvene until receipt of a response from the Funding

---

<sup>26</sup> Refer to Appendix G for explanation of decile groupings.

Division, MidCentral DHB, on 4 November 2003. At this meeting the Funding Division outlined the approval process by reading a section of a letter written to the Steering Committee:

The initial application is considered by the Primary Health Care Reference Group. Once the Reference Group has had input and endorses the application it is submitted to the Community and Public Health Advisory Committee for recommendation to the Board. Once the Board has approved it, the application goes to the Ministry of Health. Once the Ministry of Health has approved the application there is a three-month process involving a variety of establishment tasks – for example register cleansing.

Personal Communication from Funding Division, 29 October 2003

The Reference Group, through the Funding Division, required further work to be done on the application before it would recommend to the CPHAC that approval be given for planning to continue. Specifically, the following areas required further development in the document:

- Community participation in governance.
- Alignment of the values and service delivery principles with the vision and the objectives.
- Clarification of the relationship between the PHO and Iwi Providers and plans for future contractual arrangements.
- Detail on Board administration, health status monitoring, provider monitoring, external reporting, community consultation and stakeholder engagement.
- Identification of key health issues in the district, and how these issues will be managed. Suggestions for further consideration were the needs of people moving out into the community from the local physical and intellectual disability Centre, “Kimberley”, rural workforce issues, the Pacific community and the future of Horowhenua Hospital.

Horowhenua Steering Committee Minutes, 04 November 2003

The tasks required of the Steering Committee were varied and complex. Environmental scanning, ability to access local resources and information, navigating the Ministry of Health website for relevant information, understanding terminology and acronyms and addressing complex health and environmental issues were skills required by Steering Committee members for preparation of the Establishment Plan. To illustrate, the Steering Committee was asked by the Funding Division to provide additional information on health status monitoring, provider monitoring, external reporting, identification of key health issues and how the PHO considered it would approach these matters. Rural workforce

issues (particularly recruitment and retention of GPs) were also raised as an area that needed further attention. It is interesting to note that many of the issues which required additional attention were not unique to the Horowhenua and have been the focus of attention for Ministry of Health officials and interest groups. Questions needed to be raised about the reasonableness of the Funding Division's expectations that the Steering Committee provide insights or solutions to these issues. The Funding Division, on numerous occasions, offered assistance to the Steering Committee, however, the Committee did not request help during the preparation of the Establishment Plan. One reason for this was that they did not know what their knowledge deficits were, and therefore what guidance they should be seeking.

While the Committee had access to the expertise within the MIPA to undertake the additional tasks, it became evident during meetings that there had been discussions between the MIPA and Funding Division representatives independent of the Steering Committee, and that - as a result of these discussions - decisions had been made about what information to be included in the revised Establishment Plan. The Chairperson of the Steering Committee was not always involved either in these discussions or the subsequent decision-making. An additional challenge at the time of preparing the Establishment Plan was that the Steering Committee had no funding to complete this task and relied upon the goodwill of the MIPA to resource this activity. Further, in the initial planning period, it could be assumed that there was no guarantee funding would be forthcoming as continuation of the project was dependent on the DHB approving this Establishment Plan.

The MIPA continued to refine the application with input from Steering Committee members and the revised proposal was resubmitted to the Funding Division on 21 November 2003. At the meeting of the Steering Committee on 16 December 2003 the Funding Division informed the Committee that approval to proceed with planning for establishment of a PHO had been given – however, further work was required. The Steering Committee Minutes noted that:

- Still some areas that need extra work.
  - PHO needs to recognise and strengthen Nursing position.
  - the disability strategy.
  - further strengthening of Māori Issues.

These additional areas for consideration were not subsequently addressed by the Steering Committee and there was no further follow-up by the DHB. At this meeting it was moved that the PHO commencement be deferred from 1 April 2004 to 1 July 2004.

### **5.3.2 Maintaining a Local Planning Focus**

The desire of Steering Committee members to involve the community in planning processes was discussed regularly at Committee meetings. There was a general view that the community's knowledge of the national primary health care strategy and PHO development was minimal. Some Committee members reported that most questions asked by people coming to see their GP or practice nurse related to cost of service. This was confirmed at the public information sharing day which took place in February 2004. From a stall set up in the main street of Levin Ministry of Health and locally developed brochures about PHO formation were distributed. The public had an opportunity to have questions answered on an informal basis. Approximately one thousand pamphlets were distributed over the two days. Twenty people completed a questionnaire and comment sheet. Comments ranged from whether the cost of primary health care would reduce, to transport issues as they related to access to health services for the Horowhenua communities, to the need for improved reassessment and coordination of personal primary health care - and some took this opportunity to state their views on the Horowhenua/Otaki Health Services Review Project. All Steering Committee members agreed that there was a need for tangible messages to be developed before the general public would engage an interest in the PHO and see the new development as meaningful and relevant to them.

We need to get a project up and running to increase community awareness.

Iwi Representative II, Steering Committee Meeting, 19 April 2004

There were two GPs on the Steering Committee initially, with a Foxton (Kere Kere) GP joining the Committee in May 2004. These GPs provided the link between the planning process undertaken by the Steering Committee and general practices. A number of meetings for GPs were convened by either the MIPA or the GPs themselves during the establishment period. None were convened by the Steering Committee. I understand that much of the discussion at these meetings focused on the primary health care strategy implementation and PHO administrative changes which would be required in general

practices before joining the PHO. Very importantly, the financial implications for practices of moving to capitation-based funding, uncertainty about eligibility for Access funding, the new funding streams which would be available to PHOs and issues around patient register “cleansing” and ongoing register management were key issues for the general practices.

The Steering Committee had one meeting with providers during the establishment period (January 2004). This meeting gave opportunity for the Committee to provide an overview of PHO establishment plans and update providers on how the Committee was managing the integration of national requirements and the unique needs of the local communities. Comment was received on current service provision, its strengths and weakness as well as the opportunities which would be available to the PHO to assist with the development of new services. Feedback was also sought on how relationships amongst primary health care providers could be enhanced and the best way to establish channels of communication between all interested and prospective providers and the PHO. Twenty-one providers attended with representation from rural GPs, Plunket, midwives, physiotherapy, pharmacists, District Nursing, Public Health, Practice Nurses, Iwi Providers, Aged Care Services and specialist nurses (e.g. Diabetes Educator).

While a meeting was planned for one month later, Steering Committee members did not proceed with this meeting as they were of the opinion that they could not provide sufficient tangible new information. It was agreed that the best way to keep providers informed of progress was by newsletter – however, this form of contact did not eventuate. Workload of Steering Committee members was the reason for this not occurring.

Plans in the initial Establishment Plan for engaging the community were considered to be weak by the Funding Division. The PHO Steering Committee Chairperson pointed out:

And I did try to get [people identified] to actually see that the community wasn't in that proposal. However, yeah - I just don't think that they had that sort of a perspective at that time. And so indeed I found myself arguing on my own for the community, and then ended up in one awful rush after it came back [the Application returned to the Steering Committee for further work] to actually get it back in again quickly - putting the “community” into it.

From interview, 18 August 2004

I observed Steering Committee members, over the nine month period, gaining increased knowledge and understanding of the primary health care strategy, the role and scope of the PHO and the notion of community participation. This learning was experience-based. I also observed an increased dependence on the MIPA for completion of the technical requirements. Because of the skill mix within the Steering Committee there was limited ability for the Steering Committee to make judgments about the MIPA's outputs. In short, the MIPA, who were the advisors and providers of administrative support to the Steering Committee, were central in decision-making processes.

A final comment needs to be made about the manner in which health professionals and the community external to the Steering Committee, were engaged in the planning. The perception held by the Steering Committee was that these stakeholder groups had the expectation that they would be kept informed of decisions made, rather than be involved in the determination of decisions. This perhaps reflects the experience in previous years of being consulted, but not having the ability to contribute in a meaningful way to decisions being made. The community may not have understood the opportunities for involvement that were available to them.

### **5.3.3 Ministry of Health and DHB Establishment Requirements**

Government strategy documents, service development toolkits, various rules and guidelines, funding details, information for the public and standard service agreements were readily available on the Ministry of Health website. *Primarily*, a newsletter published by the Ministry of Health, also available on the website, provided valuable information about PHO establishment throughout New Zealand, along with editorial comment and anecdotal information about individual PHO successes.

The “Starter Pack” for PHOs, prepared by the Ministry of Health, clearly identified the requirements for PHOs during the establishment period. Critical tasks required by the Ministry of Health for the Horowhenua PHO are summarised in Table 5.3.

Table 5.3 Critical Tasks Required by the Ministry of Health and DHB for the Horowhenua PHO Establishment.

	<b>Critical Task</b>	<b>Purpose</b>
1	Submit application for establishment funding.	Funding allocated by the Ministry to assist PHOs in the establishment phase. The decision re level of and /or whether in fact a PHO receives any funding was with the Ministry of Health.
2	Application to DHB to establish a PHO.	Preparation of an Establishment Plan (Business Case).
3	Capitation Information Cleansing (CIC) processes.	There was one compulsory CIC process required no later than 2 months prior to the intended commencement date of the PHO.
4	Process register through CIC.	This was a compulsory requirement and was an intensive analysis of the PHO patient register (combined GP patient registers). The process validated people on the registers using National Health Index (NHI), Community Services Card (CSC), High User Card (HUHC) and geocodes street addresses. Following the cleansing process, the PHO was required to upload the register back into the practice registers and subsequently extract cleansed registers for submission to HealthPAC for Capitation Based Funding (CBF) payment processing.
5	Establish processes for CBF payment.	This was required to enable the PHO register to be submitted electronically for CBF payment processing.
6	PHO legal entity established.	This information was required to enable the provider identification numbers to be generated.
7	Submit cleaned, aggregated PHO register to HealthPAC.	This needed to be submitted on time to ensure payment is received on 15 <sup>th</sup> of first month of quarter.
8	Agree and sign DHB – PHO agreement.	

Adapted from Ministry of Health (n.d.). Retrieved October 4, 2004

There was no funding allocation for the Steering Committee until an application was made to the DHB and approval was given by the Ministry of Health. In April 2004 \$75,000 was paid into a MIPA account for the purposes of meeting PHO establishment costs.

#### **5.4 DISTRICT HEALTH BOARD FUNDING DIVISION**

The Funding Division which acted as the DHB representative throughout the establishment period had two quite distinct relationships with the Steering Committee. Firstly, a formal relationship required that the Funding Division ensure that all Ministry of Health specifications were met, establishment processes achieved and that a formal funder-provider contractual relationship was entered into prior to the PHO's commencement date.

Secondly, the Funding Division was required to be a resource for the Steering Committee, providing support in the form of guidance and the supply of information.

The Funding Division representatives attended PHO Steering Committee meetings both by invitation and, on occasions when there needed to be discussions about key milestones. Table 5.4 identifies the Meetings attended by the Funding Division representatives where key milestones and compliance requirements were discussed. Table 5.5 identifies occasions when the Funding Division's attendance was primarily to provide support and guidance.

Table 5.4 Funding Division Attendance at Steering Committee Meetings – Focus: Compliance

<b>Date</b>	<b>Summary of Primary Purpose for Funding Division Representatives Attendance at Steering Committee Meeting</b>
4 November 2003 and 3 February 2004	Feedback and review of the Establishment Plan (Business Case).
10 November 2003 and 15 December 2003	Combined discussions with Horowhenua, Otaki and Kere Kere Steering Committees in an effort to agree on the number of PHOs to be established.
29 March 2004	Arranging for two representatives from Kere Kere and Horowhenua to visit a PHO of similar size in another region.
19, 26 April 2004, 3,10, 11, 17 May 2004	Combined discussions with Kere Kere and Horowhenua regarding plans to establish one PHO.
20 January 2004 29 March 2004 24 May 2004	Ensuring that key milestones would be achieved within required timeframe. Priority items discussed: <ul style="list-style-type: none"> <li>• Care Plus - 20 Jan</li> <li>• SIA Funding - 29 March</li> <li>• Legal entity - 29 March</li> <li>• Board Representation - 29 March</li> <li>• Contract negotiations - 17 May</li> <li>• Governance - 24 May</li> <li>• Community representation – caucuses 24 May</li> <li>• LMG structure - 24 May</li> </ul>

Table 5.5 Funding Division Attendance at Steering Committee Meetings – Focus: Guidance and Support

<b>Date</b>	<b>Purpose of Funding Division Representatives' Attendance at Steering Committee Meeting</b>
20 January 2004	Invitation extended to Funding Division to clarify Funding Division role and clarification of critical tasks
26 January 2004	Attendance at Provider Information meeting
3 February 2004	Update on PHO development Provide a 'Starter Pack'
27 & 28 February 2004	Attendance at the Community Information Sharing Day
29 March 2004	Arranging for two representatives from Kere Kere and Horowhenua to visit as PHO of similar size in another region

The Funding Division deliberately took a “hands off” approach in the initial stage, allowing the Steering Committee to determine planning processes which best suited the needs of the group and their communities. Funding Division representatives were available to attend Steering Committee meetings and provide additional information and guidance when they were sought. They were readily available to individual members and to the MIPA to deal with specific issues as they arose.

In the month immediately prior to the PHO commencement date the Funding Division became focussed on achievement of the required Ministry of Health milestones and moved from a role of facilitation to one of leading the project and determining the tasks to be completed. During this period an increased amount of work was undertaken outside the Steering Committee or without Steering Committee sanction. Despite this, the Chairperson continued to chair the meetings.

### **5.4.1 The Horowhenua and Kere Kere Establishment Groups Combine**

In a report from the Primary Health Care Project Manager, Funding Division, to the 6 April 2004 CPHAC meeting it was noted:

....the Funding Division remains focused on attaining the best possible benefit for our population that can be derived from the opportunities of the new PHO environment. For these reasons, the Funding Division has asked the Kere Kere PHO establishment group to give serious consideration to joining the Levin based group [Horowhenua PHO Steering Committee] to form one PHO.

There were four combined meetings of the Steering Committee and the Kere Kere Healthy Communities Network during the April and May 2004 period. The plan to amalgamate the two PHO working committees was decided by the Funding Division. There was no discussion at the Horowhenua Steering Committee meeting on 29 March 2004 about plans to include the Kere Kere Healthy Communities Network representatives in the Horowhenua PHO planning process. However, at their next meeting three weeks later, five representatives from the Kere Kere Healthy Communities Network attended - along with Funding Division representatives. A Funding Division representative chaired the meeting and announced “that there were exciting new developments with the PHO establishment in the Horowhenua and Foxton [Kere Kere] area.” (Steering Committee Minutes 19 April, 2004).

The first meeting of the combined groups occurred less than ten weeks before the Horowhenua PHO was to be launched. The Steering Committee had made a commitment for a 1 July 2004 commencement date and considered that delaying this a further three months<sup>27</sup> would be detrimental to the PHO buy-in by the communities it was to serve. Tight timeframes made working through a number of integration issues challenging. While identification of these two communities was based on geographical location and physical boundaries, it became evident as the joint discussions progressed between the Kere Kere and Horowhenua representatives that other determinants were central to the interpretation of “community”. Each group exhibited their own unique “ways of doing”, managing vested

---

<sup>27</sup> The Ministry of Health required that new PHOs set their establishment date at either 1 January, 1 April, 1 July or 1 October.

interests and negotiating power relationships. The one element that blurred the boundaries between these two communities was the portion of Kere Kere residents who used primary health care services in the Horowhenua.

After a three-week period where the two groups endeavoured to work towards a common planning strategy the Funding Division revised its position and considered the preferable solution for developing effective long-term relationships between the Horowhenua PHO and the Kere Kere Healthy Communities Network was to allow more time for the two communities to develop a shared understanding of each other's needs and priorities, and develop an approach to service planning which would meet the unique needs of all communities the PHO would serve. While the Funding Division made every effort to facilitate the amalgamation the Horowhenua Steering Committee was adamant that it was not prepared to delay the PHO commencement date of 1 July 2004. This position was taken because of the perceived interminable delays which had occurred in other health service projects in the region. Steering Committee members did not want the community at large to assume that they were not able to achieve goals within an agreed timeframe. A second reason for this inflexibility regarding the establishment date was expressed informally by Steering Committee members as being their reluctance to make a personal commitment to this project for an extended and perhaps indefinite period.

While the Funding Division was committed to enabling communities to determine the most suitable configuration for PHO establishment, one of the issues for the Funding Division with respect to Kere Kere was size of the enrolled population and its sustainability into the future. The logical solution from a DHB perspective was that the Horowhenua and Kere Kere communities should combine their PHO plans. In this instance there was a management of the tensions on the part of the Funding Division between, on the one hand, allowing communities to determine the most appropriate primary health care service structure for their community and on the other, utilising the pragmatism of the primary health care strategy initiative and long-term viability within the existing PHO structures. Because of its size, the DHB representatives did not consider the Kere Kere to be a viable PHO (CPHAC Minutes, 8 April 2004).

Interestingly, the Reference Group was not involved in this effort. The minutes of their meeting on 2 March 2004 reported Kere Kere's intention to be a PHO. At their next meeting on 20 April 2004 a Funding Division representative informed the Group that; "...after several meetings between the Horowhenua and Kere Kere groups, they had decided to combine into one PHO." (Reference Group Minutes).

## **5.5 THE DHB PRIMARY HEALTH CARE REFERENCE GROUP**

The Reference Group's Statement of Intent included to: "Ensure the development of a sound platform for ongoing Primary Health Care development in the MidCentral District Health Board area." (MidCentral DHB, 2002, p 15). The Group was established in October 2002 for the purposes of providing expert advice to the Funding Division (Reference Group Minutes, 17 December 2002). Members did not represent any particular group or organisation but rather were invited by the Funding Division to join the group for the knowledge, skills and perspectives they brought to the primary health care strategy implementation (MidCentral DHB, 2002).

Reference Group direct input into the planning of the Horowhenua PHO occurred at two points in the PHO development. The Reference Group worked closely with the Funding Division in the review process for the initial application to establish a PHO in the Horowhenua region (refer section 5.3.1). The Reference Group clearly had influence over the approval process. The second occasion of direct involvement was in May 2003 when the Reference Group expressed concern about the possibility that there may be three PHOs in the Otaki/Horowhenua/Kere Kere area:

Group members reiterated the need for a collaborative approach and did not favour the set up of a number of PHOs given the limited funding and resources available for PHO establishment and development. The Group wanted to see a long-term view incorporated into robust planning processes to ensure economic efficiencies would reduce the cost of primary health care services to consumers.

Reference Group Minutes, 20 May 2003

The first attempt to bring the three groups together had been made by the Funding Division at the outset of the planning period, in May 2003. A second attempt was initiated by the Reference Group in November 2003. A combined meeting with the three PHO working

parties was scheduled for 10 November 2003 to; “Discuss the Group’s [Reference Group] concerns about the casualisation, duplication and variability issues that would be the result of more than one PHO for the area.” (Reference Group Minutes, 28 October 2003) - in an attempt to bring them together to form one PHO.

Horowhenua had already submitted its application to the Funding Division. Otaki and Kere Kere again stated their intention to proceed with individual applications. One main concern expressed by these two working parties centred on funding. There was some certainty that Kere Kere would be eligible for Access funding, while Otaki was optimistic they would also achieve the 50 percent of population in the 9 – 10% decile range, a requirement for Access funding. The 2001 census confirmed that Horowhenua would be unlikely to secure Access funding. In addition to the funding issues both Otaki and Kere Kere representatives spoke of their communities’ unique needs and the importance of formulating local solutions to improve primary health care services and access to services. At a second meeting, five weeks later, the position of the three groups remained unchanged. The Otaki and Kere Kere communities continued with its separate planning. Otaki formed a PHO on 1 April 2004. In this instance the Reference Group had no influence over outcome.

There was one significant influence that the Reference Group had on the Horowhenua Steering Committee which was not observable to the Committee. The Chairperson of the Steering Committee joined the Reference Group in December 2002 as a community representative. During the data collection period the Reference Group met on thirteen occasions. Minutes of most meetings recorded “Debriefings” and “Roundtable” sessions where members gave an update of relevant activities or events with which they had been involved. Examples of the contributions made by the Horowhenua PHO Steering Committee Chairperson included Horowhenua’s intention to lodge an application to form a PHO (Reference Committee Minutes 29 July 2003), the lack of interest in PHO establishment following public notification in local newspapers (12 September 2003), the potential impact on PHO enrolments that the anticipated 500 seasonal workers would have (23 September 2003), the Horowhenua Steering Committee’s contact with the Otaki and Kere Kere Working Groups (2 December 2003), details of the Steering Committee’s publicity programme (3 February 2004 and 2 March 2004) and progress on the joint

Horowhenua and Kere Kere Steering Committee (20 April 2004). The PHO Steering Committee Chairperson confirmed (interview, 18 August 2004) that the networks established as a result of her membership on the Reference Group, the insights gained in the course of her involvement and the informal advice she received were invaluable in her role as Chairperson of the Horowhenua PHO Steering Committee.

## 5.6 BEING A PARTICIPANT OBSERVER

There is no pure, objective, detached observation; the effects of the observer's presence can never be erased. Further, the colonial concept of the subject (the object of the observer's gaze) is no longer appropriate. Observers now function as collaborative participants in action inquiry settings.

Denzin and Lincoln, 2000, p. 634

This section sets out the issues, challenges and strategies I used to ensure I maximized the advantages of proximity to action and process, yet maintained a balance of objectivity to maintain data quality. The time and care taken to clearly identify this strategy at the outset was affirming during the nine-month period when I was very much part of the establishment process. There were two important assumptions that gave me confidence as I moved down the data collection path in this inductive research process. The first was that I felt comfortable that the sequence of events and the process of PHO establishment were determining my data collection pathway. The second assumption was the confidence I had that the range of data collection strategies - observations, attendance at public meetings, document review, media releases and semi-structured interviews along with informal conversations with participants – would provide me with some comfort that while being a “*collaborative participant*” (ibid.) data quality would be maintained.

