

Learning from New Zealand's independent practitioner associations

Primary care for the 21st century

Research report

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Contents

List of figures, tables and boxes	2
Glossary	3
Summary	5
Key points	5
1. Introduction	7
NHS policy background	7
2. New Zealand's health care system	10
3. Origins of independent practitioner associations	12
Early characteristics of IPAs	14
Evolution of IPAs, 1990–2001	15
4. Adapting to Labour, 2000–08	19
Surviving structural reform	20
5. A new government: 2008 to the present	22
6. The future direction of IPAs in New Zealand	24
7. Implications for the NHS	26
8. Conclusion	33
References	34
Appendix: Case study: the evolution of Wellington IPA into Compass Health	37

List of figures, tables and boxes

Figures

Figure 1: Reasons for joining an IPA	13
Figure 2: Wellington IPA governance in 1999	37
Figure 3: Governance structure of WIPA in the early 2000s	38
Figure 4: 2011 – WIPA becomes Compass Health	39

Tables

Table 1: Overview of health systems in New Zealand and England	10
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Boxes

Box 1: Three big top-down reorganisations of the public health sector in New Zealand	12
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Glossary

The English NHS

Clinical commissioning groups. These new bodies were established by legislation (the Health and Social Care Act 2012) to purchase – or commission – hospital and other health services on behalf of local populations. All GP practices will be required to join a clinical commissioning group, the governing body of which will be made up of GPs, other specialist clinicians and lay members drawn from the local community. Clinical commissioning groups will formally take over from primary care trusts in April 2013. There are currently 212 clinical commissioning groups being prepared for authorisation.

Primary care trusts. These statutory bodies were created in 2002 in England to purchase health services on behalf of local populations. They are responsible for spending about 80 per cent of the NHS budget and their functions include holding contracts with hospitals, arranging and funding primary care and organising preventative public health services. They are predominantly managerially led, but their governing bodies include lay and clinical members. There were initially over 300 primary care trusts, but the government reduced their numbers to 152 in 2005, and in 2011 they were grouped into 50 ‘clusters’.

New Zealand

Better, Sooner, More Convenient. Originally the health policy document of the National Party when in opposition, adopted as government health policy following their election to power in 2008. The policy aims to encourage joined-up working between primary, hospital and community services. Nine demonstration projects have been established across New Zealand to test out different approaches to implementing this policy.

District health boards. Created by the New Zealand Public Health and Disability Act 2000, district health boards directly provide or contract for the bulk of hospital and primary health services in a local area. There are currently 20 district health boards in New Zealand. Their funding comes from central government.

Independent practitioner associations (IPAs). IPAs are autonomous networks of GP practices, formed in the early 1990s. They are privately owned, non-statutory and a mixture of profit- and non-profit status. They have changed in number and form over the past two decades, with many evolving into larger organisations, providing a range of primary care and management support services with an increasingly multidisciplinary workforce.

Primary health organisations. Primary health organisations were introduced in 2002, as part of the Labour Government’s Primary Health Care Strategy, which aimed to increase funding to primary care, reduce the cost of access to general practice and reduce overall health inequalities. Primary health organisations were new non-governmental bodies, with a variety of community-focused governance forms. They contract with district health boards to provide primary care and preventive services to a defined population. There are currently 31 primary health organisations in New Zealand, following mergers, from the high point of 82 in place when Labour left office in 2008.

Regional health authorities. Four regional health authorities were set up in 1993 as part of the reforms that brought in a purchaser–provider split. They contracted with a range of providers including hospitals, mental health services, independent practitioner associations and other community-based primary care organisations. They were abolished in 1998, their functions being taken over by a national Health Funding Authority.

Summary

As the the National Health Service (NHS) in England prepares to give general practitioners (GPs) a leading role in commissioning local health services, it is clear that general practice itself needs to be strengthened and made into an effective foundation for transformed, integrated care. This report offers insights from the experience of organised general practice in New Zealand.

Over the past two decades, many GPs and other primary care clinicians in New Zealand have worked collaboratively in independent practitioner associations (IPAs). These networks of primary care providers developed in the early 1990s, from the grassroots of general practice. Although they have not held budgets on the scale of that planned for clinical commissioning groups in England, they nevertheless demonstrate the significant potential of organised general practice to enable innovation and expansion in the local provision of care.

IPAs have developed networks whose functions include: standard-setting and scrutiny of primary care practice; taking on contracts for delivering new intermediate and extended primary care services; acting as collective budget holders for some local health services; and improving the quality of primary care. They are now an important part of an infrastructure that is aspiring to create new integrated health organisations and networks within New Zealand.

IPAs have had a variety of organisational forms, governance structures and size since they were formed. They have also weathered a succession of shifts in government policy. Their experience of building strong primary care organisations from within and across general practices, while responding to change and reform, provides useful insights for NHS policy-makers, primary care commissioners and all those involved in the provision of general practice services.

This research report is based on a series of in-depth interviews with IPA leaders, senior policy-makers and health officials in New Zealand, all of whom have been closely involved with IPAs since the early 1990s, supplemented by previous research on IPAs, and analysis of documents related to the development, operation and evaluation of organised general practice.

Key points

Reform of the English NHS has focused on using GPs as the basis for renewing the *commissioning* of care. Comparatively little policy attention has been given to the future *provision* of primary care in terms of quality, service model, or organisation.

There are significant challenges facing the quality and organisation of primary care in the NHS. The old 'corner shop' model of general practice does not work economically for many GPs, struggles to accommodate demand, and lacks the resources and organisational capacity to take on work shifted from hospitals as part of plans to develop more integrated care.

Policy attention needs to focus on establishing strong and sustainable management and organisational infrastructure that can support the development of general practice and primary care, in a way that enables it to meet the financial and health challenges ahead.

New Zealand's IPA experience shows that collectivised general practice has the potential to extend and improve local primary care services. There is much that the English NHS can learn from these autonomous, privately owned non-statutory organisations that bring independent practices together into primary care provider networks.

The New Zealand IPA experience highlights the importance of primary care organisations being clinically led and owned. Some of these organisations have evolved into important and influential bodies, enabling significant capacity for the planning, development and support of local primary care providers. As IPAs have expanded, the retention of strong links to front-line practices and practitioners has been critical to their success.

IPAs demonstrate the potential of GP-owned provider networks to deliver benefits for member practices, while becoming sophisticated primary care development and management organisations at the heart of new integrated health care networks.

Primary care provider networks based on private organisations such as IPAs can pose a threat to senior managers and policy-makers. There is tension between the necessary accountability for public funds and leaving sufficient leeway for local clinicians to innovate in service provision.

The significant devolution of financial and commissioning responsibility to clinical commissioning groups means that they have to be statutory and subject to significant central control, despite the original policy intent. This will compromise their ability to appeal to, and engage, frontline practitioners.

Clinical commissioning groups will have an opportunity to stimulate the development of local federations or networks of general practice and other primary health providers. This would seem to be vital if commissioning groups are to be able to make the changes to primary care required to support 'transformed' local care that meets the financial challenge in the NHS and the demands from rising rates of chronic disease.

New Zealand's experience of bringing GPs into IPAs suggests that it is in the provision, rather than commissioning, of care that the majority of GPs are most likely to engage with new organisations. This is also the message from 20 years of evaluation of primary care-led commissioning in the NHS, where primary care-led commissioners have consistently turned their attention to the strengthening and extension of primary care provision. So, new primary care provider organisations may be the most enduring legacy of clinical commissioning groups. Clinical commissioning groups therefore stand to gain from exploring how to stimulate new general practice provider networks, capitalising on New Zealand's experience of IPAs.

1. Introduction

This research report is based on a review of the literature (both academic and ‘grey’¹), together with a series of semi-structured interviews with 22 clinicians, policy-makers and researchers, about the experience of organised general practice in New Zealand over two decades. Interviewees were selected purposively by the research team, with a focus on identifying the main policy-makers, GP leaders, academics and health care managers who had worked within or alongside IPAs during the 1990s and 2000s. Of 25 individuals identified, 20 accepted the invitation to be interviewed and two additional individuals were identified on the recommendation of other interviewees. The interviews have been interpreted through the lens of English health policy and the current challenges facing the NHS in England. The report is aimed at policy-makers in the Department of Health, national primary care organisations, and those clinicians and managers in the NHS Commissioning Board, primary care trust clusters and clinical commissioning groups charged with developing new forms of community-based integrated care in England. The research team plans to publish another paper that focuses on the implications of this analysis of IPA experience for New Zealand health policy.

New Zealand’s experience is not an exact parallel to the proposed reforms to the NHS in England: IPAs have not held budgets to purchase care on the scale of what is planned for clinical commissioning. Nevertheless, the story of IPAs offers policy-makers and practitioners a glimpse of how GP-led organisations might look if they were allowed to evolve in a more bottom-up manner, develop significant infrastructure to support and extend general practice, and have freedom to innovate as providers. Indeed, the IPA experience suggests that primary care organisations that focus on the *provision*, rather than commissioning, of care seem to offer most potential to engage and excite local health professionals.

NHS policy background

At the heart of the government’s reform proposals for the NHS in England is the idea that primary care clinicians will be better at leading the planning and purchasing of health care than non-clinical managers. The Health and Social Care Act 2012 created statutory clinical commissioning groups, which will take responsibility for spending local NHS budgets transferred from primary care trusts in 2013. All GPs will have to belong to a clinical commissioning group and it is expected that GPs will lead these groups, in conjunction with other clinicians and managers. Primary care trusts were originally designed to be clinically led (Department of Health, 2001), with primary care professionals as ‘the engine room’ (Department of Health, 1999). In practice, clinical input into primary care trust decision-making has been variable and primary care trusts have been led largely by managers (Smith and Curry, 2011). The government believes that GP-led clinical commissioning groups will deliver more efficient and

1. ‘Grey’ literature here includes government and academic papers, and material presented at conferences.

responsive care for NHS patients, because of the pivotal role of GPs and primary care in the health system:

It [clinical commissioning] will bring together responsibility for clinical decisions and for the financial consequences of these decisions. This will reinforce the crucial role that GPs already play in committing NHS resources through their daily clinical decisions – not only in terms of referrals and prescribing, but also how well they manage long-term conditions, and the accessibility of their services. It will increase efficiency, by enabling GPs to strip out activities that do not have appreciable benefits for patients' health or healthcare. (Department of Health, 2010: p. 27)

The policy has faced numerous criticisms. These include concerns about capability, for example that GPs lack the expertise to commission, or to build statutory organisations. There are also concerns about accountability and conflicts of interest – whether GP commissioners will be compromised if they want to develop their own services, or whether adequate safeguards exist over the disposal of such large sums of public money. There are also worries that the centralised nature of NHS governance will obliterate GP entrepreneurialism and that individual GPs will be divorced from commissioning, not least because GP contracts will still be held centrally.

