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2 March 2026

s 9(2)(a)

By email: s 9(2)(a)
Ref: H2026078234

Tēnā koe s 9(2)(a)

Response to your request for official information

Thank you for your request under the Official Information Act 1982 (the Act) to the Ministry of Health – Manatū Hauora (the Ministry) on 3 February 2026 for information regarding the Primary Health Care Strategy 2001. You requested:

“Ministerial briefings, cabinet papers, consultation papers, and submissions that fed into the development of the Primary Health Care Strategy 2001 and its implementation.”

On 9 February 2026 you refined your request to:

“Yes, I am happy to refine the request to only documents from 1999-2001. I am only interested in documents relating to the creation of the strategy itself until the release of the strategy in 2001.”

I have identified 13 documents in scope of your refined request. These documents are itemised in Appendix 1 of this letter, and copies of the documents are enclosed. All documents have been released to you in full.

In addition, a consultation paper from December 2000 which was published by the National Health Committee may be of interest to you. This was advice to the Minister of Health which was produced independently from the Ministry and contributed to the development of the Strategy in 2001. You can find this here:

<https://ndhadeliver.natlib.govt.nz/webarchive/20090411193716/http://www.nhc.health.govt.nz/moh.nsf/indexcm/nhc-improving-health-phc?Open>.

I trust this information fulfils your request.

If you wish to discuss any aspect of your request with us, including this decision, please feel free to contact the OIA Services Team on: oiagr@health.govt.nz.

Under section 28(3) of the Act, you have the right to ask the Ombudsman to review any decisions made under this request. The Ombudsman may be contacted by email at: info@ombudsman.parliament.nz or by calling 0800 802 602.

Please note that this response, with your personal details removed, will be published on the Ministry website at: www.health.govt.nz/about-ministry/information-releases/responses-official-information-act-requests.

Nāku noa, nā

A handwritten signature in blue ink, appearing to read 'Caleb Johnstone', is positioned above the printed name.

Caleb Johnstone

Group Manager Strategy

Policy and Legislation | Te Pou Rautaki

Appendix 1: List of documents for release

#	Date	Document details	Decision on release
1	10 August 1999	Health Report: Primary Care Strategy (HC01-16-0)	Released in full.
2	21 January 2000	Health Report: Primary Health Care Strategy Discussion Document (HC50-07-36)	
3	February 2000	Consultation paper: New Zealand Health Strategy Discussion Paper 1 – Primary Health Care Towards 2010	
4	2 February 2000	Health Report: Cabinet Business Committee paper about releasing the Primary Health Care Strategy document	
5	7 February 2000	Cabinet paper and Minute: Primary Health Care Strategy: Release of Discussion Paper SPH (00) 1	
6	10 February 2000	Health Report: Cabinet paper on release of the Primary Health Care Strategy discussion document	
7	17 March 2000	Health Report: Amended version of primary care discussion document (HC50-07-26)	
8	19 June 2000	Health Report: Preliminary information about Primary care organisations (HC01-16-4)	
9	September 2000	Report on the submissions to <i>The Future Shape of Primary Health Care: A discussion document</i> (HC01-16-4)	
10	1 September 2000	Health Report: Summary of responses to the future shape of primary health care	
11	30 November 2000	Cabinet paper and minute: The Primary Health Care Strategy SPH (00) 189	
12	11 December 2000	Cabinet Minute: Primary Health Care Strategy CAB (00) M 41/6	
13	November 2001	Minimum Requirements for PHOs	

991235



HEALTH REPORT COVER SHEET

Subject: Primary Care Strategy

Date: 10 August 1999

File Ref: HC01-16-0

Attention: Hon Wyatt Creech

Copy to: Hon Georgina te Heuheu
Hon Tuariki Delamere

	Action Sought	Deadline
Minister of Health	Note the contents of this report	
Associate Ministers of Health	Note the contents of this report	

Contact for telephone discussion (if required)

Name	Position	Telephone Direct Line	After Hours	Suggested First Contact
Marilyn Goddard	Portfolio Manager, Sector Strategy	496 2325	472 2507	1
Cathryn Ashley-Jones	Director, Policy	496 2199	475 4007	2

Purpose

The purpose of this report is to brief you on the proposed project plan for the development of a primary care strategy.

Background Information

In May 1998, the Health Funding Authority (HFA) produced a document "The Next Five Years in General Practice", which called for submissions on the proposals. Despite the fact that the HFA specifically set out to address only general practice, there was criticism that the document did not address wider primary sector issues. The proposal to gradually shift from paying GPs a fee for each service to payments based on the number of enrolled patients ("capitation") drew a polarised response with both strong support and opposition. The HFA decided not to proceed with the controversial parts of the strategy.

Instead the HFA is now concentrating on developing contracts with primary care providers which are more flexible and can be used for different organisations, can accommodate different payment mechanisms, and can incorporate special projects and targeted services.

Briefing papers dated 23 February 1999 prepared for you by Mason Durie, Chair of the National Health Committee (NHC), set out the specific projects the NHC is currently working on, including its work on primary care. This year the National Health Committee (NHC) commissioned six individual pieces of work on primary care to examine the evidence for a need to change from a number of perspectives. The focus was on population based approaches in primary care settings to achieve improvement in health status, particularly for disadvantaged groups. They include primary care models for delivering population based health outcomes, third sector primary health care, Maori, Pacific, nursing, and economic and community development. The NHC plans to make these documents available to the sector as background papers in September. Each paper represents the views of the authors and does not necessarily reflect the opinion of the NHC. The papers will be useful background material for the Ministry's primary care strategy project.

In June 1999, you met with representatives from the New Zealand Medical Association who are strong advocates of the need for a primary care strategy. We understand that you have subsequently indicated to them your support for the development of such a strategy and have asked the Ministry to undertake this project.

Primary Care Strategy

The Ministry proposes to work jointly with the HFA and have invited them to second a member of their staff to the Ministry to work with us. The key points of the strategy project plan are:

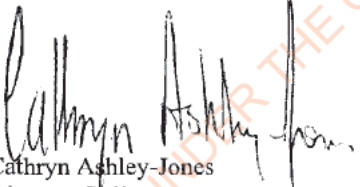
- the objective is to produce a strategy which will ensure access for all to first level care and support services that are comprehensive, continuing, co-ordinated and involved with the health of a population

- the scope of the project will include services (health education, prevention, support for self help, diagnosis and treatment, managing chronic conditions, terminal care); access including cost to individuals; issues around community and population health; demand management and referral; and appropriate skill mix
- phase one of the project will include analysis of developments in the sector, a review of existing material and international experience and development of an outline discussion document - end of September 1999
- phase two will involve discussions with key interested organisations and individuals to produce a definitive discussion document - end of November 1999
- phase three will involve publication of the discussion document and a consultation process - end of February 2000
- phase four will produce a recommended primary care strategy

Recommendation

It is recommended that you:

Agree that the Ministry proceed with the development of a primary care strategy with the aim of having a draft outline of a discussion document by the end of September 1999 for consultation with interested sector groups.


Cathryn Ashley-Jones
Director, Policy

Yes/No


MINISTERS SIGNATURE:

DATE:

Quality of Policy Advice Rating

Not Applicable	Poor	Fair	Satisfactory	Good	Excellent

**SIGNED COPY NOT
SIGHTED FOR SCANNING**



MANATU HAUORA

Dispatched 25 January 2000

000034

HEALTH REPORT COVER SHEET

Subject: Primary Health Care Strategy Discussion Document

Date: 21 January 2000 **File Ref:** HC50-07-26

Attention: Hon Annette King (Minister of Health)

Copy to: Hon Ruth Dyson (Associate Minister of Health)
Hon Tariana Turia (Associate Minister of Health)

Output Class:

	Action Sought	Deadline
Hon Annette King (Minister of Health)	Agree to release the discussion document	
Hon Ruth Dyson (Associate Minister of Health)	Note	
Hon Tariana Turia (Associate Minister of Health)	Note	

Contact for telephone discussion (if required)

Name	Position	Telephone		Suggested First Contact
		Direct Line	After Hours	
Philip Davies	Deputy Director-general, Policy	2320		1
John Marwick	Senior adviser	2052	562 8801	2
Mark Booth	Senior analyst	2347		3

Primary Health Care Strategy Discussion Document

Purpose of Report

This report seeks your approval to release a discussion paper on the Primary Health Care Strategy.

Background

The Ministry of Health has been working on the Primary Health Care Strategy since before the recent election and submitted a draft discussion document to you as one of several briefing papers in December. At a meeting with the Royal New Zealand College of General Practitioners on 21 December 1999 you asked that the Ministry should prepare the discussion document for release in January.

According to Government policy, the Ministry has now started to develop the wider New Zealand Health Strategy. The Primary Health Care Strategy document will form a discussion paper as part of the development of the New Zealand Health Strategy.

An edited and restructured version of the discussion document "Primary Health Care: Towards 2010" is attached.

Comment

The strategy emphasises population approaches and people affiliating with a provider

The strategy aims for a system that can help improve health status, reduce disparities and unnecessary hospitalisation, and be able to meet future challenges. People would affiliate with a primary health care provider (not usually a single practitioner). These providers would, through service agreements with the District Health Board, take responsibility for making sure their affiliated populations received a comprehensive set of services to improve, maintain and restore their health. Provider organisations would be funded by the Board according to the needs of the people they were serving and would be required to work towards national and district plans.

Various organisational forms are possible for providers

The strategy does not prescribe a particular organisational form for primary care providers. They could be community owned and led (like community trusts, Māori organisations, or the Union health centres). Or they might be provider led (like Independent Practitioner Associations, some proposals from publicly owned hospitals, or ideas from some nursing groups). While various forms are possible, the key issues would be the requirements and accountabilities specified in agreements with District Health Boards.

The approach is consistent with previous developments and with Labour's manifesto

The approach is consistent with recent developments in the Health Funding Authority's (HFA) primary care contracting process and with key parts of the HFA's 1998 proposed strategy for general practice. Emphasis on population approaches and reaching the more disadvantaged groups are the key aims of the National Health Committee's consultation with the sector on primary health care. The Committee will report separately about that. The strategy is aligned with various proposals in the Labour Party manifesto - especially the idea that primary health care should be funded according to the population served (capitation funding).

New services will be specified and funded by capitation - but there may be transitional costs

Under the strategy, primary health care providers will be asked to undertake new responsibilities such as increased health education and prevention, monitoring health needs, managing budgets for primary referred services and so on. Detailed implementation work has already been started by the HFA to specify these services, negotiate service agreements, and establish prices with primary care organisations. At present much primary care spending is driven by demands on the system since it is linked to individual consultations, prescription items and other items of service. The strategy proposes funding primary care provider groups according to the needs of the population rather than the number of services given. This will mean some redistribution from groups that currently are 'over-funded' to those that receive less. The new services and the transitional process to move towards equitable funding is likely to involve additional expenditure in the short to medium term (though there may be savings elsewhere over a longer period). Further work will be required to quantify and timetable such expenditure and identify to what extent it can be met from within existing funds.

Defining the relationship with District Health Boards

Clarifying the nature, structure and operations of District Health Boards will be part of the broader work programme associated with sector design. In relation to primary health care there will be issues such as:

- the roles of primary health care committees;
- Boards' responsibilities and freedom in terms of district planning;
- the extent to which District Health Boards have power to set, change or add to national primary health care service definitions and funding levels;
- how to ensure that the optimal balance is struck between primary and secondary care (without the Board being dominated by its secondary care provider role);
- ways to ensure that, if primary care organisations are given responsibility for meeting the needs of an affiliated population, their voice can be heard at the District level.

Discussions and submissions in response to the Primary Health Care Strategy paper will be an important contribution to New Zealand Health Strategy planning.

Release of the strategy document

The attached document contains a proposed forward by the Minister. There is a feedback section that sets out the discussion process and contains a number of issues on which we seek particular comment. The Ministry recommends that you authorise the release of the document in mid-February. This is the earliest date that a final version can be prepared for distribution (the attached draft needs further editing work). Wide circulation is proposed to interested community groups, primary care providers, hospitals, professional groups, academic institutions and interested individuals. Preliminary discussions indicate good support for the strategy's approach. You may wish to make a public release of the document with media releases. A possible occasion would be the national IPA network meeting that you will be speaking at on 18th February in Wellington. Three weeks lead time is required to print the document.

Recommendations

It is recommended that you:

1. **Indicate** whether you wish to meet with officials to discuss the Primary Health Care Strategy.

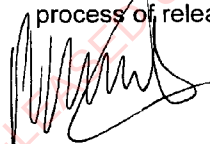
Yes/No

2. **Approve** the release of the discussion document "Primary Health Care Towards 2010" on 18th February 2000.

Yes/No

3. **Indicate** whether you wish the Ministry to work with your office about the process of releasing the document on that date.

Yes/No



Philip Davies
Deputy Director-General
Policy Branch

MINISTERS SIGNATURE:

DATE:

Quality of Policy Advice Rating

Not Applicable	Poor	Fair	Satisfactory	Good	Excellent

New Zealand Health Strategy Discussion Paper 1

Primary Health Care Towards 2010

Hon Annette King
Minister of Health

107386

February 2000

MCH Library



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Foreword

The Primary Health Care Strategy is the first step in the development of the New Zealand Health Strategy. This Government is committed to working with all interested people to create a quality health service to meet New Zealanders' needs.



In New Zealand we can be proud of the care provided by GPs, nurses, midwives, pharmacists, Māori health workers and many others. Every day well over 50,000 children and adults receive advice, treatment and care from primary health care professionals and most are highly satisfied by the quality of the service.

The state of New Zealanders' health continues to be concerning. Despite improvements, recent studies show that improvements in our health have not kept pace with those enjoyed by people in other comparable countries. We still have high levels of preventable illness and avoidable hospital admissions.

A strong primary health care system is crucial. Good primary health care takes responsibility for meeting the needs of the people served, and working closely with local communities. As well as responding when people are worried or sick, primary health services should educate and support people to improve their health, prevent illness, and support them to look after themselves and their families. Services need to be conveniently available to all – yet there should also be continuity over time and co-ordination between different providers.

A strong primary health care strategy is central to the Government's overall health strategy for the country. Primary health care services and funding must be consistent with and contribute to the Government's overall goals as well as addressing needs and priorities determined by District Health Boards. The primary health care strategy lays down a framework that will contribute to the development of plans by the Ministry of Health, District Health Boards, local communities and providers of primary health care.

Some people will find concepts that are unfamiliar, others ideas that are challenging. I am very interested to hear all responses to make sure that the proposed system is one that will really make a difference.

Submissions on this document will form part of the work on the New Zealand Health Strategy. The Feedback section (page vi) contains a set of questions and issues that will help when you are considering your response. The Ministry of Health will be collecting responses, consulting on the strategy, and reporting to me. Please take the time to carefully consider the proposals and express your views.

Hon Annette King
MINISTER OF HEALTH

Feedback

This Primary Health Care Strategy is the first part of a New Zealand Health Strategy which the Government plans to release for consultation later this year. Comments from this discussion document will be used in preparing the overall strategy.

This discussion document is being widely distributed among primary health care providers, Hospital and Health Services, organisations and individuals with an interest in primary care, and the general public. Meetings will be held with interested parties.

Written submissions are invited from organisations and individuals. If sent on behalf of an organisation, please indicate the position of the person within the organisation making or signing the submission and indicate the extent of the consultation, discussion and support within the organisation for the opinions and advice expressed.

Individual submissions should indicate any connection the writer has to primary health, whether as a patient or a provider, and should give the name of any primary care organisation that the writer belongs to.

Comments on any aspects of the strategy are welcomed. The questions below cover some specific issues where comment is sought. It would be helpful if submissions are presented according to these questions, to those areas you are addressing or according to specific chapters of the strategy.

Submissions should be sent to: Primary Health Care Strategy Consultation
Policy Group
Ministry of Health
PO Box 5013
WELLINGTON

faxed: (04) 496 2342

e-mailed: PHCS Consult@moh.govt.nz

This document Primary Health Care Towards 2010 and questions are also posted on the Minister of Health web site. Submissions can be made via the Internet:
www.moh.govt.nz/primarycare.html

The closing date for submissions is Friday 28 April 2000.

Question 1

This document gives a vision of how primary health care will be for people using it in 2010 (page 16).

What do you think of this vision?

Question 2

The strategy recommends that all people who wish to access Government-subsidised services are affiliated with one lead provider (page 26). They will still be free to seek care elsewhere, for example, for a second opinion or when sensitive problems are involved.

Note that a 'provider' is most likely to be an organisation and not a single practitioner. What do you think of the requirement that people must be affiliated with one provider if they are to access Government-subsidised primary health care services?

Question 3

The strategy recommends that providers link with other providers in primary care organisations of various kinds (page 29).

Comment on primary care organisations and what forms they should take.

Question 4

Primary care organisations will be required to take responsibility for meeting the primary health care needs of their affiliated population (page 20).

What comments do you have on this population-based approach?

Question 5

This document outlines a variety of services that a primary care organisation or an individual service provider would be responsible for providing (page 22).

What do you think about this list of services? Would you extend or reduce this list? What about services for mental health, disability support, and public health?

Question 6

The strategy recommends that there should be nationally consistent minimum levels of access to first-line primary health care services when needed (page 30).

What comments do you have about such levels and how they should be specified?

Question 7

The strategy recommends that primary care organisations be funded to provide a specified set of services on the basis of the health needs of their affiliated population (page 32).

What is your opinion of this method of funding?

Question 8

The strategy seeks greater co-ordination or integration of services (page 24). Greater co-ordination with secondary services is envisaged.

Is co-ordination an appropriate role for primary health care and, if so, how should it progress?

Question 9

The strategy suggests that there will be a greater emphasis on quality at the level of the provider and the organisations involved in funding and delivering health care services (page 26).

Please comment on issues to do with ensuring quality.

Question 10

The strategy recommends that the special relationship between the Crown and Māori should be reflected in service agreements with primary health care providers (page 29).

What comments do you have about how this strategy will meet the needs of Māori?

11 Other issues

We welcome comment on any issue. Other issues that you may think appropriate for comment include:

- the role of Government in promoting primary health care organisations;
- future relationships between primary health care providers and the District Health Boards;
- confidentiality issues;
- the expectation that more information on self-help will be easily available for people to use self-help;
- greater emphasis on information systems.

Summary

This document sets out a proposed strategy for primary health care. Primary health care is the first level of contact people have with the health system and has a strong emphasis of working with communities to improve health, prevent illness and offer supportive care as well as assessing and treating acute problems. Services are provided by a range of organisations and individuals – including health workers educating and supporting local communities; those providing information and advice services; and many doctors, nurses, midwives and other professionals who assess, treat and care for individuals and families over many years.

This strategy will be a key part of an overall New Zealand Health Strategy. The Minister of Health is seeking submissions from all those interested in improving New Zealand's health system. The Feedback section (page v) identifies a number of questions and key issues on which specific comment is sought and details the process for making your views known.

Chapter 1 (page 8) sets out why we need a strategy for primary health care. Chapters 2 to 4 (pages 16 to 33) present the strategy itself: first a picture of what the future system would be like for those using it, looking in more detail at what is entailed, and finally signalling how the changes can be achieved.

Chapter 1: Why we need a primary health care strategy (page 8)

Chapter 1 discusses the health problems and challenges that New Zealand faces. It shows how recent developments by some primary health care providers and their communities have started to address these problems and challenges. The need for an overall national strategy to give these changes a direction that is consistent with the Government's overall health strategy and with District Health Boards' plans is considered.

Problems that must be addressed (page 8)

When compared with the majority of the world's population, New Zealanders have good health status and access to high quality health care. When measured against our own high standards, however, and against the standards of similar economies around the world, there are areas of concern. These concerns include:

- disparities in health status between different groups
- high levels of preventable illness
- high levels of avoidable hospital admissions
- apparent barriers for some people in accessing primary health care services.

Changes that will affect primary health care (page 10)

Over the next 10 years there will be significant changes in New Zealand society and health services. These changes must be taken into account in planning for future primary health care. The significant changes include:

- the continuing trend towards treating patients in community settings with hospital stays being increasingly brief and intensive

- changes in the balance of our population, particularly the increasing numbers of older people and an increase in the proportion of Māori and Pacific peoples
- changes in social patterns including increasing urbanisation and mobilisation, changing work patterns, and changes in family structures
- alterations in the burden of disease and disability with more emphasis on diseases of old age, increased mental health problems, high rates of diabetes, and possible re-emergence of certain diseases
- advances in key fields such as genetics, pharmaceuticals, surgical techniques and information technology.

Recent primary health care changes need a focus (page 12)

The organisation and the delivery of primary health care services have been evolving over several years. A national strategy will set out a clear statement of the direction for future developments.

The major trends that are discussed are:

- the establishment of new organisations of primary health care providers (organisational groupings not just practitioners) including Independent Practitioner Associations (IPAs), rural community trusts, and Māori providers
- the changing roles and boundaries for many primary care professionals including nurses, pharmacists, midwives and GPs
- the increase in the number and variety of services provided by Māori for Māori
- a similar, but slower, growth of Pacific services for Pacific peoples
- greater emphasis on mental health in the community and in the role of primary health care in providing services
- the changing perception of disability and alterations in disability support services delivered in the community
- a growing emphasis on population-based services; matching care to community needs and greater attention to health improvement and disease prevention
- the development of links between communities and primary care providers
- increased co-ordination and integration between primary health care and other parts of health and other relevant sectors such as education and social welfare
- an increasing emphasis on targeting services to those at need through both individual subsidies and the development of population-based services.

Chapter 2: A vision for primary health care (page 16)

This chapter paints a picture of what primary care provision might be like in 2010 when today's weaknesses have been eliminated, tomorrow's challenges have been met and the opportunities for positive change have been realised.

- There will be a broader view of health, and people's expectations of the problems that primary care can address will continue to grow. They will expect providers to draw on a wide range of skills and to work alongside other agencies to meet their needs.

- People will be affiliated with an organisation of primary care providers of their choice. It will take responsibility for the primary health care needs of its affiliated population and will ensure effective means for its communities to participate in shaping health services.
- People will need and expect a wider range of services from their providers including advice on remaining healthy as well as advice and assistance when they are unwell or concerned. Providers will monitor the health of the population to identify people at risk.
- New technology will make it easier for people to play an active part in monitoring their own health and they will become more expert in assessing their own health needs. Practitioners will treat more people in the community rather than in hospital and expertise will be shared.
- There will be a wider range of services that will be available at more flexible times. Practitioners will have greater access to patients' histories and use sophisticated best practice guidelines to help them plan treatment.
- As medical equipment becomes cheaper and more widely available, first contact services will be able to offer a more comprehensive range of services than is currently the case. Primary care providers will link with specialists to increase the range of services that can be delivered in the primary setting. Co-ordination will be improved and funding applied to ensure the right care, in the right place, by the most appropriate provider.
- The diversity of individuals and organisations who provide primary health care will continue to grow. All provider organisations will be comprehensive, deliver appropriate and quality services, and be committed to supporting the public health system.
- Funding will be distributed according to the identified need of the population. Some people will continue to pay for primary health care services and Government subsidies are likely to be targeted to those with the greatest need.

Chapter 3: Looking closely at the primary health care vision (page 20)

The vision described in Chapter 2 is a significant evolution from the current primary health care system. There are eight key features that will be associated with the new primary health care system. Primary health care will:

Reflect the needs of those it serves and Government goals (page 20)

A key change will be the move from a system that is largely set up to respond to individuals who seek care to one that actively ensures that services meet the needs of the population. This will place more emphasis on health education, disease prevention, supporting self-care and support for those with ongoing problems. It will also mean providers take responsibility for reaching those who may miss out on care they need.

People will be required to affiliate with a primary health care provider and this will establish the population for each provider. Government will establish national goals, District Health Boards will determine needs at the district level and providers will then be expected to involve the population in the process of meeting the needs of the affiliated population.

Provide comprehensive services to maintain, restore and improve people's health (page 22)

People need primary care services that take a broad view of health covering physical (taha tinana), mental (taha hinengaro), social (taha whānau) and spiritual (taha wairua) aspects. These services will cover the range of health education, disease prevention, support for self-care, diagnosis, treatment, ongoing care, rehabilitation and referral.

To improve health outcomes, primary health care providers must put more emphasis on health promotion and disease prevention. To do this, accountability based on evidence about what works, appropriate incentives and good accountability methods will be needed.

In most cases the appropriate services for first contact advice and care will continue to be general practice services. However, other providers will continue to be involved. The delivery of more specific services such as well child services, maternity care, physiotherapy or family planning require specialised competencies often outside the role of a generalist practitioner. There must be careful specifications and protections to ensure that people continue to receive these services from current providers but with better links to the rest of primary care. With an ageing population there will also be a demand for ongoing care and support skills. Appropriately skilled practitioners and infrastructure will be needed.

Provide appropriate and accessible services (page 23)

It will be necessary to pay close attention to how easily people access services. Evidence suggests that most people are able to access first contact services when they need them. However, some people do face barriers to access.

- Some rural areas have difficulty attracting and retaining primary care providers.
- Māori and some people on low incomes appear to consult less frequently than their health status would suggest is necessary. This may help explain New Zealand's high rate of avoidable hospitalisations.
- Services such as midwifery may not be sufficiently accessible and the numbers of midwives may not be sufficient in the future.

Ensure effective co-ordination of care (page 24)

From an individual's perspective, care should be provided by the most appropriate practitioners in the most appropriate setting. Studies of the patterns of disease and ease of access justify this approach.

Effective co-ordination should ensure consistent advice, avoidance of duplication of treatment, effective distribution of resources among providers and systems which prevent people 'falling through the cracks' between different providers. Greater co-ordination would improve the quality of service and reduce confusion for users.

Primary care should involve co-ordination among a wide range of community-based services. Currently services such as community nursing, mental health nursing and family planning often operate completely separately. Links between primary and secondary care are often limited. Secondary and primary services will co-operate to prevent avoidable hospitalisations and to improve co-ordination between services when people leave hospital.

Many of the health problems that New Zealand faces are concentrated in areas of deprivation. Greater co-ordination is needed between the sectors, for example, health and housing which

influence wellbeing. Primary care has an important role to play in co-ordinating these services using techniques such as case management and facilitating communication.

Provide continuity of care over time and across episodes of ill health (page 25)

Continuity of care means that a person has a usual source of care, whether by an individual or a team. Continuity improves management of chronic, complex or unclear problems. It determines the extent to which a holistic approach to treatment can be adopted. Research indicates continuity of primary health care is associated with better preventative care, better recognition of problems, better patient compliance, fewer hospitalisations and lower total costs.

Continuity of care will be improved when people are affiliated to a primary care provider as they will know who has responsibility for them. While most people can identify a usual source of first contact care, some appear on more than one provider's list of enrolled patients. A system of affiliation must be flexible enough to allow people freedom of choice between providers, although one provider will retain a lead role.

Be of the highest quality consistent with available resources (page 26)

Individuals should have access to a high quality primary health care system where the quality of care is consistent across the country. Clinical governance (involvement of practitioners in monitoring and, where necessary, altering each other's standards) will be accepted as the norm. Practice will be based on the best available evidence and this will be readily available to practitioners (and patients who wish it) at the time clinical decisions are made. Practitioners will be able to compare their performance with that of colleagues and use the information they gain to make changes to practice where desirable.

Ensure that resources are fairly distributed according to need (page 26)

The current system does not ensure the allocation of resources to providers working in the areas of greatest need. Public resources will be distributed according to need, and areas with the highest level of need will receive proportionately more resources. These resources will be distributed according to a formula based on the size and characteristics of the population covered.

Primary care providers who are delivering individual and population services will receive a fixed amount of money for each patient, weighted to reflect the needs of the population. This system of funding will facilitate population-based approaches to health care and the use of appropriate skills. This change will not mean that practitioners will all be paid in one particular way.

Acknowledge and respond to the special relationship between Māori and the Crown (page 27)

Healthy whānau, hapū and iwi are critical to the future of Māori development. Māori require support to be able to nurture their people. Primary health care with an emphasis on wellbeing, community and disease prevention has a critical role to play in improving Māori health status and advancing Māori development. Additional strategies will need to be developed to ensure Māori reach their potential.

The Government acknowledges the special relationship between Māori and the Crown that exists under the Treaty of Waitangi. This relationship extends to a need to consult with Māori in the development of primary health care.

Chapter 4: Moving forward – how changes can be made (page 28)

The strategy is designed to develop a primary care system where providers are paid to deliver a defined range of services to defined levels of quality to an affiliated population. This chapter explains changes that are needed to achieve the vision.

Who will primary health care providers be serving? (page 28)

Individuals who seek subsidised care will be required to affiliate with a particular primary care provider of their choice. They will be entitled to change providers without difficulty and, although they will only affiliate with one provider at a time, they will be free to seek care elsewhere for a second opinion or when sensitive problems are involved. Primary health care providers will be expected to play a larger part in assessing and meeting their population's needs within the priorities set out by the Government and the District Health Board plans.

The ways the population assessment will be done requires further consideration. Factors to be considered when choosing a method of assessment will include its effectiveness, the relationship between this method of assessment and other forms of assessment such as those used for disability support services (DSS), the levels of skill available to conduct it, and the level and type of detail required.

Primary care providers will also be expected to encourage relationships between the primary health care system and the community. There are various ways that this might happen including giving members of the community a greater role as advisors or as part of the governance system.

Affiliation, however determined, will increase the need for good information systems.

Who will be providing the services? (page 29)

This strategy does not describe how providers and communities will organise and structure themselves. This will depend on the circumstances and characteristics of the affiliated population. However, it is likely that in order to provide the range of services required, practitioners who are not a part of larger organisation will need to establish networks with other providers.

The Government will ensure that taxpayer funds are used to improve health and health services. While providers can legitimately receive a fair reward for their work and level of investment, all organisations will be expected to explicitly address the goals of the District Health Boards and to be fully accountable in using Government funds.

District Health Boards (DHBs) will cover a geographic area and be responsible for all publicly funded health services delivered to the populations they serve. They will have service agreements with primary health care providers. It is not presently envisaged that they will become primary health providers themselves.

All primary health care professionals who receive public funding will be part of a primary health care organisation. How professionals and organisations work together may differ. For example, an organisation may be led by a community group that contracts with different independent providers or may be owned and led by professionals.

What services should be provided? (page 30)

The Government will expect primary health care providers to provide a minimum range of services (as outlined in chapter 3, page 22) to prescribed quality standards. Standards will be determined and defined in consultation with users, professional bodies, providers, funders and Government. Accreditation of providers and practices is likely to be the norm.

Co-ordination of services will bring together a number of different provider agencies. Primary care providers may become strong advocates of the need for co-ordination with other sectors such as education and justice which also impact on people's wellbeing. More intensive co-ordination provision arrangements may be needed in areas of deprivation to address underlying causes of ill health, such as poor nutrition and poor housing.

Information transfer and sharing of information among providers on an 'as required' basis will facilitate effective service delivery (subject to the agreement of the people affected). Safeguards around information will be developed.

How should the services be paid for? (page 32)

The issues and changes discussed in the strategy will impact on and be influenced by future funding arrangements.

- A system for funding according to the needs of the population served will be required. This will reflect the relative needs of each patient taking into account factors such as the age, sex, ethnicity, socioeconomic status and health of the affiliated population.
- Maternity services will have separate funding arrangements to ensure that women continue to have the choice of independent midwifery services that has been available since the Nurses Amendment Act 1990.
- The current system of targeted part charges will be reviewed to improve effectiveness. Subsidies should ensure that any fees do not pose a threat to people's health. Providers will be expected to document their compliance with measures to ensure affordability.
- Public funding will allow some flexibility to address the problems created by funds being isolated and tied to particular practitioners, services and/or organisations.

Managing and funding change (page 33)

Although the vision is for 2010, some changes will occur earlier. A focused management process will be needed to ensure the users and providers of primary health care services are informed and encouraged to take part. Some early development funding will be necessary, and clear identification of costs and how they will be met is essential to the strategy's success.

Chapter 1: Why a Primary Health Care Strategy?

Primary health care is the first level of contact that people have with the health system and has a strong emphasis of working with communities to improve health, prevent illness and offer supportive care as well as assessing and treating acute problems. Services are provided by a range of organisations and individuals – including health workers educating and supporting local communities; those providing information and advice services; and many doctors, nurses, midwives and other professionals who assess, treat and care for individuals and families over many years. A well-developed primary health care system is crucial to improving the country's health.

This chapter discusses the health problems and challenges that New Zealand faces and considers some of the developments in primary health care services that form the basis of the proposed strategy. It shows that there are now many different practitioners involved with providing the full range of educational, preventive, supportive and treatment services and that primary health care providers have been established, including a number of practitioners from different disciplines.

Problems that must be addressed

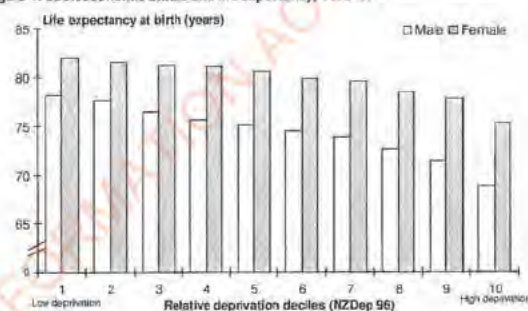
There can be no doubt that when compared with the majority of the world's population, New Zealanders have good health status and have access to high quality health care. When measured against our own high standards and against the standards of similar economies around the world, however, there are areas of concern. These concerns include disparities in health between different groups, high levels of preventable illness, hospital admissions that could be avoided, and apparent barriers for some in accessing primary health care services. Each of these problems is discussed further below.

Disparities in health status

In many respects most New Zealanders are healthier than at any time in the past and, as a result, we live longer. For example, between 1950/52 and 1995/97 life expectancy has risen from 71.3 to 79.6 years for females and from 67.2 years to 74.3 years for males. While this increase is impressive, New Zealand is lagging behind countries such as Canada, Australia and the UK. (Our life expectancy has increased by 7–8 percent since 1960 whereas in other countries increases range from 8 to 11 percent. Men and women in Australia, for example, can now expect to live 1.3 and 1.7 years longer than in New Zealand.) In addition, recent analysis has identified inequalities at both an ethnic and a socioeconomic level (Ministry of Health 2000).

Figure 1 shows the relationship between socioeconomic group (as shown by New Zealand deprivation scores) and life expectancy. For males, life expectancy at birth varies from 68.9 years for the most deprived to 78.1 years for the least – a difference of 9.2 years. For females, a similar relationship exists, with a difference of 6.7 years of life expectancy between the highest and lowest groups.

Figure 1: Socioeconomic status and life expectancy, 1996–97



Source: Ministry of Health 2000

When comparing the health status of different groups of New Zealanders, there are marked differences between Māori and non-Māori. Pacific peoples also have a lower health status on average when compared with other groups. The reasons for low health status are complex, and are related to a variety of factors including levels of economic activity, poor levels of educational attainment, and housing. The inability of services to meet the needs of their consumers and, in some cases, cultural 'inappropriateness' are also important.

Preventable illness

The above section highlights differences in health status, yet illness can be potentially avoidable by modifications in lifestyle and/or delivery of health services. The Ministry of Health's *Our Health, Our Future* study (Ministry of Health 2000) has estimated that approximately 70 percent of premature mortality in individuals aged under 75 is potentially avoidable. This means that the majority of these deaths could be avoided principally through individual behaviour change or population level intervention. Avoidable morbidity (ill health rather than death) is more difficult to assess, although avoidable hospitalisations can be used as a good indication.

Avoidable hospitalisations

Avoidable hospitalisations fall into two categories: those avoidable through the use of population-based health promotion strategies, and those avoidable by the use of specific health service interventions such as vaccination. The *Our Health, Our Future* study estimates that one-third of total hospitalisations in the 0–74 age group fall into one of these two categories.

Barriers in accessing primary health care services

Primary health care services are the most frequently used health services. The Ministry of Health's national health survey for 1996/97 showed that in a year 80 percent of New Zealanders visited a GP at least once, 44 percent a pharmacist (for health advice or to obtain

medicines), 25 percent a nurse or midwife, 14 percent physiotherapist, and less than 10 percent for other types of primary health care practitioners (Ministry of Health 1999d). These patterns of use had changed little from the previous survey in 1992/93 (Ministry of Health and Statistics 1993).

General practice services (general practitioners and practice nurses) are the most commonly used services. Government funding of general practice was \$276 million in 1997/98. When the subsidies paid for prescribed medicines and diagnostic tests are included, a total of \$1.2 billion was spent (Ministry of Health 1999e). It is important to look at whether these funds are reaching people with the greatest need.

Comparisons of how frequently different groups of people use services must take account of differences in their health (since less healthy people clearly have greater need for services). Analysis of the health survey data shows that Māori visit a health professional less than would be expected given their lower health status (Scott et al 2000). Moreover, this finding is *not* explained by Māori people's lower average incomes – it is presumably related to cultural rather than financial factors.

Unlike the comparison between Māori and non-Māori, people on low incomes are as likely to see a GP at least once during the year as are those on higher incomes (after adjusting for health status). However, those on low incomes are less likely to be in the group who only see the GP once or twice in the year compared to those on higher incomes. Holding a Community Services Card (Government subsidy) mitigates this effect of low income and cardholders tend to be over-represented in the high-frequency users of GP services. Some cost barriers remain, however, since the health survey also showed that 8 percent of people said that in the previous year cost caused them to miss seeing a GP when they needed to (Ministry of Health 1999d).

Changes that will affect primary health care

Over the next 10 years there will be significant changes in New Zealand society. These changes must be taken into account in planning for future primary health care.

Ongoing change in where care is provided

The last 20 years have seen a reduction in the length of time that people spend in hospital for acute services, although actual volumes of discharges have increased. Figures 2 and 3 illustrate these trends. This increase in throughput has occurred at the same time as continued deinstitutionalisation, the move to support people with disabilities (many with complex needs) in the community rather than in an institutional setting, and the introduction of home support services. These have all had significant impacts on primary health care in terms of the type and volumes of work carried out and the staff needed to carry out that work.

Figure 2: Average length of hospital stay, 1988/89–1996/97

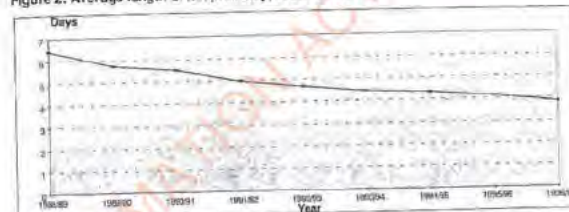
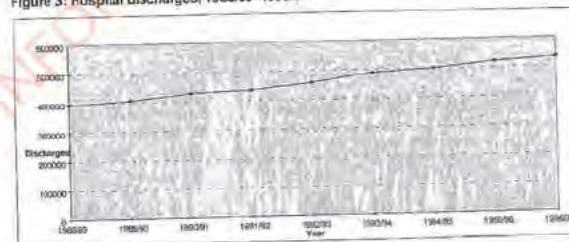


Figure 3: Hospital discharges, 1988/89–1996/97



Demographic and social factors

In common with similar nations, New Zealand is slowly moving towards an ageing population. There is evidence that older people will become relatively more healthy but that there will be an increase in the 'frail elderly', who will display complex multi-system problems at a more advanced age.

An overall ageing of the population hides some significant differences between sub-groups of the population. Māori and Pacific populations are younger than the rest of the population and Pacific peoples have significantly higher fertility rates. These differences mean that projected ageing changes will lead to changes in the ethnic mix of the population, with an increase in the proportion of Māori and Pacific peoples. There is also expected to be increasing numbers of people of Asian descent.

Other social changes that will impact on primary health care include:

- an increased trend towards urbanisation
- moves towards a more mobile lifestyle, in terms of geographical mobility of individuals and their families
- changing work patterns, with the notion of a single 'job for life' no longer accepted and no compulsory retirement age
- changing family patterns with, for example, increased numbers of single-parent families.

Epidemiological factors

An older population brings an increase in particular ailments, particularly of the musculoskeletal system, and an increase in the impact of dementia and depression. There is a projected increase in diabetes and there may be continued re-emergence of certain diseases such as tuberculosis. There will be issues around the ageing of people with disabilities, for example, those with intellectual disabilities who may now live longer than previously and require high levels of community support.

Technical advances

Technical advances will continue to have considerable impact upon health services. Advances are expected particularly in the fields of genetics, pharmaceuticals and surgical techniques, and these will continue the trend towards shorter and more intensive hospital stays. Miniaturisation, automation and the development of expert computer systems will allow more services to be provided in the home and other community settings by a variety of health professionals.

New, cheaper and more available information systems will allow patients to get better access to health information from a variety of sources and increase their ability to manage their own health care. These changes will also enable much better transfer of information between health care providers and will allow improved co-ordination, increased communication and better monitoring of the health of individuals and populations.

Recent primary health care changes need a focus

The organisation and delivery of primary health care services have been evolving over several years. Changes have often developed in a piecemeal way and have only been available to certain groups of the population. Moreover, changes sometimes overlap or conflict, and various groups have called for a clear statement of direction.

Some recent changes are outlined below. They have been chosen after discussions with individuals and groups in the sector, and a review of the information and literature. The themes described here are not a complete or definitive list. They have been chosen as they are consistent with the direction of the strategy proposed in this document.

These changes are described in greater detail in Appendix 1 (page 34).

The development of new forms of primary health care provision

There has been significant growth in the types of organisation for primary health care providers. Approximately 80 percent of GPs have formed Independent Practitioner Associations (IPAs) for contracting purposes. These associations manage the budgets for pharmaceuticals and laboratory tests. There are various different ownership, governance and management arrangements with some being companies, others incorporated societies, non-profit trusts, or partnerships (Malcolm 1999b). Malcolm reports that almost all IPAs are opposed to the concept of retaining savings from their budgets as personal profits.

Another change in general practice funding is the growth in the number of practitioners who receive their Government funds according to the number of subsidised patients they have registered rather than by a fee for every service they provide to these patients. Such capitation

arrangements were first introduced some years ago (Sedlow et al 1983) but have grown in recent years until now some 15 percent of practitioners are paid that way (Ministry of Health 1998d).

A strong 'third sector' of non-Government, non-profit-making organisations with a community focus has emerged (Crampton 1999). These include some organisations that provide primary medical and nursing services, health services provided for Māori by Māori, and various patient support groups. Other organisational developments include the emergence of rural trusts, nurse-led organisations, midwifery groups and Pacific 'friendly' organisations.

The changing role of primary care providers

At the same time the 1990s have seen many changes in the roles and tasks of primary care providers. GPs are affected by new guidelines for clinical performance, increased information and administrative demands, new technologies, the shift of some work from hospital to community and the need for new preventive care and education activities. Nurses have had an increasing responsibility in primary care practices and some have established themselves as nurse practitioners.

Pharmacists have found their role as providers of information on pharmaceuticals and self-care increasing. This change is promoted by their organisations. There has been a rapid increase in the number of independent midwives following the Nurses Amendment Act 1990 that permitted them to practise independently.

The role of these and other providers such as public health professionals, alternative carers and psychologists continues to change. This change is leading to a redefinition of both professional boundaries and the boundaries of primary health care.

New ways of delivering services for Māori

There has been a tenfold increase in the number of Māori providers over the last five years. A wide and growing range of primary care services are being provided.

These services include those focusing on health promotion and education, disability support services, mental health services, traditional healing services, and intervention and clinical services.

The delivery of services for Pacific peoples

Studies have shown that services provided by Pacific providers can address many of the health problems of Pacific peoples. New initiatives are emerging, particularly in the Auckland region. These services include general practices that involve a wide range of providers including practice nurses and community health workers, services focused on women and health promotion services.

Changes in primary health care for people with mental health problems

Today there is greater recognition of mental health problems, and the number of people with mental health problems living in the community has increased as a result of deinstitutionalisation. This has led to an increased need for education, prevention and early intervention.

These changes have increased the need for primary mental health care providers such as GPs and Māori health workers to be able to understand and treat people with mental health problems in the community. Training for these professionals is increasing. Many different services provide mental health care and there has been an increase in co-operation and integration among some of these services.

New ways of delivering disability support services

Nowadays disability support services are mostly being delivered in the community. Having a disability is not the same as being sick. People with disabilities require an approach that integrates medical interventions with the delivery of broader social and disability support services. Responding to these changes has led to an increased role for voluntary organisations, home support workers and daycare services.

This has led in turn to an increase in the skill demanded and a related emphasis on increased training. As is the case with mental health services, many different services and providers are involved with individuals. There has been an increase in the integration of these services.

Developing a population-based approach

The current emphasis in primary health care is typically on one-to-one interactions between providers and patients that are usually the result of the patient's choice. This pattern does not facilitate the delivery of population-based services such as prevention and provision of health care information.

However, an increasing number of providers are involved in providing services for populations. Some organisations, including Māori providers and rural organisations such as Hauora Hokianga, identify the populations that they serve and provide a range of population-based services. Most general practices have lists of patients to whom they regularly provide services and in some cases is the basis of the Government funding they receive (i.e. capitation funding).

Building links with the community

GPs and other primary care providers are increasingly interested in taking an active role in the community. This involvement can include activities such as taking part in public meetings, regular written communication with patients or surveying community views. A few organisations include patient and community representatives in the governance of their organisations.

Increasing co-ordination and integration of care

The nature of primary care provision has often meant that a wide range of providers and services are involved with an individual or group. This has had the potential for duplication of services, lack of continuity of care and confusion for the patient.

Increasingly primary care providers are seeking to co-operate and integrate their services to reduce the likelihood of this happening. Some providers are developing links with secondary services and with other sectors, for example, education and housing which can impact on a person's wellbeing.

An increasing number of providers are working to extend the range of co-ordination among their organisations. Some of these developments bring together different providers working in one area such as elder care. Others focus on disease management and/or developing links with the community.

Targeting those in need

The present range of public subsidies for primary care services are targeted according to a mixture of income and age factors. Subsidies have lowered the barriers to consultation for some people although there is evidence that significant barriers remain for others.

Various services have developed for populations (rather than individuals) in need. These include a growth in Māori services for Māori, services for those with low incomes such as the Union Health Care Clinics and broad support for rural providers. Recently communities and providers in deprived areas, such as South Auckland and Porirua, are looking to develop more co-ordinated services.

Chapter 2: A Vision for Primary Health Care

Chapter 1 pointed out how current health inequalities and levels of preventable illness pose challenges for primary health care in the future. It went on to describe developments over the last decade, many of which have come from providers and communities driven by the desire to address these problems. In this chapter we paint a picture of what primary health care might be like in 10 years' time, when today's weaknesses have been eliminated, tomorrow's challenges met and the opportunities for positive change realised.

A broader view of health ...

In the future, people will live even more varied lifestyles than they do today. Social structures will continue to evolve and the notion of a 'typical' Kiwi or an 'average' family will lose meaning. It will become increasingly difficult to disentangle the various factors that impact on people's wellbeing.

Tony is a single parent. When his primary health care nurse is checking through the latest list of overdue immunisations, the computer alerts her to the fact that his children have been attending various practitioners very frequently for minor conditions. When Tony brings his youngest in for her immunisation, the nurse finds out that he has major budgeting and housing problems.

The nurse shows Tony how to find information about his entitlements on his home Internet connection. She puts him in touch with the budget and housing advice centre, and plans to see him at home when she next has a visiting day.

As a result, people will expect primary health care to reflect a broad view of health. They will look to primary health care to help them deal with a wide range of problems, and they will expect providers to be able to draw on a varied range of skills and knowledge to do so.

People will want providers to consider their needs as a whole person and to be able to deal with the wider determinants of health.

Where necessary, they will expect primary health care services to work alongside agencies from outside the traditional health sector – such as education, recreation and housing providers – to meet their needs.

... calls for providers linked to populations ...

People will be affiliated with a primary health care provider organisation of their choice. The organisation will be responsible for fulfilling the Government's goals and District Health Board plans. It will be responsible for knowing the people it serves, and planning services to meet their needs.

The organisation will take responsibility for knowing and reaching everyone in the affiliated population rather than only reacting when people seek service. Organisations will ensure that they have effective ways for their communities to participate in shaping health services.

... providing a wider range of services ...

Primary health care providers will supply people with the information and assistance they need to lead a full life and to achieve their maximum potential, regardless of any disability or chronic disease. They will ensure people know how to keep healthy and will offer them appropriate screening, prevention and health checks. Providers will monitor the health of the population to see where people are at risk.

People will not only look to primary health care when they are unwell, but will also see it as offering them and their families a longer-term relationship for advice and support. Such longer-term support may be particularly important for people who are living with chronic diseases or permanent disabilities.

When someone feels unwell, is anxious about their health or the health of a family member, a range of advice and triage services will be accessible by telephone or via the Internet. These services will offer expert guidance on health and sickness and will suggest how individuals can best deal with specific problems or concerns.

... supported by new technology ...

Jean, a generally fit 87-year-old widow, has a deep cough after a bout of the flu. Her doctor's diagnosis of basal pneumonia is confirmed by a low radiation portable imager and analyser; the associated specialist telelink is not needed.

Since she lives alone, Jean spends three days in the primary health care centre's inpatient unit, where she responds to treatment. She is followed up at home by a community nurse with repeat imaging and home blood analysis to ensure she is fully recovered.

Cheap – but sophisticated – equipment and information access will become widely available and make it easier for people to monitor aspects of their own health status and be alerted when expert help is needed. People will continue to become more informed about health and illness and this will alter – though not necessarily reduce – the role of the professional.

Information technology will make it much easier for people to maintain contact with primary health care providers. Various practitioners will be better able to communicate and share information.

The use of technology will make home and community care safer and more affordable. It will be backed up when appropriate by computer-assisted analysis and by links to distant technical expertise and advice.

... with greater choice and more convenience ...

When they are unwell or alerted to a potential health problem, people will be able to access the services they need to understand their condition and, where possible, be restored to good health. To do so, they will call on readily available, appropriate and convenient first contact health services. There will be a greater choice of such services, and a wider range of health professionals will be involved in delivering them. They will be comprehensive in scope but tailored more closely to meet individuals' preferences. Many services will be provided under the auspices of the organisation that the individual is affiliated with – though some services, like maternity care, sexual health and family planning may be provided by other providers, and there will be choice of providers for second opinions and for conditions that are especially sensitive.

Services will be delivered more conveniently. They will be available at times that tie in with people's other commitments and in places that are easily accessible, such as homes, schools, shopping malls or places of work. To meet demands for greater flexibility in service delivery, providers will need to have ready access to relevant past history and sophisticated 'best practice' guidelines. They will do so by accessing relevant computerised databases (with patients' permission), or by means of patient-held records. Technological developments will provide confidential, secure and convenient access to a vast range of information. Integrated electronic clinical records will improve the safety and quality of care and support opportunistic care by prompting practitioners about treatment and diagnosis during consultations.

... and better co-ordination ...

As medical equipment becomes both 'smarter' and cheaper, first contact service providers will be able to offer a more comprehensive range of primary health care services themselves. These will include some that are currently viewed as part of secondary care.

In some cases, access to more specialist expertise and to other primary care providers will continue to be required. In this case primary health care providers will have formal links and referral arrangements to allow access to those who can deliver the service(s). As a result, they will be able to communicate and share relevant records to ensure effective co-ordination of care.

At the District Health Board level funding too will be co-ordinated across primary and secondary services so that it can be applied in the most effective way to provide the right care, in the right place, by the most appropriate provider. Responsibility for secondary care will not be devolved to primary care organisations.

... among diverse providers ...

All parties, whether they are Government-owned, non-Government organisations, groupings of health professionals, or privately owned providers must be committed to supporting the public health system and the Government's goals in health.

The Government will ensure that all provider organisations deliver services that are both comprehensive in scope and of appropriate quality.