There are some specific strategies which I used to ensure that I maintained collaborative relationships with key participants and that my presence was maintained at a level of “non-obtrusiveness”. Maintaining this level of non-obtrusiveness was particularly challenging as there were numerous occasions when I was tempted to contribute to discussion and issue resolution at Steering Committee meetings. There were occasions when I did contribute. These were carefully determined with the view to finding a balance between ensuring my influence on the PHO planning process was minimal, and that when I did contribute my

contribution added value but did not alter the PHO planning process set by the participants. These situations were invariably related to offering resources in the form of information. Examples of instances when I contributed were:

- At the 18 November 2003 Steering Committee meeting a question was asked by a Steering Committee member about the common elements which had been raised during the Funding Division public consultation round for the DHB primary health care strategy. As I was the only person at the Steering Committee meeting who had attended all public meetings I offered to the meeting my views on the common themes which had emerged at each public meeting. This brief feedback did influence some minor aspects of the Establishment Plan refinement.
- At the Provider meeting hosted by the Steering Committee (26 January 2004) a section of the meeting involved breaking up into small groups (6 people approximately) to receive feedback and comment on current service provision and future opportunities, and to discuss the enhancement of relationships and the establishment of communication channels with - and between - all interested and prospective providers and the PHO. There was no alternative but for me to join a group. All participants were aware I was a doctoral student undertaking research on the Horowhenua PHO establishment. I contributed to the discussion, but did not record detail for the purposes of data collection.
- Waddington (2004, p. 156) notes that it is useful to “do favours or try to help people whenever possible.” Public meetings invariably involved the serving of refreshments. Whenever possible, I assisted with this and the tidying of the venue at the conclusion of the meeting.
- At the Information Sharing days for the public in January 2004 the Steering Committee members were required to roster themselves for a period of time over the two days. I volunteered to be on the roster which required that, for a

two-hour period, I distributed pamphlets and respond to questions raised by the public.

- There were numerous occasions when I had informal conversations with Steering Committee members before and after Steering Committee meetings. These conversations were captured on the record of Steering Committee Meetings (Appendix C) and provided valuable insights into process and events.

## **5.7 CONCLUDING COMMENTS**

In this chapter the sequence of events from the time the Health Services Review Steering Committee initiated plans to establish a Horowhenua PHO in March 2003 until the PHO formation date of 1 July 2004 has been outlined. The approach to planning was determined by a group of community representatives who had previously been involved in health service planning for their community. The traditions and historical influences of the Horowhenua region contributed to determining the path they followed. The interface between the PHO Steering Committee and the DHB Funding Division and Reference Group demonstrated the way in which these local and unique needs were combined with the national and DHB requirements to reflect the foundation of a PHO which would best suit this small rural community. Establishment of the Steering Committee highlighted how this community managed the balance of the need for community involvement with the expediency of completing the project within their desired timeframes. As a result of the approach taken, opportunities for the community at large to be involved in the planning were diminished. Actions taken by DHB stakeholders illustrated their commitment to both facilitate processes and influence direction. The DHB's decision to allow the PHO planning process to evolve from the community provided opportunities for the Horowhenua Steering Committee and the Otaki and Kere Kere working groups to have a significant influence on process and outcome and determine the configuration of PHOs in their regions. The sequence of events presented in this chapter highlighted the tasks, challenges and issues presented to the Horowhenua Steering Committee as they worked towards PHO establishment.

Chapter Seven will provide further insights into the planning processes by providing a record of the exploration of the voices of the Steering Committee and their key stakeholders as it prepared for PHO establishment.

# CHAPTER SIX

## FINDINGS - PART II: THE VOICES

Yo Ho Ho

What's a PHO?

Tis the people's choice

To improve their health, their wealth, their future

Steering Committee Iwi Representative I

Steering Committee Meeting 1 December 2003

### 6.1 INTRODUCTION

In Chapter Five the sequence of events which occurred over the establishment period was captured and outlined to gain increased insight into the challenges, demands and opportunities created by preparing for PHO establishment planning. This chapter will present the voices of key contributors to the process. In addition to gaining an understanding of the relationships stakeholders had with one another and the ways in which these relationships influenced the planning process, the voices also highlight the impact context had on events and how individuals and groups responded during the planning period.

The first section of the chapter identifies the origins of the voices and the context in which they were recorded. The voices are then presented within a framework of events which occurred over the planning period and which raised the following questions:

1. Why did the Steering Committee members make this commitment?
2. How did the Committee get started?
3. Whom did they represent?
4. How did they “move it along”; what was their strategy for achieving tasks?
5. What contacts did they make?
6. How were they resourced?
7. What skills and knowledge were required and how did Steering Committee members access information?

These questions provide the basis for the seven remaining sections of the chapter.

The PHO Steering Committee members contribute to a significant proportion of the voices. Over the nine-month period in which I attended Steering Committee meetings I recorded discussion and documented relevant contextual issues.<sup>28</sup> Table 6.1 is the summary of participants as set out in Appendix D and provides detail of how Steering Committee members were identified for the purposes of recording interactions presented in this chapter.

Table 6.1: Identification of Voices from Steering Committee Meetings and Interviews

Steering Committee Community Representative and Chairperson
Steering Committee Community Representative II
Steering Committee Practice Nurse Representative
Steering Committee General Practitioner Representative I
Steering Committee General Practitioner II
Steering Committee Iwi Representative I
Steering Committee Iwi Representative II
Steering Committee Pacific Representative
Steering Committee Pharmacy Representative
Funding Division Representative A
Funding Division Representative B
Funding Division Representative C

Not all Steering Committee members contributed to the voices. Some members participated more willingly to discussions than did others. Presentation of the voices in this chapter is used to illustrate critical events and perspectives rather than the degree of contribution made by individuals.

At the conclusion of the PHO establishment period six semi-structured interviews were conducted with a selection of stakeholders.

---

<sup>28</sup> See Appendix C for template used for recording Steering Committee meetings.

Individuals interviewed were:

1. Chairperson Horowhenua PHO Steering Committee
2. Iwi Representative II, Horowhenua PHO Steering Committee
3. General Practitioner I, Horowhenua PHO Steering Committee
4. Chairperson, Community and Public Health Advisory Committee, MidCentral DHB
5. DHB Funding Division Representative B
6. DHB PHC Reference Group Representative

The interview questions can be found in Appendix E.

## **6.2 WHY DID STEERING COMMITTEE MEMBERS MAKE THIS COMMITMENT?**

There were a range of contributing factors which influenced individuals' readiness and availability to join the PHO Steering Committee. In this research no consideration was given to how GPs, iwi and Pacific groups determined their representation on the Steering Committee. For several of these groups, as was the case with community representatives, involvement in previous health service projects in the community, - particularly the local Health Services Review Project<sup>29</sup> - influenced their readiness and willingness to be involved in PHO development. Ten of the thirteen Steering Committee members were involved with the Health Services Review Project. The DHB had no direct influence over Steering Committee membership. The Funding Division representatives' interest did, however, focus on ensuring that the PHO Board had representation which reflected DHB expectations.

The iwi representatives attributed their involvement, in part, to the Health Services Review Project.

---

<sup>29</sup> Refer to section 3.12.

I suppose it was a flow on from the group that had worked on the new Health Centre and I was involved in that as an iwi representative. And of course PHOs were beginning to be discussed and for me it was just a natural progression from the ending of one project to another. Then again through the Muaupoko Tribal Authority [iwi] as their rep my participation went from there into the development of the Horowhenua PHO. So yeah, it's just been an ongoing involvement in health over a long period of time for me personally in terms of Māori and with the local iwi in this area.

Steering Committee Iwi Representative II from interview, 2 September 2004

The willingness of the Chairperson of the Steering Committee to be involved reflected a desire to contribute to the development of primary health care services for the community at large:

Because, basically I've always had an interest in health.... And I guess my interest - I've always had a political interest. Sometimes it's been more active than others. My concern with the government that we had in the 90s was that we would actually end up with the health maintenance organizations and it was just a different way of getting - privatising the whole health system. That system doesn't work - it doesn't work in America - and it's unlikely to work here. And furthermore we have a history of being able to supply health much more cheaply than most other OECD countries. Yeah, so it's just been my basic interest and I thought - well I've got a few skills.

Chairperson, Steering Committee, from interview 18 August 2004

The time commitment the Chairperson gave to all aspects of this project would suggest that her involvement went beyond the willingness to simply contribute to achieve project outcomes to that of determination to improve primary health care services for those population groups in the Horowhenua community whose needs have previously not been met: what Wandersman and Florin (1999) describe as doing one's duty and acting on a sense of responsibility.

The desire of some health professional members of the Steering Committee to become involved with this new development was balanced with a degree of pragmatism. When asked why he joined the Steering Committee GP Representative 1 replied: "Because nobody else would!"

He further explained his motivations for involvement:

... it became obvious that the only way of actually getting going with the increased funding - and the concern is that the area's pretty poor round the Horowhenua and we want to get the money coming in and so the only way to do that was to get the PHO going. And that means there would be substantially more financial support so people would not have to pay so much to see the doctor, with all the other sort of funding things that would come with it. So unless we got it going our population would miss out on that funding. And nobody else seemed to be able to get it going.  
ibid.

Steering Committee Iwi Representative II commented on the reality of balancing the desire to contribute to this community initiative and peoples' readiness to participate:

And I suppose in terms of looking for people to participate in these things – you're not flooded with a whole lot of people. It's a matter of selecting from those people who are attending meetings. Again, my recollection is that those people who were representing groups on the formation of the Health Centre [Health Services Review Project] were the same people and representing the same groups, more or less, on the PHO.

From interview, 2 September 2004

### **6.3 HOW DID THE STEERING COMMITTEE GET STARTED?**

Two Steering Committee representatives recall the initial efforts to establish a Steering Committee:

Well, during the consultation for the health facility [Health Services Review Project] I was aware that we should have been doing something about a primary health organisation. And as that was drawing to an end - that consultation process – I actually spoke to the group about the primary health organisation systems. That was where we really needed to be directing our energies.

Steering Committee Chairperson, from interview 18 August 2004

and:

So I wanted to get it going but we were really floundering around in the dark having various odd meetings where we had explained what PHOs were by DHB people. But we never actually got things started. So it took months – probably 4 or 5 months from wanting to get the thing going and getting it underway - before we got any traction, before we were starting to get anywhere.

Steering Committee GP Representative I, from interview, 19 August 2004

At the commencement of the project individual Steering Committee members had varying perceptions of their abilities to contribute, the legitimacy of their skill, knowledge and experience and differing expectations about the role of health professionals, especially the GPs, during the planning period. The decision made by the Steering Committee not to proceed with commissioning the Grafton Group to lead the PHO establishment process was made because of the Committee's desire to control process and to maintain direct contact with local and external stakeholders. Previous experience had given them confidence that they could succeed. The GP Representative I acknowledged the important 'learning' which had occurred and the corresponding leadership provided by the Chairperson and iwi representatives in incorporating community issues into planning:

The people who did actually get involved had been exceptionally well trained by the Grafton Group. They had been looking at all the community issues and all the health issues of the area and were really very much up to speed. In fact, the iwi reps. and [Chairperson] were way ahead of any of the GPs in town in the knowledge of how the whole thing was going to work and so on, from being involved in that community participation thing.

ibid.

The GP continued:

Until those people came on board from the community [onto the Steering Committee] it didn't get any traction - particularly, of course, [Chairperson identified]. We wouldn't be there yet if it wasn't for her, I don't think. There were a lot of people who were quite interested but it was only [Chairperson] really who actually rolled her sleeves up and got into it.

From interview, 19 August 2004

This also illustrates the opportunity participatory processes provide for people who traditionally hold positions of power to gain insights into the value of contributions made by people who do not traditionally hold the same "legitimate" power.

Strong leadership is considered an essential component of the establishment of successful participatory partnerships (Labonte, 1999; Laverack, 2004; Rifkin, 1990). The Chairperson of the CPHAC acknowledged the importance of having individuals within communities who were prepared to initiate and take a leadership role in establishing a project:

Because without those strong single-minded individuals, nothing will ever happen. ... And that's a powerful tool – that's one of the real strengths that small communities have, is this commitment from their community to take control of their own services.

From interview, 18 August 2004

However, she also had a word of caution:

It has its drawbacks in that those people can burn out very quickly and there may not necessarily be people coming up behind them because – I know in this community [Otaki] that people think they're doing a good job so we will just leave them to do it. So I think in the future there is going to have to be some planning for succession.

ibid.

While it was evident that constituency interests were addressed outside the Steering Committee (e.g. GP funding arrangements, co-location issues and GP patient register management), there was a strong sense of camaraderie between all Steering Committee members and a valuing of the contribution each member made to the planning process. In addition to Steering Committee members bringing constituency agendas to meetings, shared values were held by all members about the community at large and the anticipated opportunities a PHO would provide for improving primary health care services. This was reflected in their consensual decision-making processes:

I think we didn't come and discuss and then say who's in favour – yes or no. I think it was done on a more gradual process than that. It was much more of a consensus thing. An issue wasn't decided – it appeared that if one or two people weren't comfortable with it, it got worked through to a fairly great extent to decide what we wanted – really with very little dissention.

Steering Committee Iwi Representative II, from interview, 2 September 2004

However a GP Steering Committee member identified gaps in skill mix as having an impact on achieving tasks:

I think we probably suffered to a great extent from not having someone up to speed with administration. I think a lot of other groups [PHO establishment groups] had got lawyers and accountants sort of into these groups and got these administrative things going a lot earlier. I think we mucked around a lot over that sort of thing and we were looking a lot more at the sort of theoretical things and looking at community needs rather than getting on with getting the whole thing going.

Steering Committee GP Representative I, from interview, 19 August 2004

Deadlines established were those set by the DHB and Ministry of Health for achieving key tasks. Apart from setting the PHO commencement date, the Steering Committee did not formally set any timeframes nor was a project management or similar approach used to planning tasks and determining outcomes.

Basically the first three or four months we were just mucking around. Nothing was achieved at all until those particular people got on board and started working there and that would have had to have been about October, November. And that was about the stage that you [Jan Lockett-Kay] got involved with the group – so it was really just as you were getting involved that it started to gel. And, ah, it was quite surprising how well it seemed work. Everyone seemed to get on pretty well. It seemed to be fairly focused on where we needed to go.

ibid.

On reflection at the conclusion of the planning period the Steering Committee Chairperson noted that two things should have been done differently. Committee rules should have been agreed, and a programme should have been planned for achieving key tasks to ensure that the workload was spread more evenly over the entire planning period and across members of the Steering Committee.

#### **6.4 WHOM DID THE STEERING COMMITTEE REPRESENT?**

The majority of members on the PHO Steering Committee had either direct involvement or some interest in the Health Services Review Project. The Steering Committee Chairperson recalled the process used by the Health Services Review Steering Committee for PHO Steering Committee appointment:

We came up with a list of people to ring around between us to see if they would attend a meeting in relation to that [PHO]. And so really that is how the committee was selected. ...In a sense the representation was fairly ad hoc.

From interview, 18 August 2004

The rationale given for this process of selection was the desire to see planning begin immediately and a concern was expressed that the lack of community knowledge about

PHOs may hinder the selection process (Minutes Horowhenua/Otaki Health Services Review Steering Committee, 20 June 2003).

The issue of representation was also raised by the Reference Group Representative:

..... it is terribly easy to relate to the people who put their hands up. It's much more difficult to get to the people who don't put their hands up or don't turn up at night meetings and don't participate. So to me the community has been a very invisible and unheard group in this, despite the very vigorous work by some of their representatives on their behalf. I think they have steered a very difficult course.

From interview, 24 August 2004

White (1996) proposes that participation has the potential to entrench existing power relations. The majority of individuals who put themselves forward for the Horowhenua PHO establishment project had participated in previous health service planning in their communities and understood the "ways of doing". This process for selecting community representatives to the Steering Committee may have excluded representatives from other groups in the community who had not been "socialised" in the required ways of doing, thus supporting a pattern of dominance at the grassroots community level. Another possible interpretation of why choice and opportunity to participate was exercised in this way was that the community at large were content to allow this small group of willing participants to undertake the project.

While individual members' contributions to the Steering Committee were influenced by their constituency representation, an iwi representative did not believe that specific agendas dominated the approach taken to planning:

I'm on that group because iwi see all of those groups as part of health overall, and so it is a matter of participating in all these important health groups – or as many as we are able to anyway - because the overall aim is to get an overall view of where we are in terms of iwi in the area. So they didn't directly guide me as to, you know, specific things – but more or less to say, yes, it is positive that we be there and that we have a voice there. And if anything comes up then we are able to respond to it.

Steering Committee Iwi Representative II, from interview, 2 September 2004

And he describes in practical terms his link back to the Iwi:

Yes I always felt comfortable about my role on the PHO Establishing Group and that there were no issues that I required to go back to the Iwi and get their view on it. But over the time that the group – that the PHO was establishing - we did have regular Iwi meetings and meetings with kaumātua and kuia, and there were forums where I brought them up to date.

ibid.

The need for a presence and opportunity to contribute across a range of activities did, however, raise issues of demand placed on individuals:

Muaupoko [Tribal Authority] haven't got any health programmes and is not a provider of health programmes and they don't have lots of people participating in terms of being available to be on committees or groups. And so it has been a matter of picking where we need to be really, because in terms of people resources we are pretty thin on the ground. And I suppose in a way that has disadvantaged Muaupoko in terms of advocating what they really need in terms of their health.

ibid.

This reinforced the comment made by the Chairperson of the CPHAC (from interview, 18 August 2004) that often a few individuals are relied upon to be involved in a number of community initiatives.

The Chairperson of the CPHAC advocated realistic reward for contributions.

I think you need to give greater weight to the community representatives and I think a way of doing that and a way of valuing them and a way of encouraging them is to make sure that their role on a PHO board is a paid one.

From interview 18 August 2004

She then goes on to say that the level of remuneration needs to be reasonable:

... to sustain the commitment of high quality community individuals.  
... if they take a risk that risk needs to be acknowledged in some way.

ibid.

There were times during the establishment period when it was observed that the roles and relationships which GPs on the Steering Committee had with their communities went beyond that of solely health professionals thus blurring the boundary between their role of health practitioner and that of member of the community. Health professionals had been

parents at local schools, members of various community and sporting organisations and considered the Horowhenua to be not only their location for work but also “their community”. This adds to the complexity of representation and raises issues of the extent to which roles legitimise or exclude individuals to specific constituency representation.

At Steering Committee meetings Funding Division Representatives clearly articulated the DHB’s expectation about representation on the PHO Board and were firm about the exclusion of individuals as community representatives if they had health professional roles in the community. Discussion on this issue identified the difference in perspective of some community representatives about individuals’ ability to represent the group who had nominated them. To illustrate, the Pacific representative challenged the traditional understanding of community and provider representation at the 26 April 2004 Steering Committee Meeting:

If we have voted a provider on as the community rep, they are representing the community, not the provider.

Steering Committee meeting, 26 April 2004

and:

The GPs may want to appoint an accountant [as their representative].

ibid.

This illustrates individual Steering Committee members’ desire to give consideration to skill mix and knowledge to ensure constituency interests are well represented, but also raises the question as to whether vested interests could be managed adequately if such an approach was adopted.

Vested interests influenced process throughout the project. Despite the commitment of all Steering Committee members to the success of PHO establishment for the benefit of the community, it was to be expected that stakeholder interests were an important consideration for some Steering Committee members. The CPHAC Chairperson supported the need for balance in representation on PHO Boards:

I think there is a tendency to be over-dominated by GPs, and while I understand that this is their livelihood and this is their business, the principles – the government principles of PHOs - are for the community to be involved in it and so

I would like to see more community input on their Boards and more nursing input on their Boards.

From interview, 18 August 2004

Community representation on the inaugural Board was reduced from that of the Steering Committee.

## **6.5 WHAT WAS THEIR STRATEGY FOR ACHIEVING TASKS?**

The first important achievement was the approval of the Establishment Plan by MidCentral DHB to form a PHO in the Horowhenua District. Formalising the legal entity, determining PHO Board membership and completing the Ministry of Health requirements for establishing patient databases which would support the transfer of GP practices to capitation-based funding were among the other important tasks to be completed during the establishment period.

The Funding Division deliberately left the Steering Committee to determine how it was going to commence planning:

We put some frameworks in terms of requiring them to ... present an establishment plan, but we didn't ... structure them a heck of a lot. We sort of at that stage took a reasonably passive approach to PHO establishment, saying we want this to come out of the community rather than us ushering them through the process.

Funding Division Representative B, from interview, 19 August 2004

Agendas were circulated prior to each meeting and minutes distributed normally within one week of the meeting. At times there was an expectation that Steering Committee members did prior reading or agreed to undertake specific tasks between meetings. My observations were that this often did not occur, with explanations invariably relating to heavy workloads. On numerous occasions discussions resulted in the Committee digressing from the agenda for lengthy periods. This, along with the variability in knowledge about primary health care strategy and the actual process for PHO establishment, posed challenges to the Committee in general and the Chairperson specifically.

Steering Committee Iwi Representative II made this observation about meeting process:

I suppose in terms of being clear as to what we were wanting to do in the establishing stage of the PHO, I think we sort of did have problems with people grasping the overall picture one wanted to get to and we got trapped into the nuts and bolts of it. ... And because we got trapped into the nuts and bolts we did, in my view, waste a lot of time and energy, sort of debating little things, when we were not at the stage to debate that. It was a matter of looking at the bigger picture and as we moved one step then perhaps those other issues could have been discussed at that stage. I think we were discussing some issues before we actually got to that stage. ... And looking back I think we could have achieved what we have achieved in perhaps less time.

