Change through continuity: a quiet revolution in primary health care in New Zealand

Toni Ashton

IN A RECENTLY PUBLISHED paper entitled *Continuity through change: the rhetoric and reality of health reform in New Zealand,* I and my co-authors Nick Mays and Nancy Devlin pointed out that, in spite of a series of major health sector reforms during the 1990s and early 2000s, some key aspects of the system have endured.[1] Moreover, many incremental changes to existing processes and systems that occurred during the reform period have, arguably, been more important to improving the functioning and performance of the system than the more high level (and more visible) structural changes.

Since that paper was written, many further changes have occurred in the organisation, funding and management of the New Zealand health system. However, in contrast to the 1990s, the focus now is on continuity and stability rather than on any need for further major change. Indeed, terms such as "reform" or "restructuring" have now all but vanished from any debate about health policy in New Zealand. Perhaps the reformers have learned that health system reform is akin to training for the Olympics. The whole process takes a fair bit of time and effort, and results are unlikely to be achieved in the short term. Further major reform is also not regarded as politically viable. As noted in an article in the *New Zealand Herald* just before the general election in September, there is "… considerable public sensitivity over any whiff of restructuring in health".[2]

Toni Ashton, PhD, Associate Professor in Health Economics
Centre for Health Services Research and Policy, School of Population Health, The University of Auckland, Auckland, New Zealand.

Correspondence: Professor Toni Ashton, Centre for Health Services Research and Policy, School of Population Health, The University of Auckland, Private Bag 92019, Auckland, 1020, New Zealand. **t.ashton@auckland.ac.nz**

Primary health care foundations revisited

It is therefore somewhat ironic that in the primary health sector some of the most profound changes are now in train since the foundations of the public health system were first laid in New Zealand in 1938. A brief historical journey is required to place the current changes into context. The aim of the first Labour government that was in power at that time was to introduce a wide range of health services free of charge for all New Zealanders, as part of a comprehensive revision and expansion of the welfare state. The proposed services included a range of health promotion programs as well as the more traditional curative services. The vision was to shift the focus away from treatment to prevention by emphasising public health and early intervention.[3] However, the proposals for a primary health service that was fully funded by the government met with bitter opposition from the medical profession, causing a delay in implementation. Eventually the proposals were modified, and a compromise was reached in 1941. The result was that not only could general practitioners choose to be paid the subsidy on a fee-for-service basis rather than by capitation as favoured by the government, but they also retained the right to charge a nominal patient fee over and above this subsidy.

These arrangements for the funding of general practice remained largely unchanged for the next 60 years. Over time, the real value of the patient subsidy was inevitably eroded by inflation. However, subsequent governments were reluctant to increase the subsidy back up to its original level because they could never be sure that the additional funds would be passed on to patients in the form of reduced co-payments. GP subsidies were eventually targeted to the lower income bracket in an effort to ensure affordable access to those most in need. Even so, many who were entitled to the higher subsidies were not receiving them and, by the end of the 1990s, more than half of the population were paying the full cost of a visit to the GP (NZ$50 or more).

Primary Health Care Strategy 2001

In 2001, the Minister for Health announced plans for reorganising GP services and other primary health care through the Primary Health Care Strategy.[4] The vision this time around is that "People will be part of local primary health services that improve their health, keep them well, are easy to get to and coordinate their ongoing care" [4] (page vii). This vision mirrors that held by the first Labour government 60 years ago, the aim once again being to shift the focus of primary health care away from treatment to prevention, from individual practitioners to teams of primary health providers, and from the health of individual patients to the health of communities. The central feature of the strategy is the grouping of GPs, primary care nurses and other health professionals (such as Mäori health providers and health promotion workers) into networks called Primary Health Organisations (PHOs). These organisations are funded on a capitation basis to provide a specified set of treatment and preventive services to their enrolled populations.

These proposals for reform of both the structure and funding of primary care once again met with opposition from some providers. This time around, however, the government encouraged GPs to buy into the reform proposals by funding PHOs at a higher rate than standard GPs, and by regularly increasing the subsidies paid to PHOs in line with the Consumer Price Index. Therefore any GP who decides *not* to join a PHO risks losing patients because they will have to pay a higher co-payment. The result has been the very rapid development of PHOs, with 79 being established in the 3 years between July 2002 and July 2005.[5] Almost 95% of New Zealanders now belong to a PHO.