Tai, who is 76, has had diabetes for 20 years and despite diet, medication and careful monitoring he is now showing signs of kidney and eye damage. His complex health needs are mostly provided by the health team (community workers, nurses and doctors) at the local iwi-owned health centre. They monitor his progress physically, mentally and socially.

He has had several specialist interventions over the years and may require more. A joint plan has been established with specialist input to maximise Tai's independence and ensure that interventions are optimally timed.

Tracey has just given birth to her second child. Tracey's independent midwife is concerned that her post-natal depression screening score is high. She refers her to a psychologist and puts her in touch with the local new parents' support group.

Four weeks after the birth the midwife hands over her care to her GP and the nurse who will be the team continuing primary health care for Tracey and the baby.

... with continued Government funding

The Government will continue to be the dominant funder of health care services. Funding for primary health care in the future will be distributed according to the identified needs of the populations served, taking account of such things as age, sex, socioeconomic status, ethnicity and (possibly) the prevalence of disease and disability.

While people will still pay some charges for primary health care services, these will be structured so as not to create barriers to getting advice and care at an early stage. This will mean addressing the costs of non-GP care such as that given by psychologists, counsellors or physiotherapists where their involvement is part of the best practice team for the client. Government subsidies will continue to be targeted at those with the greatest need.

Chapter 3: Looking Closely at the Primary Health Care Vision

The vision we have presented of primary health care in 2010 is a significant evolution from our current system. Its key features can be understood in terms of the following eight characteristics. Primary health care will:

- reflect the needs of those it serves
- provide comprehensive services to maintain, restore and improve people's health
- provide appropriate and accessible services
- ensure effective co-ordination of care
- provide continuity of care over time and across episodes of ill health
- be of the highest quality consistent with available resources
- ensure resources are fairly distributed according to need
- acknowledge and respond to the special relationship between Māori and the Crown.

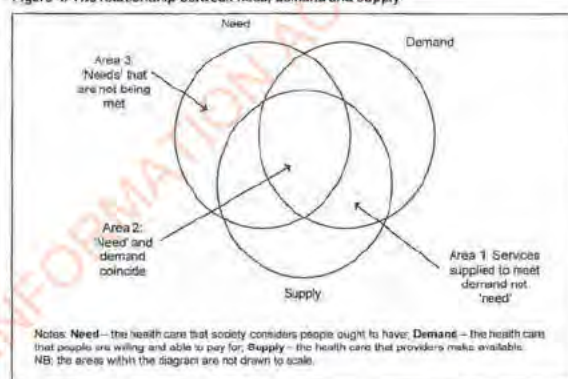
Each of these characteristics is described in detail below.

Reflect the needs of those it serves and Government goals

At present many primary health care providers simply provide services in response to user demand. Primary health care providers are not required to address the needs of those who do not consult; no organisation clearly carries this responsibility for the population. There is no explicit targeting of individuals who are not seen by the system but who may be those in greatest need of the services it offers.

The concept of reflecting needs is explored in Figure 3, which looks at the relationship of need, demand and supply. At the current time primary health care in New Zealand is principally focused on areas 1 and 2. Area 3 represents services such as health promotion, preventive care and earlier intervention. Gains are possible here, but people miss out on receiving care either because they are unaware of the benefits, the barriers they face are too great or, under current arrangements, no primary health care provider has responsibility for supplying services that reach people.

Figure 4: The relationship between need, demand and supply



Primary health care at its most effective reflects and caters for the needs of the population it serves, takes account of local priorities, and assumes a degree of responsibility for community health outcomes. The concept is not new to New Zealand. The population approach was a strong theme of the Action for Health and Independence conference sponsored by the Ministry of Health in November 1998, and lies behind much international thinking.

This increased emphasis on meeting the needs of the population is consistent with the District Health Boards that are to be established. Boards will have a responsibility for meeting health service needs of those living in their district. They will plan district services to meet national targets. Under this strategy, primary health care providers will be key players in achieving the district's health goals.

If primary health care providers are to take responsibility for matching services to the health needs of a population and to district plans, they must know who the members of this population are. People will need to affiliate with a provider. The provider will then be able to set up ways to assess the needs and preferences of the affiliated population and reflect these in the services provided.

Some current New Zealand primary health care providers closely involve their communities in the planning and operation of primary health care services (Crompton 1999). Others increasingly encourage community participation in service planning. Such links with communities range from the primary health care sector involving communities in articulating and defining their needs, to community ownership of primary health care services. Interested communities should be encouraged to become involved with primary health care and providers should be responsive to those who affiliate with them. However, there are strengths in allowing providers and communities to develop this in ways that best suit them.

Provide comprehensive services to maintain, restore and improve people's health

People need primary health care services that take a broad view, covering physical (taha tinana), mental (taha hinengaro), social (taha whānau) and spiritual (taha wairua) aspects. Services, which may not all be provided directly by providers from the same primary care organisation, include:

- health promotion and education (to individual and population groups)
- population health monitoring
- prevention (including, for example, well child and family planning services)
- patient education, information and support for self-help (for example, phone services, Internet, pharmacy advice)
- early intervention in physical and mental health problems
- assessment of undifferentiated problems (for example, by GPs and practice nurses)
- treatment of most problems without referral (including associated tests and prescriptions)
- first level assessment and treatment in more narrowly focused situations (for example, primary mental health services, disability assessment, maternity care)
- rehabilitation (as appropriate for first level and community care)
- treatment in consultation with experts from secondary services
- support and care for ongoing conditions (including chronic disease and physical and psychiatric disability)
- referral where necessary (when more specialised expertise is needed).

To improve health outcomes, primary health care providers must put more emphasis on health promotion and disease prevention. But this must be done with care. Before any preventive activity can be recommended, good evidence of its effectiveness in a particular population is needed. The dangers of introducing preventive activities without good evidence include:

- inappropriate reassurance from false negative results
- unnecessary anxiety and risky interventions from false positives
- detecting conditions that cannot adequately be treated
- intervening earlier but with no overall gain in outcome
- achieving benefits but at too high a cost to either the individual or others in the population who miss out.

Evidence shows that primary health care can play an effective part both in large scale screening and preventive programmes (Smaile et al 1996) and in effecting some change in people's lifestyle choices (Ashenden et al 1997). However, at present there is significant variation between providers and individual practitioners in the preventive activities they provide (Williams et al 1999). Achieving a greater emphasis on these activities will need clearer specification in service agreements based on evidence about what works, appropriate incentive arrangements, and good accountability methods.

Appropriate services in future will include support for people to self-manage minor illness appropriately, or to manage within the family/whānau. As modern technology makes more information directly accessible, people may manage more problems by themselves. Some

information services are already operating (Plunketline), and others are being tested (Healthline). Development of such services – as well as increasing use of the Internet – is an international trend.

In most cases the appropriate services for first contact advice and care will continue to be general services. International evidence (Chande et al 1996; Martin et al 1989; Moore 1979; Forrest et al 1996) suggests there are advantages in having generalist practitioners as the first level of face-to-face contact with the health system. They can assess problems and are usually able to offer treatment without the need for referral to other services in the majority of cases. This system tends to be more efficient in terms of ensuring appropriate use of expensive secondary treatment.

However, primary health care also covers services for a range of situations that are more narrowly focused. These are services directed towards a particular sub-group, as with well child services and primary level maternity care; or particular types of services, such as physiotherapy, psychotherapy, counselling, family planning advice and sexual health care. Covering this range of services requires a particular set of skills that are often outside the competence of the generalist practitioner. There must be careful specifications and protections to ensure that people continue to receive these services from current providers but with better links with the rest of primary care.

To meet some of the other challenges of the future, such as our ageing population, increasing emphasis needs to be placed on continuing care and support services. These aim to maximise independence and prevent deterioration for those with chronic conditions and disabilities. Appropriately skilled practitioners and infrastructure will also be needed for these tasks.

At the other end of the spectrum, primary health care services will be working much more closely with hospital-based services to identify and prevent avoidable admissions to hospital and to support people after a stay in hospital – particularly as hospital stays get shorter. In particular, primary providers of mental health services will work more closely with secondary mental health services.

Provide appropriate and accessible services

Achieving the vision of fully developed primary health care means paying attention to how easily people are able to access services. This needs to address barriers related to availability (number and distribution of services), affordability and cultural appropriateness.

Most people at present seem to be able to access generalist first contact services (mostly doctors and nurses working together in general practices) when they need to (Ministry of Health 1999b). However, some people do face barriers and poor availability of these general services and there may be access problems for other primary health care services.

For example, while the overall ratio of patients to GPs in New Zealand is average compared with OECD countries (OECD 1999), there are some rural areas that have difficulty in attracting and retaining health professionals. Current requirements about availability need to be more clearly specified so that people, especially those living in small communities, have greater certainty about the availability of primary services.

New Zealand rates for ambulatory care (GP and outpatient visits) are in the lower third of OECD countries (OECD 1999). There are indications of cultural and cost barriers for some New Zealanders seeing GPs. While Māori and Pacific peoples consult as frequently as others overall, when adjustment is made for differences in the Māori population's age, income and

health status, Māori consult less frequently than would be expected (Scott et al 2000). People with lower incomes tend to be under-represented in the group who visit the doctor only once or twice a year (after adjustment for other factors). Lower income and Māori or Pacific peoples also report higher rates of not seeing doctors when needed because of cost (Ministry of Health 1999d). These findings may be relevant to our high rates of some avoidable hospitalisations (Ministry of Health 2000). They suggest that affordability, access and cultural barriers mean that some people who are usually fairly healthy (and infrequent users of GP services) are not getting help early enough when they do develop symptoms.

Ensure effective co-ordination of care

Optimal care for the individual requires co-ordination when more than one practitioner is involved. From the individual's point of view care should be given by the most appropriately skilled provider in the most appropriate place. This may sometimes involve a multidisciplinary team, which may in turn require a co-ordinated management plan being developed. This co-ordination should appear seamless to the patient.

Effective co-ordination should ensure:

- no duplication of tests and treatments
- consistent advice
- that resources across various providers of care are used most economically for the individual and for members of the wider population
- that people/patients do not 'fall through the cracks' between providers.

Primary health care should involve co-ordination of a wide range of community-based services. Services such as community nursing, mental health nursing, maternity services, well child services, family planning, and sexual health services currently operate separately. Some are linked to a hospital base, others are operated by non-Government organisations (NGOs), while some are offered in general practices or by other private providers. Co-ordination could improve the quality of the service, reduce confusion for the users, increase effectiveness and consistency of approach, reduce duplication, and improve efficiency.

In addition, co-ordination is required between primary and secondary care services. This is particularly clear in some areas of high need such as South Auckland, where the demand on secondary care services has increased rapidly for conditions that could be avoided with better and more timely access to appropriate primary health care (for example, flu vaccinations might reduce respiratory admissions, early access to antibiotics would reduce admissions for rheumatic fever, better home monitoring could identify deterioration in cardiac failure at an earlier stage). In other areas, closer co-ordination would allow better discharge planning to increase community support after hospital treatment and would also allow the implementation of integrated approaches to chronic disease management (for example, increasing community care for diabetes).

Many of the health problems New Zealand faces are concentrated in areas of deprivation and are driven by factors largely outside the health sector. More co-ordination is needed across sectors such as health, education, housing, justice and welfare. Primary health care has a key role to play using techniques such as case management, facilitating communication between various agencies, and brokering services for individuals and families.

District Health Boards will have responsibility for most health services in their districts and will receive funding for primary as well as secondary services. They will be in a position to organise and fund services in the most appropriate way and to shift funds around the health system. Strong primary care organisations taking responsibility for co-ordinating services needed by their identified populations and working closely with other parts of the system will ensure that services are optimally provided.

Provide continuity of care over time and across episodes of ill health

Continuity in primary health care means that people have a usual source of care, and use that source for a variety of problems over time. A relationship is established. It may not be necessary to have complete continuity of an individual carer – a team can be the usual source of care. But the larger the team, the more difficult it is to establish and maintain a relationship over time.

Continuity can be shown to result in a number of benefits, and these appear to be greater where there is a relationship with a particular practitioner rather than with a practice or organisation. Continuity of care particularly improves:

- management of chronic problems
- management of complex or rare problems
- non-physical problems that rely on a good relationship between patient and provider
- the extent to which an holistic approach can be taken.

Research from many settings and various countries shows that continuity of primary health care is associated with:

- better preventive care (Lien et al 1994)
- better recognition of problems (Galbraith et al 1997)
- less recourse to medication as a first line treatment (Hjortdahl et al 1991)
- better patient compliance with prescribed medication (Flecker et al 1974)
- fewer hospitalisations (Weiss et al 1996)
- lower total costs (Flint 1987).

Continuity will be improved when people are affiliated to a primary health care provider. All concerned will know clearly who has the responsibility for ensuring continuity of care over time.

There may be a tension between first contact care and continuity of care. Currently, although most people can identify a usual source of first contact care (Flint 1987), there are some people who appear on more than one provider's list of enrolled patients (Malcolm 1999a). However, since many of the benefits of the ongoing relationship can be gained without absolute continuity of care, the system should be flexible in allowing people freedom to choose a first contact provider, although individuals would only be affiliated with one provider at any one time. There will be mechanisms to allow individuals to change the provider with whom they are affiliated. Good information systems that allow patient information to be easily transferred (with consent) will be a key part of such a system.

Be of the highest quality consistent with available resources

Individuals should have access to a primary health care system that provides the highest quality of care within the resources that are available. New Zealanders should be confident that quality standards are consistent across the country and do not vary by provider or geographic location.

From a practitioner's perspective, quality should be integrated as a normal part of professional work. Clinical governance (the involvement of clinicians in managing each other's clinical decisions within the organisation) will be accepted as the norm. Practice will be expected to be based on the best available evidence and this will be facilitated by making the evidence readily available to practitioners (and to patients who wish to use it) at the time clinical decisions are made. Practitioners will have information comparing their clinical practices to that of colleagues and to the best evidence. This information will be used by them and their colleagues to determine where changes should be made to improve quality of care.

Ensure resources are fairly distributed according to need

The basic principle here is that public resources will be distributed differentially across the country according to a measure of the needs of the population. This will ensure that those areas that have the highest levels of health need (for example, South Auckland or East Cape) receive proportionately more resources.

This will be the principle followed when allocating resources to District Health Boards. However, since this strategy involves primary health care providers taking responsibility for an affiliated population, it is proposed that primary health care organisations should also be funded according to the needs of their population for primary health care services.

Resources will be distributed according to a formula based on the features of the population covered. A primary health care organisation or provider that supplies the range of individual and population services described above will receive a fixed amount of money for each patient in the population covered. The amount of money received will be weighted to reflect the needs of the population.

This system aims to ensure that resources are directed to those areas that are in most need. Population-based funding of this sort provides an incentive for the primary care providers to maintain the health of their populations (Cumming 1999), though, given the usually great time delay between a preventive activity and associated reductions in treatment costs, such an incentive is a very weak one. It also supports continuity of care and the use of the most economical provider with appropriate skills. However, it is not suggested that incentives in the system would be sufficient. Government through the District Health Boards will still need to carefully specify services and ensure accountability for their delivery and for the achievement of outcomes.

The current system does not ensure the allocation of resources to providers working in areas of greatest need. Indeed, it could be argued that the system has perverse incentives which encourage practitioners to establish themselves in areas where individuals can more easily afford services.

Payment to organisations according to the population they cover does not in itself determine the way that the organisation will pay individual practitioners. There is currently a range of different payment mechanisms used both here and overseas, all of which have advantages and disadvantages depending on what the payer expects those providers to deliver (Cumming 1999).

However, when organisations are required to meet the needs of their populations from a set sum of money, they will need to ensure that clinical decisions take account of the budget. This is already happening in many parts of our current primary health care system.

Acknowledge and respond to the special relationship between Māori and the Crown

The Government acknowledges that a special relationship between Māori and the Crown exists under the Treaty of Waitangi. This acknowledgement has led to the development of policies that have sought to meet the health needs of Māori and help improve their health status through Māori structures. Whānau, in particular, need to be recognised as important for improved Māori health and development. The special relationship also extends to a particular need to involve and consult with Māori in developing primary health care.

Māori approaches to health reflect two key ideas: keeping people well, and recognising that there are a number of factors that affect the wellbeing of an individual or collective group. Healthy whānau, hapū and iwi are crucial to the future of Māori development as they nurture, support, care for, encourage and protect their individual members. But whānau themselves require support to be able to nurture their members. The impact of socioeconomic, cultural, lifestyle and attitudinal factors can affect the operation and health of whānau positively or negatively. Therefore policy should seek to enhance and/or affirm whānau wellbeing as a pivotal force in the lives of a diverse range of Māori people.

Primary health care that emphasises wellbeing, the importance of whānau, hapū and iwi, and prevention (not just illness, the individual and treatment) has a critical role to play in improving Māori health status and advancing Māori development. The strategies outlined in this paper will assist in achieving these goals through community participation, population-based approaches, needs-based funding and co-ordinated service provision.

Chapter 4: Moving Forward – How Changes can be Made

The changes detailed in the previous chapter will mean:

A primary health care system where providers are paid to deliver a defined range of services to defined levels of quality to an affiliated population.

Primary care providers will need to ensure that defined services are provided for individuals who seek help or advice, as well as assuming some responsibility if services are not delivered to individuals in need. This will involve individuals choosing a primary health care provider (affiliation) and for the public funding of those providers to be on the basis of the population that is affiliated.

This chapter details the changes that will be needed, and looks at issues to do with: the population who are being served; the providers; the services; and some other considerations.

Who will primary health care providers be serving?

A population-based system needs to link providers with groups of people. As explained below, people will be expected to make a choice of provider and to formally affiliate with that provider. The providers will then play a part in identifying health needs of the affiliated population and ensuring there are primary health care services to meet needs.

Affiliation

Individuals will be required to be affiliated with a primary health care provider of their choice before they can access Government-funded primary health care services. The details and mechanics of the process will need to be decided. While most people in New Zealand can already identify a family doctor they may not automatically choose that doctor as the primary care provider with whom they wish to affiliate. Of course, if someone chooses not to make use of Government subsidies for primary health care (including pharmaceuticals) then there will be no need for them to affiliate with a provider. Affiliation will not be obligatory.

People will need to understand what they should expect from their affiliated provider and individual providers will make it clear who their carers are and what services they offer.

It is anticipated that most individuals will receive most primary care services from the provider they affiliate with or from others associated with that provider's organisation. However, the system must not only allow free choice when affiliating and the ability to change without difficulty but also allow people to have choice of provider for sensitive conditions and problems.

Meeting the needs of the affiliated population

Primary health care providers will play a larger part in assessing the needs of affiliated people. How this is done needs further consideration.

Different kinds of needs assessment are required for different parts of the health system and different sizes of populations. Nationally, the Ministry of Health will be tasked with priority and target setting according to the country's needs. District Health Boards will have a responsibility for knowing the overall health needs of their districts and making decisions about appropriate allocation of services and resources. Primary health care provider organisations will be taking responsibility for a population and so must identify needs and plan services as well as achieving targets and goals set for the district. Individual practitioners may similarly need to address the needs of the people who have chosen to affiliate with them.

Another important consideration at the local level will be the relationship between the process of identifying population needs, and the process for determining and co-ordinating individual requirements for disability support services.

Arrangements to have primary health care organisations identify the services their populations require must be mindful of the relative scarcity of skills for the more formal types of needs assessment (for example, epidemiological and demographic skills).

The Government will expect continued acceptance of and responsiveness to the Treaty of Waitangi and refinement of how the Treaty is reflected within service agreements. Many Māori continue to use mainstream health services. Conversely some do not access services because those services are not provided in a culturally sensitive or appropriate manner. New primary health care arrangements are critical to meeting the needs of Māori. They will involve both Māori primary care providers and responsive mainstream providers working closely with Māori communities to meet the needs of affiliated Māori people.

Involvement of the population

As well as establishing the needs of affiliated individuals, primary health care providers will be expected to encourage relationships between the community and the primary health system. There are various ways the community and the primary health system can interrelate. The community can be advisor, owner or have a governance role. Some models involve links with local Government; others have community committees, while in others the relationship goes little further with the providers communicating with their local community and enabling comment and suggestions. All are valid and should be encouraged.

Information

Affiliation will increase the need for primary health care to have access to good information technology and information systems. In addition to supporting affiliation, this will be needed to underpin the population approaches to preventive health care as well as the needs-based funding formula (both items are discussed below).

Who will be providing the services?

Organisations

Various types of organisation may be suitable to achieve the proposed strategy. They will vary according to the characteristics of the affiliated population (for example, urban or rural, Māori or Pākehā), or to the way that providers have been organised in the past (for example, practitioners employed in larger groups as opposed to multiple small and independent practices). Since the strategy requires providers to ensure that their affiliated population gets a

wide set of primary health care services, individual practitioners will need to link with other practitioners to supply the required range of services and will thus become members of at least a networked organisation.

A range of different organisational forms have developed over recent years. Different forms have different strengths and no particular one will be mandatory. The Government will ensure that taxpayer funds are applied to improving health and health services. At the same time it recognises that providers can legitimately receive a fair reward for their work and level of investment. All organisations will be expected to explicitly address the goals of the public health system and to be fully accountable for the use of Government funds.

How District Health Boards will interact with these organisations will be an important part of future arrangements. The Boards will cover a geographic district and will have responsibility for all publicly funded health services. To ensure that people receive primary health care they will have service arrangements with primary health care organisations and will need to ensure that everyone in their catchment area is affiliated to one or other primary health care organisation of their choice.

Although District Health Boards will be providers of publicly funded hospital and related services, it is not at present envisaged that they will themselves become primary health care provider organisations. However, such an arrangement could be appropriate in certain circumstances – perhaps as an interim option for people who are not affiliated to any existing organisation – or in particular locations.

Professionals

All primary health care professionals who receive public funding will be part of a primary health care organisation. The arrangement between the professional and the organisation may take various forms. The organisation may, for example, be owned and led by a community group and contract with different independent professionals to provide services. Or it could be owned and led by professionals (for example, doctors, nurses and others) some of whom have arrangements with the organisation to provide services, while other professionals may be salaried.

What services should be provided?

The Government will expect primary health care providers to offer a specified minimum range of services. These services will have a number of common features such as prescribed quality standards.

Specifying services

All primary care provider groups will be expected under service agreements with their District Health Board to supply a specified minimum range of primary care services. There will be a nationally agreed set of such services covering the range of health education, disease prevention, support for self-care, diagnosis, treatment, ongoing care, rehabilitation and referral (as detailed on page 22).

There will also be nationally consistent levels of access to this minimum set of primary health care services. National specifications will set down availability to first-line services so that all

people, especially those living in smaller and more remote communities, will have certainty of what they can expect.

District Health Boards may choose to go beyond the nationally agreed minimum. This might, for example, be to address particular community needs, to move services from the hospital to the community, or to develop more integration among providers. Similarly, communities or providers may wish to pursue new ventures or their own priorities. Such changes would need to be in addition to the minimum service and would either have to be provided within the existing budget and/or would require negotiation and agreement with the District Health Board.

Common features of the services

As well as a nationally specified set of primary health care services, there will also be national standards for quality, co-ordination and information transfer.

Quality of services

All primary health care services will need to meet quality standards. Quality processes and measures will be determined and defined in consultation with users, professional bodies, providers, funders and the Government. Agreed and explicit standards may be used for approving practitioners for certain aspects of primary health care just as is beginning to happen in secondary care. Accreditation both of practitioners and of practices is likely to be the norm and may either be required by District Health Boards or will become an important sign of quality to consumers. Data gathered in the process of ensuring quality may be also made publicly available.

Co-ordination of services

Co-ordination will entail primary health care providers working with a number of different provider agencies. In future, primary health care may be a strong advocate for community development in health and related areas such as education, social welfare, housing, and justice, which often have major impact on health status. The Government expects that the objectives within this strategy will consolidate primary health care's ability to undertake this type of work.

Certain areas of New Zealand have higher levels of deprivation and need a more intensive approach to address underlying causes of poor health status. Population-based funding must be sufficiently sensitive to variations in local conditions so as to reflect the extra needs of such communities. Administrative systems also need to be responsive to enable agencies from various sectors (not just health) to work more effectively together to achieve particular common goals.

Information transfer and sharing

Sharing information with other providers on an 'as required' basis will facilitate effective service delivery (subject to permission being granted to use the information).

Safeguards will be needed around the exchange of information so that users:

- know who will get their information
- have the chance to refuse the sharing of information on all occasions
- can ask to see what information about them is being passed on
- know how they can change their usual primary health care provider if they wish to.

There are great benefits for both providers and patients in developing integrated information systems, which should ensure that patients get a better service.

How should services be paid for?

Clearly the issues and changes discussed within this strategy will both impact upon and be influenced by funding arrangements. Future approaches to funding primary health care will achieve the following.

Pay providers for taking responsibility for a defined population, rather than for delivering specific items of service

This will require a system for funding according to the needs of the population served. Under such a needs-based system a fixed amount of public money is allocated for each patient covered. The fee would reflect the relative need of the patients.

A variety of methods can be adopted for determining relative need. These will take account of such factors as the age and sex profile of the population, the ethnic mix, socioeconomic status, and measures of the health status of the population (for example, standardised mortality rates or measures of morbidity).

Taking responsibility for a defined population will mean additional work for current primary health care providers. The tasks will be specified in contracts and appropriately recompensed. The expected benefits will include improved health and a reduction in some avoidable health care services (though there may also be detection of currently unmet needs especially in the short term).

Extra costs will be involved, especially in the short term. While some costs may later be recouped as a result of reduced demand, there will be short-term fiscal impacts. Further work to quantify such impacts will be needed before planning the pace of implementation of the strategy.

Maintain the current principle of targeted part charges – albeit with some modifications to improve effectiveness

Some user charges for access to first contact services will be retained. Targeting subsidies for accessing primary health care services according to income will continue.

More attention will be given to ensuring people know about and take up subsidies. Current subsidy arrangements appear to leave an affordability barrier for some people. There is also evidence (Gribben 1996) of incomplete uptake of subsidy entitlements, which may reach significant levels in some communities. Subsidies should be targeted so that the barrier of part charges is unlikely to pose a threat to people's health. This may require agreement from providers and/or organisations about passing on subsidies to patients and maintaining relativity of user fee levels. All providers will be expected to document their compliance with measures to assure affordability.

Allow public funding to be applied more flexibly by providers – including budget holding and subcontracting

There are problems at present because of funds being isolated and tied to specific practitioners, services and/or organisations. Possible solutions may include joint ventures between different providers so that funds can be shifted, with both parties having a share in gains made as a result of more efficient care being provided. Consideration needs to be given to determine how much responsibility for resources beyond primary health care may be devolved to primary health care organisations.

Other issues

The focus of this discussion document has been on the vision for primary health care. In order to turn that vision into reality, the Government is seeking the views of health care providers and health care users on the strategy and its implementation. Additional areas that need to be covered for implementation include the following.

Workforce

This document presents a view of primary health care in 2010. However, the pace of technological change in health care is such that some changes may impact on us sooner than that. In addition many areas need to be planned for and implemented much sooner, for example, training and workforce issues need to reflect the fact that it can take up to 10 years to train some health care professionals.

Information

Any changes in primary health care need to be accompanied by appropriate developments in information technology and systems to enable the vision to become a reality.

Managing and funding change

The achievement of the strategy for primary health care clearly involves a period of change. Although the vision is for 2010, some changes will occur much sooner. A focused change management process is needed to ensure that users of primary health care services and primary health care professionals are fully informed and encouraged to play an active part in achieving the vision.

New and better services will have costs to meet as well as benefits to reap. Change in itself carries costs that may need to be met by early development funding. Clear identification of costs, and their inclusion in the budget process and in funding for providers, is essential to the strategy's success.

Next steps

The Ministry is now seeking comment on the strategy and on what is needed for implementation (see Feedback section page vi).

Appendix 1: Recent Trends in Primary Health Care

There have been considerable and ongoing changes in both the organisation and delivery of primary health care services over the last 10–20 years. Many of these changes have led to improvements in the quality of primary health care. They have also broadened the focus of services to give more attention to improving health, preventing illness and giving attention to the needs of a whole population as well as individuals who seek care.

In a sector as complex as primary health care, many of these changes are interrelated. Changes have often developed in a piecemeal way or they have only been available to certain groups of the population. Moreover, changes sometimes overlap or conflict, and various groups have called for a clear statement of direction.

Some of the key changes that have developed are outlined below. They are not a complete or definitive list. They have been chosen because they reflect the direction of this strategy.

The development of new forms of primary health care provision

The way that primary health care is organised and delivered has changed markedly in the last 10–20 years. To users most of these changes have had minimal impact but for health care professionals, and for the future, they are very significant.

Before the 1990s solo and small group general medical practices (typically one or two doctors, a nurse and a receptionist) were the usual organisational format for those providing most primary health care services. Other providers such as community nurses and community health workers were employed by area health boards (AHBs) or voluntary organisations. Large disability support groups often supplied mainly residential care for specific groups, for example, the Royal New Zealand Foundation for the Blind. There were also a small number of other organisations, such as nurse practitioner groups, women's health groups and some non-profit community organisations such as Tipu Ora, a Māori provider of pregnancy and child support services.

The 1990s saw the emergence of new health care organisations. Many of these were small and were delivering services to specific population groups.

Some organisations, such as iwi providers and home help organisations, provided new services that consumers had been unable to obtain earlier. Other organisations, such as Independent Practitioner Associations (IPAs) for GPs, were designed to manage demand and provide services more efficiently. To users, however, changes were largely unseen since most people continued to receive essentially the same service.

This new flexibility was driven by a variety of factors. These included changes in the General Medical Subsidies (GMS) and the use of research and surveys to determine health needs and preference.

Independent Provider Associations (IPAs) and other GP associations

GPs have formed larger organisational groups called Independent Provider Associations (IPAs). The first IPAs were established in about 1992 and by 1999 there were some 32 IPAs with more than 2000 members. Most cover small areas in larger centres, though some (such as Southlink, Pinnacle and First Health) cover far wider geographical areas. In addition there are nearly 100 GPs in 10 smaller contracting practices, approximately 400 in loose networks, and some 60 who are members of 'third sector' providers (see below). In all, over 80 percent of GPs are members of some type of primary health care organisation (Malcolm 1999b). They provide care for an estimated 3.1 million patients, approximately 85 percent of the population.

Increasingly IPAs are involved with payments to GPs, with some 15 percent of GPs now receiving public funding according to the number of patients registered rather than the number of services provided (Ministry of Health 1998d).

Nearly all IPAs manage expenditure within a budget for the laboratory tests ordered by their GP members and the medications prescribed. Any savings must be used for health-related purposes in the practice rather than being retained as profit. Examples of these include access to new services such as smoking cessation programmes and audiology, improved access (say, for the terminally ill), medical education, and IPA administration. Most GPs are paid subsidies for each patient visit (if the patient is eligible for subsidy), a payment for each immunisation, and a subsidy to cover part of the cost of employing a practice nurse.

Not all GPs belong to IPAs. CareNet is a network of nearly 400 GPs in sole practice or small group practices. This organisation is opposed to budget holding and capitation. Other GPs continue to operate independently of any group.

'Third sector' primary health care

There has been a growth of 'third sector' primary health care (Crampton 1999). The third sector comprises non-Government, non-profitmaking organisations with a strong community orientation. These services were among the first to make innovative use of other providers such as practice nurses. Some of these services, such as the Union Health Clinics (Matheson 1992) are funded by capitation.

The Union Health Clinics developed Health Care Aotearoa, a national organisation. This has expanded to include a number of iwi providers and other community groups and currently has 33 members. Health Care Aotearoa provides financial, legal and management support for its members as well as providing them with training and quality management services. It is exploring the development of new services. Other third sector providers have continued as independent organisations or as parts of smaller informal organisations.

Member groups are structured in a variety of ways, including incorporated societies, charitable trusts and limited liability companies. They are generally governed by management committees made up of providers, community representatives and patient representatives. They have a number of funding mechanisms including capitation (for GP-based organisations), direct grants for particular services, and other forms of population-based funding.

Māori and Pacific organisations

There has been a desire among Māori for greater autonomy in health service delivery and a number of providers, both iwi-based and operated by urban Māori authorities have been developed. Services include marae-based clinics, health education and support organisations for mothers, people with mental disabilities, etc. A smaller number of providers for Pacific people have emerged. Many of these are focused around the delivery of support, prevention and education services for mothers and children. These developments are further described in separate sections below.

Other new forms of provider organisations

Various new primary health care organisations have grown up around the provision of services to specific groups or for people with particular needs. Two examples are new organisations for disability support and new maternity provider groups.

In the 1980s most support services for people with disabilities were provided by Area Health Boards, large non-profit organisations and small voluntary organisations. The disability support reforms provided the opportunity for the development of support-service organisations. Some of these are private organisations or non-profit organisations employing staff to provide services to those who qualify for these services (see the disability section below).

During the 1990s primary level maternity care changed dramatically following the passage of the Nurses Amendment Act 1990. Under this midwives were allowed to practise independently of doctors. Increasingly, midwives have been forming small groups in order to provide continuity of care to women. More recently a few groups of doctors and/or midwives have formed new organisations (for example, Wellington's MATPRO) to work together to provide maternity services.

The changing role of primary health care providers

Organisational changes have been accompanied by changing roles for many primary health care providers.

There have been many changes in the roles of primary health care providers, and these are continuing. Some of these have been in response to changes in service delivery; for example, the move towards deinstitutionalisation has meant that a large number of disability and mental illness support workers now work in the community. There have also been professional changes (for example, development of nursing and pharmacist roles). Some of the major changes are discussed below.

General practitioners

GPs continue to be the most frequently visited primary health care practitioners (Ministry of Health 1999d; Ministries of Health and Statistics 1993). There has been a steady increase in the number of practising GPs over the decade (from 2429 in 1990 to 3159 in 1998). This increase has outstripped population growth and increased the rates of GPs per 100 000 from 72 to 84 over the same period.

There are few data over the decade to illustrate changes in GPs' roles. Average rates of consultation per capita are estimated to have stayed fairly constant (Ministry of Health 1997, 1998; Malcolm 1993). When combined with increasing numbers of doctors this means that the number of consultations each doctor carries out will have decreased. There are also few data available on consultation length or complexity but it seems generally true that both have increased.

Various factors have led to changes in the work that GPs do. There are demands for more information and for GPs to be more involved in monitoring quality – both their own and that of colleagues. Many providers claim work demands appear to have increased, with the recent accident compensation and earlier maternity changes cited as key examples. It is likely, though at present not well documented, that the changes in secondary care towards shorter hospital stays and the increasing tendency for chronic conditions to be managed in general practice rather than as hospital out-patients will have contributed to increasing complexity in the problems that GPs have to deal with.

Another key change, at least in urban areas, is the advent of after-hours medical centres. At the start of the decade most GPs provided cover for patients out of hours, either personally or through arrangements with a small local group of other GPs. Nowadays, most urban GPs belong to large after-hours organisations that operate from special facilities in order to provide a single contact point for patients and better equipment for emergency care. One effect of this change has been to reduce the frequency (though not the intensity) of out-of-hours work for individual GPs and to increase the demand for doctors to work in these arrangements (probably, as a consequence, reducing the pool of available locums in towns as well as in rural areas).

Nurses

Nursing roles in primary health care have changed and will continue to do so. There are more than 4000 practice nurses employed in general practices.¹ They are the most frequently seen community nurse. Eighteen percent of people reported that, during the previous year without seeing the GP at the same time (Ministry of Health 1999c). Practice nurses carry out a range of tasks, including health promotion, disease prevention, self-help advice, problem assessment, treatment advice, basic procedures and the management of chronic conditions.

In some practices the nurse's role is restricted. In others it is extensive for several reasons especially where practices are funded by capitation and/or actively pursue team working and an increased role for nurses. The introduction of capitation in some practices has assisted this process as primary care providers are able to decide how to use the funds they receive for treatment without these being specified for certain types of provider.

Early leaders in this field included a few group practices (Seddon et al 1985) and the Union Health Care Clinics (Ministry of Health 1998). The difficulty of attracting and retaining doctors in rural areas has led to more attention being paid to the development of nurse-led primary rural care. However, although capitation funding of practices has increased (Ministry of Health 1998), it is uncertain whether the role of practice nurses will change significantly in future without accompanying attitudinal and power shifts in practices (Ministerial Taskforce on Nursing 1998).

Another development, so far on a small scale, is nurse-led primary health care (McClellan et al 1988). Practices have developed in urban areas (Brash 1986) and among some Māori providers (Crengle 1999).

¹ Information from NZNO College of Practice Nurses.

Other types of nurses continue to provide many primary health care services in the community. These include public health nurses, Plunket nurses, district nurses and nurses in family planning and student health clinics. While the roles of these nurses has remained fairly constant over the past decade, they have been affected by changes such as competitive pressures and pressures on staff numbers.

Some new initiatives have a significant potential to widen the scope of primary nursing practice. These include Healthline, a telephone advice and triage system and the passing of legislation that will allow selected nurses to prescribe. The Ministerial Taskforce on Nursing (1998) made recommendations for changes that will further broaden the scope of nurses' contribution in primary health care.

Pharmacists

Pharmacists have traditionally been a source of information on pharmaceuticals and advice on self-help. After doctors, they are the second most commonly seen health professional. Forty-four percent of adults visited a pharmacist for health advice or to obtain medicines at least once in the previous 12 months (Ministry of Health 1999c).

In the late 1990s pharmacists have increased their advice role. They provide more information to patients about the purpose and effects of medications, both prescribed and over the counter. Liberalisation of access to some pharmaceuticals has meant pharmacists have a wider range of medications available without the need for a doctor's prescription. Pharmacist groups are promoting the concept of the pharmacist as a further source of professional advice for self-help and management, particularly of chronic conditions. Some pharmacists are undergoing further post-graduate training to increase their skills in this area and are setting aside consultation space on their premises.

To date there have been few examples of pharmacists working closely with other primary health care providers. Many IPAs have employed pharmacist facilitators to help in the education and review of doctors' prescribing in order to manage within the IPA's prescribing budget. However few IPAs have established working arrangements with independent pharmacists. There may be opportunities for more collaboration in future if disease management approaches are adopted.

Midwives

Arrangements for maternity care have changed markedly over the decade. This has led to a rapid increase in the number of women who receive their maternity care from an independent midwife and a corresponding decrease in GPs taking full responsibility for a birth.

Independent midwives provide maternity care for normal pregnancies and birth. There is an agreed set of guidelines for when women should be referred for specialist assessment or care (Transitional Health Authority Maternity Project 1997). Midwives are permitted to prescribe any medication as part of providing normal maternity care and they are also allowed to order from a specified schedule of laboratory tests. Most births take place in hospital, less than 5 percent are planned home births.

During the first half of the 1990s some 20 percent of women chose care from a midwife while up to 60 percent had both a midwife and a GP. This changed with the introduction of new arrangements in 1996 whereby women had to nominate a lead carer. Since the introduction of this scheme many GPs have ceased to be involved as lead carers. The latest data (July-

September 1999)² shows that independent midwives are lead carers for 60 percent of births (GPs 18 percent) and are also probably the main practitioner for many of those where the hospital is lead carer (5 percent).

Other primary providers

There are many other primary health care providers including dentists, opticians, physiotherapists, chiropractors, osteopaths, podiatrists, occupational and speech therapists, social workers, psychologists and counsellors, and a range of alternative health care practitioners and traditional healers.

Thirty-six percent of the population visit a dentist each year and they are the third most visited practitioner (Ministry of Health 1999c). This strategy has not addressed dentistry since work is proceeding on a specific oral health strategy.

More than 10 percent of people see opticians and physiotherapists once or more in a year. Fewer than 10 percent had seen one of the professionals listed in the survey in the previous 12 months. It is difficult to determine whether use of these professionals has changed over the decade.

One significant recent event that may affect the use of some of these professionals is the change to accident insurance provisions introduced with the Accident Insurance Act 1998. The Act includes acupuncturists, audiologists, chiropractors, counsellors, dentists, laboratory technicians, nurses, occupational therapists, optometrists, osteopaths, physiotherapists, podiatrists, registered medical practitioners, and speech therapists as treatment providers. People are entitled to go to any of these providers for accident assessment and treatment. This is a significant change to the previous law whereby only a registered medical practitioner was entitled to assess people for accident compensation. The law change is likely to lead to increased use of these treatment providers and perhaps a widening of the tasks they undertake.

New ways of delivering services for Māori

A desire to improve Māori health has led to innovative approaches, especially the development of Māori providers. The number of primary health care Māori providers has increased tenfold in the last five years. These providers take an holistic approach to addressing health needs and evidence of success is starting to appear.

Māori health a priority

Although Māori health status has increased significantly over the last 10-20 years it remains lower than that of non-Māori New Zealanders. Māori life expectancy at birth is eight years less than that of non-Māori. Māori experience a higher prevalence of most diseases, especially diabetes, cardiovascular disease and respiratory diseases. The rates of sudden infant death syndrome (SIDS) is five times higher among Māori than non-Māori. Young Māori men have high rates of unintentional injuries.³

² Information provided to the Ministry of Health by the HFA, based on Health Benefits Ltd data/m2000.

³ Briefing for the incoming Minister: Māori Health.

Māori health is a health gain priority area and the Health and Disability Services Act 1993 refers specifically to the special needs of Māori. Māori health policy has largely focused on access and utilisation issues by encouraging:

- greater Māori participation at all levels of the health sector
- resource allocation priorities that take into account Māori health needs and perspectives
- the development of culturally appropriate practices and procedures as integral requirements in the purchase and provision of mainstream services for Māori.

Māori providers

Responses to the health needs of Māori have led to Māori provider development and Māori workforce development. These developments have also enhanced the responsiveness of mainstream health services, promotes intersectoral initiatives and encourages the development of co-ordinated or integrated care developments.

Māori health providers encompass more than just 'health' improvement. In seeking to address the full range of population and client needs (whether they are funded for them or not), Māori providers' goals tend to be consistent with broader development objectives of iwi, hapū and whānau.

Māori provider development has been actively fostered through schemes such as the Māori Provider Development Scheme. Most Māori providers deliver community and primary health services, including some traditional Māori healing. They tend to focus on areas with few services such as remote rural areas or areas where services are inaccessible and/or irregular. They are also a vehicle for linking Māori into other services (other providers and/or secondary services), guiding Māori through unfamiliar services, and promoting preventive health strategies using the approaches, support systems and networks of the Māori communities around them.

These services rely on the assumption that effective providers of services to Māori begin with a knowledge and understanding of the circumstances of diverse Māori communities. They also rely on the provider ability to engage effectively with whānau, hapū and iwi networks to meet the requirements of te ao Māori, as well as physical and/or mental health needs. Some provide services for large populations, but many have a relatively small client base.

To date most provider initiatives have been in the primary health sector. The concentration on the primary sector is based on the notion that the best means to improve Māori health is to prevent illness using strategies geared to Māori lifestyles and networks.

The number of independent Māori providers delivering health services targeted to Māori has grown significantly and there are now 240 providers. Māori providers include iwi providers, those that have emerged from within mainstream health providers, or have been built by Māori health professionals, and community-based Māori social service providers.

There are, as yet, few definite indicators of improvements in Māori health as a consequence of the increase in Māori providers. However, there is evidence that Māori providers are making some difference.

- Te Raukura Hauora o Tainui has attracted over 3600 patients who previously did not have consistent arrangements for health care.
- A Wellington School of Medicine study in Wairarapa indicated that asthma control by Māori participants improved significantly as a result of marae-based asthma clinics.

- Use of Te Ariwara Raukura Medical Trust primary health services has resulted in a 30-50 percent reduction in hospitalisation rates for respiratory problems at Tararaki Healthcare; the same practice was successful in controlling diabetes in many patients through diet alone.
- In those regions where it is active Tipu Ora has achieved immunisation rates well above the national average for Māori babies.

There is also a high level of enthusiasm among Māori for the new opportunities because they foster direct Māori participation in health services and health planning.

While the number of Māori providers has increased, their coverage and participation remain patchy. Most are less securely established than mainstream providers, largely because of problems encountered in the contracting processes and establishment costs.

The higher needs and lower resources of Māori populations are not yet reflected in capitation formulas. Despite this 'shortfall' few Māori providers do not charge for services because cost is seen as a significant barrier for Māori consumers.

The delivery of services for Pacific peoples

Pacific peoples living in New Zealand make up 5 percent of the population. Most Pacific peoples are under 65 and it is expected that they will be 20 percent of the New Zealand population by 2050. However the health status of Pacific peoples is not as high as that of the total New Zealand population. A number of Pacific 'friendly' health care services are being developed as a response to this.

The life expectancy of Pacific peoples is lower than that of the total population. Particular concerns are non-communicable diseases such as diabetes, cardiovascular and respiratory diseases. The abortion rates for Pacific women are high. Among children concerns include acute rheumatic fever, hearing loss and a number of parasitic and infectious diseases. These health problems have a number of causes, including low socioeconomic status, language and cultural barriers, a lack of information about services, reliance on traditional methods, and (sometimes) a low priority for health.

Many of these health problems are preventable through the intervention of a range of primary health care providers. For adults these could include improvements in diet, greater physical activity levels and a reduction in smoking rates. Better health education on these and other issues (for example, contraception and diet) could improve health status. Child health status could be improved by improving immunisation rates, better screening for diseases and improving access to primary health care.

Use of services

Most Pacific people use mainstream health services. Pacific adults' and children's use of GPs is similar to that of other ethnic groups (Ministry of Health 1999c) though their health status is lower. They are less likely to visit pharmacists or other health professionals than Europeans, which is a concern given the lower health status of this group.

Research and anecdotal evidence suggest that an increased availability of Pacific 'friendly' services could improve access to primary health care services (Tukuafonga 1999). At present

Pacific peoples are more likely to access secondary services than other population groups and they have a high rate of hospitalisation.

Research and consultation has identified several issues that could improve Pacific people's access to health care. These include:

- increasing the training and numbers of Pacific providers
- contracting Pacific programmes for Pacific peoples
- developing alliances between Pacific and mainstream and/or Māori services
- encouraging mainstream services to be more "Pacific friendly"
- improving intersectoral communication
- community empowerment
- comprehensive evaluation and research.

At present there are still only a limited number of Pacific programmes for Pacific peoples. The success of these suggests that further development would improve Pacific health status. Current programmes, many based in Auckland, include the following (Tukuitonga 1999).

- Pasifika Healthcare in Auckland is owned and managed by Pacific people. The services provided include general practice, practice nursing, community health and cervical screening services using Pacific providers. Co-payments are kept to a minimum and the service is available seven days a week. Over 7000 patients are enrolled and rates for completed immunisation and cervical screening rates exceed the national average.
- Southseas Healthcare in Otago provides general practice, practice nurse and well child services. All staff are Pacific people.
- Health Star Pacific is a company owned by Samoan people which provides children's and women's health (pregnancy support, immunisation and well child services). It is staffed by registered nurses and community health workers.

Challenges for the future

A number of developments have the potential to improve Pacific people's health in the future. These include the development of Pacific services in areas where there is sufficient Pacific population to support these and the encouragement of the development of Pacific friendly mainstream services.

Changes in primary health care for people with mental health problems

Primary mental health care is an essential component of the delivery of adequate health care. It is an integral part of the range of mental health service provision. While up to 20 percent (Oakley-Browne et al 1989) of the population may have diagnosable mental health disorders at any time, only 3 percent will need access to specialist mental health services. The remaining 17 percent can be appropriately treated by primary mental health services.

A number of changes have already taken place to improve prevention, detection, treatment and referral, and more are planned.

Over the last 20 years there have been major changes in mental health services. The closure of large mental hospitals led to a consequent movement of care into the community. Department of Social Welfare funds for social support were transferred to the Ministry of Health in the 1990s enabling the linking of clinical services and social support.

Other changes have focused on the need for more and better mental health service provision. Related to this is the improvement of access to primary health care providers for people with, or at risk of developing, mental disorders (including alcohol and drug disorders).

In 1996 the Mason Report (Mason 1996) recommended a substantial increase in the funding for mental health services, the establishment of a Mental Health Commission to monitor changes, work to improve community understanding, and a strengthening of the mental health workforce. As a result of this funding increase there have been significant changes in secondary mental health care, and an awareness of the need for improved provision of mental health care in the primary sector. Areas where further changes are needed have also been identified. An extension to this funding in order to meet the goals of the original report is being explored at present.

Increased emphasis on education, prevention and early intervention

A number of services have emerged that focus more on promoting mental health and preventing illness. New services include some of which target children and young people with mild to moderate mental health problems, and others that target children with severe mental health problems who are also under the care of the Department of Child, Youth and Family Services.

Activities related to primary mental health care for children and youth have included:

- a review of effective early intervention and prevention services
- production of a booklet for social sector workers to help in the identification, support and appropriate referral of children and young people with mental health problems
- a project on developing the workforce for non-mental health specialists in the social sector, most of whom are primary health care workers
- social workers in schools
- the inclusion of mental health modules in the primary health curriculum.

Increasing the role of general practice in providing mental health services

Some relatively recent New Zealand studies (McAvoy et al 1994; Penrose et al 1999) show that GPs report psychological problems as the principal diagnosis in only 4–5 percent of encounters. This number represented only 2.4 percent of patients (and 3.5 percent of scripts written) and is considerably less than overseas studies, which show rates of 15 percent or more of visits related to mental health problems (Fry 1983).

Failure to recognise 50 percent or more of mental health problems in general practice has been described elsewhere (Simon et al 1999) and New Zealand GPs recognise these problems. The National Health Committee has responded by producing a series of guidelines for the management of depression, anxiety and drug and alcohol problems for GPs and other primary health care workers to use. The Royal College of General Practitioners (1999) also recently

released guidelines for primary health care providers for the detection and management of young people at risk from suicide.

Increasing the number and expertise of Māori mental health care providers

A particular concern for mental health services is the low number and low status of Māori involved in the provision of mental health services. It is acknowledged that Māori workforce development will need to reflect Māori needs for appropriate primary mental health service provision. The development of appropriate staff – such as GPs, nurses and community health workers who are able to access, identify and treat people with mental health problems – must be part of the overall development of the Māori health workforce.

Co-operation and integration of mental health services

Co-operation between mental health services and other providers working with people with mental health disorders has not always been good. In the past this has led to difficult access to services, less than optimal treatment and poor referral to needed services.

Recently an increasing number of mental health providers have become aware of the need for more co-operation and integration between the specialist mental health services and primary health care. A growing number of primary health care providers have begun to work more closely with secondary services. As a result this enables them to confidently provide primary health care for people with severe mental health disorders. Examples of this include the Newtown Union Health Clinic, the Wellington Primary and Secondary Mental Health Liaison Programme, and the Shared Care Project in Hawke's Bay.

In addition, some Hospital and Health Services have established specific positions within the secondary services to provide consultation/liaison to the primary sector.

Recent progress

Initiatives since 1997 that may impact on primary health care include:

- better outcomes from the use of new atypical antipsychotic drugs
- access for GPs to newer antidepressant medication
- progress towards a national mental health information database
- production of best practice guidelines in primary health care, which cover the treatment of depression, anxiety and alcohol and drug dependence, and the detection and management of young people at risk of suicide (National Health Committee 1996, 1998, 1999a, National Health Committee and Ministry of Education 1998a, 1998b)
- a national project to counter discrimination and stigma
- the funding of Māori mental health service provision pilots.

New ways of delivering disability support

The challenge for services for people with disabilities is to address their needs in an holistic and proactive way. Having a disability is not the same as being sick. Many of the barriers to full participation and independence faced by people with disabilities are environmental (for example, physical and social) rather than due to personal impairments.

People with disabilities access health-related services for the treatment of illnesses or injuries like everyone else. Some also have specific health needs related to their disability (for example, treatment for complications resulting from paralysis, acute psychiatric illness or conditions associated with some forms of intellectual disability). These groups, and others with high, complex needs (notably some children with disabilities and older people) require an approach that integrates medical interventions with their broader social and disability support needs.

