

# The future shape of primary health care in New Zealand

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## Abstract

*The Minister of Health in New Zealand earlier this year released a discussion document titled “The Future Shape of Primary Health Care” which outlines some far-reaching proposals for the provision of primary health care services within New Zealand. This article sets the discussion document in the context of primary health care within New Zealand by examining current arrangements for primary health care, previous arrangements and the proposals outlined in the discussion document.*

## Introduction

In common with Australia and most other developed countries, primary care provision within New Zealand is facing a number of challenges. These relate to factors such as demographic change, increasing treatment options and rising consumer expectations. In response, New Zealand’s Ministry of Health has recently completed consultation on a discussion document entitled “The Future Shape of Primary Health Care” which points to a number of potentially far-reaching changes in the provision and funding of primary care in New Zealand. The discussion document is available at: <<http://www.moh.govt.nz/primarycare.html>>. This article highlights some of the changes that are proposed.

To understand fully the nature and extent of these changes, it is first necessary to understand how primary care in New Zealand has developed. This article therefore outlines the past (how primary care was funded and delivered prior to the health sector reforms of the early 1990s), the present (how services operate today, more than seven years after the previous reforms were implemented), and the future (the direction for primary care proposed in the Government’s discussion document).

## The past

Prior to New Zealand’s 1993 health reforms, the country’s system of primary care had changed little from that which grew up as a result of the Social Security Act of 1938 (Gauld 1999; Poutasi 2000). Primary care was largely synonymous with general medical services, provided by general practitioners (GPs). Services were funded by a combination of user charges (co-payments) and subsidies paid to providers by the central Department of Health. Government subsidies were tied to particular providers (eg, the general medical services benefit could only be claimed by GPs) and paid on a fee-for-service basis. Consumers could use any provider, which meant that they could change providers at will or use multiple providers if they chose to do so. There was no requirement to affiliate with a specific GP, although many individuals and families doubtless remained loyal to a single provider for considerable periods of time.

The combination of fee-for-service payments and no formal, enduring linkage between consumers and providers resulted in a service that might have best been described as transactional rather than relational.

The system offered no real incentive or imperative to form group practices or to establish multi-disciplinary services. GP practices could access a practice nurse subsidy, but since the main driver of revenue was subsidies that required services to be delivered by GPs, most services were, unsurprisingly, delivered by GPs. The role of the practice nurse was thus tightly circumscribed and there was effectively no mechanism for new types of provider to begin to offer publicly funded or subsidised services.

From the Government's point of view, the reliance on open-ended fee-for-service payments meant that expenditure was effectively uncontrollable. Furthermore, as increasingly tight controls were placed on hospital spending via the introduction of capped budgets and case-based payments, the opportunity to shift costs onto the uncapped primary care sector was difficult to ignore.

The system did not encourage population-based approaches. Providers were only given incentives to take an interest in the patients who came to see them. They were not (and could not be) held to account for meeting (or even understanding) the health needs of the wider population. People who were unable (or chose not) to access GP services were essentially no-one's responsibility with the result that they all too easily 'fell down the cracks'. Often those whose need was the greatest were the worst served. In a clear demonstration of the 'inverse care law' in action, GPs tended to congregate in the more affluent suburbs with few choosing to practice in socially-deprived or rural areas where neither the lifestyle nor the potential income stream from fee-for-service payments could be considered to be particularly appealing.

There were some notable exceptions. They included a number of group practices that were funded on a crude capitation basis, and a series of Special Areas (typically in more remote parts of the country) where GPs were salaried and co-payments were waived or abated.

## The present

The reforms of 1993 resulted in large-scale changes to publicly funded health care in New Zealand. From the perspective of primary care, the most significant change was undoubtedly the introduction of a 'purchaser/provider regime' which assigned responsibility for funding and delivery of health services to separate agencies. This had a number of implications for primary care, as follows.

**Integrated funding.** The distinct funding streams that had previously led to cost shifting from secondary to primary services disappeared and the four new purchasers (Regional Health Authorities) were responsible for purchasing all aspects of health and disability support services for their resident populations.

**Cash limits.** The Regional Health Authorities were allocated a fixed annual sum with which to purchase services. The previous open-ended funding obligation of the former Department of Health was gone and purchasing decisions became a zero-sum game with every dollar spent on primary care being a dollar less available for secondary care or other services (and vice-versa).

**Contracts in place of entitlements.** Regional Health Authorities were not obliged to use the same system of entitlement-based payments as had previously funded most aspects of primary care. In principle, therefore, they could contract with a much wider range of providers; and they could negotiate whatever basis of payment they thought fit, including movement from uncapped fee-for-service arrangements to capitation or other risk-sharing arrangements.

In response to these changes, the period following the 1993 health reforms saw three significant developments in primary care. First, solo GPs and group practices came together to form larger Independent Practitioner Associations. These often started life as a defensive response to balance the perceived power of the Regional Health Authorities in contract negotiations. Many, however, have since grown to become highly competent and effective groupings of GPs that play a significant role in service development, quality assurance and, increasingly, management of capitated budgets.

Second, new providers entered the market and succeeded in securing public funding. The most notable example is the phenomenal growth in 'by-Māori-for-Māori' providers (that deliver services for the indigenous Māori population) from just over 20 prior to the reforms to more than 300 at the last count (a fifteen-fold increase) (Ministry of Health 1998a).