However, evidence from England's previous experiments with primary care-led commissioning in the 1990s (for example, GP fundholding, total purchasing pilots and locality commissioning) suggests that this strategy could yield some benefits, especially in relation to primary care provision (Le Grand and others, 1998). GP budget holders were particularly successful in developing new approaches to improving quality in primary care and additional services at primary and community levels. There is evidence that some primary care-led commissioners secured shorter waiting times for their patients and reductions in prescribing costs, but made little impact on costs overall or utilisation in secondary care (Smith and others, 2004). This has led some commentators to suggest that clinical commissioning groups will need to develop distinct provider networks or organisations, while having a 'commissioning core', within which a minority of GPs will act as commissioners on behalf of the majority (Smith and Mays, 2012).

There is also international evidence of relevance to the development of clinical commissioning groups in the English NHS. In the United States, physician-led provider organisations have held capitated contracts with health insurers to provide a range of health care services with a strong incentive to keep quality high and costs down. Some of these organisations have been successful in delivering higher-quality care at a lower cost than equivalent organisations, but many initially underestimated the intensity and complexity of the management processes needed to deliver these benefits, and the time and support needed to engage local professionals in delivering new forms of care. (Casalino, 2011; Ham, 2010; Thorlby and others, 2011).

This research report aims to contribute to this evidence base by analysing the experience of IPAs in New Zealand. Two forms of primary care organisation formed spontaneously in the 1990s: community-owned primary care organisations (which were primarily focused on providing care to deprived communities) and IPAs, independent, GP-owned groups (Smith and Mays, 2007). This study focuses on the experience of the IPAs. The development and achievements of community-governed groups have been ably described elsewhere (Crampton and others, 2001; 2004).

Although New Zealand IPAs have not to date been fully 'budget holding' to the same extent as English clinical commissioning groups will be, their experience of managing budgets for specific services and working as collectives of independent GPs to improve the quality of primary and intermediate care, developing strong local organisations to support and develop general practice, is highly relevant.

It is this spontaneous collectivisation of general practices into autonomous organisations that is of particular relevance to the NHS. As the NHS faces a major financial challenge, and persistent calls are made for the 'transformation' of care to enable more community-based services (Ham and others, 2012), it is the capacity of primary care which appears to be a rate-limiting step. Much has been written about the need for integrated care (for example Goodwin and others, 2012) but there has been relatively little analysis of how general practice could and should 'scale up' to meet this challenge. The experience of New Zealand IPAs illustrates how organised or collectivised general practice can provide the basis for local integrated care networks.

2. New Zealand's health care system

There are many similarities between the health care system in England and New Zealand, but a few important differences. In terms of similarities, New Zealanders have access to a range of health services, which are largely funded from general taxation. Inpatient and outpatient hospital services are free at the point of delivery, along with preventive health care, mental health care and some disability support (social care) services, but there are co-payments for accessing general practice and related services. These co-payments are offset partially by government subsidies for all patients, with additional support for those on low incomes, children and people with long-term conditions (Gauld, 2011). The average consultation fee for adults is around NZ\$30 (about £15), although many people are either exempt (for example, children under the age of six) or pay reduced fees (Ministry of Health, 2012). New Zealand's per capita spending on health care is slightly lower than England's (and its economy is much smaller) but it spends a higher proportion of its gross domestic product (GDP) on health care and a larger proportion of this spending comes directly from patients ('out-of-pocket' costs, which include co-payments and expenditure on private medical insurance). It should also be noted that New Zealand's much smaller population is spread over an equivalent area, requiring comprehensive health provision to very dispersed communities (see Table 1).

Table 1: Overview of health systems in New Zealand and England

	New Zealand	England
Population (millions), 2009	4.317	51.809
Population density (per km ²), 2010	16.59	401
Total spending on health as a percentage of GDP, 2008	9.6	8.7
Public expenditure per capita (purchasing power parity, US\$), 2009	2,400	2,934 (UK)
Out-of-pocket expenditure as a percentage of total health spending, 2009	15.1	10.9 (UK)

Source: Boyle (2011); *OECD Health Data 2011*

As in the UK, in New Zealand most primary care is rooted in doctor-owned, small group practices with GPs acting as gatekeepers to secondary care (Smith and Mays, 2007), but unlike the UK, New Zealanders pay a fee to see a GP. The continuing presence of user charges for accessing primary care is the result of an important structural difference between New Zealand's health system and the NHS: most primary care doctors operate as private businesses, outside the state-funded health system, even if they receive a significant element of public subsidy. This is the product of the government's failure to persuade primary care doctors to join the newly nationalised health service when it was

formed in 1938 (Barnett and others, 1998). After lengthy negotiations in the 1930s, GPs kept their status as fully independent businesses and retained their right to levy user charges. A system of subsidies for low-income people was put in place to ensure access. This was substantially reformed in 2002 by the Labour Government, which set up new primary care organisations (primary health organisations), designed to administer additional capitated payments to GPs in order to reduce co-payments particularly for disadvantaged groups as well as provide a range of preventive services for all (Gauld, 2011).

The independence of general practice from the state-funded health service in New Zealand is an important backdrop to the IPA experience. In the NHS, although most GPs operate as independent businesses, the state is effectively their sole source of income. In New Zealand, GP income derives from both patient charges and government subsidies and there is no equivalent nationally negotiated GP contract that specifies the core services to be delivered by GPs. As a consequence, many of the policy developments since the 1980s can be seen as repeated attempts by government to increase the share of public funding of GP services, in order to improve access but also to impose greater control and accountability over primary care (Cumming and Mays, 2011). For their part, even though public funds make up an increasing proportion of their income, many New Zealand GPs remain equally determined to preserve their autonomy, including by organising into groups (Croxson and others, 2009; Dovey and others, 2011).

3. Origins of independent practitioner associations

In 1984, New Zealand's Labour Government began privatising state-owned enterprises and implementing other wide-ranging market-based reforms to the public sector (French and others, 2001). In 1991, against a backdrop of fiscal pressure from a recession that began in the late 1980s, the newly elected right-of-centre National Party Government published plans to extend some of these market principles to health, including a purchaser–provider split, competition for contracts and the establishment of hospital and mental health providers as independent enterprises, in order to increase efficiency and reduce waiting times (see Box 1) (McAvoy and Coster, 2005).

Box 1: Three big top-down reorganisations of the public health sector in New Zealand

1991 – purchaser–provider split. The National Party Government published a White Paper announcing its intention to set up a purchaser–provider split in the New Zealand health sector. Four regional health authorities were set up across New Zealand to contract with hospitals and mental health providers, which were established as 'for-profit', autonomous entities called crown health enterprises. Regional health authorities also let contracts for other services, including pharmaceuticals and laboratory services, for which some IPAs managed the budgets. In addition to IPAs, community-owned and governed primary health bodies were formed, mostly in high-needs and Māori communities, and again under contract to regional health authorities.

1996 – purchasers reorganised. Following a change of government (to a centre-right coalition), the four regional health authorities were amalgamated into one purchaser, the Health Funding Authority, with effect from 1998. The emphasis on competition in the health sector was dropped, as was the for-profit status of hospitals, but contracts with IPAs for laboratory and other services continued in some areas.

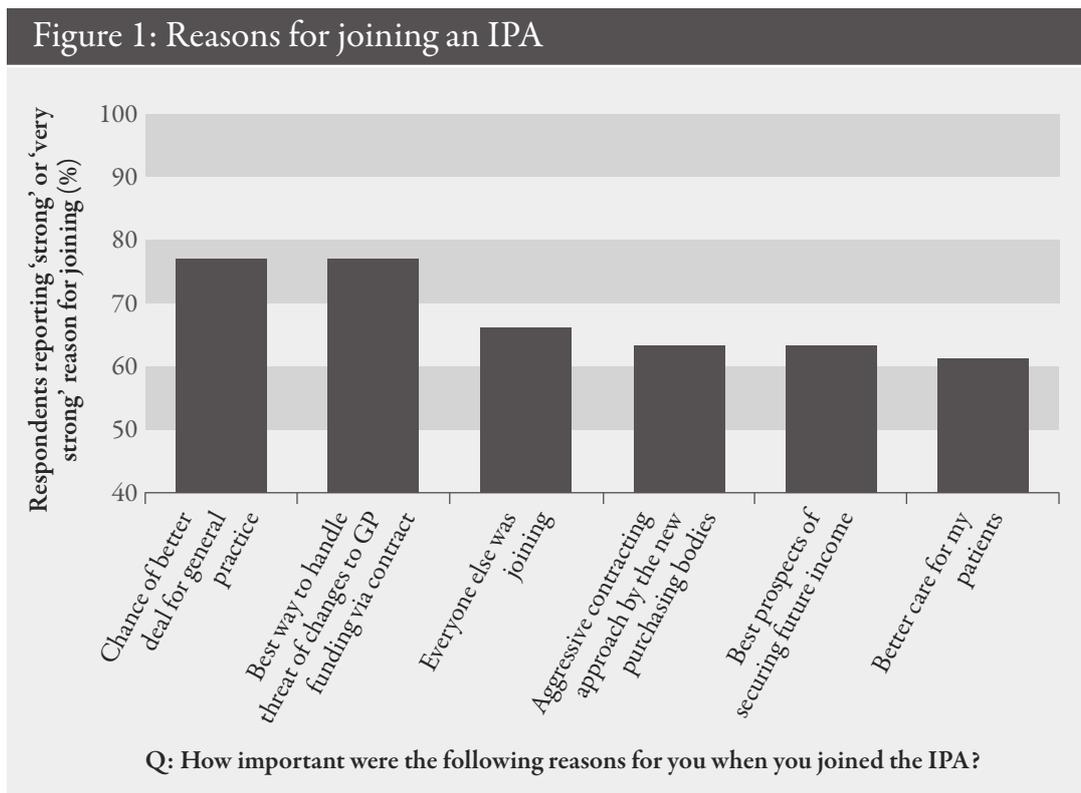
1999–2001 – primary health organisations. In 1999, voters in New Zealand returned a Labour-led Coalition Government, which abolished the Health Funding Authority and set up 21 district health boards, which had a majority of directly elected members. In 2001, the government published the Primary Health Care Strategy (King, 2001), which introduced primary health organisations as part of a policy to increase funding to primary care, reduce the cost of access to general practice and reduce overall health inequalities. Primary health organisations were new non-governmental bodies, with community-focused governance, contracted to district health boards to provide primary care and preventive services to a defined population (Smith and Mays, 2007). There are currently 31 primary health organisations in New Zealand, following mergers, from the high point of 82 in place when Labour left office in 2008. The primary health organisations were superimposed on the existing network of IPA and other primary care organisations. In some cases, IPAs became primary health organisations, in others they provided management support to primary health organisations and in others they remained as independent provider bodies.