The disability sector

The disability sector is complex and diverse. It is often characterised as consisting of five broad groupings of people: those with an intellectual, psychiatric, physical, sensory or age-related¹ disability. In a survey conducted during 1996/97, 20 percent of respondents (equating to approximately 702,000 people nationally) reported a disability resulting in some functional and/or role limitation. Approximately half of these reported needing assistance either intermittently or continuously.

Disability support services

Disability support services (DSS) are the core support services for people with disabilities. Policy and structural reforms between 1993 and 1995 transferred service funding from the Department of Social Welfare to the health sector. The DSS framework was developed. The framework consists of three distinct processes:

- needs assessment, which identifies and prioritises needs
- service co-ordination or planning, which identifies the most appropriate services and support options to meet assessed need within available funding. This also includes financial targeting for some services
- provision of support services.

Some recent changes in disability support services

Disability support services have grown considerably in number and range over the last 10 years. Changes include:

- the emergence of more home support agencies providing more household management and personal care services²
- some not-for-profit agencies are extending their range of services (for example, some CCS branches now contract for specialised needs assessment for children)

¹ Generally refers to people over the age of 65 years.

² Household management includes help such as cleaning and laundry. Personal care includes help with eating, dressing and other daily activities.

- some increase in respite care or relief of caregivers
- an increase in daycare services
- consideration of individualised funding packages for individuals to purchase their own support packages
- a greater number of people with complex disabilities being cared for in the community following deinstitutionalisation over the last 10 years.

The relationship between the disability support sector and health sector

Integration of health and disability services

The ring fence for DSS funding was intended as a temporary measure to safeguard DSS funding. However, it has sometimes also acted as a barrier to fully integrating services for people with disabilities across DSS and other health funding streams (personal/primary health and mental health in particular).

Disability support services operate within a different philosophy and service framework to the health sector. While DSS focus on providing long-term support, many health services are based on clinical intervention, or offer short-term support or palliative care. However, many individuals – especially older people, children who are medically fragile and people with dual diagnoses or complex disabilities – have both health and support needs. These are best met by an approach that integrates health and disability support services in an holistic way.

There have been some initiatives to improve integration and co-ordination across health and disability support services for some groups.

- The Elder Care Canterbury initiative [www.kniew.govt.nz] which began in July 1997 involves integration of programmes across public hospitals in the area, community support agencies, primary care providers (and their IPAs) and voluntary services. This project involves combining funding from several streams, including a sub-project to integrate services funded by ACC. The focus is on integrating services through improving relationships among providers and between providers and the community.
- DSS services are underutilised by Māori with disabilities and their whānau, and Māori-for-Māori disability services have been slow to become established. Tainui is an example where iwi social services provide integrated health and disability services to address Māori aspirations for an holistic service.

Unique health needs

Each disability group has its own particular health and disability issues. Primary health providers need to tailor services appropriately. For example, some people with intellectual disability are given little accurate information about general health issues, such as contraception or routine health screening. This has at times limited their ability to make decisions on health care.

Workforce

The DSS reforms have created a high demand for both responsive health and disability professionals, and for skilled support workers. There has been a significant increase in the number of household management and personal care workers. Consideration is also being given to personal care workers or assistants performing some of the tasks previously undertaken by district nurses and other health professionals. Some concern has been raised recently,

particularly by the nursing profession (Ministry of Health 1999b), over the level of skill, training and supervision of some personal care workers. Workforce concerns also include a shortage of health professionals with specialist skills (for example, paediatricians with skills to diagnose and assess children with autistic spectrum disorder).

Developing a population-based approach

Primary health care providers are showing an increased interest in population-based approaches. This means delivering care to groups of people rather than just individuals. It involves identifying and meeting population needs and includes health promotion and disease prevention.

Primary health care services are sometimes thought of as being delivered for individuals who seek them out, whereas public health services are directed at large populations of people to protect and promote health and prevent illness. In fact many primary health care professionals provide a range of preventive services to individuals on their register (for example, immunisation).

However, over the last 10–20 years the idea that primary health care services should be more closely associated with a given group of people has gained increasing acceptance. The notion, as described by the National Health Committee (1999b), is that primary services should be directed at a defined group of people whose needs would be assessed so that service provision can be matched to need. Primary health care providers would assume a degree of responsibility for maintaining and improving the health of their given population.

Most New Zealanders can identify a source of primary medical care where they most commonly seek treatment (Ministry of Health 1997). Over the last decade most general practices have built up lists of the patients to whom they regularly give treatment. Keeping such lists has been considered a mark of good practice for many years.⁴ The availability of such links between patients and practices has made a population approach feasible and has been an important tool in the growth of primary health care organisations such as IPAs (Malcolm 1999b).

Other primary health care organisations, such as Māori providers, have started to define the populations they serve by actively enrolling people (Malcolm 1999b). Still others are operating in clearly circumscribed rural localities, and all the people who live there make up the identified population (for example, Haurua Hokianga and Kaipara Care (Health Funding Authority 1998).

These groups have defined improving the health of the population they serve as a key objective (Crumpton 1999; Malcolm 1999b). In order to achieve population health improvements, organisations provide a range of services. These include opportunistic education, advice and checking of patients who are seen for other problems in clinics, homes, schools or mātene. More explicit population health programmes include such immunisation programmes, stop smoking education, nutritional advice, exercise advice and cervical screening.

Other primary health care providers take various different population approaches. For example, public health nurses have an important role in monitoring the health of people living in defined

⁴ Royal New Zealand College of Practitioners.

neighbourhoods or whose children attend certain schools. Pūkete and Tipu Ora provide well child and family advice and support to all families in an area.

There is a growing interest among GPs (and other primary health care providers) in extending the range of population-based services they provide. Many primary health care providers report an attempt to establish better relationships with Crown-funded public health providers. There are reports that these have not always been welcomed (Malcolm 1999b).

Most generalist first contact services face financial difficulties associated with the provision of population services in a fee-for-service environment. These make often require either lengthier consultations or the provision of services to groups rather than individuals. In such cases it is difficult to claim subsidies. The Triple S scheme was established to fund health education programmes but first contact providers have found this limited.

By contrast, iwi providers and those generalist first contact providers who are funded largely by capitation have found it easier to incorporate population-based services. The wider provision of population services through capitation is one of the Government's goals for general practice.

Building links with the community

Community involvement and participation in primary health care is important and has been growing through the 1990s. Involvement may range from primary health care groups informing communities of their activities, to actual community ownership of primary health care services.

The notion of community participation and involvement in health services is not new to New Zealand (Michel 1997).

Primary health care providers have communicated with and consulted their communities in various ways. Some IPAs market their 'brand' through their member practices, especially where there is more than one IPA in the area. Others publicise new services or improved access they have provided from savings on budget holding or new initiatives funds. Other primary health care groups that have informed potential clients about their services include midwife groups, disability support organisations, and independent nurse practitioners (McClellan et al 1988).

A recent survey (Malcolm 1999b) showed that 50 percent of primary health care organisations thought that community involvement was important. Consultative processes described by respondents included taking part in public meetings, submission of written documents and conducting surveys of community views.

A few organisations have sought to involve community members more actively in the management of their organisation. Healthcare Aotearoa providers and the Mangere Health Trust have a longstanding involvement with the community (Crampton 1999). Some members of Healthcare Aotearoa involve representatives of patients and the community in the governance of their organisations. The Mangere Health Trust, an IPA in South Auckland, involves a community trust in the governance and delivery of a range of services, often population based. Iwi providers usually involve the local community/iwi in the governance of the organisation.

Increasing co-ordination and integration of care

Over the last few years improving the co-ordination and integration of services among providers, and between providers and the community, has become much more common. The actual terms 'integration' and 'co-ordination' have caused some debate because they mean different things to different people. The underlying concepts are, however, an important component of the Primary Health Care Strategy.

In common with many other international health care systems, the New Zealand health care system has some significant divisions between its various parts. For example, there is virtually no continuity for patients between the care they receive from GPs and practice nurses in the community and what happens when they are admitted to hospital. People with complex needs can see a confusing collection of specialist carers who are often poorly co-ordinated. There can also be confusion and duplication when an individual's needs span different parts of the health sector, such as mental health, disability support and personal health.

Over the last decade there have been a number of moves to increase co-ordination and integration of care. In general, these have involved a number of providers delivering services to the same population, for example the elderly in Christchurch, working together more closely. As a result:

- services are organised around people's needs – not the system's
- there is better co-ordination and co-operation
- the best solutions to local problems are found
- decisions are taken by those closest to the people and with the best information.

Early plans tended to be based on a competitive contracting model of funding. However none took root and over the last two years initiatives have been much more collaborative and less based on the idea of devolving financial risk.

Recent developments and ideas range across a spectrum. At one end are initiatives that are developing better co-ordination and communication between separate providers, with no plans to alter funding arrangements. A number of integrated care pilots at this end of the spectrum. A good example is the cardiac failure project between a Christchurch general practice, some specialist community nurses and the hospital department of cardiology.

A second idea that of bundling up a number of local services that are currently provided by several providers and contracting with a co-ordinating group (maybe a joint venture between several providers and local community representatives) to manage these services in a more integrated way. The co-ordinating group would develop protocols and ways to better provide service, and there would be ways to pool funds so as to be able to apply them in the optimum way and by the best provider. An example of this is some of the ideas being pursued (though not yet realised) by a number of Māori co-ordinated care organisations.

Targeting those in need

Public subsidy of primary health care is based on a mixture of income and special assistance for children. This has generally been effective, but there are still barriers for some. Other initiatives have targeted rural, low income, Māori and Pacific groups.

Targeted subsidies for accessing general practice and pharmaceuticals

Most primary health care in New Zealand has always involved a charge to the user. Since the 1940s, however, Governments have in various ways subsidised GPs' fees.

Currently subsidies are targeted according to family income. The Community Services Cards and high use health cards mean higher subsidies are available for those with cards. GP visits and pharmaceuticals for children under six are free in most cases.

The cost of pharmaceuticals is subsidised. Except for some premiums (levied when manufacturers' prices are higher than the lowest available price in a given therapeutic group), patients under six pay no part charge, community and high use cardholders pay \$3 per item, and others pay up to \$15. After receiving 20 prescriptions in a year, family members' charges for subsequent prescription items that year are limited to \$2 per item or zero for cardholders.

The latest evidence from the largest and most representative New Zealand study (Ministry of Health 1999c) shows that there is no overall difference in frequency of visiting GPs between those people who have a Community Services Card and those who do not when adjustment is made for differences in age, sex, ethnicity, education and people's perceived health status. However, the same analysis shows that cardholders are more likely than non-cardholders to be in the group who visit the doctor three or more times in a year. These data suggest that overall the Community Services Card scheme lowers the barrier against accessing GP services. There were similar findings for the use of prescriptions.

There is however some evidence (Gribben 1996) that, at least in certain parts of the country, considerable numbers of people who would be eligible for a card do not have one. A recent study (Waldegrave et al 1999) that focused on low income people showed high proportions (56 percent) who had not visited a doctor because of lack of money. The national survey showed that overall 8 percent of people said that in the previous year they had not visited the doctor when needed because of the cost, and this was more common among Māori and Pacific peoples and those with lower incomes.

The most likely conclusion from these somewhat variant findings is that most people on low incomes who have a Community Services Card can afford to see a GP when needed. However, there are some for whom the costs they face, even with a subsidy (a \$20-\$30 GP fee plus some prescription fees and other costs such as transport, childcare and opportunity costs) are still too great a barrier. There are other people who, while eligible for a card, do not have one (or do not use it).

Other initiatives that target primary health care to particular groups

Price is not the only barrier to utilisation of health care services. Others include geographical access in remote rural areas, transport costs in low income suburbs, and cultural barriers, especially for Māori and Pacific peoples.

Some developments have reduced some of these barriers. These include a wide range of services focused on Māori (and to a lesser extent Pacific peoples). These developments have included both the provision of services for Māori by Māori (and Pacific peoples by Pacific peoples) and the increase in sensitivity of mainstream services. (These have been addressed in greater detail in earlier chapters.)

A number of services have been developed that are focused on the needs of people on low incomes. The Union Health Clinics (McGrath 1989) were an initiative that received early funding, and more recently Health Care Aotearoa has received support for the establishment of

new centres targeting low income people (Crampton 1999). These practices are funded according to their enrolled population rather than by the number of services that doctors provide, and this has allowed more innovative use of other providers such as nurses with an accompanying reduction of the costs of providing and accessing some services (Cumming 1999).

In South Auckland and Porirua/Kapiti establishment of innovative integrated approaches to target areas of particular need is being explored. These developments will involve various primary health care providers as well as the local communities and secondary services providers.

Rural areas also have problems maintaining primary health care and secondary services, although for different reasons. New ways to attract and retain health care providers are being explored. Possible responses might include direct financial incentives for GPs in remote areas, the provision of guaranteed minimum incomes, encouraging and training practice nurses sharing on-call duties, specialised training for rural providers, and an extension of a telemedicine link to provide support for rural providers in some areas providers are encouraged to deliver disability support services as well as other services.

There are two specific issues that need to be addressed to ensure that appropriate primary health care services are available to the 10 percent of the population who have mental health problems. Firstly, GPs in particular have commented that current funding models do not address the much longer time needed to carry out a comprehensive mental health assessment. This results in a lack of acknowledgement, identification and treatment of mental health problems. The second issue compounds the first, namely, the lack of subsidies for people with mental health problems to access providers other than GPs. For example, a person with a Community Services Card who is suffering from depression cannot use that card when seeing a psychologist, and so is restrained from what may be the most appropriate treatment through the uneven subsidy structure. It is noteworthy that these restrictions do not apply to ACC clients.

Addressing inequitable distribution of primary health care funding

There is evidence (Malcolm 1999b) that public funds spent on primary health care services in different communities are inequitably distributed. When subsidies for general medical services, prescribed pharmaceuticals and community laboratory tests are included it appears that people from the most deprived areas of New Zealand get significantly less funding than those from less deprived areas.

Work has been carried out on the development of a suitable formula that might be applied to primary health care organisations in order to derive a budget that would reflect population needs (Gribben 1996). Some 15 percent of GPs have moved from subsidies paid for each service to 'capitation' payments based on enrolled populations.

Appendix 2: Selected Primary Health Care Statistics

Introduction

This appendix provides background statistical information on primary health care for the preceding chapters. Information is given on the numbers, utilisation and funding for a number of professions within primary health care.

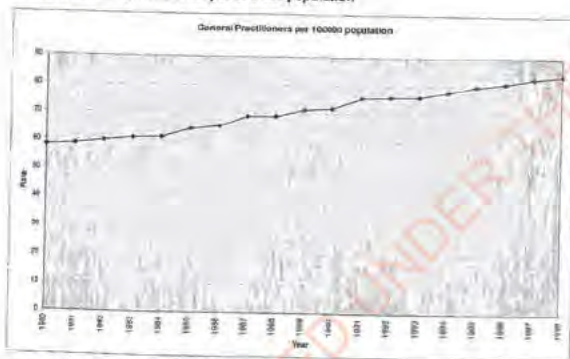
It should be noted that data are not necessarily available in a consistent format across all professions or time periods. Where necessary, explanatory notes have been included. Where possible for activity figures, rates per 100 000 population have been used to take account of population changes while financial information has been deflated to allow consistent comparisons to take place.

General practitioners

Numbers

The total number of GPs in New Zealand has risen consistently over the last two decades. Figure 5 shows the number of GPs per 100 000 population.

Figure 5: General practitioners per 100 000 population



Source: New Zealand Health Information Service
Note: Numbers include part-time working.

Utilisation

The recently produced National Health Survey (Ministry of Health 1999c) shows that GPs are the most consulted primary health care provider, with approximately 80 percent of adults and children having seen a GP at least once in the previous 12 months. Some of the key points relating to utilisation of GPs are given below.

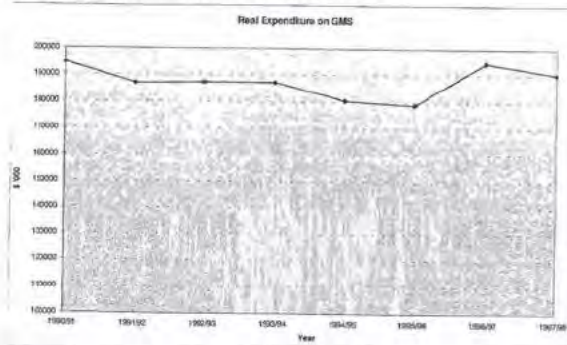
- Women (84 percent) are more likely to see a GP than males (74 percent) and they are also more likely to visit doctors more often than men.
- Children, particularly those under five are heavier users of GP services than adolescents and adults under 65.
- People over 65 are more likely than younger adults to see a doctor, and do so more frequently than younger adults.
- Income is not significant in determining the likelihood of a person seeing a GP at all. However, those in the lowest income groups were likely to visit a GP more often and people from more deprived areas (regardless of income) were more likely to visit a GP six times or more.
- There is little difference in the number of Europeans (81 percent), Māori (75 percent) and Pacific peoples (79 percent) who visited a GP over the previous 12 months. However, people from other ethnic groups (62 percent) were considerably less likely to have done so.
- Adults (90 percent) and children under 15 (87 percent) with a disability were more likely to see a GP than the total population (Department of Statistics 1998).
- Eleven percent of men and 14 percent of women had not visited a GP at least once in the previous 12 months when they felt they needed to. They were most likely to be young (15–24 years), from deprived areas on low family incomes, Māori or Pacific people.
- Reasons people gave for not consulting a GP included cost, being unable to find a suitable time or being able to spare the time. Children were less likely to miss an appointment than adults.

Funding

Real expenditure on general medical services (GMS) is shown in Figure 6. It can be seen that expenditure in real terms has fallen slightly over the last 10 years although there have been some peaks and troughs.

³ This is calculated using the NZDep96 score which is a measure of the level of deprivation in an area calculated using factors such as the proportion of people on some form of benefit.

Figure 6: Real expenditure on general medical services



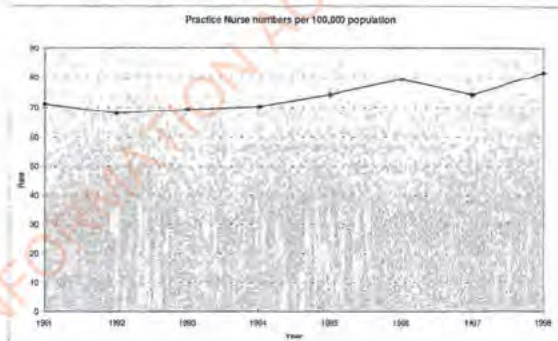
Source: Ministry of Health 1999

Practice nurses

Numbers

As with GPs the number of practice nurses has consistently risen. Data are available for the last decade and these are given in Figure 7 below. In terms of absolute numbers this represents a rise from 2404 in 1991 to 3077 in 1998.

Figure 7: Practice nurse numbers per 100 000 population



Source: New Zealand Health Information Service

Utilisation

Patients see a practice nurse either as part of a consultation with a GP independently. The 1997/98 National Health Survey found the following key messages:

- just under a quarter of respondents reported that they had seen a nurse⁸ in the previous 12 months
- women (28 percent) were more likely than men (18 percent) to have seen a nurse in this time
- 18 percent of people had seen a practice nurse without seeing a doctor at the same time
- children were more likely to see nurses than older adults
- in the Midland survey a quarter of respondents reported that they had consulted a nurse without seeing a doctor at the same time. On over half of these occasions the nurse was a practice nurse. Other nurses consulted included Plunket nurses (18 percent), public health or school nurses (14 percent) and district nurses (10 percent)
- nearly a third of adults and children with disabilities had seen a nurse in the previous 12 months.

Funding

Funding for a practice nurse subsidy is, in some cases, bundled with capitation payments to general practice and in other cases paid separately. For this reason it is not possible to give an accurate picture of the amount of funding for practice nurses.

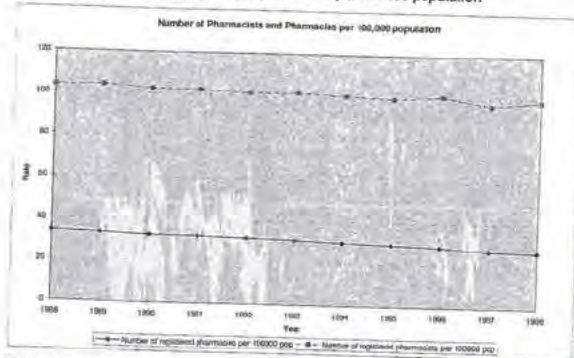
⁸ This includes practice nurses, midwives, district nurses, public health nurses and Plunket nurses.

Pharmacists

Numbers

Figures are collected on both the number of pharmacies and the number of pharmacists within New Zealand. These figures are given in Figure 8 as a rate per 100 000 population.

Figure 8: Registered pharmacists and pharmacies per 100 000 population



Source: Pharmaceutical Society of New Zealand 1998

Utilisation

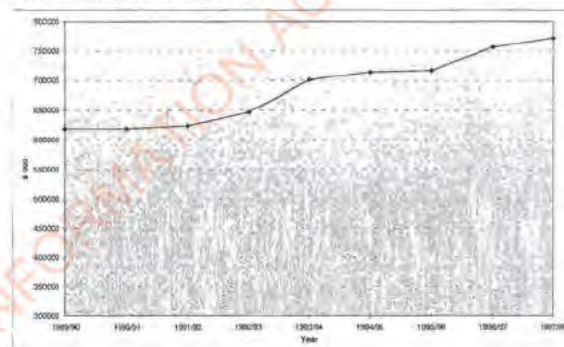
Other than GPs (and others in a general practice), pharmacists are the health professional that people are most likely to see. Reasons for doing so include picking up a prescription, seeking health advice and purchasing medicines not on the schedule. The New Zealand Health Survey indicates that in the previous 12 months:

- 44 percent of New Zealanders had visited a pharmacist for advice or medication
- 70 percent had collected a prescription
- women were more likely than men to have visited a pharmacist, and children were less likely than adults
- 70 percent of people with disabilities had visited a pharmacist.

Funding

Expenditure on pharmaceuticals by individuals includes both over-the-counter and prescription purchases. The Government expenditure on pharmaceuticals, which represents the subsidy paid by the Government, is shown in real terms in Figure 9.

Figure 9: Real expenditure on pharmaceuticals



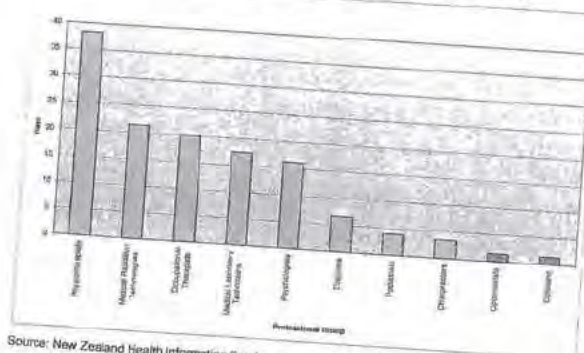
Other primary health care providers

Numbers

Dentists are the third most visited practitioner, but this strategy has not addressed dentistry since work is currently being done on a specific oral health strategy.

It is difficult to get accurate information on other primary health care providers in New Zealand because of the range of providers. Information from an annual survey of certain professional groups is available, but the accuracy depends on the response rate to the survey. For this reason time series data have not been included in this section. Rates per 100 000 population for 1998 are shown in Figure 10.

Figure 10: Primary health care staff groups: rates per 100 000 population 1998



Source: New Zealand Health Information Service

Utilisation

Apart from dentists, people rarely see other health care providers, mainly because the reasons for doing so are usually fairly specific. Some of the relevant findings from the health survey are that in the previous 12 months:

- people with disabilities (24 percent) are more likely to have seen a physiotherapist than the general population (approximately 15 percent)
- approximately 5 percent of people had seen a social worker, psychologist or counsellor; twice as many people with a disability had seen one of these professionals
- approximately a third of people with intellectual or psychiatric disabilities had seen another primary care provider done so compared with less than 10 percent of people with other disabilities
- approximately 1 percent of people had seen a traditional healer or a Māori or Pacific health worker; the rate for Māori and Pacific peoples is higher.

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URGENT

URGENT



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HEALTH REPORT COVER SHEET

Subject: Cabinet Business Committee paper about releasing the Primary Health Care Strategy document

Date: 2 February 2000

File Ref:

Attention: Hon Annette King (Minister of Health)

Copy to: Hon Ruth Dyson (Associate Minister of Health)
Hon Tariana Turia (Associate Minister of Health)

Output Class:

	Action Sought	Deadline
Hon Annette King (Minister of Health)	Table the accompanying paper at Cabinet Business Committee on 10 February 2000	3 February 2000
Hon Ruth Dyson (Associate Minister of Health)	Note	
Hon Tariana Turia (Associate Minister of Health)	Note	

Contact for telephone discussion (if required)

Name	Position	Telephone		Suggested First Contact
		Direct Line	After Hours	
Dr John Marwick	Senior adviser	496 2052	562 8801	1
Philip Davies	Deputy Director General	496 2320		2

Cabinet Business Committee paper about releasing the Primary Health Care Strategy document

Purpose of Report

This paper provides you with a paper to table at the Cabinet Business Committee on 10 February 2000 seeking their approval for the release of the Primary Health Care Strategy discussion document.

Background Information

At its meeting on 26 January 2000, Cabinet Business Committee noted that "as part of the work towards the New Zealand Health Strategy a discussion document on the future of primary health care in New Zealand will be released in February 2000, following approval by the relevant Cabinet Committee" CBC (00) M 1/4 Item e refers.

The completed discussion document entitled "Primary Health Care Towards 2000" is attached. You plan to release it during your address to the Independent Practitioners' Association Network meeting on 18 February.

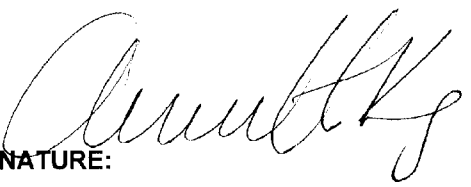
The attached paper for the Cabinet Business Committee provides committee members with copies of the report and asks them to note its contents and, as agreed at the meeting on 26 January, to approve its release.

Recommendation

It is recommended that you table the attached paper at the Cabinet Business Committee meeting on 10 February 2000 along with a copy of the attached Primary Health Care Strategy discussion document.

Yes / No


Judy Glackin
Acting Deputy Director General
Policy


MINISTERS SIGNATURE:

DATE:

3.02.00

Quality of Policy Advice Rating

Not Applicable	Poor	Fair	Satisfactory	Good	Excellent

OFFICE OF THE MINISTER OF HEALTH
WELLINGTON

MEMORANDUM TO CABINET BUSINESS COMMITTEE

RELEASE OF PRIMARY HEALTH CARE STRATEGY DISCUSSION PAPER

PROPOSAL

1 Cabinet Business Committee is asked to approve my releasing on 18 February 2000 a discussion paper on a Primary Health Care Strategy.

BACKGROUND

2 Cabinet Business Committee, at its meeting on 26 January 2000, noted that "as part of the work towards the New Zealand Health Strategy a discussion document on the future of primary health care in New Zealand will be released in February 2000, following approval by the relevant Cabinet committee" CBC (00) M 1/4 Item e. A copy of the discussion document that is to be released on 18 February accompanies this paper.

COMMENT

3 The Primary Health Care Strategy paper seeks submissions by the end of March on a proposed strategy. Key aspects of the proposed strategy are listed below.

- a) A population-based approach is proposed, with people affiliating with a primary health care provider organisation of their choice. These organisations would, through service agreements with District Health Boards, ensure their affiliated populations received a comprehensive set of primary health care services (health education, disease prevention, and supportive services as well as treatment). They would be funded according to the population they served (i.e. capitation funding) and would be required to work to national and district plans based on the New Zealand Health Strategy.
- b) Various organisational forms would be possible (including community owned, NGO operated, or groups of private health professionals) but they would be clearly accountable to District Health Boards to ensure that taxpayer funds were only applied to improving health status and/or health services and that local communities have effective ways to participate in shaping their primary health care services.
- c) Funding will be equitably allocated to organisations according to the people they are serving rather than the number of services they provide. This will mean some redistribution from areas that have been 'over-funded' relative to their needs compared to areas with greater needs. The implementation of these changes will need careful management over time.

OFFICE OF THE MINISTER OF HEALTH
WELLINGTON

MEMORANDUM TO CABINET BUSINESS COMMITTEE

RELEASE OF PRIMARY HEALTH CARE STRATEGY DISCUSSION PAPER

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- c) Funding will be equitably allocated to organisations according to the people they are serving rather than the number of services they provide. This will mean some redistribution from areas that have been 'over-funded' relative to their needs compared to areas with greater needs. The implementation of these changes will need careful management over time.

- d) The relationship with District Health Boards will need to be fully determined so as to clarify the roles of District Health Board primary health care committees, the extent to which services and funding will be nationally prescribed, ways to ensure that primary care is not dominated by the Board's role as hospital provider, and how primary health care provider organisations and their communities can have an appropriate voice at district level. These matters are also being addressed by officials (ref CBC (00) M 1/4 Item gg).

CONSULTATION

4 The Ministry of Health has consulted both with central government agencies and with key sector stakeholders in developing the strategy to its current stage. Medical and nursing groups support the main proposals and have been asking for a clearer statement of future Government policy in this area to guide development. The strategy builds on a number of the concepts that were generally accepted by providers in the consultation process over Health Funding Authority's 1998 proposed strategy for general practice, while also seeking to address some criticisms of that document.

5 5000 copies of the discussion document will be distributed to provider groups throughout the health and disability sectors as well as to interested consumer groups and individuals. Submissions will be invited asking that responders pay attention to key issues. Meetings will be held with principal stakeholders including Māori and Pacific people's groups. The Ministry of Health will collect and analyse responses. The report on responses will be part of the process for developing the New Zealand Health Strategy that the Cabinet Business Committee approved on 26 January 2000 (CBC (00) M 1/4 Item b).

FINANCIAL IMPLICATIONS

6 The Primary Health Care Strategy discussion document does not commit Government to any changes in expenditure. Under the proposed strategy, funds for primary health care will be more equitably distributed according to the characteristics of the population served.

LEGISLATIVE IMPLICATIONS

7 There are no proposals for legislative change included in the strategy. If, as a result of consultation, legislative changes were to be required to implement primary health care changes, they will be considered as part of the changes arising from the New Zealand Health Strategy and structural design work.

COMPLIANCE COST STATEMENT

8 There are no relevant compliance costs associated with releasing the Primary Health Care Strategy discussion document.

PUBLICITY

9 In general it is anticipated that the primary health care proposals will be welcomed. Some members of the public are likely to react against the notion of being expected to affiliate with a primary health care provider organisation and will wish to discuss issues such as any loss of freedom to visit a provider of their choice and questions of confidentiality. Some provider groups may also react against aspects of the strategy such as being required to establish primary health care organisations or they may complain about the breadth of the vision.

10 These issues are covered in the strategy document and are identified as questions that the Minister wishes to receive comment about. In releasing the document I will openly ask for responses while supporting the positive gains for health and health services that the strategy will achieve.

Recommendations:

11 I recommend that Cabinet Business Committee:

- a) note the contents of the attached discussion document on a Primary Health Care Strategy: "Primary Health Care Towards 2010"; and
- b) approve my releasing the discussion document on 18 February 2000 and inviting responses.



HON ANNETTE KING
MINISTER OF HEALTH

CONSULTATION ON CABINET AND CABINET COMMITTEE SUBMISSIONS

Certification by Department

DEPARTMENTS CONSULTED: The attached submission has implications for the following departments whose views have been sought and are accurately reflected in the submission:

.....

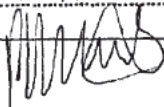
DEPARTMENTS INFORMED: In addition the following departments have an interest in the submission and have been informed:

Treasury, PPMC, SSC, T.P.K.

OTHERS CONSULTED: Other interested groups have been consulted as follows:

HFA

Signature



Name, Title, Department

P DAVIES, DEPUTY DIRECTOR GENERAL

Date

2.2.00

HEALTH

Certification by Minister

Ministers should be prepared to update and amplify the advice below when the submission is discussed at Cabinet/Cabinet committee.

Consultation at Ministerial level

The attached submission:

- ☒ does not need consultation with other Ministers
☐ has been the subject of consultation with relevant Ministers

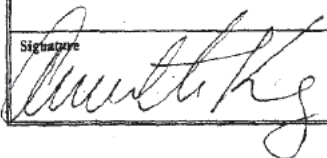
Consultation with Government MPs

- ☒ does not need consultation with the government caucuses
☐ has been/will be the subject of consultation with the government caucuses (detail if appropriate)
☐ Labour
☐ Alliance

Other consultation at Parliamentary level

- ☒ does not need consultation at parliamentary level
☐ has been/will be the subject of consultation with other parties represented in Parliament (detail if appropriate)

Signature



Portfolio

Health

Date

3.12.00

**CABINET SOCIAL POLICY AND
HEALTH COMMITTEE**Discussion Paper Not
Not Signed**SPH (00) 1**

7 February 2000

Copy No: 32

This paper is the property of the New Zealand Government. As it includes material for Cabinet or Cabinet Committee purposes it must be handled with particular care, and in accordance with any security classification or other endorsement assigned to it. The information in it may be released only by persons having proper authority to do so, and strictly in terms of that authority.

Title	PRIMARY HEALTH CARE STRATEGY : RELEASE OF DISCUSSION PAPER
Purpose	This paper seeks approval for the Minister of Health to release the discussion paper "Primary Health Care Towards 2010", on a Primary Health Care Strategy (copy attached), on 18 February 2000.
Previous Consideration	At its meeting on 26 January 2000, CBC noted that the discussion document would be released in February 2000, following approval by the relevant Cabinet committee [CBC (00) M 1/4 refers]. Responses will contribute to the development of the New Zealand Health Strategy approved by CBC on 26 January 2000.
Summary	The discussion paper seeks submissions, by the end of March 2000, on a proposed Primary Health Care Strategy. Key aspects of the proposed strategy are: - a A population-based approach, with people affiliating with a primary health care provider organisation of their choice; - b Various possible organisational forms; - c Funding would be equitably allocated to organisations according to the people they are serving, rather than the number of services they provide; - d The relationship with District Health Boards will need to be fully determined. Officials are currently addressing this issue.
Baseline Implications	None indicated.
Legislative Implications	None indicated.
Timing Issues	Proposed date of release: 18 February 2000.
Announcement	The Minister notes that in releasing the document she will openly ask for responses, while supporting the positive gains for health and health services that the strategy will achieve.

Consultation The Minister indicates that caucus consultation is not required.
Treasury, DPMC, SSC, TPK.
HFA.

The Minister of Health recommends that the Committee:

- e note the contents of the attached discussion document on a Primary Health Care Strategy: "Primary Health Care Towards 2010"; and
- f agree that the Minister of Health release, and invite responses to, the discussion document "Primary Health Care Towards 2010" on 18 February 2000.

Wendy Adams
for Secretary of the Cabinet

COPIES TO:

Cabinet Social Policy and Health Committee
Chief Executive, DPMC
Minister of Finance
Secretary to the Treasury
Director-General of Health
Chief Executive, Crown Company Monitoring Advisory Unit (HHS)
State Services Commissioner
Chief Executive, Te Puni Kokiri
Chief Executive, Ministry of Social Policy (Senior Citizens)
Chief Executive, Ministry of Pacific Island Affairs
Chief Executive, Ministry of Women's Affairs
Chief Executive, Ministry of Youth Affairs

OFFICE OF THE MINISTER OF HEALTH
WELLINGTON

MEMORANDUM TO CABINET BUSINESS COMMITTEE

RELEASE OF PRIMARY HEALTH CARE STRATEGY DISCUSSION PAPER

PROPOSAL

1 Cabinet Business Committee is asked to approve my releasing on 18 February 2000 a discussion paper on a Primary Health Care Strategy.

BACKGROUND

2 Cabinet Business Committee, at its meeting on 26 January 2000, noted that "as part of the work towards the New Zealand Health Strategy a discussion document on the future of primary health care in New Zealand will be released in February 2000, following approval by the relevant Cabinet committee" CBC (00) M 1/4 Item e. A copy of the discussion document that is to be released on 18 February accompanies this paper.

COMMENT

3 The Primary Health Care Strategy paper seeks submissions by the end of March on a proposed strategy. Key aspects of the proposed strategy are listed below.

- a) A population-based approach is proposed, with people affiliating with a primary health care provider organisation of their choice. These organisations would, through service agreements with District Health Boards, ensure their affiliated populations received a comprehensive set of primary health care services (health education, disease prevention, and supportive services as well as treatment). They would be funded according to the population they served (i.e. capitation funding) and would be required to work to national and district plans based on the New Zealand Health Strategy.
- b) Various organisational forms would be possible (including community owned, NGO operated, or groups of private health professionals) but they would be clearly accountable to District Health Boards to ensure that taxpayer funds were only applied to improving health status and/or health services and that local communities have effective ways to participate in shaping their primary health care services.
- c) Funding will be equitably allocated to organisations according to the people they are serving rather than the number of services they provide. This will mean some redistribution from areas that have been 'over-funded' relative to their needs compared to areas with greater needs. The implementation of these changes will need careful management over time.

- d) The relationship with District Health Boards will need to be fully determined so as to clarify the roles of District Health Board primary health care committees, the extent to which services and funding will be nationally prescribed, ways to ensure that primary care is not dominated by the Board's role as hospital provider, and how primary health care provider organisations and their communities can have an appropriate voice at district level. These matters are also being addressed by officials (ref CBC (00) M 1/4 Item gg).

CONSULTATION

4 The Ministry of Health has consulted both with central government agencies and with key sector stakeholders in developing the strategy to its current stage. Medical and nursing groups support the main proposals and have been asking for a clearer statement of future Government policy in this area to guide development. The strategy builds on a number of the concepts that were generally accepted by providers in the consultation process over Health Funding Authority's 1998 proposed strategy for general practice, while also seeking to address some criticisms of that document.

5 5000 copies of the discussion document will be distributed to provider groups throughout the health and disability sectors as well as to interested consumer groups and individuals. Submissions will be invited asking that responders pay attention to key issues. Meetings will be held with principal stakeholders including Māori and Pacific people's groups. The Ministry of Health will collect and analyse responses. The report on responses will be part of the process for developing the New Zealand Health Strategy that the Cabinet Business Committee approved on 26 January 2000 (CBC (00) M 1/4 Item b).

FINANCIAL IMPLICATIONS

6 The Primary Health Care Strategy discussion document does not commit Government to any changes in expenditure. Under the proposed strategy, funds for primary health care will be more equitably distributed according to the characteristics of the population served.

LEGISLATIVE IMPLICATIONS

7 There are no proposals for legislative change included in the strategy. If, as a result of consultation, legislative changes were to be required to implement primary health care changes, they will be considered as part of the changes arising from the New Zealand Health Strategy and structural design work.

COMPLIANCE COST STATEMENT

8 There are no relevant compliance costs associated with releasing the Primary Health Care Strategy discussion document.

PUBLICITY

9 In general it is anticipated that the primary health care proposals will be welcomed. Some members of the public are likely to react against the notion of being expected to affiliate with a primary health care provider organisation and will wish to discuss issues such as any loss of freedom to visit a provider of their choice and questions of confidentiality. Some provider groups may also react against aspects of the strategy such as being required to establish primary health care organisations or they may complain about the breadth of the vision.

10 These issues are covered in the strategy document and are identified as questions that the Minister wishes to receive comment about. In releasing the document I will openly ask for responses while supporting the positive gains for health and health services that the strategy will achieve.

Recommendations:

11 I recommend that Cabinet Business Committee:

- a) note the contents of the attached discussion document on a Primary Health Care Strategy: "Primary Health Care Towards 2010"; and
- b) approve my releasing the discussion document on 18 February 2000 and inviting responses.



HON ANNETTE KING
MINISTER OF HEALTH

CONSULTATION ON CABINET AND CABINET COMMITTEE SUBMISSIONS

Certification by Department

DEPARTMENTS CONSULTED: The attached submission has implications for the following departments whose views have been sought and are accurately reflected in the submission:

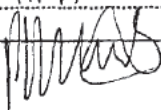
DEPARTMENTS INFORMED: In addition the following departments have an interest in the submission and have been informed:

Treasury, PMO, SSC, T.P.K.

OTHERS CONSULTED: Other interested groups have been consulted as follows:

HFA

Signature



Name, Title, Department

P. DAVIES, DEPUTY DIRECTOR-GENERAL

Date

2.2.00

HEALTH

Certification by Minister

Ministers should be prepared to update and amplify the advice below when the submission is discussed at Cabinet/Cabinet committee.

Consultation at Ministerial level

The attached submission:

- ☒ does not need consultation with other Ministers
☐ has been the subject of consultation with relevant Ministers

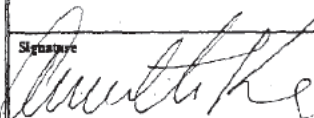
**Consultation with Government
MPs**

- ☒ does not need consultation with the government caucuses
☐ has been/will be the subject of consultation with the government caucuses (detail if appropriate)
☐ Labour
☐ Alliance

**Other consultation at
Parliamentary level**

- ☒ does not need consultation at parliamentary level
☐ has been/will be the subject of consultation with other parties represented in Parliament (detail if appropriate)

Signature



Portfolio

Health

Date

3.12.00



000036

HEALTH REPORT COVER SHEET

Subject: Cabinet paper on release of the Primary Health Care Strategy discussion document

Date: 10 February 2000

File Ref: NE R6.

Attention: ~~Hon Annette King (Minister of Health)~~

Copy to: Hon Ruth Dyson (Associate Minister of Health)
Hon Tariana Turia (Associate Minister of Health)

Output Class:

	Action Sought	Deadline
Hon Annette King (Minister of Health)	Table the accompanying paper at Cabinet on 14 February 2000	11 February 2000
Hon Ruth Dyson (Associate Minister of Health)	Note	
Hon Tariana Turia (Associate Minister of Health)	Note	

Contact for telephone discussion (if required)

Name	Position	Telephone		Suggested First Contact
		Direct Line	After Hours	
Marilyn Goddard	Principal Analyst	496 2325	472 2507	1
Dr John Marwick	Senior Advisor	496 2052	562 8801	2

CABINET SOCIAL POLICY AND HEALTH COMMITTEE PAPER ON RELEASE OF THE PRIMARY HEALTH CARE STRATEGY DISCUSSION DOCUMENT

PURPOSE OF REPORT

1. This paper provides you with a paper to table at the Cabinet meeting on 14 February 2000 seeking its approval for the release of the Primary Health Care Strategy discussion document.

BACKGROUND INFORMATION

2. At its meeting on 26 January 2000, the Cabinet Business Committee noted that "as part of the work towards the New Zealand Health Strategy a discussion document on the future of primary health care in New Zealand will be released in February 2000".
3. The document was reviewed at the Cabinet Social Policy and Health Committee on 7 February. You were invited to revise the document in light of the discussion at the meeting. In particular:
 - a) to specify more explicitly that primary care organisations will be expected to deliver programmes and services specified by the District Health Boards in accordance with the Government's goals for primary health care.
 - b) confirm that impact on funding for midwifery will not be tied to funding for Independent Practitioner Associations.
4. The amended discussion document entitled "Primary Health Care Towards 2000" is attached. You plan to release it during your address to the Independent Practitioners' Association Network meeting on 18 February. If the paper is approved at the Cabinet meeting on Monday it should be possible to meet that timeframe.

RECOMMENDATION

5. It is recommended that you table the attached paper at the Cabinet meeting on 14 February 2000 along with a copy of the attached Primary Health Care Strategy discussion document.

Yes / No


Judy Glackin
Acting Deputy Director General
Policy

MINISTERS SIGNATURE:

DATE:


10/2/00

Quality of Policy Advice Rating

Not Applicable	Poor	Fair	Satisfactory	Good	Excellent

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1962

OFFICE OF THE MINISTER OF HEALTH
WELLINGTON

MEMORANDUM TO CABINET

RELEASE OF PRIMARY HEALTH CARE STRATEGY DISCUSSION PAPER

PROPOSAL

- 1 Cabinet Social Policy and Health Committee was asked to approve my releasing a discussion paper on a Primary Health Care Strategy on 18 February 2000. Cabinet's approval is now sought for release of the amended document.

BACKGROUND

- 2 The Cabinet Social Policy and Health Committee (SPH (00) M 1/1) reviewed the document on 4 February. At that meeting the Committee:
 - a) noted the contents of the discussion document on a Primary Health Care Strategy: "Primary Health Care Towards 2010," attached to submission under SPH (00) M 1/1;
 - b) noted that responses to the discussion document will be sought by 30 March 2000;
 - c) invited the Minister of Health to revise the "Primary Health Care Towards 2010" discussion document in the light of the discussion at the meeting to more clearly reflect the new Government's policies, including:
 - i. a clear indication that primary care organisations will be expected to deliver programmes and services specified by the District Health Boards, and in accordance with the Government's goals for primary health care;
 - ii. clear specification of the impact on funding for midwifery, confirming that it will not be tied to funding for Independent Practitioner Associations;
 - d) invited the Minister to refer the document, amended as outlined in paragraph (c) above, to the Cabinet meeting on 14th February 2000.

COMMENT

- 3 The Primary Health Care Strategy paper has been amended as outlined above. I propose to extend the timeframe for responses to 28 April 2000.

RECOMMENDATIONS:

11 I recommend that Cabinet

- a) note the contents of the attached discussion document on a Primary Health Care Strategy: "Primary Health Care Towards 2010";
- b) note that responses to the discussion document will be sought by 28 April 2000; and
- c) approve my releasing the discussion document on 18 February 2000.

A handwritten signature in black ink, appearing to read 'Annette King', is positioned above the printed name.

HON ANNETTE KING
MINISTER OF HEALTH

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

CONSULTATION ON CABINET AND CABINET COMMITTEE SUBMISSIONS

Certification by Department

DEPARTMENTS CONSULTED: The attached submission has implications for the following departments whose views have been sought and are accurately reflected in the submission:

N/A

DEPARTMENTS INFORMED: In addition the following departments have an interest in the submission and have been informed:

N/A

OTHERS CONSULTED: Other interested groups have been consulted as follows:

N/A

Signature

H. Goodland

Name, Title, Department

Minister of Health

Date

10.2.00

Certification by Minister

Ministers should be prepared to update and amplify the advice below when the submission is discussed at Cabinet/Cabinet committee.

Consultation at Ministerial level

The attached submission:

- ☒ does not need consultation with other Ministers
- ☐ has been the subject of consultation with relevant portfolio Ministers
- ☐ has been the subject of consultation with relevant coalition consultation Ministers

Consultation with Government MPs

- ☒ does not need consultation with the government caucuses
- ☐ has been/will be the subject of consultation with the government caucuses (detail if appropriate)
 - ☐ Labour
 - ☐ Alliance

Other consultation at Parliamentary level

- ☒ does not need consultation at parliamentary level
- ☐ has been/will be the subject of consultation with other parties represented in Parliament (detail if appropriate)

Signature

Minister of Health

Portfolio

Health

Date

10.2.99

=SCANNED=
URGENT



HEALTH REPORT

Subject: Amended version of primary care discussion document

Date: 17 March 2000

File Ref: HC50-07-26

Attention: Hon Annette King (Minister of Health)

Copy to: Hon Ruth Dyson (Associate Minister of Health)
Hon Tariana Turia (Associate Minister of Health)

Output Class: 1. Health and Disability

	Action Sought	Deadline
Hon Annette King	Agree the wording of the primary care discussion document with the Prime Minister and agree to release the document	
Hon Ruth Dyson	Note	
Hon Tariana Turia	Note	

Contact for telephone discussion (if required)

Name	Position	Telephone		Suggested First Contact
		Direct Line	After Hours	
Dr John Marwick	Senior adviser	496 2052	562 8801	✓
Marilyn Goddard	Portfolio manager	496 2325		
Judy Glackin	Deputy Director General	496 2195		

PURPOSE OF REPORT

1. This report provides an amended version of the primary health care discussion document incorporating changes discussed with your office and the Prime Minister's office. It recommends that, as authorised by Cabinet, you agree the final wording of the document with the Prime Minister and agree to release the document.

BACKGROUND INFORMATION

2. At its meeting on 14 February 2000, Cabinet authorised yourself and the Prime Minister to agree the final wording of the discussion document on primary health care (CAB (00) 40; SPH (00) M 1/1). Following that decision, officials from the Ministry, your office and the Prime Minister's office have made a significant number of changes to the document. In particular, these clarify the relationship between the proposed primary health care arrangements and the other changes that the Government plans for the health sector.
3. Significant amendments and clarifications include:
 - District Health Boards, not primary care organisations, will have the responsibility for analysing people's needs
 - while people will be encouraged to affiliate with primary care organisations in order to strengthen the population approach to health care, affiliation will not be obligatory and practitioners will not be required to join primary care organisations
 - primary care organisations must be not-for-profit; must have representation from the community and the range of involved practitioners; and must not be owned or governed by health insurers
 - primary care organisations will not hold secondary care budgets
 - certain services such as maternity and well-child care will still be able to be provided and funded outside primary care organisation arrangements.

COMMENT

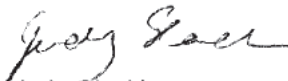
4. The Ministry believes that the attached document accurately includes all the amendments suggested by your office and the Prime Minister's office.
5. There is considerable interest in the primary care community and the medical press about when the document will be released. The Ministry recommends that you should launch it in the week beginning 27 March 2000. This would require an agreement from you by 20 March in order to allow time for the copies to be printed and distributed. The Ministry will work with your office to confirm a suitable date and format for the launch and an accompanying communications strategy.

6. The document allows eight weeks for submissions with a closing date of 26 May 2000. This will be close to the time that the New Zealand Health Strategy consultation is expected to commence. The Ministry will collect and analyse submissions on the primary health care document and will hold meetings with selected interested parties.

RECOMMENDATIONS

7.

- (a) **Agree** the final wording of the primary health care discussion document with the Prime Minister. ☒ Yes ☐ No
- (b) **Agree** to release the document in the week following your agreement with the Prime Minister; preferably in the week beginning 27 March 2000. ☒ Yes ☐ No
- (c) **Ask** the Ministry to work with your office to arrange the launch and a communication strategy. ☒ Yes ☐ No


Judy Glackin
Acting Deputy Director General

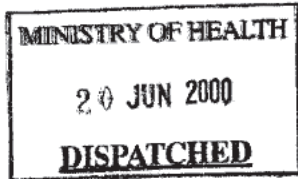


MINISTERS SIGNATURE:

DATE: 19/3/00

Quality of Policy Advice Rating

Not Applicable	Poor	Fair	Satisfactory	Good	Excellent



HEALTH REPORT

Subject: PRELIMINARY INFORMATION ABOUT PRIMARY CARE ORGANISATIONS

Date: 19 June 2000 **File Ref:** HC01-16-4

Attention: Hon Annette King (Minister of Health)

Copy to: Hon Ruth Dyson (Minister for Disability Issues)
Hon Tariana Turia (Associate Minister of Health)

EXECUTIVE SUMMARY

This paper has been prepared in response to your request for information about Primary Care Organisations and whether there was a model that could be used for approving a Primary Care Organisation. These are issues that are currently being considered as part of the work around the primary health care discussion document.

Some 300 submissions have been received on the document and about 40 meetings held. Analysis of comments will take some weeks. You will receive a report in mid-July.

The Primary Health Care discussion document talks about primary care organisations but leaves a number of questions about them unanswered. Answers will be needed before a primary health care strategy is finalised. It is too early to favour any particular model and, indeed, it may be that various different models should be allowed.

