

A future for primary health care in New Zealand

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Abstract

The attempt to implement a health market in New Zealand by separating funders and providers in 1992 has not delivered improved health outcomes. Indeed there is increasing concern that deprived populations are not accessing appropriate health care. This article describes the models of primary care that have evolved in the new environment and suggests that these new structures, given appropriate support, are ideally placed to increase the focus of primary care on population health. A capitation funding model with patient enrolment and low fee-for-service barriers is proposed as the most promising model for delivering improved health outcomes. The model incorporates a needs-based funding formula, locality health needs assessment, an increased role for primary care nurses and improved responsiveness to local communities, especially Maori.

Introduction

A recent study (Anderson 1998) showed that New Zealand was spending 59% of total health expenditure on hospitals; the highest proportion in the Organisation for Economic Cooperation and Development (OECD). Most OECD countries, including the United States of America, spend between 42% and 46%, with a median of 42.7%. However, New Zealand's health status statistics do it little credit. Where we once led the world in life expectancy and infant mortality we are now near the bottom of the league tables. Our immunisation rates are so low that we now bear the dubious distinction of being an exporter of infectious diseases.

If New Zealand spent just the median proportion of health expenditure on hospitals this would allow an extra NZ\$1.3 billion to be spent on primary health care. When one considers that most of our pressing health problems are best tackled by primary health care or public health strategies (for example, reducing smoking, improving nutrition, increasing our immunisation rates and preventing rheumatic fever) the

argument for transferring resources to primary care and public health becomes compelling.

This article describes the major models of primary health care delivery in New Zealand and suggests how primary health care can be developed using a population-based focus to improve health outcomes, particularly for those members of society who currently experience poor health status.

Context

In 1992 the New Zealand Government began a major reform of the health sector culminating with the enacting of the *Health and Disability Services Act 1993*. This legislation was based on the assumption that health services would be delivered more efficiently if the purchasing and providing of health services were separated and a competitive health market was allowed to develop. This led to the establishment of four Regional Health Authorities to purchase services. These four authorities were subsequently amalgamated into a single Health Funding Authority in 1998. Hospital services were restructured into 23 Crown Health Enterprises which, in 1998, were renamed Hospital and Health Services. These publicly-owned, limited liability companies provide hospital, related community and some public health services.

Before the legislation came into effect, the Health Reforms Directorate and New Zealand General Practitioners' Association jointly commissioned a report from the University of Auckland to consider the response of general practice to these changes in the organisation of the health sector (Auckland Uniservices 1992). The report recommended the formation of independent practitioner associations (IPAs) based on a North American model. In these organisations, general practitioners (GPs) came together to work collaboratively and take contracts with a Health Authority for the provision of primary medical care. This included general medical, maternity and immunisation services, along with responsibility for management of primary care laboratory and pharmaceutical expenditure.

In New Zealand today the large majority of primary health care services are delivered by general practices affiliated with an IPA. The two other forms of primary health care provision are non-IPA traditional GPs and the so-called 'third-sector' (non-government, not-for-profit) providers.

Independent practitioner associations

The predominant organisational form in New Zealand is the privately-owned general practice, in which the GPs belong to an IPA. These are groupings of doctors, usually constructed as limited liability companies or trusts, formed to act as umbrella organisations to take contracts with the Health Funding Authority for the provision of a range of primary care services. In May 1999, 83% of GPs belonged to an IPA (Houston, Coster & Wolff forthcoming).

The development of IPAs has been described in the literature (Malcolm & Powell 1996; Malcolm 1997a, 1997b). At the beginning of 1996 there were 42 IPAs, with an average membership of 38 GPs. By the end of 1996 there were 35 IPAs with an average membership of 54 GPs (ranging from large group practices to the central Auckland IPA with a membership of 340 GPs). In May this year there were 32 IPAs nationally and three similar organisations that do not consider themselves IPAs. Of the 35 IPAs, 25 completed a questionnaire; a response rate of 78%. Respondents came from organisations representing 2092 GPs caring for an estimated 3.1 million patients. Organisations covered between 10 500 and 500 000 patients with a mean of 130 000 patients and 87 GPs.