Source: adapted from McAvoy and Coster (2005)

Many GPs anticipated that the government's plans would include another attempt to reform the subsidised fee-for-service funding system, possibly via the introduction of

contracts (Barnett, 2001). This threat prompted GPs to come together into collective networks (over the period 1991–95) to contract with the four new regional health authorities for local community-based services. These primary care networks quickly became known as independent practitioner associations (Barnett, 2003).

GPs responding to a survey in 1999 revealed mixed levels of enthusiasm for joining IPAs: 44 per cent said that they had been 'keen or very keen' to join an IPA, whereas 35 per cent were 'indifferent' and 18 per cent were 'reluctant' (Barnett, 2003). The same survey found that the most commonly held motivations for joining an IPA (reported by over two thirds of respondents) included peer pressure and the chance to be in a strong position to win service provision contracts from the new purchasers (see Figure 1).



Source: adapted from Barnett (2003)

The interviewees in our study confirmed the prevailing narrative from the research literature: that IPAs were primarily set up as a defensive mechanism in response to a change in government policy, which raised the threat of new contractual arrangements with GPs. Many interviewees described the creation of IPAs as a form of collectivisation, bringing isolated GPs together to strengthen their voice in any negotiations and to create a local entity with which funders could hold a dialogue. A number of respondents pointed out that the perceived threat was also understood as a significant opportunity for the development of general practice and primary care provision, especially if GPs were organised within collectives:

We realised that if we didn't have organisations capable of contracting, we'd be at the whim of policy-makers, and we needed something to enable us to be on an equal footing and to have the ability to control our own destinies. (IPA leader)

The reforms were seen by GPs as a threat because we were being required, for the first time, to explicitly sign up to a contract. And to some extent we circled our wagons

while we figured out what this meant, but quite quickly moved from a defensive positioning to a – looking for the opportunities. (IPA leader)

Although the primary driver might have been defensive, GPs recalled that in some areas practices had already begun to come together for more positive reasons, for example, to take collective action to improve specific areas of service quality, such as out-of-hours cover.

There was also inspiration from abroad: several respondents described how GPs had been influenced by the IPAs in California, where groups of physicians had come together to hold budgets from insurers and provide comprehensive local care, while still retaining their independent status (Casalino, 2011; Thorlby and others, 2011), which is where interviewees said the ‘language of IPAs’ came from. Those GPs who had been influenced by the experience of the United States were keen to push for IPAs to have more budgetary control, including over secondary care services. Networking and comparisons with international colleagues in primary care organisations continued over the two decades. In particular, the IPA Council (and latterly General Practice New Zealand) formed strong links with the Australian General Practice Network, which represented divisions of general practice, and in England, the NHS Alliance and National Association of Primary Care, which represented GP fundholding, GP commissioning, primary care groups and primary care trusts. In this way, leaders of IPAs sought to be part of international moves towards ‘managed primary care’ (Smith and Goodwin, 2006).

By 1996, 60 per cent of New Zealand’s GPs were reported to have joined an IPA (Barnett, 2003). In 1999, there were over 30 IPAs, which varied in size from seven members to 340 members (Malcolm and Mays, 1999). By 1999, IPAs were the dominant form of primary care organisation in New Zealand, encompassing 67 per cent of GPs (Barnett, 2001). Since the late 1990s, the range and number of IPAs have reduced and some became primary health organisations, set up by government, in 2001 (see below). Nevertheless, the underlying idea of IPAs as networks of primary care providers working in a collective manner, and with significant management and organisational capacity, has proved very durable despite changes in name and form.

Early characteristics of IPAs

GPs involved in the formation of IPAs recall an informal, bottom-up process of establishment, based on a few GPs coming together – generally on a geographical basis – and hinging on personal relationships. There was no standard approach to form, size or governance:

Many were set up as companies, but some as incorporated bodies, as charitable organisations, and the actual organisational form and governance arrangement depended on local circumstances. (IPA leader)

A survey conducted in 1999 looked at the ownership models of 18 IPAs: 14 were limited liability companies, three were incorporated societies and one was a trust (Malcolm and others, 1999a). In the early days, success depended on a small, critical mass of GPs interested in taking a clinical leadership role locally, often with an interest in a specific clinical or management area, such as information technology or quality. Although some of the IPAs grew quickly (in some cases numbering over a hundred GPs within a few years), the essentially personal nature of the relationships has persisted in many cases, even where IPAs have grown larger:

I think a lot depends on relationships – I still know most of the GPs by name and still have that direct kind of communication. If we got any bigger I couldn't, and what's still quite important to the way the organisation works, is that our key staff do still interface with most of the providers and key people on a reasonably regular basis. (IPA chief executive)

Evolution of IPAs, 1990–2001

Most of the interviewees described IPAs as predominantly GP-led and -owned organisations in the beginning, typically involving GPs closely in the leadership and governance of the IPA. There were a few exceptions – for example an IPA that had brought in midwives and obstetricians and had modified the ownership and governance as a consequence:

Obstetricians and midwives are not GPs and they were not going to be happy with an organisation that was seen to be solely governed and owned by just GPs. And so in that example we did form a separate organisation and that organisation has shared equal governance between the doctors and the midwives. (IPA chief executive)

An example of an IPA is set out in the Appendix, which shows the evolution of Wellington IPA. IPAs have evolved into very different kinds of organisations and this variation was described by several interviewees as being a function partly of their location within New Zealand. Different typologies of IPAs were offered in the interviews, but a common distinction was between larger IPAs that evolved into more business-oriented organisations, focused on winning contracts to deliver local services or providing management services, and IPAs that had more of a population health focus from the outset and tended to have higher levels of community involvement or ownership. These latter IPAs were perceived to be more common in areas with higher levels of deprivation, but fewer in number:

I think the big ones were the particular innovators, for they had collective resources to innovate. But the smaller ones served their communities well. (Chief executive of a national organisation)

Asked to reflect on the early achievements of IPAs, interviewees described the value of bringing independent GPs together as an important benefit in itself, given the isolated and somewhat dispersed nature of general practice in New Zealand:

Well I think the IPAs for the first time genuinely brought general practitioners into seeing themselves as part of a collective. The model from the fifties onwards, was as sole trader working on their own, or perhaps with one colleague, not part of the government machine at all, quite isolated from the governmental health system except that they got subsidies from it. There was no sense of being an industry or a sector. So that IPAs dramatically changed that, and began to help general practitioners see themselves as part of something bigger. (Chair of a national organisation)

Some interviewees described a process of fairly rapid consolidation within the first five years. IPAs realised that they needed to be bigger in order to take advantage of the opportunities that were beginning to emerge, namely competing for contracts with funders, engaging in quality improvement in primary care, developing management support services for practices and primary health organisations and in some cases actually becoming new primary health organisations (see Box 1, page 12). This process of transformation has continued, as some former IPAs are now complex organisations,

playing a central role in developing integrated health networks focused on shaping new forms of care, and acting as convenors of local community health, primary care and acute service providers within local health districts, as described in Chapter 4.

Contracting for services

A key period in the development of IPAs came between 1993 and 1996, when the regional health authorities, which were responsible for assessing health needs and purchasing a range of preventative and curative services, began to let contracts to IPAs. These contracts were for a range of services, including laboratory testing, pharmaceuticals, radiology, immunisations, sexual health services and maternity care. IPAs sometimes acted as the budget holders for these services, purchasing from a range of providers, and in other cases they took on a contract to be the provider of a specific service commissioned by the regional health authority, for example for sexual health, maternity care or mental health. In this way, IPAs started to act as significant general practice provider organisations.

In some cases, IPAs proved very successful at containing costs and generating a surplus from these contracts. One GP interviewee recalled their IPA saving 25 per cent of the previous year's expenditure by monitoring GPs' use of laboratory services and applying an evidence-based approach (drawing on data from Australia) to set benchmarks and use laboratory tests appropriately. Evaluations subsequently found that although large savings (more than 20 per cent) were not generally sustained over the longer term, some IPAs consistently made savings of between 5 and 10 per cent over a number of years, compared to the national average pharmaceutical and laboratory spending (Mays and Hand, 2000).