From interview, 2 September 2004

Steering Committee GP Representative I was in agreement regarding the time taken to achieve tasks:

The whole lot could have gone through at least about five times as quickly. So great for getting on and efficiency, but in fact a lot of that time was spent with relationship building inside the PHO Committee. So by the end of the time people got to know each other very well. And that would make a huge difference, I would think, long-term.

From interview, 19 August 2004

Consequently, frustration was expressed towards the end of the project about the perceived tight timeframes for achieving specific tasks. These tight timeframes, particularly in the two months immediately prior to the commencement date, were largely a result of the Committee not having some form of project management approach which would have provided certainty about achieving key tasks within a predetermined timeframe.

I really thought in May, June [2004] that it was going to be an impossible situation – that we would have to delay the introduction ...I'm surprised it ended up sneaking through. I'm quite sure some of the deadlines that were officially laid down - we broke a fair chunk of them but we seemed to get in OK. I think MidCentral had to go flat out at the end to get it organised.

ibid.

Steering Committee Members expressed anxiety at times about the tasks that had to be achieved and their expertise in achieving them, as illustrated at the 20 January 2004 Steering Committee meeting:

We have to be realistic. We are looking at problems. We're an establishment group and as we face problems we will get the right people to help us.

Iwi Representative I

We need to be tapping people on the shoulder.

Steering Committee Chairperson

I don't understand everything, but we can move forward.

Iwi Representative I

Humour often helped alleviate anxieties when it appeared that no progress was being made:

We're swimming in porridge

Pharmacy Representative, Steering Committee Meeting, 3 February 2004

and:

We're like a 737 [aircraft] without headlights

Pacific Representative, Steering Committee meeting, 3 May 2004

Throughout the planning process there was an acceptance of the likely changes to primary health care services which would result as a consequence of this policy implementation. Frustrations were expressed on occasions when there appeared to be minimal progress being made. To manage this, when time frames were tight, an increasing amount of project business was undertaken outside the Committee. Frequently the need for this to occur was not identified as part of Steering Committee business and often completion of such tasks were not reported back to the Committee.

The lengthy time taken for the Committee to establish a strategy for progressing the planning process could be attributed to the Committee's failure at the outset to establish expectations and legitimise the role of the Chairperson along with each member within the Steering Committee so as to ensure positions of power held by each member external to the Committee had minimal impact on decision-making processes. Process considerations

such as determining shared goals, understanding vested interests, and agreeing on preferred ways of doing were not addressed by the Committee at the commencement of planning but rather unfolded over time in response to tasks and challenges. This resulted in decision-making and achievement of milestones taking a long time and health professionals and the MIPA capturing decision-making opportunities.

## **6.6 WHAT CONTACTS DID THE STEERING COMMITTEE MAKE?**

The first task to be completed by the Steering Committee was a particularly challenging one. Preparation of the Establishment Plan required a sound understanding of current health services, primary health care needs in the region, establishment priorities and detail of how outcomes would be achieved. The Steering Committee was at the beginning of its journey in establishing relationships with stakeholders, in particular the Funding Division, health professionals in the region and the community at large. The Funding Division Representative did not underestimate the enormity of the task:

Well apart from the fact of the huge [emphasised] amount of work they had to do and the constant meetings – attending constant meetings, dealing with really tricky issues, dealing with very difficult people in many cases, dealing with a DHB who had its own ideas about what it thought ought to be happening. Yeah, and a community down there that was actually quite sensitive to health stuff. You know there are a lot of issues going on down there - when you look at Horowhenua Hospital, Kimberley Centre. Kimberley Centre is going to be a huge issue for them to face in the future. The aging, elderly population and the poor population down there - the issue of the Access funding.

Funding Division Representative B from interview, 19 August 2004

He goes on to say:

What they have been doing [the Steering Committee] on their particular plans and ideas I think this is amazing. [The Steering Committee] had reached quite good understandings with their GPs, and you know sort of quite a lot of involvement and participation. ibid.

The desire of Steering Committee members to involve the community in planning processes was discussed regularly at meetings. There was general agreement that the community's involvement was important, however there was unanimous agreement that

there was a need to provide tangible information; information about decisions when they had been made, rather than to involve communities in the actual decision-making process.

The experiences of involvement in health service planning in this region had historically focussed on consultative processes where views and information were sought by decision-makers with no commitment necessarily that the information would influence final decisions. The community had no reason to believe that it would be different on this occasion to previous experiences of community consultation. The bureaucrats (particularly the Funding Division representatives) were considered to be central to decision-making processes for PHO establishment. Stakeholder power relationships fluctuated depending on issues being addressed. For example, when decisions were being made about the inaugural PHO Board representation the health professionals and community representatives together agreed on the constituency representation. When discussions occurred about preparations for establishing capitation-based funding arrangements the community representatives were excluded from decision-making.

Two disincentives for increased grassroots community involvement were identified. All Steering Committee members had a finite amount of time to give to the project, and therefore were wary of the time it would take to engage the community at large. The second disincentive was resourcing. The potential costs associated with communicating with community groups, the hireage of venues for meetings, toll calls and vehicle running expenses would have to be incurred personally with no assurance of reimbursement at a later date.

General practitioners were the health professional group most affected by the changes the new PHO would bring. The move from a subsidy-based funding arrangement to capitation-based funding had significant implications for their privately owned businesses. There was a degree of scepticism about the PHO model amongst GPs. The transfer to a PHO had added implications for GPs because of the expectation held by the DHB that they would co-locate their practices in the planned new health facility.

All GPs have been turned off – it's crazy because that's where primary health care will come from. The PHO had to be up and running before any possibility of a commitment.

GP Representative I, Steering Committee meeting, 1 March 2004

The health professionals on the Steering Committee acknowledged that over the previous ten years there had been a decline in the level of collaboration and communication generally between health service providers in the region as a result of the quasi-market health policies and contracting arrangements during this period:

[We need to be] starting a process of communication like we used to have ten years ago but the competitive arrangements killed that.

ibid., Steering Committee meeting, 16 December 2003

and:

I don't even know what the District Nurses look like now. We used to meet regularly and often talk on the phone. Then we weren't allowed to phone them – had to send them a fax.

ibid., Steering Committee meeting, 3 February 2004

While it was expected that most health service providers who had in the past had a contractual relationship with the DHB or the Ministry of Health would eventually have a contract for service provision with the PHO, the iwi contracts were expected - for the interim at least - to remain with the DHB. Steering Committee Iwi Representative I explains his understanding of the nature of their relationship with the PHO at the 4 November 2003 meeting:

Some providers will have separate contracts. Raukawa doesn't come under the PHO but the PHO is involved at an integration level.

and:

Iwi providers stay where they are [referring to their contractual relationships] but we work together and the PHO provides the focal point where we can discuss coordination.

## **6.7 HOW WAS THE STEERING COMMITTEE RESOURCED?**

Prior to their involvement, Steering Committee members understood that their commitment to the Committee would be in their “personal” time. Meetings were held in the evening at a committee member’s workplace. Resourcing of the Committee for stationery, printing, photocopying, postage, internet access and toll calls initially came from individual members or the goodwill of businesses and organisations with which committee members were associated. Steering Committee members travelled varying distances to the Steering Committee meetings, the greatest being 34 kilometres return.

The Steering Committee Chairperson highlighted the problems this created:

Because the Establishment Committee had no resources for eight months the committee members were constrained. Electronic communication precludes many from participating and the messages received via this route leave much to be desired, and difficulties arise, and there is a cost, disseminating the information to all committee members. The Chairperson, the only member of the Committee not in paid employment, was reluctant to make toll calls, although toll calls were reimbursed, for what was very basic information. We needed in our situation an administrative person based in our locality. Photocopying was done by MIPA in Palmerston North, but not all of it, and this created another stressor. The photocopier was free but the Chairperson had to travel 34 kilometres round trip to do it. There was little understanding of the frustration this caused.

From interview, 18 August 2004

The issue of personal financial cost was raised on a number of occasions at Steering Committee Meetings. The following statements made at various meetings by the Steering Committee Chairperson illustrates this:

The hall has been booked for next Monday. We got a bill for its hire. [Steering Committee Member identified] has sorted it out – there is no charge to us now.

20 January 2004

I’m sick of having to get [person identified] to pay me [reimburse]. I send the accounts to MIPA when I can and pay myself when I have to. The advertisement for the free local newspaper [advertising the promotion day] would not be accepted unless I paid for it then and there.

16 February 2004

In April 2004, following Ministry of Health approval, the DHB paid an establishment grant of \$75,000 to meet establishment costs of the Committee.

The Steering Committee Pharmacy Representative made an effort to acknowledge the personal contribution made by the Steering Committee Chairperson at the 3 May 2004 meeting:

Can we pay [Chairperson identified] for the work she's done? Can we write a cheque? We need to be able to give proper compensation for getting it [the PHO] on the road - getting us here and keeping it going.

The MIPA Advisor replied:

\$75,000 has gone through. MIPA has a contract with the DHB to get it going. We need to be sure that we have funds, for example, for legal fees. So \$15,000 held for directors' fees should be held till we are aware of all the establishment costs.

At a Steering Committee Meeting a fortnight later the Steering Committee Pharmacy Representative persisted:

Can I talk to the man that holds the money? Can we pay her [Chairperson identified] \$3,000? She has put so much in .....

17 May 2004

To which the reply was:

We agreed to wait until we were aware of all our costs. We also agreed to ensure [Chairperson identified] and others would be compensated.

MIPA Representative

This was the only occasion when overt frustration and anger was expressed. The pharmacy representative was appreciative of the personal costs being experienced by the Chairperson in relation to time and incidental expenses. Importantly acknowledgement was also being made to the contribution the Chairperson had made to the success of the project. Timely

reimbursement which reflected actual costs incurred would have acknowledged this contribution.

While there was an understanding and acceptance that voluntary input into the PHO planning at the community level was required, the way in which the Steering Committee was resourced necessitated personal financial contribution from all members in order to conduct the Steering Committee business. This was a source of resentment throughout the PHO planning period.

At another level demands were also being made on volunteer input, specifically in the giving of time. By implication, the Funding Division - in securing the expertise of the Reference Group - required the Steering Committee Chairperson to make an additional personal contribution:

At the time [of receiving the Establishment Plans] I didn't have a lot of resources but I was using the Primary Health Care Reference Group as the - to do some of the work around looking at the Establishment Plans and making sure that they were OK.

Funding Division Representative B from interview, 19 August 2004

The CPHAC Chairperson was an advocate for a level of resourcing for projects of this size:

Yes I would have said that money is needed up front, right at the beginning. So that - there is so much work to do that - for community volunteers to do it, it's almost impossible. Its almost - it's just a huge [emphasized] commitment in time and I think that there has to be seeding funding ahead of the establishment date. When they get their establishment money they need that up front - they need that early - so that they can do what [Otaki] did and employ somebody to get to the start date. Levin [Horowhenua] didn't have that.

And so that is a real big tick for that community [the Horowhenua] that they actually have the volunteers prepared to put in the time. And it's a really complex process. So that would be the big thing I would argue for - money up front. - right at the beginning.

From interview 18 August 2004

The enormity of the task for the Horowhenua PHO Steering Committee and the amount of volunteer input were further highlighted by Steering Committee GP Representative I:

So the community involvement and so on can't just happen out of thin air – you have to actually have it organised in some way and you have to have someone who can do that as did happen in the other places. We didn't really have someone who could do it apart from [Steering Committee member identified] who put in hundreds of hours and without her doing that, very much unfunded, there is simply no way we would have got off the ground in the time we did. We would have been delayed forever.

From interview, 19 August 2004

Simpson et al., (2003) contest that projects must be supported by adequate resourcing so that positive capacity building experiences can occur. Failure to do so can create a risk that new pressures on previously sound community networks become a "... catalyst for 'cracks' ....." in the community social infrastructures (ibid., p. 282). While there was no evidence of "cracks" some Steering Committee members were clearly frustrated about the personal time commitment required for this project.

## **6.8 WHAT SKILLS AND KNOWLEDGE WERE REQUIRED AND HOW WAS INFORMATION ACCESSED?**

A level of understanding about the health environment and the primary health care strategy was an essential requirement for those working towards PHO establishment. The Ministry of Health website was the primary source of information about PHO establishment and provided all detail of key milestones and requirements to be met during the planning phase. Some members of the Steering Committee were not computer literate. This had implications for access to Ministry documentation and for internal communications within the Steering Committee such as distribution of meeting minutes. As time progressed it became apparent that it was not only computer ownership and literacy which influenced this access, but also the capability of the individual member's personal computer system and the level of technology support available to them when problems arose. Frustration was expressed at Committee Meetings on numerous occasions about lack of personal infrastructure support. To illustrate when the Chairperson was attempting to keep to deadlines in the lead up to the provider meeting:

My computer is down, my telephone has been out of order twice since Christmas and was out all day today. And my car is in the panel beater's!<sup>30</sup>

Chairperson, Steering Committee meeting, 20 January 2004

There was another illustration at the 3 February 2004 Steering Committee Meeting when reference was made to the Ministry of Health "Starter Pack". The Pharmacy Representative raised the question: "Why didn't we know about the Starter Pack when we started?" The reply from the Steering Committee Chairperson: "It's on the Ministry of Health website", quickly prompted an emotional response by the Pharmacy Representative: "That assumes everyone is IT literate."

There was much evidence at Steering Committee meetings that members had varying degrees of knowledge about project management, the health sector generally, the primary health care strategy and DHB and Ministry of Health requirements and responsibilities for PHO establishment. To illustrate, at the 20 January 2004 Steering Committee meeting, just over five months before project completion, the Chairperson raised the following questions for the Funding Division:

- What we want to know are things like the role and responsibilities of the PHO and the role and responsibilities of the Funding Division – what practical assistance the Division will provide. What is the PHO governing?
- We need to have detail so that we can be informed.
- Who writes the policies? How are we going to get all this done? What will be the practical help?
- What resources are available to inform the community?

And at the 3 February 2004 Steering Committee meeting:

What do we have to get done by 1 July?

ibid.

Frustrations experienced in obtaining and assimilating the information available for PHO planning were expressed by a number of Steering Committee Members:

---

<sup>30</sup> Chairperson lives 17 kilometers from the Steering Committee Meeting venue.

Yes, over the time there was lots of information that came from lots of areas. And the DHB was one. ...The government sort of had a launch on PHOs and a whole lot of information followed after that. And even though, with all that information coming out you can see what it's about, but to me unless you begin to work it through, some of the questions remain unanswered until you actually get to do it and then it starts to become more clearer. So my understanding of the PHOs now is a wee bit better than it was when we started off.

Steering Committee Iwi Representative II from interview, 2 September 2004

We wasted an awful lot of time floundering around figuring what on earth we were supposed to be doing. ibid.

and:

I'd have to say information generally is a lack and that relates to my own – my inability with this computer and it's always going wrong. It's just being stuck out in the wilds. And I did try to access a couple of books through the public library and they were not available – they had to go through the loan system - the national loan system and they weren't available because they were university texts or they were from a university library and they weren't going to lend them out – So! [showed expression of frustration]. ..... MIPA produced some bits and pieces and I got stuff from the Ministry's website and then I was getting information from the Reference Group. That actually was very useful for me.

Steering Committee Chairperson from interview, 18 August 2004

The DHB Representative acknowledged that there were issues associated with access to useful information when the Steering Committee was preparing their Establishment Plan:

To my mind the material from the Ministry plus our own DHB requirements, etc., don't make for a logical user-friendly establishment plan.

Funding Division Representative B from interview, 19 August 2004

The broad scope of knowledge and expertise expected of the Steering Committee was further highlighted when they received feedback from their initial Establishment Plan for PHO establishment. Examples of additional information required by the funder before the proposal could be approved have been discussed in section 5.3.1.

The Steering Committee Pharmacy Representative summed the situation up:

There's a hell of a lot of learning we have to do.

Steering Committee Meeting, 3 February 2004

To ensure effective implementation of the national and DHB primary health care strategy the Steering Committee needed not only to be conversant with the tasks and timeframes, but also have a sound knowledge of the broader social factors and an appreciation of the context within which the government policy for primary health care was set. During the planning period minimal reference was made to either *The Primary Health Care Strategy* (King, 2001) or the *Primary Health Care Strategy* (MidCentral DHB, 2004b) documents at Steering Committee meetings. The primary health care strategy involved new direction for primary health care with greater emphasis on population health and the role of the community. The Steering Committee members needed an in-depth understanding of these directions and the context in which the overall strategy was set.

Accessibility of information was one issue, but equally important was the need to place it within the context in which it was going to be applied. Funding Division personnel along with Steering Committee Members agreed that determining in advance strategy implementation would have been difficult. The Steering Committee Chairperson identified the need to have some facilitation of what to do with the information if and when it was obtained:

Nobody had any entrenched views about how a PHO should work specifically - but in saying that, I harp back to the information we didn't have. From my perspective, we didn't have adequate information or support from anybody in relation to the information.

From interview 18 August 2004

## **6.9 CONCLUDING COMMENTS**

The voices presented in this chapter provide a rich tapestry of perceptions, understandings, energies and emotions. In addition, using this approach to presenting this section of the findings provided a vehicle for ensuring the contextual influences were presented in a way which accurately depicted the impact they had on the sequence of events and human responses to these events. The interconnectedness of networks maintained by the Steering Committee generally and the community representatives specifically, had a significant impact on PHO planning processes. The invisibility of these interrelationships emphasised the importance of legitimising the “ways of doing” established by the community. The findings highlighted the complexities of representation and the need to consider interests beyond simply interest group representation. The sequences of events highlighted the challenges posed by the tasks that needed to be completed, the lack of project planning and the impact of inadequate resourcing. The tension between having people involved who have the necessary skill and knowledge and using the participatory process for building competency and community capacity was highlighted. Power relationships had an enormous impact on planning process. The traditional roles held by health professionals and bureaucrats accorded them with influence over selective decision-making and secured their position of dominance throughout the project. These traditional power relationships superseded the accustomed role and responsibilities of Committee Chair – a position held by a community representative. For community inclusiveness to be of maximum benefit for both the specific project being undertaken and the individuals who contribute, considerations of how best to facilitate individuals engaging in community initiatives must go beyond the scope and life of any one particular project.

In the light of the findings presented in Chapters Five and Six, the analysis in Chapter Seven will conclude with identification of key determinants which would strengthen the notion of community participation both for individuals who participate and the ongoing development of community capacity.

# CHAPTER SEVEN

## COMMUNITY PARTICIPATION: DETERMINANTS

The community has immense influence on primary health care. The community is driving the future form of practices. I doubt if the community sees it that way.

Funding Division Representative C,  
Steering Committee Meeting, 3 February 2004

### 7.1 INTRODUCTION

The formation of a PHO Steering Committee to undertake the planning required for PHO establishment was the preferred option chosen by this community. This approach to planning emerged out of an existing consultative process which had been instigated by the MidCentral DHB in an effort to secure community input into the review of the existing health services in the region. The analysis places the contextual uniqueness of the Horowhenua community central to determining process for community participation. The Steering Committee's ways of conducting business reflected their values about individual contribution, decision-making and maximising individual strengths - along with managing vested interests, power disparities and stakeholder relationships. The approach to analysis is based on the four themes identified in section 4.9 and is depicted in Table 7.1.

Table 7.1: Approach to Analysis

<b>Theme</b>	<b>Approach to Analysis</b>
The origins of the Horowhenua PHO Steering Committee.	Contextual uniqueness
Relationships Steering Committee members had with each other, their community and stakeholders.	Relationships
The Steering Committee members' experience of participating in this PHO development.	The experience of participating
Steering Committee and stakeholder perceptions of community readiness to participate.	Steering Committee's influence over process

The final section of this chapter presents determinants of community participation and practical strategies for ensuring such participation is inclusive and capacity building for the New Zealand health service planning context.

## **7.2 CONTEXTUAL UNIQUENESSES**

The way in which the Horowhenua PHO Steering Committee was established, along with the manner in which PHO establishment tasks were completed, reflected the uniqueness of this rural community. Experience with previous community projects, the role of various community leaders and interest groups in project formulation, and the informal community networks were all strong contextual influences at the commencement of the PHO planning process.

### **7.2.1 Community Infrastructure**

There were two local formalised grassroots committees which were central to determining how PHO planning was initiated: the Joint Transport and Health Services Subcommittee<sup>31</sup> and the Health Services Review Steering Committee. Both committees were established to meet specific local needs and were seen to complement the work of other community organisations such as Senior Citizens, Citizens' Advice Bureau and Horowhenua Grey Power<sup>32</sup>. Shared membership and aligned goals created an opportunity for both a formal and an informal coordinated effort between these two committees and the Steering Committee. It was the Health Services Review Steering Committee's identification of the need to commence PHO establishment planning which provided the impetus for the PHO Steering Committee formation to occur. This subcommittee determined the PHO planning process (that there be a PHO Steering Committee), the membership and provided one option for commencing work (seeking a proposal from Grafton Consulting Group). The Joint Transport and Health Services Subcommittee provided an avenue for disseminating information about PHO establishment progress to the wider community. The Chair of the

---

<sup>31</sup> The Joint Transport and Health Services Subcommittee reports through the Horowhenua District Council's Development Committee to the Horowhenua District Council. It comprises both Council representatives and selected public members and deals with predominantly local health and transport issues. It has no formally ratified Terms of Reference.

<sup>32</sup> Grey Power is a Federation established to support and protect the wellbeing of older people.

Joint Transport and Health Services Subcommittee was the deputy mayor and also a member of the PHO Steering Committee.

There were community links at the DHB and local government governance levels which were central to the PHO establishment success. At the DHB governance level there were two elected members<sup>33</sup>; one lived in the Horowhenua and the other in the Otaki. The Horowhenua DHB Board member was also a Horowhenua District Councillor. While not directly involved in initiating plans for PHO establishment, he did attend the public meetings called to discuss PHO establishment (March to May 2003) and observations made of proceedings at the CPHAC meetings confirmed that he had been briefed about Steering Committee issues and acted as an advocate for this Committee at the CPHAC meetings. The DHB Board member who resided in Otaki was Chairperson of the CPHAC and also a member of the Reference Group for part of the data collection period.