The size of the organisations is undefined. A degree of flexibility is preferred to a more prescriptive approach. Since a key requirement is to have strong community links, small groups may be best. On the other hand larger groups are able to support things that small ones cannot. Organisations might cover between 5 000 and 20 000 people but they could work in with other organisations for those services that could best be shared.

Matters of governance and profit raise various questions. More work is needed to be clear about meaningful community 'voice.' The not-for-profit requirement needs to be further explored to be clear about what risks are being avoided and hence how the requirement should best be implemented. When private or non-Governmental organisations provide primary services, they must still be consistent with public health service ideals.

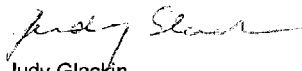
The **services** to be included need further definition. All organisations should be providers of first level generalist clinical care as well as a set of services for education, prevention, and ongoing care at the individual and local level. Other services might be added to this set or linked in from other providers. The set of services should be nationally agreed and would have implications for the type, size and distribution of the organisations.

We propose using a sector reference group to help finalise a strategy for Cabinet in September or October. A first step will be to release a report on the submissions.

RECOMMENDATIONS

The recommendations are that you:

- (a) agree that the Ministry should, by the end of September, prepare a Cabinet paper recommending adoption of a definitive primary care strategy; ☒ Yes / ☐ No
- (b) note that the Ministry will use a small sector reference group in preparing the strategy; ☒ Yes / ☐ No
- (c) note that the Ministry is currently analysing around 300 submissions and comments from some 40 meetings and will draw on these submissions in preparing the strategy; ☒ Yes / ☐ No
- (d) note that the size, nature, roles and responsibilities of primary care organisations are key issues for further definition and it is too soon to favour any particular model. ☒ Yes / ☐ No


Judy Glackin
Acting Deputy Director-General


MINISTER'S SIGNATURE:

DATE: 24/9/00

PRELIMINARY INFORMATION ABOUT PRIMARY CARE ORGANISATIONS

BACKGROUND INFORMATION

1. This paper has been prepared in response to your request in late May for information about Primary Care Organisations. You were interested in whether there was a model of a Primary Care Organisation that could be used for approving Organisations. The paper explains what the primary health care discussion document proposes about Primary Care Organisations, outlines comments made in meetings and submissions, comments on current Ministry thinking about various aspects, and recommends a process for finalising a strategy and model for Organisations.

What the discussion paper proposes

2. The discussion paper proposes a more population-based approach. Most providers will be part of an organisation paid to deliver a defined range of services of a defined quality to an affiliated population.
3. While primary care organisations can take a range of forms they must:
 - have meaningful patient and community representation in governance processes
 - have appropriate representation from the range of health providers in the organisation
 - be not-for-profit organisations
 - be fully and openly accountable for public funds and ensure that any surpluses are used to improve health status or increase access to agreed health services.
4. Some 300 submissions have been received on the document and around 40 meetings held.

Some comments and issues raised in discussions and submissions

5. Comments and early submissions contain a number of commonly mentioned issues. Some of these are listed below.
 - Primary care organisations are often thought to be the same as Independent Practitioner Associations (IPAs). This leads some people to various conclusions about size, form and operation.
 - Some people think primary care organisations must be quite large – sizes such as 30 000 or even 100 000 people have been mentioned. This would exclude some smaller groups and leave large groups such as IPAs in a dominant position.
 - Because of the supposed size requirements, rural community trusts and some Māori organisations are concerned that they would be disbarred from becoming primary care organisations.
 - Because doctors currently dominate IPA ownership, other health professionals are concerned that they will not be able to develop.
 - Some groups are concerned that community representation on primary care organisations may be tokenism rather than truly meaningful representation.
 - Others say that private GPs have driven many useful developments and it is unreasonable to expect such groups to involve communities and other professionals in their governance.

- Some commentators wonder how it is possible to have not-for-profit primary care organisations when so many primary care services are delivered by private providers.
- Some have suggested that District Health Boards are the appropriate body to carry out co-ordination and to meet population health needs. They argue that primary care organisations represent an unnecessary extra layer of management.

COMMENT

Size - flexibility but smallish (5 000 - 20 000) organisations have some strengths

6. The discussion paper does not specify any particular size for primary care organisations.
7. A previous HFA paper about the future of general practice¹ had suggested a minimum population of 30 000 for future organisation of general practices. Other discussions about setting up entities that would hold budgets for a range of primary and secondary services proposed that 100 000 was the minimum suitable population. These figures were largely reached in the context of organisations being expected to carry significant financial risk. They were not developed in the context of the redesigned health system with District Health Boards.
8. The current proposals put more emphasis on being close to the community, allowing it 'voice,' knowing those served and increasing coordination and continuity of care. Rather than quite large groupings that are necessarily more remote from their communities, these considerations point towards smaller units covering a community of interest such as a small town or a neighbourhood. In this case the ideal population may be 5 000 to 20 000 people.
9. Is there any necessity to specify a particular size? The HFA's GP proposals were quite strongly opposed in some quarters because they stipulated a minimum 30 000. The Primary Health Care Strategy might usefully consider the extremes of size and make some other comments about groups that are small or large.
10. At the smaller end of the spectrum, groupings serving less than, say, 5 000 people, may not be able to sustain the provision of the minimum range of quality services (such as health education, preventive care, first level clinical care, and ongoing support).
11. The smallest viable primary care organisations would therefore cover 5 000 or more people. Such organisations should be able to have excellent knowledge of, and links to their community. They will not, however, be able to provide a sufficiently large base for some important primary health care services. For example, they will not be in a position to provide a range of primary mental health services. For such services they would have to have networks and arrangements with other providers. They would also need to make arrangements with larger bodies to provide certain sorts of support for their operations (e.g. information capability, management services, contracting expertise, professional education and support and so on).
12. The difficulties these very small units have in providing even a quite narrow range of services and support may lead towards larger groupings that are able to broaden the range of services and the support they offer. Groups of, say, between 20 000 and 50 000 are able to offer more population services.
13. Larger groupings of 100 000 plus can support a range of educationalists, researchers and other support specialists, as well as being a base for extended primary services such as diabetic or other specialist nurses. However, at this size, the organisation will have difficulty in maintaining meaningful links with the communities that it serves.
14. One model that is developing in some places could combine the advantages of smaller local groups with the economies of scale of larger ones. The primary care organisations would be

¹ Health Funding Authority. 1998. *The next five years in General practice* Wellington: Health Funding Authority.

fairly localised and moderately small with good community buy-in (perhaps owned by a community trust or some sort of joint organisation between the community and providers). The organisation might cover a small town or perhaps a part of a larger metropolitan area. Each such local organisation would link in to an overarching body that would supply a set of services such as management, information, professional support and contracting services. Existing large IPAs might take on this management support role while the current member practices form primary care organisations at the more local level.

Governance, not-for-profit considerations - clarity needed

15. Organisations that have existing contracts with the HFA take a variety of forms.
16. IPAs are mostly limited liability companies owned by their general practitioner members, and governed by boards that are predominantly, but not exclusively, made up of doctors. They all state that improving health is a key goal, though support of the providers who make up their membership is another common aim². Mostly they are not set up to maximise profits and they have various controls around what is appropriate use of any budget surpluses.
17. Some IPAs have already moved towards an approach more attuned to public health service ideals. These IPAs are involving community people on their boards or setting up formal consultation processes so that the community can have an impact on governing policy decisions about the organisation. Some have involved nurses and other practitioners on governing bodies. About a third have changed their legal status from company to a not-for-profit status such as an incorporated society or charitable trust.
18. Other existing organisations include Māori and Pacific groups and the 'third sector' members of Health Care Aotearoa. These groups are community-owned providers that employ their nurses and doctors. Most are charitable trusts and are governed by boards of community representatives. Various rural community trusts operate in similar ways (although most at present do not hold comprehensive primary health care contracts).
19. The primary care discussion document proposes that all primary care organisations should be not-for-profit and should involve meaningful community and provider representation in their governance processes. Further thought needs to be given to what types of organisational and governance arrangements should be accepted.
20. Policy advice on these matters will depend on analysing the risks that are avoided or lessened by the requirements for community input and not-for-profit status. This analysis is likely to centre on issues such as:
 - ensuring that services reflect local priorities and needs, not provider preferences or interests
 - making sure that the most disadvantaged sectors of the community have their needs considered
 - clarifying what types of community and patient involvement are acceptable as being 'meaningful' or how organisations could demonstrate meaningful involvement
 - ensuring that public funds for health are used only for that purpose - the need for rules about, for example, disclosure of financial information and possibly controls on levels of salaries and fees, and issues to do with owner's equity and valuation of capital
 - whether health providers are motivated (and/or incentivised) to maximise health rather than profits

² Malcolm L. 1999. *The development of primary care organisations in New Zealand*. Wellington: Ministry of Health.

- how to also ensure that organisations are efficient and sustainable
- the importance of open co-operation between providers, rather than a defensive, competitive approach
- how to manage the potential conflicts between the interests of private providers, locally owned providers, and providers owned and controlled by Government.

Services to be included - *at least preventive services and first level care*

21. The paper talks about primary health care being comprehensive. However, to a certain extent this conflicts with some other points of the document where it is stated that particular services may not be included in the services that primary health organisations must provide – services such as maternity care, well-child care, sexual health services, and family planning.
22. Some of the apparent confusion arises from the need to build on existing arrangements even if the longer-term vision is a move towards a more encompassing primary health care service. In the short term there may only be a few places where it is possible for first line general clinical services to be integrated with, for example, midwifery care, community nursing or mental health services. In the longer term it makes sense to reduce duplication and improve co-ordination by moving towards more comprehensive primary health services.
23. In discussions, we have found that those providers whose main involvement is with health education and prevention programmes to communities, schools and in people's homes, wonder where they will fit in the proposed scheme. Similarly disability support service providers who offer long-term support need to understand their place. Some providers of particular primary care services (e.g. dentists, midwives, family planning) have asked whether they should be able to set up primary care organisations and have patients affiliate.
24. More definition is required about which services are considered essential for all primary care organisations. The document proposes that there should be a nationally agreed set of such services that all organisations must provide. The list will include health education and disease prevention services, as well as first level diagnosis and treatment, and care for those with ongoing problems.
25. What is not clear is the extent to which all such services are expected to be provided under the auspices of a primary care organisation or whether some will continue to be provided separately. For example, many existing generalist practices would argue that they already provide education, disease prevention, and ongoing care as well as first line diagnosis and treatment. They do not, however, provide community-wide health education programmes, nor do they run all disease prevention initiatives or provide much of the long-term support for those with ongoing conditions.
26. If it is accepted that all primary care organisations should include practitioners who were able to provide first level clinical services to any member of the population regardless of their particular reason for seeking help, there are certain consequences for the size, distribution and make-up of the organisations. The organisations must also be able to take a population approach to the group of people they serve – and this too has implications for its capabilities and structure.
27. Work is needed to define these matters more clearly.

Timetable and process

28. The Ministry expects to have completed and reported on its analysis of submissions by mid-July. We will recommend that the analysis be made available to all submitters and any other interested parties.
29. We plan to submit a completed strategy for consideration by Cabinet towards the end of September (probably after approval of the New Zealand Health Strategy). To achieve this in a way that credibly takes account of feedback on the discussion document the Ministry plans to

establish at least one small advisory panel consisting of people with community, Māori, Pacific, and provider backgrounds. The panel will be asked to consider policy questions from a broad perspective and comment on what should be in the final strategy.

30. Ministry and HFA staff will use the submissions and comment from the advisory panel to develop a preliminary draft of the strategy. Once you are satisfied the draft reflects your intent, drafts will be presented to central agencies, the Minister's office and the offices of other key Ministers.

Too early for any particular model of primary care organisation

31. It would be helpful at this stage to dispel some people's fears about primary care organisations being large, exclusive bodies dominated by doctors and controlling large parts of primary care funding. On the other hand, there are dangers in presenting any particular model of an organisation since considerable further work is needed in the light of submissions. In any case, the future system will probably encourage a fair degree of diversity to meet local differences.

IMPLICATIONS FOR CLOSING THE GAPS

32. Primary care organisations will have specific requirements about meeting national and district priorities including decisions taken under the Closing the Gaps work. There will be specific requirements about Māori health and operating in accordance with the Treaty of Waitangi. Primary care organisations will be funded equitably according to a formula that reflects the health needs of the population they serve - and the formula will reflect the extra health needs that Māori and Pacific people have. In addition to matters to do with primary care organisations, the primary health care strategy will, in various other ways, address the gaps in health status.

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Report on the submissions to *The Future Shape of Primary Health Care: A discussion document*

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1 Introduction

There have been increasing calls from the primary health care sector for a strategy to provide direction for the future of primary health care services. While funding issues have been the most predominant areas of concern, there are also a number of other issues that the sector would like to see addressed, including:

- the growing number of seemingly unconnected developments in the sector, such as pilots promoting greater co-ordination between primary health providers and between these providers and the secondary care sector
- the Nursing Taskforce, which had supported an expanded role for nurses in primary health care delivery and prescription rights for nurses
- an number of general practices and Independent Practice Associations (IPAs) have been unsuccessfully seeking capitation contracts following their introduction in the former Midland Regional Health Authority area
- an increasing call for greater support for Māori and Pacific services
- rural consumers and providers were increasingly concerned about access to services
- concern from providers that the General Medical Services benefit (GMS) was no longer adequately addressing access issues.

At the same time, the Government has set a programme of change for the health and disability sector. The Government is reconfiguring the sector, and is introducing District Health Boards (DHBs) to help ensure that services reflect the needs of individuals and communities at a local level. Through population-based funding, DHBs will be responsible for the health of their local populations.

The Government is particularly committed to reducing the disparities in health outcomes among Māori and also among Pacific peoples, to ensuring that there is good co-ordination across the health sector so that the whole system works and those working the sector feel part of the total system, to better community and consumer involvement at all levels, and to a better focus on population needs.

The Government is in the process of finalising a New Zealand Health Strategy, which will be released later this year, following extensive consultation. This strategy will identify principles, goals and objectives for the wider health sector.

Within the framework of the New Zealand Health Strategy there will be a number of 'umbrella' strategies. These will help clarify the roles that particular parts of the sector will play in achieving the New Zealand Health Strategy's goals and objectives.

In order to develop a primary health care strategy, the Minister of Health published a discussion document *The Future Shape of Primary Health Care: A discussion document* in March 2000. She requested a wide consultation with the sector and with other people who were interested in the future of primary health care.

The primary health care discussion document proposed a vision for primary health care and suggested ways that primary health care services might be organised to

achieve this. The prime aim of the consultation was to obtain a wide range primary health care consumers' and providers' views both on the vision and the ways that were suggested to achieve this vision.

This document reports on the submissions that were received in response to the discussion document. A summary of the responses has also been produced.

The information obtained during the consultation process will provide a major input into the decisions of the sector wide group who will help to design a final strategy. Later this year, the Minister of Health will release the final Primary Health Care Strategy.

1:1 The consultation process

1:1:1 Making a submission

The consultation period ran from 1 April 2000 to 26 May 2000. During the consultation period, 4500 copies of the discussion document were distributed, and the document was also on the Web.

Submission in response to the discussion document were received in the following ways:

- 290 written submissions were received from a wide range of providers and consumers. Most of these covered some or all of the questions outlined in the document. (For a breakdown of who the responses came from, see Table 1.)
- A total of 54 meetings were held (for a breakdown of the meetings, see Table 2):
 - Meetings were held with various organisations, such as the New Zealand Medical Association, the Pharmacy Guild, Healthcare Aotearoa. These meetings were by invitation.¹
 - A series of 'focus group' meetings were held with groups of medical and health care providers. In these groups 10–15 providers and sometimes community representatives were brought together to discuss the document. These meetings were often very productive as people with different perspectives were able to discuss issues between themselves.
 - Eight meetings were held with Māori co-funders and providers. The strategy was also discussed as part of a national hui on changes in the health sector. Two individual meetings were held with the Chief Executive Officers of co-funding organisations and one with representatives of an iwi authority. A number of Māori providers also took part in other meetings.
 - Three meetings were held with Pacific provider groups, which were attended by a total of around 70 people. A number of Pacific providers also took part in other meetings.

¹ Not all organisations invited to these meetings chose to attend.

Table 1: Written responses by groups

Providers	
National organisations (most representing providers)	29
General practices and independent general practitioners	48
Other providers	26
Rural health trusts	13
IPAs	14
Māori providers and co-funders	14
Pacific providers	3
National and regional health groups	16
Hospital and Health Services	
Boards and CEOs	5
Sections	18
Subtotal	186
Consumers	
National and regional consumer groups (health and related)	33
Individuals (not identified members of any grouping)	26
National and regional groups (non-health)	11
Territorial local authorities	13
Tertiary Institutions (most from individual staff)	13
Government agencies	6
Other	2
Subtotal	104
TOTAL	290

As already stated, 54 meetings were held with groups and individuals. The majority of these meetings were with providers or their representatives. Some of the focus groups included both consumers and providers.

Table 2: Meetings

Focus groups of providers and consumer representatives	18
Independent practitioner organisations	6
Health care organisations	7
Māori health providers	8
Pacific fono	3
National organisations	12
TOTAL	54

1:1:2 Content of responses

The discussion document included nine questions to guide responses. One question included a number of suggestions about 'other' topics that might interest the person or group making the response. The majority of written responses addressed either all of the questions or those questions that they found most relevant to them. Some responses addressed other issues such as a fear of hospital domination in DHBs or a perceived failure to recognise Pacific or rural issues.

The responses varied in the complexity of the responses and the variety of issues addressed. The length of the responses varied from just one or two pages addressing just a few issues, to some responses of over 50 pages addressing all or most of the issues raised in the discussion document as well as other issues. Some provided detailed descriptions of ways they were already addressing the issues highlighted in the discussion document.

The content of the meetings was often more fluid than written submissions and most covered a range of issues including the new health system, with emphasis on the issues of greatest concern to the group. For example, the meetings with groups of nurses focused on ways that the proposed changes might affect their profession.

1:2 Analysis of submissions

The written responses and the written summaries of the content of the different meetings were entered onto a database. Each written submission and the record of the comments at each meeting were coded in relation to the issues that they covered.

The coding was initially developed on the basis of the questions provided in the document and preliminary analysis of the meetings and early submissions. After initial data was entered the coding schedule was revised and additional codes created to cover other areas coming through in the submissions.

All major points in each submission were entered onto the database. Issues that did not correspond to the coding on the original databases were also entered.

The coding of the first data entered onto the database was checked by the team who conducted the consultation and discussed with the coders. A further analysis of data entered was made after 50 submissions had been entered and further changes made to data as appropriate. The four people who entered the data also consulted among each other on a regular basis to ensure consistency of coding.

1:3 Reporting back on responses

This document:

- reports on the views of respondents to the issues raised in the document and to other issues that they wished to raise
- identifies all the major issues that both providers and consumers thought needed to be addressed in the development of any strategy if it was to be successful
- identifies any suggested 'solutions' to problems the responses identified.

The analysis is thematic rather than quantitative. However, where a view is widely held or held by one group rather than another, this is made clear in the document. The document does not make any judgement on the accuracy or otherwise of the views expressed in any submission.

1:3:1 Structure of this report

The feedback on the discussion document was largely determined by the range of issues covered and the depth in which they were addressed. While most responses were shaped by the questions provided in the discussion document, some issues attracted considerably more attention than others.

Some issues, such as population-based services and affiliation, were covered in several sections of the feedback. These issues were brought together in the coding. Therefore this report does not exactly mirror the questions asked in the discussion document.

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2 Organisation of primary health care services

The discussion document proposed that most primary health care services would be delivered by Primary Care Organisations (PCOs) responsible for the delivery of a range of services that would increase primary care's focus on the health of populations. The document did not provide detail about what the structure of a PCO would entail or endorse one type or size of PCO. It did propose that such organisations would:

- have meaningful patient and community representation in the governance structure
- have appropriate representation from the range of health care providers in the organisation
- be not-for-profit organisations
- be fully and openly accountable for public funds and ensure that any surpluses are used to improve health status or increase access to agreed health services.

Many providers and consumers in meetings and written submissions expressed uncertainty about what a PCO was or would be. During meetings officials were often asked to define what a PCO was and/or to give examples of existing organisations that the Ministry thought might be seen as PCOs.

Two hundred and twenty-four responses addressed one or more aspects of PCOs and they were usually a topic in meetings. Many of these responses thought that a PCO could be an effective mechanism for delivering primary health care services. However much of this support was conditional on what final form was adopted and it was apparent that some of the visions of what a PCO could be were mutually exclusive.

One-third of responses were essentially neutral about the concept, either because they did not think that they would be involved or because they felt unable to make a decision until they saw more detail about PCOs. A small number of responses could see no way at all that a PCO could be effective.

2:1 Primary care organisations

2:1:1 Advantages of PCOs

Many responses were supportive of the idea that primary care providers needed to be better integrated, more focused on health promotion and disease prevention and should be able to identify the populations it was working with. Some believed that the organisational structures currently in place in primary health care would need to change to achieve this vision.

Many GPs and their organisations thought that PCOs had the potential to improve the delivery of primary health care services. The Okataina Declaration (a discussion document produced by most major GP organisations²) thought that with an extension of affiliation, PCOs had the potential to enhance the provision of population services. Other possible advantages cited in responses included:

- more equitable targeting of available funding
- an increased focus on health promotion and disease prevention
- a more efficient way of targeting individuals and populations
- closer liaison between different providers leading to greater integration of comprehensive primary health care services under one organisation
- a more holistic approach to primary health care provision.

However many non-GP providers, particularly those that identified PCOs as IPAs, were more hesitant about the model. A particular concern in these responses was that PCOs would be very GP-dominated and were really just IPAs 'in disguise'. Midwives and nurses in particular thought that this could be a major danger for the development of PCOs. Māori and Pacific providers were also concerned about the possibility that the vision of PCOs in the document would exclude them setting up their own PCOs.

2:1:2 Models of PCOs provided

Some responses provided models of what they thought that a PCO might look like. Four models were proposed more frequently than others.

PCO as umbrella organisation of a wide variety of providers

Some providers saw the potential to develop a PCO as an umbrella organisation involving a range of providers in addition to GPs and practice nurses. They thought that these organisations would then be able to provide the wide range of services expected of a PCO. One response, from a low income area, saw the potential to involve the hospital services in a DHB in such a structure, while several others stressed the need for PCOs to work closely with local hospitals.

Our local experience has demonstrated the benefits of a single strong organisation in terms of ability to co-ordinate and deliver services, and to build collaborative local relationships (IPA).

The DHB as a PCO

A model sometimes suggested was that the DHB itself could act as a PCO. People adopting this model were concerned that PCOs would otherwise be dominated by GPs whereas a DHB would be free of partiality and would be willing to support smaller, more specialised services. Other advantages seen were that this model could avoid staff and resource duplication implicit in having several PCOs in the same

² These were CareNet, New Zealand Medical Association, IPA Council of New Zealand, General Practitioner Council of New Zealand, the Medical Association, the Royal New Zealand College of General Practitioners, NZ Rural GP Network, the General Practice Department of Wellington School of Medicine and First Health. Hereafter it is referred to as the Okataina Declaration.

geographical area, would be in a better position to promote integration and could provide reasonable-sized populations for a PCO.

There should be just one primary care organisation for all of South Auckland. It should be large enough to offer a full range of services up to plaster casts for simple fractures . . . an organisation with 380,000 geographically enrolled people may have that capability (IPA).

Rural trust models

A number of rural health trusts saw the potential for their existing organisations to be reorganised as PCOs if there was sufficient flexibility. They observed that the trusts already involved a number of providers, were sometimes based on (and staffed) the local hospital, and provided a wide range of services including hospital-based primary health care services such as district nursing and public health nursing. However, as a rule, they were dubious whether such a model would work well in urban areas where there was a wide range of competing providers.

Māori co-funder organisations

A number of Māori providers and co-funders saw a potential to maintain and expand the co-funding models as PCOs. A concern they had however was that some groups might not be able to provide the entire range of services suggested, at least initially. A few however saw the potential to reach partnerships with other organisations to provide these services.

2:2 Issues that need to be considered in the future development of PCOs

As noted, the lack of detail on the structure of a PCO led many responses to identify issues that they thought would need to be considered in any future development of the model. Some issues such as affiliation and funding are dealt with separately (see sections 3 and 6).

2:2:1 A need to build on current initiatives and allow for variation

Many providers and some consumers were concerned that changes that emerged as a result of the strategy should not interfere with initiatives under way in areas such as affiliation, capitation, enrolment and population-based services. Groups particularly concerned about this possibility included rural trusts, IPAs who felt they were already developing innovative responses, Māori and Pacific providers and community focused 'not-for-profit' organisations.

Some responses were concerned that the Ministry might be looking to develop a single model to apply in all areas and for all populations. People observed that the population in their area or the services that were delivered to meet the populations needs were often quite different from that in other areas, even within the boundaries of one DHB. They were keen to see this flexibility maintained, rather than the development of a 'one size fits all' solution.

2:2:2 Size and range of people and providers in the organisations that become PCOs

The number of consumers who would need to be part of a PCO was seen as being important. Forty submissions addressed this in detail and it was often raised in meetings.

Many providers and consumers felt that a PCO with relatively small consumer numbers would allow for more community input and would allow providers to know their populations better. This was seen allowing a greater emphasis on population-based services. Some responses doubted that there was any evidence that larger models were effective in New Zealand.

It is probably almost the opposite in New Zealand where the culture of being small, connected and locally accountable drives quality much more than being large and technically driven (Healthcare Aotearoa).

Related closely to this concern was one about the range of services to be provided by a PCO. If the PCO had to be able to directly provide these services, the organisation itself would have to be large, and to support itself would need a large number of consumers.

Māori, Pacific and other developing providers were concerned that if the consumer population were too large, or the range of services required in a PCO were too large, they would be unable to establish themselves as a PCO. This would force them to amalgamate with larger established primary care organisations.

Primary care organisations must be small enough to enable providers which cover populations as small as 5,000–10,000 to operate independently (Pacific providers group).

Larger providers (often IPAs) were more supportive of a model that involved larger numbers of people. They believed that there were considerable advantages to be had from having a large population base and a large number of providers could be involved. Advantages included:

- the ability to contain a wide range of health professionals with special interests within one organisation
- greater opportunities for quality management processes
- effective risk management
- a financial basis to develop effective data management systems
- DHBs would not have to contract with a whole raft of smaller providers.

A few IPAs thought that the advantages of small scale could be maintained within a model where the PCO allowed the development of smaller location or population based 'localities' within it. Some groups were already exploring these options and existing examples were cited in this context.

[Our IPA] demonstrates a size that has economies of scale to enable it to have skills and capabilities to develop new innovative solutions . . . a flexible approach should be adopted in defining the required structures and configurations (IPA).

Some Māori, Pacific, rural providers and larger national organisations such as the National Heart Foundation and the Family Planning Association believed that 'populations' should not always have to be geographically defined. They thought that there should be flexibility for a PCO's population to be defined by age, ethnicity gender or a common need for services. They thought that the use of exclusively geographical boundaries could cause the marginalisation of some people within a large PCO or inadequate service delivery for groups who would be relatively small numbers in the total population of a PCO.

2:2:3 The future role of IPAs

Most IPAs found the idea of PCOs less threatening than many other providers and community groups. However most IPAs recognised that the current structures of IPAs, such as the range of providers they involved and the range of services they provided, could be unable to meet the definitions of a PCO provided in the discussion document. Some were already considering what changes would be necessary for them to meet the criteria.

Some were concerned about the emergence of a definition of a PCO that would make it difficult for an IPA to transform itself into one. They feared that the benefits that they saw had emerged from the IPA structure might be lost in the new structures.

While the NZMA accepts that other health providers may need to be brought within the ambit of PCOs and that there is a case for governance and representation to be broadened, it is very important that the enthusiasm and initiative which IPAs have brought to the primary care sector are not lost or unreasonably constrained (New Zealand Medical Association).

Others, including some GPs and consumers, also identified the proposed PCOs as IPAs. Their response to this development was often more negative, as many did not think that IPAs were a good model of service delivery. Their concerns included a belief that:

- the budget holding associated with IPAs was an incentive to reduce services
- PCOs would be unable or unwilling to involve the community
- the establishment of PCOs would lead to a lack of opportunity for Māori and Pacific providers.

Some geographically large providers were concerned that PCOs might be required to develop within the boundaries as one DHB. One IPA observed that if this were to happen they would lose approximately 40 percent of their members. This would limit the services they were able to provide.

2:2:4 Māori attitudes to PCOs

As noted above, some Māori providers and funders were concerned about the development of PCOs where these were required to have large population bases and/or to provide a wide range of services. They feared that this would reduce their ability to become PCOs themselves and thus to provide the services that their people required.

An important issue for some Māori providers was that the concept of PCOs (especially if they followed the IPA model) would not recognise the partnership agreement in the Treaty of Waitangi.

The risks for Māori providers in clients registering at the primary care organisation level is that Māori clients may base their decisions to affiliate on the capacity of a primary care organisation that may not deliver effectively to Māori (Māori provider).

Some Māori co-funders and providers saw the opportunity for a Māori PCO, or a PCO developed along the approaches taken by Māori providers in delivering services. They considered that this would not only increase choice, but would also improve health outcomes. If the purpose of PCOs is to improve the health of its affiliated population, then offering services in culturally effective ways and a holistic manner, and one that reflects the needs of the populations served, would provide appropriate and acceptable health services.

In this way, services would not only be more culturally appropriate, but they would also be able to focus on the 'hard to reach'. Further, such an approach would provide further impetus to Māori provider development, and build on other Māori umbrella organisations such as MAPOs and Māori Development Organisations.

While there can be no doubt that affiliation with one primary health care organisation can be advantageous to Māori, particularly from a continuity and relationship perspective, primary care organisations must demonstrate that they are able to offer a range of services that give Māori choice, including accessing of tohunga and rongoa as acceptable and valid health options (College of Nurses Aotearoa – Māori caucus).

A number of suggestions were advanced about what alternative models or safeguards needed to be put in place to protect Māori providers and consumers. One model being considered by several Māori funders and providers was to explore a model that involved partnership between Māori and Pākehā providers. One MAPO suggested an innovative approach to the enrolment process which they saw would complement the diverse reality of New Zealand's health sector and build upon successes to date.

This approach would allow for shared enrolment with a nominated primary care service provider and a Māori provider. It would be premised upon a partnered relationship between two primary care organisations (Māori or Mainstream), or a PCO and a Māori health care organisation (MHCO). Enrolment could occur with either the PCO or the MHCO.

Irrespective of whom the Māori consumer is enrolled with, they would retain their option to choose and access Māori provider services because:

- it would be mandatory for the PCO to enter into partnered health care arrangements with existing Māori providers in order to offer a full complement of services (both type and targeted delivery style) to Māori enrolees, or
- it would be mandatory for the MHCO to ensure that the Māori enrolee has a lead primary care service provider (who can deliver GMS etc) where an MHCO does not currently provide such services.

Enrolment, partnerships, referrals and co-ordination standards would be provided by the Ministry of Health and DHBs for effective partnerships. These would be monitored and enforced by government agencies. A Māori Health Service Plan, based upon assessment of Māori health needs, measurable health gain targets and other developmental issues, would be required annually to measure and monitor performance. These plans could be incentive based (positive /negative) and the partnership supported by initial development funding.

2:2:5 Implications for Pacific providers and people

Pacific providers also had some concerns about the potential (or otherwise) of PCOs to deliver adequate services for Pacific people. The development of large PCOs was seen as a threat by current Pacific providers. A particular concern was that if PCOs were required to be large and to provide a wide range of services, then Pacific providers would be unable to create one. They would then have to join Palangi PCOs, and be dominated with their agendas. The possible marginalisation of Pacific health providers who wished to continue to maintain health services 'by Pacific for Pacific' was seen as contradicting the concept of what primary health care is all about.

A related concern was that, other than in Auckland and Porirua, there would not be the population basis to support a Pacific PCO their services. The concept of one or two PCOs for all Pacific people was advanced in this context.

The difficulties that might arise for Pacific providers providing appropriate advice for Pacific people was also noted. It was felt that the Ministry would need to ensure that there were sufficient resources for Pacific providers to explain what was happening and available would be necessary.

Pacific peoples may not know how to select the right PCO for their needs and may not be informed of the mechanisms to change, or worse be discouraged from changing. The ongoing saga of poor information to Pacific women about their choices of lead maternity carers is a good illustration of this (Pacific provider).

2:2:6 Other issues

A number of other issues about the role of PCOs were raised in submissions and meetings. Many of these related to fear that PCOs would be dominated by GPs. These concerns included:

- Many non-GP providers such as nurses and midwives, community groups and consumers were concerned that PCOs should not be captured by any one sector group, particularly doctors. They were concerned that doctors would run the organisations and be the gatekeepers who would determine what services would be delivered and by whom and the quality required.

There is a risk that primary care organisations which were controlled by one group run the risk of offering health services which were not fully integrated but dominated by the services provided by the lead provider (New Zealand Society of Physiotherapists).

The Okataina Declaration recommended that PCOs (of whatever size) should be required to co-operate with other providers in order to better meet the needs of DHB populations.

- Some providers and consumers were concerned that the sheer size of a PCO (as they envisaged it) would have negative effects on the providers who were part of it or on other providers in the same region. The concerns included:
 - large PCOs would have difficulty being flexible in the types of services it delivered and/or the relationship they developed with other providers
 - other providers would have difficulty in developing or maintaining themselves in the areas that were already covered by large PCOs
 - patients (individuals and groups) were concerned about the effect that belonging to a 'large PCO' would have on their relationship with their present general practitioner
 - being affiliated to a large PCO would limit a person's ability to access alternative services they wished to as freely as they could now
 - some providers and consumers were concerned that large PCOs would obtain too much power under the new structure as was currently the case with IPAs.

Primary care organisations due to their size and potential market dominance, run the risk of becoming inflexible and unresponsive to community need. It will be important to ensure that new providers can emerge even if they provide only part of the full range of services (Co-ordinated health provider group).

2:3 PCOs will have meaningful patient and community representation in their governance processes

Over half the written submissions commented on the requirement for community involvement in the governance of PCOs. Many of these submissions addressed the general theme of community involvement in primary health care rather than looking specifically at how this might work with a PCO. There was high level of support for increased community and consumer involvement from both providers and consumers.

2:3:1 Ways that community and or consumer groups are currently involved with primary care providers

A number of providers and other groups observed that they already had methods of involving the community and patients at some level in the governance of primary health care provision. They suggested that these models might achieve at least some of the goals thought desirable in the discussion document.

Examples given included:

- One large IPA had established a Trust to act as a sounding board and provide independent perspectives on the IPAs' programmes. Members were appointed from nominations by the Mayor, other health care organisations and Pacific Community leaders.
- A large medical practice in a low income area reported that it had developed a close working relationship with an organisation of community health care providers.
- A community group, part funded by the local council, which included both local health care providers and community groups, met regularly to discuss health issues affecting their city.
- A midwives group described its trust board which is made up of two elected consumer representatives, one elected Māori consumer representative, one elected midwife representative and one elected home birth representative. The chairperson is always a consumer representative. The group believes this structure ensures that it is consumer led.

2:3:2 Expected benefits from service users and community representation

Nearly two-thirds of these responses commented on the benefits they expected from the development of a closer relationship between community and providers. This expectation was often based on the respondents' current experiences with community involvement.

The major benefit expected was that provider groups would be more responsive to local needs and their services would be delivered in a manner that is appropriate and consistent with community requirements. Other expected benefits included the following:

- Community representation on PCO boards would denote a formal relationship with patients, for example, providers would need to explain their decisions in a way that could be understood by the communities affected by them.
- Some consumer groups anticipated that community representation on PCO boards would lead to greater transparency in issues such as identifying who was responsible for purchasing services.
- Some responses referred to the confidence and empowerment that consumers would gain from more active participation in addressing their health concerns. They also hoped that opportunities would be given for representatives to gain useful skills and knowledge.

- Some individual GPs suggested that the community would develop a more responsible attitude towards spending on primary health care as their representatives became more aware of the issues involved in apportioning budgets.

Community representation must be across the board so that health professionals 'can walk the talk'. PCOs need to be open and approachable, invite suggestions, view complaints as a way of improving service. Have varying points of contact and communication (Consumer group meeting).

Community participation is very important to ethnic communities. The present set up of primary care ignores this [fact]. Communities are better informed of their own health problems [than providers] and their active participation in addressing their health concerns will give them confidence and empowerment (Auckland Refugee Health Centre and New Zealand Federation of Ethnic Councils).

2:3:3 Suggested structures to allow community effective voice with providers

There was some discussion about the most appropriate form for community representation in the governance structure. While the election or selection of a member or two onto any board structure was one suggested answer, there was also some debate over the effectiveness of this strategy.

A number of alternatives to the model of 'a seat on the board' were suggested including:

- Several responses from Territorial Local Authorities (TLAs), GP practices and consumers suggested they saw advantages in PCOs working with a separate umbrella organisation that had balanced representation of other providers and consumers representatives and the ability to advance a community vision.
- The establishment of community health committees that were constituted on a locality basis based on the experience of Area Health Boards. These might include DHB members and meet regularly to discuss decisions that the PCO was making.
- A health sector equivalent of the Education Review Office to monitor PCOs' level of response to the community. One supporter of this model believed that this could relieve pressure on communities to provide board representatives who would be able to fulfil this function.

[We] recommend a system similar to that of the education system's board of trustees. Representation should be encouraged from different geographic groups, including rural, from within a community and if none is elected then they should have the ability to co-opt an appropriate person (Consumer group).

Responses from both providers and consumers suggested that there needed to be adequate structures and processes for representatives to be part of decision-making once they had been appointed or elected. This might involve special training.

Some responses suggested the UK and Australia have developed effective models of community representative on primary health care bodies. They thought a study of

these would be valuable before any final decision on how this would be achieved was made.

2:3:3 Community groups that should be represented on the Boards or other forms of representation

Some responses nominated groups that they felt were not adequately represented at present. They felt these groups should be represented, in some way, in any future PCO governance structure. These included:

- Māori
- Pacific peoples
- mental health consumers who need safeguards to ensure their interests are protected
- community-based disability support groups
- service groups and perhaps organisations like Citizens Advice Bureaux
- youth
- older people
- local government representatives
- ethnic communities such as refugees and recent migrants.

2:3:4 Selection procedures for obtaining community representation on PCOs

Many submissions addressed the issue of how members were selected. Some, particularly from Māori and Pacific providers, thought that a consultation process must ensure that selection procedures were acceptable to the local community and that representatives were actually available.

Some responses noted that a number of organisations such as TLAs already had experience with ensuring community representation and recommended they be consulted with before any final decision on ways to select representatives.

Effective representation could be achieved by consulting with communities to discover what mechanisms are already available e.g. councils, health groups etc. It will be important to use what already exists and is acceptable to communities and to ensure that community representatives are available (TLA).

Some responses noted that it was important to recognise that effective community consultation could mean that a wide range of different models of consumer representation would emerge. These could vary with the needs of particular communities. Māori and Pacific groups were concerned that where PCOs had only one or two 'elected' representatives, they would be unlikely to come from their communities.

It must be left to Māori to determine (representation) at the hapū-iwi level rather than having the nature of representation dictated to them as a group from a national perspective (College of Nurses Aotearoa – Māori caucus).

I support this if the voice of Pacific Island and other groups are truly heard. It is important how this is driven and by who. It should have clear guiding principles in place to avoid domination by any one or two groups. There should also be a 'partnership' agreed process to determine how representation from various groups is sought (Pacific community worker).

A number of IPAs also suggested that their own experience in community consultation would provide useful models and some already had developed systems for selecting representatives that suited their needs. These were reluctant to have a centrally determined system imposed on them.

2:3:5 Concern about the ability of the community to generate effective representation at PCO level

Despite overall approval of the principle of community representation, a few consumer groups were concerned about the ability of communities to provide adequate representation. They feared that the general public might not be motivated to participate in PCOs or similar organisations.

Another concern, particularly from Māori providers and consumers, was that there was only a limited number of people who had the expertise to take on this role (whether on a board or a similar organisation). People with expertise were often already over-committed and this small group could be further limited when representation is also required at DHB level.

A number of groups recommended remuneration would be necessary as a way of ensuring broad-based community representation.

The community should be funded to supply representation – genuine representation from a wider range of community interests (Community health providers group).

2:4 PCOs will have appropriate representation from a range of health providers in the organisation

Sixty submissions, nearly all from providers or their organisations, commented on the requirement to have health care providers represented in the governance of an organisation. Most accepted the concept in principle although there were some caveats about the way that this might operate in practice.

2:4:1 Current practice

Responses about current practice were more likely to refer to the development of general practice teams and better working relationship than to formal governance arrangements. Practice nurses were the professional most likely to have been involved in these to date and were already involved in several IPAs. The nurses from one large IPA listed a number of ways they had been involved with decision-making there. These included nurse representation on all initiative and project working groups and having nursing representatives at senior management level.

However, this did not appear to always be the norm. At a meeting with nurses, practice nurses voiced their feeling that they were still unable to contribute fully despite changing attitudes in some IPAs. Some GPs suggested this was because nurses themselves were unwilling to become involved and one nursing group suggested that it was nurses themselves that needed to change their attitudes for this to be a reality.

Relationships between GPs and other providers were less frequently mentioned. The Royal New Zealand College of General Practitioners mentioned a large joint venture between GPs and midwives, where these practitioners worked together as an example of co-operation between providers. A response from a group of rural trusts spoke of the value of their multi-skilled and flexible teams where different providers worked together.

2:4:2 Who should be represented

There were few responses detailing the providers that should be involved. Nurses were more likely to be mentioned than other providers and the College of Nurses Aotearoa stressed the importance of nurses being represented in PCOs. Other responses suggested a range of future members of any PCO including pharmacists, physiotherapists, community workers and traditional healers. The Pharmacy Guild was keen that the pharmacists' role as first contact providers should be recognised and that they have a role in future PCOs. They observed they already had a key role advising GPs about pharmaceuticals.

2:4:3 GPs' views on representation of other providers in PCOs

Most IPAs and other groups of GPs agreed with the principle of wider provider representation in PCO administration. The major advantage seen was the development of closer relationships between providers. Some noted factors that would need to be resolved before this became practice. These included:

- Many GPs have made a substantial capital investment in setting up a practice as a business and they are often the owners. This gives GPs a greater stake than non-owners and some had doubts about sharing governance with non-owners where it might affect this investment.
- Several responses noted that the intellectual input and time commitment made by GPs in the setting up of IPAs had generated considerable enthusiasm and also a sense of ownership not always shared by other providers. It was felt that this input should be taken into consideration when determining the level at which other providers should have input.
- Some IPAs commented that the way GPs (and the practices) were funded made it difficult for other providers to contribute to strategic decision-making in any meaningful way. Apart from those services that were capitated it was necessary that patients see a GP to attract funding.

Fee-for-service funding of general practice supports GP dominance and disempowers the role of the practice nurse as an independent practitioner within the general practice team (IPA).

- If PCOs were to involve the range of providers implied in the discussion document, and that all of those providers had to be represented, it could lead to unmanageably large committees. This could make it difficult to obtain consensus and one response observed that clear rules for representation would be needed.

Overall, the consistent message from GPs and their representatives was that they supported the principle but that they thought it would take time for this relationship to be implemented satisfactorily. They thought that the development of a culture and environment where other providers would be able to play a meaningful role would not happen overnight. One response observed that this would be a matter of evolution rather than revolution.

Clearly if multiple healthcare professionals are forced into an organisation before there is an environment and culture for addressing common tasks co-operatively, there will be significant conflict and the net loser will be the community (IPA).

2:4:4 Other providers' views on the current situation concerning representation

All other providers who commented on the future role of other providers in the governance of PCOs were uniformly in favour of increased representation of other providers. They felt that this closer working relationship could only benefit the delivery of health care services.

Representation provided opportunities for different professionals to network and share information, but more importantly it could help reduce competitiveness between providers (Hospital and Health Service).

Some responses noted that GPs dominated most current primary care provider organisations. They thought that this could make it extremely difficult to make any meaningful changes to the level of input by other providers in these organisations. Other potential problems identified included:

- GPs controlled the capital investment in most general practices and it was difficult for nurses (or other providers) to become financial partners. The resulting budget control by GPs gave them the power to control salaries as well of determining the strategic direction of the organisation.
- Several providers such as midwives and nurses groups commented on the differences between their views on effective primary health care delivery and those of many GPs. At least initially this might hinder their working together.
- Some responses noted that GPs in IPAs and other organisations were a concentrated group with shared interests. This gave them a stronger influence in decision-making than individual providers with more fragmented interests. The nurses, the counsellor, the pharmacist all have different training and different interests. This could make it difficult for them to form a united body of opinions.
- Many of these providers observed that the future PCOs would need completely different structures from IPAs if effective representation from a range of providers was to be achieved. In IPAs there were structural reasons for GP dominance, some of which had also been addressed by GPs themselves (see above).

National providers such as the Family Planning Association and the New Zealand AIDS Foundation were concerned that the interests of the particular groups they represent needed to be recognised on any PCOs in the future (whether or not they themselves were a formal part of a PCO). These groups often felt that at present they were unable to represent these views to GPs in any meaningful way. This could mean that some other form of representation would need to be developed if there were to be closer relations between these providers and PCOs.

2:5 Be not-for-profit organisations

Only a small number of responses addressed the requirement that PCOs be not-for-profit entities. These included those from provider organisations such as IPAs and nurse groups and number of consumer groups including TLAs and women's health groups. There was general support from both providers and consumers for the concept of PCOs being not-for-profit organisations. However, many responses were concerned about a lack of clarity in the discussion document about the exact meaning of the term.

2:5:1 PCOs or individual providers to be not-for-profit?

Most GPs and their organisations accepted that PCOs or similar organisations should be not-for-profit. However some were concerned about whether this implied that providers themselves should be not-for-profit. This perception was generated by a fear the Government might be intending to make it a requirement for general practice (as opposed to provider organisations).

I am concerned that I and my husband have made a significant investment in our local community, both financially and emotionally. We worry that these changes will erode our income and make our practice unviable (Wife of rural GP).

Some of these responses observed that many primary sector providers, for example GPs, pharmacists and physiotherapists, had little choice about operating as for-profit operations. They had to fund buildings and infrastructure, pay staff and take the related financial risks.

For many years the government has depended on doctors willing to invest significant capital into establishing suitable facilities and infrastructure for general practice and thus establishing the primary care sector. In recent years greater investment has been necessary for information and compliance technology and consumerism and improved standards of practice... At this level it is legitimate for the primary care provider to be a profit making entity (IPA).

2:5:2 Attitudes to PCOs being required to be not-for-profit

Most IPAs and other GPs who commented were supportive of the concept and some IPAs were already exploring the changes necessary to give their organisations not-for-profit status. Some observed that in practice, if not in legal structure, most IPAs already operated in this fashion.

One provider group observed that it was appropriate that government-supplied funds should not be a source of profit for organisations.

Most PCOs will be comfortable with a not-for-profit structure. [This organisation] supports the allocation for health initiative funding through a not-for-profit trust that has a charitable status for tax purposes (IPA).

Consumer groups were more likely than providers to comment on this and all were in favour of the concept. People commenting were concerned that there would be incentives for future providers to limit services if they were for-profit organisations in order to maximise profits.

There may be perverse incentives for PCOs to retain greater profits by not providing services – how would the District receive services if PCOs chose not to deliver them (TLA).

Some doubted that the IPA structure had had the desired effect of limiting the ability of the organisation to generate profits from budget holding. Several consumers and some consumer groups observed that they believed that some IPAs had large bank balances, distributed unrealistically high payments to GPs to attend meetings or had unnecessarily large support staffs. This often led to the suggestion that PCOs in future needed to be differently structured from today's IPAs.

A few responses raised other concerns about how not-for-profit would be interpreted. These included:

- a PCO could be not-for-profit but still purchase services from for-profit organisations such as laboratories and pharmacies. They saw this as threatening the intention of the policy
- the practicality of not-for-profit status in a system where most providers were for profit small businesses. This led one respondents to suggest that a system like the National Health Service in the United Kingdom was a more practical way to achieve what they saw as the goal of the policy.

2:6 Be accountable for use of surpluses

Only a small number of responses dealt with the requirement to be accountable for funds received from the Government. There was general agreement that 'accountability' meant that organisations should be transparent in their spending of public funds including any surpluses that might be generated. Most submissions did not explore the meaning of accountability or transparency beyond this general statement.

One IPA described a Trust it had established to assist community development. This Trust has a founding document based on the Treaty of Waitangi and the Ottawa Charter. It was owned by the community and has a three-year strategic funding plan that is currently focused on adolescent wellness. It has funded initiatives in six state secondary schools and is funding activities in Intermediate schools this year.

There was some debate over how it would be decided what was an appropriate way to spend money. Some consumers and a few providers favoured direction from the centre on this. One consumer group favoured the introduction of legislation to ensure that any surpluses go to areas of high need.

Capitated funds should be used for health services to consumers and not business enhancements or professional developments. (Advocacy Group)

However responses from most providers were less enthusiastic about central guidelines. Some were concerned that decisions on how to spend 'profits' should involve the wider community.

However we object to a central body making the decisions about how to use these funds. We must be able to – in consultation with the local consumer and Māori groups – to decide how the surpluses should be spent. (General practice)

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3 Affiliation with a primary care organisation

The discussion document proposed that people would be encouraged to affiliate with one primary care organisation. They would nominate a preferred practitioner or practice within that organisation in order to facilitate a population approach to health. Two-thirds of the written submissions commented on some aspect of affiliation and the topic was often raised in meetings. The responses came from a wide range of providers and consumers. Many responses identified affiliation as enrolment and referred to it as such in their responses.

There were many comments on how the discussion document had used the term 'affiliation'. Just over one-third of responses suggested there needed to be more clarity in the document around definitions of terms such as affiliation, enrolment and registration. One IPA suggested the term 'membership' be used instead of affiliation or enrolment. They thought that this term could be interpreted to mean that a member could expect something out of the membership and that there are also some expectations of the member. This accentuated the concept of a two-way partnership between provider and patient in the provision of health care. A similar argument was advanced by a religious organisation.

Most of these responses agreed with the concept of affiliation, but this support was often conditional on how the system would work. Fifty submissions had very significant concerns about affiliation³ or were totally opposed.

Providers were generally, though not always in favour of the concept while consumers were more likely to be hesitant, particularly when affiliation was discussed in the context of capitation (see also section 6).

3:1 Current use affiliation/enrolment

There was wide support for affiliation among those provider organisations that already had similar systems in place. In the former Midland Regional Health Authority area, most IPAs already had voluntary enrolment to facilitate capitation. Members reported that providers' early concerns about people enrolling with more than one group or attending more than one provider were not the problem they initially feared. One observed that in balance 'unders and overs' were under 5 percent and tended to balance out between practices.

³ However some of these could also accept affiliation if it met certain conditions.

Health Care Aotearoa members already work with registered populations for whom they accept responsibility to provide a specific range of services. They believed that this system leads to strong relationships with their patients.

We do not have a problem with everyone in the community being affiliated or registered with a specific organisation. We do not believe that the concerns of some, that people will register with several providers is a significant issue (Health Care Aotearoa).

3:2 Attitudes to enrolment

3:2:1 Reasons for support of enrolment

Many providers and some consumers were in favour of affiliation. It was seen as a necessity if primary health care was to adopt a greater focus on population-based services or population-based funding. Without affiliation providers would have difficulty knowing the population that they were serving.

A core requirement for any population based funding model is identifying the population. Any devolution of funding from DHBs level to PCOs will require a process of actively identifying the population. . . . The parties to this submission support (or do not oppose) a process of formal affiliation (Okataina meeting).

