Business of Care: Global perspectives

Fiona Doolan-Noble RGN, PostGradDip PH, MPHC, PhD;[1] Richard Greatbanks BSc, MSc, PhD, CEng, MIEE;[2] Carol Atmore MBChB, FRNZCGP, MSc(PH), DipComEmergMed, DipObs[3]

The eleven articles in this inaugural special issue of the *Journal of Primary Health Care* all focus on balancing the tensions between operating a sustainable business and providing health care, known as hybridisation tension. Hybridisation tensions arise when a primary care practice is exposed to the demands of antagonistic goals—namely providing patient centred high quality care that meets the needs of the population it serves, and maintaining a business that is at least sustainable and meets the expectations of funders and business owners. These tensions have been present in the sector going back to the inception of general practice services as we know them in New Zealand in 1938.[1,2]

This special issue considers various effects of hybridisation tensions on primary health care; are they increasing, what are appropriate strategies for addressing these tensions, and are the impacts of these tensions always negative or can they provide opportunities for practices in a rapidly changing sector?

The first paper by Greatbanks, Doolan-Noble and McKenna explores the presence of these tensions within primary care in the Southern region of New Zealand.[3] The authors used business performance measures as a proxy for how a practice responds to hybridisation tensions. They highlight the emergence of process measures, such as general practitioner (GP) utilisation, as an indicator of the need to ensure a practice operates efficiently and remains viable.

The next three papers illustrate the experiences of people working at the coalface of health care delivery. Hines and Ruddle, part of a team of nurses and a practice manager who recently became practice owners, represent innovations occurring around practice ownership.[4] Gray discusses the importance of trust in funding relationships, and highlights the tensions that often arise when trust breaks down.[5] Through these practice ownership perspectives both papers emphasise the vagaries of the current funding model and its unintended and often dysfunctional consequences. As Gray says, 'the irony is that the amount of money for each of these services is out of proportion to the documentation required to receive that money'. Carryer examines this dysfunctionality further by highlighting the inadequacies of the funding formula to support the appropriate deployment of the primary care nursing workforce.[6]

An international perspective, with papers from America, UK, Australia and the Netherlands, broadens discussion on the feature topic. Liaw and colleagues, from Georgetown University and the Robert Graham Centre in Washington, discuss lessons the US has learnt about the hybrid tensions that arise when there is a dual payer system, public and private.[7] They note that hybridisation can permit innovation and experimentation with funding models, but they concede that the multiple private and public funder's model is administratively complex. They also consider the consequences associated with the assortment of reporting lines their system requires.

Miller draws attention to a multiplicity of hybridity issues in English general practice—noting that 'what is striking about English general practice is that it is still owned by general practitioners, rather than by or with other health professionals'.[8] Miller concludes by speculating on the benefits greater hybridity could bring to the sector in terms of greater innovation and more imaginative partnerships. Reddy presents an Australian perspective, again emphasising that hybridisation holds promise, as it creates synergies (collaborations) and opportunities for creativity, and that these factors can lead to more effective and efficient public service provision and funding.[9] These three international contributions all speak to the potential opportunities that arise from hybridisation.

[1] Rural Aotearoa Research Network, Department of General Practice and Rural Health, University of Otago, New Zealand

[2] Department of Management, Otago Business School, University of Otago, Dunedin 9054, New Zealand

[3] Department of General Practice and Rural Health, University of Otago; Current Foxley Fellow, Health Research Council of New Zealand

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CORRESPONDENCE TO:
Fiona Doolan-Noble
Rural Aotearoa Research Network, Department of General Practice and Rural Health, University of Otago, New Zealand
fiona.doolan-noble@otago.ac.nz

In the final international paper from the Netherland's Broekman and colleagues examine the effect of integrating out of hours general practice services and emergency departments on cost, length of stay and patient satisfaction, compared to separate services.[10] Their assumption that cost would decrease in the collaborative model did not prove to be the case, while patient satisfaction was similar in both settings. This is a useful reminder that assumed benefits of new ways of working are always worth testing.

The paper by Atmore takes a chronological perspective to explaining the emergence and presence of hybridisation tension in New Zealand primary care.[11] In doing so, the paper looks to the future and outlines how the tension of providing preventive and population health approaches, alongside individualised patient centred care, while running a viable business is driving innovation around new models of primary care ownership and health care delivery. Atmore suggests that the prevailing tensions have acted as a driver of transformation, by creating opportunities to establish new models of practice ownership and health care delivery.

The final two papers draw on some of the optimism regarding hybridisation in the New Zealand context. Christie and colleagues discuss the implementation of a pastoral care programme employed by Pegasus Health Charitable Trust to support doctors working in primary care who may be fatigued and suffering from impaired judgement.[12] Given our ongoing workforce challenges, this initiative speaks to the need to be able to ensure we treasure, cultivate and value our healthcare workforce.[13]

Finally, Hefford provides insight into a model of primary health care delivery that is gaining traction in New Zealand – the Health Care Home. In this paper, he uses three vignettes to illustrate how the Health Care Home model differs from current practice.[14] While acknowledging this model is still a 'work in progress', it would seem this method of working has the potential to improve patient care and provider satisfaction within a viable business model. Greater consideration of how this model works to support not only better patient care but its potential ability to assist health care professionals avoid burn out is worthy of further investigation.

As three guest editors, we would like to acknowledge the trust placed in us by the Journal's editor, Professor Susan Dovey and the College, and thank them for allowing us to lead this inaugural special edition of the Journal. We would also like to thank all those who contributed papers to this edition, as without their work there would not be a special edition. Finally, we would like to thank the team at CSIRO for all their support and guidance over the last ten months. We hope you all enjoy this Special Edition.

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