To summarise, community representatives on the Steering Committee were also members of the:

- Horowhenua District Council,
- Joint Transport and Health Services Sub-Committee,
- Health Services Review Committee, and,
- Reference Group.

All committees had a shared commitment to improving health services in the Horowhenua. The Horowhenua District Council, as the local government authority for the region, played a particularly important role in indirectly influencing the success of the PHO establishment project because of its decision-making authority and power relationships with the primary health care stakeholders – particularly the DHB. The DHB Board, as the governing body for the funding of primary health care services in the region, and the District Council shared comparable authority and power over decisions made about community infrastructures and services. The Horowhenua District Councillor who is a MidCentral DHB member played a crucial role as advocate and informant for the PHO at these governance levels. This multi-level involvement of community leaders in planning for PHO establishment should

---

<sup>33</sup> MidCentral DHB has seven elected Board Members and four appointed by the Minister of Health.

theoretically enhance the likelihood of meaningful community participation. Rifkin (1990) holds the view that if local leadership is ignored projects have a diminished chance of long-term success. However, from another perspective, these community representatives influenced decisions not to seek wider community input into the Steering Committee establishment and membership. In effect these decisions further diminished opportunity for new grassroots community representatives to come forward and be involved in PHO planning. Campbell and Jovchelovitch (2000) support the notion that the process of participation provides opportunity for dialogue between different representations. While this is the case for the community representatives at the different decision-making levels in this community, it also provided an avenue for patterns of dominance to be reinforced. Labonte (1997) concurs - communities are often involved but decision-making authority occurs within clearly determined parameters. The PHO planning process illustrated how control and exclusion can result from actions not only taken by individuals who have institutional power (for example, Funding Division Representatives and health professionals) but also by community representatives who, through their representation, have been accorded power and authority.

The process adopted for commencing PHO establishment was not the result of just one individual's or one group's effort to determine a pathway forward. Rather, it was the combined effort of members who were part of a number of established infrastructures within the community. They represented groups who held considerable decision-making power (local government and DHB governance), as well as the grassroots community committees. Throughout the planning process, the impact of these infrastructures was not always visible, particularly to external stakeholders. The benefits of these interrelationships for the Steering Committee were that often other committees and organisations fulfilled an advocacy and information sharing role for the Steering Committee within their separate networks. In effect, the Steering Committee was supported, albeit indirectly, by a range of community leaders and decision-makers all of whom were aligned to the Steering Committee's goals and desired outcomes.

At another level, and occurring at the same time as the PHO Steering Committee was preparing to establish, the DHB Reference Group<sup>34</sup> was formed, with a community representative appointed to the Group from the Horowhenua. This person later became the PHO Steering Committee Chairperson. This provided reciprocal opportunities; the Reference Group secured the expertise of a community representative who was actively involved in preparing for PHO establishment, and the Chairperson of the PHO Steering Committee benefited from the networking and access to information which resulted from her involvement in the Reference Group. The Chairperson considered these collegial associations, and the opportunity this membership provided her to access relevant information, to be of valuable assistance to her throughout the planning period (from an interview, 18 August, 2004).

An added dimension, not specifically relevant to PHO establishment but important when considering community infrastructures and partnerships, was the relationship between the Horowhenua District Council and the Health Services Review Steering Committee. These two groups were aligned in a collective effort to secure funds from an external agency (New Zealand Treasury via the Ministry of Health and the DHB) for their reconfigured local community health service. This illustrated a combined effort of two groups within the Horowhenua community: one which comprised predominantly community representatives working from the “bottom up” (Health Services Review Steering Committee) and another working from the “top down” (Horowhenua District Council). Both groups shared the same goal and brought to the partnership different, but valued kinds of knowledge, perceptions and skills to achieve a common goal: resourcing for a reconfigured health service. Labonte (1999), Laverack (2004) and Rifkin et al. (1988) all draw attention to the importance of established networks and relationships in communities which contribute to strengthen and support community participation. This case study illustrates their invisibility and influence. Stakeholders, particularly those external to the community, did not seem to fully appreciate their presence or their influence on process and outcome.

---

<sup>34</sup> See Appendix A for Terms of Reference.

### 7.2.2 Grassroots Community Participation

Analysis showed that the Steering Committee members' perception of the community's readiness to become involved was dependent on people's past and current experiences and the perceived relevance or importance of the issue or project in question. Expectations placed on the Steering Committee by the Funding Division to secure increased involvement from the community at large in the planning for PHO establishment were not fulfilled. It was unanimously agreed by all Steering Committee members that the community's levels of knowledge and their desires to become involved in PHO planning were minimal, and that this would not change until the community saw tangible evidence of the new opportunities the PHO would provide. There were other factors which contributed to the Steering Committee's reluctance to embark on a community awareness programme. The first was the added workload demand which would be required in addition to all other PHO set-up tasks. Willingness of Steering Committee members to undertake tasks over and above attending meetings varied and inevitably rested with the Chairperson. Placing expectations of time commitments beyond what individuals are able to give can act as a demotivator and can lead to individuals withdrawing from projects and others being excluded because they do not have the personal resources to give (Irvin & Stansbury, 2004). The second consideration is the anticipated incidental personal costs associated with embarking on a deliberate community-wide involvement and awareness programme. This acted as a deterrent for the group, in view of personal costs that had already been incurred as part of the PHO establishment planning and the reality of no guarantee that actual costs incurred would be fully reimbursed. The Committee's position was reinforced by the zero response to invitations placed in the local newspapers to make contact with members of the Steering Committee if they wished to be involved or if they required further information. Primary health care for most was interpreted as primary medical care as had been experienced in the past. At the Information Sharing days members of the public were keen to provide their views and pass judgement on specific issues or decisions that had been made rather than to contribute directly to *making* decisions.

Campbell and Jovchelvitch's (2000) statement: "We cannot assume that every community will participate in a similar way." (p. 266) highlights the need to understand the context and

uniqueness of each community and their quest for information rather than expect to and assume that one model fits all communities. External stakeholder groups, such as the Funding Division and the Reference Group, needed to be cognisant of the factors which influence the readiness of communities to participate and the way in which they do it. A policy initiative to engage communities, on its own, is not a sufficient incentive for communities to embrace change.

### **7.2.3 Historical Influences**

Over the years the Horowhenua communities have lived through various degrees of consultation and participation. These historical events have contributed to determining community definitions of consultation and participation. One major influence on perceptions was the plans to build a hospital<sup>35</sup>. This project, supported by politicians, central government and the community saw the construction of a new facility. One stakeholder, the regional health service funder, was faced with the community expectation of service provision within a funding structure which did not cater for a population the size of the Horowhenua at that level.

Although it [the Horowhenua Hospital] was campaigned for, and subsequently built, to be a full general hospital, it has only ever offered a limited range of services to the general population, having had a greater focus on care for the elderly. ...This situation has historically been the source of much dissatisfaction in the community and has led to a widespread feeling that the community has been short-changed both by central government and successive health authorities.

Grafton Group Ltd., 2003, Part B, S1

Steering Committee GP Representative I draws attention to the importance of community participation endeavours being aligned to government policy and strategy.

There was very much an ideological crusade that the Horowhenua Hospital had to get established in the first place and no communication with the reality was really allowed by this community group who were promoting it. They were highly successful in doing it. They managed to get two Prime Ministers to promise [emphasized] to build the hospital - they were marvellous! Getting a group like that you could build a pyramid. That's really what it was. Certainly, talking to

---

<sup>35</sup> Refer to Section 3.12

Health Department officials and the old Hospital Board officials they were all aghast that a hospital was being built and did their very best to stop it. But they had absolutely no show against the tenacity of the local community. But it stopped at building the buildings. Actually getting something to work is an entirely different story. Their [the community's] expertise stopped at that level and successive hospital boards and DHBs have really been floundering with how you cope with the Horowhenua Hospital and the excessive cost in keeping it going.

At interview 19 August 2004

While the community was actively “participating” in determining their future health services, and at one level being very successful, the key stakeholder - which would have responsibility for its ongoing funding - was not able to meet the expectations within the government funding arrangements of that time. As Harrison, Dowswell and Milewa (2002) claim: “...giving people what they want may not be compatible with what the evidence says they should have.” (p. 63).

The community's understanding of community participation at the time of preparing for PHO establishment was influenced by this past experience. Memory in a rural community such as the Horowhenua region remains for many years after a particular “success story” or “failure”. Failing to acknowledge this, irrespective of the relevance of such events to the current project, is a failure to give consideration to important contextual influences from which people's perceptions about partnerships, consultation, power and influence emerge. Participation does not simply happen but evolves over time, and members of the community may not differentiate between “consultation” and “participation” but rather consider both to be the same. If community participation is seen to be meaningful and capacity building, understandings about the benefits of actively participating will change as people see for themselves the new “ways of doing” and the results of these endeavours. The sequence of events which occurred following the Horowhenua community's determination to have a base hospital could not be repeated within the current strategy implementation environment. Implementation of the primary health care strategy is clearly determined by the Ministry of Health. Toolkits, checklists, guidelines and approval processes are centrally determined. The challenge this prescriptive centrally driven strategy implementation process places on communities is ensuring that they meet their expectations that participation is *meaningful* and that they play an integral part in ensuring primary health care services meet the *unique* needs of their communities.

#### 7.2.4 Steering Committee Representation

The Funding Division needed to be assured that the inaugural PHO Board membership would reflect the characteristics and specific interests of the community. The Funding Division was concerned not only about *whom* the community representatives would represent, but also about *how* the process for election or appointment would be conducted. At the 29 March 2004 Steering Committee meeting, Funding Division Representative A asked: “What will be the process for [electing or appointing] community reps?” and further clarified that this needed to be “community group representation”. This implied an interpretation of “representation” which reflected a traditional view of individuals being nominated from clearly identifiable community groups, and took into account what Rifkin et al. (1988) describe as geographic considerations and common interests. The Horowhenua region’s “ways of doing” were influenced by the existing infrastructures where established committees had determined how PHO planning was to begin and who was to be involved. It was the Steering Committee’s intention that a similar approach would be used for determining membership on the inaugural PHO Board. Brown (1994, p. 338) proposes that consideration needs to be given to the degree to which “groups of shared interest” fit with the needs of the organisation or project. A balance between collaborative planning, maintaining an impetus for change, managing capture by interest groups and ensuring that the required skill mix was available were all considerations. As Zakus and Lysack (1998) propose, determining who is a legitimate representative of the community is far from straightforward. They add: “When groups within the community lack the prerequisite skills or power to represent themselves efforts to increase their abilities in this area can be undertaken.” (ibid., p.7). This will be an important medium-range consideration for the Horowhenua community in terms of building the capability within groups who were not directly involved in PHO establishment.

The process used for selecting Steering Committee members eliminated the possibility of opposing interest groups being elected. The risk associated with the process used for membership selection in this instance is that the Steering Committee may not necessarily represent the diversity of views that reflects the community voice and may provide opportunity for one community voice to strengthen its dominance, thus further dis-

empowering other groups in the community, especially high need groups and those for whom issues of access to health services must be addressed.

### **7.3 RELATIONSHIPS**

At the outset, it was apparent that most members of the Steering Committee knew each other. There was a complex array of relationships both within the committee and with external stakeholders as depicted in Figure 7.1. Established relationships had resulted from networks within members' respective constituencies, involvement on established committees or simply from informal contact in the course of living and working within this small rural community. Labonte (1997) highlights the importance of relationships in underpinning participation and the need for these to be negotiated in the *process* of participation.

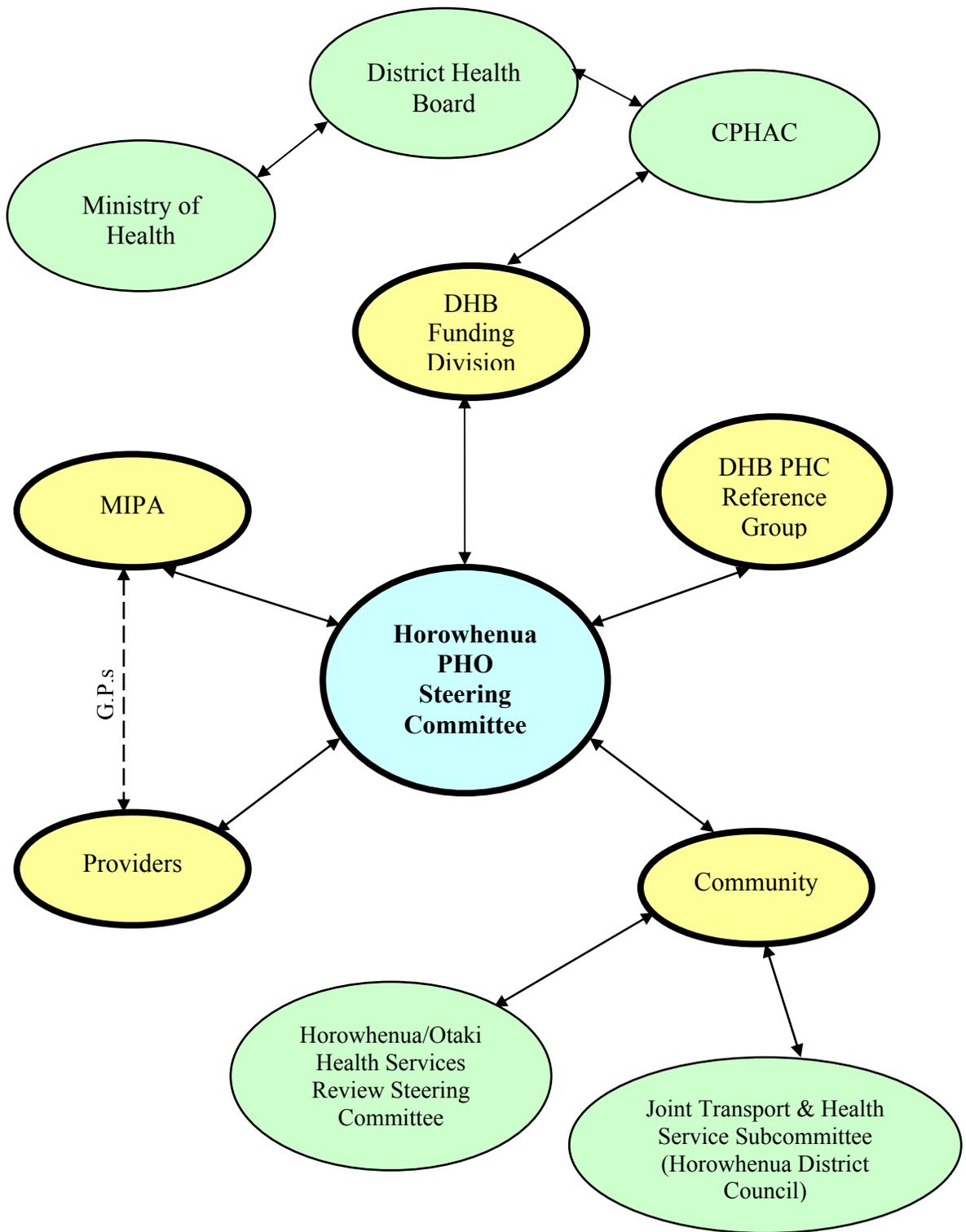


Figure 7.1: Steering Committee Relationships with Stakeholders

### **7.3.1 Relationships within the Steering Committee**

The Voices in Chapter Six provide insight into how the Steering Committee established themselves as a team and how they approached the planning and achievement of required tasks.

Steering Committee meeting times were central to the establishment of relationships between members. The way of conducting business at Steering Committee meetings reflected a climate of valuing all contributions, tolerance of knowledge deficits, support for personal learning, inclusiveness and decision-making by consensus. Everyone's contribution was valued and expectations of individual members differed depending on their knowledge and time availability. Decision-making at meetings, made by consensus, often took some time. The demands of DHB timeframes or deadlines did not deter this consensual decision-making process. The agenda item "Matters arising from the minutes of the previous meeting" was frequently used by members to raise whatever they wished, irrespective of whether it was an item from the previous minutes or on the current agenda. On these occasions, and throughout the meeting, there were often lengthy deviations from the agenda.

Steering Committee members all managed the tension between achieving the commonly shared project goals of PHO establishment while also attending to their individual stakeholder and personal interests. This was evidenced by changing power relationships both within the Steering Committee membership and between the Steering Committee as a whole and stakeholders external to the Committee, depending on the issue being addressed. The roles and professional relationships which the health professionals on the Steering Committee, the MIPA Advisor and Funding Division representatives had separate from the PHO planning process provided these groups with a platform to exclude the legitimised planning structures and processes set in place by the Steering Committee. Iwi and community representatives were marginalised on these occasions. This emphasised the synergies established between the traditional holders of power: the professional and "expert" stakeholders. It could be argued that time constraints, along with skill and

knowledge deficits, necessitated this approach for completion of some tasks. Baum (1990) acknowledges that while individual health professionals are open to changing their mode of practice, they often maintain and promote their power and privilege and that: “Experts should be able to make their area of knowledge understandable to the non-expert.” (ibid., p. 149). The impact of constantly changing roles and power relationships observed within the Steering Committee added to the complexity of achieving the task of PHO establishment for committee members. The perception of the role and value of community representative input into this project was diminished on occasions when dominant stakeholder needs (e.g. those of GPs and the DHB) became a priority. This was especially difficult for the community representative Chairperson, whose responsibility it was to ensure that the Steering Committee conducted its business in an open and inclusive fashion. Despite this the Voices in Chapter Six reflected a sense of trust within the Steering Committee and a commitment to determining the “ways of doing” that best suited the needs of the Steering Committee members.

Three significant events were identified by different Steering Committee members as contributing to the strengthening of relationships within the Committee and the formation of a cohesive team. The first was the decision made by the Committee to undertake the planning themselves rather than contract the Grafton Group to lead the project. The cost to secure their services was one issue, however, equally important were the observations made of the degree of community inclusiveness the Grafton Group allowed when managing the Health Services Review:

And my perspective of the consultation with the health facility [Health Services Review] was that if that had been me involved in the actual organizing of that, I would have actually had those groups together that they consulted with instead of getting just the information that was perceived to be important.

Steering Committee Chairperson, from interview 18 August 2004

This perception of “consultation” fits with Arnstein’s (1969) description of consultation where individuals “... lack the power to insure (sic) that their views will be heeded by the powerful.” (p. 217) and reflects what she describes as tokenism. While the Steering Committee was aware PHO establishment was a huge task for which they did not have all

necessary expertise, the importance of maintaining “a degree of citizen power” (ibid.) outweighed the challenges that self-management would bring (refer to Figure 2.1).

Engaging the MIPA to take responsibility for the administrative functions gave the health professionals on the Steering Committee the assurance that local control would be achieved. Community representatives supported this local solution. At this early stage of planning they had not experienced or considered the impact on planning of the MIPA’s and GP’s vested interests or their desire to maintain the status quo. Establishing a model of partnership which would enable meaningful community participation across power structures is essential if community representatives are to contribute effectively to planning and decision-making.

The second significant event which contributed to developing a sense of team was the process experienced when gaining approval for the PHO Establishment Plan. As the Steering Committee Chairperson described at an interview:

I think it [the Steering Committee] did [gel] after our first proposal was knocked back.

18 August 2004

The Committee went on to prepare a revised plan which was accepted by the DHB. Findings highlighted the superior knowledge community representatives had of the positive contribution community participation can make to health service planning.

The third event was the decision made by the Steering Committee to delay merging with the Kere Kere Healthy Communities Network. The Steering Committee Iwi Representative II gave his perspective:

And I think when everything got to the stage where it was decided that the Kere Kere group may need to follow their own pathway and that we be left to follow ours ... . And I think that was the moment we sort of suddenly decided - yes we are a group, we are a PHO, and we are ready to do this now.

From interview, 2 September 2004

Some perceptions about the development of team cohesiveness were linked to specific events, however, this iwi representative also aligned his perception to the level of comfort

or perception about being successful in achieving the desired outcome for the PHO establishment project. The determination to achieve the agreed outcome contributed to the cohesiveness within this group and thus acted as a motivator for success.

In reality relationships within the Committee were managed at a number of levels depending on the issue being addressed. A cohesive conciliatory Steering Committee team was evident when all committee members were in agreement and vested interests were not an issue. On other occasions the traditional health professional / bureaucrat alliance which excluded community and iwi representatives was apparent. When the Funding Division placed demand on the health professionals to change they aligned themselves with the community and iwi representatives, who invariably supported the health professional position. The decision made regarding the mix of health professionals and community representatives on the PHO inaugural Board highlights this. While community representatives had constituted the majority on the Steering Committee the balance on the Board was in favour of health professionals by six to four. The community representatives supported this decision.

### **7.3.2 MIPA's Relationship with the Steering Committee**

The MIPA provided administrative support, took responsibility for preparing the Establishment Plan and provided the technical expertise in preparation for meeting the Ministry of Health requirements for capitation funding. All GPs were members of the MIPA. As time progressed the MIPA Advisor to the Committee became increasingly central in decision-making processes. No processes were in place for reporting to the Steering Committee when decisions external to it were made. The Steering Committee responsibility was unchanged, but with respect to some tasks it had no authority. To illustrate, the establishment funding budget application, prepared by the MIPA Advisor, was not presented at a Steering Committee meeting for approval and was submitted to the DHB without the Committee's or Chairperson's knowledge. Another illustration of this control over process was the management of the budget. The project funds were placed in a MIPA bank account by the DHB and the MIPA determined expenditure. On these and other occasions this non-consultative approach was in response to time constraints, perceived

complexity of tasks in achieving the Ministry of Health and DHB requirements and vested stakeholder (the MIPA and GP) interests. As the Steering Committee Chairperson described at an interview (18 August 2004):

Dialogue occurred between MIPA and the DHB which the Steering Committee was not privy to, and so the information was third hand, rarely going through the Chairperson.