Some providers, mostly doctors, saw that the strength of New Zealand's health system is the ability for patients and their doctors to have an ongoing long-term relationship. They thought that the extension of this relationship into an explicit enrolment arrangement, whether voluntary or compulsory, would create opportunities to enhance the provision of population services. The Hillary Commission believed that affiliation might increase the likelihood that providers would work to keep their consumers healthy.

Some responses thought that affiliation would lead to better services for some groups that were often not well covered at present. Groups mentioned in this context included children, based on the experience of the New Traditions Health Integration Project in Hamilton; and people with mental health problems. However one response arguing the advantages for people with mental health problems also noted that operating affiliation effectively would not be easy for this group.

A number of other key reasons to support affiliation were advanced, whether or not the respondents favoured voluntary or compulsory enrolment. These included that affiliation:

- was a necessary pre-requisite of capitation payments
- would provide consumers with an incentive to make a conscious choice of the provider or PCO that best suited their health needs

- would provide an opportunity to develop positive relationships between individuals and their chosen provider or PCO in such a way that respect, trust, responsibility, access, quality and entitlement were maintained.

The majority of primary health care providers said that affiliation would mean that they would have a defined and identifiable population base to work with. This would lead to a movement away from the current de facto registrations with a general practitioner to an explicit affiliation with a wider network of providers.

We accept the place of enrolment in a population-based funding system, . . . we believe that for enrolment to be successful, almost 100 percent enrolment will need to be achieved (New Zealand Medical Association).

3:2:2 Reasons for concern about affiliation

Many and some providers had some significant concerns about affiliation although some conditionally accepted it. Some who were opposed to it questioned whether the system had been demonstrated to have any positive effects on health status or other expected benefits elsewhere. They thought that compulsory affiliation could limit choices, especially where doctors had an incentive to not to affiliate people.

There is no evidence produced [in the document] as to what advantages enrolment will offer consumers. It does not offer lower costs, it limits choice, it may increase the difficulty of consumers accessing the services they want (Health advocacy group).

Some responses from both providers and consumers saw affiliation as a major risk for communities where significant numbers might choose not to affiliate. These communities would be disadvantaged both through loss of funding for practitioners and by the possible underestimation of the health care needs of the community.

Providers who were concerned about capitation had similar. Some such as nurses and Māori providers and some consumers thought that affiliation would inevitably favour GPs rather than other providers.

A preferred practitioner is almost always a doctor. But this does not always in fact represent the best means of delivering a population based service. We believe that the Ministry of Health has taken an overly bureaucratic approach believing that all primary health care services can be centralised into one service (Provider organisation)().

Providers with national contracts were often concerned about whether a consumer would be able to enrol with more than one provider. They feared that if this were not so, the consumer's right to choose a range of providers or to seek a second opinion would be greatly reduced. This was particularly a concern for midwives and groups that supported them.

The Family Planning Association feared that unless people could enrol with more than one provider, affiliation would reduce people's access to non-GP services where individuals did not find it easy to exercise their right to informed choice. This would then prevent them from seeing other providers in addition the 'registered' providers in a PCO. They felt that this barrier would act against their ability to access specific specialised, complex and sensitive advice they might not wish to see their GP about.

General practitioners however did not believe that enrolment would or should prevent people from using these services.

We do not believe that affiliation will be a barrier to choice, nor accept that it will undermine valued national bodies such as Plunket (Independent Practitioner Association Council).

Some providers, generally general practitioners, were worried about the possibility of double enrolment. This could mean either that they would not be reimbursed for seeing people or that the Government would be paying twice for people.

Some Māori providers were concerned about the requirement for individuals to enrol with only one body. They were concerned that most Māori providers would be unable to provide the full range of services required of a PCO (see also sections 2 and 4), and therefore would be unable to set up a PCO in some areas. Some Māori might then chose to enrol with a PCO in another area. Māori providers might therefore need to sub-contact mainstream providers who had enrolment and thus lose their independence. Pacific providers also had very similar concerns.

3:3 Issues to be resolved before affiliation is introduced

Although many responses agreed with the concept of affiliation they often had concerns about the ways that this might operate. A number of issues were raised that they thought would need to be resolved in greater detail before any widespread adoption of affiliation. Some of these concerns were similar to those raised by responses that were more uncertain about affiliation.

3:3:1 Compulsory or voluntary affiliation

Most responses from providers and consumers supported the proposal that affiliation be voluntary. They saw that that this was necessary to protect the ability to 'shop around' for services, the flexibility to choose between providers and the ability to have access to a variety of services. Other reasons to support voluntary enrolment included:

- Some IPAs, local bodies, community groups and national organisations thought it would be easier to encourage people to enrol in a voluntary system.
- It would be easier for people to maintain existing affiliation arrangements if they were not obliged to enrol.
- People might not necessarily want to go to the same practitioner as their parents, wives or husbands. Voluntary affiliation would allow for people to be more flexible in their choice.

A smaller number of providers, usually GPs, thought that affiliation should be compulsory. There were a number of reasons advanced to support this perspective including:

- It was necessary to gain more accurate and reliable information about populations in order to achieve population based health improvement with a greater emphasis on prevention. This would require an accurate identification of individuals in that practice or PCO.
- Compulsory enrolment would make it easier to identify those who were currently missing services, such as people who lived transient lifestyles like low income groups or students.
- Some saw compulsory affiliation as the logical basis of population based funding where nearly 100 percent of the population would need to be enrolled.
- The accurate definition of a population would allow government and DHBs to measure the success of individual primary care organisations in meeting Government and DHB objectives.

Some people in rural areas reported that in reality they experienced little choice in nominating a preferred practitioner in practice. Some said they are lucky if they have one general practitioner in residence in their area. Only an increase in availability, rather than whether an affiliation process that was voluntary or not, would change this.

3:3:2 Affiliation with practice or provider

Many providers were concerned about the concept that people would be encouraged to initially enrol with a PCO rather than a practice. Over half the submissions and most GPs supporting affiliation would prefer to see process of affiliation that started with the nomination of a preferred GP or other provider. This provider would in turn register patients with a primary care organisation.⁴

A number of reasons why people should enrol with a practice rather than a PCO were advanced including:

- Those who assumed that PCOs would be a large body felt that this organisation would be remote for patients who might not have even heard about it. By contrast, patients were more likely to feel comfortable enrolling with the practice. The process of enrolment could include a 'waiver' allowing the practice to enrol the patient with the PCO or not as they wished.
- Several providers expressed concern such an affiliation process with a PCO could impinge on the patient-doctor relationship if it resulted in the community forming relationships with a primary care organisation instead of the provider. One IPA stated they would 'strongly oppose' affiliation if it were to replace, rather than build on, the current successful, quality-assured enrolment system they had in member general practices

⁴ This is also the preferred model in the workstream on enrolment that has been working with the HFA this year.

- A few Māori providers expressed concern that the Māori consumers may end up feeling they have less choice about who their provider will be if they had to enrol at primary care organisation level.
- The New Zealand Medical Association was concerned that if its patients enrolled at the level of a PCO rather than with the practice, the GPs' own choice would be limited. They would be unable to move from one PCO to another (or solo practice) because their patients would remain with the PCO.

Affiliation should start with the doctor, and/or the practice, and then the provider organisation affiliation. Affiliation should not be with the DHB, as this is too remote a level from the patient, and services (IPA).

However a number of other providers supported the idea that affiliation should be at the PCO level rather than the provider level. These tended to be providers other than GPs, such as independent nurse practitioners, midwives, occupational therapists and national organisations such as Plunket. The reason they preferred this model was that they felt that if affiliation had to be at a provider level, most people would tend to enrol with a GP. This was because GPs tended to be better organised for enrolment, already having registers; and because many people tended to see their GP on a more regular basis.

3:3:3 Promoting affiliation

There was general agreement in many responses (both providers and consumers) that any move to widespread affiliation would require major public information and educational campaigns to promote it. The community would need to know about the reasons for the changes, and the benefits these changes would bring. Most responses agreed that such campaigns would need to be well supported by Government and should involve primary care providers.

It is important that enrolment or affiliation is accompanied by a determined effort by the Ministry of Health to explain the process to the community at large and to allay the genuine apprehensions held by individuals who value choice and whose daily activities regularly cross the boundaries of enrolling or affiliated organisations (IPA).

3:3:4 Other issues about affiliation

A number of other issues on the topic of affiliation were raised in a few responses. These issues included:

- An enrolment with just one provider or practice would be impractical for many. Some people might choose to see one provider where they lived and another where they worked, or to see different providers for different concerns. This could then lead to double or even triple enrolment.
- Some providers and consumers expressed concern that a focus on affiliation could lead to increased competition between providers seeking to enrol people for capitation purposes. They thought that this trend could then lead to further competition between providers, rather than promoting co-ordination between providers as the discussion document had envisaged.

- There would be significant costs involved in enrolling patients for providers. These responses wanted to know whether these costs would be paid for by the Government, absorbed by the providers or passed to patients. This would work against the aim of the strategy to reduce access costs.
- Some providers questioned whether there were sufficient incentives for providers to enrol people other than capitation which was seen as the obvious incentive.
- There were few incentives for patients to enrol. The ability to deliver a more effective population health practices might occur to providers but they were not sure this would be so obvious to consumers. Financial incentives were probably the most effective. A few suggested that this might involve a discount for patients who were enrolled or denying state subsidies to people who were not enrolled somewhere.
- A few providers suggested that the relationship between emergency and after-hours centres and PCOs (or existing organisations) would need to be clarified in relationship to affiliation, as some entrepreneurial after-hour services were encouraging patients to register with them. By contrast those after-hour services owned and operated by GPs were clear that they did not favour affiliation with the centre.

The Health Promotion Forum of New Zealand observed that services such as community development advocacy and policy development work required for health promotion often takes considerable developmental and consultation work which does not always result in quickly identifiable health outcomes. They were concerned that for-profit PCOs might not see it as cost effective to work in these areas.

4 Range of primary care services and who should provide them

The document listed a range of services that it was expected that primary care providers would deliver. DHBs would contract these services with a range of providers including PCOs and some nationally funded groups such as midwives and well child providers.

Three-quarters (168) of the responses addressed the range of services. Two-thirds agreed with the entire list. Forty responses wished to see additional services added while a small minority wished to see some excluded.

4:1 The proposed range of primary health care services

Most responses from both providers and consumers agreed with the list of services that should be provided by primary health care services (whether or not by PCOs). Comments of the range of services included that:

- all services listed were seen as an important part of primary health care
- the list was well defined in terms of features such as comprehensiveness of services, access to services, co-ordination of services and the importance of continuity of care
- the delivery of these services was essential to improving, maintaining and restoring people's health
- support for the holistic approach to health with an desirable emphasis on population-based services.

The list of services allows the inclusion of patient-defined problems as being the core of the primary health care response at the personal health level. The list of services has a focus on promotion and prevention which are activities at both the PCO and practice levels (IPA).

4:1:1 Services that should be added or removed from the list

A number of submissions suggested that other services should be added to the list. These included:

- There was some concern about the availability of affordable oral and dental care within New Zealand and a number of respondents saw value in dental care being provided under the umbrella of a PCO. Several responses were concerned that dentistry had not been addressed in the document.
- A number of responses saw value in pharmacy being incorporated into the provision of services by PCOs. Issues were raised about funding, the increased utilisation and responsibility of services provided by pharmacists, the need for pharmacies in rural areas and the need for pharmacies to be a key component in the self-help area of primary health care.

Self help information should be a key component in future primary care services. The key is to make such information relevant and easily digestible. Community pharmacy provides an ideal outlet for the interpretation and dissemination of information (Pharmacy Guild).

- tohunga and traditional health services for Māori and Pacific people
- social work, counselling and family therapy
- disability support services
- occupational therapy
- promotion and prevention programmes such as tobacco control, melanoma prevention, cancer screening programmes
- promotion of physical activity, nutrition and exercise
- natural therapies.

A few responses identified services that were not services for the community but would be necessary if PCOs were to have a significant role in the provision of population-based services. These included provider co-ordination, auditing and evaluation, management and payments.

The main services over which there were significant reservations were population promotion and population disease monitoring. Several public health providers and an HHS thought that these should be removed from the list.

4:1:2 Provision of mental health services

Several responses, often from providers, emphasised the inadequacy of primary mental health services in New Zealand. One observed that mental health services are only available to 60 percent of the population, and often not at all in some small geographical areas.

Several observed that GPs and other providers often lacked the basic skills to work with people with mental health problems. These submissions sometimes advocated the availability of adequate training programmes for primary care personnel. Particular areas noted included detection, support and management. One community care committee noted that a result of the absence of these skills was that there was too much reliance on family members and volunteers, often without the skills themselves.

There was also support for community-driven services. Suggestions for new or extended services included a 24-hour help line, a cultural awareness programme, increased community education and wrap-around service with other related services

At the same time some responses were concerned that there would be a loss of identity (for mental health and disability support services) if they were engulfed under a PCO. These submissions believed that mental health services were specialist areas and would therefore require separate budgets. Those commenting on disability support services believed that if the ring fence were removed there would be a danger that funding would disappear.

The Mental Health Commission believed that there is a need for a strong national strategic focus on primary mental healthcare. This should centre on:

- increasing primary care capacity to detect risk factors and prevent mental illness and promote good mental health for the whole population
- increasing primary care capacity to detect mental illness and deliver mental health care
- improve access to culturally relevant primary care services that have mental health expertise
- improve relationships and increasing collaboration between primary care services and specialist mental health service.

4:1:3 Provision of population-based services

On the whole, GPs welcomed the greater emphasis on population-based services and some gave examples of ways that they were working in this area already. However many other health care providers, public health units and some health advocacy groups were uneasy about the skills, ability or even the willingness of doctor-dominated PCOs to deliver these services, particularly population-based public health services. Some public health organisations stressed the need for funds to be kept separate.

Some responses noted that the document seemed to have confused personal health education, which they saw as an appropriate task for personal health care providers, with health promotion which is better delivered on a population basis and not the role of these providers. One health protection service thought that while population-based science underpins the delivery of many primary care services there was a danger that PCOs and the document would identify prevention services as the totality of population-based services. They felt that population-based services were far wider than this.

Some responses were concerned that if PCOs started to deliver these services it would lead to unnecessary duplication of some services with a danger that others would no longer be delivered at all.

One HHS noted that potential PCOs did not have these skills or staff at present to deliver these services. To develop these would involve a considerable and unnecessary development of staff and information systems. Some responses were also concerned about what would happen to public health services and practitioners if they had to become part of a PCO.

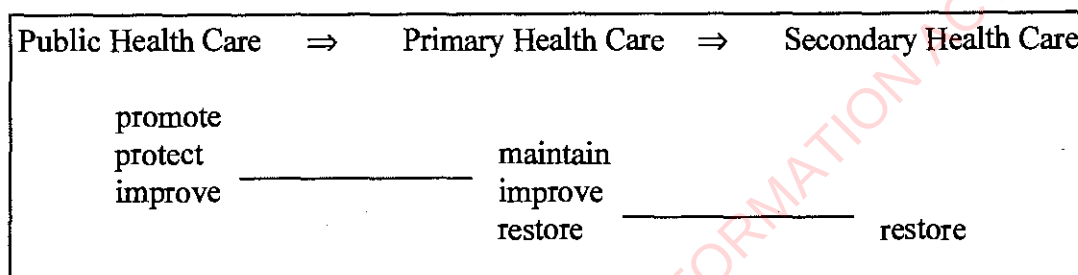
Health promotion practitioners work with groups rather than individuals. They can become marginalised if they work solely in primary care settings because their work is frequently misunderstood and the primary care environment is not set up to support their work process (Public Health Association).

One of the major problems seen by public health providers if PCOs were to deliver population public health services was that PCOs would be unable to provide the necessary regional or national focus, such as for tobacco control,

injury prevention. These involve a planned set of multi-level and multi-agency interventions. Their populations would probably be too small to effectively deliver services and they would be unable to provide full time employment for the necessary experts.

The number of population health activities in both health promotion and health protection, as well as a needs analysis and health planning are more appropriately carried out at a level over and above that of a PCO (HHS)

However there was strong support for greater co-ordination between public health services and primary health care services. One Public Health Registrar provided a diagram of how he saw the role of each sector.



A number of consumer groups had reservations about population-based services being provided by PCOs or other primary health providers, including:

- Some consumer groups were concerned that if these services were delivered by PCOs or GPs they would become medicalised. The services would then be ineffective and insensitive to the needs of consumers.
- Others were concerned that an undue focus on population-based services might compromise the rights of the individual to appropriate services.
- Some were concerned that certain groups in the community such as those with disabilities or Māori with poor health might be disadvantaged by a generalised population-based service delivered by PCOs.

4:1:4 Need for services to be comprehensive and acceptable

While many of those who commented thought the list of services was comprehensive and acceptable, there were concerns about the consistency of the services provided. There were several themes raised in this context:

- Co-operation between the various providers needed to be increased. Different sectors, in particular primary health care organisations, community organisations and secondary providers, must all have a commitment to the range of services set out.
- Professional co-ordination is important for effective co-ordination of services. This must be based on good relationships, trust and good communication. There was some concern that doctor dominance in PCOs (see section 2) might work against this co-operation between providers.

- A few people suggested the value of a regional co-ordinator employed by the DHB who had a comprehensive knowledge of the full range of available community based services. These services may not necessarily be health related.

4:1:5 Services should be community orientated

Some providers and consumers, particularly those involved with community-based groups, felt that community involvement is an essential component of services. These services included health promotion and prevention projects. Some of these thought that the document did not give enough emphasis to Trusts and other community-based organisations.

Some saw a need for an approach to health care that was outside previous strictly medically dominated models. These services would be more holistic and encompass social and environmental factors. Community consumers and providers believed there was a need for providers to tailor their services to the needs of their community rather than vice versa.

Population needs as determined by the population should be an important factor in determining the particular services to be provided (Educational Institution).

4:2 Who should provide the services

There was more disagreement over which the most appropriate providers to deliver this range of services or parts of it, than the services themselves. The major focus of this debate was over whether or not national contracts were necessary or acceptable to an co-ordinated primary health care system. There were also a number of perspectives on whether PCOs were the most appropriate body to deliver some of the services.

4:2:1 Support for the delivery of the full range of services by primary care organisations

Most IPAs and national GP organisations believed that PCOs were appropriate organisations to deliver all or most of the list of services. Arguments in support of this model included:

- While not all the listed services are available from all general practices, one would be able to find most of these under a PCO umbrella.
- The quality and effectiveness of care would be improved by giving PCOs the task of providing or co-ordinating the full range of services.
- If one organisation were responsible for co-ordinating and delivering all services, this would reduce the current fragmentation of primary health care services.

Some providers mentioned that there were a number of pre-conditions that need to be met before PCOs could effectively deliver services. PCOs must know the needs of their community and they must be open to developing local responses to local needs.

If the organisation can understand the make-up of their population, health needs, risk profile, and service utilisation patterns, they will be in a position to target services to most appropriately meet the needs of that population (IPA).

4:2:2 Doubts about the appropriateness or ability of primary care organisations' ability to deliver all services

Not all responses were convinced that a PCO was the best mechanism for delivering some or all these services. Many of the doubters were consumers or non-GP providers. Much of this debate centred around the appropriateness of national contracts and is covered in more detail below.

A number of community health groups, including rural trusts, noted the role that they had played in service delivery in their region. They were concerned that this would not be possible if PCOs were established. Some rural responses thought that in some areas, services may be better delivered by provider who are not part of a primary care organisation.

The idea that a PCO can 'do the lot' sounds attractive, but may not be the best or most pragmatic approach (Consumer).

4:3 National contracts for services

The major debate about the appropriate providers of services was about whether there should be national contracts for some services such as Well Child/Tamariki, midwifery and sexual health. Providers with national contracts such as Plunket, other Well Child services, the College of Midwives and the Family Planning Association believed that their service should be nationally funded rather than to a PCO.

There were a number of responses from midwives and women's health groups endorsing the value of national contracts. An important issue for these groups was that they felt that GPs provided a medicalised service which was not appropriate for pregnancy. They observed that the fact that many women made use of their services was an essential reason to their existence and they believed that their role would be to provide a service that is distinctly separate from a PCO's.

Other reasons people gave to support national contracts included:

- the ability of these services to target specific proportions of the population, for example, the Family Planning Association serves to target women and specifically services youth
- the increase in access they provide for certain poorly served groups in society who do not comfortably access GPs (who they assumed would be the core of any PCO)
- long-standing support by consumers for their services, such as Plunket services

- as there will probably be overlaps between the boundaries of some PCOs and DHBs, there will be economies of scale and effectiveness if some services are maintained on a national basis
- the importance of providing another option for consumers when they do not wish to see their GP for a specific service eg advice on contraception.

The services listed are excellent. But it will not be necessary, perhaps even undesirable for the same organisation to deliver all needs based services. The key to effective services is co-operation rather than competition and there needs to be incentives to ensure this happens (New Zealand Plunket).

GPs and their organisations were less supportive of national contracts, though not usually critical of the providers themselves. Some thought that the discussion document appeared to be endorsing fragmentation and competition by promoting the ongoing separate existence of these services. One IPA suggested that while there may once have been a reason for some of these services being separate, GPs now provided many of them. They thought that the services had outlived the need for them and continued simply because they were there.

Many GP responses preferred such services to be delivered under the umbrella of PCOs but not necessarily by GPs. Reasons for this included:

- GPs and Practice Nurses already delivered many of these services to patients. If the other providers and GPs were part of the same organisation this would reduce the tendency to duplication. It would promote greater co-operation between providers and promote the health of consumers.
- The New Zealand Medical Association observed that the discussion document produced little or no evidence of the health gains that would be achieved by having health services delivered by a great diversity of professionals outside the general practice teams.

IPAC believes that this paper supports the continuance of such an approach through the ringfencing of particular services (family planning, well child etc) IPAC supports the continuance of these services but believes that such services should be offered as part of the range of services provided by PCO's representing a continuum of providers . . . IPAC suggest that it should be made clear the long term strategy is to include such services under an umbrella PCO (IPA Council of New Zealand).

4:4 The services will meet agreed quality standards

Forty-five responses, addressed the issue of quality in depth.

4:4:1 Definitions of quality

The emphasis in definitions of quality provided usually referred to care rather than to the technical skills and qualifications of providers. GP groups referred to the nature of the relationship between provider and patient, and continuity of care as fundamental

aspects of quality. Some groups thought that quality would include the length of time the doctor spent with the patient.

Continuity of care and the nature of the doctor-patient relationship are crucial components of quality health care (Royal New Zealand College of General Practitioners).

General practitioners and nursing groups believed that their own professional bodies should develop and monitor their own quality standards. One noted that Royal New Zealand College of General Practitioners had already developed standards for GPs and for general practices. The pharmacist groups also noted that they had put considerable resources into developing their own standards and methods of monitoring quality. An HHS believed it was important that primary care followed the lead of secondary care and introduce a comprehensive quality assurance programme.

Māori and Pacific responses were concerned with culturally appropriate services and access as a marker of quality. They believed that this an important reason for the development of Māori and Pacific services. However it was also important that 'mainstream' services were culturally safe.

Please bear in mind what 'quality' means for each Pacific nation – cultural, privacy, a warm and friendly environment, methods of communication (face to face is most times most appropriate) (Pacific community worker).

4:4:2 Developing and maintaining quality

Accreditation was favoured as an appropriate method for ensuring quality by over half the submissions, albeit sometimes with some caveats. A particular reservation expressed both by IPAs and by some Māori providers was whether accreditation alone would guarantee quality.

The document appears to equate agreed standards as the same as a process of accreditation. The accreditation approach tends to define minimum standards external to the provider (IPA).

Consumer groups that addressed this topic were generally in favour of nationally agreed standards for accreditation. One community health group believed that any resulting assessments of 'providers quality' should be made publicly available.

Some providers endorsed Continuous Quality Improvement as an effective way of ensuring and improving quality service delivery. This method aims to build up a culture within organisations and encourages ownership among services providers of their own improvement. Several IPAs and Māori providers cited the good results that they had found from the adoption of such a system.

We believe a better approach would be to define quality in terms of Continuous Quality Improvement methodologies and health outcomes (Māori provider).

It is disappointing to see a reductionist approach of agreed minimum standards of quality, rather than a continuous process of quality improvement, which engages practitioners more successfully (College of Nurses Aotearoa).

Other methods that respondents advocated as effective methods for improving quality levels included:

- benchmarking or Best Practice standards, which requires access to data from several other providers .
- peer assessment and review was an increasingly common method in IPAs, which a few feared might disappear with the development of consumer representation on PCO boards
- the development of a quality environment for providers and good management systems which are recognised in continuous quality improvement as essential to quality service delivery.

GPs (often through IPA submissions) and some consumer groups often favoured patient involvement in defining quality standards. The main reason for this was a belief that the provider's view of quality was not always focused on the aspects of provision that patients think are important. A number of methods for achieving patient input were suggested including:

- consumers having a formal role in committees developing standards
- customer satisfaction surveys
- public meetings where practitioners face consumers
- clinician and patients involvement in systems design and management
- patients having a formal role in monitoring and evaluation services.

Perceptions of quality will vary between provider and user. Perhaps the publication of standards of service that the public can expect to receive in the primary care setting will assist the user in objectively evaluating the service they are receiving (National Heart Foundation).

4:4:3 Measuring and monitoring quality

Responses from some IPAs and some consumer groups saw auditing as an essential component of quality control. One noted with concern that there was no mention of quality monitoring and audit in the document. Both providers and consumers saw a role for government and other independent bodies in the audit of the standards.

While it is important that overall quality requirements and standards are established by government agencies, the detailed quality processes and their implementation must remain in the hands of the medical profession while being subject to external assessment and audit where this is appropriate (New Zealand Medical Association).

Several submissions from individual GPs and IPAs indicated concern about the adequacy of quantitative measurement of achievements which they saw as 'too easy' indicators of quality. One submission questioned whether the use of quantitative

measures was based on the expectation that improvements in health would be measurable within a short period of time. Another questioned whether these measured real health gain issues.

Quality requirements are currently based mainly on things that can be counted, such as immunisation rates, cervical smear rates, pharmaceutical expenditure and so on. These measures take no account of the health needs or resources of the population involved. We need to move towards more comprehensive indicators of quality, but only those which are shown to be meaningful in terms of health gain or health status of the population (IPA).

While most accepted the need for such measures, there was a feeling that additional qualitative measures were necessary. One general practice observed that qualitative measures could monitor behaviours that had more influence on the health of the population.

Some responses were clear that one of the roles and function of the PCO would be to work with their members to determine the levels of care, method of delivery, quality of care and the integration to their providers with others in the system. A few thought that failing to do this should lead to a loss in funding.

4:4:4 Barriers to achieving quality

Compliance costs currently borne by the providers were a concern to several IPAs and Māori providers. One general practice observed that although there were considerable incremental costs involved in measuring quality, there was no way to pass these on to patients and this meant that GPs had to bear the costs. The New Zealand Medical Association and other national organisations felt it was important that the Government recognise that IPAs and other provider groups had borne much of the costs of developing and implementing these processes. Small providers were concerned over the implications of auditing standards for these costs for their service delivery.

A health provider with a \$50,000 contract should not be expected to meet quality standards that a health provider with a \$250,000 contract should have to meet in terms of quality standards as is the case in some areas. Whilst it is appropriate for access and quality standards to be agreed nationally [this organisation] believes that such standards need to be flexible to be achieved locally, and reflect the level of resourcing to ensure the most basic of providers can meet them (Māori provider).

The Royal New Zealand College of General Practitioners listed several other barriers to quality in New Zealand. These included:

- poor GP morale
- poor links between primary health care providers, secondary care and community
- lack of data about general practice and
- fragmentation of primary health care between different providers.

4:4:5 Other issues

A number of other issues about quality were raised by some providers. These included:

- The measurement of outcomes was a complex issue that had already been the subject of considerable national and international research. A few noted that there was little agreement about 'easy to measure' indicators, particularly in the primary sector
- There was a perceived danger that consumers could have difficulty effectively interpreting statistical information on measurable outcomes. This could mean that quality measures might be of limited value to consumers.
- There was some concern that different standards would be put in place for different providers. The New Zealand Medical Association was concerned that non-GP providers would have lower standards while some of these providers, particularly Māori providers, were concerned that they were held to higher standards than GPs.
- The need for an appeals procedure for GPs and PCO who were found to have delivered poor quality services.
- The need to initiate and promote a consistent complaints process for consumers.

4:5 Greater co-ordination of services

Two-thirds of the written submissions referred to the need for increased co-ordination between different sectors within health and between health and other sectors. These responses came from a wide variety of providers and many consumer groups. Fourteen responses, most from consumer groups, were either opposed to greater co-ordination or very concerned about its implications for access.

4:5:1 Attitudes to greater co-ordination

Most of these responses were enthusiastic about increased moves toward greater co-ordination and usually referred to co-ordination between different sectors in the health services. They often identified a greater need for co-operation between primary and secondary services as well as between different primary health care providers. Many responses also identified a need for greater co-operation between health and other sectors (eg, housing, welfare and employment) impacting on health care outcomes (see below).

The proposal of greater co-ordination between primary care and primary/secondary services is central to the document and a very exciting concept. From the District Nurses perspective this co-ordination has been terribly lacking in recent times (District Nurses Section: New Zealand Nurses Organisation).

Co-ordination was identified by the majority of these responses as the ability of providers across primary, secondary and tertiary sectors to work together in an environment that fostered co-operation and trust. The keys to success were identified as more effective communication on plans and projects and greater sharing of data on referrals to avoid duplication of services. It was hoped that this would reduce costs

thus freeing up existing money for new levels of service and reduce waiting times for patients.

Other advantages seen by some responses from co-ordination included that it could:

- provide incentives for service providers to expand the range of tasks they undertook. For example, GPs could perform minor surgery within their practices as some, particularly those from rural areas, already did
- develop good working relationships and the strengthening of trust at both primary and secondary levels of health care, and the remove of barriers such as lack of communication and the sharing of information across boundaries
- co-ordinate support from DHBs for PCOs and other providers and assist the development of standards for consistency of services and quality standards.

However some responses expressed reservations about the outcomes that the document expected from greater co-ordination. Some providers thought the authors seemed unaware of the increasing levels of co-operation that was already occurring between providers. As a result the document seemed to expect that greater co-operation was a 'panacea' that would lead to improved primary care services.

A few were more opposed to greater co-operation in principle. These responses tended to come from those who thought that PCOs would be dominated by GPs. They doubted that many GPs would be able to be effective members of a co-operative organisation without significant changes in their culture. For example, some midwives felt that where midwives had had greater co-operation with GPs this had led to a less satisfaction for women with higher rates of intervention. There was also some concern that the sharing of data had the potential to threaten patient confidentiality.

4:5:2 Current moves towards greater co-ordination of services

A number of responses identified different way that services were already moving towards greater co-ordination in their areas. These projects were seen as examples of how integration could lead to less duplication and better services for consumers:

- Different groups (both providers and consumers) reported that there was already a degree of co-operation between different community-based primary health care providers, such as nurses, support workers for the elderly and community workers. However some thought that GPs were not well linked at this level.
- A TLA reported that an integration project in their region co-ordinated central government, local government, iwi providers, health providers and consumers. The group was involved in health planning and needs analysis and would lead to recommendations to ensure better services for consumers.
- A number of groups in Christchurch referred to ElderCare, a co-ordinating service funded by the HFA. This group brought together services from hospital acute and rehabilitation services, a wide range of support groups and general practice, and was seen as developing more efficient programmes for service delivery for the elderly.
- Responses from rural areas reported that a number of services in their areas were working closely together, sometimes as a result of the closure of the local hospital.

Co-ordination was seen as vital if adequate primary health care services were to be continued in some rural areas.

- Some provider organisations such as IPAs reported the ways that they were involved in co-ordination with different services for different populations such as the elderly, people with mental disabilities, Māori and youth. One identified the establishment of IPAs as a positive development, since they had brought GPs and other providers together.

4:5:3 Barriers to co-ordination and responses

Many of the responses identified one or more barriers to greater co-operation between providers. A number of these responses also identified ways to respond to these barriers. These barriers included:

Traditional 'patch protection' by different providers, often based on their training, was often mentioned as a barrier. GPs were seen by some people as being responsible for some of this patch protection, although GPs themselves observed that other professions had very similar reactions. Some responses noted that this reaction would be a major barrier to future co-operation where providers had different paradigms of health care. One observed that to work well together, a team of providers from different backgrounds would require help and several responses identified the need for resources for this purpose. The lack of commitment to additional resources to provide this assistance was sometimes seen as a failure of the discussion document.

A number of providers and consumers identified the competitive model of health care delivery as a major cause of breakdown between providers. Financial survival had meant that providers (including non-GPs) had had to be protective about their patients. Providers with national contracts observed that GPs were reluctant to refer to them, while GPs themselves thought that these providers did not use GP services appropriately.

A variety of solutions were identified to remove these barriers. These included bringing these different providers together as part of a PCO which might reduce the concerns held by providers and more realistic levels of funding for GPs and other providers (see section 5). Other providers noted that it would not be necessary to bring people into one organisation if appropriate liaison or 'case management' was provided.

Several providers mentioned the fact that HHSs provided a number of primary health care services as a case of duplication of services. Again this "problem" might be overcome by either amalgamating these services, possibly no longer under DHB control, or again by promoting better liaison of services. A few favoured a model of PCO (or similar) that bought both primary health care providers and the secondary sector together in the one organisation.

Some providers noted that there were inadequate databases to keep track of patients using different services which impacted on the ability of a range of providers to ensure that services were available to an individual. For example, this was seen as a cause of New Zealand's low immunisation rates and some services were working on

developing databases that would be accessible to different service providers, while ensuring confidentiality.

Responses from GPs often observed that they had poor communications with secondary services, and were not informed when their patients were admitted or discharged, or what arrangements (if any) had been made for their patients after discharge. This sometimes led to either duplication of services or the non-provision of services that people needed. Effective databases that incorporated both primary and secondary services were seen as a way to avoid this occurring.

Some responses identified the existence of different funding silos as a major cause of fragmentation of services and believed that any form of co-ordination needed to address the perverse incentive this caused. For a few, the only way that this could be achieved was by bringing these silos into one budget. However others felt that any disincentives caused this way could be addressed through greater co-ordination at all levels, including the DHB who would hold the budget.

4:5:4 Greater inter-sectoral co-operation

Fifty-three responses from consumers and providers specifically identified a need for greater co-operation between health and other sectors, such as housing, welfare and education. Many of these identified the importance of addressing these determinants in improving health status.

If local government and other agencies know that GPs are seeing an increase in respiratory problems associated with poor housing conditions it increases the likelihood of a successful and collective planned approach to work with communities in dealing with the problem (Advocacy Group).

Several TLAs identified the important role they felt that they had to play in the delivery of primary health care services. They suggested that primary care organisations should be encouraged to work in partnership with local bodies to take advantage of their knowledge of the broader issues affecting the wellbeing of the community.

4:5:5 Who would be responsible for greater co-ordination

Many responses identified the level at which they thought that co-ordination should be driven. One saw the DHBs as 'being the co-ordinating body, charged with the responsibility of ensuring a working partnership among all providers' (Rural Health Trust). Many of these responses came from those who thought that the different roles of DHBs and PCOs had not been sufficiently differentiated.

Some of the support for the model of DHBs (or some other unspecified body) as the co-ordinating body came from providers (including midwives, nurses and other providers such as acupuncturists) who were uneasy about PCOs as a GP-dominated body. They preferred a model where no one provider would dominate, and where they could remain autonomous and independent of PCOs.

There were a number of other reasons for this preference:

- DHBs would have a unique population whereas different providers would have smaller (and often overlapping) populations of consumers.
- Effective co-ordination would require a higher level of resource than most providers would be able to offer. There would also be unnecessary duplication if different providers created their own co-ordination teams.
- DHBs would be the most effective at persuading HHS-provided primary health care services, secondary services and tertiary services to co-operate with independent primary health care services.

There was also considerable support for PCOs to be the organisation that would be responsible for co-ordination. These responses often came from groups such as IPAs which saw the PCO as an umbrella group that bought together a wide range of services. Some other providers such as the Royal New Zealand Plunket Society also saw a distinct advantage in PCOs having this role, as long as this meant that they were willing to have better relations with these bodies, rather than incorporating them. The IPA Council of New Zealand favoured this model because:

- *PCOs are the co-ordinating organisation closest to the consumer*
 - *PCOs are best placed to support consumers and providers to navigate the system*
 - *PCOs are well placed to understand the impact of other factors on health eg inadequate insulation in housing*
 - *Population-based funding of PCOs will mean that they will have the incentive to act across sector barriers to implement prevention and early cure strategies*
- (IPA Council of New Zealand).

Whether responses favoured the DHB or the PCO undertaking the role of co-ordination, they were clear that close liaison was thought to be necessary. Without this they believed that effective co-ordination would be impossible.

Some responses specified that the body that should be responsible for greater co-ordination must include the general practice team (though not necessarily the general practitioner). This was because the general practice was the organisation that usually had the most ongoing contact with the patient. These responses tended to favour the PCO model for that reason.

Some Māori responses observed that any effective co-ordination needed to involve them as equals, not as an afterthought. They were mostly supportive of a model that included other sectors such as welfare and education. Several mainstream responses also commented that co-ordination between PCO and providers would be an opportunity to work co-operatively rather than competitively with Māori organisations in order to meet the health needs of the communities they both served.

5 Nationally consistent rules for availability and affordability

Two-thirds of responses coming from both providers and consumers commented on the proposition to develop nationally consistent rules for availability and affordability and almost all agreed with the need for these rules. Most agreed that access to primary was negatively affected by many factors. Cost, availability and cultural appropriateness were the most commonly mentioned.

5:1 Barriers to access

The importance of reducing barriers to access was widely recognised. Many responses described ways that different factors acted as barriers.

5:1:1 Affordability as a barrier

The majority of responses recognised that cost was an increasing barrier to access for some groups in the population. For many people and groups responding current levels of co-payments were a significant barrier to access. GPs (organisations and individuals) felt that the reason that these (co-payments) had risen over the years was the failure of the Government to maintain adequate levels of subsidy and people were increasingly unable to afford the resulting increases in co-payments. In addition they believed that the Government had not recognised that the costs of general practice had risen.

Many consumer and advocacy groups also addressed the fact that they saw co-payments as a major barrier to access. Groups identified as particularly vulnerable were most low income people, Māori, Pacific and people living in rural areas. In this context, some responses observed that the currently free services such as maternity, Well Child and sexual health services should be maintained and possibly extended, for example, extending the 'under 6' policy to 12 or more.

5:1:2 Rural living as a barrier

Rural access issues were frequently raised in responses. Many rural-based groups (providers and consumers) identified lack of availability as a barrier, often in association with the ethnicity and the low income levels of many rural inhabitants. While many 'rural' responses observed that criteria about the availability of services were desirable, they felt that there were also many other issues in rural areas that needed to be addressed to increase accessibility. One rural TLA observed that other issues affecting residents access to services included the state of the roads, the geography and the availability of transport.

General practice was the major service addressed in terms of limited availability. Other services identified as being difficult to access included hospitals, specialist visits, dentistry and support services for aged people and those with mental or physical disabilities.

The single greatest need for primary health care for rural dwellers is the availability of care. Many rural areas are understaffed, particularly in terms of GPs. This lack of services in some areas, coupled with poorer health statistics in many rural areas, indicates a clear need for additional primary care resources to go to identified rural areas (Federated Farmers).

5:1:3 Lack of appropriate services as a barrier

A number of responses commented on one or more of the barriers that a lack of appropriate services caused. The major barrier identified was the lack of Māori services and/or services appropriate for Māori. This was raised by both Māori providers and a number of other non-Māori providers and consumers. Pacific providers raised similar issues for their own populations.

Māori and Pacific peoples were the main groups identified as being in need of appropriate services. However a number of other groups were identified as being in need of appropriate services, including aged people; young people who had a variety of needs such as information about sexuality, drugs and mental health; and those with mental health problems.

5:1:4 Other barriers to access and availability of services

Many responses identified other barriers or more specific aspects of the barriers that they thought would need to be considered. Not all of these barriers were seen as easily amenable to rules.

Both providers and consumer groups raised the concern that many people lack of knowledge of the subsidies for services that were available. This was seen as a major barrier to access and a particular concern to Māori and Pacific peoples.

This group supports the view expressed in the document that a major initiative is needed to make people aware of their subsidy entitlements (especially under 6s, CSC and HUHC) as these remove many of the financial barriers to access and uptake in some communities where this is currently inappropriately low given the known socio-economic profile (Hospital and Health Service).

The availability and/or skill level of the workforce (rather than its location) was sometimes mentioned as a barrier to access. As for other barriers, submissions were not always sure that rules would address these problems.

There are important implications for workforce planning. Not just planning the numbers of health professionals being trained but the funding of quality training and innovative schemes of the retention of trained professionals in the areas of greatest need. The issues of availability and access require central co-ordination and accountability. They are not solvable simply by injecting more money (Royal New Zealand College of General Practitioners).

A number of other barriers to access were identified. These included:

- a lack of knowledge among consumers about the services that were available and appropriate for their condition; this was an issue to some groups of older people and their providers
- difficulties with access to affordable transport were often identified by respondents for low socioeconomic areas in urban areas as well as in rural areas
-
- the costs of pharmaceuticals and referrals
- lack of a common language was an issue for recent immigrants and refugees.

5:2 Current developments responding to access barriers

A number of responses by providers addressed ways that they currently attempt to improve access barriers: These included:

- One large practice in a low income area noted that transport was a major barrier in their area. They had purchased a van and this was used to provide transport to and from consultations for people.
- Several rural-based responses (providers and consumers) spoke of mobile rural services as a specific way to address the transport barriers facing many people in rural areas. They thought that a range of services including general practice, nursing, care for the elderly, screening and 'specialist' services such as asthma and diabetes could be delivered this way.
- In the same context, some of these respondents addressed the value of one-stop-shops as a way of improving access in rural areas. Some of the projects I were promoting integration when small hospitals were closed and Dargaville and Balclutha were given as examples that could be copied.
- Several practitioners thought that more rather than less flexibility would enable them to address the barriers to access. One thought that an allowance might be given to the practitioner to be distributed as most appropriate for those having problems accessing services. In some cases this might turn out to be subsidies for taxi fares rather than reduction in the cost for the patient, which he thought may already be very low. There could also be flexibility for providers to sign service agreements that will allow participants to reduce or eliminate charges on a case-by-case basis in the fees that they charge priority populations.
- Some responses suggested that widening the scope of other non-GP providers might be as effective a response to access barriers as increasing rules. A considerable number of suggestions were made including:
 - greater use of nurses
 - allowing independent nurse practitioners to receive GMS or greater funding to make them more affordable to patients,
 -
 - greater emphasis on health in the school curriculum.

5:3 Response to the concept of nationally consistent rules

5:3:1 Reasons for support of the concept

Most responses were generally supportive of the concept that there should be nationally consistent minimum standards and many supported the concept without going into much detail. The concept was particularly attractive to some communities in rural and low-income areas, who felt that they might be better served if there were such rules in place. They saw such rules as a way of ensuring that people would be sure of being able to receive a level of service wherever they lived.

Another advantage seen by some responses, particularly from providers and advocacy groups, was that the development of such standards might be a useful way to ensure that there was consistent services delivered across all 21 DHBs. They thought that national rules could then reduce the ability of DHBs to set differing standards for primary care. Some responses, particularly among advocacy groups, reported that such a strategy would enable people to have a sense of 'right' to access services. The advantages of such an approach was it would reduce a sense of stigmatisation felt by some people who currently are receiving subsidies or should be doing so.

Most respondents to this issue assumed that such criteria would deal mainly with general practices. However some noted that such standards would be desirable for other primary health care services. Mental health services was raised frequently by such respondents as needing greater access.

5:3:2 A need to maintain flexibility in rules

Many responses, often from providers otherwise in favour of rules, were concerned that flexibility be maintained. The core of this concern was that such rules should not be too rigid and unable to take account of local circumstances.

Providers were concerned about the impact of rules that were inflexible on their services. They observed that their populations may differ from others and rules would need to be flexible for them to be able to provide appropriate services.

Rules for availability may be difficult to define for the whole population. There are different kinds of urban and rural environments – problems include local geography and transport services. Flexibility will be needed to allow communities and their providers to define access (IPA).

Some Māori providers were concerned that national criteria might not take into account the specific difficulties faced by Māori providers. These might include the availability of staff and the nature of the population they were serving such as largely rural or low-income areas. For example, a Māori funder was concerned that there were relatively few Māori living in their area. They were keen therefore that any criteria be flexible enough to recognise these factors.

Some consumer responses were also concerned that national guidelines would not take appropriate notice of their specific population group or the services in their region. This particularly concerned Māori and those from low income and rural areas.

There should be flexibility for recognition of local situations and needs. In our area there is a high Pacific Island population and it is very young (Consumer).

5:3:3 Issues that need to be considered in developing rules

Although most responses were comfortable with the general principles of nationally consistent rules, many identified issues that they thought needed to be considered when such rules were developed. Some providers were concerned that such an approach could suffer from simplicity. They observed that accessibility was a complex issue and there was a danger that simply making a few rules would be ineffective or even counterproductive.

Access to health care is a multi-factorial issue that requires careful assessment prior to the implementation of piecemeal measures that may be divisive and reduce the effectiveness of current constructive initiatives (IPA).

Some responses were concerned that such criteria would be little more than 'minimum standards'. Some thought that these standards would tend to be quite low and that they would be very centrally driven. Two respondents suggested guidelines as alternatives.

A concern was also expressed about whether criteria could address cost barriers to access that were not related to the cost of a consultation. These costs included transport (cost and availability) in low-socioeconomic and rural areas and the costs of pharmaceuticals. Without some sort of attempt to address these cost, even to a free or nearly free services, barriers would remain.

The rules should include such things as differing health needs and costs associated with ethnicity, gender, age and disability as well as the times when consultation is available. The costs of attending after hours clinics is prohibitive as is the cost of taking time off work to see health care providers during office hours (New Zealand College of Practice Nurses).

Other issues raised included:

- Whether standards would be truly consistent between rural and urban regions, between the two islands, and about the level of subsidies for Māori and non-Māori. One response observed that it may however be difficult to develop criteria that would apply to the entire population without disadvantaging some parts of it.
- Whether there was sufficient data available for such criteria to be developed. These responses observed there was a lack of knowledge at the Ministry and HFA level about the needs of certain groups in the community, such as rural people, refugees or Chinese women. Would the Ministry be able to set criteria that accounted for the needs of all members of the population without this data?
- Whether centrally devised rules might deprive local communities (geographical or demographic group) of their right to have an input into developing the standards

for their community. This possibility was seen as working against the intent of other statements in the discussion document, such as the need for community representation.

5:4 Appropriate resources to address access barriers

5:4:1 Need to address funding levels

Many providers and some consumers questioned whether rules would reduce the barriers without an increase in the level of funding for primary health care services. A few responses suggested that the overall funding system for the different sectors (included primary, community, secondary and ACC) needed to be reviewed if affordability was too be fully addressed. Without an attempt to line up these subsidies perverse incentives would continue. Rules and inadequate funding could also have unexpected consequences.

If the work currently being carried out on population based funding results in tighter targeting or funds those in greatest need without a commensurate increase in funding co-payments for those who currently receive subsidies but are in less need variations will necessarily increase. This is in effect not 'taking from the rich and giving to the poor' but 'taking from the moderately disadvantaged and giving to the more disadvantaged' (IPA).

In this context some providers, mostly GPs, observed that most GPs were independent business people. They were responsible for a large percentage of their costs and received between 50 percent and 70 percent of their income from fee for service. These respondents observed that the right of the Government to set tight rules without appropriate compensation for any losses was, or should be, limited.

There was some concern among GPs that the implication of national rules was that costs were the result of GP greed rather than subsidy levels. They were concerned that rules about how much they could charge, and particularly about co-payments, would be identifying the wrong cause of this barrier.

I thought that barriers to access often had more to do with the Government, and subsidy levels, than to the actions of GPs. I doubt that criteria alone will therefore change this (General practitioner).

Some practitioners were concerned that while subsidies for routine visits were usually adequate, this did not apply to all visits. There were a number of types of patients who needed more intensive attention but the current level of subsidy did not encourage this. Services and groups mentioned included health promotion and prevention, immunisation, consultations for those with chronic conditions and those with disabilities. Any rules developed would need to consider these factors if they were to be effective.

Some respondents were concerned that services for low-income groups should be free rather than controlled by rules. Most of the people who advocated this saw this as a

targeted service rather than one that would apply to all communities and providers. There were a number of ways they identified that this could be achieved. These included:

- development of specialist services for low income people such as Union Health Care Clinics and the Free Clinic. These services should be adequately funded by the Government (through capitation or bulk funding) and practitioners paid by salaries
- extensive increases in GMS and/or capitation formula to allow practitioners to provide free services
- the development of a National Health Service similar to that in England

Many providers recognised that there were already higher levels of subsidies available to some practitioners than others and response to this was mixed. Generally there was a recognition that this was appropriate in some cases, particularly for Māori and Pacific providers. However some GPs were concerned that some groups received a higher level of funding than they did to provide the same services to the same groups.

5:4:2 Workforce development for Māori and Pacific providers

Many Māori providers thought that that development of Māori providers was the most appropriate response to the development of appropriate services. They questioned the extent to which rules alone would change this, at least in the short term. There was a recognition that, at least in the interim, many Māori would continue to attend mainstream providers, the majority of who were Pākehā. It was therefore important that these services also be appropriate.

Other related issues identified included a need for mainstream providers to make a commitment to employing Māori medical professionals and nurses and a commitment by non-Māori providers to develop and provide appropriate services

Given the shortage of Māori providers, particularly GPs, it is likely that many non Māori practices will continue to deliver services to Māori. They will need support and assistance so that services are sensitive and responsive to Māori needs (New Zealand Medical Association).

Similar issues were identified for Pacific peoples. These responses came from Pacific respondents and those providing services for Pacific peoples. An additional barrier for these population identified at some meetings included language for immigrants.

6 Funding primary health care

The discussion document proposed that primary care providers would be funded to provide a specified number of services on the basis of the characteristics of their population rather than on the number of services provided. Current bundling of payments for prescriptions and laboratory services would continue.

Many responses identified the way that PCOs would be funded as capitation and referred to it as such in their responses.

Almost all responses mentioned one or more aspects of funding. Over one hundred responses commented on the lack of detail provided and made little other comment.

A few responses, particularly from providers, felt that it was time that the Government 'simply made a decision' about how to fund primary health care services and stuck with this. They observed that a major problem for providers was that funding strategies were constantly changing between or sometimes even during administrations.

No system is perfect. We should be prepared to accept a workable system and not keep striving for the illusory perfect funding mechanism. Choose one and make it work as well as possible rather than changing because it's not perfect (General practitioner).

A comment often made at meetings and in some written responses was that the primary care system visualised in the discussion document would be more expensive than the current one. Some responses questioned whether the lack of specific detail in the document about how the new services would be funded might suggest that there was a lack of real commitment to the changes envisaged.

6:1 Population based funding formula

Eighty written responses commented on the population based funding formula being developed to determine equitable funding for DHBs. Most of these generally favoured this form of funding allocation while 14 were completely opposed to it.

There was support for the use of New Zealand Deprivation Index in the formula and some providers also supported this for the determination of the capitation formulae. There was also strong support for the inclusion of ethnicity as a factor in the formula, particularly from providers working with Māori and Pacific peoples. These responses believed that other factors such as socioeconomic status were not sufficient to allow for Māori and Pacific health needs. Other factors suggested for inclusion in the formula's development included health status, predicted health needs, the nature of the geographic area served, the level of cultural diversity and the disease profile.