In 1999 nearly all IPAs hold budgets for laboratory and pharmaceutical expenditure. Significant savings have been achieved, in some cases up to 23% of total expenditure, with savings in most cases being shared equally between the IPA and Health Funding Authority. Savings have been used in a variety of ways including:

- payment to GPs to attend Continuing Medical Education courses
- IPA administration
- IPA information systems, and
- provision of additional services (such as free mammography, bone density and ultrasonography services, and health promotion services including smoking cessation and patient education).

Funding is also used:

- to salary 'pharmacy facilitators'
- to develop guidelines, in conjunction with GPs, for prescribing, visiting general practices and getting feedback on prescribing data
- to assist with GP information systems, and
- for practice nurse support.

IPAs and capitation

In 1996 about 20% of GPs were funded through capitation arrangements. Moreover, a survey by Malcolm indicated that more than 50% of IPAs supported capitation along with very strong support for patient registration (Malcolm & Powell 1996). *The Next Five Years in General Practice* (Scott 1998) signalled the intention of Government and the Health Funding Authority to develop new primary care contracts based on capitation. This was presented as 'population-based funding' and had the support of a wide variety of groups including IPAs and Maori provider groups. However many GPs in the consultation round associated with the document expressed opposition to capitation.

The reasons behind this are clear. With a capitation formula covering General Medical Services, immunisation, practice nursing subsidy, and laboratory and pharmaceutical

services based on average previous utilisation, it is likely that those GPs whose patients have had above-average access to that funding will experience decreased income. Conversely, GPs providing care to disadvantaged populations, who receive less than the expected amount of health resources, are likely to experience an increase in their income.

Malcolm and Powell (1996) have shown that within IPAs – and after adjusting for characteristics of practice populations such as age, gender, community services card and high-user health card – there is still wide residual variation when top and bottom practices are compared. The community services card entitles the holder to increased subsidies for medical visits and pharmaceuticals. A family qualifies on the basis of total family income adjusted for family size. The high-user health card also entitles the bearer to increased subsidies. Entitlement is on the basis of a high level of utilisation (12 paid visits per annum). Analysis shows that, for both laboratory and pharmaceutical services, the variation is almost entirely due to variation in volume and not price. It was concluded that high expenditure practices therefore see their patients more often, request more laboratory tests and prescribe more drugs than low expenditure practices.

CareNet

CareNet is a national primary care network claiming a membership of 383 GPs functioning as a provider organisation recognised by the Health Funding Authority. The stated goals of CareNet are:

- to provide health care that is high quality, clinically appropriate and cost effective
- to maintain a focus on patient health outcomes
- to maximise the benefits of GP-referred services, and
- to emphasise professional values rather than financial incentives.

CareNet is an Incorporated Society and has a not-for-profit status. It enables non-IPA GPs to collectively consult and contract with the Health Funding Authority on changes to proposed primary care strategies. Members remain on Section 51, a provision which allows doctors to be paid directly for the provision of services by the Health Funding Authority, and one of CareNet's major roles is in advocating for the continuation of Section 51 as an alternative to a national IPA contract.

CareNet argues that recent changes in funding of primary care have the potential to adversely affect the doctor–patient relationship. It will not hold budgets for laboratory or pharmaceutical expenditure and is opposed to capitation funding.

The third sector

The 'third sector' is the non-government, non-profit sector. In the New Zealand health sector, the major third sector providers are union-based health services and Maori tribally-based (iwi-based) health services. These organisations have developed as a

response to financial barriers to access for primary health care services, especially amongst low-income populations. Patient charges are typically very low compared with traditional general practice – often zero. Another motivation for the development of the third sector has been the desire of iwi and consumer groups to exercise more control over primary health care services.

The largest third sector organisation is Health Care Aotearoa, an umbrella group for around 30 separate providers. All Health Care Aotearoa members are capitation-funded and typically have a non-hierarchical management structure which includes community and staff representatives. All staff are salaried. Approximately 120 000 patients are registered with Health Care Aotearoa services with care being provided by primary care teams, including 63 GPs.

Community development models

It has been observed that the more participation local communities have in identifying both the health problem and in providing the solution, the more successful the interventions designed to reduce health status inequality are likely to be. The empowering of communities to act in this way has been called ‘community development’. There is a vast and growing literature in this area, much of it concerned with how to turn good theory into practice. The community development approach evolved from social reform movements in the 1960s and is relatively new to the health sector.