Third, while many GPs retained fee-for-service payments, there has been an increase in both capitation and budget-holding. Some 15% of GP practices are now capitated while many more are involved in some form of budget holding for laboratory tests and/or pharmaceuticals (Ministry of Health 1998a). These arrangements also allow practices greater flexibility in the use of nursing and other staff to deliver services.

Notwithstanding the above, most GPs are still self-employed contractors. The system of co-payments has also remained more or less unchanged with the result that almost all New Zealanders are obliged to meet all or some of the cost of primary care services. The main exceptions are services delivered to deprived communities by not-for-profit providers who often waive co-payments and children aged under 6 who, since 1997, have been entitled to a level of subsidy that makes most routine GP visits and prescriptions free.

As far as primary care is concerned, the past seven years have been a period of generally positive change. Nevertheless, a number of problems remain.

**Figure 1: Life expectancy by deprivation categories (1996/97)**

| Deprivation Group  | Male | Female |
|--------------------|------|--------|
| 1 (least deprived) | 77.6 | 82.1   |
| 2                  | 76.5 | 81.5   |
| 3                  | 75.7 | 81.2   |
| 4                  | 75.1 | 81.1   |
| 5                  | 74.5 | 80.6   |
| 6                  | 73.9 | 79.9   |
| 7                  | 72.7 | 79.6   |
| 8                  | 71.4 | 78.5   |
| 9                  | 68.9 | 77.8   |
| 10 (most deprived) | 68.1 | 75.4   |

(Ministry of Health 1999)

First, in common with many other countries, life expectancy in New Zealand still displays a marked socio-economic gradient (Figure 1).

Second, despite steady improvements over much of the last 50 years, there is still an unacceptable gap in health status between Māori and non-Māori New Zealanders - whether measured in terms of overall life expectancy or the burden of disease as expressed by disability adjusted life-years lost (Figure 2).

Third, the present fragmented system of primary care is proving incapable of delivering population based health services. For example, between one-third and one half of people with diabetes in New Zealand are believed to be undiagnosed (Ministry of Health 1999). Estimates suggest that as many as 40% of two-year olds in New Zealand may not be fully immunised (the fact that this figure can only be estimated is, in itself, something of an indictment of the current state of population health activity) (Ministry of Health 1998b).

Fourth, almost 20% of hospitalisations among people aged under 75 in 1997/98 are considered to have been potentially avoidable through better ambulatory services (Ministry of Health 1999).

Faced with these realities the Government has decided to offer a clearer direction for primary care. In doing so, it hopes to ensure that the system is able to respond to the social, demographic and technological changes of the next 10 years.

**Figure 2: Disability-adjusted life-years lost by cause & ethnicity (1996)**

| Cause group         | Māori | Non Māori |
|---------------------|-------|-----------|
| Infectious Diseases | 6.9   | 3.7       |
| Musculoskeletal     | 4.1   | 4.1       |
| Endocrine           | 18.5  | 4.6       |
| Other Chronic       | 7.3   | 5.2       |
| Infant              | 11.9  | 7.3       |
| Neurosensory        | 9.6   | 7.4       |
| Respiratory         | 19    | 11.4      |
| Injury              | 19.3  | 12.3      |
| Mental              | 18.1  | 16.2      |
| Cancer              | 33.4  | 21.5      |
| Cardiovascular      | 49.7  | 22.4      |

(Ministry of Health 1999)

## The future

The Government's plans for primary care are set out in a discussion document entitled "*The Future Shape of Primary Health Care*" that was published in March 2000. Providers and members of the wider community have recently completed commenting on the document and the proposals it presents.

The key element in the proposed strategy is the establishment of new Primary Care Organisations. These will act as umbrella organisations for primary care services - but will not necessarily employ all or any of the providers who deliver those services. In contrast with the current Independent Practitioner Associations they will be multi-disciplinary with representation from the full range of primary care providers.

Individuals will be able to affiliate to the Primary Care Organisation of their choice; and the Organisation will be expected to ensure access for its affiliated population to a defined and comprehensive range of first contact advice, treatment and preventive services. The affiliation relationship is expected to facilitate the delivery of health education and disease prevention services to a degree that the current transactional approach has been unable to achieve. It will not, however, act as a brake on an individual's ability to use the provider of their choice, even if that provider is not formally part of the Primary Care Organisation to which the individual is affiliated. The Primary Care Organisation may, however, wish to be informed when other providers are used as a means of maintaining the integrity of patient records.

Primary Care Organisations will be responsible for a population rather than for delivering items of service. Consequently it is proposed that they should be funded on a weighted capitation basis. Patient co-payments will, however, remain much as they are at present and budget-holding for secondary care has been ruled out.

The Government has indicated that Primary Care Organisations, if not the organisations/individuals that deliver services under their auspices, must be 'not-for-profit'. They will also be required to have meaningful patient and community representation in governance processes, and to ensure that any surpluses are used to improve health status or increase access to health services. Given the nature of the proposals, the strategy is looking at a ten-year timescale for changes to occur.

Changes to primary care are just one element of the Government's plans for health (King 2000). In addition to the proposals outlined here, work is also underway to replace the current purchaser/provider arrangements with new District Health Boards that will combine funding and delivery roles at local level. A comprehensive New Zealand Health Strategy is also being developed and will form the basis of accountability arrangements for the sector.

## References

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