While the literature focuses on the importance of communities taking responsibility for their own development and growing capacity (Labonte, 1999; Rifkin et al., 1988; Simpson et al., 2003), the *actual mechanisms* for conducting business which facilitate empowerment of decision-making by the grassroots community representatives when they are working with professionals such as GPs, the MIPA Advisor and with bureaucrats, (Funding Division representatives), require further development. Laverack and Labonte (2000) attribute one of the tensions when engaging communities to be the emancipatory discourse when experts implement top-down projects. The Horowhenua PHO planning processes exhibited a mix of inclusive, empowering engagement of community groups on the one hand to exclusion in decision-making on other occasions. The MIPA, GPs and the Funding Division representatives worked closely on addressing such matters as register cleansing and agreeing on the DHB / PHO contractual agreement. Community representatives (including the Chairperson) did not question the reasons for their exclusion. In some instances they were not aware that they had been excluded because they were unaware that such discussions / decisions had occurred until sometime after the event. The traditional role of “expert” determined the discussion and decision-making processes rather than agreed Committee process. Development of interdependencies within the Committee membership would have ensured a degree of inclusiveness of all members and opportunity for community representatives to learn and over time develop their capacity for contributing to these decision-making processes thus reducing the disparities of power and control.

### **7.3.3 DHB Funding Division’s Relationship with the Steering Committee**

The Steering Committee and the Funding Division did not agree on roles, expectations or responsibilities at the outset of the project. There was no question about the accountability

requirements that the Ministry of Health had of the DHB in relation to PHO formation. However, the Funding Division maintained a traditional bureaucrat / community relationship with the Steering Committee when dealing with compliance requirements - for example, content of Establishment Plan and governance structure<sup>36</sup>.

Managing the tension between the Funding Division responsibilities for effective implementation of the primary health care strategy and the opportunities for the community to exercise their right to determine the best approach to the planning for PHO establishment highlighted the need for the Funding Division and PHO Steering Committee to formalise their partnership arrangements at the outset to ensure expectations were met. Doing this would have acknowledged that both parties brought to the process valued knowledge, skill and commitment. This approach is supported by Labonte (1997), whose Partnership Development model incorporates deliberate consideration of how the process would be managed, agreeing on shared mutual goals, making time and resource commitments at the outset and recognising that the various partners bring to a project unique and complementary attributes.

Voyle and Simmons (1999) propose that the first task of establishing a partnership is to reflect on the aspirations of all parties. Doing this would ensure that the attributes which the Steering Committee brought to the partnership, in the form of community knowledge and an understanding of the context and networks, would be legitimised and valued. The Funding Division regularly indicated that they were available to offer assistance. However, the Steering Committee did not ask for this assistance as they were not aware of what assistance they required. To illustrate, when decisions needed to be made about the type of legal entity and governance structure for the PHO, the Steering Committee had minimal knowledge or background information on which to make an informed decision and did not appear to see the importance of this decision for the future of the PHO. They did not seek advice from the Funding Division or any other source. While there were no immediate consequences resulting from this decision, the PHO, as a limited liability company with charitable status, would be contracting all GPs through the MIPA. Opportunities in the

---

<sup>36</sup> Refer to Table 5.3, Section 5.3.2 for details of compliance requirements.

future to replace traditional GP services with innovative models of service delivery could be challenged by proponents of the old primary medical care model.

#### **7.3.4 The DHB Reference Group's Relationship with the Steering Committee**

Throughout the period of data collection it became apparent that there were some inconsistencies and confusion regarding the actual role of the Reference Group. As previously outlined there were two occasions when the Reference Group was "visible" in the Steering Committee planning processes. The first occasion was at the time the Steering Committee was seeking approval for its Establishment Plan. On this occasion the Funding Division clearly stated and adhered to a process whereby the Reference Group was charged with the task of endorsing the application before the recommendation was made to the CPHAC that planning proceed. The Reference Group's function on this occasion was to "approve".

The second occasion of Reference Group direct involvement in PHO Steering Committee activities was at the time all three PHO Steering Committees were preparing separate applications. Efforts made by the Reference Group to intercept were fruitless; the Group had no influence on outcome. At their 18 November 2003 meeting it was recorded in the minutes that members expressed a "feeling of dis-connect". It was suggested that this was due to: ".....the role of the Group being advisory rather than operational."

The Reference Group's Minutes for the same date recorded their reflections on the process:

It was agreed that in future the Funding Division needed to be more careful in clearly communicating timeframes and processes to the steering groups. It was iterated that the Board's approach to Horowhenua/Otaki was that: no decision had been made on the number of PHOs for that area; ...

and:

Further, that the Division had been taking a "hands-off"/supportive role with groups looking to develop PHOs.

The issue of whether the Reference Group had a monitoring and evaluative role in addition to their advisory role was presented to the CPHAC meetings on 3 February 2004 and 4 May 2004. It was noted in the CPHAC Minutes on 4 May 2004:

Management was asked to clarify the likely nature of the monitoring and report back. It was agreed that the Reference Group provided advice to management who in turn advise the Committee [CPHAC].

While this clarified the Reference Group's scope of input into planning, their Terms of Reference conveyed a much wider scope:

- To review all Registrations of Interest and provide feedback to the MidCentral District Health Board as to potential partner/s and approach/es.
- To recommend an appropriate consultation process with providers and communities of interest to ensure optimal provider and community support is achieved.
- To ensure that expert advice is available when required throughout the transition to Primary Health Organisations. This includes establishing appropriate local and national linkages.
- To work towards ensuring that this region secures an appropriate share of the national establishment funding pool by working with preferred providers to develop robust business plans that meet the national criteria.
- To monitor and report proposed developments to ensure they are aligned with the strategic intentions of MidCentral's District Strategic Plan.
- To assist in the development of MidCentral's Strategic Plan for Primary Health Care.

(MidCentral DHB 2002, p. 15)

These roles and functions reflected priorities at the commencement of implementation of the primary health care strategy within the DHB. They did not identify the way in which the Reference Group would contribute to PHO development specifically. Importantly, the verbs used in describing the Reference Group's role and function cover *advisory*, *monitoring* and *directive* functions. It is perhaps understandable that some confusion was experienced by the Group regarding their role.

At another level the Reference Group's efforts to raise issues associated with a number of small PHOs highlighted the differences in criteria used by the Reference Group and the respective PHO working groups to determine what was considered best for the communities the PHOs were to serve. The Reference Group, in expressing its preference

for one PHO, gave consideration to casualisation, duplication, viability (Reference Group Minutes, 28 October 2003). Otaki and Kere Kere PHO Working Parties placed high value on locally planned services which met local need, local autonomy in decision-making, community networks and local control. Criteria for determining success were quite different. As the Ministry of Health and DHB had not explicitly specified a minimum size for PHOs the working groups argued size to be of less importance than other imperatives, the most important being the opportunities for community participation in governing which the PHO would provide. The confusion within the Reference Group about their role had little impact on the Steering Committee planning. The pragmatic approach taken by the Committee was that the Funding Division had ultimate sanction and authority in relation to approval processes.

#### **7.4 THE STEERING COMMITTEE'S INFLUENCE OVER PROCESS**

There were a number of key decisions made by the PHO Steering Committee which contributed to the Committee's ability to maintain autonomy for aspects of the planning process which were important for them and considered to be essential for maintaining a level of self-determination.

##### **7.4.1 The Influence of the Grafton Consulting Group and MIPA**

There were two occasions when the Grafton Group provided opportunity to the Horowhenua community to consider options for preparing a pathway forward to PHO establishment. The first occurred in April 2003 when the Grafton Group, at the request of the DHB, presented a proposal to the Horowhenua, Otaki and Kere Kere communities for the establishment of one PHO for the region<sup>37</sup>. The second occasion occurred when the Group was asked by the Health Services Review Steering Committee to submit a proposal to manage the PHO formation process on behalf of the about-to-be established Horowhenua PHO Steering Committee<sup>38</sup>. Upon receipt of the proposal the PHO Steering Committee agreed that the Committee would undertake the project itself with the assistance of the MIPA. The Steering Committee indicated that establishing the way forward needed to be

---

<sup>37</sup> Refer to Section 5.2

<sup>38</sup> Refer to Section 5.2

determined by the Steering Committee rather than by an entity external to the Committee, despite the expertise the Grafton Group would bring to the project.

Steering Committee members had witnessed the Grafton Group's approach to managing the Health Services Review. Acknowledging that the nature of this review was different from that of PHO establishment, one of the Steering Committee's priorities was to determine and control process. A contributing factor to their taking this position was the level of comfort all GPs in the region required for implementation of the primary health care strategy, particularly the transfer to a capitation-based funding arrangement. All GPs were members of the MIPA, therefore the MIPA was seen by the GPs to be ideally positioned to provide that level of comfort. In addition, the MIPA was willing to underwrite this project until funds were forthcoming from the Ministry of Health and DHB. GPs were also aware that as a result of the Grafton Group's involvement in the Health Services Review they had established a close working relationship with the DHB, the funding agency with responsibility for implementing the government policy of capitation-based based funding for primary health care. Elements of mistrust resulting from memory of previous health reforms along with the demands being placed on GPs to co-locate to the new health facility were also contributing factors.

The community representatives on the Steering Committee supported the GP position. One reason for this may have been the desire by the Steering Committee to comply with the wishes of this more powerful group, thus ensuring existing patterns of dominance were not challenged. Another reason was the dependence the region had on GPs for the continuation of primary health care services. If the primary health care strategy negatively impacted on GPs and provided an incentive for them to discontinue their commitment to local primary care services this would pose a serious threat to primary health care services for the entire Horowhenua region. While the primary health care strategy provided opportunities for new models of service delivery, the consensus of all Steering Committee members was that maintaining as much as possible of the existing model of primary medical care within the context of PHO environment at the outset of PHO establishment would ensure risk was managed effectively and provide increased certainty for the continuation of primary health

care services in the Horowhenua. Changes to the mode of primary health service delivery could occur over time.

Both the Steering Committee and the GP stakeholders supported the MIPA's role in providing administrative services, thus ensuring GP vested interests were managed effectively. The impact of this primary health care strategy implementation on GP businesses required that they had some level of comfort about PHO planning processes. This was a significant influence on the ways in which the Steering Committee was established and in the way in which they approached various tasks. Despite this, the mechanisms for ensuring community inclusiveness in planning were not seen to be compromised by the key community stakeholders. Decisions made by the PHO Steering Committee reflected the impact and influence one dominant stakeholder's interest (GPs) had in determining process for primary health care policy implementation. It was envisaged that the passage of time and demonstration of sustainable, innovative PHO models for primary health care service delivery in regions similar to the Horowhenua would need to be seen by this community before they adopt change. Planning decisions were influenced by a sense of mistrust which both the community and iwi representatives as well as health professionals experienced regarding the primary health care reforms and the political agendas associated with managing the cost of primary health care delivery (particularly moving from subsidy arrangements to capitation-based funding). Even if community representatives did not hold this position it would be difficult for them to establish a different position without the cooperation of GPs. The very nature of their involvement as a community participant reinforced their position of powerlessness in this situation.

#### **7.4.2 Steering Committee Self-determination**

There were a number of occasions on which decisions were made by the Steering Committee which had a major influence on the PHO planning direction and processes. Table 7.2 provides a summary.

Table 7.2: Significant Events Supporting PHO Self-determination.

<b>Issue</b>	<b>Activity</b>
PHO planning process.	Decision to secure the services of MIPA rather than the Grafton Group to manage the project.
Membership of the PHO Steering Committee and inaugural Board membership.	Steering Committee membership decided by the Health Services Review Steering Committee and the inaugural Board members appointed by the Steering Committee.
PHO commencement date of 1 July 2004.	The Steering Committee was committed to this date and was not prepared to extend it. The starting date came under threat when : <ul style="list-style-type: none"> <li>• It appeared that the Steering Committee would not achieve compliance requirements within Ministry of Health timeframes.</li> <li>• Additional time was required for Horowhenua and Kere Kere working groups to align.</li> </ul>
Community involvement in planning.	The Steering Committee agreed that there would not be a deliberate programme to engage the community prior to PHO establishment.
One PHO for Horowhenua and Kere Kere.	The Horowhenua Steering Committee decided planning for one PHO was not achievable within the timeframe available.

One other important decision, not made by the Steering Committee, but which impacted on the Committee, was that decision made early in the planning stages by Otaki and Kere Kere communities to prepare for separate PHO establishment. Laverack (2001) claims that a community must have a sense of ownership of their programme. This was always the case for all three PHO planning groups in the region.

The Funding Division, while endeavouring to influence the number of PHOs to be established, supported the decisions made by the Horowhenua Steering Committee and neighbouring working groups. Clearly the DHB preferred one PHO for the Otaki/Horowhenua region, they made an attempt to have the Horowhenua and Kere Kere PHOs combine, they wanted community group representation on the inaugural PHO Board to be elected using transparent processes, they wanted increased community involvement in the PHO establishment planning processes, and they were not unduly concerned if the PHO establishment date was deferred to 1 October 2004. If the DHB's

preferences had been achieved this it would have aligned the PHO establishment in this region more closely to the DHB and national primary health care strategy. The willingness of the DHB to support this community's autonomy in decision-making illustrates their commitment at the strategic level to strengthen opportunities for communities to participate in the planning and development of health services in a meaningful way. Laverack and Wallerstein (2001) propose that participatory approaches redefine the role relationship between stakeholders. Putland, Baum, and MacDougall (1997) support the notion that effective involvement does not occur in a vacuum but forms part of a continuing "organic" relationship (p.306). While there is much documented evidence in this case study of the DHB demonstrating autocratic behaviours at an operational level, at this strategic level the DHB had demonstrated its commitment to empowering the community by supporting their preferred pathway forward.

## **7.5 THE EXPERIENCE OF PARTICIPATING**

This section focuses on the Steering Committee's experience of participating during this complex and lengthy project. This case study provided insights into the demands, challenges and reality of undertaking this work within the unique context of the Horowhenua community. This section of the analysis will focus on three distinct areas; (a) knowledge, skill and access to information, (b) resourcing the project, and, (c) community leadership.

### **7.5.1 Knowledge, Skill and Access to Information**

Members of the Steering Committee acknowledged that they did not have the necessary skills within their membership to achieve all tasks required for successful project completion. Not all Steering Committee members were computer literate, so were not able to access the prime source of information from the Ministry of Health website. Procuring paper copies of documents was at individual members' expense and many of the documents were lengthy; for example, the draft contract - which all members were encouraged to read - exceeded 90 pages in length.

Identifying what generic information was relevant and making it contextually appropriate required time. Steering Committee members needed a sound knowledge of the primary health care strategy and PHO implementation as well as an understanding of the technical requirements, acronyms and jargon commonly used. The Steering Committee Chairperson summed up the situation:

In relation to information or lack thereof, nothing was explained to people, they had to read everything themselves and draw their own conclusions.

From interview, 18 August 2004

The Funding Division Representative B agreed when referring to the Establishment Plan:

I think that the Establishment Plan is hard to get your head around in some ways. ... You know, you've got all the guidelines, minimum requirements, etc, from the Ministry. Some of these are a bit obscure from a community group's point of view as to why you would want them in. ...

From interview, 19 August 2005

Steering Committee members' lack of knowledge and understanding of the full array of establishment requirements made decision-making processes time consuming.

Labonte's (1997) *Partnership Development* and Laverack's (2004) *Domains of Community Capacity* begin to address these issues by illustrating the importance of ongoing learning and personal development. Time taken to address knowledge and skill gaps would not only increase the probability of personal satisfaction and motivation but also reduce barriers to individuals' becoming involved in community initiatives. For the long term this would make a valuable contribution to building capability within the community which would enhance the likelihood of sustainability for subsequent projects and increase the number of people willing to contribute in the future. It was difficult to determine the extent of Steering Committee members' willingness to be involved in future projects. The two community representatives were continuing as members on the inaugural PHO Board.

### **7.5.2 Resourcing the Project**

There was no assurance at the outset either that the project would gain DHB approval or that establishment funding would be forthcoming. The establishment funding was paid to the MIPA in April 2004, nine months after the planning commenced and three months before the PHO was established.

The need to adequately resource community projects is well documented in the literature (MacIntosh & Cormack, 2001; Rifkin et al., 1988; Zakus & Lysack, 1998). Simpson et al. (2003) identify the significant investment in terms of time, money and personal energy. They postulate, based on research undertaken in Australian rural communities, that there are fewer people available to undertake an increasing number of tasks. They argue that there are limited stocks of time and energy and this will have implications for a community's social infrastructure as individuals make difficult decisions about where to direct their energies. Individuals and groups will be excluded if time and financial expectations are personally prohibitive. Laverack and Wallerstein (2001), Simpson et al. (2003) and Wanderman and Florin (1999) agree that community representatives willing to contribute to planning initiatives are a finite resource. Putland et al. (1997, p. 302) contend that "... making the necessary resources available can be a powerful expression of 'official' endorsement ...". Section 6.7 identifies instances when Steering Committee members had no option but to incur personal costs such as travel, printing, toll calls and venue hire costs. Some of these were reimbursed, however, a significant proportion of the incidental costs were borne by individual Steering Committee members. There was no evidence that the DHB had given consideration to the material resourcing issues associated with their expectation that this community would participate in the PHO establishment process.

### **7.5.3 Community Leadership**

Leadership and authority in decision-making fluctuated throughout the planning period and were determined largely by task. The summary below identifies over which outcomes the Horowhenua Steering Committee, the DHB Funding Division and the Reference Group had predominant influence.

The Steering Committee successfully influenced decisions which were critical for ensuring they had the autonomy to decide on planning process and outcome. These included:

- Membership of the Steering Committee and method for determining community representation.
- That the Palmerston North-based MIPA - rather than a consultancy firm from outside the region - would provide administrative support.
- The frequency and processes used to involve the community at large and health professionals in the region.
- The Steering Committee's unwillingness to extend the establishment planning period beyond 1 July 2004 so as to allow more time for joint Horowhenua / Kere Kere planning.

These decisions were instrumental in determining the pathway for PHO establishment planning and the relationship the Steering Committee had with other stakeholders, particularly the DHB. If the Funding Division representatives had been successful in implementing their preferences:

- the Grafton Group (or a similar consultancy service) are likely to have project managed the establishment process,
- the three separate plans to establish PHOs are likely to have combined,
- the Horowhenua formation date would have been delayed so as to allow time for a combined establishment strategy to be formulated by Horowhenua and Kere Kere, and,
- the community at large would have had greater input into the Steering Committee membership and planning process.

The Funding Division demonstrated its authority by providing leadership when completing the following tasks:

- Approving the application to establish a PHO.
- Meeting the Ministry of Health funding and reporting requirements within the required timeframes.
- Representation on the inaugural PHO Board.

Strictly speaking, the Reference Group had no direct influence over events because of its advisory role to the Funding Division. However, the Funding Division did rely on this Committee for the:

- Initial review of Registrations of Interest, commencing February 2003.
- Preparation of the MidCentral District Health Board primary health care strategy.
- Review of the *Application to MidCentral District Health Board to form a Primary Health Organisation in the Horowhenua District*. (Horowhenua PHO, 2003).

At an individual level the Steering Committee Chairperson demonstrated that she was - and was acknowledged by Steering Committee members as - the “driver” of the establishment process. Rifkin (1990) supports the notion that local leadership facilitates community ownership. The Chairperson as a community representative on the Horowhenua PHO Steering Committee demonstrated exemplary personal leadership. Her motives for being part of this process were grounded in improving both the access to primary health care services and improving the community’s health status. She was a member of the Joint Transport and Health Services Subcommittee, the Health Services Review Steering Committee and the Reference Group. She had been involved in a range of community initiatives in the region for an extended period of time. Difficulties she experienced have been highlighted in section 7.3.2 where the relationships between the Funding Division, GPs and the MIPA precluded her as Chairperson from the usual recognition accorded to a person in this position.

## 7.6 KEY DETERMINANTS OF COMMUNITY PARTICIPATION

This research focuses on advancing the understanding and knowledge of ways in which communities participate in the planning and development of health services. One common theme which emerges in the literature is the synergies between community participation and community development – a community development approach is considered an effective way for ensuring communities are involved in health service planning in a meaningful way. While the overall objectives for engaging communities embraces community development principles – that is, inclusiveness, self-reliance and self-determination so as to enhance the development of health services which are accessible, collaborative and which not only meet the needs of the unique communities they service but also contribute positively to the social and economic health of a community – there is within the Horowhenua context the need also to implement health policy which meets requirements for national consistency, and compliance with the prescriptive, central government determined implementation process. The approach to including communities within these parameters requires consideration of factors not traditionally incorporated into a community development approach. There is a need to acknowledge power discrepancies as a reality rather than as a limitation to empowering communities. It is only then that effective strategies will be developed to *manage* these imbalances to the benefit of community empowerment and self-determination.

The need for a quality primary health care sector throughout New Zealand which addresses the issues for high need populations and improves overall health status is essential. Relevant to this research is the context in which the primary health care policy is implemented in New Zealand. To recap there:

1. must be consistency in the type and quality of health services throughout New Zealand,
2. is a policy implementation process which is prescriptive and centrally determined,
3. is a requirement that the unique health needs of the population are reflected in planning process and delivery of health services, and,

4. must be involvement from the community in planning, governance and monitoring of health services.

Central to the involvement of communities is that participants must be actively involved in decision-making processes. The challenge for health service planners is to manage the contradictions and tensions which emerge when endeavouring to achieve the four requirements identified above.