It should be emphasised that a community development approach to reducing health status inequality is not merely a community-based one. Community-based approaches are usually defined by external experts or institutions and involve the mobilisation of community resources to address an identified health problem. An example is an immunisation program delivered by multiple community agencies in response to an outbreak of meningococcal meningitis. In the community development paradigm, needs are identified by the community and resources made available to help the community meet those needs.

Some IPAs (for example, the Mangere Services Health Trust) are adopting the community development model; and the not-for-profit organisation HealthCare Aotearoa, with 120 000 registered patients, is explicitly encouraging this form of health care delivery and moving towards community ownership.

It is unclear whether community development should be integrated with the formalised systems of primary health care delivery currently evolving in New Zealand. We consider that, while space should be provided for such models to flourish (and to be evaluated),

the community development model would not be acceptable to the vast majority of health professionals in New Zealand at present.

Community-orientated primary care

Community-orientated primary care represents a less radical re-orientation of primary health care than community development, although in some contexts it may be regarded as a transitional organisational form. Power and resources are not transferred to the community but services are specifically provided to meet the measured needs of a defined community.

Community-orientated primary care uses epidemiological and clinical skills in a complementary fashion to tailor programs to meet the particular needs of a defined population (Starfield 1998). It gives specific recognition to the interaction between the various socioeconomic determinants of health as well as the overlap between the health services system and the social and individual behaviours that influence health.

Nutting and Connor (1986) say that a community-orientated approach applies the methods of clinical medicine, epidemiology, social sciences, health services research and evaluation to four tasks:

- defining and characterising the community
- identifying community health problems
- modifying programs to address these problems, and
- monitoring the effectiveness of the program modifications.

Intrinsic to this approach to primary health care is the continuing relationship between the community and the provider organisation, often described as 'longitudinality' of care.

Dr Tudor Hart, from a Welsh mining town, is regarded by many as the first GP in Great Britain to illustrate community-orientated primary care by taking responsibility for both community and clinical functions. His concept was that the community GP is a new type of physician engaged in local participatory democracy in the pursuit of the maximisation of health (Hart 1983). Mant and Anderson (1985) proposed that GPs accept responsibility for:

- the health of their patients and for publicising the results
- monitoring and controlling environmentally determined disease
- auditing the effectiveness of preventative programs, and
- evaluating the effects of medical interventions.

Primary care organisations adopting a community-orientated primary care model demonstrate a number of features. First, and critically, they assume responsibility for the health of populations. Those that are organised around a geographical area assume

responsibility for community-based services. Second, the GP becomes part of a team in primary care that is responsible for providing population-based care. As patients live longer and patterns of morbidity change in community settings, primary care organisations will be responsible for health promotion and maintenance of wellbeing. Third, GP training programs will become more concerned with population-based care. Fourth, attention will be drawn to community-orientated primary care as health planners recognise the ability of primary care organisations to work with communities to organise more efficiently in disease prevention and health promotion, using newer medical technologies in a responsible manner. Finally, advances in health information will inform communities regarding trends in health and disease and therefore allow planning for the health of communities.

Community-orientated primary care and public health

The margins between primary care and public health will become blurred in the future. It is anticipated that many of the functions of public health will become the responsibility of primary care organisations taking a population-based approach to health care.

The potential for collaboration between clinical medicine and public health was documented by a review of over 500 initiatives existing in the United States in the mid-1990s (Lasker 1997). Six types of synergies were identified:

- improving services by coordinating care for individuals
- improving access to care by establishing frameworks to provide services for the uninsured
- improving the quality and cost-effectiveness of services by applying a population perspective to medical practice
- using clinical practice to identify and address community health problems
- strengthening health promotion and health protection by mobilising community campaigns
- shaping the future direction of the health system by collaborating around policy, training and research.