A concern often mentioned, usually by consumers and by providers in areas of higher need, was whether a needs-based system of funding at DHB level would be flexible and sensitive enough to account for local variations and local conditions. A

Community Health Group from a low-income area commented that there had to be an emphasis on establishing the particular needs of the populations to be served within the board.

This formula for funding allocates monies to large regional groups but doesn't ensure that allocation of these funds within the defined population matches the needs of individuals or the needs of smaller groups (Academic).

The mobile nature of the New Zealand population, particularly those on lower incomes, concerned some who feared that the formula quickly became out of date. Some providers, usually GPs, thought that the formula could be based on affiliated populations at practices or with PCOs rather than census figures. Some responses, often from TLAs in areas with a high seasonal variation in population due to tourism or seasonal employment, were also concerned that their regions would be under-funded as a result.

Some Māori groups were concerned about the accuracy of any measures of need used to develop the formula. Te Puni Kōkiri thought that the lack of accurate ethnicity data recording within the health sector might lead to Māori health needs being under-reported. Several Māori groups (both co-funders and providers) stressed that they did not think that current funding formulae for either secondary or primary care services addressed the need of Māori. They believed that there was lack of recognition that Māori health needs spread beyond the health sector to housing and welfare. Another issues frequently raised was that any formula would also need to include allowance for workforce development for Māori providers.

6:2 Current funding mechanisms

6:2:1 Currently under-funded services

Some responses from both providers and consumers felt that the services they were associated with were currently under-funded. A wide range of services were identified as in need of greater funding. These included:

- health prevention and promotion
- chronic illness
- mental health
- services for the elderly
- GP and other services for low-income people who found costs high despite current subsidies.

There were a number of responses in favour of alterations to the current level of funding for specific groups along the line of the under-sixes policy. This change was seen as a way of increasing access to services for those with high needs, such as asthmatics and/or people on low incomes. These changes were advanced by those both for and against capitation.

A few respondents, usually consumers or their advocates, advocated the adoption on a National Health System. This was on the grounds that they could not see the proposed strategy being capable of achievement in a private enterprise system.

6:2:2 Current capitation

Some responses, particularly those from GPs, described current capitation funding in more detail. A growing number of general practices including those in Healthcare Aotearoa and many in the former Midland Regional Health Authority area currently have capitation contracts. Many of those who made submissions or attended meetings favoured capitation, although there was often some dissatisfaction with the capitation formula or other aspects.

A few IPAs observed that they had been unsuccessfully attempting to obtain a capitation funding system for some time. Those providers on capitation made a number of comments about how this had worked for them including:

- The need to have an enrolled population had allowed the practices to better monitor the health status of their population. Some felt that capitation had consequently enabled them to deliver a better service with a greater emphasis on preventative and promotion work. It had facilitated a change in the culture of general practice teams to include population related outcomes as well as personal health outcomes.
- They were able to make wider use of other non-GP health professionals, and in particular practice nurses, when the requirement that people see a GP in order to obtain government funding was removed.
- The enrolled population provided a denominator against which the practices could measure quality.
- Flow over of patients between practices in the IPA or organisation was less than expected and these occurrences tended to even out.

The practice has been capitated since 1998 and the capitated environment has changed the approach to the way a patient's care is given. Doctors take a more holistic approach and practice nurses play a greater role in providing patient information, education and support . . . Practice nurses will be upskilled to provide a greater level of patient care in the future (GP practice).

Other providers who wanted a capitation contract had similar reasons for supporting this. The possibility of a greater emphasis on population health services and the ability to use a wider range of providers were the most frequent advantages advanced.

6:3 Funding of primary health care

Approximately one-third of responses addressed bulk funding, usually identified as 'capitation', in some detail. Two-thirds of these favoured the use of this form of funding. Many of the remainder were undecided although a few were strongly opposed.

The lack of detail was a concern to many and areas of concern raised were similar whether the responses favoured or opposed capitation. The difference was sometimes

that one group thought these concerns could be satisfactorily addressed while the other was less convinced.

6:3:1 Will capitation make a difference?

Some responses suggested that the advantages of capitation that the discussion document outlined were in fact based on the outcomes of capitation in other countries where all or most of the fees for a consultation were covered. This was not expected to be the case in most New Zealand practices.

Much 'evidence' regarding the benefits of capitation comes from overseas systems where patients do not pay consultation fees. Even the proponents of capitation agree that these advantages are lost in a co-payment system (CareNet).⁵

Some thought that the fact that most practices were small businesses might limit the ability of the government to 'require' significant changes from a practice even if it were capitated. They thought that this might also make it difficult for the Ministry to set rules about capitation to prevent cream skimming or under-servicing

6:3:2 The future of co-payments

Some providers were concerned that the introduction of capitation might lead to either the abolition of co-payments or the right to set the level of part charges. Many GPs, both those on capitation contracts and those hoping to be so, thought that it was essential that this right to make part-charges be protected if their financial viability was to be maintained.

[While] GPs operate in a capitated environment it is important that the ability to charge a co-payment not be removed. It is essential to general practice which fears that once this ability is lost they will have no mechanism to protect the viability of their business from future funding decisions that do recognise the true cost of delivering a service (IPA).

However responses from many other providers and consumers thought that unless co-payments were controlled by the Government, capitation alone would not address the access problems faced by many New Zealanders.

While primary health care remains largely privately owned and operated it will remain outside the public health system. This matter can be addressed by increasing the level of capitation within primary health care to closer to 85 percent of the cost of the service. A model for this was proposed by Coster and Gribben in a paper submitted to the National Health Committee (Educational institution).

6:3:3 The formula to be adopted for payment of capitation

The level at which a capitation formula would be set and what services would be covered by it was a source of comment from GPs and some consumers groups. Both groups were concerned that any formula was sensitive enough to allow for consumers

⁵ National Primary Care Network.

with higher service needs such as those with disabilities or chronic conditions. GPs worried that an inadequate formula might mean they were financially disadvantaged while consumers worried that this might lead to inadequate treatment or adverse selection of these groups.

It is critical that the needs of high users such as the elderly or chronically ill and indeed those requiring expensive treatment are protected and allowances made in funding formulae for those extra needs (New Zealand Medical Association).

Some providers were uneasy about the idea that the current formulae would be adopted unchanged and there was wide support for the development of a new formula.⁶ A particular concern for some providers was the use of the Community Services Card to determine the formula. They believed that the use of this card was erratic and thus a poor indicator of total need. There was a preference among these groups for the use of the New Zealand Deprivation Scale on a community basis in determining the formula.

Another issue of some concern to providers in low income areas and to Māori providers was the continued use of historical patterns of utilisation to determine the formula. They felt that this would also lead to an underestimation of need.

We support capitation funding but the current formula is unfair in the way that is calculated. It is based on age with a modification for socio-economic status based on CSC standards. We want a formula that has the following elements; the main determinants remain age and gender and the main modifiers are socio-economic status (measured by deprivation not CSC), ethnicity and rural isolation (Healthcare Aotearoa).

Other issues raised about the capitation formula raised included:

- There was a need for a general simplification of the process of determining the formula applicable across the country.
- There was some support for determining the capitation formula on a community rating rather than an individual one. The Public Health Association believed that a community risk rating would discourage adverse selection (cream skinning).
- There was a perceived need from some rural providers and TLAs for a rural allowance which would include the recognition that the providers had to cover a wide area with a small population.
- There was a need to recognise higher needs for immigrants and refugees, such as translation services, which should be included in the formula or through some other allowance.

⁶ GP providers, the Health Funding Authority (HFA) and local HHSs all referred to the considerable experience that they felt that Midland region of the HFA had in the development of formula which could be drawn on. Several providers also made reference to the work programme that the HFA and the Ministry had under way to develop an appropriate capitation formula. The continuation of this was also supported by providers.

- Some Māori providers observed that they needed to be closely involved in the development of any formulae for funding primary health care services.

In principle capitation is supported. A shift to capitation funding is likely to facilitate a population-based approach to primary health care and multi-disciplinary teamwork. In practice this will be totally dependent on the, as yet, unknown capitation formula and level of funding (Royal New Zealand Council of General Practitioners).

In principle we support a needs based funding formula. However the practical reality of introducing this formula which appropriately and accurately takes into account 'total Māori needs' is currently not a reality. To date we have not seen a funding formula that produces an equitable approach to total Māori needs (Māori funder organisation).

6:3:4 Adverse selection (cream skimming) and under-servicing

Responses from both providers and consumers identified cream skimming and under-servicing as potential dangers in any form of capitation. The latter groups were more likely to think that this was a serious concern than providers. One HHS that was otherwise supportive of capitation expressed some concern that 'difficult' patients might be referred to hospital services by GPs as a method of cost shifting.

Providers in the former Midland Regional Health Authority area observed that in fact there had been few if any complaints about under-servicing (or declining to enrol patients) since enrolment and capitation had been introduced there.

Many providers commenting on capitation recognised the dangers of adverse selection and under-servicing at a theoretical level. However they thought that it was either unlikely to happen in New Zealand, if only because of the competition between providers.

Economic theory might predict that capitation can perversely encourage under-servicing. However that theory also predicts that if there is a reasonable level of competition patients will move away from services that organisation which provides poor services whether capitated or otherwise funded. While this may not always be the case and incentives will be necessary most primary care providers are very concerned to ensure that their consumer base is satisfied with their service (IPA).

There were some responses from both providers and consumers who were convinced that these practices were inevitable with capitation. Some GPs cited their own experience elsewhere or said that they themselves would inevitably feel tempted to avoid enrolling patients with high needs.

Some consumer groups, such as organisations representing people with high service needs, were concerned about the possibility of adverse selection and under-servicing. While some believed that this might be addressed by an appropriate funding formula,

others such as the Royal New Zealand Foundation of the Blind were less convinced that capitation was flexible enough to allow for individuals with high health needs.

The document is very unclear about the HFA will prevent general practice organisations from being able to select out clients likely to have higher costs, select in clients likely to have lower health care costs and under service vulnerable clients. These are critical issues for capitation systems (New Zealand AIDS Foundation).

Those supportive of the role of capitation and those concerned about it both saw an important role for the Government in monitoring to prevent this. Some thought that the document did not address this issue sufficiently.

6:3:5 Other concerns about capitation

A range of other concerns about capitation were raised in the responses although less frequently. Some of these issues specifically related to and were raised mainly by providers. These concerns included:

- There could be a tendency for senior doctors in a capitated practice to exploit junior doctors and other providers by making them provide a disproportionate amount of services that they should be providing themselves.
- Some providers feared that capitation would reduce the ability of single or small groups of providers (usually GPs) to compete with larger groups. Those not on capitation would not be able to offer the same prices or cover any losses that resulted from attempting to compete.
- Fee-for-service was often seen as more able to deal with transients and casuals. This was mentioned by a practice in a tourist area who were comfortable with capitation for residents.
- There was some concern that the New Zealand health care system's ability to support a range of ways of funding and providing services would be reduced if a strong support for capitation at the expense of any other form of funding were promoted.
- Some felt that fee-for-service gave patients power in their relationship with GPs as they had the right to withdraw their support for a provider. They were worried that capitation would remove this power.
- A few providers thought that a system that made no allowance for the number of uses of a service, particularly for those in high need areas, would be unfair. Eventually one GP observed, this could lead to bankruptcy for the provider.

There were a number of concerns about the possible effects of capitation raised by both providers and consumers. These included:

- A fear that a focus on enrolment and capitation would necessarily lead to greater competition between providers as they sought to enrol as many people as possible. This was seen as potentially acting against the document's preference for a non-competitive system, contrary to increased co-ordination and could lead to a reduction in the services available in an area

- The advantages of GMS subsidies which were seen as ‘belonging’ to the patient would be removed and become the “right” for the provider, whether or not s/he provided the services. This would change the balance between doctor (or other provider) and patient.
- Some respondents feared that a capitation based funding system was more susceptible to sinking lids by government than fee-for-services, making fee-for-service a preferred model, almost by default.
- Some expressed concern about the implications of capitation for privacy if it were based on the use of a unique identifier.

6:4 Other funding issues

Many of the comments about funding were related to population-based funding for DHBs and capitation for general practices. A number of other issues were raised by smaller numbers of responses.

6:4:1 Determining allocations for primary health care providers

Some providers and consumers expressed unease at the role that DHBs might come to play in the funding and delivery of primary health care services. They saw a need for an adequate and transparent system of determining the amount of money to be available to PCOs as part of the total funding that DHBs received. Some form of needs analysis was often endorsed by these responses, and this was sometimes seen as a possible advantage of affiliation.

The allocation of funding will need to be based on robust needs analysis and subsequent resource prioritisation at DHB level. Without clear guidelines and direction on how DHBs should allocate this process . . . there is potential for inconsistency and duplication between the DHBs (Hospital and Health Service – Māori Unit).

Some responses were concerned that two different funding formulae were being proposed. While DHBs would be funded through a population based funding formula, DHBs themselves would take over funding primary health care using the current formulae, albeit with a greater emphasis on capitation. Several providers argued that primary health care itself could be funded on a population based funding formula.

There needs to be consistency between the population based funding formula and the capitation formula for both technical and policy reasons. They should include similar variables (Educational institution).

6:4:2 Redistribution of existing funds between providers

Some responses from both consumers and providers observed that some practices and IPAs were better funded than others. These thought that if a national capitation system was developed this would become apparent. If funding for under-funded practices were to be addressed within currently available resources the source of funding would need to be through:

- some redistribution of current health funding between practices and other primary health care providers
- between primary and secondary services
- between health and other social services.

Organisations and practices whose funding was reduced would find that they could no longer afford the staff that they had or to be able to deliver the full range of services they currently did.

While some (providers) are under-funded others are over-funded. Well off populations, such as those serviced by PCOs in Central Auckland receive services well in excess of their fair share, and almost certainly well in excess of the needs. There will be major problem in reducing expenditure of those who are currently overfunded (Health researcher).

6:4:3 Funding providers other than GPs

Some responses observed that the discussion document provided little detail on how providers other than GPs or those providers with national funding arrangements would be funded in future. Although some providers, particularly practice nurses, received funding through capitation this was only in organisations that included GPs. Many of these providers, such as Māori providers, assumed or preferred that existing funding mechanisms for their services were continued.

Some providers such as nurses felt that the current practice of funding most services through GPs did not always provide the most efficient or economical services. The Independent Nurse Practitioners Association observed that they were able to provide many services currently provided by GPs for less. However, because they could not access GMS and other benefits many patients could not afford to use their services.

Other issues raised included:

- Some providers were worried that the introduction of capitation, particularly if better funded than at present, would prove an incentive for people, especially those on lower incomes, to use GP services in preference to their own.
- Ancillary services were concerned about what their future would be in a world dominated by capitation funding for PCOs.
- Providers such as physiotherapists who could currently take patients without a GP referral for ACC were also keen to see this practice continued and extended.

Within the present health system low income people are able to access GP services through their use of CSC but this does not apply to other types of services such as physiotherapy. This places a significant barrier for low income people in accessing treatment that may contribute greatly to their recovery (New Zealand Association of Physiotherapists).

Several complementary health providers observed that the services that they provided were popular, as shown in the level of support that they had, and effective. They believed that they too should attract some support from government funding.

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7 Special relationship between Māori and the Crown

Nearly two-thirds of the responses addressed the expectation that the special relationship between Crown and Māori would be reflected in service agreements between DHBs and primary health care providers. These responses covered a wide range of issues such as need, affordability, representation and the structure of PCOs. Some of these issues have been addressed in those sections. This section deals largely, but not exclusively with the Treaty-related issues.

Twenty written submissions were received from Māori groups including Māori health providers and co-funders, national organisations, research units and Te Puni Kōkiri (the Ministry of Māori Development). In addition a number of hui were held with Māori providers and consumers.

The basic principles of the relationship were widely accepted by almost all respondents. Where there were concerns these tended to be about details rather than the principle.

7.1 Māori concerns about the wording and meaning of the commitment

Many Māori responses emphasised the importance of the Treaty of Waitangi in improving the health of Māori. They considered that the Treaty of Waitangi provided the basis for the protection of Māori interests, Māori participation in all levels of health care, and the development of Māori primary health care initiatives.

Many of the Māori responses were concerned about the wording and implied meaning of the statement that the relationship between Māori and the Crown would be reflected in funding agreements. These respondents believed that recognition of the partnership implicit in the Treaty of Waitangi meant that Māori should have a significant and equal voice in deciding their own services. They did not believe that this partnership was recognised by the wording in the discussion document.

The Treaty of Waitangi entrenches a partnered relationship between the Crown and Māori. This partnership was intended to be characterised by, amongst other things, good faith, mutual respect, co-operation, active protection of Māori interests and participation (Māori co-funder).

If a true partnership were established Māori providers and consumers would not have to be dependent on largely Pākehā DHB for those services that were delivered. They would be able to decide and fund what services were appropriate for their needs. Some respondents suggested a rewording might address this issue.

This group supports that this be amended to 'acknowledge and respond to the special relationship between Māori and the Crown under the Treaty of Waitangi' (Māori Health Provider).

Others suggested that the important issues for Māori was not recognition per se. Rather, one participant in a hui suggested, it was time that the Government started to act on its commitment.

Some responses were concerned about the lack of detail in the discussion document on how the principle was to be implemented. They thought that without any discussion of how the principle is to be operationalised, the Treaty of Waitangi would be marginalised.

However, many respondents proposed a number of mechanisms through which Treaty of Waitangi obligations would be integral to the operation of both PCOs and DHBs. To some Māori groups this failure in the document was reflected in the very development of the strategy. They felt that if this were consistent with the Treaty that there would already have been wide consultation with Māori before it was written which they did not believe had occurred.

7:2 Māori concerns about District Health Boards

Māori groups expressed some concern about the future role of DHBs in the funding and provision of health care services (not just primary health care). Some of this concern was based on memories of the difficulty they had had developing Māori services before the emergence of a separate funder. Many of these issues are addressed in the section on the structures.

There was some concern about the fact that boards would be largely elected as some responses believed that Māori had not been well served by elections. A related concern was the extent to which a person might truly represent the community if s/he was not chosen by Māori. Members of one group suggested that to be consistent with the Treaty half the members of any boards should be Māori.

Some thought that these concerns could be at least in part addressed by a specific mandating of DHBs about their obligations to Māori. Suggested commitments included:

- full participation in the design and governance of the overall health system by Māori
- the active practical and ideological support by the Crown for the establishment and growth of independent Māori health providers to work within the framework of kaupapa Māori
- the DHB should give a high priority to be given to initiatives which would impact on improving the health status of Māori with the intention that their health status is at least as good as that of the non Māori population.

Participants at a national hui of Māori providers considered that the DHB could pose problems to existing Māori health structures, particularly where Māori providers

delivered services across a number of DHB boundaries. While the development of DHB relationships with Māori were considered to be important, some thought that such relationships should be Māori as opposed to iwi based:

We accept that it is important for the Crown to have a relationship with mana whenua but we do not accept that this relationship needs to be exclusive (Respondent 178).

7:3 Māori concerns about PCOs

A number of responses from Māori groups were concerned about the impact that the development of PCOs might have on Māori providers. They feared that these services would not be able to establish themselves as PCOs and thus, at best, have to become part of a mainstream organisation. This was seen as a retrograde step. This fear was based on a number of concerns, many of which have been canvassed in detail elsewhere in the report:

- If PCOs were required to have large population bases, Māori providers would have difficulty in establishing themselves in many areas.
- It was unlikely that many Māori providers would be able to provide the full range of services outlined in the document. If this were to prevent them from becoming a PCO they would be obliged to join together with mainstream providers.
- Some were concerned about affiliation and the need for people to enrol with one PCO. They feared that many consumers would choose to enrol with inappropriate organisations for any of a number of reasons.

The risks for Māori providers in clients registering at the primary care organisation level is that Māori clients may base their decisions to affiliate on the capacity of a primary care organisation that may not deliver effectively to Māori (Māori provider).

The concerns expressed by Māori (and others) was based on the fear of a loss in momentum of the significant gains in Māori provider development which have been made already. The need to compete for funds with PCOs and the likelihood that many Māori would choose to access more readily available PCOs would be detrimental to continued Māori provider development.

Therefore they felt it was important to build on the gains that have been made thus far through the provision of additional funding to Māori providers. More funding would allow for the provision of a wider range of services and improved quality. This latter point was important, as some responses considered that Māori providers should have to face the same accountability arrangements and clinical standards as non-Māori providers. It was also important for Māori providers to continue to develop, as their holistic approach provides a model for the delivery of primary health care services.

Not all Māori respondents were so opposed in principle to PCOs. A number of suggestions were advanced about what alternative models or safeguards needed to be put in place to protect Māori providers and consumers. For some a PCO that was delivering appropriate services such as tohunga and rongoa was acceptable. Such an

organisation would probably be Māori based or have a close relationship with Māori providers. There was also some support for larger Māori PCOs which might be geographically larger than DHBs.

One model being considered by several Māori funders and providers was to explore a model that involved partnership between Māori and Pākehā providers.

This approach would allow for shared enrolment with a nominated primary care service provider and a Māori provider. It would be premised upon a partnered relationship between two primary care organisations (Māori or Mainstream), or a PCO and a Māori health care organisation (MHCO). Enrolment could occur with either the PCO or the MHCO.

Irrespective of whom the Māori consumer is enrolled with, they would retain their option to choose and access Māori provider services because

- it would be mandatory for the PCO to enter into partnered health care arrangements with existing Māori providers in order to offer a full complement of services (both type and targeted delivery style) to Māori enrolees
- it would be mandatory for the MHCO to ensure that the Māori enrolee access to other primary care service providers where an MHCO does not currently provide such services

7:4 Pākehā and mainstream responses to the relationship

Pākehā health providers, consumers and organisations agreed that an improved understanding of the Treaty and its implications would lead to an improvement in services. Many reported that for primary health services to be effective it was essential that they understood by and were responsive to the needs of Māori, whether or not delivered by Māori.

In their submission the Royal New Zealand College of General Practitioners noted:

An improved understanding of the 'specialised relationship between Māori and the Crown under the Treaty of Waitangi' would increase the potential to improve primary health care to Māori.

Groups representing consumers, maternity services and nursing practitioners agreed that the health status of Māori would only improve once all primary health care providers offered services in ways that were culturally appropriate and in line with the principles of the Treaty.

Many providers, some of them IPAs and general practices, supported the significance being placed on the development of 'for Māori by Māori' health initiatives as a way to recognise this relationship.

We support the continued emphasis upon the development of Māori providers along with mainstream providers working with Māori to ensure that PCOs are

responsive to the needs of Māori people. This is an area where a number of IPAs are beginning to make progress in partnership with local Iwi and Māori health providers (IPA).

However they also recognised the importance of mainstream enhancement in improving Māori health and were hopeful that Māori providers would want to work with mainstream providers. Some examples of where this was currently happening were advanced. One IPA was working on the development of a formal relationship with the local co-funder. Another already involved specific Māori services within the umbrella of the IPA. Other providers also reported that they worked closely with Māori providers in a number of fields. Service agreements and contracts would also provide another means to ensure Māori needs, Treaty of Waitangi obligations and the development of relationships with Māori would occur.

7:5 Choice between providers

Most providers, both Māori and non-Māori, agreed that Māori should be able to access primary health care through their provider of choice, whether this was a mainstream or a Māori provider. Some mainstream providers pointed out that many Māori (and Pacific peoples) chose to use their services when they might use others.

However some Māori providers questioned how effective this choice was. One provider argued that this 'choice' was driven by necessity rather than real choice. In many areas Māori providers were not available or were unable to provide a full range of services. Choice he argued would only become real when the workforce had been developed. A number of responses (including some from mainstream providers and consumers) argued that increased emphasis on workforce development was essential.

One co-funder suggested that many Māori were not aware of the services that were available for Māori. They suggested that part of the affiliation process for any PCO or practice should be to fully inform prospective Māori enrolees of all relevant issues such as the availability of Māori services, to ensure that when they enrol they make an informed choice.

We strongly believe that the consumer should be free to choose health care from either a 'mainstream' PCO or Māori Provider based PCO, according to the wishes of the consumer (IPA Council of New Zealand).

7:6 Consultation and relationship with DHBs and PCOs

Some responses were concerned about who was to be consulted about the development of services. They argued that the relationship in the Treaty was with hapū-iwi, not a generalised Māori population. Therefore any negotiation between the Crown (or PCOs) and Māori should be conducted at that level. This was also seen as important by a number of Hospital and Health Services.

Consultation should be facilitated through Iwi organisations such as [organisation]. This would include Māori providers, hapū groups and would effectively contribute to

consultation with 14 percent of the Māori population in the country (Māori co-funder).

A few responses from Māori groups and providers however pointed out that this ideal was problematic. Many Māori did not live in the iwi areas and the health authorities with whom they would have a relationship was not necessarily in the same area as their iwi.

One provider suggested that the relationship should be conducted with any Māori group which represented (or is mandated to represent) the views of a Māori population.

Some also felt that iwi politics could create some problems for DHBs in determining who the relationship should be with. This relationship not always clear in areas where there are large numbers of Māori not part of the tangata whenua.

Representation by is problematic. Issues of mandate and Māori living outside their tangata whenua are not addressed. A solution to this problem is critical. . . . More than half the Māori in the South Island do not identify with Ngai Tahu (Māori Studies – Educational institution).

Several responses observed that while a formal relationship with a DHB was necessary, this did not mean that it was not important for PCOs to also develop a similar relationship with Māori. These responses, often from Pākehā groups, reiterated how important it was that Māori were strongly represented in the governance structures of PCOs.

8 Roles and Structures in the new health service

Many responses and most of the meetings addressed aspects of the proposed changes to the health care delivery system and the establishment of DHBs. Most of these responses were in the context of the expected impact of these changes on primary health care.

A number of responses made general statements of support for the proposed developments of DHBs, elected members and the DHBs' role as funders of primary care services. There was support for the changed emphasis in the health care system from a contractually based system to one where funding was based on need. Some responses thought that the election of members was also seen as a way of ensuring that boards were more responsive to the needs of their community.

8:1 Attitudes to the proposed changes

8:1:1 Fear that DHBs will be dominated by hospital services

The major concern expressed by primary care providers and consumers about the DHBs, and particularly their role with regard to funding primary care, was a perception that they would be dominated by secondary services. Several major themes came through:

- There was considerable unease in some responses including those from national organisations, health care providers and consumers that when DHBs were established they would be dominated by existing HHS staff and reflect the culture of HHSs.
- Many respondents saw a potential conflict between the role of the DHB as a direct provider of hospital services, some primary health care and community services and their role as funder of most primary health care and community services. It was feared that board and staff members would tend to give preference to the services that they delivered directly.

The old view that [only] services that have been done in hospital are secondary care services do not reflect the 21st century. It is however important that hospitals do not use their larger share of funding from the DHBs in a commercial way and drive valid and quality PCOs from the health field (IPA).

A few community providers suggested that they had sometimes been funded to develop a service in a difficult area. However once the HHS saw a model that worked they would then develop it with their own staff. They were concerned that this practice would continue with DHBs.

A few providers suggested that DHBs should be required to divest themselves of primary services to reduce the dangers of unfair competition and/or duplication.

What will happen to providers in the community when there is change. A lot of employees from HHSs will be moving into the community. Why are they doing this? It is stepping on our toes in the community. Isn't this a duplication of services (Meeting with Māori providers and community representatives).

- People making responses were worried that hospital providers and advocates would dominate the committees providing advice to the board. There was increased unease when the Primary Care sub-committee referred to in the document was changed to the Health Improvement Advisory Committee with a wider brief.

8:1:2 Presence of elected members on the boards

A variety of concerns were expressed about the presence of elected members on boards and several reasons were offered for this concern. These ranged from outright opposition to fears about adequate representation for groups or areas. The major themes were:

- Elected members would be more likely to reflect the concerns and interests of the hospitals than of primary or community services. Their 'electorate' would expect this and the 'tangible' needs and demands of the secondary sector such as beds and wards would be more apparent to them than those of the primary sector.
- Elected members would not necessarily have the skills required for administering the funding structures necessary.
- Some members would represent specific lobbies or interests such as hospital services or a specific population group rather than the whole population.

There is a concern that DHBs may end up being captured by certain groups with vested interests, and the intention of the strategy will be lost before it gets to the people it is intended [to help] (Pacific provider).

- Some areas or population groups feared they might not have any representation if members were elected. Māori and Pacific people, small centres and those where a community of interests was currently divided between two or more HHSs were particularly concerned that if there was not an alternative way that representation could be arranged they would not have members advancing their cause.

8:1:3 The number and size of boards

The proposed number of DHBs raised a variety of concerns for some providers and consumers. One frequent concern was that if the boards were to have a high level of independence this could lead to different types or quality of services being available (or not being available at all) in different areas. One national provider observed that this had been a problem even with four RHAs and they thought it would be much worse with 21 boards. This issue was a particular concern to maternity groups, well child providers and other providers with national contracts, Māori co-funders and large IPAs.

Other concerns raised included:

- Nationally funded providers and providers such as IPAs which operated in several DHBs were worried that they would need to make separate funding agreements with more than one board instead of with one central funder. They thought that this would lead a significant increase in transaction costs when they needed make funding arrangements with each.
- The end of a centralised funder for primary health care services was a concern to some providers, particularly Māori, Pacific and rural providers, who feared that this could mean the end of innovative programmes that they were developing.
- Some responses were concerned that there would be a shortage of staff to carry out the tasks such as writing funding agreements, carrying out needs analyses and evaluation in 21 boards. This would probably disproportionately affect smaller boards and could lead to intense competition between the boards for the staff that were available.
- A few responses were concerned that in time the 21 boards would prove to be unsustainable. This would lead to a process of amalgamation (or take over) by large boards. They feared that smaller regions and the providers would suffer when this occurred.

8:1:4 Māori and Pacific people and interests

Many Māori services were concerned about what would happen to them under DHBs. Some observed that because of the funder-provider split and the existence of the HFA, many Māori providers were able to gain funding and develop responsive services. Similar concerns were expressed by Pacific peoples. There was a concern that DHBs would be dominated by Pākehā/Palangi with limited understanding the health needs and rights of Māori and Pacific peoples.

Some responses were concerned that while there might be a Māori on the board this would not give expression to the Treaty obligations to hapū and iwi. As a result on group feared that existing contractual arrangements between independent Māori providers (and the HHSs) may be vulnerable under the new system.

At a minimum there should be one tangata whenua representative and one Māori, not just one Māori. These are different concepts and need to be treated separately (Māori co-funder).

We are unlikely to be well represented on DHBs. We only have one representative on one HHS. If the idea of DHBs is that we will be represented we have no confidence in it. Democracy doesn't mean that we have adequate representation, or even representation that reflects our population (Pacific provider).

8:2 Suggested safeguards and solutions

Although there were many concerns expressed about the role of DHBs in regard to the future of primary health care, many of the responses also included suggestions about how the new system could be adapted to safeguard against these.

8:2:1 Māori and Pacific representation

One frequent response to the fear of inadequate representation for Māori, from both Māori and 'mainstream' groups of providers and consumers, was that there should be reserved seats on DHBs for Māori.⁷ Some Pacific responses also identified a need for guaranteed Pacific representation on boards, particularly in areas where there were many Pacific peoples.

Several responses (often from Māori provider and funder responses) cited the positive role groups that groups such as Māori Development Organisations (MDOs) and Māori Co-Purchasing Organisations (MAPOs) had played in the development of Māori services. They were anxious that this role should continue with DHBs.

Another suggestion from some Māori and Pacific responses was the development of one separate body to fund services for Māori or Pacific people. A similar solution had also be advanced by some national providers and other providers.

Perhaps one national health board in addition to the 21 DHBs could be established to dealing with national organisations such as Plunket and Māori and Pacific Nations could be a solution (General practice).

8:2:2 Safeguarding primary health care budgets

One of the major concerns was that money that should be spent in the primary health care sector would be spent on hospital services or primary health care services provided by hospitals. A number of respondents suggested that this could be guarded against by ring fencing the primary care budget and one IPA saw this as a way to avoid commercial friction between the two groups.

Some had innovative suggestions about how the amount to be included in the ring fence could be determined.

One suggestion is to have a ring-fenced budget for primary care that could be set as a percentage of total expenditure to be devoted to primary care services. This could be set as a performance target for DHBs with a goal of reaching an OECD average balance of primary and secondary expenditure over some years (IPA).

A few respondents were more cautious about whether ring-fencing could have the desired goals. It was observed that the purpose of ring-fencing could easily be overridden by a redefinition of services as primary health care.

Some respondents favoured the establishment of more rigorous controls over expenditure and accounting rather than ring-fencing. Such controls could then be used to prevent inappropriate movement of primary funds to secondary care, and unidentified cost-shifting between different parts of the system. A national organisation suggested that rather than ring-fencing primary health care spending, a more productive solution might be to limit the amount of the budget that could be

⁷ There will be between one and six reserved seats for Māori on the DHBs.

spent on secondary care. They thought that this would provide an incentive for DHBs to spend money in the community and primary sector to avoid secondary admissions.

8:2:3 Establishing standards for the DHBs

Some responses saw an ongoing role for the Ministry of Health as a way to ensure that adequate and appropriate primary health care services were delivered. The Government would set and monitor rigorous standards which DHBs had to follow. This could then ensure that the primary sector was 'protected' and that all the DHBs delivered similar services. Some other responses saw the potential for the rules about availability and accessibility to address these issues. In this model the freedom of DHBs to make decisions about the services it supplied would be on the margins.

Māori providers and other providers with national contracts were particularly supportive of an ongoing role for the Ministry. Some qualified this by saying that as DHBs proved they were capable they should be allowed more freedom.

I see it as the job of government to set minimum standards for the provision of care and to ensure that these are met. A health board should have limited rights to move funds around, at least in the early days (Consumer).

At the least the Crown needs to ensure that they will operate under set guidelines to ensure that the DHBs do not have complete autonomy in their makeup and functions (Māori provider).

Some respondents suggested that there should be regular monitoring of performance that would ensure that DHBs (and PCOs) were delivering on their expectations.

8:2:4 Appropriate representation for primary health care providers

Some people who were concerned about hospital domination thought that one way to respond to this concern was to make sure that primary health care providers (not necessarily only GPs) were guaranteed a place on the Boards and their committees⁸.

Some responses suggested that there needed to be 'reserved' places for primary health care providers. They were concerned that without this representation it was unlikely that appropriate decisions would be made.

⁸ Initially people had thought that this would be achieved through the Primary Care Committee and the decision to change this to the Health Improvement Advisory Committee caused some concern in both written submissions and at meetings.

9 Other issues

A number of other issues were addressed in some of the submissions to the discussion document. Those additional issues most frequently raised were:

- the provision of Pacific health services
- workforce and training
- information systems and confidentiality
- issues for TLAs
- issues for rural areas.

9:1 Issues for the provision of Pacific services

Three fono were held with Pacific providers and approximately 70 people attended them. Pacific providers also attended several of the focus groups organised for providers to comment on the document and a meeting with a general practice staff. Several of the 'mainstream' providers who attended meetings had a large number of Pacific people on their registers and commented on aspects of the delivery of services to them. Three written submissions were received from identifiably Pacific people or groups and Pacific people were also part of several organisations that made written submissions.

9:1:1 Health needs of Pacific people

While there were differences over some issues such as the provision of services for Pacific peoples by 'mainstream' providers or the structure of PCOs, there was substantial degree of agreement over the high health needs of many Pacific peoples and the difficulties that Pacific providers had meeting these needs. Responses identified several reasons for this situation which included the low socioeconomic status of most Pacific peoples, language problems for immigrants and the young population structure.

There was a recognition from both Pacific providers and 'mainstream' providers that the high level of service needs for Pacific peoples that was not always being adequately addressed at present. In this context one provider was concerned that these high needs could discourage providers from affiliating Pacific peoples if their needs were not recognised in any capitation formula.

One submission and some people at one of the meetings thought that these needs could have negative effects on a system of affiliation and capitation if this did not allow for the higher health needs of Pacific peoples were introduced. The submission also noted that many Pacific peoples moved often and this might lead to double enrolment.

9:1:2 Pacific workforce needs

Most responses from both Pacific providers and 'mainstream' providers agreed that Pacific providers had a substantial role to play in the delivery of appropriate services for Pacific peoples.

Early indications suggest that service provision by Pacific peoples for Pacific peoples have better outcomes than conventional service delivery. However, these initiatives have not been formally evaluated (Pasifika Medical Association).

Workforce development was identified as a major issue for the development of these services and there was a preference for this to become a priority for the Government. It was recognised that there were only small numbers of Pacific people trained as professionals such as doctors and nurses at present and it was recognised that this was unlikely to change in the immediate future.

One mainstream provider noted that there was a number of Pacific trained nurses in New Zealand who were unable to practice here. He suggested that the skills of these nurses could also be utilised in other ways. There could either be additional training for these people to enable them to practice here, or they could (and often did) play a significant role in the delivery of community based services such as the promotion of immunisation.

One provider at a community health group meeting noted that the shortage of Pacific providers was sometimes disadvantaging Pacific providers. Many 'mainstream' providers had identified a need for Pacific providers and were taking them on staff at the same time there was a great need for them in Pacific providers themselves to find staff.

Most responses accepted that 'mainstream' providers were likely to be significant providers for Pacific peoples, at least in the interim. They were concerned that these providers should be competent to provide services for Pacific people.

Cultural competence and good practice is essential if Pacific people are to be encouraged to attend (Pacific provider).

9:1:3 Funding Pacific services

Some concern was expressed about the level of funding for Pacific providers and for Pacific services (whether provided by Pacific or 'mainstream' providers). Issues raised included:

- Existing funding arrangements did not recognise the high health needs of Pacific people and the high costs of delivering services.
- Pacific people often lived in suburbs of low socioeconomic status where health care utilisation was traditionally low. Budgets set on historic information therefore disadvantaged Pacific people.
- There was some concern from Pacific providers that some 'mainstream providers' obtained funding to provide services for Pacific people without necessarily being able to provide adequate services. One provider suggested that any PCO providing services for Pacific people should be screened and monitored by the Ministry of Health and the DHBs to ensure that it was delivering adequate services and to ensure that any money that were obtained for this purpose were being spent on Pacific services. At the same time one 'mainstream' provider with a large Pacific register wondered why they were ineligible for such funding.

- Several people observed that it was difficult for Pacific providers to set up in business as they lacked the financial resources necessary to begin a practice (of whatever sort). They observed that they would need 'hump money' in the short term to be able to compete equally with mainstream funders.

9:1:4 Provision of services for Pacific people

There was some concern about the types of services that would be delivered by PCOs and a fear that these would be GP dominated. Both mainstream and Pacific peoples observed that Pacific people often needed access to a wide range of community-based services in addition to services from other sectors such as housing. Effective services for Pacific people needed to be more community- and family-focused than most services provided.

Responses observed that providers needed to be aware of these needs and able to either provide them directly or to make appropriate referrals. One mainstream provider noted that they had established a close working relationship with a community service that included several Pacific providers, in part for this purpose. A focus on population services was seen as vital for any effective service for Pacific people and this was seen as a positive feature in the document.

Several responses noted that it was important to be aware that there was more than one Pacific nation and the services appropriate for one were not always appropriate for others. It was also seen as important that different Pacific peoples were involved in consultation about services before they were finalised.

Defining a range of services and quality is good but the defining process has to be 'bottom up'. So consultation with local community groups and providers is important (Pacific provider).

Co-ordination of services was also discussed and endorsed. Intersectoral co-ordination was identified as important because of the range of issues, such as housing and welfare, impacting on Pacific health. Two responses also noted that Pacific peoples were often high users of nationally funded services such as maternity services, well child services and mental health services. They felt that it was important that these services be well integrated with PCOs so that Pacific people were not disadvantaged.

Effective co-ordination is absolutely vital to the delivery of the new system. We have failed and confused PI people so much that they have little faith in the system. Competition will be lowered and openness and co-operation which has not been evident in the past will be the new behaviour among PCOs (Pacific consumer).

The future size and structure of PCOs was a matter of some concern to Pacific providers and to other organisations concerned with the provision of services to Pacific peoples. Pacific providers were uneasy about the idea that PCOs would have to have a large number of patients or would have to deliver the complete range of services identified in the discussion document. This could mean that most Pacific providers would be unable to establish PCOs in their own right and therefore lose the independence in a larger Palangi dominated organisation.

The criteria for PCOs are a worry to Pacific providers. There are many versions of what a PCO might look like being mooted and no clear direction We started to feel a bit of unease that there are hidden agendas in this document. . . .

As a consequence Pacific providers would either be forced to look for a sympathetic PCO which may hold the same values as us (which means returning to the old habit of having 'big brother' monitoring and directing your future from their perspective' or join up to whatever PCO is available – despite any contradictions in terms of culture, priorities and community values (Pacific provider).

9:1:5 Other issues

There was some concern among providers that Pacific people had not been identified as a priority issue for the delivery of Pacific services although the discussion document had described the development of Pacific services as one of the positive developments of the last 10 years. This issue was the subject of heated debate at the largest fono with a demand that the importance of Pacific issues be recognised by the Ministry of Health.

Other issues that were noted included:

- One provider noted that even where there were Pacific representatives on boards, the people providing this representation did not always have the skills needed. Potential representatives sometimes needed training.
- It was important that adequate information was available for Pacific people and this had often not been the case in the past. A particular concern was that Pacific people were adequately informed about the range of services that PCOs could supply and their cultural competence.
- It was important that the Ministry have a stand alone section or directorate for Pacific issues in order that it was appropriately informed on Pacific needs.

9:2 Workforce and training

Fifty-six responses, almost all from providers or their organisations, addressed some aspect of workforce and training. Issues addressed included the adequacy of the current workforce, the type of workforce necessary to deliver the Primary Health Care Strategy and the need for a larger Māori and Pacific workforce.

There was some concern expressed in meetings and submissions that the current workforce needs were being met on an ad hoc basis rather than being planned to meet identified needs. There was general support for the need for planning in the workforce through a committee or other body⁹ that was able to co-ordinate the workforce skill

⁹ The Health Workforce Advisory Committee was being established during period of the consultation. Those organisations that knew about it, eg, the Medical Council of New Zealand and the New Zealand Association of Occupational Therapists were in favour and it was generally supported in meetings when discussed.

needs of various sectors and ensure the provision of appropriate training and education.

There is a need for a clear and consistent strategy to lead an approach to workforce development and training in the health sector that aligns itself with the health strategy and the direction of primary health services (Māori provider).

9:2:1 Does the current workforce have the skills to provide the proposed strategies?

Many non-GP providers and some consumers questioned whether the current GP-focused primary health care workforce would be able to provide the wide range of services envisaged in the discussion document. The areas that GPs were seen as unlikely to be able to deliver included population-based public health, services for Māori and Pacific peoples, and services for people with mental and physical disabilities. Some community groups questioned whether GPs worked effectively or well within the community development approaches required by the strategy.

The difficulty is that GPs are a closed culture – like teachers. A lot of them don't recognise the role of the patient and his/her family as important. And the role of other providers, many of who are more 'educated' in the needs of the community than GPs (Group of community health providers).

Some responses (including some from GPs) thought that GP training would need to be changed to focus on issues such as the role of GPs in facilitating relationships between providers and with the community and cultural awareness. This training should provide them with the requisite tools to work effectively or well within community development approaches.

Responses from GPs and other providers highlighted the importance of ongoing education for primary health care. There was a concern that there was a lack of opportunity for ongoing education in primary health care, particularly from practice nurses. Some questioned whether the future role of PCOs would include the provision of ongoing education and, if so, how this would be funded.

Some GP and representative organisations believed that they had or were developing appropriate training programmes that would enable providers to work for the new vision. Two IPAs identified the range of skills that they thought they would need if they were to become PCOs.

9:2:2 Provision of rural services

A number of responses addressed the specific needs of certain areas. The provision of training opportunities and staff retention in rural areas (particularly for nurses and GPs) was emphasised in many responses from rural areas. They believed there was a failure to address the problem of recruiting to rural practice and this would result in further decline in rural New Zealand.

One response suggested a number of strategies to support rural career development. These included maintaining recruitment without fear of entrapment, recognising rural health care as a distinct discipline and making routes for relocation from rural practices. The financial disincentives for practice in rural areas and the need for some form of guaranteed income were also raised by some responses

Providing opportunities for GP registrars in rural settings will increase the likelihood of registrars working in rural general practice in completion of that training (Royal New Zealand College of General Practitioners).

9:2:3 Development of the nursing workforce

Responses from many GPs (as individuals, GP organisations such as IPAs and practices, and national organisations), nurses and some consumer groups saw an expanded role for nurses in the delivery of a new strategy. They believed that the further development of the nursing workforce could and would make a significant impact on the health of populations. One large IPA suggested that a suitable way to start increasing the roles and responsibilities of nurses would for the Government to lead the way and ensure adequate Practice Nurses representation on primary care advisory groups and DHBs.

Some responses saw a number of advantages in having nurses deliver services currently provided by GPs,¹⁰ namely that nurses:

- already have a wide range of skills in the provision of health care
- are accepted and valued by the communities they work with
- are less expensive than GPs, and the use of nurses instead of GPs would facilitate expanding the range of services they supplied.

Some responses listed one or more in a range of services that they thought nurses could be involved with. One of the most comprehensive lists of services that nurses could supply in a PCO was supplied by a HHS:

- diabetes, asthma, incontinence, oncology, disability, endocrinology, hearing and vision screening services, cervical and breast screening
- Well Child checks including immunisation
- nutrition advice
- school services
- family therapy services
- sexual health services
- needs assessment
- home visiting for early intervention, assessment and ongoing primary care.

One nursing lecturer believed that there needed to be a national education framework that was recognised nationwide for its quality and acceptability to upskill practice nurses so they can achieve this greater role,.. It was noted in this response that there is

¹⁰ One of the major reasons for support of capitation was that it would enable practice nurses to provide a range of services without the patient needing to see a GP.

a strong will to develop a programme and tertiary institutes would be keen to provide this.

9:2:4 Development of the Māori workforce

There was a wide consensus among mainstream and Māori providers that the Māori health care workforce needed to be developed in order to ensure that the health needs of Māori were addressed and to lead to true equity between Māori and non-Māori providers. Some addressed the critical shortage of Māori GPs and a shortage of Māori nurses. Some responses identified a need for significant capital expenditure by the Government and a need for the Government to actively promote and protect Māori provider development.

[There must be] concerted efforts in attracting Māori into the various facets of the health workforce. This may require methods of education delivery to be reviewed to ensure that programmes are delivered in a way that maximises the learning and subsequent success of Māori (College of Nurses Aotearoa).

It was recognised that many Māori would continue to attend mainstream providers for a number of reasons. Both Māori and mainstream providers thought that it was important that all health sector staff underwent training in cultural awareness issues to improve their effectiveness when dealing with Māori. One response suggested that this meant that professional training colleges and institutions must address their own attitudes to improving cultural awareness.

A group of Māori health researchers saw a role for the proposed workforce committee to undertake a review of the current status of Māori health workforce and then to develop a strategic plan of how to enhance Māori workforce for all levels of the health sector.

9:2:5 Development of the Pacific workforce

Pacific providers reported that they had a great shortage of Pacific providers to meet the high need of Pacific people, especially in areas such as Porirua and South Auckland. This problem was exacerbated because there are fewer Pacific health workers for each Pacific nation.

Providers reported that they had access to fewer resources for the development of an appropriate workforce than other groups. The fact that Pacific people were not included as a priority in the discussion document was a source of much concern to one meeting with Pacific providers.

Poor socioeconomic status and therefore limited finances is only one of the reasons why young Pacific Islanders leave school prematurely and seek employment . . . I feel that the belief that most Pacific Island students have about health training programmes like medicine is that it costs too much. Students are coming out with up to \$100,000 student loan debts which is a hindrance to studying such courses in the first place (Pacific GP).

One Pacific provider observed that there was an unusual problem for Pacific providers now. Pacific had become a high priority issue for many mainstream providers. Consequently the limited number of Pacific providers were in high demand at the very time that they were trying to develop a Pacific workforce to provide services for Pacific people.

9:2:6 Other workforce issues

A number of other workforce and training issues were raised. These included:

- Several GPs thought that the cost of training and the resulting size of some students' debt at the end lead to young doctors not choosing general practice because of its relatively low of earning power. The Royal New Zealand College of General Practitioners regarded cost as a particular barrier to education to Māori, Pacific and other low-income trainees.
- IPAs and organisations emphasised the need for greater integration of training, specifically in relation to doctors, nurses, midwifery and pharmacy schools. They thought that better integration of training would lead to much a more effective primary health care sector. Working groups within Healthcare Aotearoa had already done some preliminary work in this area. One IPA believed that New Zealand needed an organisation similar to the UK Council for the Advancement of Inter-professional Education, which fosters inter-professional education.
- There was a perceived need for the increased training for ethno-specific health care workers. These would address Asian and refugee groups as well as Māori and Pacific groups.

9:3 Information systems and confidentiality

The need to develop appropriate information systems to enable practitioners was raised by 40 submissions and was also covered in some meetings. Responses from providers were more concerned about this than those from consumers.

Confidentiality issues associated with information systems was a topic in 30 submissions, many of which came from consumers. While providers were generally sure that confidentiality would be maintained, consumers were more likely to be worried about the prospect of information being misused.

9:3:1 Role and development of information systems

Most felt that effective databases, sometimes based on an affiliated population, would help PCOs and providers to be aware of the health status of their affiliated population and the regions that they served. The important role that information systems had to play in the management of some population groups (such as children and those with mental health problems) was stressed by groups working with these populations. Some responses were concerned that information systems had hardly been addressed in the discussion document.

Some noted that without this easy access to data on patients, keeping track of utilisation of different services by consumers would be difficult if not impossible. Responses thought that without this continuity of care and greater co-ordination

between the primary and secondary sectors would also be very difficult. One patient observed that because of effective and transferable information between his providers he was able to enjoy continuity of care. However he noted that not all providers were happy to share records.

A concern to some providers was that there was not an easily transferable information database at present. They recommended that the development of such a database should become a priority if population health were to become a reality. One large IPA stressed the need for standardisation in the field of health informatics with standardised disease codes, codes to describe common conditions, standard laboratory codes and cost codes for the entire health sector.

A few respondents mentioned the National Health Index (NHI) number and the role that this would presumably play in ensuring that data was not duplicated, kept up to date and was easily transferable between agencies. There was some concern about how accurate this information was and about what sort of data would go onto any system identifiable by NHI number.

Will the Government be promoting the National Health Index? We consider the use of the NHI to be quite critical to the development and maintenance of comprehensive information systems on health utilisation and health needs and for the integration of information on individual patients in a PCO (Pharmacy Guild).

One consumer organisation questioned whether there had been any reviews of the accuracy of the information currently held by hospitals using the number. Many providers also observed that there would be costs associated with such a process and one observed that IT systems also had a limited life. They felt that the Government should assist with the funding of the development of common systems as these were very expensive.

Several general practices reported that they had already made large personal investment in information systems and were reluctant to start again without some incentives. These systems had age/sex registers, immunisation registers and recall systems already in place, as well as fully electronic systems.

9:3:2 Need for confidentiality

Many of the health care providers who responded, particularly GPs and their organisations, noted that confidentiality a major importance in their work. They saw complying the Health Information Privacy Code 1994 and the Privacy Act 1993 as essential. Consumers also stressed the need for confidentiality, although they sometimes doubted that this was properly observed at present.

The maintenance of confidentiality was seen to require strict guidelines about who could collect and access data, the reasons for this collection, what data was identifiable and what not and what data could be reported to who and in what form. For example, providers did not want to report identifiable data to bodies such as the HFA for monitoring purposes. At the same time they and some consumer

representatives were aware of the constant need to balance privacy against the need for monitoring and audit.

Some providers also thought that it was important that consumers were informed of who had access to their data by the provider themselves rather than finding out later or not at all.