There was considerable variation between areas in the rules on the use of savings by IPAs. In all areas, savings had to be reinvested into patient care, but some IPAs were allowed by their regional health authority to keep the entirety of their savings (this was later changed to a proportion of savings), which in some cases were considerable. They also enjoyed a degree of autonomy over the use of the money:

And suddenly we got a cheque for a lot of money. So then we went to our GP colleagues and said, 'Gee, guys you've done well, you've followed the evidence, you've provided best practice, we haven't wasted money, there's a whole lot of money left over. What do you want to do with that money? What do your patients need?' (IPA leader)

This was not, however, the case everywhere. There were disputes between funders and IPAs, and at least one IPA had to use the courts to gain access to the savings it had made. Furthermore, there was no standard format for contracts let to IPAs and there was considerable variation in management styles between the four regional health authorities. In one area, an IPA member remembers this period as one of considerable autonomy, with high levels of trust in contrast to procedures put in place latterly, which were portrayed to be more bureaucratic:

We basically had a lunchtime meeting for an hour, hour and a half, which we presented, 'This is what we want to do.' They [the regional health authority] said, 'Fine, great, go for it.' Then agree the contract, get on with it. And that model was very successful. We couldn't do that now. (IPA leader)

For their part, some of the funders also recall a period of relative autonomy from the Ministry of Health, during which they were allowed to develop new ways of working with IPAs and other health care organisations. IPAs' relationships with funders were

variable, and not all funders were spoken about with equal affection by those involved in IPAs, particularly if the IPAs and funders did not share a common vision for change:

Then you go right to the other end of the spectrum in [X] – my view was that they came from a different point of view, that GPs particularly as an example were out to screw the regional health authority, were paid too much money and were trying to get things out of the regional health authority. (Former regional health authority manager)

Quality improvement and management support

In the first decade, some IPAs chose to focus their efforts primarily on providing support to general practice and primary care, in the form of quality improvement programmes and management support services. One interviewee described this as an evolution from holding budgets for services:

So they kind of drifted from being 'let's manage the budget' through to 'let's manage the quality'. And that became very important for a lot of organisations. (IPA leader)

Activities included setting annual quality targets for GPs, tying financial incentives to the quality targets, using peer review and, in some cases, developing referral guidelines:

We also developed guidelines for referrals and access to secondary care, along with rules about rationing of elective care. The national work that was carried out in New Zealand and priority setting for electives would never have been possible without IPAs making it happen on the ground as they made referrals. (IPA leader)

Many IPAs also provided their own educational programmes for GPs, practice nurses and other general practice staff, using these as an opportunity to support the wider work of the IPA in terms of establishing prescribing and other care protocols. This educational activity also served an important purpose in bringing practices and staff together on a regular basis, and hence serving to support the overall organisational development of the IPA (Barnett, 2003; Malcolm and Mays, 1999). Some IPAs specialised in developing management services to support their GP practices, and in this way, put in place the meso-level primary care organisations that are now commonplace within New Zealand:

I think a really important driver was, as the IPAs employed skilled management, the GPs got a lot of confidence in having this new tier, this new level of support of management employed by us to work with us. (IPA leader)

These support services included information technology advice, financial management, contracting expertise, needs assessment and data management. During the late 1990s and early 2000s, the Commonwealth Fund's international surveys of primary care physicians rated New Zealand highly in terms of its use of information technology in primary care (Blendon and others, 2001), something that was accelerated by the activity of IPAs. Indeed, the work of IPAs in the 1990s in developing the infrastructure of general practice helped GPs to move beyond the marginalisation and isolation they had often felt within the public health system in the 1980s and early 1990s, and offered them clear incentives to belong to (and remain with) the IPA.

Some of the IPAs that had invested in these functions later evolved into management support organisations and were therefore well placed to support the development of the new primary health organisations from 2001, in some cases providing management support to more than one primary health organisation (see Chapter 4). This support frequently included general management, service planning, the provision of community

nursing services, health promotion and 'back-office' support such as human resource management and finance. The move to become management services organisations marked, for many IPAs, a move into a more extended role, as both population health planners and significant local community health service providers:

For me, there's absolutely no doubt at all. It was the establishment of rudimentary and, following on from that, very sophisticated infrastructure of primary health care in New Zealand. No one else did that. I think their superb achievement has been the establishment of that infrastructure. And it hums, you know, it just hums along.
(Academic)

We wouldn't have a platform for the next phase of integrated care development without the existence of these IPAs and their management organisations.
(Health manager)

The creation of improved primary and community health infrastructure and management services was, for some interviewees, the most enduring legacy of the IPA movement, allowing many organisations to adapt to new policy initiatives in 2000 and again in 2008.

It should be noted that the performance of IPAs has not been subject to any systematic evaluation in New Zealand so it is not possible to say to what degree the quality and/or efficiency of health care improved, relative to either the past or non-IPA forms of primary care organisation. Such evaluation that exists refers to the relative success of IPAs in holding contracts for individual services, either as a whole (Mays and Hand, 2000) or studies of individual IPAs (see for example Kerr and others, 1996; Malcolm and others, 1999b).

IPA leadership

This period also witnessed the evolution of a distinct national IPA leadership, to advocate on behalf of IPAs. Before 1990, leadership to secure the economic and clinical autonomy of GPs came largely from the GP branch of the New Zealand Medical Association and the New Zealand General Practice Association (NZGPA). The NZGPA was reported by some interviewees to have been largely reactive, but by 1990 it was noted to have taken a more proactive role in examining options for the organisation of general practice, being interested specifically in the American IPA model. As IPAs formed in New Zealand, they gained the support of their members to take on a stronger representational role, in many ways taking the place of functions previously provided by national organisations to general practice. The national member organisation (NZGPA) therefore gave way to the new, local and more 'work-based' IPA collectives.

An informal national network of IPAs emerged to provide basic information sharing and coordination. In 1999, this network became a fully fledged organisation: the Independent Practitioner Association Council. It was formed by the 15 largest IPAs and combined active leadership of the sector with a strong representational role.

4. Adapting to Labour, 2000–08

After nearly a decade of development, IPAs faced a changed policy environment in 1999, when a Labour-led government was elected. Interviewees described a change of policy direction driven partly, in their view, by three latent tensions resulting from the emergence of IPAs:

- hostility towards their status as privately owned entities generating savings from public funds
- the dominance of general practice within IPAs relative to other primary care professions
- a perception that IPAs had focused on commercial rather than population or community health goals.

Whereas clinicians and managers involved in the founding and running of IPAs argued that their independence and autonomy were the foundation of their enterprise and innovation, interviewees from central government or regional funding bodies had an alternative perspective: that there had been an absence of accountability in relation to general practice during the 1990s, particularly with regard to the use of public funds:

I think that small business model for the IPAs, plus their fierce independence, to be independent and not part of the health system, posed to me a huge problem as a policy-maker. (Government official)

This sense of unease was particularly acute in relation to public money being retained as ‘savings’ by IPAs, as a result of contracts for laboratory tests and pharmaceutical expenditure based on historic budgets where IPAs were able to reduce utilisation and costs without obvious compromise to service quality (Malcolm and Mays, 1999). While some IPAs invested their savings in new services (for example, sexual health services, specialist community nursing or clinical education), others kept back savings in the form of reserves, and funders were unable to control the rate or direction of spending:

I think over time they [the IPAs] amassed something like between NZ\$10 and 20 million [c. £5–10 million]. That was seen by ministers as quite an irritation, because it was seen actually fundamentally as the government’s money now in private hands and which they had very little control over. (Government official)

Underlying tensions about accountability were brought to a head with the arrival of the Labour-led government in 1999, because of what was perceived to be an ideologically driven dislike of the more business-oriented form of the IPA, compared to the more community-focused IPAs and community-governed and -owned primary care organisations (Smith and Mays, 2007):

Labour didn’t like them one bit and so when it had the chance to reform ... it established primary health organisations. The primary health organisations had some very particular characteristics that were clearly aimed at IPAs, so the fact that they were not for profit in particular was clearly a view that they didn’t want the IPAs, and the fact that they took on community engagement was another one. (Academic)

Allied to this idea was a perception among some interviewees that some IPAs had been too dominated by GPs and failed to take a sufficiently population health focus as well as neglecting to involve the public, particularly people from Māori and Pacific communities:

The Ministry of Health kicked back about IPAs serving the interests of doctors rather than populations. That was why general practice wasn't mentioned much in the eventual Primary Health Care Strategy document and [a] community-focused approach ended up being the focus of the Primary Health Care Strategy. (IPA leader)

Surviving structural reform

Labour's Primary Health Care Strategy (King, 2001) led to the creation of primary health organisations. These were initiated by government but were designed to be locally owned (that is, non-statutory) and locally led. They were intended to be a vehicle to purchase preventive and other community health care as well as a channel for new sources of public funds intended to improve access to primary care by reducing the cost, especially for the more vulnerable sections of the population.

The network of primary health organisations was superimposed on IPAs from 2002 onwards, forcing IPAs to respond. Put simply, if an IPA's general practices wanted to have access to new government subsidies for primary care (money intended to reduce patients' co-payments for general practice) along with other new funds for chronic disease management and health promotion, they needed to find a way for practices to be part of a primary health organisation.

Labour took a relatively permissive approach to the setting up of the primary health organisations, publishing only minimal requirements on governance (Ministry of Health, 2002), which allowed IPAs considerable latitude about how to respond and adapt. Requirements about community governance and not-for-profit status meant that IPAs could not simply become primary health organisations. IPAs responded in a number of ways. A small number wound up operations as an IPA and re-established themselves as primary health organisations. Others chose to become management services organisations providing administrative and other support to one or more primary health organisations. A few others chose to become GP network organisations, existing alongside primary health organisations.

Although most IPAs did weather the transition to primary health organisations, this period was described by a number of interviewees as a particular low point for the IPA movement. It was seen as having stifled innovation and enterprise and, in some cases, undermined the desire of GPs to take on leadership roles. An interviewee from government recalled the atmosphere at the time:

They were really angry with the advent of primary health organisations. We had them in the room many, many times banging the table, that they were to be independent and they were not going to be nationalised, over their dead body.