The potential exists for community-orientated primary care to provide the functions of some public health needs through using different models in primary care organisations. Some primary care organisations are already conducting needs analysis and locality planning and taking responsibility for some of the previously held public health functions. This is mostly on a small scale, but they will be able to develop these responsibilities if given more support. This will require monitoring and evaluation to ensure that the public health is protected. Government policy will be the primary determinant of the direction of such change. However, there are indications that this change is already occurring and it may therefore be advisable to support and encourage, rather than retain models that do not foster innovation and development.

A model for primary health care in New Zealand

We believe that the general practice team can be significantly strengthened to achieve improvements in health outcomes. There will always be populations that need different methods of primary care delivery, such as extremely isolated communities. However, the vast majority of the primary health care needs of New Zealanders can be delivered through well-resourced primary health care teams that represent an evolution of the existing models.

Evolutionary change

The most promising model for delivering population-based outcomes relies upon capitation funding and patient enrolment. Capitation is necessary to allow primary care organisations to allocate resources in the most efficient and effective manner. In particular, capitation removes the financial incentive to deliver unnecessary services. In theory, capitation reduces incentives to over-service that fee-for-service funding encourages, and encourages preventative health care and health promotion. The extent to which this outcome is financially encouraged depends upon the level of patient co-payment. If providers derive significant income from co-payments, this benefit of capitation is lost. Co-payments should be as low as possible, and preferably zero.

Patient enrolment is essential to the logistics of capitation funding and philosophically desirable in order to make explicit the responsibility that a primary care organisation has for a population. People would enrol with a particular practice. Most practices already have practice registers and making these formal will soon be a relatively simple exercise. Perhaps the two most difficult aspects of implementation are managing the inevitable privacy issues (through extensive public consultation and information campaigns) and the identification and resolution of duplicate enrolments. Over 570 000 people are already formally enrolled with a primary practice either on capitation or block contracts.

The practice perspective

The required changes can be considered from a variety of perspectives. At the practice level, the key observation is that practice nurses are medically trained professionals whose skills are under-utilised. Legislative and educational initiatives are required to allow practice nurses to use their skills more fully.

There is widespread support for a more independent role for practice nurses within the primary care team, but GPs are wary of some of the necessary changes. Proposals such as nurse prescribing – while entirely logical in the context of maintenance therapy or expert management of chronic illnesses like diabetes and asthma – seem less carefully considered when applied to first presentations requiring general diagnostic skills. The realisation of the full potential of practice nurses as interdependent partners in the

primary care team must proceed with considerably more consultation with doctors and nurses than has occurred to date.

One consequence of moving towards population-based primary health care, particularly under a zero or low-fee capitation funding model, is that cost-shifting becomes more likely. A primary care team will be able to reduce costs (and therefore increase services or income) by taking decisions which require a different health care provider to deliver services. An example is the inappropriate use of hospital outpatient clinics. Improved information systems may assist in limiting cost-shifting by providing feedback to all primary care teams on their referral rates.

Another example of possible cost-shifting, that may be occurring now, is the use of district nursing services (community nursing). The move to population-based primary health care and the often overlapping roles of district and practice nurses, and some public health nurse functions, suggest that some consideration be given to establishing a 'primary care nurse' amalgamating these roles. Responsibility for patients discharged from hospital could then be immediately transferred to the primary health care team.

At the organisational level above the practice, we propose adaptation of the United Kingdom model of primary care groups, delivering primary care services to defined populations of around 100 000 people. We suggest the term 'primary care organisation', which is already beginning to be used in New Zealand.

Primary care organisations

The key elements of primary care organisations are a population-based approach for improving health outcomes including a program for health needs assessment, and frameworks for clinical governance and quality improvement. The primary care teams belonging to primary care organisations should use community-orientated primary care as defined earlier.

Primary care organisations may take a variety of forms to meet the structural needs of different provider and patient groups, including Maori. The primary care organisations will deliver community-orientated primary care to a defined population, typically the amalgamated registers of member primary health care teams.

