

Reforming primary care

Are New Zealand's new primary health organisations fit for purpose?

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Attempts to make New Zealand's health care more equitable have resulted in rapid change. But the reforms are largely untested and their effects difficult to predict

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Evidence is growing that primary care has a crucial role in healthcare systems.¹ Governments therefore need to ensure that they get any reforms right. In the United Kingdom, attempts to improve primary care through competition between existing general practices and new corporate entrants have been suggested to undermine some of its strengths: quality, efficiency, and equity.² The New Zealand government has also pursued a bold strategy for improving primary care. Irrespective of its merits in principle, the strategy has produced a wide variety of organisations of varying capability and complex funding arrangements. We assess the changes and their likely effects.

Rise of organised primary care

Before the 1990s, organisation of primary care in New Zealand was minimal. General practitioners were mostly sole private operators and received state subsidies and patient fees for each consultation.³ Contract funding arrangements, introduced in 1993 as part of the government's market reforms of the public health system, stimulated organisation.⁴ In response, general practitioners formed independent practitioner associations to negotiate on their behalf with government purchasers, and various non-profit groups also developed, focusing on specific, often deprived, populations.⁵

By the late 1990s, primary care had progressed enormously. About 84% of general practitioners were affiliated with independent practitioner associations or other groups. Larger associations had over 100 members and well established clinical governance practices.⁶ An array of clinical and organisational innovations had been introduced, and information technology was widely deployed.⁵⁻⁷ Immunisation rates and other preventive measures were improving.⁸ New free

services were being developed, financed by savings from the improved use of prescribing and laboratory budgets,⁹ and professional education, including dissemination of guidelines and quality improvement measures, was common.⁵⁻⁶ The non-profit groups had also made advances.¹⁰

Government reforms

In 2001, the new Labour led coalition government introduced a strategy to reform primary care.¹¹ The strategy prescribed replacing existing associations with new primary health organisations funded according to the number of patients enrolled with general practitioners. Unlike independent practitioner associations, primary health organisations have to be community owned and governed, not for profit, and include other primary care professionals and lay members on their governance boards (table). Primary health organisations sit outside the public sector, unlike English primary care trusts. Thus, the New Zealand government's chief tool to drive change has been additional funding, with about \$NZ500m (£175m; €262m; \$334m) extra a year (6-7% of the health budget) invested in primary care from 2002-8.¹²

Formation and funding of primary health organisations

The government has pursued the formation of primary health organisations rapidly, with limited attention to the details of implementation, including the effect on existing institutions, the shape of the primary sector, or capacity to deliver the intended goals. Furthermore, it seems the government does not have a clear vision of what it wants for primary care.

Comparison of independent practitioner associations and similar groups (pre-2001) with primary health organisations

	Independent practitioner associations and others ^{5-6,13}	Primary health organisations
Size	59 groups with 2000 to 500 000 patients	81 organisations with 4000 to 340 000 patients
Ownership	Mostly private companies with growing proportion shifting to non-profit status; others all community owned, non-profit	Community owned, non-profit
Governance	Governing board (GP dominated) elected by members (GPs and practice nurses). Wide range of mechanisms for consulting community. Member practices remain separate businesses but receive services and some funding from associations	Governing board elected by members (GPs, practice nurses and others, including lay representatives). Practices remain separate businesses
Funding	Mostly fee for service subsidies and patient copayments; some capitation; some had budgets for laboratory tests and drugs	Capitation at the primary health organisation level passed to practitioners and patient copayments (two separate funding streams)
Patient registration	GPs held patient records, but no formal enrolment with GPs	Patients must enrol with primary health organisation through their GP
Patient subsidies	For children under 6 year olds, those on low incomes, and those with high health care needs	For all New Zealand residents by mid-2007
Patient charges	GPs set fees. Free for most under 6 years. Up to \$NZ25 for subsidised patients and \$NZ55 for others	Fees likely to be \$NZ0-\$NZ30 once universal subsidy is in place. GPs still free to set fees after negotiation with district health boards and between primary health organisations
Services provided	Wide range of primary care, with some secondary care integration. Additional free services funded through savings from budgets for laboratory tests and drugs	Wide range of primary care, with some secondary care integration. Additional services to improve access and care for patients with chronic needs. No budgets for laboratory tests or drugs

GP=general practitioner.

The first primary health organisations were formed in mid-2003, and by late 2004 over 95% of New Zealanders were notionally enrolled with an organisation through their general practitioners. By mid-2007 a single capitation formula will be used for all primary care organisations. However, to try to improve care for deprived populations more quickly the government has replaced subsidies per consultation with two interim capitation funding formulas for organisations caring for the most needy. An access formula is paid to 37 organisations that have over half of their populations consisting of Maori and Pacific people or other deprived groups. These organisations offer reduced consultation fees for all patients. A further 25 organisations with less deprived populations receive additional money for administrative costs and to subsidise treatment for patients aged 6-25 years and over 45 years. Extra money is also available to all organisations through the care plus programme to provide care for people with chronic illnesses, to improve access, and for health promotion.