A common view among IPA leaders was that this period knocked the enthusiasm out of many GPs, and that there was a loss of creativity as a result:

Innovation came to a standstill. The 2000s became a fight for survival and an attempt to find a place in the sun. (IPA leader)

It is not clear how extensive resentment from general practice was in relation to the Primary Health Care Strategy (which was deemed by many as underplaying the central

role of general practice within primary care). Nevertheless, IPAs were seen by interviewees to have adapted successfully in most cases, reflecting an underlying pragmatism of GPs when faced with changed circumstances. With hindsight, some interviewees described the period of the Labour Government from 2000 to 2008 as having offered new opportunities, kickstarting a range of new activities on the part of IPAs. The period was also seen as being the most vivid example of how the best IPAs have proved themselves able to adapt their skills and purpose to national policy developments, however unwelcome they might be at first sight:

I, in particular, thought that IPAs wouldn't survive except as doctors' clubs. But we were proved wrong as they reinvented themselves as management services organisations, primary health organisations and provider bodies. (Chief executive of a national organisation)

IPAs that had developed management support services for their practitioner membership were reported to have found themselves in a strong position with the advent of primary health organisations from 2002 onwards, as they were able to provide them with new and much-needed services. One of the leaders of an IPA that did well during that period reflected that part of the success of IPA leadership meant being able to survive these big shifts in policy:

It's a bit of clinical and business leadership actually in terms of knowing what are the opportunities or not and how to sort of set yourselves to sail in the wind that's currently blowing, keep looking for what's needed next and how do we go there. You need to fight but you choose your fights, you know? (IPA leader)

Notable during this period was the emergence of the IPA Council as a political force at a national level, with the ability to negotiate with government for better contractual terms for GPs, particularly in relation to access to funding streams. Some respondents felt that the IPA Council had proved to have more relevance for GPs than for other representative bodies, such as the New Zealand Medical Association, whereas others felt that the bodies served different and complementary purposes.

5. A new government: 2008 to the present

Elections in 2008 brought a new coalition into government, led by the right-of-centre National Party. The new government pledged not to undertake major reorganisation of the health sector during its first term (2008–11). Instead, it promised to focus on issues of patient access, service quality and productivity, under a policy termed ‘Better, Sooner, More Convenient’, drawing on ideas set out in its health policy document of the same name developed in 2007, while in opposition (National Party of New Zealand, 2007). Other elements of the new government’s health policy included: developing integrated family health centres (akin to polyclinics/‘Darzi centres’ in the NHS¹); emphasising clinical leadership and engagement (in an apparent attempt to bring doctors back into the policy fold after their experience of the Labour Government); and improving health sector productivity (National Party of New Zealand, 2007).

In 2009, as part of the Better, Sooner, More Convenient policy, the Minister of Health issued a call for proposals from the health sector for collectives of health organisations to suggest ways in which they might deliver better-integrated primary and community health services for their local population (Ministry of Health, 2011). There was no additional funding for services on offer through this call, simply the chance to be a national demonstration site and to have some project funding to help with the preparation of proposals. More than 70 applications were received, and following an assessment process, nine national pilot sites were approved and went live in 2010. The pilots ranged in size from 30,000 patients (West Coast) to over one million patients (Greater Auckland) and had a range of objectives concerned with improving access to primary and community health services, developing more integrated services, improving the management of chronic disease and reducing reliance on hospital care.

It is of note that all of the nine Better, Sooner, More Convenient pilot sites have strong involvement, and in some cases leadership, from the local IPA or IPAs. The positive response of IPAs to government policy was reflected in the interviews, and this was particularly evident in relation to the 2008 government. Many interviewees described how government–IPA relations changed with the election of a centre-right government in 2008 (and continued with its re-election in 2011), especially with the appointment of a minister who was perceived by many interviewees to be more comfortable with the small business ethos of general practice. Some interviewees reported that the IPA movement had hoped that it would regain a dominant position in health policy post 2008 and persuade the government to give it full control of health commissioning budgets (as is being proposed in the NHS). However, the Minister of Health had instead expressed an objective to forge new alliances between primary, secondary and community services through the Better, Sooner, More Convenient pilots, choosing to harness IPA and wider primary care leadership as part of wider moves to develop more integrated care.

1. ‘Darzi Centres’ (GP-led health centres) were established in the NHS to provide walk-in primary care (and in some cases diagnostic and treatment) services 365 days per year.

Some IPAs wanted all the dollars to manage, but they [the government] can't give that to entirely private organisations to manage. They can give them their own dollars but not that of other people. (Health manager)

Instead, IPAs and management support organisations have been encouraged to enter joint bids to deliver integrated care with other providers, under umbrella contracts known as 'alliance contracts'. Proponents of the IPA movement argued that IPAs were now in a very strong position to collaborate with other professions to create integrated networks:

The IPAs started out as doctor organisations, rapidly became practice organisations, but now we are looking at organisations that are going to have pharmacy, midwifery, physiotherapy and a raft of other people involved in them or with them in some way. (Chair of a national organisation)

Not everyone, however, was convinced that IPAs had successfully overcome their identity as GP-led organisations and some reported that tensions were still present between GPs and other professions. Indeed, it was pointed out that integrated family health centre developments were being led mainly by GP business owners, even though such proposals entailed more work for nurses and allied health professionals:

Allied health professionals and nurses are concerned that the expression of interest process and the development of the Better, Sooner, More Convenient pilots is another doctor-run initiative. The mind boggles at moving from a situation of almost no trust between primary care, district health boards and the Ministry, to one based on high trust. It's a huge leap. (Leader of a national organisation)

There is, therefore, a sense of unfinished business in relation to the creation of truly multidisciplinary primary care, albeit that the Better, Sooner, More Convenient schemes appear to be enabling the planning of more integrated and inclusive services.

6. The future direction of IPAs in New Zealand

Although relations between IPAs and the New Zealand Government have warmed since the change of government in 2008, trust has not yet been entirely rebuilt. Suspicions about the government's desire to control the business of general practice, perceptions in some quarters about a lack of accountability on the part of general practice, and questions about the motivations of some IPAs with respect to profit-seeking at the expense of population health and community engagement, have taken their toll. One government official summed this up as follows:

For me this is about the fact that our GPs still don't see themselves as part of the New Zealand health system. They are more so, but they're still combative. It's a fraught relationship and that's a disappointment to me. It hasn't got any easier really... It tends to blow up and be difficult. There's often passive aggressive behaviour on both sides – that's the Ministry of Health and general practice.

Others pointed out that it would take time for general practice to recover from what many GPs felt was a time of being marginalised from mainstream health policy (1999–2008), as one former regional health authority manager noted:

I know quite a few GPs. Their reaction I guess through the second and especially the second to third stints of the then Labour Government was that they felt disrespected, disregarded, marginalised and treated like dirt.

An emerging theme in the narratives of those involved with the IPAs was the ability of many of them to survive these changes in policy and political direction. One longstanding IPA GP leader commented:

The organisational structures [of IPAs] may not have changed, but behaviour has. General practice organisations consider themselves to be culturally and population-health competent now.

Part of the reason for this was their independent status: IPAs were not statutory organisations and therefore could not be abolished, for example in the same way that NHS GP fundholding had been terminated by the New Labour Government in 1997, and primary care groups were subsumed into primary care trusts in 2002. Some smaller IPAs had disappeared, others had merged or become primary health organisations, while others had prospered, particularly where they had been successful in holding contracts, providing management support services to primary health organisations, and more latterly, forming the core of new integrated health networks or alliances. One GP leader described IPAs as having been on a “journey of maturation” as they moved from “the fiercely independent nature of general practice being reflected in the IPA movement” to a situation where IPAs were comfortable with community engagement, population health management and much more multidisciplinary working.

There were differing views about the likely future development of IPAs. A frequent theme was the need for IPAs to develop beyond the confines of general practice and embrace other disciplines within primary care in the future. Although some (usually GP)

interviewees asserted that this had already happened, others were yet to be convinced that such inclusivity of leadership and decision-making was yet embedded.

A further challenge for IPAs is how they will work effectively with secondary care, and with community health providers (including those services managed by the district health board) to create better-integrated services. One government interviewee felt that working relationships and collaboration between some IPAs and district health boards, particularly in provincial areas, were already good:

You can feel it when you're at those organisations, at their board meetings, that we're all in this together. And so they're actually functioning as a single system between primary care and community, between primary and secondary and... and also you get a sense that there's not a reliance on Wellington [central government] to sort it. And that's quite a different sort of conversation to what you get in the larger urban centres in my experience.

The leadership of the wider IPA movement in New Zealand mirrors the journey of the IPAs themselves. Just as IPAs have evolved from being GP-led and -owned organisations to become broader primary care development and support bodies, so the IPA Council formed in 1999 has become General Practice New Zealand (GPNZ), seeking to have a stronger 'whole-of-primary care' voice. GPNZ was formed in 2008 from the 16 largest IPAs, with governance representation from GPs, nurses, practice managers and primary care organisation chief executives. GPNZ has strategic relationships with other key primary care organisations, including the New Zealand Medical Association and the Royal New Zealand College of General Practitioners, and these bodies now come together in an overarching GP Leaders' Forum. Besides leadership development, information sharing and technology development, GPNZ continues the work previously carried out by the IPA Council in respect of contract negotiations with government.

There was a frequently expressed hope among interviewees that the current government's Better, Sooner, More Convenient initiative might yield new models of collaboration and integrated health service provision between organisations. However, not everyone was optimistic that new models of integration would be possible without more fundamental organisational and cultural change and some argued that at the root of this was the insoluble problem of the ownership of health care provider organisations:

There's a mutual mistrust still between primary and secondary clinicians. The two ownership models are hugely problematic in breaking through that interface, where you've got one, where you have a group of salaried people who are working for the state, engaging with self-employed people who run their own businesses. That, I think, is problematic. (Chair of a national organisation)

On the other hand, there was also a belief among some interviewees that the current government might have learned an important lesson from the experience of IPAs, namely that their strength derived from their bottom-up formation and ownership. A view was expressed that policy-makers needed to try to avoid imposing top-down solutions within the health sector, and learn to tolerate the inevitable variability that arises from this:

We have seen the tensions that have been created through top-down forced marriages, if you like. So if you're wanting people to work together collaboratively, the success of it in the long term is going to depend on the relationships that are developed. And so that's something that has to be given time. So there's got to be a bottom-up willingness to work together. (Chair of a national organisation)

7. Implications for the NHS

New Zealand IPAs are longstanding networks of primary care providers, now representing significant primary care management and service development capacity within the wider health system. IPAs are private organisations, but at no point have they handled such a large proportion of the health budget as clinical commissioning groups are expected to do in the NHS in England. Clinical commissioning groups are public, statutory organisations, which will need to be fully accountable for their actions and therefore cannot expect the degree of autonomy, nor diversity of organisational form, that IPAs enjoy.