Population-based approach for improving health outcomes

The primary care organisation model is designed from the outset to implement a population-based approach to improving health outcomes. By having explicit responsibility for a defined population, primary care organisations will evolve population-based responses for improving health outcomes. Some of these will evolve as the most effective ways of meeting contractual targets, whereas others may be explicitly specified in contracts. To implement the population-based approach primary care organisations will need to take the following actions:

- identify significant health inequalities within its population
- identify the local health services that can contribute to health gain for this population
- establish the cooperative structures necessary for inter-sectoral action
- consider how access to services can be improved to achieve the Government's medium-term health policy goals including fair access, effective delivery, patient satisfaction and improved health outcomes
- identify health provider workforce requirements to ensure that health services are delivered by the most appropriate health professional
- ensure that their primary care organisations is appropriately resourced to enable it to undertake the tasks that are required
- ensure that necessary information technology is in place to collect the required health data
- plan for the improvement of the health of the population
- involve the community in health improvement programs
- use population-based performance indicators to monitor health gain against targets.

There is a large base of skills and knowledge for performing these tasks within the public health sections of Hospital and Health Services. Formal liaison between Hospital and Health Services (public health) and primary care organisations will be essential. The demand for public health expertise will increase significantly.

Local health needs assessment is a growing area of research, and primary care organisations may need practical support to establish programs. The elements of a successful program include:

- comprehensive research on the demographics of the population
- analysis of the patterns of morbidity and mortality of the population
- analysis of health needs across that population (by survey, focus groups and expert advice from public health specialists)
- taking account of people in special circumstances (for example, the elderly, children at risk and the disabled), and
- sharing of the results of the health needs assessment within the primary care organisation.

Types of primary care organisations

The primary care organisation model is very flexible and all current primary care providers could work within it. IPAs (and Health Care Aotearoa) are already implementing some of its features. A few have made considerable advances in

establishing inter-sectoral cooperation and implementing community-oriented primary care.

One of the important features of the model is that there are no assumptions about the ownership, type of population served or geographical location of a primary care organisation. The only requirements that a primary care organisation must meet would be specified in a generic contract. They would include a list of the primary care services that had to be provided, but there would be no requirement that the services be delivered by a particular type of provider.

GPs and practice nurses would play key roles in providing many of the core primary care services that the state purchases (for example, primary care diagnosis, chronic disease management, palliative care, minor wound care). However primary care organisations could determine what other personnel were most appropriate to deliver the full set of services to their enrolled populations.

Maori health and the primary care organisation model

Another important feature of the primary care organisation model is that Maori providers may find it facilitates the development of health care delivery models which reflect Maori models of health. There are several models which describe Maori perspectives of health and wellbeing. The most frequently cited (Durie 1994) is Te Whare Tapa Wha (the four-sided house) incorporating four health components:

- *taha hinengaro* (emotions and mind)
- *taha wairua* (spirituality)
- *taha tinana* (body), and
- *taha whanau* (extended family).

Disruption in any one component can interfere with the wellbeing of other components.

In addition, a number of principles relating to health service delivery have been described. They include:

- *whaka piki* (enablement of client decision-making on service options)
- *whai wahi* (participation of clients, whanau and Maori institutions)
- *whakaruruhau* (safety, including both physical and non-physical safety)
- *putanga* (accessibility which requires good service information and service availability), and
- *whakawhanaungatanga* (integration by making links with other appropriate services).

Services which attempt to incorporate both Maori models of wellbeing and the principles given above, are more likely to be appropriate for and acceptable to Maori

and have greater opportunity to impact positively on their health. There is a risk of under-funding if, in a predominantly Maori population-based integrated care organisation, a capitation formula is used which does not take sufficient account of ethnicity and socioeconomic status.

We believe that primary care organisations as described here, implementing community-oriented primary care, could be highly effective in reaching the hard to reach. The extent to which they succeed will depend on their ability to form partnerships with the communities whose members are enrolled with them, and whether or not they are realistically funded.

A proposed funding model for primary care organisations

We noted above that patient enrolment is essential for capitation. Careful consideration must be given to the idea that people should have a right to choose a different health care provider for different services, and rights of access in this regard will need to be made explicit. Unsubsidised access to any provider would be unrestricted. Furthermore if there was sufficient demand for a specific mix of health care services, a provider might offer that mix and an individual could then enrol with that provider.

The funding model would involve a global budget for primary health care, including medical services, pharmaceuticals and pathology tests. The country would be divided into areas of need based on epidemiological data (such as standardised mortality ratios or a deprivation index). High-need areas would receive a greater global budget.