When services are working together need for confidentiality is heightened. We talk to people when they leave hospital. They are aware that information is shared between providers (Integrated Care Project).

Several providers (and their organisations) argued that confidentiality was best maintained if the information was stored near to where it was collected. That is with the general practice. Other IPAs usually favoured the PCO as the level at which data should be managed.

Other issues sometimes raised included:

- Knowledgeable use of information technology is essential for the integration of health care delivery.
- Providers need to focus on developing effective transfer of information to support superior patient care.
- Ethical requirements for processes about the provision of health information to consumers and other providers have to be included in funding contracts.
- Stringent monitoring will need to take place in the initial stages in order to set the standard and context of information sharing appropriately.
- Further effective use of standardised databases will require the government to undertake a publicity campaign for the public to explain why this is being done and the confidentiality requirements associated with it.

9:3:3 Concerns about confidentiality

Some consumers and a few providers expressed greater doubts about the ability of providers, and in particular GPs, to maintain confidentiality. One response from a consumer noted that while many providers were zealous in their maintenance of confidentiality, others treated the regulations with 'flagrant disregard'. The response cited the use of fax machine to transfer patient information between providers and agencies.

One advocacy group had a number of concerns about confidentiality. These included that consumers were often unaware of who had access to their health information and that the very process of denying a provider access to some data could compromise the consumer. For example, stating that one does not wish a provider to have access to abortion or sexual health clinic records would indicate that these records existed. They recommended that records should only be held by the providers of a service rather than available to a PCO or similar organisation. An IPA had similar concerns:

There is a need for a person to be able to visit any provider (with confidence of) confidentiality secure in the knowledge that this information does not get back to

any party unless the nominate this. This is a fundamental right and must be addressed in (any) working parties on enrolment rules and access (IPA).

9:4:4 Māori concerns about databases and confidentiality

Māori providers raised a number of specific concerns about national databases and confidentiality. These had some similarities to the issues raised by other providers and consumers. These concerns included

- For Māori health information is a taonga and it was important that Māori play a significant role in the development of protocols for the sharing of information and its transfer.
-
- One Māori health provider was supportive of greater transfer and sharing of information as long as safeguards were put in place to protect how the information was used. They were of the view that information sharing should always be optional for the provider and with the written consent of the client.
- One provider was concerned that if the information was available for DHBs they might use this data to advantage their own providers at the expenses of independent providers. They thought that if they were required to provide information to a DHB that it should be reciprocal.

9:4 The role of territorial local authorities

Thirteen responses were received from District Councils and City Councils, some of which were keen to be involved in the further development of primary health care. Generally they were strongly in favour of the proposals enclosed in the discussion document.

TLAs were strong advocates of community representation as they believed that this would assist communities to obtain the services that they needed. Some believed that there should be an opportunity as of right for community health groups and TLAs to provide feedback for PCOs. Most emphasised the fact that Māori groups need to be represented at all levels of health provision including the development of a health strategy.

They noted that many of the services provided by councils had a role in the determinants of health and that it was important that there was closer co-ordination between council services and those provided by the health sector. PCOs should involve existing community services as real improvements to health will require initiatives from a wide range of community and government agencies because health is influenced by a wide range of social and economic conditions.

Other common themes included:

- PCOs should be open and accountable for public funds and be therefore be evaluated for the services that they provide.
- Rules for access and availability should be set nationally but they should be sufficiently flexible to allow for local arrangements.

- Several stressed that it was important that there are ongoing development funds available to ensure that Māori providers are on the path towards the provision of the full range of services.

9:5 Provision of services in rural areas

There were over 50 submissions from rural areas or from organisations with a significant interest in the provision of services in rural areas. Several meetings also addressed these issues. A particular concern for many responses was that rural issues were rarely mentioned in the document. Several responses noted that there had been considerable work about rural health issues undertaken by the Ministry of Health and the HFA in the past but since the change of government this seemed to have gone into abeyance.

Many submissions pointed out problems that were exacerbated by or unique to rural areas. A major one was the difficulties for consumers (and some providers) living in small areas, often in isolation from services. This led to high travel costs, the inconvenience of travelling long distances and the travel expenses involved in providing rehabilitative care after hospital treatment.

Many submissions raised workforce issues and the availability (or otherwise) of appropriate staff and institutions in rural areas. They believed that financial incentives would be the most effective way of reversing the current shortages. Suggestions included the ability to retain flexibility in charging for services; helping pay back student loans for doctors willing to work in rural areas; assistance in obtaining further education and training; and assistance in obtaining locums so that leave can be taken and 'burn-out' avoided. A concern for GPs was the effect of isolation on rural GPs and the lack of opportunity for peer review and training.

The single greatest primary health care issue for rural dwellers is the availability of care. Many rural areas are understaffed, particularly in terms of GPs (Federated Farmers).

Some rural providers and consumer groups were concerned about the implications of population-based funding for rural areas. They suggested that any formula developed to distribute funds must include consideration of the special needs of rural areas such as high transport costs. There was some interest in ringfencing rural funds to prevent funds being withdrawn to finance needy urban areas.

Another concern was whether successful local rural initiatives such as the Balclutha Health Trust and Kaipara Care could survive when PCOs were established. It was feared that these might not be able to continue if PCOs had to have large patient populations. There was also a perceived danger that population based funding would mean that there would not be sufficient funds for these initiatives.

There is no indication in this document about the desired size for a population for a PCO. This is an issue for rural communities. They would be disadvantaged because they would need to be affiliated to a large centre, they

would lose their identities, potential to be asset stripped and lose their ability for local solutions for local issues (Rural general practice team).

Other concerns included:

- Elected DHB boards would be unlikely to have many rural representatives and this would make it difficult for these representatives to voice rural concerns.
- There is a high transient population in rural areas, especially those which are tourist or seasonal employment centres. These responses were concerned whether there would be adequate funds for the provision of these services and whether affiliation would be flexible enough to cope with those who lived in rural areas and worked in urban areas, often seeing providers there and where they lived.

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HEALTH REPORT

Subject: SUMMARY OF RESPONSES TO THE FUTURE SHAPE OF
PRIMARY HEALTH CARE

Date: 1 September 2000 **File Ref:** HC01-16-4

Attention: Hon Annette King (Minister of Health)

Copy to: Hon Ruth Dyson (Minister for Disability Issues)
Hon Tariana Turia (Associate Minister of Health)

EXECUTIVE SUMMARY

A summary of the 290 submissions and 54 meetings on the *Future Shape of Primary Health Care* is attached. A fuller report is available.

Responses were generally supportive of the need to increase and focus on population health, reduce disparities, improve access, increase co-ordination, increase community involvement and ensure all providers have a voice. Concerns were expressed that primary care organisations could be dominated by large GP groups, that District Health Boards might not understand and support primary care, that details of enrolment and funding formulae might disadvantage some, and that the proposals would not be adequately funded.

The Ministry has begun the process of developing a definitive strategy that takes on board these responses. The plan is to have a definitive strategy for you to take to Cabinet towards the end of October.

RECOMMENDATIONS

The recommendations are that you:

- (a) **note** the contents of this report and the attached submission summary; Yes / No
- (b) **agree** that the Ministry should distribute the summary along with the attached message from you; Yes / No

- (c) **note** that the Ministry plans to prepare a definitive strategy ☒ Yes / No
for you to take to Cabinet towards the end of October.

Deborah Woodley

Deborah Woodley
Acting Manager, Health Services Policy
Personal and Family Services Directorate

[Handwritten Signature]

MINISTER'S SIGNATURE:

DATE:

18/9/00

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REPORT

BACKGROUND INFORMATION

1. In March you released the discussion document, *The Future Shape of Primary Health Care* and asked for submissions. The Ministry has now completed an analysis of the 290 written submissions and comments from 54 meetings. A 16 page summary report is attached and a more detailed document is available on request. About two thirds of those commenting were provider groups or individual providers while the rest came from a variety of consumers or non-provider organisations.
2. The response to the vision for primary health care was generally positive. In particular, people supported:
 - the important role that primary health care services have in improving health status;
 - improving Māori and Pacific people's health and the services available;
 - improving access to services;
 - improving co-ordination among primary health care services and between primary and secondary health care services;
 - a formal role for the community and service users in decision making about primary health care services; and
 - the focus on population-based services rather than just episodic services.
3. Support for aspects of proposed mechanisms was more mixed. For example:
 - many GPs supported primary care organisations, while some other providers and consumers were concerned that these organisations would be dominated by existing GP groups to the detriment of other interests;
 - many people were worried that District Health Boards would be dominated by a focus on the provision of hospital services rather than recognising the key role of primary health care;
 - questions were raised as to whether the Government was committed to the financial cost of an improved primary health care model;
 - moving to population-based funding, capitation and affiliation was supported by many who thought it would lead to a better population focus. However, others were concerned that this could lead to possible under-servicing, providers selecting only people they thought were good risks, and restriction of choice.

COMMENT

4. The discussion document deliberately left many questions unanswered in order to seek people's opinions about proposals. Many of the responses are helpful in guiding the further development of a workable strategy.
5. The support for the aims and broad concepts is reassuring and shows that it will be possible to strengthen primary health care in order to achieve the gains the Government is seeking in the health sector. There was an unusually united and

positive response from the leadership of primary medical providers with an apparent willingness to see significant change in the way that they provide services.

6. Many of the objections raised were about aspects of the proposals where detail was lacking but people were concerned to ensure that the final arrangements met their needs. For example, some commentators assumed primary care organisations would be the existing Independent Practitioner Associations and that other groups would be cut out. They therefore wanted to ensure that smaller groupings would be allowed, that there would be support given to others to build capacity, and that the GP dominance of existing groups would be challenged.
7. The Ministry has already begun a process for developing a definitive strategy taking account of the responses that have been received. As described in Health Report 20001105 (19 June) the Ministry has set up a sector reference group and is preparing a definitive strategy for you to present to Cabinet in October.
8. This will restate how important primary health care is to improving health, reducing disparities and ensuring everyone has fair access to services. It will clarify the proposals for primary health care organisations in order to get providers better focused on the needs of populations and who is missing out. There will be details about not-for-profit status, how to ensure the community and providers influence decision taking, the essential services required, funding arrangements and so forth.
9. The Ministry believes there is an opportunity at present to arrive at a strategy that will satisfy most objections, and not antagonise supporters, while still allowing primary health care services to evolve in the right direction. The proposals involve new services and approaches that will require significant changes and some increased costs. While some funds may be able to be redirected from other parts of health expenditure over time, some new funding will have to be found over the first five years. The strategy will discuss the rate of change and indicate where efforts and funds should first be directed to make the most significant health gains.
10. There is significant interest in the development of the strategy and the response to the submissions. Many people, especially those who made written submissions, will want to know what was said. We recommend that the summary should be distributed to all who made a submission and to a selection of key sector and media groups, that it should be posted on the Ministry's website and made available on request. The fuller report which includes brief extracts from various submissions would be made available on request.
11. The Ministry has drafted a covering letter from you to accompany the summary of responses document. This is attached for your approval.

IMPLICATIONS FOR CLOSING THE GAPS

12. Good primary health care is central to achieving the Government's aims of closing the gaps in health. The primary health care strategy will clearly signal that Māori and Pacific health is a priority for primary health services. This will include developing the capacity of Māori and Pacific providers and primary health organisations as well as ensuring that all mainstream providers identify and address the needs of the Māori and Pacific people they serve.
13. The summary report has sections on issues that are important to Māori and to Pacific people. It acknowledges that Pacific people especially were under-represented in written submissions and has included comments made at hui and fono in order to capture the concerns that were expressed.

Contact for telephone discussion (if required)

Name	Position	Telephone		Suggested First Contact
		Direct Line	After Hours	
Dr John Marwick	Senior Advisor	496 2052	562 8801	X
Stephen Lungley	Senior Advisor	496 2111		
Deborah Woodley	Acting Manager Health Services Policy	496 2187		

A summary of the responses received to *The Future Shape of Primary Health Care: a Discussion Document*

I am very pleased to be able to send you a copy of the summary of responses that were received to the discussion document on primary health care that I released at the end of March.

People showed considerable interest in the paper and the proposals it contained. Nearly 300 written submissions were received and many other people expressed their views through the 54 meetings that were held around the country. The quality and detail of responses was considerable and I am grateful to the time and effort that has been given.

Clearly, everyone agrees with me that strong primary health care is essential to achieving the Government's goals for health. Those goals will be set out in the New Zealand Health Strategy and many people have also made their views known on my discussion document about that strategy. I will shortly also make a summary of those comments available.

The Government will now finalise the New Zealand Health Strategy and the other strategies that form part of it - including the Primary Health Care Strategy.

It is very important that plans such as these take account of people's comments. Our health system must meet the needs of those it serves and it needs the support of those who provide the services.

I thank everyone who has taken a part in this process so far. I assure you that the future health system, especially the primary health care services that are close to where people live and work, will continue to match people's needs and involve patients and communities in how they operate.

Hon Annette King

MINISTER OF HEALTH

Summary of responses to *The Future Shape of Primary Health Care: A discussion document*

1 Getting feedback

The consultation process on the development of a Primary Health Care Strategy took place between 1 April 2000 and 26 May 2000. The consultation was based around a discussion document, *The Future Shape of Primary Health Care: A discussion document*. Four thousand five hundred copies were distributed during the consultation period, and the document was also available on the Web.

The discussion document outlined a vision for primary health care and ways that this could be realised. It also provided questions to initiate feedback.

This document is a summary of the 290 written responses to the vision and the 54 meetings that discussed the proposals in *The Future Shape of Primary Health Care: A discussion document*. A full, detailed analysis of the submissions is available from the Ministry of Health on request.

The analysis of the submissions is now being used to prepare the final Primary Health Care Strategy, which is expected to be released by the Government later in 2000.

2 The submissions

Two-thirds of the submissions were from groups and individuals who provide primary health care services and other health care services. These included organisations such as the College of Nurses, the Pharmaceutical Guild and the New Zealand Medical Association; GP groups such as Independent Practitioner Associations (IPAs) and general practices; community-based providers; other providers such as midwives, independent nursing providers; and Māori providers and co-funders.

One third of responses came from individual consumers or groups representing them (including some groups which involved providers). These groups included community health groups, health support and advocacy groups, academics and Territorial Local Authorities.

The Ministry of Health also ran a series of 54 meetings around the country with a wide range of providers, some consumers and organisations representing providers; nine hui with Māori providers and co-funders; and three fono with Pacific providers. Organisations met with included the New Zealand Medical Association, the Pharmacy Guild, the New Zealand Nurses Organisation and the Family Planning Association (FPA). Fifteen focus groups, each comprising a range of providers and consumers, were also held.

Pacific providers were under-represented in the responses and few written responses were received from identifiably Pacific groups or individuals. Feedback from Pacific groups has mainly come from the three fono that were held, which were attended by approximately 70 providers. A few individual Pacific providers also attended some of the general meetings in Auckland, Wellington and Christchurch.

3 Overall response to the discussion document

The discussion document set out a broad vision for primary health care in New Zealand. Around three-quarters of the responses either explicitly or implicitly supported aspects of this vision. People responded most positively to the following aspects of the vision:

- The recognition of the important role that primary health care services (although not necessarily Primary Care Organisations) has to play in improving health status.
- The need to improve access to services for individuals and groups.
- The need to increase services for Māori and Pacific peoples.
- The need to improve co-ordination among primary health care services and between primary and secondary health care services.
- The introduction of a formal role for service users and the community in decision making about health care services provided in the primary sector.
- The need to focus on population-based services rather than episodic services.

Support for how the vision would be achieved was more mixed. Some proposals were frequently debated including:

- The structure of primary care organisations (PCOs). While many GPs saw potential for setting up a system where most primary health care providers were part of a primary care organisation (though how they envisaged PCOs operating often differed), many other providers, consumer groups and some GPs were less sure about this model and the role that GPs would play in them.
- There was a concern that District Health Boards (DHBs) would be dominated by hospital services and that primary and community health care services could suffer as a result.
- There were some questions about the lack of apparent financial commitment to the increased level of services this vision would require.
- Although many GPs who responded saw the value of capitation in a more population-focused service, they were concerned about how any formula would be determined. Other providers, including a number of individual responses from GPs and many consumer responses, had more concerns about this. Adverse selection and under-servicing were particular concerns.
- Most providers were willing to accept affiliation but there were concerns, particularly from GPs and non-GP providers, about who people would enrol with or whether they would be able to enrol with more than one provider. Many consumers were less positive about affiliation especially when associated with capitation. They were concerned about reduction in choice and that providers would try to avoid enrolling people with high service needs.

4 A more detailed look at the feedback

Primary care organisations

The discussion document proposed the development of a primary health care system where most primary health care providers would be part of primary care organisations (PCOs). PCOs would be paid to deliver a defined range of services at defined levels of quality to an affiliated population. Two-thirds of all the responses addressed one or more aspects of PCOs.

Many responses were concerned at the lack of detail in the discussion document about what a PCO would be like. Some responses identified these organisations as IPAs and these responses were often negative.

There were a number of interpretations of what a PCO might look like in the future. Four models were suggested most frequently:

- PCOs as umbrella organisations for a wide variety of providers
- the DHB filling the role of a PCO
- the Rural Trust Model
- organisations focused around current Māori co-funders.

Many GPs and their organisations such as IPAs supported a role for PCOs although most IPAs recognised that the current IPAs would have to make changes to their structure if they were to become PCOs. Some were concerned to ensure that the model that was adopted would maintain the advantages that had emerged under IPAs. A number of IPAs and other providers cited some of their recent developments that they thought were compatible with the PCO model.

Responses outlined a number of areas that they thought would need to be addressed before any models for PCOs were developed. These included a need to build on current initiatives, the number of people covered by a PCO, the range of providers to be involved and the future role of IPAs. There was also concern that any model should be flexible and allow the development of different structures rather than imposing a 'one size fits all' model.

Many GPs favoured a PCO covering a larger number of people. They saw that this would be needed to allow for economies of scale, involve a wide range of health professionals, help to maintain effective databases and provide greater opportunities for quality management processes.

In contrast, many other providers (including some GPs) were concerned that the number of people a PCO would need to provide services for and the range of services a PCO would need to provide should not be too great. Māori and Pacific providers in particular were concerned that unless the size was small and the range of services was flexible, they would be unable to form an independent PCO. Non-GP providers were also

concerned that a large size might lead to them having to work in a GP dominated organisation.

Non-GP providers and consumers who responded were, in general, more hesitant about the PCO model than GPs were. Reasons for their concerns about the concept of PCOs included:

- a belief that IPAs had not provided a good model of service delivery because the budget holding associated with IPAs was believed to be an incentive to reduce services
- a belief that large PCOs would be unable or unwillingly to involve the community
- a perceived lack of opportunity for Māori and Pacific providers
- a concern that PCOs would be dominated by GPs who would run the organisations and make decisions about other providers.

A number of responses (including some from provider groups) were concerned that the sheer size of PCOs as envisaged would give them disproportionate power in the delivery of primary health care.

Community and patient representation on PCOs

The discussion document proposed that all PCOs would be required to have meaningful representation from patients and/or their communities in their governance processes. Over half the responses commented on this requirement and almost all everyone was in favour of it. Both groups expected a number of advantages from such a relationship, including that:

- provider groups would develop a greater understanding of the needs and preferences of the community they served
- it would be clearer who was responsible for making decisions
- there would be enhanced communication between providers, communities and those who used the services which in turn would improve services
- it would increase people's understanding of the choices made in the primary health care system.

A number of models of effective representation were advanced, often based on the respondents' current practices. Some of the models suggested were:

- a separate committee of consumer representatives which would comment on decisions made by the board of the provider organisation
- a formal or informal relationship with groups of community providers or representatives
- ongoing consultation with a wide range of other health care providers and ongoing relationships with iwi organisations.

A small number of providers and consumers raised some concerns about the practicality of such a process, including concerns that:

- it could be difficult to maintain patient confidentiality
- it may be difficult to resolve differences between the interests of provider as owner and the community representatives
- representation on boards could be captured by people from interest groups with limited agendas
- appropriately qualified people may not be available in the local community to go onto boards.

Provider representation on PCOs

The discussion document proposed that PCOs would be required to have representation from the range of health providers in the organisation. About one-third of the submissions, mostly from providers or their organisations, commented on this requirement. Most were in favour, although some mentioned concerns about how this would be implemented in practice. Some community-based organisations such as rural trusts reported that different types of providers were involved in management already.

Although most respondents who commented about it supported the idea of having provider representations, the following concerns were raised:

- GPs are usually the owners of general practices, and the other providers in the practice are usually their employees. This can sometimes lead to providers having different interests.
- Different types of providers often had different perspectives on effective primary health care.
- In general practices that were not capitated, patients had to see the GP for a subsidy to be claimed. This reinforced the dominant role of the GP at the expense of other providers such as practice nurses.
- If PCOs were large organisations with many different types of providers, ensuring that the entire range of providers was represented could lead to unmanageably large committees.

Not-for-profit status of PCOs

Overall there was general support from both providers and consumers for the concept of PCOs being not-for-profit organisations. Some IPAs observed that in practice, if not in legal structure, they already operated in this fashion and some were already exploring the changes necessary to make their organisation not-for-profit.

Some consumers supported the concept because of concerns about the quality of service that they might expect from a for-profit organisation. Some feared that PCOs would have incentives for providers to limit services if they were 'for-profit'. This fear was shared by several independent GPs.

A few providers questioned to what extent a not-for-profit emphasis was realistic in the current system. They observed that many primary sector providers such as GPs, pharmacists and physiotherapists were operating as 'for-profit' businesses. A related

concern among some providers was about how the concept would be interpreted for individual practices and for small practices (GP and otherwise) that were not a PCO.

Affiliation

The discussion document proposed that under the new system for primary health care, people would be encouraged to make a free choice to affiliate with a primary care organisation. They would affiliate with their chosen organisation and nominate a preferred practitioner or practice within the organisation. People would be entitled to change providers without difficulty and would be free to seek care elsewhere, for example for a second opinion and when sensitive problems were involved.

The concept of affiliation was commented on by two-thirds of responses. While GPs were generally (although often with reservations) supportive of the concept other providers were more guarded and many consumers were hesitant or opposed. Those who were opposed to capitation were usually also opposed to affiliation, and those who supported capitation likewise usually supported affiliation.

Those organisations favouring affiliation outlined a number of reasons for doing so. These included that affiliation:

- builds on the positive relationships between GPs and their patients
- would provide practices with a defined population to which they can deliver population-based services
- would provide a population against which an organisation can measure its success in delivering funded services
- was necessary for capitation.

A number of concerns were raised by those opposed to or unsure about affiliation. Some of these concerns were shared by those in favour of affiliation. These included:

- lack of evidence that affiliation has a positive impact on health status in New Zealand
- privacy issues
- concern that many people use more than one GP or other provider
- non-GP providers were concerned that people would tend to affiliate with a GP. This could disadvantage other providers such as nurses, midwives, health promoters and Māori and Pacific providers unless there was some form of affiliation with more than one provider.

A number of issues were identified that would need to be resolved before many of the respondents would be happy to see affiliation introduced on a national basis. Some of these concerns were shared by those in support of affiliation and those who were less positive about it:

- Most responses favoured voluntary enrolment. However a small number of groups, particularly GPs, thought that if true population-based funding were introduced, it would be better to have compulsory affiliation.
- There was some debate over whether it would be better to enrol with a practitioner or with a PCO. Most GPs favoured the former model. However non-GP providers preferred the latter model as they feared that enrolment with a practitioner would favour GPs.
- There was a role for the government to promote the advantages of affiliation to the general population rather than relying on individual providers.
- Some community groups and providers were concerned that a focus on affiliation (and capitation) would lead to greater (not less) competition between providers wishing to enrol people.

Services to be delivered by PCOs and other primary health care providers

The discussion document listed the services that a PCO would be required to either directly deliver to their affiliated population, or ensure are available. Three-quarters of responses addressed the list.

Range of services

Almost all the submissions that addressed the range of services agreed that they were appropriate for primary care providers. Overall they felt the range of services was:

- necessary to deliver the visualised holistic approach to health
- an important part of primary health care
- well defined in terms of comprehensiveness of services, access to services, co-ordination of services and the importance of continuity of care to best manage the services.

A number of respondents felt that one or more additional services should be included in any list of primary health care services. These included:

- medium-term care
- access to tohunga and traditional health services
- complementary health services
- promotion of physical activity, nutrition and exercise
- social work, counselling, and family therapy services
- disability support services
- occupational therapy
- current nationally provided services, such as family planning, Well Child–Tamariki Ora and Plunket services
- programmes such as tobacco control, melanoma prevention
- other services, such as dietary and natural therapy services.

There was some concern that the list did not sufficiently address mental health provision. Several responses were concerned that while there was a significant call for

provision of mental health by primary care that many providers did not have the appropriate skills.

On the whole GPs and other providers welcomed the increased focus on population-based services. Other providers and consumers, while accepting that there was a greater role for GPs in delivering personal health services with a more preventative perspective (for example, immunisation), had greater concern about the possibility of PCOs or GPs delivering population-based services. Reasons for this included doubts that GPs had the skills or inclination to deliver population-based services and a concern that this could lead to duplication of some services while others would not be delivered at all. Some noted that many of these services required a national perspective that PCOs would not be able to provide.

There was some concern from GPs about the continuation of national contracts for services like midwifery, well child–tamariki ora services and family planning. While many GPs said they were happy to work with these providers, they were concerned that the discussion document seemed to be encouraging fragmentation of services rather than greater co-operation.

Providers with national contracts did not believe that it was appropriate for PCOs to provide all the services proposed in the discussion document. They thought that there was a demand for their services and that people should have the choice that their organisations represented.

Quality of services

Around one-sixth of the submissions, most from providers or national organisations, commented on quality in depth and all agreed that quality was an important issue. National organisations such as the Royal New Zealand College of General Practitioners noted that they have already developed standards for practitioners. Other groups noted that they were also working in this area.

Over half the submissions noted that accreditation was an essential part of ensuring quality. Some, however, doubted that accreditation alone would ensure quality. Other methods of ensuring quality were also noted by a few people, including benchmarking, peer assessment and developing quality focused organisations.

Both consumers and some providers commented that it was important that the quality of services provided by PCOs and other providers be monitored. They favoured a variety of methods such as satisfaction surveys and noted the importance of including health service users in any assessment of quality. Other issues raised included:

- Cost and the use of only quantitative measures were barriers to assessing quality.
- Despite considerable international research on quality, there is little agreement about easy-to-measure indicators for primary health care and further work is necessary to prevent these from becoming false markers of quality.
- Health service users sometimes have difficulty in interpreting complex data on indicators of quality.

- There is a need to recognise different dimensions of quality for Māori and Pacific providers.

Increased co-ordination of services

The discussion document noted that there was a need for greater co-ordination of services, and two-thirds of responses, many of which were from providers, addressed this point. Most were in favour of greater co-ordination and some noted that there were already many co-ordination initiatives under way. Some consumers had concerns that a greater use of databases might have implications for patient confidentiality.

Most responses supported greater co-ordination between primary and secondary health care services. They hoped that this would reduce duplication of services and improve the quality of services that people received. There was also strong support, particularly from Māori providers, for greater inter-sectoral co-operation.

Some people thought that co-ordination should be organised at the DHB level, in part because DHBs would be unlikely to prefer one provider over the other, which might otherwise occur in GP-dominated PCOs. Some responses also saw a possible duplication of services between PCOs and DHBs. However, there was also strong support for PCOs having this role, particularly for those who supported the model of PCO as an umbrella organisation.

A number of submissions identified constraints and limitations to the further development of co-ordination, including:

- the difficulty of achieving co-ordination between secondary and primary sectors while they were unable to merge budgets
- patch protection by professionals and protection of revenue streams and information
- a difficulty in proving that there had been cost savings as a result of co-ordination.

Affordability and availability of services

Almost all the responses supported the concept of rules for accessibility and affordability of services, which the discussion document proposed. Some providers gave examples where they were already attempting to respond to barriers to affordability and availability.

Availability of services was seen as less of an issue than affordability other than for those in rural areas. Some providers, particularly Māori and Pacific providers and those from rural areas, observed that appropriateness of services was also an issue.

However some responses observed that, by themselves, rules were unlikely to address these issues, particularly for affordability. Although most providers and consumers agreed that rules might help improve access for some services, some also noted that these rules would need to take into consideration and respond to, as far as is practical:

- the fact that without increased subsidies practitioners would be unable to increase the level of subsidies available for patients
- a variation in service delivery within areas smaller than DHBs or large PCOs, for example, an area with a high young and Pacific population would need different levels of access from a region of high income older people.

GPs were also concerned that their flexibility to design and deliver services for specific groups and areas in their region might be limited.

There was a concern raised that national rules could lead to little more than minimum standards. These had failed to deliver adequate services in the past and there was concern that they were unlikely to do so in the future.

Many responses identified other barriers to service delivery that needed to be addressed in the final strategy, though not necessarily in the form of 'rules' per se. These barriers included:

- the availability of the appropriate workforce to deliver the services that people needed, particularly for those in rural areas and for Māori and Pacific providers
- access to transport, particularly in rural and low income urban areas
- lack of knowledge among people of the services available to them, the appropriateness of these services for different conditions, and the subsidies available for some of these services
- poor co-ordination between providers which makes continuity of service difficult to ensure
- lack of common language for recent immigrants and refugees.

Funding primary health care

The discussion document proposed that DHBs would be funded through a population-based funding formula (PBFF) and that PCOs would be funded to provide a specified set of services on the basis of the characteristics of their population. Almost all responses mentioned one or more aspects of funding. One-third noted only the lack of detail provided in the discussion document and made little other comment.

Population-based funding

Well over one-third of the written responses commented on the concept of DHBs. Most favoured it on the basis that using PBFF to calculate funding would in turn lead to a more equitable distribution of funding available for primary health care across the country.

Some providers were concerned that the PBFF was not to be applied to funding primary health care. They thought that this could lead to inequitable variations between PCOs and between populations receiving care.

However, some people were concerned that PBFF would not be sensitive enough to identify areas of higher need within individual DHBs and thus ensure appropriate funding. Some Māori responses were concerned that there was inaccurate data on Māori and that they would suffer as a result.

There was also strong support for the use of the New Zealand Deprivation Index in calculating the formula, and for including ethnicity as a separate factor.

Capitation funding

The discussion document suggested that primary health care services would be funded according to the needs of the population served. Under this system, a fixed amount of publicly funded money would be allocated for each patient covered, regardless of the volume of services provided to that person. This was usually identified as 'capitation' and described as such in the responses.

Most organisations and national bodies were prepared to accept capitation, though not all were convinced that it would lead to the health gains that the discussion document proposed it would. A number of organisations already on capitation described their experiences and the advantages they thought it had brought to the practice of primary health care. A few IPAs who did not have capitation contracts noted that they were either trialling it or had been trying unsuccessfully to obtain a capitation contract.

The three major reasons the concept of capitation was supported were:

- because it would allow practices to be more flexible in the range of staff who worked with patients. This could also be an incentive to GPs to increase the range of staff that were employed in a practice or with whom they had close working relations. It could also increase the role of nurses and other providers
- it would be easier for practices in low income areas to increase access for their populations
- because capitated practices needed to have enrolled populations, this made it easier for providers to deliver population-based services.

However some consumers and individual GPs were concerned about the impact of the widespread introduction of capitation. Those against it as a method of funding, and even many of those who supported it, raised a number of issues they thought needed to be resolved before it was adopted on a national basis. These included the following.

- There would need to be good evidence that capitation would make the expected differences in a system that was still in part funded through fee-for-service.
- There would need to be clarity about the future role of co-payments. Most GPs believed that these were needed if practices were to be able to guarantee their financial viability. Other GPs and community providers were less convinced that capitation would make a difference to access unless there were strict rules.
- Many people (though not all) who discussed current capitation formulae thought that these were not adequate. Many providers thought these needed to be increased to

ensure their financial viability, while consumers and those representing them thought that unless the level was adequate it would encourage risk selection (cream skimming) and under-servicing.

- Both providers and consumers were aware of the dangers of risk selection (cream skimming) and under-servicing. While most providers thought that this was unlikely to happen in New Zealand, many consumers and some individual GPs thought that it was more likely. Many from both groups thought there was a role for the Government in making rules and monitoring capitation.

Māori providers had a number of concerns about capitation. These included:

- that they should be closely involved in the development of any formulae
- that this formula should take account of the wider (holistic) health needs of Māori
- that capitation should include workforce development
- that development of capitation for PCOs' practices should not negatively affect Māori provider services.

Pacific responses had similar concerns.

Some responses, from both providers and consumers, thought that it was probable that when a national capitation formula was developed, it would become apparent that some practices were over-funded and others under-funded. Because there might be no additional funds, a redistribution of funds between providers was thought to be very likely. There was considerable support for redistribution from the secondary health care sector to the primary health care sector.

Most responses assumed that capitation would apply in PCOs or other groups that included GPs. Non-GP providers, apart from those who would continue to be funded through national funding arrangements, were concerned that there was little reference to their own funding apart from an apparent assumption that this would be covered by capitation. To some, this implied that they would have to become part of a GP dominated PCO. They were uneasy about being dependent on GPs for their income. Some nurses and other providers felt that they were able to provide many services currently provided by GPs for less cost.

Relationship between Māori and the Crown

Nearly two-thirds of the respondents addressed the expectation that the special relationship between Crown and Māori would be reflected in the service agreements between DHBs and service providers. There was overwhelming support for this.

Many Māori providers and co-funders had a number of concerns about how this principle would work in practice. A significant concern in some Māori responses was the wording and implied meaning of the statement in the discussion document about the relationship. They did not believe that this showed a commitment to partnership or to taking the action required to make this a reality.

Several respondents noted that the partnership implicit in the Treaty of Waitangi meant that Māori should have a significant and equal voice in deciding their own services. They felt they had not been consulted in the development of the strategy and that the discussion document would have looked different if they had.

Some Māori responses expressed concern about the future role of DHBs in the funding and provision of all health care services (not just primary health care). Some of this concern was based on memories of the difficulty of developing services before the emergence of a separate funder. Some thought that their concerns could be partly addressed by a specific mandating of DHBs about their obligation to Māori. These commitments would include:

- full participation in the design and governance of the overall system by Māori
- the active practical and ideological support by the Crown for the establishment and growth of independent Māori health providers to work within the framework of kaupapa Māori
- a high priority given to initiatives which would impact on improving the health status of Māori with the aim of ensuring that Māori health status is at least as good as that of the non-Māori population.

There was also some concern about the impact of PCOs on the future of independent Māori services for Māori. There was concern, shared by some Pacific providers, that most Māori providers would be unable to establish independent PCOs if the number of people to be covered or the range of services to be supplied by a PCO were too large. A number of alternative models involving the continuation of Māori co-funders and dual enrolment with Māori and non-Māori providers were suggested.

Mainstream providers were generally supportive of the need to recognise the needs of Māori and the role that Māori provision for Māori had in addressing these. There was a willingness to work co-operatively with these services. Several provided examples of how they were currently doing this. However some providers expressed concern that they were not eligible for similar funding to improve their services for Māori despite the fact that they provided services for many Māori people.

Roles and structures in the new health service

There was a broad level of support for the proposed changes in the structure of the health care system. In particular people approved of the fact that the system would be less commercially focused.

However, there was a high level of concern about the impact that DHBs might have on the future funding and development of the primary health care sector. These concerns included:

- a perception that DHBs would be dominated by hospital services, because they would be providing hospital services as well as funding them while only funding primary care services

- a concern that primary health care providers would not be represented on the DHB board or the committees that made decisions about the division of funding
- a concern that elected members would be more focused on hospital services than other less immediately obvious services such as primary health care and that boards may be captured by interest groups
- a concern that some DHBs would continue to provide a wide range of primary health care services and would probably give preference to their own services if choices had to be made about who should receive funding
- a concern by many providers, particularly larger IPAs and national organisations such as Plunket and the FPA, who operated in several DHB areas, that DHB establishment could lead to higher transaction costs
- the risk of different levels of funding for the similar services in different DHBs
- a concern by Māori and Pacific providers that some or most DHBs would be less responsive to their needs than the Health Funding Authority has been. There was a related fear that Māori and Pacific peoples would always be a minority of any boards.

However many of these responses also proposed ways that these issues could be addressed within the proposed structure, including:

- a significant ongoing role for the Ministry of Health in determining services to be provided, funding agreements etc
- reserved places for primary health care providers on committees
- ring-fencing of the funding for primary health care services
- a reduction in the number of DHBs or the development of regional services for a number of DHBs
- the maintenance of agreements with Māori Co-Purchasing Organisations (MAPOs) and Māori Development Organisations.

Other issues

A wide range of other issues was raised in the context of the responses to the discussion document.

Provision of services for Pacific peoples

Three fono were held to address the issues surrounding the delivery of services for Pacific peoples. These covered a wide range of issues which included the following:

- Pacific providers thought that it was important to recognise the low health status of many Pacific peoples which was due to many reasons. Those making responses felt that mainstream services were not always able to meet these health needs.
- In this context some responses were concerned that Pacific health had not been recognised as a priority, whereas Māori health had been.
- Workforce development was identified as a significant area that needed to be addressed. Responses thought that funding and priority should be allocated for the development of Pacific services for Pacific peoples. This would involve funding for training and for establishing services as few Pacific providers had access to sufficient resources.

- There was a concern that if PCOs had to cover large numbers of people, Pacific providers would not be able to become PCOs and would lose the ability to operate independent services. This was seen as a potential 'step backwards'.
- It was generally accepted that 'mainstream' providers would continue to provide many services for Pacific peoples but there was some concern that these providers should be competent to deliver services for Pacific peoples.
- Some responses were also concerned about the level of funding available for Pacific peoples. They felt that existing funding formulae did not recognise the high health needs of Pacific peoples. Some felt that affiliation and capitation could have negative effects for Pacific peoples if these needs were not recognised and built into any formula adopted.
- Co-ordination of services was seen as very important. Responses noted that many of the causes of Pacific ill health were due to failings in education, housing and employment. They thought that it was important that these services were co-ordinated with health services if improvements in Pacific health status were to be expected.

Workforce and training

Around one-sixth of the responses, almost all from providers or their organisations, discussed various aspects of workforce and training:

- Many people responding to this issue believed that current workforce development was ad hoc and supported the development of the Health Workforce Advisory Committee.
- Many non-GP providers and some consumers questioned whether there was the workforce to deliver the community-oriented services visualised in the discussion document. Some questioned whether GPs had the skills for an extended role working with the community that was implied by population-based services.
- Many of the responses, including those from GPs, highlighted the significant and increased role they saw nurses having in delivering the new strategy. They were seen as potentially having a greater role in the delivery of population-based services. Possible roles included nutrition advice, a wide range of preventative strategies, sexual health services and home visiting for early intervention, assessment and on-going primary health care.
- Many responses, including some from mainstream providers, highlighted the importance of developing the workforce for the provision of Māori and Pacific services.

Information systems and confidentiality

Forty responses addressed the need for the development of appropriate databases to facilitate the delivery of better co-ordinated services and to enable effective monitoring and auditing of services. The critical role that the National Health Index (NHI) number would play was highlighted and some doubt was expressed over the current accuracy of the data currently held. The need for funding from the Government was stressed in many responses.

Confidentiality was a concern in some responses. Most providers noted that they were bound by and observed the Health Information Privacy Code 1994 and the Privacy Act 1993. However some consumers and groups representing them were concerned about whether this was so for all providers. They stressed the need for effective confidentiality codes to precede any widespread development of databases.

The role of Territorial Local Authorities

Seventeen responses were received from territorial local authorities (TLAs). They indicated that they are keen to play an active support role in the delivery of primary health care services, and are already strongly involved in providing services that affected the determinants of health. They strongly supported community involvement in PCOs and some urged that they should be consulted on a regular basis. Several described ways they are already involved in supporting community health groups. In their responses many stated that they believed that they had considerable expertise with community involvement and that they were willing to share this knowledge with DHBs and PCOs.

Provision of services in rural areas

Over one-sixth of all the responses received were from rural areas or services with a significant role in rural areas. Many were concerned that rural issues had received little coverage in the discussion document and that an expected rural health strategy appeared to be no longer a priority. Many were also concerned about the implication of population-based services. They believed that there was a real possibility that this would lead to them receiving even fewer resources than was currently the case because they had low, dispersed populations.

The most frequent issue raised by people in rural areas was the availability of services in those areas. A number of ways to encourage providers to work in rural areas were advanced. There was also some concern that current successful initiatives, such as rural health trusts, were threatened by the development of PCOs.



CABINET SOCIAL POLICY AND HEALTH COMMITTEE

SPH (00) 189

30 November 2000

Copy No: 35

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Title	The Primary Health Care Strategy
Purpose	This paper proposes that the Primary Health Care Strategy be released in January 2001, following release of the New Zealand Health Strategy.
Previous Consideration	On 14 February 2000 Cabinet considered the discussion document "Primary Health Care Towards 2010" and noted the intention of the Minister of Health to release it for consultation [CAB (00) M 4/2 refers]. Responses to the discussion document are summarised in Appendix 1.
Summary	The final Strategy has been completed following: a comprehensive two-month period of public consultation, the receipt of 282 written submissions, departmental consultation, technical analysis and the advice of the Primary Health Care Reference Group (see page 29 of the Strategy for a list of the members). The six key directions for the Primary Health Care Strategy are to: • work with communities and enrolled populations; • identify and remove health disparities; • offer access to comprehensive services to maintain, improve and restore people's health; • coordinate care across service areas; • develop the primary health care workforce; and • continuously improve quality using good information. The shape of the new Primary Health Care Sector is depicted on page 8 of the Strategy.
Baseline Implications	None from this paper.

Legislative Implications None.

Timing Issues None indicated.

Announcement A comprehensive communications plan is being developed to ensure that the key messages of the Strategy are publicised across the sector when it is released.

Consultation The Minister indicates that these proposals have been the subject of consultation with the relevant coalition consultation Minister.

DPMC, TPK, PIA, Treasury, Youth Affairs, Women's Affairs, ACC, MSP have been consulted. SSC has been informed.

The Minister of Health recommends that the Committee:

- a note that the Primary Health Care Strategy attached to the submission under SPH (00) 189 has been completed following extensive public consultation and with input from a sector reference group and other Government agencies;
- b invite the Minister of Health to release the Primary Health Care Strategy in January 2001, following the release of the New Zealand Health Strategy.

Wendy Adams
Secretary

COPIES TO:

Cabinet Social Policy and Health Committee
Chief Executive, DPMC
Bettina Schaer, DPMC (OSPH)
Minister of Finance
 Secretary to the Treasury
 Secretary of Labour (Accident Insurance)
Chief Executive, Ministry of Social Policy
 Elizabeth Rowe, Ministry of Social Policy (OSPH)
Director-General of Health
Associate Minister of Maori Affairs (Hon Sandra Lee)
State Services Commissioner
Chief Executive, Te Puni Kokiri
Chief Executive, Ministry of Pacific Island Affairs
Chief Executive, Ministry of Women's Affairs
Chief Executive, Ministry of Youth Affairs

OFFICE OF THE MINISTER
OF HEALTH

MEMORANDUM TO THE CABINET SOCIAL POLICY AND HEALTH COMMITTEE

TITLE: THE PRIMARY HEALTH CARE STRATEGY

PROPOSAL

1. I propose that the Cabinet Social Policy and Health Committee approve the release of the Primary Health Care Strategy in January 2001.

BACKGROUND

2. The Cabinet at its meeting on 14 February 2000 (CAB (00) 40; SPH (00) M 1/1 refers):
 - i. noted the contents of the revised discussion document on a Primary Health Care Strategy: "Primary Health Care Towards 2010" attached to the submission under CAB (00) 40 amended following discussion at the SPH meeting of 8 February 2000 [SPH (00) m 1/1 refers];
 - ii. authorised the Prime Minister and Minister of Health to approve the final wording of the discussion document;
 - iii. noted that the Minister of Health intends to release "Primary Health Care Towards 2010" on 18 February 2000;
 - iv. agreed that the date for responses to the discussion document be 28 April 2000.

THE PROCESS FOR DEVELOPING THE PRIMARY HEALTH CARE STRATEGY

3. The Primary Health Care Strategy Discussion Document was subsequently released for a two month period of public consultation in March 2000. During the consultation period 54 meetings on the Strategy were held with focus groups, professional groups, providers, and Māori co-funders. 282 written submissions were also received. A one page summary of the key themes arising from the consultation is attached as Appendix 1.
4. A sector reference group was set up to advise the Ministry of Health on the development of the final Strategy. It contained representatives from across the health sector including Māori, Pacific, and consumer representatives. The sector reference group reached broad agreement on the Strategy's direction.
5. The Primary Health Care Strategy has now been completed on the basis of the consultation, the advice of the reference group, consultation with other Government agencies, and technical analysis by the Ministry of Health.

6. If Ministers agree, the Primary Health Care Strategy will be released in January 2001 following the release of the New Zealand Health Strategy. It provides a vision and direction for the development of primary health care that the Government wishes the sector, the Ministry of Health, and particularly the newly established District Health Boards to address.

KEY ISSUES COVERED IN THE PRIMARY HEALTH CARE STRATEGY

7. The Primary Health Care Strategy provides a clear direction for the future development of primary health care so that it can play a central role within the new health sector. The Strategy sits below the New Zealand Health Strategy and has been informed by the Health Strategy objectives and goals which should be addressed as priorities by the newly formed district health boards, and the rest of the health sector. The Disability Strategy and Māori Health Strategy, which are still being developed, have also helped shape the Primary Health Care Strategy.
8. The Strategy is pitched at a reasonably high level. This is important because an overly prescriptive strategy could prevent district health boards from developing arrangements that are responsive to their local needs. Rather, the emphasis is on defining the new direction and some minimum requirements (for example, not-for-profit), and leaving flexibility about how the directions are achieved.
9. The Strategy notes that district health boards have overall responsibility for assessing the health and disability needs of communities in their regions, and managing resources and service delivery to best meet those needs. The Strategy is therefore designed primarily to give district health boards and the sector some direction about how to best achieve health and independence gains through primary health care.
10. The Strategy outlines six key directions:
 - Work with communities and enrolled populations
 - Identify and remove health disparities
 - Offer access to comprehensive services to improve, maintain, and restore people's health
 - Co-ordinate care across service areas
 - Develop the primary health care workforce
 - Continuously improve quality using good information.
11. Major initiatives outlined under these seven directions include:
 - The development of not-for-profit primary health organisations which will involve their communities and all primary health care practitioners in their service delivery and decision making processes. While primary health care practitioners will be encouraged to join primary health organisations, this will remain voluntary.
 - People will be encouraged to enrol with a primary health organisation to gain the benefits of better continuity, coordination, and more attention to preventive services. Enrolment, however, will be voluntary. Those who

chose not to enrol will still be able to access primary health care services in the usual way and with existing cost subsidies. Likewise, people who are enrolled will still be able to access any primary health carer with appropriate cost subsidies.

- Māori and Pacific primary health care providers and development organisations will continue to be supported and developed by district health boards. Such providers will also be supported to become primary health organisations in their own communities if they chose to, and if it is appropriate for their population.
 - All primary health organisations will be required to identify need and reach out to populations such as the socio-economically disadvantaged.
 - Primary health organisations will be funded according to a formula which reflects the relative need of their population. They will provide a range of services that are appropriate for the needs of their population, which will include health promotion and preventative services to improve health and reduce disparities. To do this, primary health organisations will need health teams with an appropriate range of practitioners. Maternity services, Plunket, and Family Planning/sexual health services will be funded and provided outside primary health organisations through existing arrangements (SPH (00) 1 refers).
 - The first priority for reducing cost barriers to accessing services will be the groups with the greatest health need. This will occur over time as funds become available.
 - Primary health organisations will have responsibility for facilitating the co-ordination of patient care. They will also be expected to work with district health boards and public health services to contribute to intersectoral initiatives that address the wider social, economic and cultural impacts on the community's health.
 - The development of the Māori, Pacific, and primary health care nursing workforces are identified as priorities. The development of practitioner competencies and rural health issues are identified for further attention.
11. The Ministry of Health intends to involve and collaborate with the primary health care sector, communities, and particularly district health boards in the implementation process. To ensure that all issues are considered, working parties of officials and people from the sector will be formed to work through the details of the key areas of development. A primary health care advisory group may also be set up to help guide developments in the sector.

CONSULTATION

12. As well as the extensive public consultation, the Ministry of Health has also provided information and drafts of the Strategy for comment to interested central agencies, including the Department of Prime Minister and Cabinet, Te Puni Kōkiri, the Ministry of Pacific Island Affairs, the Treasury, the Ministry of

Youth Affairs, the Ministry of Women's Affairs, ACC, and the Ministry of Social Policy. Their feedback has been taken into account in the draft Strategy.

FINANCIAL IMPLICATIONS

13. This paper has no direct financial implications. Options relating to specific initiatives to implement aspects of the Strategy will be considered at a later stage.

LEGISLATIVE IMPLICATIONS

14. There are no legislative implications associated with the Primary Health Care Strategy.

HUMAN RIGHTS ACT 1993

15. The proposals do not have Human Rights Act 1993 implications.

REGULATORY IMPACT STATEMENT

16. A regulatory impact statement is not required.

COMPLIANCE COSTS

17. This paper has no compliance cost implications.

PUBLICITY

18. The Primary Health Care Strategy will be launched in January 2001. A comprehensive Communications Strategy is currently in development to ensure that the key messages of the Strategy are publicised across the sector.

RECOMMENDATIONS

19. I recommend that the Cabinet Social Policy and Health Committee:
- a) **note** that the Primary Health Care Strategy has been completed following extensive public consultation and with input from a sector reference group and other Government agencies
 - b) **agree** the Primary Health Care Strategy be released in January 2001, following the release of the New Zealand Health Strategy.



Hon Annette King
Minister of Health

Appendix 1: Overall response to the Primary Health Care Strategy discussion document

The discussion document set out a broad vision for primary health care in New Zealand. Around three-quarters of the responses either explicitly or implicitly supported aspects of this vision. People responded most positively to the following aspects of the vision:

- The recognition of the important role that primary health care services (although not necessarily primary care organisations) has to play in improving health status.
- The need to improve access to services for individuals and groups.
- The need to increase services for Māori and Pacific peoples.
- The need to improve co-ordination among primary health care services and between primary and secondary health care services.
- The introduction of a formal role for service users and the community in decision making about health care services provided in the primary sector.
- The need to focus on population-based services rather than just episodic services.

Support for how the vision would be achieved was more mixed. Some proposals were frequently debated including:

- The structure of primary care organisations (PCOs). While many GPs saw potential for setting up a system where most primary health care providers were part of a primary care organisation (though how they envisaged PCOs operating often differed), many other providers, consumer groups and some GPs were less sure about this model and the role that GPs would play in them.
- There was a concern that District Health Boards (DHBs) would be dominated by hospital services and that primary and community health care services could suffer as a result.
- There were some questions about the lack of apparent financial commitment to the increased level of services this vision would require.
- Although many GPs who responded saw the value of capitation in a more population-focused service, they were concerned about how any formula would be determined. Other providers, including a number of individual responses from GPs and many consumer responses, had more concerns about this. Adverse selection and under-servicing were particular concerns.
- Most providers were willing to accept affiliation but there were concerns, particularly from GPs and non-GP providers, about who people would enrol with or whether they would be able to enrol with more than one provider. Many consumers were less positive about affiliation especially when associated with capitation. They were concerned about reduction in choice and that providers would try to avoid enrolling people with high service needs.