Nevertheless, the original vision for GP-led commissioning set out in the 2010 NHS White Paper *Equity and Excellence* (Department of Health, 2010) was based on harnessing the energy of general practice, a semi-private element of the NHS system. New Zealand's experience of bringing private GPs into IPAs suggests that it is in the *provision*, rather than commissioning, of care that the majority of GPs are most likely to engage with new organisations. Indeed, UK experience of primary care-led commissioning over the past 20 years likewise points to the likelihood of clinical commissioning groups needing to stimulate the development of strong and effective local primary care provider networks, from which these groups can commission new forms of extended primary and community health services (Smith and Mays, 2012). GP fundholding, total purchasing, and practice-based commissioning all spawned new forms of primary care provision, including services and organisations that survived long after the particular commissioning policy had been abolished.

In the NHS in England, there are already a number of primary care provider organisations that, although on a smaller scale, are similar to New Zealand IPAs. Many of these came about through the Personal Medical Services (PMS) local contracts that practices were able to negotiate with local commissioners. Examples of these organisations include Integrated Health Partners and Epsom Medical in Surrey, Smethwick Pathfinder in the West Midlands, and the Hurley Medical Group in London. There is also evidence of new general practice networks or organisations being formed – one such example is the Vitality 'super-partnership' in Central and West Birmingham.¹ The drivers for these developments appear to be:

- that many practices are struggling in a constrained economic environment, as costs rise and income is frozen
- the quality of primary care in the English NHS remains variable (Goodwin and others, 2011)
- the increasing awareness of a need for more effective coordination of care for people with multiple chronic conditions, and that this should be based in general practice
- an expectation by the population that primary and community health services be available '24/7'

1. See www.vitalitypartnership.nhs.uk

- the need for primary care services that can deliver intensive and integrated home support to people at risk of hospital admission.

The original intention for clinical commissioning groups was for them to be local organisations that would be bottom-up in nature, formed by communities of like-minded clinicians and held together by personal relationships between GPs, rather than structures imposed from above. The vision also intended clinical commissioning groups to enjoy enough autonomy from central control to allow primary care clinicians to innovate (as both commissioners and providers), improve the quality of primary care through peer-review processes and use this as a base to design new services across primary and secondary care. However, the inevitable requirements of accountability for large sums of public money have led to larger clinical commissioning groups that are more often aligned with local authority boundaries than 'natural communities' of GPs, face a very extensive process of authorisation as 'fit to commission' and have significant constraints in terms of management funding and organisations (NHS Commissioning Board, 2012). A risk for clinical commissioning groups is that too much regulation and central direction will undermine the very autonomy and innovation they were designed to encourage.

Much of this balancing act will fall to the NHS Commissioning Board, a new body set up by the Health and Social Care Act 2012, which has been developing the rules and procedures for clinical commissioning groups and will begin authorising them from April 2013. This analysis of the New Zealand's experience of IPAs since 1990 across three distinct time periods reveals some important themes that might be valuable in that process. These are discussed below.

Clinical commissioners will need to find ways to stimulate the development of new forms of local primary care provision

A particularly striking feature of the New Zealand IPA story is their persisting interest in using their organisational capacity as the basis for developing new services. Indeed, they are essentially primary care provider networks that have developed a broader range of functions over time. Some IPAs have invested and specialised in the provision of management services to practices, and latterly to the primary health organisations set up as part of Labour Government policy from 2001. These management support organisations have enabled IPAs to consolidate their role in the wider health sector, becoming significant population health management entities, and the channel through which many primary and community health service funds and developments flow. This role in management services appears to have added to the durability of IPAs, allowing them to be at the forefront of shaping many of the recent initiatives to develop integrated family health centres and new networks of primary and community health services.

This focus by IPAs on supporting the development of general practice itself offers an important message for new clinical commissioning groups in the NHS. It suggests that clinical commissioning groups will need to take an active role in developing some of these core services, rather than leaving such activity to the NHS Commissioning Board as the contractor of general practice services, or otherwise buying primary care development support from outside. As noted earlier, research evidence suggests that clinical commissioning groups are likely to find that some of their GP members are more interested in developing new ideas about provision, rather than commissioning per se (Smith and Mays, 2012). It will, however, be important for clinical commissioning groups to find ways of fostering and rewarding innovation among their members

without creating conflicts of interest that compromise public accountability (Thorlby and others, 2011).

GPs need to be part of primary care networks with which they have a strong affinity

Although IPAs emerged originally for defensive reasons, this does not seem to have inhibited the growth of strong, clinically led and owned organisations with a desire to grasp opportunities and develop local health services. There are similarities between the experience of IPAs and physician groups in the United States in the 1990s, which came together for fear of losing out to powerful health maintenance organisations run by insurance companies. Some of them became successful primary care-based health provider organisations (Casalino, 2011; Thorlby and others, 2011).

In the case of IPAs, GPs came together on the basis of natural communities of interest: IPA boundaries were not imposed on GPs, who could, if they chose, move or even avoid joining. By contrast, membership of clinical commissioning groups is mandatory for GPs in England. Although the intention was to allow organic formation of clinical commissioning groups, there has been some compromise and movement as the process of authorisation has proceeded: smaller groups have disappeared as the number of prospective clinical commissioning groups had, at the time of writing, fallen from over 240 to 212.

Once formed, IPAs have offered clear and tangible benefits to constituent GPs in New Zealand. Our research has described how dispersed and isolated GPs have been able to access information technology (often for the first time) as well as continuing education and support for quality improvement. Savings from contracts managed by IPAs have also been ploughed back into additional services of benefit to GP patients, for example sexual health, maternity or mental health services. This has been reinforced by the ownership of IPAs by the GPs themselves, with governance structures that have allowed multiple routes for active involvement.

In the English NHS, it is much less clear how constituent GPs will relate to their clinical commissioning group. General practice in England in 2012 is more developed than its equivalent in New Zealand in the 1990s in terms of information technology and infrastructure. Benefits may flow to English GPs in the form of financial incentives available for investment in new services, but the rules governing such savings by clinical commissioning groups have yet to be worked out.

It is also not clear whether English GPs will feel that they 'own' clinical commissioning groups. The equivalent GP-owned and -led organisations of the 1990s – multi-funds and total purchasing pilots – were swept away in the New Labour Government's reforms of 1999, which saw the abolition of GP fundholding and its variants. Since that time, primary care-led commissioning organisations in the English NHS have arguably been led and owned more by statutory NHS bodies than by general practice, with primary care groups, primary care trusts and practice-based commissioning being initiatives of the Department of Health and not general practice itself (Smith and Mays, 2007; Smith and Walshe, 2004). Crucially, individual GP contracts are not held by clinical commissioning groups but will be held centrally by the NHS Commissioning Board.

Furthermore, the statutory nature of the clinical commissioning groups means that they could be abolished with new legislation. The durability of the IPAs in New Zealand is clearly linked to their status as GP- (or clinician-) owned, non-statutory organisations.

This has meant that each IPA has different structural arrangements and organisational form, but it has also meant that they cannot be abolished by the state, and hence they are able to adapt to the prevailing policy and health sector context.

To secure active and enthusiastic engagement of the majority of GPs, clinical commissioning groups may need to stimulate the development of provider networks or federations (Royal College of General Practitioners, 2008). These networks could choose to take the form of autonomous or private organisations which resemble more closely Personal Medical Services (PMS) provider organisations, or New Zealand IPAs, rather than statutory NHS bodies. In this way, they could establish organisations that are literally owned by local GPs, cannot be swept away in NHS reorganisations, and can take on formal service delivery contracts within a robust framework of public commissioning and accountability.

Primary care provider networks could form the basis of more integrated care. New Zealand's IPAs have provided the health sector with important infrastructure for current initiatives aimed at strengthening primary and community health services, and developing care that is more integrated for patients. IPAs have also, over time, assumed a role as convenors within the local health system, drawing together different primary and community health providers and funders to plan and deliver new forms of care, plan capital developments and respond to emerging national health policy. It is of note that in 2009 when the New Zealand government sought 'Better, Sooner, More Convenient' bids to develop integrated local health services, the majority of the successful schemes had IPAs as lead or main organisational partners.

Twenty years of organised general practice, as expressed through IPAs, and also community-governed primary care, have left a legacy of extensive management infrastructure that supports, develops and (at times) represents primary care in the wider health system. It seems that IPAs, in particular those that have operated as management services organisations to primary health organisations, are being viewed increasingly as 'system integrators,' particularly in relation to efforts to try to bring about better-coordinated care for people with complex needs. New Zealand's small population size has undoubtedly helped here: establishing relationships with other organisations has been made easier by the small and relatively close-knit community of policy-makers, clinicians and managers.

The Better, Sooner, More Convenient pilot schemes are using a new form of contracting to underpin partnership arrangements between multiple local health providers and funders. 'Alliance contracting' is a concept borrowed from the construction, defence and minerals industries, and entails the partners signing up to a contract with a common shared objective, and with gain-sharing/pain-sharing built into the overall agreement (Stephenson, 2000). The application of this approach within integrated care initiatives will be watched with interest by policy-makers and researchers elsewhere, for one of the issues that persistently dogs such experiments is how to craft contracts, incentives and sanctions for a range of providers that need to have aligned objectives, rewards and penalties.