The higher subsidy rates were initially paid only to those PHOs which have an enrolled population which is more than 50% Mäori, Pacific and/or people living in a deprived area. This is in line with the aim of reducing inequalities in health by removing the financial barriers to care for disadvantaged people. However the intention of the government is to extend subsidies for primary health care to all New Zealanders on a universal basis. Higher subsidy rates have already been extended to all young people up to the age of 24 years, and to older people aged 65 years or over. The government plans to continue the roll out to those aged between 25 and 64 years through until July 2007, at which time the higher subsidy rates will apply to the whole population and will cover both GP services and pharmaceuticals.

The objective of the subsidy increases is obviously to reduce the level of co-payments for primary care. So far, the policy appears to be working, with most of the subsidy increase being passed on to patients in the form of reduced co-payments.[6] People who were previously not subsidised at all are enjoying the greatest gains, with their GP charges having fallen from an average of around $50 per GP visit to $25 or less. Others are paying $10 or less for a GP visit, and some services are provided free of charge. Pharmaceutical charges for subsidised patients have fallen from a maximum of $15 per item to $3.

Will it happen this time?

So will the vision of a population-focused, prevention-oriented, team-based primary health care system finally be achieved for New Zealand? Unfortunately, a number of barriers still remain. First and foremost, although subsidies have been increased, a fee of up to $25 or more for a GP visit is still likely to make access to primary medical care unaffordable for some people. In addition, GPs have once again retained the right to set their own level of co-payments over and above any government subsidy. At present, any GPs who do not pass on a sufficient proportion of the subsidy to their patients can be — and have been — excluded from the higher subsidies. Thus, there is some incentive to keep co-payments down. Even so, the concern remains that, in spite of regular inflation adjustments, patient charges may eventually creep up again over time to a level that prevents people from seeking the care that they need.

The continued existence of co-payments is also likely to inhibit the development of a primary health system which is truly population-focused and prevention-oriented. In effect, it means that around 30%–50% of a GP's income will still be paid on a fee-for-service basis via patient fees rather than by the government through capitation.[7] Therefore, the incentive remains to keep patients walking through the door, rather than to put programs into place that may prevent them from needing to access the service in the first place. Co-payments may also

inhibit a more team-based approach to care if patient charges are higher for services provided by more highly qualified members of the team.

Another potential obstacle to the development of a primary health service that is population-focused is the fact that in some areas there are multiple PHOs rather than a single network of providers which covers all of the population living in that area. The existence of multiple PHOs will hinder the development of community-based initiatives such as taking screening services to shopping malls or schools, or presenting health promotion programs in workplaces, churches or other locations where communities frequently gather.

Another issue of concern for many PHOs is that opportunities for them to offer "comprehensive services to improve, maintain and restore people's health"[4] (page vii) may not be realised under the current structure. Developments in technology have enabled services which were previously provided in a hospital setting to be devolved into the community. The development of teams within PHOs opens up further opportunities for expanding the role of primary health care. However, unlike the United Kingdom, where Primary Care Trusts hold the budget for their local populations, in New Zealand it is District Health Boards (DHBs) which hold the budgets and which are responsible for either purchasing or providing all personal health services, including primary health care. DHBs own the public hospitals and some community-based services. Therefore there is a danger that they may tend to protect their own services and employees by "making" services themselves rather than "buying" them from PHOs and other community-based providers.

One other objective that may prove difficult to achieve is the coordination of patients' ongoing care by the PHO team. Such coordination requires, among other things, the integration of electronic information systems across a wide range of service providers. This in turn requires leadership, cooperation, funding and high level support. Yet information systems are being developed separately in different parts of the health sector. While some DHBs are collaborating on IT development, in many cases it has been left up to individual PHOs to develop their own IT infrastructure. Failure to take this opportunity to ensure compatibility of systems across PHOs, DHBs and other providers will inevitably inhibit the coordination of care, and result in expensive duplication of services and delays in access to timely care.

Conclusion

All of these points suggest that there is still a fair bit of work to be done in New Zealand if the vision of a population-focused, prevention-oriented, team-based primary health care system is to be achieved. The foundations have been laid and opportunities now abound for developing new ways of delivering primary health services. However, seizing these opportunities and finding ways to overcome some of the barriers described above will take leadership, determination, and collaboration. It will also require some reorientation of programs for the training and continuing education of the primary health workforce, and some further restructuring of PHO networks. So, many challenges remain. Only time will tell if the outcome of this quiet revolution will be a primary health care system that assists in preventing people from falling down the cliff rather than one that, for the most part at least, simply picks up the pieces at the bottom.

Competing interests

The author declares that she has no competing interests.

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