The process chosen for the Horowhenua region reflected both the need for pragmatism – that they succeeded in establishing a PHO, thus ensuring their communities benefited from the additional funding available to PHOs - and the desire to include community representatives in the planning of their primary health care services. Rather than take a community development approach where the community at large determined the process and parameters of the project within the scope of the primary health care strategy implementation, the approach taken by this community was to establish a small group of community representatives and health professionals to complete the project. By the very nature of the process chosen the predominant formalised partnerships were between (a) Steering Committee members and (b) the Steering Committee and the Funding Division of the DHB.

To achieve PHO establishment the Steering Committee and the MidCentral DHB needed to establish a model where facilitative and directive behaviours were negotiated and understood by all stakeholders. If communities are to grasp the dynamism of these complex planning processes, and experience an involvement which is consistently participatory – rather than fluctuating between genuine participation and tokenism or exclusion – new understandings needed to emerge about the working relationships of the traditional holders of power with the grassroots communities. The notion of partnership needs to reflect the complexities of these relationships.

Central to the preferred model for community participation presented in this thesis are a number of underlying assumptions:

1. All efforts must contribute to building capacity within the community. That is, the skill, knowledge and expertise which evolves as a result of community representatives participating must, over time, contribute to strengthening community self-sufficiency and self-responsibility.
2. Consideration of sustainability of programmes is essential and must be considered within the wider community context over time.
3. Representation must be understood as more than community group representation. Consideration needs to be given to the skill and knowledge required to successfully complete a project. Importantly, the balance must be found between involving community representatives who already have the necessary skills and those who will develop the skills in the course of their involvement. This links with the investment which must be made to ensure sustainability and building capability.
4. Partnerships and interdependencies must develop across the range of power relationships. These relationships will establish as a result of community representatives working with community leaders, health service experts, bureaucrats and health professionals.

In order to place the outcomes of this analysis within the context of the existing body of knowledge relating to community participation and to address the issues surrounding power-sharing partnerships I returned to the literature. Labonte's (1997) *Model of Partnership* and Laverack's (2004) *Domains of Building Capacity* provided a starting point for consideration of the essential determinants for community participation in the Horowhenua PHO planning process.

Table 7.3 Labonte’s (1997) Model of Partnership Development and Laverack’s (2004) Domains of Capacity Building

Partnership Development (Labonte 1997)	Domains of Building Capacity (Laverack 2004)
Creating a Partnership Vision	Participation
Identifying a Shared Mutual Goal	Leadership
Identifying Partners	Organisational Structures
Managing the Context	Problem Assessment
Managing the Process	Asking “Why”
Making the Time and Resource Commitments	Resource Mobilisation
Empowering Full Participation	Links with Others
Evaluating from the Start	Role of the Outside Agents
Building in Sustainability	Programme Management

The models presented in Table 7.3, while providing sound mechanisms for operationalising community participation in health service planning, fall short of presenting all the practical strategies required for the current New Zealand context. The relationship between the funder, health professional and community stakeholders must receive prominence and ensure knowledge, skill, expectations and responsibilities along with decision-making power are incorporated into a framework so as to ensure all parties work collaboratively towards the realisation of new services. Heightened emphasis on “knowing the community” and “enabling participation” would capture these additional elements and address the issues associated with the disparities between knowledge, skill and power. The first domain; *Knowing the Community*, would require that *all* stakeholders have a sound understanding of

the array of local community contextual realities which impact on the planning process. The second domain, *Enabling Full Participation*, would ensure development of enabling strategies which are contextually relevant for community participants and provide mechanisms to ensure they are part of all decision-making processes. The components of these two additional domains are presented in Table 7.4.

Table 7.4: Strengthening Partnerships: Knowing the Community & Facilitating Full Participation

Knowing the Community	Enabling Participation
Understanding local knowledge	Managing the dynamism of roles and power relationships during the life of the project
Identifying customary ‘ways of doing’	Maintaining sense of ‘citizen power’ in all decision-making processes
Identifying existing infrastructures	Availability of contextually relevant knowledge, information and expertise
Understanding previous experiences of participation	Resource requirements are agreed and secured at the outset of the project

Agreed partnerships comprising funders, health professionals and grassroots community participants who work together, mutually agreeing on roles, responsibilities, processes for project completion and resourcing would signal an expectation that “expert” stakeholder groups *work with* and *along-side* communities. Each party would bring to the partnership a set of attributes and knowledge which would collectively inform the entire planning process. These domains acknowledge that all stakeholders require new knowledge and understanding. The “experts” require insights into the community “ways of doing” which would be achieved through increased understanding of networks and infrastructures, local knowledge and the influence of other local events. This approach will also ensure this knowledge is legitimised. The community participants, in turn, would receive timely and relevant information and support for achieving project goals. The complexities of vested

interests and role relationships external to the planning process would be acknowledged as realities within the planning process and strategies would be developed for managing them.

## **7.7 CONCLUDING COMMENTS**

In Chapter Seven an analysis of the stakeholder perceptions, understandings, energies and emotions was presented along with the sequence of events which led to PHO establishment in the Horowhenua. This analysis provides insights into the way in which expert stakeholders and the Horowhenua grassroots community worked to achieve commonly agreed goals. Central to the analysis is the important role which the community context played in determining the community's "ways of doing" and thus the preferred strategies used by the Steering Committee to complete the project. Stakeholder roles and relationships were determined by the issues being addressed at any point in time and this impacted on the extent to which community representatives were included in decision-making processes. Central to the analysis was the need to establish meaningful community participation across power structures.

The management of genuine, inclusive participation for community representatives when implementing the centrally determined primary health care strategy requires that new dimensions of community participation are explored. Two domains emerged as a result of the analysis; *Knowing the Community* and *Enabling Full Participation*. These domains provide a mechanism to support the establishment of partnerships between all stakeholders which reflect equitable power-sharing and inclusiveness in decision-making. Incorporation of these two domains into planning would ensure that essential determinants for successful partnerships between "industry experts" and "community experts" were established. Establishing mechanisms to manage power imbalances is essential if communities are to continue to participate in a meaningful way in the implementation of government health policies. This approach would contribute constructively to addressing these power imbalances.

## CHAPTER EIGHT

### CONCLUSION

Science is a journey, and the existing theory is not its destination.

Gummesson, 2000, p. 90.

The requirement that communities participate in the planning and development of primary health services is central to the New Zealand Primary Health Care Strategy (King, 2001). Reflecting on the succession of health service reviews and reforms which have occurred in New Zealand since 1975, there have been varying opportunities for meaningful community involvement in the planning, governance and evaluation of public health services. The implementation of the New Zealand primary health care strategy in February 2002 provided an opportunity for me to investigate how the Horowhenua, a small rural community in New Zealand, led the preparations for the establishment of a Primary Health Organisation. The thesis records and analyses the sequence of events and the way in which Steering Committee members and other stakeholders responded to the demands and opportunities this project afforded them.

Returning to the research strategy, Hartley (2004) describes the aim of case study research as providing “... an analysis of the context and processes ...” (p. 323). She elaborates by stating that the focus is to understand how behaviour and processes are influenced by, and influence, context. The real benefit of using this research strategy was the opportunity it provided me as a participant observer, over an extended period of time, to use a range of methods for gathering data. This inductive approach required that the sequence of events and emerging processes determined the pathways for the data collection, thus ensuring that I captured all events as they unfolded, along with peoples’ reactions and responses to the situations in which they found themselves. I was able to observe the ways in which Steering Committee members responded to their successes, the challenges, and the disappointments as well as the ways in which they attended to their constituency and personal vested interests. As stakeholders external to the Steering Committee moved in and

out of the Committee's domain, patterns emerged illustrating the ways individuals and groups addressed the complex demands of the project.

By the PHO formation date on 1 July 2004 the Steering Committee had become a strong, cohesive team which took great pride in its achievement of Primary Health Organisation establishment and demonstrated a strong sense of ownership. The research strategy ensured that the richness of human responses and full array of project events were captured thus providing an extensive source of data on which to base the analysis. In Chapter Six the findings highlighted a number of elements associated with community participation that have not received prominence in the literature. The events recorded and observations made throughout the planning period formed the basis for identifying essential determinants of community participation for this rural community. These observations are summarised as follows:

1. *Knowledge of community and “ways of doing”*

All Steering Committee members had an in-depth knowledge of the formal and informal health networks in the community and their links to the various community groups. Memory of previous projects – the “successes” and “failures” - irrespective of their relevance to the current project, influenced the PHO planning process and was a powerful influencer of peoples' willingness to participate. Knowledge of the community also influenced (in part) the decision not to involve the community at large in the PHO planning. However, this decision resulted in lost opportunity for increased grassroots inclusiveness in the planning process. External stakeholders, particularly the DHB representatives did not place high value on understanding the community “ways of doing”. These ways of doing determined the roles and power relationships of individual community representatives and health professionals in the Horowhenua community.

2. *Interdependencies*

All Steering Committee members had involvement in a number of community organisations and decision-making committees. These activities influenced how Steering Committee members contributed to PHO planning processes. Many of interrelationships were not apparent to stakeholders external to the Horowhenua. People who formed the

networks and links within the community were not necessarily aware of their interdependencies and contribution to community connectedness. There was a strong sense of camaraderie between Steering Committee members despite the imbalance of power on certain decision-making occasions.

### 3. *Power relationships*

Not all community infrastructures which influenced PHO planning decisions were visible to external stakeholders. These local community infrastructures – at both a local governance level and at the grassroots level - had a strong influence on the Steering Committee’s “way of doing”. There was a strong commitment by the Steering Committee to control the planning process despite the efforts by the traditional holders of power (Funding Division) to influence direction. The Steering Groups in the Horowhenua, Otaki and Kere Kere regions determined the overall PHO configuration for the Horowhenua / Otaki region, the timing for PHO establishment and the way in which the establishment groups would conduct their business. Throughout the planning process roles and relationships within the Steering Committee fluctuated between a united, collaborative team to one where vested stakeholder interests excluded the community and iwi members from essential decision-making opportunities. The Reference Group came to the PHO planning process with a view of what was “best for the community” and attempted to impose this, rather than work with the community to support them in determining what was best.

### 4. *Resourcing issues*

Inadequate material resourcing was a source of frustration and resentment throughout the project. Funding for the project was received five months before the end of this twelve month project. Incidental costs were incurred by individual Steering Committee representatives throughout the project. Allocation of reimbursement costs to individual members was based on the funds available rather than the actual and reasonable costs incurred. The Steering Committee did not actively contribute to the establishment of the budget which formed the basis of the funding allocation.

##### 5. *Accessibility to information*

A proportion of Steering Committee members were denied the opportunity to access essential resource material because this information was available only in electronic form. Because a number of Steering Committee members were initially unfamiliar with the details of the primary health care strategy implementation, PHO formation and technical compliance requirements, the generic Ministry of Health and DHB information was of minimal relevance or assistance to them. This had a major impact on the time commitment required by Steering Committee members to achieve tasks. Throughout the establishment period health industry jargon and terminology posed a further barrier to meaningful community participation.

Issues associated with sharing power, acknowledging the diversity of knowledge and skill among project participants, and determining individuals' ability to access essential information must be addressed if successful outcomes for community participation are to be achieved. In this case study all stakeholders demonstrated a commitment and determination to succeed. The data highlighted both the Steering Committee's and the Funding Division's frustration, caused by the lack of project planning and the lack of knowledge and skill necessary for all stakeholders to be involved in meaningful decision-making.

A collaborative approach to planning requires new competencies for both the "experts" and the community representatives. This places new expectations on all stakeholders. Central to managing the partnership process is the consideration of expectations for each stakeholder group, the skills and knowledge each group bring to the project and understandings which need to be gained as part of participating in the project. The funders and health professionals would bring to the partnership knowledge and understanding of the primary health care strategy, the issues relating to its implementation, the opportunities this new strategy provides and the Ministry of Health compliance requirements. The community representatives would bring to the partnership their knowledge relating to the community networks and infrastructures, understandings about leadership within the community, the community's "ways of doing", the relevance of current and past events in influencing project outcomes and understandings about the community's unique primary health care requirements. Critical would be that all groups understand that the knowledge unique to the

community is legitimate and valid – it is the community’s reality. This does not necessarily imply that all such knowledge influences project direction, but rather that it contributes to the project planning processes. Underpinning this collaborative approach to stakeholder partnerships is that:

- power imbalances are addressed,
- the unique needs of a community are incorporated in planning,
- all stakeholders (community, health professional and bureaucrat) learn from each other, and,
- community participants are involved in all decision-making processes.

To achieve this collaboration would require all stakeholders to take a different approach to establishing relationships with one another - working together, legitimising all groups’ knowledge, involving all parties in decision-making and working collaboratively. Apportioning a level of prominence to these considerations adds credence to the community’s “being” and “way of doing”. It legitimises the complexity of the tasks and expectations placed on all stakeholders.

The outcome of the analysis from this research provides a practical tool for operationalising the notion of community participation in the planning and development of health services where the expectation to engage the community occurs within the context of a centrally implemented strategy. This research provides practical tools for building community capability and maintaining sustainable community capacity for projects which are imposed by funding bodies. Labonte (1997) argues that meaningful participation is not achievable if individuals and groups do not share a common power-base. The model of partnership proposed in this thesis - *Knowing the Community* and *Enabling Full Participation* (Table 7.4) – where bureaucrats *work with* and *along-side* communities would address power imbalances evidenced in this case study. The overall benefit of this approach would be that participation would be a transformative tool for social change.

This research focuses on one specific community. Stake (2000) proposes: “The utility of case study research to practitioners and policy makers is in its extension of experience.” (p.

449). Replica case studies in other communities would provide opportunities to further develop the two new domains presented in this research: *Knowing the Community* and *Enabling Full Participation*. Evaluation of the impact of these domains on addressing both power imbalances and increasing community capability would lead to further development of the essential determinants for meaningful participation. Incorporation of both urban and rural centres would be particularly useful and provide insights into the influence of proximity to secondary and tertiary health services on community participation. In addition there is the need to better understand, from a community participant perspective, the factors which facilitate and impede sustainable and meaningful community participation. A research focus which covers a range of projects and communities would ensure that the large number of variables which influence community involvement, process, personal satisfaction and outcome be understood.

Baum (1990) poses a challenge:

The new public health is based on the notion that all these different sectors [bureaucratic, professional and consumer] will co-operate for a common good – a consensus approach. Perhaps this is naïve given our knowledge of the history of medicine and public health in the past.

p. 148

The New Zealand primary health care context provides excellent opportunities for the experts and grass-roots communities to establish a collaborative top-down *and* bottom-up approach to health service planning. If this is not achieved then there is the risk that consultation processes will continue to keep decision-making in the control of the experts and the community's input as mere tokenism.

## REFERENCES

- Adam, B. (2003). The challenges of running a District Health Board. In R. Gauld (Ed.), *Continuity amid chaos: Health care management and delivery in New Zealand* (pp. 27- 47). Dunedin, New Zealand: University of Otago Press.
- Angen, M. J. (2000). Evaluating interpretative inquiry: Reviewing the validity debate and opening the dialogue. *Qualitative Health Research*, 10, 378-395.
- Ansari, W. E., Phillips, C. J., & Hammick, M. (2001). Collaboration and partnerships: Developing the evidence base. *Health and Social Care in the Community*, 9, 215-227.
- Area Health Boards Act 1983. Retrieved August 20, 2004, from <http://rangi.knowledge-basket.co.nz/gpacts/public/text/1983/an/134.html>.
- Arnstein, S. R. (1969). Ladder of citizen participation. *Journal of the American Institute of Planners*, 35, 216-24.
- Barnes, M. (1997). *Care, communities and citizens*. London: Longman.
- Barnett, P., & Barnett, R. (2005). Reform and change in health service provision. In K, Dew & P. Davis (Ed.), *Health and society in Aotearoa New Zealand* (2<sup>nd</sup> ed.). (pp. 178-193). Australia: Oxford University Press.
- Bassett, M. (1976). *The third Labour government*. Wellington: Dunmore Press.
- Baum, F. (1990). The new public health: Force for change or reaction? *Health Promotion International*, 5, 145-150.
- Beierle, T. C. (1999). Using social goals to evaluate public participation in environmental decisions. *Policy Studies Review*, 16, 75-103.

- Berridge, G. (2003). Adopting sustainable ethics: Voluntary practice amongst event organisers. In R. A. Stebbins & M. Graham (Eds.), *Volunteering as leisure/leisure as volunteering: An international assessment*. (pp 216-238). UK: Oxon.
- Blank, R. H. (1994). *Health policy: A comparative study*. Auckland: Oxford University Press.
- Bloom, A. L. (2000). *Health Reform in Australia and New Zealand*. Australia: Oxford University Press.
- Boraas, S. (2003). Volunteerism in the United States. *Monthly Labour Review*, 126, 3-11.
- Boston, J. (1987). Transforming New Zealand's public sector: Labour's quest for improved efficiency and accountability. *Public Administration*, 65, 423-442.
- Bowling, A. (1997). *Research methods in health: Investigating health and health services*. Buckingham: Open University Press.
- Box, R. C. (1998). *Citizen governance: Leading American communities into the twenty first century*. Thousand Oaks: Sage Publications.
- Brown, I. (1994). Community and participation for general practice: Perceptions of general practitioners and community nurses. *Social Science and Medicine*, 39, 335-344.
- Brunton, W. (2000). Out of the blue comes the whitest wash: An authorial reflection on the 1974 health white paper. *Health Manager*, 8, 3-8
- Burgess, R. G. (1991). *Field research: A source book and field manual* (2<sup>nd</sup> ed.). London: Allen & Unwin.
- Campbell, C., & Jovchelovitch, S. (2000). Health, community and development: Towards a social psychology of participation. *Journal of Community and Applied Social Psychology*, 10, 255-270.
- Caygill, D. (1988). *Health: A prescription for change*. Wellington: Government Printer.

- Chetty, S. (1996). The case study method for research in small and medium firms. *International Small Business Journal*, 15, 73-85.
- Clark, H. (1989). *A new relationship: Introducing the new interface between the government and the public sector*. Wellington: Department of Health.
- Community and Public Health Advisory Community Meeting Minutes. Unpublished.  
2002, 5 March.  
2002, 17 December.  
2004, 8 April.  
2004, 4 May.
- Cooper, D. R., & Schindler, P. S. (2003). *Business research methods* (8<sup>th</sup> Ed.). Boston: McGraw-Hill.
- Crampton, P., Dowell, A.C., & Bowen, S. (2000). Third sector primary health care in New Zealand. *New Zealand Medical Journal*, March 24, 92-96.
- Crampton, P., & Starfield, B. (2004). A case for government ownership of primary care services in New Zealand: Weighing the arguments. *International Journal of Health Services*, 34, 709-727.
- Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. Australia: Allen & Unwin.
- Cumming, J., & Mays, N. (1999). Shifting to capitation in primary care: What might the implications be in New Zealand? *Australian Health Review*, 22, 8-24.
- Davenport, K. (2000). Corporate citizenship: A stakeholder approach for defining corporate social performance and identifying measures for assessing it. *Business & Society*, 39, 210-219.
- Davis, P., & Ashton, T. (Eds.). (2001). *Health and public policy in New Zealand*. Auckland: Oxford University Press.
- Davis, P., & Dew, K. (Eds.). (1999). *Health and society in Aotearoa/New Zealand*. Melbourne: Oxford University Press.

- Denzin, N.K., & Lincoln, Y.S. (Eds.). (2000). *Handbook of qualitative research* (2<sup>nd</sup> ed.). Thousand Oaks: Sage Publications.
- Department of Health. (1982). *Health services reorganisation: A discussion document*. Wellington: Author.
- Department of Health. (1989). *A new relationship: Introducing the new interface between government and the public sector*. Wellington: Author.
- District Health Board Minutes. Unpublished.  
2004, 16 March.
- Donaldson, T., & Preston, L.E. (1995). The stakeholder theory of the corporation: Concepts, evidence and implications. *Academy of Management Review*, 20, 65-91.
- Dow, D. (1995). *Safeguarding the public health: A history of the New Zealand Department of Health*. Wellington: Victoria University Press.
- Easterby-Smith, M., Thorpe, R., & Lowe, A. (2002). *Management research: An introduction* (2<sup>nd</sup> ed.). London: Sage Publications Ltd.
- Eyre, R., & Gauld, R. (2003). Community participation in a rural community health trust: the case of Lawrence, New Zealand. *Health Promotion International*, 18, 189-197.
- Fontana, A., & Frey, J. (2000). The interview. From structured questions to negotiated text. In N.K.Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research*. (2<sup>nd</sup> ed.). (pp. 645-672). Thousand Oaks: Sage Publications.
- Freeman, R. D., & McVea. (2001). A stakeholder approach to strategic management. In M. Hitt, R.E. Freeman & J. Harrison (Eds.), *The Blackwell handbook of strategic management* (pp 189-207). Malden Mass.: Blackwell Publishers.
- Gans, H, J. (1999). The participant-observer as a human-being: Observations on the personal aspects of fieldwork. In A. Bryman & R.G. Burgess (Eds.), *Qualitative Research: Volume II* (pp. 39-54). London: Sage Publications.