Significant time is needed for organisations to develop. New Zealand's IPAs offer an interesting insight into how GP-led groups develop over time and where their innovation and enterprise take them. IPAs are now over 20 years

old, and they have weathered many organisational and policy storms, prior to reaching their current position as central to the management and development of primary care in New Zealand. This point about the need for organisational longevity has been made by other academic commentators, including Casalino (2011) in his study of medical groups in the United States and their lessons for clinical commissioning in the English NHS. The NHS will be able to draw on some experienced GP leadership, built from fundholding and PMS schemes onwards, but the mandatory nature of clinical commissioning implies that a much wider cadre of primary care leaders will be needed, in provider as well as commissioning organisations.

The time needed for development is not just about structures and governance, but also about being able to focus on supporting and improving the provision of core services within primary care. Many New Zealand IPAs were eager in the 1990s to take on budgets for laboratory tests, pharmaceuticals and elements of community nursing, using savings to improve the range and accessibility of local primary care services. Many also chose to focus on improving the quality of primary care provision, with peer review and clinical education within general practice being regarded as a core function (Malcolm and Mays, 1999). This is encouraging from an NHS perspective, given the pressing need to extend and strengthen primary care provision, and it will be important for clinical commissioning groups to be given (or develop) tools and incentives to manage the quality of care provided by their member practices if this is to be improved as part of the overall clinical commissioning task.

Autonomy and independence is critical for GPs

The New Zealand IPA experience illuminates the dilemma facing policy-makers in England when focusing on clinical commissioning groups: clinical independence and autonomy might undermine strong public accountability and direction. New Zealand's IPAs have handled only a fraction of the public sums that are planned for clinical commissioning groups, but nevertheless the interviews for this study revealed a powerful sense of unease from policy-makers and government about the absence of control over (relatively small amounts of) public money once it had passed into the hands of IPAs, and in particular the use of savings that were made in the early years. This may prove to be an intractable policy problem in the NHS: strong public accountability and central control may not be compatible with a bottom-up, autonomous model of GP organisations.

The IPA story suggests potential solutions for such tensions. As IPAs have matured (partly as a result of organisational development over many years, and partly as they have responded to changing national policy), so they have become organisations with a wider range of funding sources, stronger community as well as professional governance arrangements, and bodies that are regarded as vital to population health management and primary care development. This suggests that NHS policy-makers need to take account not only of the requirement for strong public accountability for funds and decisions, but also of the importance to GPs of feeling that they can 'own', influence and benefit from clinical commissioning groups in ways that make sense to grassroots general practice.

A possible way of enabling clinical commissioning groups to co-exist with local GP provider organisations may lie in the community ownership idea that has been adopted by some New Zealand primary health organisations and IPAs: private (as in non-state-owned) not-for-profit bodies, with a high degree of community and

professional involvement. This may mean parallel governance arrangements for different parts of the clinical commissioning group and its functions (in particular for commissioning as opposed to provider functions), as was noted earlier in our examination of the governance and ownership of the Compass Health network in Wellington, the Wairarapa and the Mid-Central region. This issue was also highlighted in an examination of the evidence base for primary care-led commissioning (Smith and Mays, 2012), which suggested a separation of the ‘commissioning core’ of a clinical commissioning group from the ‘provider entity’ of practices.

A further solution lies in the potential for clinical commissioning groups to stimulate the development of local provider networks that are rooted in general practice. These may take the form of primary care federations as suggested by the Royal College of General Practitioners (2008), or more autonomous free-standing private organisations set up by GPs to take on contracts for extended primary care delivery. In this way, collectives of practices would build on the experience of PMS organisations, enabling the development of ‘at scale’ primary care, especially if ways can be found for clinical commissioning groups to contract with such organisations and hence build much-needed primary care capacity for the development of effective integrated care.

There is an inevitable tension between strong GP engagement and a more inclusive population health approach

From a policy-maker’s perspective, the IPA experience suggests that a bottom-up, GP-led approach might create strong and cohesive organisations, but will not necessarily deliver consistency of mission. The most obvious symptom of this in New Zealand was a patchy and inconsistent focus in the 1990s on preventative, population health and action to reduce health inequalities. It would appear that only a minority of IPAs automatically gravitated towards a population-wide health focus in that decade (leaving this work largely to the parallel development of community-owned primary care organisations of the Health Care Aotearoa network), while others adopted a more commercially focused approach. This worked well during the 1990s as IPAs assumed contracts for a range of primary and intermediate care services, but proved problematic for the subsequent Labour Government that wanted a more uniform, preventative public health approach to primary health care in New Zealand. Thus, the Primary Health Care Strategy led to the top-down solution of primary health organisations in a reform that was viewed very negatively (at least initially) by some in the IPA movement.

The IPA experience also points to variability in GP-led organisations’ inclination to involve community and patients in decision-making, a point that has been highlighted in research into primary care organisations more generally (Lupton and others, 1998; Meads and others, 1999; Peckham and Exworthy, 2003). While a minority of IPAs appear to have embraced a community-led, inequalities-focused approach from the outset, many were (and still are) perceived to be more commercially minded and with a strong professional self-interest, albeit that a core of large IPAs are acknowledged to have journeyed from GP-focused entities to broader population health organisations.

The IPA story suggests that on their own, GP-led groups will struggle to bridge the divide between general practice and public health, and will require significant time, management support and organisational development as they move through primary care priorities to focus on broader concerns such as illness prevention, proactive management of chronic disease and attention to the wider determinants of health. It should be borne

in mind, however, that the predecessors of clinical commissioning groups – primary care trusts – also struggled to address the wider agenda of population health alongside the development of general practice and community health services.

The challenge for the NHS is not to put all the primary care eggs in one basket, and expect clinical commissioning groups to achieve extensive primary care development at the same time as fulfilling the requirements of the new Commissioning Outcomes Framework (National Institute for Health and Clinical Excellence, 2012). We know from the experience of PCTs that high expectations of commissioning organisations can lead to disappointment and slow progress (Smith and Curry, 2011). The opportunity for clinical commissioning groups is to build experience and capacity to address the wider range of health priorities, and encourage the development of local primary care provider networks that resemble New Zealand's IPAs. These in turn could focus on the service delivery and practice support and development that will excite and engage local GPs and their teams, while providing the basis for much more extensive community-based integrated care.

8. Conclusion

The English NHS needs to find new ways of managing and developing primary care provision. The old 'corner shop' model of general practice is not working economically for many GPs, is struggling to accommodate demand, and often lacks the resources and organisational capacity to take on work shifted from hospitals as part of plans to develop more integrated care.

Policy attention is focused on devolving financial and commissioning responsibility to clinical commissioning groups, yet attention is arguably being diverted from where it is really needed: establishing strong and sustainable management and organisational infrastructure that can support the development of general practice and primary care in a way that enables it to meet the financial and health challenges ahead.

New Zealand's experience of IPAs since 1990 demonstrates the value to be gained from enabling strong provider organisations rooted in general practice. Some of the most effective IPAs were formed through the personal relationships and drive of GP leaders, and the loyalty and cooperation of GP members resulted from a sustained process of personal engagement with those GP leaders, resulting in GPs feeling that they have an 'ownership stake' in the IPA as a whole.

IPAs have proved durable. This reflects the essentially entrepreneurial character of IPAs as private businesses, accompanied by some adroit leadership that has been able to mould emerging policy to maximise benefit for the IPA, local enrolled patients and the wider health system. But entrepreneurialism and independence have had some downsides. Variability in form and function has at times irked policy-makers looking for uniform, national standards of service, particularly in relation to population health and health inequalities. Above all, the essentially private status of IPAs has led to an often tense relationship with government and policy-makers.

There may be no simple way to square this circle of independent ownership of general practice and the need for accountability for public funds, at least within a single organisational form. Perhaps the answer for the English NHS is to separate out the role of GPs as statutory clinical commissioners from that of GPs as independent providers operating under contract to NHS (including clinical) commissioners. The message for the NHS in England from the IPA experience is that primary care-based provider organisations have huge potential to develop, support and change the delivery of general practice services.

Evaluation of primary care-led commissioning in the NHS suggests that new primary care provider organisations may be the most enduring legacy of clinical commissioning groups. This suggests that clinical commissioning groups stand to gain from exploring how to stimulate new general practice provider networks, capitalising on New Zealand's experience of IPAs.

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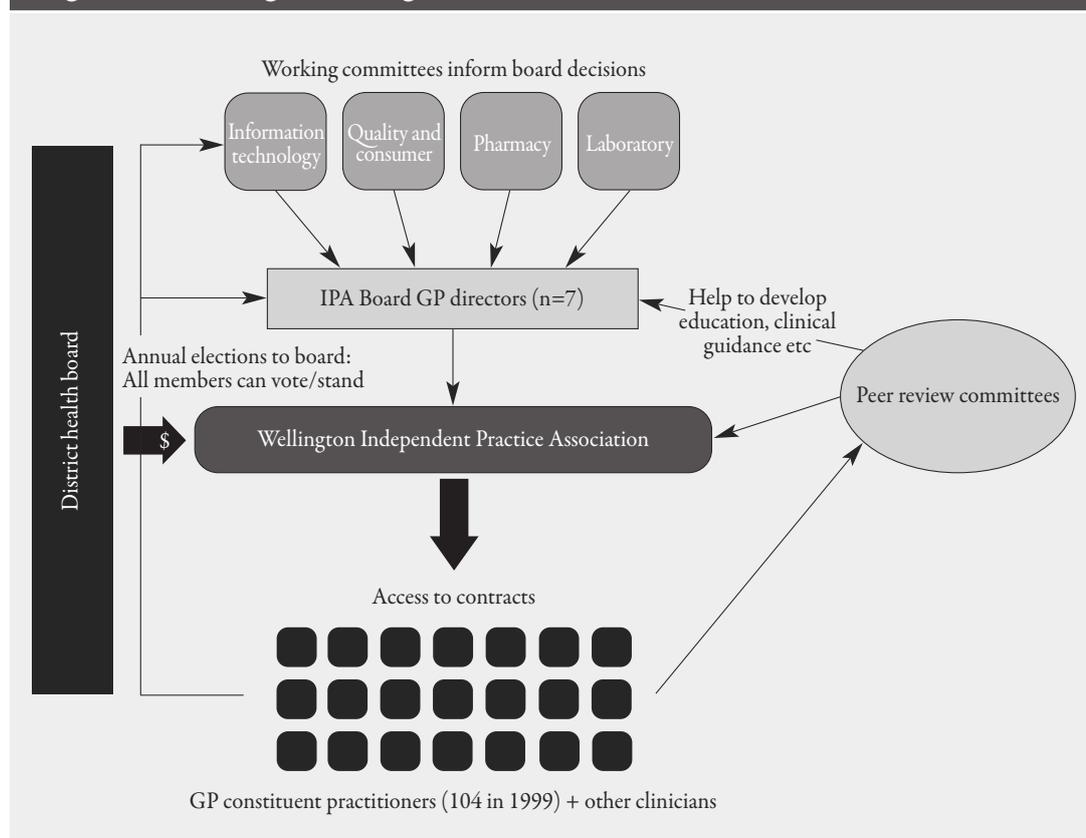
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Appendix: Case study: the evolution of Wellington IPA into Compass Health

Some IPAs have evolved from small groupings of general practices into large organisations, delivering a wide range of management support and clinical services. Wellington Independent Practice Association (WIPA) is a good example of this trajectory.