This type of geographical targeting provides a straightforward and transparent mechanism for shifting resources to areas of existing health disadvantage. It could also be used to give more resources to rural health care providers, whose difficult environment has been well described (Coster 1999). The resource shifts are of two distinct types – first, existing providers would receive more resources to provide health services, and second, there would be an incentive for providers to relocate to areas where subsidies were higher.

To be able to receive a capitation payment, primary health care providers must be able to provide a minimum set of services. There would be no restriction on the ownership of the provider group. If a primary care organisation can provide the minimum set of services, they are eligible for funding. They merely have to prove that a set of people wish to enrol with them to receive the associated funding. Capitation payments, from the budget already set for an area, would be adjusted for age and gender, and need. We propose that ethnicity and chronic illness, at least asthma and diabetes, be used to define need at the individual patient level.

Under this model, primary care organisations that were providing services to (say) predominantly Maori populations would receive more funding, everything else being equal. Funders could expect an inventory of the extra services being purchased. In the case of chronic illness, a schedule of services that would be provided could be attached to contracts.

In return for receiving a capitation payment providers would agree to provide services at no charge to the user. In exceptional circumstances a small fee could be charged, the maximum level being set in contracts (say, \$10). It is important that a co-payment is possible to prevent vexatious use of services. This is a relatively infrequent but a real problem in day-to-day general practice, and the lack of the ability to charge a small co-payment has been a criticism of the United Kingdom's capitated GP system. If the amount is small and discretionary, it should not pose a significant access barrier.

To maintain provider incomes at present levels, significant additional government expenditure on primary health care would be needed – perhaps in the order of NZ\$250–\$300 million. The past experience of doctors in New Zealand with general medical subsidies means that any proposal that limits co-payments will be regarded with suspicion. Some doctors oppose limiting co-payments on philosophical grounds as unjustified and/or undesirable price control in a market. Limiting co-payments will always be unacceptable to this group.

A more significant proportion of doctors have observed the general medical subsidies decline over many years both in relative and absolute terms (to zero in the case of adults not holding community services cards) and see limiting co-payments as restricting options for income maintenance. In agreeing to limits on co-payments, primary care organisations should be assured that the capitation level will keep pace with inflation. This could be achieved by incorporating inflation adjustment of the total capitation budget into the enabling legislation.

Conclusion

In the absence of a unifying strategy, New Zealand's primary care sector is at great risk of pathological fragmentation. The competitive models encouraged by the health reforms of the early 1990s have not delivered improved outcomes. However, the emergence of IPAs and other health provider organisations has presented an opportunity to refocus the primary sector on population-based outcomes. We have presented a concept (the primary care organisation) and a philosophy (community-oriented primary care) that recognise the existing structural features and relationships of contemporary primary health care in New Zealand. They could deliver improved quality health services (particularly to disadvantaged groups), raise overall health status and reduce health status inequality.

Note

This article is a summary of work commissioned by the New Zealand National Health Committee as one of six papers to examine evidence of benefit for population-based approaches in primary health care; in particular strategies to reach deprived populations. The other papers in this series can be obtained from Dr Hazel Lewis (<hazel_lewis@moh.govt.nz>).

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Commentary

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A future for primary health care in New Zealand

The article by Barry Gribben and Gregor Coster argues for a major but incremental shift at the primary care level from independent practitioner associations (IPAs) to primary care organisations (PCOs) based on a community model. The authors discuss the organisation and provision of services, but the fundamental reform proposed is a financing one. The article expands on a model proposed by Malcolm (1998) as an inevitable consequence of the direction of New Zealand reforms over the last decade.

Resource shifts

Two main types of resource shifts are proposed. The first is from hospital to community-based services, and the second is from user-pays to government-funded primary care within a capitated model for general practice.

The combination of a capitation model and no co-payments effectively fixes general practitioner (GP) incomes. The capitation model also requires linked populations (and possibly unique patient identifiers) – two issues on the table in New Zealand but shunned in Australia by the consumer lobby. The consequences of fixing GP incomes would be enormous, particularly if that income is essentially government controlled. In Australia such an approach at the local level would be politically difficult. The Australian approach has been to limit the government exposure through a financing agreement that allows privately determined fees to remain. In this case the government outlay is limited (albeit still with some growth capacity), but patients are still exposed to potential out of pocket expenses – limited at present by a highly competitive market.