- Gauld, R. (2001). *Revolving doors: New Zealand's health reforms*. Wellington: Victoria University.
- Gauld, R. (Ed.). (2003). *Continuity amid chaos: Health care management and delivery in New Zealand*. New Zealand: University of Otago Press.
- Ghauri, P., & Grønhaug, K. (2005). *Research methods in business studies: A practical guide*. (3<sup>rd</sup> ed.). England: Prentice Hall.
- Gibbs, A. D., Fraser, G., & Scott, J. (1988). *Unshackling the hospitals: Report of the hospital and related services taskforce*. Wellington: Hospital and Related Services Taskforce.
- Gilchrist, A. (2004). *The Well-connected community: A networking approach to community development*. Great Britain: Community Development Foundation.
- Gillies, P. (1998). Effectiveness of alliances and partnerships for health promotion. *Health Promotion International*, 13, 99-120.
- Grafton Group Ltd. (2003). *Business case proposal for Horowhenua/Otaki health services: Volume 1*. Unpublished.
- Grant R.W., & Keohane W. (2005). Accountability and abuses of power in world politics. *American Political Journal*, 99, 29-43.
- Green, B.C., & Chalip, L. (2003). Paths to volunteer commitment: Lessons from the Sydney olympic games. In R. A. Stebbins & M. Graham (Eds.), *Volunteering as leisure/leisure as volunteering: An international assessment*. (pp. 296-310). UK: Oxon.
- Guareschi., P.A. & Jovchelovitch, S. (2004). *Journal of Health Psychology*, 9, 311-322.
- Guba, E.G., & Lincoln, Y.S. (1994). Competing paradigms in qualitative research. In N.K. Denzin & Y.S Lincoln (Eds.), *Handbook of Qualitative Research* (pp. 199-124). Thousand Oaks: Sage Publications.

- Gummesson, E. (2000). *Qualitative methods in management research* (2<sup>nd</sup> ed.). Thousand Oaks: Sage Publications.
- Harrison, S., Dowswell, G., & Milewa T. (2002). Guest editorial; public and user 'involvement' in UK. *National Health Service Health & Social Care in the Community*, 10, p.63. Retrieved October 12, 2004, from <http://www.blackwell-synergy.co./links/doi/10.1046/j.1365-2524.2002.00342.x/full>
- Hartley, J. (2004). Case study research. In C. Cassell. & G. Symon. (Eds.). *Essential Guide to qualitative methods in organizational design* (pp. 323-333). London: Sage Publications.
- Hawton, M., Hughes, G., Percy-Smith, J., & Forman, A. (1994). *Community profiling: Auditing social needs*. Philadelphia: Open University Press.
- Hawe, P. (1994). Capturing the meaning of 'community' in community: Intervention evaluation. Some contributions from community psychology. *Health Promotion International*, 9, 199 – 210.
- Hays, P.A. (2004). Case study research. In K. deMarrais & S.D.Lapin (Eds.). *Foundations for Research: Methods of inquiry in education and the social sciences* (pp. 218-234). London: Lawrence Erlbaum Associates.
- Horowhenua Primary Health Organisation Steering Committee Meeting Minutes.  
 Unpublished.  
 2003, 9 May.  
 2003, 20 June.  
 2003, 4 November.  
 2003, 18 November.  
 2003, 16 December.  
 2004, 20 January.  
 2004, 3 February.  
 2004, 29 March.  
 2004, 19 April.  
 2004, 26 April.  
 2004, 3 May.  
 2004, 17 May.
- Horowhenua PHO. (2003). *Application to MidCentral District Health Board to form primary health organisation in the Horowhenua district*. Unpublished report to MidCentral DHB .

- Horowhenua District Council, (n.d.). Retrieved May 11, 2004 from:  
<http://www.horowhenua.govt.nz/District/about+Our+District/map+OF+THE+HOROWHENUA+DISTRICT.html>
- Horowhenua/Otaki Health Services Review Steering Committee Minutes. Unpublished  
2003, 9 May.  
2003, 20 June.
- Hustinx, L., & Lammertyn, F. (2003). Collective and reflexive styles of volunteering: A sociological modernization perspective. *International Journal of Voluntary and Nonprofit Organizations*, 14, 167-187.
- Irvin, R. A., & Stansbury, J. (2004). Citizen participation in decision-making. Is it worth the effort? *Public Administration Review*, 64, 55-65.
- Johnson, R., & Waterfield, J. (2004). Making words count: The value of qualitative research. *Physiotherapy Research International*, 9, 121-131.
- Jones, T. M., Wicks, A. C., & Freeman, R. E. (2002). Stakeholder theory: The state of the art. In N. Bowie (Ed.). *The Blackwell guide to business ethics* (pp. 19-37). UK: Blackwell Publishers.
- King, A. (2000). *New Zealand health strategy*. Wellington: Ministry of Health.
- King, A. (2001). *The primary health care strategy*. Wellington: Ministry of Health.
- King, A., & Turia, T. (2002). *He Korowai Oranga: Māori Health Strategy*. Wellington: Ministry of Health.
- King, C., & Stivers, C. (1998). *Government and us: Public administration in an anti-government era*. Thousand Oaks: Sage Publications.
- King, N. (2004). Using interviews in qualitative research. In C. Cassell & G. Symon. (Eds.). *Essential guide to qualitative methods in organizational design* (pp. 11-22). London: Sage Publications.

- King, C.S., Feltey, K.M., & O'Neill Susel, B. (1998). The question of participation: Toward authentic public participation in public administration. *Public Administration Review*, 58, 317-326.
- Labonte, R. (1997). *Power, participation and partnerships for health promotion*. Australia: Victorian Health Promotion Foundation.
- Labonte, R. (1999). Social capital and community development: Practitioner emptor. *Australian and New Zealand Journal of Public Health*, 23, 430-437.
- Lancaster, G. (2005). *Research methods in management: A concise introduction to research in management and business consultancy*. Amsterdam: Elsevier.
- Laverack, G (2001). An identification and interpretation of the organizational aspects of community empowerment. *Community Development Journal*, 36, 134-145.
- Laverack, G. (2004). *Health promotion practice: Power and empowerment*. London: Sage Publications.
- Laverack, G., & Labonte, R. (2000). A planning framework for community empowerment goals within health promotion. *Health Policy and Planning*, 15, 255-262.
- Laverack, G., & Wallerstein, N. (2001). Measuring community empowerment: a fresh look at organisational domains. *Health Promotion International*, 16, 179-185.
- Lincoln, Y.S., & Guba, E.G. (2000). Paradigmatic controversies, contradictions and emerging confluences. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of Qualitative Research* (2<sup>nd</sup> ed.). (pp. 163-188). Thousand Oaks: Sage Publications.
- Lindsey, E., Stajduhar, K., & McGuinness, L. (2001). Examining the process of community development. *Journal of Advanced Nursing*, 33, 828-835.
- Local Government Act 2000. Retrieved June,28, 2005, from <http://rangitikeia.knowledge-basket.co.nz/gpacts/public/text/2002/an/084.html>.
- Locke, K. (2000). *Grounded theory in management*. London: Sage Publications.

- Love, T. (2003). Continuing change in primary care: Issues for independent practice associations and primary health organizations. In R. Gauld (Ed.), *Continuity amid chaos: Health care management and delivery in New Zealand* (pp. 68-82). Dunedin, New Zealand: University of Otago Press.
- McGuigan, T. (1975). *A health service for New Zealand*. Wellington: Government Printer.
- MacIntosh, J., & McCormack, D. (2001). Partnerships identified within primary health care literature. *International Journal of Nursing Studies*, 38, 547-555.
- Malcolm, L. (2003). Towards a more integrated health system: Is the New Zealand experience in primary health care of relevance to Australia? *Health Manager*, Winter, 20-24.
- Malcolm, L., & Mays, N. (1999). New Zealand's independent practitioner associations: a working model of clinical governance in primary care? (General Practice). *British Medical Journal*, 319, 1340-1342.
- Malterud, K. (2001). Qualitative research: Standards, challenges and guidelines. *Lancet*, 358, 483-488.
- Martin, J., & Salmond, G. (2001). Policy making: the 'messy reality'. In P. Davis & T. Ashton (Eds.). *Health and public policy in New Zealand* (pp. 44-61). Auckland: Oxford University Press.
- MidCentral District Health Board Primary Health Care Reference Group Meeting Minutes.  
 Unpublished.  
 2002, 29 October.  
 2002, 17 December.  
 2003, 20 May.  
 2003, 29 July.  
 2003, 12 September.  
 2003, 23 September.  
 2003, 28 October.  
 2003, 18 November.  
 2003, 2 December.  
 2004, 3 February.  
 2004, 2 March.  
 2004, 20 April.

- MidCentral District Health Board. (2002). *Establishing primary health organisations in the MidCentral district: Report to the Community and Public Health Advisory Committee*. Palmerston North: Author.
- MidCentral District Health Board. (2004a). *Annual report 2004*. Palmerston North: Author.
- MidCentral District Health Board. (2004b). *Primary health care strategy*. Palmerston North: Author.
- MidCentral District Health Board. (n.d.). Retrieved May 11, 2004. <http://www.midcentral.co.nz/MDHB-Info.html>
- MidCentral District Health Board. (n.d.). Retrieved October 8, 2005. <http://www.midcentral.co.nz/MDHB/Board-Member-Community.html#TOR>
- Milewa, T., Valentine, J., & Calnan, M. (1999). Community participation and citizenship in British health care planning: narratives of power and involvement in the changing welfare state. *Sociology of Health & Illness*, 21, 445-465.
- Milewa, T., Dowswell, G., & Harrison, S. (2002). Partnerships, power and the “new” politics of community participation in British health care. *Social Policy and Administration*, 36, 796-809.
- Ministry of Health. (2001). *The New Zealand disability strategy: Making a world of difference*. Whakanui Oranga. Wellington: Author.
- Ministry of Health, (2002). *Briefing paper: Intersectoral collaboration*. Retrieved August 17, 2005 from <http://www.moh.govt.nz/moh.nsf/wpg-Index/Publications>
- Ministry of Health. (2005a). *Primarily* Retrieved August 1, 2005. from <http://www.moh.govt.nz/moh.nsf/wpg-Index/Publications -Primarily+-+Issue+5+-+July+2005>.
- Ministry of Health. (2005b). *The Primary Health Care Strategy: Established PHOs* Retrieved August 17, 2005 from [http://www.moh.govt.nz/moh.nsf/wpg\\_index/-Primarily+Health+Care+ Established+PHOs+by+DHB](http://www.moh.govt.nz/moh.nsf/wpg_index/-Primarily+Health+Care+ Established+PHOs+by+DHB).

- Ministry of Health. (n.d.). Retrieved October 30, 2004, from [http://www.moh.govt.nz/nsf/wpg\\_Index/-Promary+Health+Care+Getting+PHOs+Established](http://www.moh.govt.nz/nsf/wpg_Index/-Promary+Health+Care+Getting+PHOs+Established)
- Ministry of Health. (n.d.). Retrieved: October 4, 2004, from [http://www.moh.govt.nz/moh.nsf/wpg\\_index/-Primary+Health+Care+Resources+for+Implementation#calculating](http://www.moh.govt.nz/moh.nsf/wpg_index/-Primary+Health+Care+Resources+for+Implementation#calculating)
- Morgan, G. (Ed.). (1983). *Beyond method; Strategies for social research*. London: Sage Publications.
- Morgan, L. M. (2001). Community participation in health: perpetual allure, persistent challenge. *Health Policy and Planning*, 16, 221-230
- National Advisory Committee on Core Health Services. (1993). *The best of health 2: How we decide on health and disability support services we value the most*. Wellington: Author.
- National Health Committee. (2000). *Improving health for New Zealanders by investing in primary health care*. Wellington: Author.
- Nelson, N., & Wright, S. (1995). *Power and participatory development: Theory and practice*. London: Intermediate Technology Publications.
- Netting, F.E., Nelson, H.W., Borders, K., & Huber, R. (2004). Volunteer and paid staff relationships: Implications for social work administration. *Administration in Social Work*, 28, 69-89.
- Neuwelt, P., & Crampton, P. (2005). Community participation in primary health care in Aotearoa New Zealand. In K. Dew & P. Davis (Eds.), *Health and society in Aotearoa New Zealand*. (2<sup>nd</sup> ed.). (pp. 194-210). Australia: Oxford University Press.
- New Zealand Institute of Economic Research. (2003). *PHOs and health: Implications of PHO policy for Māori health policy objectives*. Wellington: Author.
- New Zealand Public Health and Disability Act 2000. Retrived October 13, 2004, from <http://rangiknowledge-basket.co.nz/gpacts/public/text/2000/an/091.html>.

- Oldfield, A. (1990). *Citizen and community: Civic republicanism and the modern world*. London: Routledge.
- Poutasi, K. (2000). The evolving role of government in health sector reform in New Zealand. In A. Bloom. (Ed.), *Health reform in Australia and New Zealand* (pp. 132-146). Australia: Oxford University Press.
- Preissle, J., & Grant, L. (2004). Fieldwork traditions: Ethnography and participant Observation. In K. DeMarris & S. D. Lapin. (Eds.), *Foundations for research: Methods of inquiry in education and the social sciences* (pp. 162-180). London: Lawrence Erlbaum Associates.
- Pretty, J.N. (1995). Participatory learning for sustainable agriculture. *World Development*, 23, 1247-1263.
- Public Finance Act 1989. Retrived October 13, 2004, from <http://rangi.knowledge-basket.co.nz/gpacts/public/text/1989/an/044.html>.
- Putland, C., Baum, F., & MacDougall, C. (1997). How can health professionals consult efficiently about their policies and practices?: some lessons from an Australian study. *Health Promotion International*, 12, 299-309.
- Raffel, M. (1976). The white paper: An exercise in divisive planning. *New Zealand Journal of Public Administration*. 38, 11-25.
- Ramirez-Valles, J., & Brown, A. (2003). Latinos' community involvement in HIV/AIDS: Organisational and individual perspectives on volunteering. *AIDS Education and Prevention*, 15, 90-104.
- Randle, N., & Hutt, M. (1997). *Healthy cities. A report for Midland Regional Health Authority*. Hamilton, New Zealand: Midland Regional Health Authority.
- Rappaport, J. (1987). Terms of empowerment/exemplars of prevention: Toward a theory of community psychology. *American Journal of Community Psychology*, 12, 121-148.

- Rifkin, S. (1990). *Community participation in maternal & child health / family planning programmes*. Geneva: World Health Organisation.
- Rifkin, S., Muller, F., & Bichmann, W. (1988). Primary health care: on measuring participation. *Social Science & Medicine*, 26, 931-940.
- Rossman, G.B., & Rallis, S.F. (1998). *Learning in the field: An introduction to qualitative research*. UK: Sage Publications.
- Rossman, G.B., & Rallis, S.F. (2003). *Learning in the field: An introduction to qualitative research* (2<sup>nd</sup> ed.). UK: Sage Publications.
- Rowley, T. J. (1997). Moving beyond dyadic ties: A network theory of stakeholder influences. *Academy of Management Review*, 22, 887-910.
- Salmond, G., Mooney, G., & Laugeson, M. (1994). Introduction to health care reform in New Zealand. *Health Policy*, 29, 1-3.
- Schwandt, T.A. (2000). Three epistemological stances for qualitative inquiry: interpretivism, hermeneutics, and social constructionism. In N.K. Denzin & Y.S. Lincoln. *Handbook of qualitative research* (2<sup>nd</sup> ed.). (pp. 189-213). Thousand Oaks: Sage Publications.
- Scott, C. (1994). Reform of the New Zealand health care system. *Health Policy*, 29, 25-40.
- Scott, C., Fougere, G., & Marwick, P. (1986). *Choices for health care: Report of the health benefits review*, Wellington: Health Benefits Review.
- Simpson, L., Wood, L., & Daws, L. (2003). Community capacity building: starting with people not projects. *Community Development Journal*, 38, 277-286.
- Somjen, A. (2000). Distinguishing features of reform in Australia and New Zealand. In A. Bloom. (Ed). *Health reform in Australia and New Zealand* (pp. 54-68). Australia: Oxford University Press.
- Stake, R.E. (1995). *The art of case study*. UK: Sage Publications.

- Stake, R. E. (2000). Case studies. In N.K. Denzin & Y.S. Lincoln. (Eds.), *Handbook of qualitative research* (2<sup>nd</sup> ed.). (pp. 435-454). Thousand Oaks: Sage Publications.
- Stake, R.E. (2005). Qualitative case studies. In N.K. Denzin & Y.S. Lincoln. (Eds.), *The Sage Handbook of Qualitative Research* (3<sup>rd</sup> ed.) (pp.443-466). Thousand Oaks: Sage Publications.
- Starfield, B. (1998). *Primary care: Balancing health needs services and technology*. New York: Oxford University Press.
- State Sector Act 1988 Retrived October 13, 2004, from <http://rangi.knowledge-basket.co.nz/gpacts/public/text/1988/an/020.html>.
- Stivers, C. (1990). The public agency as polls: Active citizenship in the administrative state. *Administration and Society*, 22, 86-105.
- Stoney, C., & Winstanley, D. (2001). Stakeholding: Confusion or utopia? Mapping the conceptual terrain. *Journal of Management Studies*, 38, 603-626.
- Thomas, J.C. (1995). *Public participation in public decisions: new skills and strategies for public managers*. San Francisco: Jossey-Bass Publishers.
- Tolich, M., & Davidson, C. (1999). *Starting fieldwork: An introduction to qualitative research in New Zealand*. Auckland: Oxford University Press.
- Treasury (1990). *Briefing to the incoming Government*. Wellington: Author.
- Upton, S. (1991). *Your health and the public health: A statement of government policy*. Wellington: Minister of Health.
- Voyle, J. A., & Simmons, D. (1999). Community development through partnerships: promoting health in an urban indigenous community in New Zealand. *Social Science and Medicine*, 49, 1035-1050.
- Waddington, D. (2004). Participant Observation. In C. Cassell. & G. Symon. (Eds.), *Essential guide to qualitative methods in organizational design* (pp. 154-164). London: Sage Publications.

- Wandersman, A., & Florin, P. (1999). Citizen participation and community organisations. In J. Rappaport & E. Seidman (Eds.), *Handbook of Community Psychology* (pp 247-272). New York: Kluwer Academic / Plenum Publishers.
- Weber, E.P. (1999). The question of accountability in historical perspective. From Jackson to contemporary grassroots ecosystem management. *Administration & Society*, 31, 451-494.
- White, S.C. (1996). Depoliticising development: The uses and abuses of participation. *Development in Practice*, 6, 6-15.
- Wood, G.S., & Judikis, J.C. (2002). *Conversations on community theory*. Indiana: Purdue University Press.
- World Health Organisation. (1978). *Declaration of Alma Ata*. Geneva: Author. Retrieved July 28, 2005 from [www.euro.who.int/AboutWHO/Policy/20010827](http://www.euro.who.int/AboutWHO/Policy/20010827)
- Yin, R.K. (2002). *Case Study Research: Design and Methods*. (3<sup>rd</sup> ed.). Thousand Oaks: Sage Publications.
- Yin, R.K. (2003). *Applications of case study research*. (2<sup>nd</sup> ed.). Thousand Oaks: Sage Publications.
- Zakus, J. D. L., & Lysack, C. L. (1998). Revisiting citizen participation. *Health Policy and Planning*, 13, 1-12.
- Zikmund, W.G. (2003). *Business research methods*. (7<sup>th</sup> ed.). Fort Worth: Dryden.

## APPENDIX A

### Terms of Reference

#### MidCentral DHB Community & Public Health Advisory Committee

In accordance with the New Zealand Public Health and Disability Act the Board shall create a Community and Public Health Advisory Committee whose members and chairperson shall be determined by the Board from time to time.

The Terms of Reference of the Community and Public Health Advisory Committee shall be:

- To provide advice to the Board on the needs, and any factors that the Committee believes may adversely affect the health status, of the resident population of the District Health Board.
- To provide advice to the Board on priorities for use of the health funding provided.
- To ensure that the following maximise the overall health gain for the population the committee serves:
  - All service interventions the District Health Board has provided or funded or could provide or fund for that population.
  - All policies the District Health Board has adopted or could adopt for that population.
- Such advice must not be inconsistent with the New Zealand Health Strategy.
- To consider annual purchasing plans and recommend same to the Board for approval.
- To recommend policies relating to the planning and purchasing of health services for the district.
- To develop an annual workplan for the Board's consideration and approval.
- To recommend what "expert" assistance will be required in order for the Committee to fulfil its obligations and achieve its annual workplan.
- To report regularly to the Board on their findings (generally the minutes of each meeting will be placed on the agenda of the next Board Meeting).

The following authorities are delegated to the Community & Public Health Advisory Committee:

- To require the Chief Executive Officer (or delegate) to attend its meetings, provide advice and prepare reports as required.
- To interface with any other committee(s) that may be formed from time to time.

Source: MidCentral DHB, (n.d.). Retrieved October 8, 2005

**MidCentral District Health Board Primary Health Care Reference Group.**

1. To review all Registrations of Interest and provide feedback to the MidCentral District Health Board as to potential partner/s and approach/es.
2. To recommend an appropriate consultation process with providers and communities of interest to ensure optimal provider and community support is achieved.
3. To ensure that expert advice is available when required throughout the transition to Primary Health Organisations. This includes establishing appropriate local and national linkages.
4. To work towards ensuring that this region secures an appropriate share of the national establishment funding pool by working with preferred providers to develop robust business plans that meet the national criteria.
5. To monitor and report proposed developments to ensure they are aligned with the strategic intentions of MidCentral's District Strategic Plan.
6. To assist in the development of MidCentral's Strategic Plan for Primary Health Care.

Source: MidCentral DHB, 2000. p. 15

## **APPENDIX B**

### **Information Sheet and Consent Form**



## TOWARDS A MODEL OF COMMUNITY ENGAGEMENT

### **Community participation in the establishment of a Primary Health Organisation in the Horowhenua – Kapiti Region.**

#### **INFORMATION SHEET**

##### **Research Scope and Method**

Primary Health Organisations are currently being established throughout the country and provide an ideal opportunity to examine community engagement and participation. The purpose of this research is to examine the community's involvement in the establishment and monitoring of a Primary Health Organisation in the Horowhenua or Kapiti region. Data will be gathered over a 12-month period using a case study approach.