Formed in 1995, WIPA brought together over 32 GP practices in the Wellington area (the capital city, at the southern tip of New Zealand's North Island). From its inception, WIPA Ltd was owned and managed by its constituent GPs. In common with other IPAs at the time, GPs elected the board and those GPs interested in active involvement could take part in a range of committees. Figure 2 shows the governance arrangements of WIPA in 1999, drawn from a study at the time, when WIPA's membership had expanded (Kriechbaum and others, 2002).

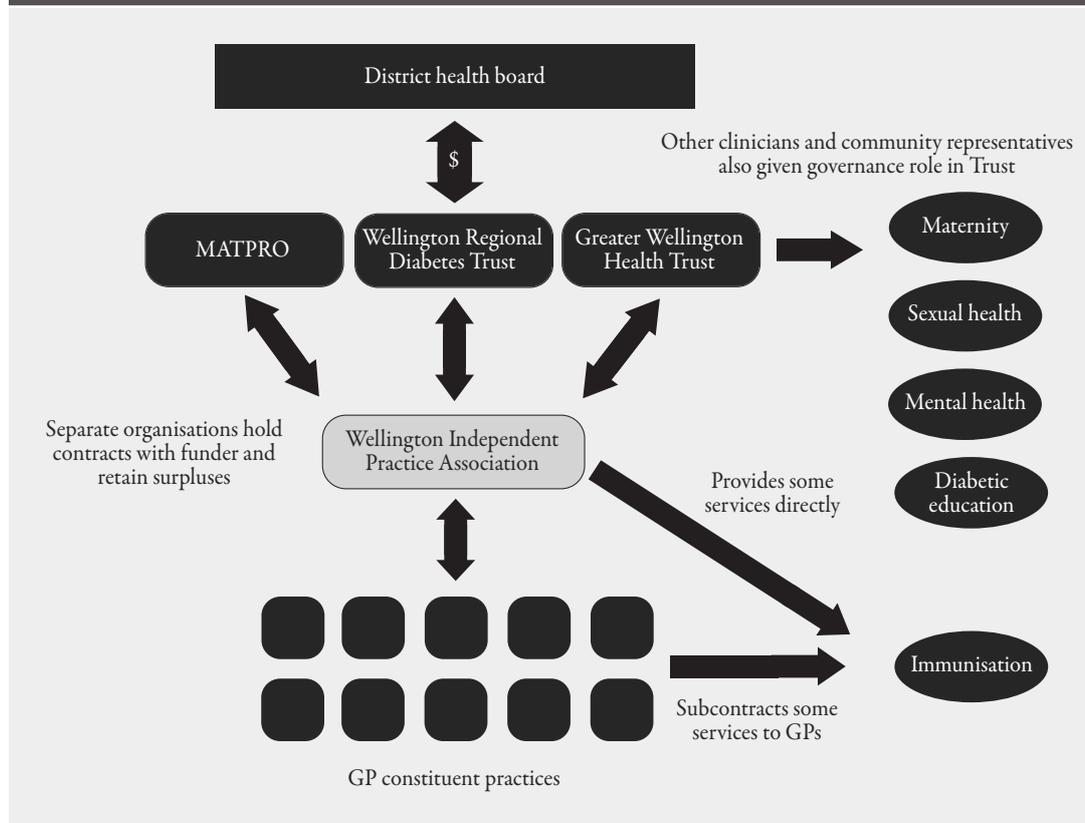
Figure 2: Wellington IPA governance in 1999



Source: Kriechbaum and others (2002)

WIPA was unusual in that one of its early developments (in 1996) with the regional health authority was for maternity services. As a result, a wider group of clinicians was involved, and a parallel organisation MATPRO Ltd was established as a joint venture with midwives and obstetricians as shareholders and managed by WIPA. Similarly, the Wellington Regional Diabetes Trust was established in 2000 involving a wide range of stakeholders with an interest in diabetes services, and managed by WIPA. Later, in 2002, the Greater Wellington Health Trust (GWHT) was set up to better reflect the political desire for 'not-for-profit' entities to hold contracts and manage any financial surpluses accrued by the IPA. GWHT was governed partly by elected GPs and partly by nurses and community-appointed representatives (see Figure 3).

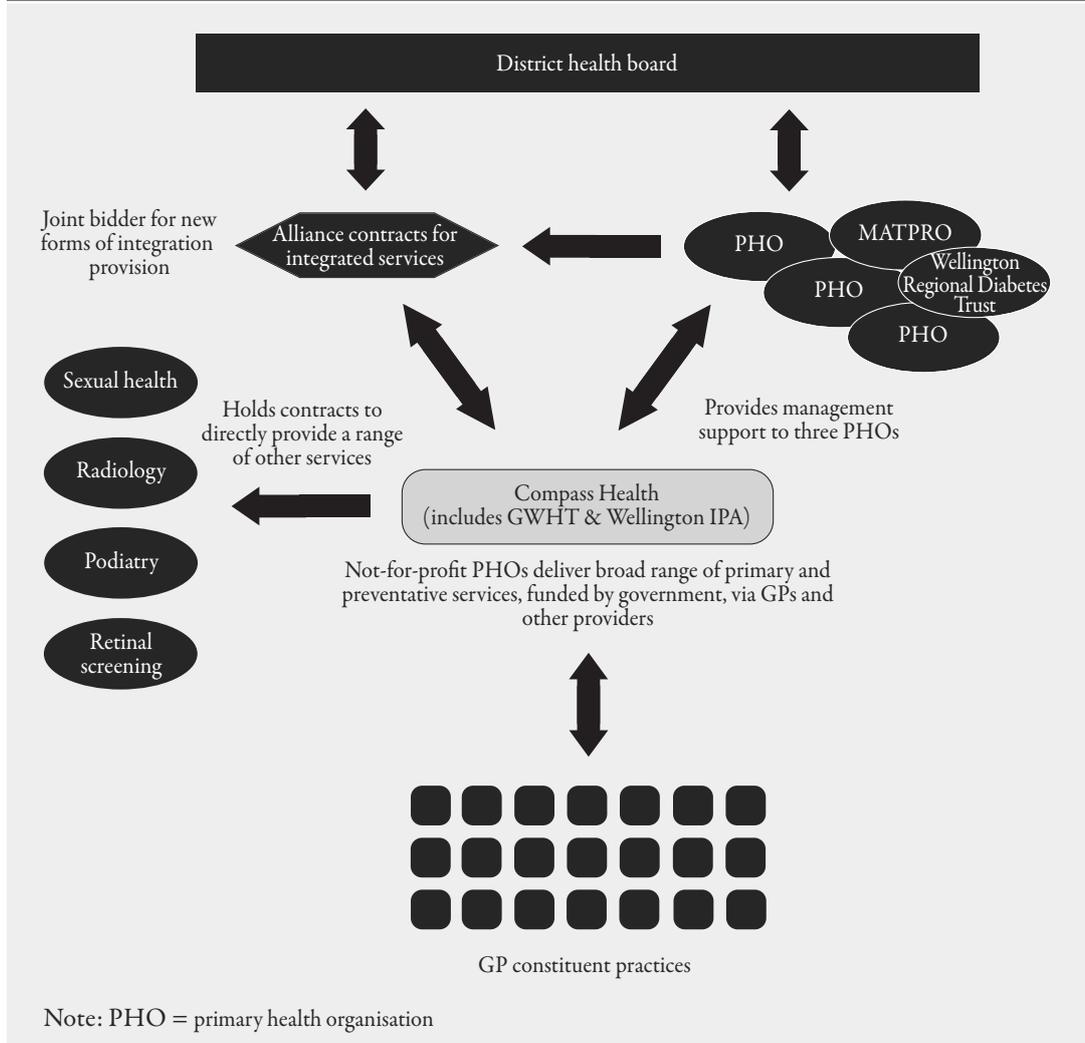
Figure 3: Governance structure of WIPA in the early 2000s



WIPA's evolution continued with the formation of primary health organisations from 2001 onwards (see Chapter 4). These organisations were created by the Labour Government to deliver a wider range of primary health services. In a few areas, IPAs became primary health organisations, but WIPA (in common with many IPAs) responded by contracting to deliver management support services to three primary health organisations in the Wellington area. These included information technology services and other back-office functions, as well as clinical leadership. Subsequent geographical

expansion, and the taking on of management support for primary health organisations in two regions north of Wellington, led to WIPA being renamed Compass Health. The organisation has expanded the range of directly provided services as well as bidding to play a central role in developing and coordinating new integrated forms of care with other providers, under the Better, Sooner, More Convenient policy (see Figure 4).

Figure 4: 2011 – WIPA becomes Compass Health



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