The article talks of funding general practice directly. As in Australia the funding currently goes via patients through a reimbursement process unless a capitation approach is taken. In New Zealand, GPs can control demand through price signals as the population is used to a significant patient moiety. In Australia a highly competitive market has seen a floor price reached at the reimbursement levels for the bulk of services – creating a push for volume as a compensatory mechanism in income maintenance.

A critical part of the reform process is that any 'savings' are reinvested into the health system – in this sense the IPA work represents a resource shift initiative rather than a savings as such – and this is alluded to later in the article. This is similar to the general practice financing agreement recently signed in Australia, which prevents money allocated to general practice from being shifted to other areas of the health system, unless the signatories agree, *and* allows general practice to access 'savings' generated through a range of activities such as improved quality of prescribing.

The article outlines the diversity of sizes and models of IPAs. Contrasts with Australian Divisions of General Practice are inevitable. In this sense the analysis by Malcolm (1998) is useful. The acceptance by New Zealand GPs that they have a responsibility and accountability function with respect to government health spending is not present in Australia to a significant degree. Indeed, the diversity of Divisions of General Practice in size complexity and philosophy makes it difficult to implement across-the-board programs. The New Zealand approach suggested would require more uniformity. Another complication is the need for Australian GPs to interact both as individuals and collectively with two tiers of government – State and Federal – as well as area health authorities in some jurisdictions.

The proposed functions for PCOs are very similar to those of Divisions of General Practice, notwithstanding individual variation. This is not surprising given the almost global trend to primary care-led reform in most Organisation for Economic Cooperation and Development (OECD) countries (Saltman & Figueras 1997). However, the article does not mention the importance of an evidence-based approach and the need for an evaluation and research agenda.

Another problem facing both countries is that the focus on financing reform may be at the expense of debate around what is it that we (as a society) actually want from our health system. That is, what are these dollars actually buying and does this need to be the same across the system? How do we encourage 'best buys'?

The issue of community responsibility is important – are GP funds a community resource? If so, what role does a community play in deciding the use of those funds? Is this the intersection of general practice and population health? Particularly relevant are the opportunities/challenges that role poses for health promotion and maintenance of wellbeing at a population level and moving into individual care scenarios. Perhaps this illustrates the complexities that have been created by past silo thinking on health care and perpetuated in current funding arrangements – that is, funding institutions not people.

This idea is well illustrated in the article in the section on community-oriented primary care and public health. The authors assert that governments will be the primary agent of change – this is partially right. Governments can only set the framework. Change of this nature requires engagement of providers if it is to succeed. Indeed, one could argue that it also needs the support of the community. Certainly in Australia substantial

changes to Medicare would be politically courageous as it has a high level of consumer support.

A pluralistic model is advocated by the authors. This is the only possible way to go with a locally diverse set of arrangements. The model acknowledges that even those who are not supportive of the general direction of reforms need to be given the opportunity to participate in the reform process – hence the CareNet proposal.

The authors call for multidisciplinary teamwork, and advocate for an exchange of clinical territory. Whilst this may be logical and even economically sensible, it may be politically difficult to achieve and would be anathema in Australia to many practising GPs.

The discussion on cost-shifting seems to imply that this is intrinsically bad. There are two issues that are worth considering here. First, is cost-shifting just a health manager's game to produce a better bottom line ('if I can get someone else to fund this, then great') or is it a function of the market-place in making resource allocation adjustments at the local level to compensate for the local inadequacies of high level policies and budget allocations? Second, does it matter if mechanisms are in place to measure the cost-shifting and manage the risks to the relevant funders? In Australia the Commonwealth Government has managed this risk through a series of agreements with other parties, including the Australian Health Care Agreements with the States and funding agreements with provider groups such as radiologists, pharmacists, pathologists and, now, general practitioners. It is important that in managing the Commonwealth risk that managing cost blowouts are not to the detriment of consumers.

Overall the article provides some interesting ideas for primary care-led reform, New Zealand style. It should be transposed to the Australian setting with caution. Despite this caveat there are some debates stimulated by the article in which Australia should be engaged.

References

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