There are three central aims to this project. The first is to investigate the notion of community engagement and participation in the planning, establishment and governance of a Primary Health Organisation. Secondly, I want to explore the actual process for establishing, governing and running the Primary Health Organisation from a community participation and engagement perspective. The final aim of the project is to evaluate the implications of community engagement, that is, identify what is in it for the stakeholders, the Primary Health Organisation and the community it serves. This evaluation will be from the perspective of the stakeholders and the PHO, not from a consumer perspective.

I am using observations and semi-structured interviews for gathering data. The participants in my research will be people who are actively involved in working towards the establishment of the PHO and, later in the research, people who work in the PHO. DHB Board Members, Funding Division staff and members of the District Health Board Reference Group will also be included.

##### **The Researcher**

I am doing this research as part of my PhD study. I am a full-time student in the Management Department. My contact details are:

Jan Lockett-Kay  
Department of Management  
Massey University  
Palmerston North  
Ph 06 323 8671 (home), 06 3505799 (Massey)  
Mobile 027 222 3053  
Email: [jlk@xtra.co.nz](mailto:jlk@xtra.co.nz)  
[J.Lockett-Kay@massey.ac.nz](mailto:J.Lockett-Kay@massey.ac.nz)

**Supervisors**

Professor Tony Vitalis  
Department of Management  
Massey University  
Palmerston North  
Ph 06 3505799  
Email: [A.Vitalis@massey.ac.nz](mailto:A.Vitalis@massey.ac.nz)

Emeritus Professor Nancy Kinross  
Department of Management  
Massey University  
Palmerston North  
Ph 06 3505799  
Email: [N.Kinross@massey.ac.nz](mailto:N.Kinross@massey.ac.nz)

**Project Procedures**

Transcripts will be stored in a locked file for 5 years at which time they will be destroyed. A staff member in the Management Department, Massey University will do this.

You have the right to:

- Decline to participate
- Decline to answer any particular question
- Withdraw from the study anytime during the data collection phase
- Ask questions about the study at any time during your participation.
- Provide information on the understanding that your name will not be used unless you give permission to the researcher.
- Ask the researcher to leave the meeting at any time
- Be given a copy of the summary of project findings when it is concluded.

No material that can personally identify you will be used in any reports of the study unless specific permission is given. At the conclusion of the research you will be informed of where a copy of the completed thesis can be obtained and you will receive a summary of the findings and conclusions.

You are welcome to contact the researcher and /or supervisors at any other time if you have any queries.

This project has been reviewed and approved by:

1. The Massey University Human Ethics Committee, PN. Protocol 03/63. If you have any concerns about the conduct of this project, please contact Professor Sylvia V Rumball, Chair, Massey University Campus Human Ethics Committee, Palmerston North, telephone 06 350 5249, email [S.V.Rumball@massey.ac.nz](mailto:S.V.Rumball@massey.ac.nz)
2. Manawatu / Whanganui Ethics Committee  
Registration Number:03/06/025



## **TOWARDS A MODEL OF COMMUNITY ENGAGEMENT**

### **Community participation in the establishment of a Primary Health Organisation in the Horowhenua Region.**

#### **CONSENT FORM**

#### **THIS CONSENT FORM WILL BE HELD FOR A PERIOD OF FIVE (5) YEARS**

I have read and understand the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I understand that taking part in this study is voluntary.

I understand that my participation in this study is confidential and that no material that could identify me will be used in any reports on this study unless specific permission is given.

I agree/do not agree to the interview being audio taped

I agree to participate in the study under the conditions set out in the Information Sheet.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Full Name – printed: \_\_\_\_\_

## APPENDIX C

### Template for Recording Observations

Date:

**Pre-Interview Prep:**

**References / supporting documentation:**

*E.g.*

*Agenda*

*Minutes*

*Correspondence*

<b>Record of discussion</b>	<b>My notes, comments</b>

**Other general comments:**

*Meetings/issues which may have impacted/be impacting on agenda items or discussions*

*Informal discussion I had with Steering Committee members before and after meetings which assisted in placing events in a context.*

## APPENDIX D

### Participants

<b>Members of the Horowhenua PHO Steering Committee</b>	<b>Interviewees</b>
Steering Committee Community Representative and Chairperson	Chairperson Steering Committee Interviewed 18 August 2004
Steering Committee Community Representative II	
Steering Committee Practice Nurse Representative	
Steering Committee General Practitioner Representative I	Steering Committee General Practitioner I, Interviewed 19 August 2004
Steering Committee General Practitioner II	
Steering Committee Iwi Representative I	
Steering Committee Iwi Representative II	Steering Committee Iwi Representative II, Interviewed 2 September 2004
Steering Committee Pacific Representative	
Steering Committee Pharmacy Representative	
Funding Division Representative A	
Funding Division Representative B	Funding Division Representative B Interviewed 19 August 2004
Funding Division Representative C	
	Chairperson, Community and Public Health Advisory Committee, MidCentral DHB Interviewed 18 August 2004
	DHB PHC Reference Group representative Interviewed 24 August 2004

## APPENDIX E

### Semi-Structured Interview Questions

Duration of all interviews: Approximately one hour

#### 1 Steering Committee Members

##### Interviewed:

- Chairperson Horowhenua PHO Steering Committee: 18 August 2004
- General Practitioner I, Horowhenua PHO Steering Committee: 19 August 2004
- Iwi Representative II, Horowhenua PHO Steering Committee: 2 September 2004

##### *Questions Prepared Prior to Interview*

1. Why did you make a commitment to being involved in this planning process?
2. What do you think were the reasons why other members of the Steering Committee got involved?
3. How did the Steering Committee get started - how did it get traction?
4. When did you start working as a team?
5. What do you consider to be the strengths of the process you used?
6. What were the weaknesses?
7. What was the community's understanding of the primary health care strategy and PHO establishment?
8. How do you think the Steering Committee influenced this understanding?
9. What comments have you got about how the Steering Committee was resourced?
10. What comment do you have about the Steering Committee's knowledge and skill mix – where were the gaps?
11. What comments do you have about the Steering Committee's access to relevant information?
12. Any other comments?

##### *Actual Questions Asked at Interview*

1. How were members of the Establishment Committee selected?
2. How did you get involved / How were you selected?
3. Why did you get involved?
4. Did you represent a group?
5. Tell me about what you see as the strengths of the process used to establish the PHO. – what were the aspects of the process which you felt very comfortable with?
6. What were the things that were not good about the process? / What aspect were you not happy with? / Were there things that could have been improved?
7. When did the Establishment Committee start moving as a team / develop as a team?
8. How did you make decisions?
9. Where did you get your information from?
10. What type of information did you have?
11. On 1 July, when the PHO 'went live' – were you satisfied with the overall process – were you satisfied with the outcome?

## 2 DHB Funding Division Representative

### Interviewed:

- Funding Division Representative B: 19 August 2004

#### *Questions Prepared Prior to Interview*

1. What role did the Funding Division play in establishing the process for getting the PHO planning up and running?
2. Following the ‘sign-off’ of the Establishment Plan, what was the next significant task for the Steering Committee?
3. If Kere Kere, Horowhenua and Otaki had established one PHO what do you see as the challenges during the establishment phase for ensuring community engagement and ensuring community need was met?
4. What input did the Funding Division have into the selection / appointment of Steering Committee members?
5. How was membership of the DHB Reference Group determined?
6. Do you have any comments to make about the community voice and the constituency representation on the Horowhenua PHO Steering Committee?
7. What are the strengths and weaknesses of the structure of the legal entity for engaging community?
8. If the last 12 months could be re-run, what do you think the Funding Division would do differently?
9. Was the skill-mix of the Horowhenua Steering Committee adequate for the demands of the task?

#### *Actual Questions Asked at Interview*

1. What involvement did you have in organising the process for PHO establishment?
2. How were members of the Establishment Committee selected? – were there specific criteria that were important to the Funder (representation)?
3. What was your involvement in the process?
4. How do you think it developed?
5. What were the key issues that arose during the establishment phase?
6. How were the decisions made from your point of view?
7. Are you satisfied with the outcome?

## **DHB Primary Health Care Reference Group Representative**

**Interviewed:** 24 August 2004

### ***Questions Prepared Prior to Interview***

1. How did the Reference Group come about and how was membership decided?
2. At the outset what contribution did you believe you could make to the Group? What was your agenda for becoming involved?
3. The Reference Group is an advisory group. Has that always been the perspective of the group?
4. What role did the Reference Group play in the establishment of the Horowhenua PHO?
5. Did the Reference Group provide guidance and feedback to the Horowhenua Steering Committee Establishment Plans – What is your recollection of this process?
6. Was it your recollection of how the Reference Group was involved when issues arose during the Horowhenua planning period – to assist the Funding Division to find a solution?
7. When the DHB draft PHC Strategy went out for community consultation, how effective do you think that process was for increasing communities' awareness of the strategy and PHO development?
8. In hindsight, was the establishment of a Reference Group a sensible move for the DHB?
9. Did you see the role of the Reference Group change over time?
10. What were the strengths of the process of PHO establishment in the Horowhenua?
11. What level of influence do you think the community had during the planning period?
12. Are there any other ways in which communities could be empowered to gain a better understanding of the opportunities they have to influence health services?

### ***Actual Questions Asked at Interview***

1. How was the Membership of the Reference Group decided?
2. Why did you get involved?
3. Tell me about the role the Reference Group played in the establishment of the Horowhenua PHO.
4. What were the strengths of the process?
5. What things around the process would you like to have seen done differently?
6. What were the key issues that arose during the establishment phase and how were they managed?
7. How were the decisions made from your point of view?
8. What were your observations about its (the PHO) development?
9. Are you satisfied with the outcome?

## **Chairperson, CPHAC**

**Interviewed:** 18 August 2004

### ***Questions Prepared Prior to Interview***

1. What was the CPHAC's role in determining process for establishment of the Horowhenua PHO?
2. How important for making progress with plans was it to have 'strong-minded' people (leaders) from the community involved?
3. What observations did CPHAC make about the establishment process (apart from receiving the Establishment Plan)?
4. What were the strengths of the planning process?
5. In hindsight, is there anything about the process which you would have liked to have changed?
6. Are you satisfied with the level of guidance and support that the Funding Division provided for the Horowhenua Steering Committee?
7. What comments do you have about the constituency representation of the Horowhenua Steering Committee?
8. Has the establishment model positioned the community well for ongoing involvement?
9. From a CPHAC perspective are you satisfied with the outcome (Horowhenua PHO planning process)?

### ***Actual Questions Asked at Interview***

1. What was your involvement (CPHAC's) in the establishment of the Horowhenua PHO.
2. What were your observations about its development?
3. What were the strengths of the process used to establish this PHO?
4. What things around the process would you like to have seen done differently?
5. What were the key issues?
6. How were the decisions made from your point of view?
7. Are you satisfied with the outcome?

## APPENDIX F

### **Ethics Approval Correspondence**

- Letter from Manawatu Whanganui Ethics Committee dated 27 August 2003 - Approval.
- Letter from Massey University Campus Human Ethics Committee: Palmerston North, dated 29 July 2003 –Approval.
- Email from Massey University Campus Human Ethics Committee: Palmerston North, dated 2 July 2003 - Requesting additional information.
- Email from Manawatu Whanganui Ethics Committee dated 26 June 2003 - Requesting additional information.

27<sup>th</sup> August 2003

## Manawatu Whanganui Ethics Committee

C/- Palmerston North Hospital  
P.O. Box 5203  
Palmerston North  
Phone/Fax (06) 356 7773  
Email: mwethics@xtra.co.nz

Jan Lockett-Kay  
Management Department  
Massey University  
Private Bag 11 222  
Palmerston North

Dear Jan

Full Study Title: **TOWARDS A MODEL OF COMMUNITY ENGAGEMENT  
COMMUNITY PARTICIPATION IN THE ESTABLISHMENT  
OF PRIMARY HEALTH ORGANIZATION IN THE  
HOROWHENUA-KAPITI REGION**

**Investigator: Jan Lockett-Kay**

Manawatu/Whanganui Ethics Committee Registration No: 03/06/025

The above study has been given ethical approval by the Manawatu/Whanganui Ethics Committee.

### Approved Documents

Protocol No 03/025

Amendment No 1 dated 25/07/03

Information sheet and consent form version 2 dated 25/07/03

### Accreditation

This Committee is accredited by the Health Research Council and is constituted and operates in accordance with the Operational Standard for Ethics Committees, March 2002.

### Progress Reports

The study is approved until 2006. The Committee will review the approved application annually. A progress report is required for this study on August 2004. You will be sent a form requesting this information prior to the review date. Please note that failure to complete and return this form may result in the withdrawal of ethical approval. A final report is also required at the conclusion of the study.

**Amendments**

All amendments to the study must be advised to the Committee prior to their implementation.

**General**

It should be noted that Ethics Committee approval does not imply any resource commitment or administrative facilitation by any healthcare provider within whose facility the research is to be carried out. Where applicable, authority for this must be obtained separately from the appropriate manager within the organisation.

Please quote the above reference number in all correspondence relating to this study.

Please note a new version of the application form (EA0502) is now available either by email from the Administrator or from the Health Research Council website, [www.hrc.govt.nz](http://www.hrc.govt.nz). Form EA0699 will not be accepted after 31 December 2002.

Yours sincerely



**Sheryl Kirikiri**  
**Administrator**  
Manawatu/Whanganui Ethics Committee

Massey University Campus Human Ethics Committee: Palmerston North (HEC: PN)  
Old Main Building, Turitea Fax: 64 6 350 5622 <http://www.massey.ac.nz/~muhec>  
Professor Sylvia V Rumball, Chair Secretary  
Telephone: 64 6 350 5249 Telephone: 64 6 350 5799 extn 7773  
Email: S.V.Rumball@massey.ac.nz Email:



Private Bag 11 222,  
Palmerston North,  
New Zealand  
Telephone: 64 6 356 9099

29 July 2003

Ms Janet Lockett-Kay  
140 Aorangi Road, RD 5  
**FEILDING**

Dear Janet

**Re: HEC: PN Protocol - 03/63**  
**Towards engagement - community participation in the establishment of a**  
**primary health care organisation in the Horowhenua-Kapiti region**

Thank you for your letter dated 25 July 2003 and the amended protocol.

The amendments you have made and explanations you have given now meet the requirements of the Massey University Human Ethics Committee and the ethics of your protocol are approved. Approval is for three years. If this project has not been completed within three years from the date of this letter, a new application must be submitted at that time.

Any departure from the approved protocol will require the researcher to return this project to the Massey University Campus Human Ethics Committee: Palmerston North for further consideration and approval.

A reminder to include the following statement on all public documents "This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Protocol 03/63. If you have any concerns about the conduct of this research, please contact Professor Sylvia V Rumball, Chair, Massey University Campus Human Ethics Committee: Palmerston North, telephone 06 350 5249, email S.V.Rumball@massey.ac.nz"

Yours sincerely

A handwritten signature in cursive script that reads "Sylvia Rumball".

Professor Sylvia V Rumball, Chair  
**Massey University Campus Human Ethics Committee: Palmerston North**

cc Professor Tony Vitalis  
Professor Nancy Kinross  
Department of Management  
TURITEA PN214

---

Massey University Human Ethics Committee  
Accredited by the Health Research Council

Te Kunenga ki Pūrehuroa

Inception to Infinity: Massey University's commitment to learning as a life-long journey

---

From: Griffiths, Mary  
To: Lockett-Kay, Jan  
Cc: Vitalis, Tony; Kinross, Nan  
Subject: HEC: PN Protocol 03/63 - Outcome  
Attachments:

Sent: Wed 7/2/2003 12:16 PM

[View As Web Page](#)

**03/63 Towards Community Engagement - Community Participation in the Establishment of a Primary Health Care Organisation in the Horowhenua - Kapiti Region**

Ms Janet Lockett-Kay (HEC: PN Protocol 03/63)  
Department: Management  
Supervisors: Professor Tony Vitalis & Professor Nancy Kinross

Thank you for the above protocol that was received and considered by the Massey University Campus Human Ethics Committee: Palmerston North at their meeting held on Thursday 19 June 2003.

The protocol was approved, subject to approval by Professor Sylvia V Rumball (Chair) of the reply to the following questions and comments:

PART III

Q4

- clarify where the snowballing starts.

PART IV

Q13

- clarify who will be transcribing. If not the researcher, a Confidentiality Agreement will be needed.

Q14.2

- The response should be "yes".

Q14.3

- note that under the Treaty, Maori are partners and therefore should not be viewed as just "stakeholders". Ensure that in conducting the research that the role of Maori in the development of a PHO is addressed.

Interview Schedule

- clarify if an interview schedule is to be supplied to participants in advance. If so, include this information in the Information Sheet.

Information Sheet

- customise and supply separate Information Sheets for interviews and focus groups to improve clarity.

[https://owa.massey.ac.nz/ex...:%20PN%20Protocol%2003\\_xF8FF\\_63%20-%20Outcome.EML](https://owa.massey.ac.nz/ex...:%20PN%20Protocol%2003_xF8FF_63%20-%20Outcome.EML) 6/15/03

- o include information about audiotaping.
- o amend 4th bullet point on page 2 to “withdraw from the study during data collection phase”.
- o include the following statement “This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Protocol 03/NO. If you have any concerns about the conduct of this project, please contact Professor Sylvia V Rumball, Chair, Massey University Campus Human Ethics Committee: Palmerston North, telephone 06 350 5249, email S.V.Rumball@massey.ac.nz”.
- o supply a copy of the amended information sheet.

Please supply to the Secretary, one (1) copy of this letter with your reply inserted under each point, plus any amended documents which should clearly identify changes made e.g. using track changes.

Any departure from the approved protocol will require the researcher to return this project to the Massey University Campus Human Ethics Committee: Palmerston North for further consideration and approval.

Yours sincerely

Professor Sylvia V Rumball, Chair  
**Massey University Campus Human Ethics Committee: Palmerston North**

Mary Griffiths, Acting PA/Office Manager  
 Office to the Assistant to the VC (Equity & Ethics)  
 Old Main Building, Turitea PN221  
 Massey University/Te Kunenga ki Purehuroa  
 Private Bag 11222, Palmerston North  
 NEW ZEALAND

Phone 64 6 350 5573

Fax 64 6 350 5622

Animal Ethics WWW <http://www.massey.ac.nz/maehc/>

Human Ethics WWW <http://www.massey.ac.nz/humethics/>

J.Lockett-Kay@misses.co.nz

Dear Jan

**RE: TOWARDS A MODEL OF COMMUNITY ENGAGEMENT**

**Manawatu/Whanganui Ethics Committee Registration No:  
03/025**

Having considered the protocol the committee has the following comments to make.

1. Please note Manawatu/Whanganui Ethics Committee is not part of the MidCentral District Health Board. The committee is under the Ministry of Health and accredited by the Health Research Council.
2. Page 3; Q 1.3 the answer should be “Yes”.
3. Page 5; Q 3.2- the committee is concerned that consumer opinion is not being sought for this research. It was felt that the exclusion of consumers has created a major difficulty when set against the criteria of community development and engagement. Consumers are major stakeholders in the process and exclusion affects the basic design of your research. We would appreciate your reconsideration of this issue.
4. Page 11; Q 9.1 - include the dollar value of the participants time.
5. Page 14; Treaty of Waitangi - The committee’s view is that this research has a community focus and there is a requirement to consult with Maori within the regions that the research will take place. Accordingly, we recommend that you contact Dennis Emery, CEO Raukawa Services, who is also a District Health Board member. Until consultation has taken place the protocol cannot be approved.
6. Information Sheet, page 2; last paragraph – the first sentence should be qualified by the statement “unless specific permission is given”.
7. Consent Form; paragraph 3 – please add “unless specific permission is given”.

If you could respond to the above issues at your earliest convenience. Once your response is to hand the matter can be addressed by a Fast-Track Committee without waiting for the next meeting.

If you have any enquiries please do not hesitate to contact the writer.

Regards

Phil Sunderland  
**Chairperson**

## APPENDIX G

### Funding Arrangements

From the commencement of PHO establishment the Government aimed to increase funding for primary health care to a level that would mean low co-payments for all, and the phasing-out of the Community Services Card. As an interim arrangement two funding formulae were established.

An 'Access' formula will allow all enrolees to be charged low patient fees, or access free care, and there will be no need to use CSCs [Community Services Cards]. In the first instance, the Access formula will be available only for PHOs, or practices within PHOs, serving populations with high concentrations of low income and high health need groups.

Until there is enough funding for all PHOs to be on the Access formula, an Interim formula will apply to other PHOs/practices. The Interim Formula will continue to use CSC status both for determining funding and setting co-payments.

Both the Access and Interim Formulae recognise ethnicity and deprivation, alongside age and sex, as key determinants of population need. Weightings for ethnicity and deprivation target extra funding to improve access for low income and high health need populations and promote better health for all enrolled persons.

Excerpts from: (2002, October) Primary Health Organisation Funding<sup>39</sup>

The following factors have been used to reflect health need for PHO's enrolled populations.

- Age
- Gender
- Ethnicity (2 groupings - 'Māori or Pacific' and 'Other')
- Deprivation (2 groupings - NZ Deprivation Index deciles 1-8 and NZDep deciles 9/10)
- High User Health Card status.

To improve access to primary health care for low income and high health need groups the weightings in the Access funding formula for ethnicity and deprivation have been set as follows:

	<b>Non-Māori Non-Pacific (Other)</b>	<b>Māori Pacific</b>
Deprivation deciles 1-8	1.0	1.2
Deprivation deciles 9-10	1.2	1.4

<sup>39</sup> Ministry of Health (n.d.). Retrieved: October 4, 2005.

The weightings for ethnicity and deprivation provide an additional amount to each PHO for improving access for these high need groups.

Additional funding has also been made available to meet specific requirements. These include funds for:

- Health promotion
- Prescription charges
- Referred services
- PHO establishment
- PHO management support
- Rural support
- Achieving specific quality requirements
- Innovative nursing initiatives
- Immunisation
- Improved primary mental health services