The complex transitional funding approaches have not gone unchallenged. For instance, a 2002 Independent Practitioner Association Council study noted the formulas would fail to target many people with high needs who live in less deprived areas while, inevitably, subsidising wealthier and healthier people in the deprived areas.¹⁴ The council suggested targeting individuals as the previous subsidy system had done. The government rejected this proposal, although care plus is a partial recognition of the criticism.

Funding continues to create conflict between the government and general practitioners. The government has endeavoured to get general practitioners to set common patient fees.¹⁵ General practitioners have resisted this, viewing state approval of fees as "bureaucratic price control" that could undermine their business viability.¹⁶ The Commerce Commission has also warned that general practitioners who collectively set fees could violate the Commerce Act because they are still deemed to be operating in a private market.¹⁷ As a result, fees (albeit reduced) continue to differ greatly between practices, primary health organisations, and patient groups.¹⁸

Problems with the new organisations

The government's attempt to over-ride independent practitioner associations on the grounds that too many of them were owned or dominated by general practitioners has been poorly received.¹⁹ Furthermore, the decision to define primary health organisations by the number of patients enrolled with general practitioners runs counter to the aim that other primary care providers, such as midwives and pharmacists, join the organisations on an equal footing. It also means that the organisations are likely to remain one of many primary care providers rather than being able to coordinate a comprehensive range of services.

The government has attempted a tremendous jump, endeavouring rapidly to restructure primary care through new organisations it neither owns nor fully funds. The task has been made more difficult by the laissez-faire approach to establishing primary health organisations. It has allowed any group that ful-



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Smaller organisations serving remote populations are struggling

fills the basic requirements to form an organisation without thinking about, for example, the appropriate size.²⁰ Responsibility for establishing the organisations was given to the 21 newly formed district health boards (local, public commissioning bodies that also own public hospitals). Some boards provided minimal support to the new organisations, partly because they had limited primary care experience. In addition, because the scheme was not piloted many policy details have had to be improvised.

Initial experience

Currently, New Zealand has 81 primary health organisations of various shapes and sizes. Some are members of Health Care Aotearoa, a network of non-profit organisations whose focus on deprived populations and community governance foreshadowed the government's reforms. Most large organisations are associated with 12 independent practitioner associations, which have mutated to provide infrastructural support. Several organisations contract management services from these associations whereas others are completely self sufficient. Similarly, the organisations get information technology support from various sources.

Half of the primary health organisations are categorised as small, with fewer than 20 000 patients. Small organisations tend to be located in remote or deprived areas and thus serve an important purpose.²¹

Summary points

New Zealand has been implementing major primary care reforms

It has created multidisciplinary primary health organisations with enrolled populations and capitation funding

The reforms are intended to reduce inequalities, improve access, and promote population health

Implementation has been rapid, tended to over-ride existing institutions, and involved complex interim funding arrangements

The diversity of current organisations raises questions about whether they will all be able to deliver what the government expects

However, some struggle to perform all the activities expected of them, partly because of their infancy but also because of restricted capacity and funding.²²⁻²³ Staffing has also been a problem. Assessments show an undersupply of most health professionals.²⁴ Smaller organisations also spend disproportionately on management. A government commissioned study found management costs accounted for up to 21% of total budget, with small organisations “struggling to remain viable.”²² The government subsequently increased management funding.²⁵ This said, there are examples of both very well run small organisations and larger ones with capability gaps.

Perhaps the biggest gap has been in the willingness and ability of the organisations to develop new payment methods for general practitioners and other staff. New methods are needed to make practitioners more responsive to patient demand and to focus on health maintenance and health promotion.²⁶ Not surprisingly, many organisations do not have the management capability to design such systems. Most simply pass on their capitation payments to practices.

The concerns about capability and scale have given rise to debate about the need for mergers and greater use of independent practitioner associations and other management services. The government's dilemma is that mergers would mainly affect organisations serving people in more remote areas, such as Maori populations. This would reduce the local control over primary care services known to be important to these populations.²⁷

Where are the reforms heading?

Ironically, given their origins in the New Zealand primary healthcare strategy, the reforms have shown the lack of a clear end point for primary care funding and organisation.²⁸ For example, uncertainty remains about how much the government expects patients to pay and how it intends to regulate fees; the extent to which primary care is to become a universal service like public hospitals; whether primary health organisations might manage extended patient care and related budgets; whether they might take on some or all district health board commissioning functions; whether they should be encouraged to compete for patients or be largely territorial monopolies; or whether the organisations should be allocated all primary care funding or whether some should go directly to practices.

Conclusions

New Zealand's reforms have continued the 1990s trend to broaden the scope of organised general practice, reduced patient fees for some groups, potentially made the geographical (if not individual) distribution of public funds for primary care fairer, and enhanced community involvement in primary care. However, questions abound over whether the reforms have been worth while. The government might have achieved the same ends if it had worked with and built on existing primary care organisations more explicitly and pursued a phased developmental strategy. It could have invited proposals to form fewer, larger organisations from groups of practitioners or community organisations with genuine commitment to the concept, and patients could have been recruited

directly into primary health organisations rather than indirectly through their general practitioner. This might have reduced some of the difficulties outlined above and allowed for comparative evaluation against the previous model followed by gradual replication.

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