CONSULTATION ON CABINET AND CABINET COMMITTEE SUBMISSIONS

Certification by Department

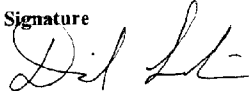
Departments consulted: The attached submission has implications for the following departments whose views have been sought and are accurately reflected in the submission:

Department of Prime Minister and Cabinet, Te Puni Kōkiri, the Ministry of Pacific Island Affairs, the Treasury, the Ministry of Youth Affairs, the Ministry of Women's Affairs, ACC, and the Ministry of Social Policy

Departments informed: In addition, the following departments have an interest in the submission and have been informed:

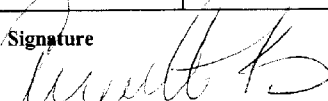
State Services Commission.....

Others consulted: Other interested groups have been consulted as follows:

Signature	Name, Title, Department	Date
	David Lambie, Deputy Director-General, Ministry of Health	27/11 /00

Certification by Minister

Ministers should be prepared to update and amplify the advice below when the submission is discussed at Cabinet/Cabinet committee. The attached submission:

Consultation at Ministerial level	☒ did not need consultation with other Ministers ☐ has been the subject of consultation with the Minister of Finance <i>[required for all submissions seeking new funding]</i> ☐ has been the subject of consultation with the following relevant portfolio Minister(s) ☒ has been the subject of consultation with relevant coalition consultation Minister(s)	
Consultation with Government MPs	☒ does not need consultation with the government caucuses ☐ has been or will be <i>[specify which]</i> the subject of consultation with the following government caucuses: ☐ Labour caucus ☐ Alliance caucus	
Consultation at Parliamentary level	☒ does not need consultation at parliamentary level ☐ has been or will be <i>[specify which]</i> the subject of consultation with the following other parties represented in Parliament:	
Signature	Portfolio	Date
	Health	27/11/00

PRIMARY HEALTH CARE STRATEGY

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

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THE STRATEGY IN SUMMARY

Primary Health Care in the New Health and Disability System

A strong primary health care system is central to improving the health of New Zealanders and, in particular, removing disparities in health.

This Strategy provides a clear direction for the future development of primary health care so that it can play this central role within the new health system. There is evidence available about the specific contribution primary health care can make to improved health outcomes which has informed the new direction.

This Strategy follows on from the New Zealand Health Strategy and the New Zealand Disability Strategy. The Health Strategy sets out principles, goals and objectives for the health system - and these have guided the development of the Primary Health Care Strategy. The Disability Strategy, which is still being developed, has also helped shape this Strategy.

The Vision, Key Directions and the Population Approach

Over five to ten years a new vision will be achieved:

People will be part of local primary health care services that improve people's health, keep them well, are easy to get to and co-ordinate their ongoing care.

Primary health care services will focus on better health for a population, and actively work to the reduce health disparities between different groups.

This vision involves a new direction for primary health care with a greater emphasis on population health and the role of the community, health promotion and preventive care, the need to involve a range of professionals, and the advantages of funding based on population needs rather than fees for service.

Six key directions for primary health care will achieve this vision:

1. Work with local communities and enrolled populations
2. Identify and remove health disparities
3. Offer access to comprehensive services to improve, maintain and restore people's health
4. Co-ordinate care across service areas
5. Develop the primary health care workforce
6. Continuously improve quality using good information.

Document 11 New arrangements for primary health care

The New Zealand Public Health and Disability Act gives District Health Boards overall responsibility for assessing the health and disability needs of communities in their regions, and managing resources and service delivery to best meet those needs. 21 District Health Boards will be supported by the Ministry of Health which will be the national regulating, funding, and monitoring agency. This Primary Health Care Strategy will guide District Health Boards and the sector to achieve health and independence gains through primary health care.

The vision and the new directions will involve moving to a system where services are organised around the needs of a defined group of people. Primary Health Organisations will be the local structures to achieve this and people will be encouraged to join a Primary Health Organisation by enrolling with a provider of primary care services such as a general practice or local health clinic. District Health Boards will work through Primary Health Organisations to achieve health goals locally.

Some of the key points about Primary Health Organisations are:

- They will be funded by District Health Boards for the provision of a set of essential primary health care services to those people who are enrolled.
- At a minimum, these services will include approaches directed towards improving and maintaining the health of the population, as well as first line services to restore people's health when they are unwell.
- They will be expected to involve their communities in their governing processes.
- All providers and practitioners must be involved in the organisation's decision-making, rather than one group being dominant.
- They will be not-for-profit bodies and will be required to be fully and openly accountable for all public funds that they receive.
- While primary health care practitioners will be encouraged to join Primary Health Organisations, it will remain voluntary.

Implementing the Primary Health Care Strategy

The Strategy will evolve over the next few years and may not be fully realised for five to ten years. During this transition there will be flexibility about how new initiatives develop, and tolerance of short term teething problems. Key priorities for early action are:

- reducing the barriers, particularly financial barriers, for the groups with the greatest health need, both in terms of additional services to improve health, and to improve access to first contact services
- supporting the development of Primary Health Organisations that work with enrolled populations
- encouraging developments that emphasise multi-disciplinary approaches to services and decision making
- supporting the development of services by Māori and Pacific providers
- facilitating a smooth transition to widespread enrolment through a public information and educational campaign to explain enrolment and promote its benefits for communities.

The Strategy outlines a new vision for primary health care. It does not contain details of implementation, which will involve evolutionary change to protect the gains already made. Involvement and collaboration with the primary health care sector will be a key feature of the implementation process in the coming months and years. This is crucial to ensure that all issues are considered in developing the new arrangements.

To achieve this involvement, working parties of providers¹, communities, District Health Boards, and the Ministry of Health will be formed around key areas of work. Consideration may also be given to developing a primary health care advisory group to help guide developments in the sector.

¹ In this Strategy "provider" is used for any entity that provides health services, and "practitioner" is used for an individual provider of health services.

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Document 11

INTRODUCTION

A strong primary health care system is central to improving the health of New Zealanders and, in particular, removing disparities in health. There is evidence available about the specific contribution primary health care can make to improved health outcomes (for example, Pincus, 1998; Baum, 1999; McCarthy, 1998; Malcolm, 1999, Starfield 1992 & 1998).

The health system is currently undergoing significant change. This Primary Health Care Strategy provides a clear direction for the future development of primary health care within the new health system, while protecting the gains that have been made in recent years.

In March 2000 the Minister of Health began consultation on this Strategy with the release of *The Future Shape of Primary Health Care: A Discussion Document*. Feedback from 54 meetings and 290 written submissions to the discussion document² has been used to develop this final Strategy, with the assistance of a primary health care reference group (see Appendix 1).

Defining Primary Health Care

Quality primary health care means essential healthcare based on practical, scientifically sound, culturally appropriate and socially acceptable methods:

- universally accessible to people in their communities
- involving community participation
- integral to, and a central function of, New Zealand's health system
- the first level of contact with our health system.

This definition is based closely on the World Health Organisation's Alma Ata Declaration.³ Primary health care covers a broad range of different services – although not all of them are Government funded:

- participating in communities and working with community groups to improve the health of the people in the communities
- health improvement and preventive services, such as health education and counselling, disease prevention and screening
- generalist first level services, such as general practice services, mobile nursing services, community health services, pharmacy services that include advice as well as medications
- first level services for certain conditions (such as maternity, family planning, sexual health services, dentistry; or those using particular therapies (such as physiotherapy, chiropractic and osteopathy services, traditional healers, and alternative healers).

The Primary Health Care Strategy aims for closer coordination across all of these services. However, in the first instance, it has particular relevance for the first three of the above categories.

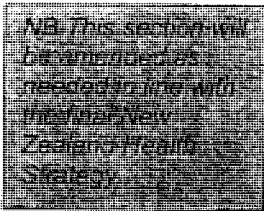
A strong primary health care system is central to improving the health of New Zealanders.

This strategy focuses on publicly funded services, particularly population health approaches and first-contact care for a general range of problems

² A summary of the submissions received is available from the Ministry of Health.

³ International Conference on Primary Health Care, Alma-Ata, USSR, 12 September 1978 (see Appendix 2).

THE STRATEGY IN CONTEXT



The Government is changing the health system and its structure to focus better on getting results through understanding the factors that determine health and by influencing them positively. The changes are being guided by overarching strategies for the health and disability sector, specifically the *New Zealand Health Strategy* and the *New Zealand Disability Strategy*. The changes are being put into effect through the New Zealand Public Health and Disability Act. Also important are population-based strategies, such as the Māori Health Strategy, the Pacific Health Strategy, the strategy for Health of Older People and other changes such as the Health Professionals Competency Assurance Bill.

New Zealand Health Strategy

The New Zealand Health Strategy provides an overall framework for the health sector, with the aim of directing health services at those areas that will ensure the greatest benefits for our population, focusing in particular on tackling inequalities in health.

Primary health care is a priority service area in the New Zealand Health Strategy

Primary health care is one of five priority service areas in the Health Strategy. Through extensive consultation, the New Zealand Health Strategy has identified seven fundamental principles for the health sector and, out of a total of ten goals and 62 objectives, the Strategy highlights 13 population health objectives for action in the short to medium term (see box). The Strategy has also identified two priority objectives to reduce disparities in health status for immediate action:

Priority Objectives for Immediate Action

- To ensure accessible and appropriate services for Māori
- To ensure accessible and appropriate services for Pacific people.

New Zealand Health Strategy

PRINCIPLES

- Good health and wellbeing for all New Zealanders throughout their lives.
- An improvement in health status of those currently disadvantaged.
- Collaborative health promotion and disease and injury prevention by all sectors.
- Acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi.
- Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay.
- A high performing system in which people have confidence.
- Active involvement of consumers and communities at all levels.

New Zealand Health Strategy

POPULATION HEALTH OBJECTIVES

- To reduce smoking
- To improve nutrition
- To reduce obesity
- To increase the level of physical activity
- To reduce the rate of suicides and suicide attempts
- To minimise harm caused by alcohol, illicit and other drug use to both individuals and the community
- To reduce the incidence and impact of cancer
- To reduce the incidence and impact of cardiovascular disease
- To reduce the incidence and impact of diabetes
- To improve oral health
- To reduce violence in interpersonal relationships, families, schools and communities
- To improve the health status of people with severe mental illness
- To ensure access to appropriate child health care services including well child and family health care, and immunisation.

New Zealand Disability Strategy

The New Zealand Disability Strategy will sit alongside the New Zealand Health Strategy once it has been developed. Feedback from consultation on the discussion document has shown broad support for the vision of:

'A fully inclusive society, where our capacity to contribute and participate in every aspect of life is continually being extended and enhanced.'

The New Zealand Disability Strategy aims to help open the way into community life for people experiencing disability, by removing the barriers to their participation. To advance New Zealand towards a non-disabling society, the discussion document proposed 13 actions.

New Zealand Disability Strategy Proposed actions

- encourage and educate for a non-disability society
- ensure rights for people experiencing disability
- provide the best education
- provide opportunities for employment and economic development
- foster leading voices by people experiencing disability
- foster an aware and responsive public service
- improve services to people experiencing disability
- improve access to quality information
- promote the participation of Māori experiencing disability
- promote participation of Pacific people experiencing disability
- enable children and youth experiencing disability to lead full and active lives
- improve quality of life for women experiencing disability
- value families, whānau and carers.

District Health Boards

The New Zealand Public Health and Disability Act establishes 21 District Health Boards and gives them overall responsibility for assessing the health and disability needs of communities in their regions, and managing resources and service delivery to best meet those needs. District Health Boards will be supported by the Ministry of Health that will be the national regulating, funding, and monitoring agency.

The Role of the Primary Health Care Strategy

To achieve the New Zealand Health Strategy goals and the vision of the New Zealand Disability Strategy, primary health care services need to be organised and delivered in a way that ensures the best health and independence for populations.

The Primary Health Care Strategy provides direction for District Health Boards in bringing about these changes. It sits below the New Zealand Health and Disability Strategies umbrella, creating an overall framework for the organisation and delivery of primary health care. District Health Boards will work through Primary Health Organisations to achieve the health goals locally.

Primary Health

Organisations will take various shapes and sizes. Some may grow up around a small town, others for example from a Pacific community, or a group of general practices.

Existing organisations will need changes to become Primary Health Organisations.

Some groups already have strong community links but may not be able to provide the expected range of services.

Other groups are built around providers and will need to develop better community links.

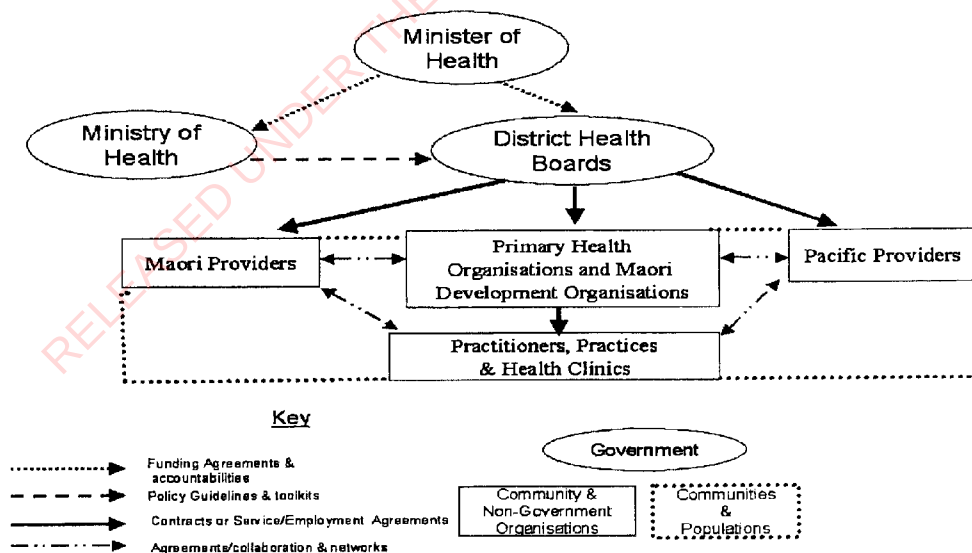
Primary Health Organisations

The vision and the new directions will involve moving to a system where services are organised around the needs of a defined group of people. Primary Health Organisations will be the local structures to achieve this. Some of the key points about these organisations are:

- Primary Health Organisations will be funded by District Health Boards for the provision of a set of essential primary health care services to those people who are enrolled.
- At a minimum, these services will include approaches directed towards improving and maintaining the health of the population, as well as first line services to restore people's health when they are unwell.
- Primary Health Organisations will be expected to involve their communities in their governing processes. They must also be able to show that they are responsive to communities' priorities and needs.
- Primary Health Organisations must be able to demonstrate that all their providers and practitioners can influence the organisation's decision-making, rather than one group being dominant.
- Primary Health Organisations will be not-for-profit bodies and will be required to be fully and openly accountable for all public funds that they receive.
- While primary health care practitioners will be encouraged to join Primary Health Organisations, it will remain voluntary.

The diagram below shows the relationships between primary health - organisations, the Ministry of Health, district health boards, communities, and other providers.

The New Primary Health Care Sector⁴



⁴ This diagram reflects the sector as envisaged under this Strategy, however, as noted previously, primary health care practitioners will be free to decide whether or not they join a Primary Health Organisation.

THE PRIMARY HEALTH CARE STRATEGY

Over five to ten years a new vision will be achieved:

People will be part of local primary health care services that improve their health, keep them well, are easy to get to and co-ordinate their ongoing care.

Primary health care services will focus on better health for a population, and actively work to the reduce health disparities between different groups.

The table below shows, in broad-brush terms, some of the differences between most existing arrangements and the vision.

OLD	NEW
Focuses on individuals	Looks at health of populations as well
Provider focused	Community and people-focused
Emphasis on treatment	Education and prevention important too
Doctors are principal providers	Teamwork – nursing and community outreach crucial
Fee-for-service	Needs based funding for population care
Services delivered in European way	Attention paid to cultural competence
Providers tend to work alone	Connected to other health and non-health agencies

The six key directions for achieving the vision and new arrangements are:

1. Work with local communities and enrolled populations
2. Identify and remove health disparities
3. Offer access to comprehensive services to improve, maintain and restore people's health
4. Co-ordinate care across service areas
5. Develop the primary health care workforce
6. Continuously improve quality using good information.

These are discussed in detail below.

1. Work with local communities and enrolled populations

Contracts with Independent Practitioner Associations, and various Māori, Pacific and other primary health care provider and community groups already accept the need to move to a population approach. The groups hold lists of the people they are covering. Increasingly they are building links with their communities.

People will enrol with a local practice or health clinic that is part of a Primary Health Organisation. They will gain the benefits of better continuity, co-ordination and more attention to preventive services.

Primary health care services can best improve the health of the communities they serve by organising services around defined populations – rather than just responding to those individuals who actively seek care.

Primary health care needs to involve participation by people in the communities covered to achieve this. Services will then be more likely to reflect needs and priorities that are set by the people, not just by providers.

Primary Health Organisations will be required to include some members of the community on their governing bodies. They must also be able to demonstrate that they have processes for identifying need and allowing community members and those who use services to influence the organisation's decisions.

Voluntary Enrolment

The first steps of linking providers to defined groups of people have already begun. Already many general practice organisations, some Māori providers and others keep lists of the people for whom the organisation is taking responsibility. A system of voluntary enrolment will be introduced to expand these moves across the country.

People will be encouraged to join a Primary Health Organisation in order to gain the benefits associated with this population approach and to improve the continuity and co-ordination of the services that they receive. Most people will enrol with a provider of first contact services (a general practice or a local health clinic) that is part of the organisation.

Existing lists of the patients who normally attend a practice or health clinic may form the starting point for enrolment but, over the first couple of years, individuals will be asked to make an active choice to join the Primary Health Organisation.

Some Primary Health Organisations will be new organisations rather than ones built up from existing providers. These groups, such as those aimed at particular Māori or Pacific populations, will seek to directly enrol people in their communities.

The move to comprehensive enrolment will involve a significant change process over several years. The system will work best when the whole population is enrolled; however, enrolment will remain voluntary.

Document 11 Enrolment and continuity of care for patients

Continuity in primary health care means that people have a usual source of care, and can use that source for advice and help over time. People using the service form important relationships with their provider. It may not be necessary to have complete continuity of an individual carer – a small team could be the usual source of care.

Continuity can be shown to result in a number of benefits, particularly where there is a relationship with a particular practitioner. It is associated with:

- better preventive care (Lieu et al 1994)
- patients who feel more able to care for themselves in future (Howie 1999)
- better recognition of problems (Gulbrandson et al 1997)
- less recourse to medication as a first-line treatment (Hjortdahl et al 1991)
- better patient compliance with prescribed medication (Becker et al 1974)
- fewer hospitalisations (Weiss et al 1996)
- lower total costs (Flint 1987).

Despite the apparent importance of continuity of care, a number of recent developments in the New Zealand health system have tended to reduce continuity. These include the growth of large-scale out-of-hours arrangements, the increasing number of 'walk-in' clinics offering episodic care, and the involvement of a wider range of practitioners in providing care.

However, many of these developments have also brought benefits in convenience and availability of service, and these factors are often more important at the time than the ability to see a known practitioner. A recent review (Guthrie 2000) states that 'it seems likely there will be patients and problems where personal continuity really matters and others where personal continuity is irrelevant or even harmful.'

The future primary health care system will enable people to have continuity of care where it is important, but not to reduce their freedom to choose between different practitioners where this is valuable to them. In the process of enrolling with a Primary Health Organisation, people will also be asked to nominate a practitioner, practice, or provider for continuity of care⁵.

There will be some national minimum requirements or protocols that will be fully explained to people at the time they make their choice. These might, for example, include ensuring that enrolled people have access to 24-hours-a-day, seven-days-a-week urgent services; that systems allow people to ask to see a particular practitioner; and that, unless people specifically request otherwise, their nominated provider will receive information about consultations or tests with other practitioners. These protocols will build on the work and advances already made by the Health Funding Authority in this area.

People will be encouraged to nominate a practitioner, practice or provider for continuity of care when they enrol. However, they will still be free to seek care wherever they wish, regardless of which provider they have

⁵ Enrolment will usually take place through the provider rather than directly with the primary health organisation, so nominating a provider of continuity will be quite straightforward.

Enrolment will not reduce people's choice of provider. They will be free to seek care wherever they wish regardless of which provider or Primary Health Organisation they have enrolled with. This is important for people's convenience and to allow them to choose a different practitioner at times when they want a second opinion, a confidential consultation, or to see a practitioner with a particular skill.

If a person chooses not to enrol they will still be entitled to seek care – but they may miss out on some preventive services because they are not in the identified population.

Regardless of people's nomination for continuity, the enrolment system will allow them to continue to see any primary health carer. The system will also allow people to change their nominated provider without difficulty and without having to explain or seek permission.

ACTIONS:

- Primary Health Organisations will be expected to respond to the needs and priorities of their communities, and involve communities in their governing processes.
- People will be invited to join a Primary Health Organisation, usually by enrolling with a provider of first-contact. Enrolment will remain voluntary.
- People enrolling with a primary health organisation will be given full information about their options so they can make an informed choice about their nominated practitioner, practice, or provider team for continuity of care.
- Regardless of their nomination for continuity, people will continue to be able to choose any primary health care provider at any time, and will also be able to change their nominated provider without difficulty or explanation.
- National protocols for enrolment will spell out the information people will be given before joining, protections that must be in place to protect confidentiality, and requirements that organisations must meet.
- Information to clearly explain enrolment will be widely communicated to all New Zealanders.

2. Identify and remove health disparities

There are significant disparities in the health of different groups of New Zealanders. Disparities are related to socio-economic differences, poor housing, lower educational levels, occupation and so on. Such health gaps are shown in higher mortality rates, in measures of the broad burden of disease and injury, and in higher rates of avoidable hospitalisation (Ministry of Health 2000).

Primary health care will play a crucial part in reducing health disparities. Primary Health Organisations will be required to identify and address those groups in their populations that have poor health or are missing out on services. In addition, primary health care organisations that take a community development approach act as advocates for, and involve the communities in finding ways to improve health for the most disadvantaged.

Māori and Pacific peoples' health lags behind that of others in the population and the differences are more than can be explained by socio-economic differences alone. Improvements for these groups will be achieved through Māori and Pacific provider development as well as by improving the delivery of mainstream services for those groups.

All primary health organisations

All Primary Health Organisations and providers will be required to understand the nature of their populations and identify disadvantaged groups in order to address their needs. Meeting the needs of these populations will often mean different strategies since they frequently represent hard-to-reach groups.

Primary Health Organisations will be required to work with their communities and will be encouraged to take a community development approach so as to find appropriate solutions for disadvantaged groups.

Mainstream providers and organisations must be able to identify different ethnic communities within their populations, and to provide for their different needs and priorities – and especially those of groups who are not being reached by the existing service configurations.

In at least the medium-term future, many Māori and Pacific people will continue to be cared for outside of Māori or Pacific providers. Mainstream providers will be expected to organise and deliver services in ways that are culturally competent and effective.

Organisations that have significant numbers of Māori or Pacific peoples among their enrolled population should, where possible, establish specific services for these people (such as services on marae or particular clinics aimed at specific groups).

Māori services

In recent years, Māori have begun to develop:

- specific culturally competent health services for their own people which are usually delivered by Māori health practitioners in the home, in marae, at kohanga reo and schools, as well as through health centres

The Porirua/Kapiti Healthlinks programme is an example of a community development approach that has wide community involvement. The project has identified significant problems for disadvantaged groups and made recommendations for change.

Primary providers and organisations must be able to identify disadvantaged groups within their populations. Meeting needs may mean approaches for hard-to-reach groups.

- Māori co-purchasing and Māori Development Organisations, which work to improve the funding and delivery of services to Māori, with responsibilities for achieving specified Māori health gain priorities, co-ordinating service delivery, and working with both Māori and mainstream providers to build their capacity to deliver comprehensive and responsive services to Māori.

It is essential that these gains are not lost. District Health Boards will continue to contract with Māori providers, and support their further development, so that Māori communities have control over their health and wellbeing.

The Māori Health Strategy will lead the way in this process.

Pacific services

Services for Pacific peoples provided by Pacific peoples can address many of the health problems of Pacific peoples. New initiatives are emerging, particularly in the Auckland region, which involve a wide range of practitioners and services.

Active involvement of Pacific communities in the delivery of services helps ensure that services are accessible to, and right for, the people in their communities.

Further building Pacific provider capacity is central to improving health outcomes for Pacific peoples. District Health Boards will fund and support further development of Pacific providers and organisations.

Pacific providers will form Primary Health Organisations in their own communities or other networks where this is appropriate for the population.

Leadership at a national level will be important to guide improvements in Pacific peoples' health. The Pacific Health Strategy will provide a framework for further developments.

ACTIONS

- All providers and Primary Health Organisations will be required to identify disadvantaged groups in their populations in order to reach out to them and address their needs.
- Primary Health Organisations will be required to show that they know the ethnic mix in their populations and address their needs in ways that are culturally competent and effective.
- Mainstream Primary Health Organisations that have significant numbers of Māori or Pacific peoples among their enrolled population should consider establishing specific services for these people.
- Māori providers and Pacific providers may form Primary Health Organisations in their own communities where it is appropriate for the population.
- District Health Boards will be required to continue to support and further develop Māori providers and Pacific providers.

An Auckland based Pacific provider which offers services in a Pacific way, attracted such a large response that it has had difficulty keeping up with demand

3. Offer access to comprehensive services to improve, maintain, and restore people's health

Primary health care services will include services that improve, maintain and restore people's health.

Improving health involves health promotion, education, counselling and helping people to adopt healthy lifestyles. In these activities primary health care practitioners and Primary Health Organisations need to work closely with providers of public health services. However, there are also many challenges at the one-to-one level that will require primary health care practitioners to be skilled at the various techniques for identifying and helping people change behaviour that threatens their health.

Marae-based cooking classes, keep-fit sessions and parenting support services aim to improve whānau health.

Maintaining health and independence involves preventing the onset and progression of disease and disability. Primary health care practitioners and Primary Health Organisations will need to focus on appropriate screening, opportunistic education, interventions to help change damaging behaviours, early detection and careful management and support for people with ongoing conditions (including specific disease management approaches).

Practice nurses, midwives and GPs have many opportunities to identify those at risk of diabetes and act early to maintain their health.

Restoring health and independence also covers a wide set of services. Primary health care must include ready access to first-level advice and treatment for people when they are unwell or concerned about their health. With the right mix of services, practitioners and supporting investigations and therapies, over 90 percent of new problems can be successfully dealt with at the primary level. Services must include appropriate use of any pharmaceuticals, diagnostic testing and other referred services needed to provide primary level care.

Nurses and doctors restore people to health every day. The best healing strengthens people's ability to look after themselves and their families next time they get sick.

Many health concerns and problems can and should be managed by individuals themselves. This requires ready access to information to support self and family care and to further help when appropriate. Primary health care practitioners need to be open to good use of new sources of health advice such as telephone helplines and the internet, increasing nursing involvement, improved technology for patients to be safely managed in the community, and community rehabilitation services.

Primary Health Organisations will all be required to provide a defined set of services including population services to improve health, screening and preventive services; support for people with chronic health problems; and information, assessment and treatment for any episodes of ill-health. Specification of these services has already been started by the HFA in discussion with providers. Some organisations may offer an expanded range of services.

Some primary health care services are directed at particular groups of people or those with particular problems. These services include, for example, maternity care, family planning, sexual health, and well-child services. In New Zealand these services have often developed along parallel paths to the more generalist services and are provided by different groups. Many of these separate arrangements offer people an alternative and preferred source of care for sensitive and confidential problems. This Strategy recognises the importance of continuing to provide such alternative choices for people – in

maternity services, the arrangements that have grown up over the last 10 years around lead maternity carers will continue.

Funding services according to health needs

Primary Health
Organisations will be
funded according to
the populations they
serve.

Most Government funding of primary health care services is currently distributed according to the number of services provided by doctors and the associated prescriptions that are written. This has led to an uneven and inequitable distribution of resources, often more related to the number of practitioners than to people's needs. There is some evidence, for example, of lower pharmaceutical expenditure in areas with greater deprivation despite these populations having higher health needs (Malcolm 1999).

A population approach to primary health care that focuses on improving, maintaining and restoring people's health, requires adequate funding, allocated fairly according to the needs of the population served. When funds are not tied to particular numbers of services or types of practitioners, there are no barriers to using the most appropriate health practitioner in each situation.

For this reason, Primary Health Organisations will be funded according to a formula that reflects the relative need of their enrolled populations, taking account of factors such as age, sex, deprivation level and ethnicity. Suitable formulae are already under development by the Health Funding Authority in consultation with providers and communities.

Primary Health
Organisations will be
not-for-profit in order
to ensure that public
funds are not
diverted from health
services to private
gain.

Population-based funding will help to reduce disparities by directing resources to communities with greatest health needs. However, additional services and funding may also be required for some hard to reach populations such as Māori and Pacific people, refugees and those in remote areas. The costs of reaching such populations are often not sufficiently taken into account in funding formulae.

Population-based funding may also help ensure a more stable forecasting and service planning environment for District Health Boards. However, the full benefits of population-based funding will not be realised while a large percentage of providers' revenue is generated through user part charges – the fee-for-service nature of user part charges encourages the continuation of episodic treatment.

District Health Boards will only fund not-for-profit Primary Health Organisations. This will guard against public funds being diverted from health gain and health services to shareholder dividends.

Best use of therapeutic, support services and referrals

Achieving good quality care at the primary level requires the best use of investigations, therapeutics, and referral to other practitioners. Attention must be given to managing the levels of utilisation of diagnostic testing, medication and referral for specialists support. In New Zealand as elsewhere in the world there is evidence of considerable variation between practitioners in their use of such services (Malcolm 1999). Examining the reasons behind such variation and moving towards best practice is a very significant challenge for the future.

As Primary Health Organisations will be funded according to their population rather than their use of investigations and medications, they will be in a good position to co-ordinate the best use of therapeutic and support services.

Document 11 **Removing barriers to accessing appropriate services**

The Government is committed to ensuring that all people can get the primary health care services they need. Because primary health care is the first level of contact with the health system, it is often at this level that an individual's need for other services is identified. Barriers to accessing primary health care therefore reduce access to health and disability services generally, with consequent effects on health status and disparities.

Barriers to access to primary health care services include where those services are delivered, how much they cost, whether the service is right for the patient and whether they know about them.

Making sure cost is not a barrier

New Zealand is unusual among developed countries in only funding about 40 percent of first contact services through Vote Health, in what is otherwise a predominantly publicly funded system.

User charges are targeted according to age, income, and family size. However, there is clear evidence (Gribben 1992, 1996; Ministry of Health 1999; Waldergrave 1999; Barnett 1998; Barnett 2000) that cost is a barrier to accessing appropriate primary health care services for many people in New Zealand, particularly people from groups with the greatest needs and who experience the worst health status. There is also evidence from various international comparisons and studies (Saltman and Figuras 1997) that user charges for health services impact more on those who are poorer and sicker – that is, those with the greatest health need who experience the worst health status. Since subsidies are at present targeted according to income, redistribution of existing funds would only result in increased costs for people already on low incomes (taking from the poor to give to the very poor). New funds are needed.

The Government is committed to reducing cost barriers to accessing primary health care services. This will occur over time with first priority going to improving access for the groups with the greatest health need. As funds become available (either by transfers from other parts of the health budget, or by preferentially using new funds for these purposes) more support will be able to be given to a larger group of people. These matters will be considered by the Government against other funding priorities in the upcoming budget process for 2001/02 and future years.

Additional funding will also be required for implementing the wider range of preventative, outreach, and disease management services outlined in this Strategy, which should also result in additional services for those most in need.

Primary Health Organisations and providers will be encouraged by their communities to also consider the affordability of services. Population-based funding formulae allow greater flexibility about use of appropriate staff and services and can reduce the cost for patients. Supporting people to care for themselves and their families will also reduce their need to visit (and pay for) health services.

Knowing about services and how to access them

Some people are unaware of how best to get care when they need it. They may, for example, be used to using the hospital A&E clinic as their source of primary care. Others do not know what to expect, how

Document 11

Healthline, a free phone service being piloted in four parts of the country, has received more than 14,000 calls since its launch in May 2000. Many favourable comments about the service have been received. Māori are significant users of the service.

much they will have to pay, or what is available when costs are too high.

Information about what primary health care services are available and how people can get to them must be provided in ways that people in the communities can understand. This will vary among communities, and may require the use of a wide range of formats and tools.

It may be written, provided orally (such as on the radio or television), or face-to-face at meetings, hui orfono. It may need to be provided in different languages and formats, including sign languages and Braille.

Some people are physically unable to get to first contact services. Primary Health Organisations will need to go actively out to people who cannot or do not come to them. They need to be open to providing services in a range of different settings, for example in people's homes, workplaces, in schools, or on marae.

ACTIONS

- Service coverage descriptions will clearly set out all the primary health care services that District Health Boards will be expected to fund – whether through Primary Health Organisations or by alternative arrangements.
- The Ministry of Health will build on existing HFA work to finalise standard service specifications for the essential primary health care services that District Health Boards will fund. This will include population services, first-contact care, and managing pharmaceuticals, diagnostic testing and other referred services.
- Other providers will be funded to provide services that are not covered by Primary Health Organisation arrangements. These will usually include maternity services as well as the provision of care to people who have not enrolled in a Primary Health Organisation.
- A national funding formula that reflects the relative need of populations for primary health care services will be finalised.
- Primary Health Organisations will be not-for-profit entities but will be able to contract for services from private, for-profit providers.
- The Government is committed to ensuring that people can afford primary health care services and will reduce costs as funds become available.
- Primary Health Organisations will be encouraged to develop innovative ways of providing services in ways that people can afford.
- The public will be informed and educated about the primary health care services that are available to them through a range of media.
- District Health Boards will actively monitor the availability and effectiveness of information about primary health care.

4. Co-ordinate care across service areas

People have diverse health needs, and use a number of services provided by different providers in various settings. It is important that there is co-ordination of care between these services, so that the best possible total package of care is provided to the patient without unnecessary duplication.

Effective co-ordination of care will become even more important as we extend the focus of primary health beyond treatment and support services towards a more comprehensive disease prevention and management approach. There is good evidence (Pincus 1998; Baum 1999; McCarthy 1998) that adopting a broader approach to primary health care can contribute to reducing health disparities and improving outcomes.

A broad, intersectoral approach

It has been estimated that health services only contribute about a fifth of health improvement. Health improvement mainly occurs through changes in the social, economic and cultural impacts on the community's health problems. A broad approach to primary health care means working with other sectors to effect change in these areas.

Primary Health Organisations will be expected to work through District Health Boards to highlight and help address intersectoral issues affecting the health of the community served. This will involve Primary Health Organisations and District Health Boards working increasingly with local bodies, education, welfare, housing, and public transport services, to facilitate and lead changes that will improve the health of their communities.

A collaborative, multi-disciplinary approach

The broad vision of primary health care in this Strategy means that no single practitioner or type of practitioner can meet people's needs completely. A range of practitioners with the skills to communicate and collaborate in the patient's interest are needed.

Providers of first-line services will usually involve nurses and doctors but may need a range of other community workers for some populations. Providers of other primary care services will continue to involve pharmacists, midwives and the range of other practitioners. Primary Health Organisations will need various professional, managerial and support staff to carry out their functions. The ability to recognise the role and importance of others, and to work collaboratively with them, will be essential. Likewise, networking and sharing some administrative services will help to minimise costs for Primary Health Organisations.

The increasing number of practitioners and their changing roles increase the risk of fragmentation of care. However, the increasing complexity of the task means that wider expertise is necessary and that new ways of working are essential. The world of primary health care is changing and old isolated ways of working must be replaced by new collaborative models.

Although Primary Health Organisations will not be responsible for providing all services, they will be a co-ordinator of care for their

Effective co-ordination will become more important as primary health becomes more comprehensive.

No single practitioner can meet people's needs completely under this Strategy.

enrolled patients. As the central point of contact for both community and secondary care providers, Primary Health Organisations will be responsible for keeping key information (for example, about immunisation and smoking status) about their enrolled patients, and for linking those patients with appropriate service providers where appropriate.

Primary Health Organisations will work with other providers and agencies to maximise opportunities for prevention and early intervention of health problems. For example, working in partnership with Māori and Pacific providers is important for reducing health disparities in these populations.

Co-ordination between primary and secondary care

Primary health care requires the assistance of secondary services in order to achieve best management of a range of health problems and conditions. For example, the best care of patients with chronic conditions such as diabetes, respiratory and/or cardiac disease may occur in primary health care settings, but with significant input and support from secondary services.

Specific initiatives that will help improve co-ordination between primary and secondary include:

- building on the advances already made, particularly increased primary health care access to secondary services such as diagnostic tests, and the development of electronic referral guidelines and decision support
- implementing evidence based guidelines and other tools that aid effective clinical decision-making and management of patients in primary health care, with responsive and appropriate support from secondary services
- developing local initiatives that bring together primary health care practitioners and hospital clinicians to develop better access to hospital services and support for primary health care in condition management.

A number of primary health care providers have implemented successful initiatives to better co-ordinate care. It is important that successful local initiatives are shared nationally with other provider groups where they offer potential solutions to common system-wide problems. This is a role for District Health Boards and the Ministry of Health, as well as Primary Health Organisations.

Co-ordination between primary and public health services

Public health is concerned with improving, promoting and protecting the health of the population through the organised efforts of society. Ensuring a cohesive linkage between primary health care and public health services will be key to the success of initiatives to improve people's health.

Primary health care will need input, advice and support from public health services to achieve the key directions outlined in this strategy. Public health services may need to be strengthened and resourced to provide this expertise.

Document 11
In building linkages and networks with public health services, Primary Health Organisations may need to consider:

- how primary health care can make the best contribution to intersectoral and population health initiatives which are being led by public health services (and vice versa)
- useful and effective ways of sharing information about its enrolled population with public health services (with appropriate protection of patient confidentiality)
- how best to draw on public health knowledge and expertise when delivering health improvement services at the one-to-one level (such as helping people to change behaviour that threatens their health).

Co-ordination between primary and disability support services

People experiencing disability are disadvantaged by social and environmental barriers to their full participation in society. Overcoming these barriers requires action on a wide range of fronts, from education and employment to housing and transport.

Primary health care has an important contribution to make to such efforts, consistent with the broad definition of primary health care used in this Strategy. Specifically, Primary Health Organisations may need to consider how best to:

- ensure that barriers (physical, psychological, communication) to accessing primary health care services and practitioners are minimised for people experiencing disabilities
- build linkages with disability organisations and input into their initiatives
- maximise, through intersectoral activities, opportunities for people experiencing disabilities to participate in the community and wider society.

Overcoming the social and environmental barriers to full participation faced by people with disabilities requires action on a wide range of fronts. Primary health care has an important contribution to make.

Co-ordination between primary and mental health services

Recovery from mental illness, including alcohol and drug problems, occurs when people can live well in the presence of, or absence from, their mental illness and the social and economic losses that may come in its wake. As with other aspects of health and wellbeing, recovery depends on people being a part of communities and being able to make their own choices.

To assist in recovery, Primary Health Organisations will need to consider:

- activities to reduce the incidence and impact of mental health problems on their enrolled population, specifically education, prevention and early intervention activities
- the skill mix of primary health care practitioners and their ability to effectively respond to the majority of mental health problems which can be managed in primary care

- building effective linkages with other providers of mental health care, so that the care of those with chronic and/or long term mental health problems is effectively co-ordinated.

Co-ordination for specific population groups

Some populations have particular needs for services that involve a number of different providers at different times. Older people, for example, often have changing needs over time due to gradual deterioration in their functioning. Similarly, children and young people often need a range of care and services from different providers simultaneously.

In order to respond effectively to the co-ordination needs of such groups, Primary Health Organisations will need to consider:

- how to maintain continuity of care for patients who have significant periods in the care of other providers (eg, hospital)
- developing joint 'plan of care' arrangements with other health and disability providers so that optimal care is provided and the patient has clarity about their care regime
- activities to maximise the health and independence of groups, usually by working/ advocating intersectorally.

ACTIONS

Primary Health Organisations and District Health Boards will:

- participate in wider intersectoral activities that aim to address the social, cultural, and economic causes of ill health.
- take responsibility for the co-ordination of care for their enrolled patients.
- be required to co-ordinate and manage resources for the services for which they are responsible in order to ensure best use of workforce and associated diagnostic and therapeutic services.
- support initiatives to help improve co-ordination between primary and secondary health care services
- consider how best to co-ordinate and link with providers from other service areas, particularly for members a Primary Health Organisation's their enrolled population who receive significant input and care from other providers.

The Ministry of Health and District Health Boards will facilitate the national sharing of successful local initiatives.

5. Develop the primary health care work force

The Strategy will have significant implications for the number, mix, distribution and education of the primary health care workforce. The current mix and distribution of the primary health care workforce has been largely an unplanned response to demand and to various initiatives and incentives in the system. As a result the ratio of practitioners to patients is not closely matched to population need (some of the lowest number of doctors are in places of highest need). Because of Government subsidies New Zealand has a higher ratio of practice nurses to population than many other countries but the roles, competencies, and training of these nurses vary considerably. In recent years there has been some growth in managerial and support staff in first contact services, as new organisations have appeared.

The workforce in other primary care services is generally less plentiful. Community health workers and Māori and Pacific general practitioners and primary health care nurses are limited, public health and well-child nurse numbers have been mostly static, and midwife numbers show signs of falling recently after growth earlier in the last decade. Deficiency of appropriately trained workforce in these and similar areas may be a significant limiting factor in the speed of future achievements. They need to be addressed at the national level by the Health Workforce Advisory Committee as well as by professional bodies and providers.

Availability of Practitioners

Most people in New Zealand can easily access first contact services (mostly nurses and doctors working in general practices) when they seek care. The numbers of general practitioners and practice nurses per head of population in New Zealand are on a par with, or higher than, comparable countries.

However, there are shortages of first contact practitioners in some places around the country. Some parts of our cities have many fewer doctors and primary health care nurses than other parts, and some rural towns have difficulties in retaining sufficient practitioners to have a viable service. There are similar problems of variable availability in other primary health care services, such as maternity service providers.

In future, explicit minimum standards for availability of first-contact services will be stated as service coverage levels that District Health Boards will be expected to achieve. Availability of first-contact general practice-type services will be stipulated according to the size and isolation of the community. Minimum levels of primary level maternity services will also be stipulated taking account of local birth patterns and the availability of facilities.

These minimum levels will be made public and District Health Boards will be required to demonstrate availability and identify where there are service coverage gaps or risks.

Primary health care nursing

The move towards greater population focus and emphasis on a wider range of services will increase the need for well-trained primary health care nurses. Such nurses will share a common set of generalist knowledge and skill as well as developing advanced skills in particular areas of professional practice. The concept of the primary health care

The Strategy will have significant implications for the number, mix, distribution and education of the primary health care workforce.

New Zealand does not have an overall shortage of doctors or nurses in general practice – but there is uneven distribution and significant shortages in some places.

The difficulties of attracting and retaining basic health services in rural communities have not lessened over recent years. Further work is planned.

Rural problems need special consideration – further work is needed

nurse needs further development with clarification of the appropriate capabilities, responsibilities, areas of practice, educational and career frameworks and suitable employment arrangements. Primary health care nursing will be crucial to the implementation of the Strategy, and will therefore be best addressed at the national level.

Rural workforce

Maldistribution of workforce is a particular issue for rural areas. Although New Zealand is now 80 percent urbanised, our rural communities are still extremely important to the economy. As well as sharing the health risks of urban people, those in the country also have risks unique to the rural environment and its agricultural industry. People living there need good access to essential primary health care services.

However the difficulties of attracting and retaining basic health services in rural communities have not lessened over recent years. Even some recent initiatives to further encourage rural general practice have so far made little impact on problems.

Rural problems need special consideration. They must encompass the issues of hospital facilities as well as the provision of services – in the country the differentiation between primary and secondary is less clear-cut.

A national stocktake of rural services is currently taking place. This will feed into further work towards a coherent policy and package of assistance for rural communities. This work will involve local communities and Iwi, all relevant providers, District Health Boards and the Ministry of Health.

ACTIONS:

- District Health Boards will be expected to achieve minimum standards for first-contact service coverage levels, according to the size and geographical nature of the district and its communities, and to identify where there are service coverage gaps or risks.
- Primary Health Organisations will deliver services in a range of settings to reach all their enrolled populations.
- The Health Workforce Advisory Committee will be asked to consider the national workforce implications of this Strategy.
- The Ministry of Health will facilitate the development of a national approach to primary health care nursing that will address capabilities, responsibilities and areas of professional practice, as well as setting educational and career frameworks and exploring suitable employment arrangements.
- The Ministry of Health will facilitate the development of a coherent approach to rural health service provision including the difficult issues of attracting and retaining appropriate workforce. This work will involve local communities and Iwi, and District Health Boards.

6. Continuously improve quality using good information

Quality and safety are critical aspects of any health services. While some recent high profile cases have shown up the risks inherent in primary health care interactions, it is important to recognise that there have also been some encouraging developments in the area of quality improvement for primary health care.

Examples of quality assurance processes among primary health care professionals include:

- the College of Midwives' annual standards review (which includes consumers)
- the growing range of College of General Practitioners' Quality Assurance resources to back up its reaccreditation requirements and recently introduced practice standards
- Health Care Aotearoa's Te Wana quality programme for community owned providers
- the range of quality tools used by various Independent Practitioner Associations.

There is now a much greater acceptance by providers and their representative bodies of the need to be accountable both to the community served and to those Government agencies that pay for services.

New primary health care groupings have also shown themselves prepared to take collective responsibility for the quality of clinical care. This has been highlighted by the requirement in some contracts to manage within a set budget – but there is also evidence of changes where no financial risk is involved. These developments and changes in professional attitude are a worldwide phenomena associated also with the move towards evidence-based medicine and nursing. They do, however, place a considerable extra burden of compliance costs on practitioners, which need to be recognised in contracts.

District Health Boards will be required to ensure that Primary Health Organisations can demonstrate the quality and safety of the services for which they are responsible. Primary Health Organisations will be required to document their compliance through their annual reports, which should be made available to the community as well as the District Health Board.

Accountability and formal reporting requirements should be the end point of other quality processes. These are most effective when they are an integral and ongoing part of the way the system operates. High-quality organisations and providers of primary health care will be those that have a culture of continuous improvement with individuals looking for learning opportunities and the organisation rewarding and supporting such behaviour.

Primary care providers and groups have accepted the need to be more accountable to users, to the Government funder, and to their colleagues.

Complying with such accountabilities increases the cost of providing services and should be reflected in contracts.

An effective infrastructure for information collection and sharing

Accurate and useful information about enrolled populations and their health needs is critical to quality as well as to the successful adoption of a population health focus in primary health care.

Information and information sharing is needed particularly to support and inform:

- needs assessment and effective service funding, planning, delivery, and monitoring
- co-ordination of provider activities and patient care
- improving the continuity of care between episodes of illness and treatment
- clinical decisions about the care and treatment options available, and their likely efficacy for individuals
- processes for monitoring and improving the quality of care.

Important information initiatives include:

- The Health Knowledge Strategy
- The Child Health Information Strategy
- Kidznet
- Maternal and Newborn Information system.

The need for accurate information will increase as we move to public funding based on the needs of an enrolled population. In particular, it will be important to ensure that cost-effective methods of capturing data about utilisation of services are developed to inform future needs analysis and funding decisions.

There are a number of initiatives already occurring in the sector that are designed to improve information collection and sharing:

- The Ministry of Health is currently developing a draft Health Knowledge Strategy that will address issues of privacy and confidentiality, and will identify key principles and goals for health information.
- The Child Health Information Strategy currently being implemented by the HFA and Ministry provides an overarching plan for the development, collection, and use of information for improving the health of children.
- There is a range of local initiatives which seek to ensure better collection and sharing of information within primary health care, and between primary and secondary providers. One example is KidZnet⁶, which links providers to basic information (particularly well child services) about the local child population, using the NHI.

KidZnet and other similar information projects could well provide a platform for broader improvements in primary health care information. Building on these initiatives, and supporting the development of further information initiatives, will be a key priority for the Ministry of Health, District Health Boards and Primary Health Organisations. All parties need to work together to ensure that accurate and useful information is collected and shared. In particular, it is important that funding agreements and contracts explicitly consider information requirements, with an emphasis on minimising costs while building a standardised primary health information infrastructure.

⁶ A joint venture between Health Waikato, Rotorua Area Primary Health Services, and the HFA.

Enrolment provides some opportunities to address information needs. In particular, improving the accuracy and effectiveness of the National Health Index (NHI) will be a priority as we move to widespread enrolment. It will also be important to ensure patient confidentiality is protected throughout the enrolment process. Primary Health Organisations and providers will need to ensure that patients are informed about information collected and its intended uses. For example, patients will need to give informed consent before personal/clinical information held at a general practice or health clinic level is passed to other practitioners inside or outside the Primary Health Organisation.

Evaluating the impact of new arrangements and guiding future policy

While this Strategy is based on the evidence where it is available, there are many aspects of primary health care where significant questions about policy and implementation remain.

More research and evaluation is required to resolve issues such as the degree of variation in service provision, the most appropriate ways to target limited resources, the most efficient ways to provide care and what services are best in different circumstances. This Strategy is an evolutionary one and allows considerable variation. It will be supported by ongoing research during its implementation so that the final arrangements are effective and acceptable.

Actions

- Minimum monitoring requirements, toolkits and other guidance will be developed to assist in the area of continuous quality assurance.
- District Health Boards will specify and monitor quality and safety standards and outcomes of care through service arrangements.
- Primary Health Organisations will be openly accountable to the public for the quality standards they plan to achieve.
- The Ministry of Health will consider the needs of primary health care in its development of the Health Knowledge Strategy, including key principles and goals for health information.
- The Ministry of Health, District Health Boards, and the New Zealand Health Information Service will develop cost-effective, administratively simple, methods of capturing data about utilisation of services to inform future needs analysis and funding decisions.
- All parties will co-operate to build on promising information initiatives that have the potential to improve patient care.
- All parties will co-operate to improve the effectiveness and accuracy of the National Health Index as widespread enrolment is introduced.
- Providers will ensure that patients are informed about information collection and give consent where their personal/clinical information is shared with other practitioners inside or outside the Primary Health Organisation.
- The Ministry of Health, District Health Boards, Primary Health Organisations and providers will be encouraged to build evaluation, research and development into new primary health programmes.

IMPLEMENTING THE STRATEGY

The achievement of the new direction for primary health care will clearly involve a period of change over the next five to ten years. In implementing the Strategy there are a number of important principles for ensuring a stable and constructive transition:

- in the first instance, protect the gains already made and build on successful initiatives
- involve, discuss and collaborate with the primary health care sector, providers and communities in the implementation of the Strategy
- focus on stepwise, evolutionary, change which is progressively consistent with the Primary Health Care Strategy.

The Government is committed to funding additional health promotion, disease prevention, and community development services in primary health care. Primary health care is a high priority for additional funding within Vote Health, as it is central to removing disparities and improving health. However, any additional funding for primary health care will need to be considered against other health priorities, as well as funding for other areas of Government and District Health Board expenditure. The first priority for any additional funding will be the groups with the greatest health need, both in terms of additional services to improve health, and to reduce financial barriers for access to first-contact services.

The implementation details will be developed and communicated through a number of mechanisms:

- Funding agreements and other accountability documents for District Health Board performance. These accountability documents will include milestones and performance measures specifically related to primary health care and the implementation of this strategy. There will be close monitoring of District Health Board performance by the Ministry of Health until key objectives are achieved.
- The Ministry of Health will develop toolkits and policy guidelines for District Health Board contracting with providers. This will support the Boards to build relationships and support local providers and communities who are interested in primary health care, develop district plans for primary health care, and manage existing local contracts in order to prepare for future change.
- Training and communication about best practice through, for example, seminars for providers and induction training for District Health Board directors.

In preparing for implementation providers and their organisations (including existing organisations that have primary care contracts) should build relationships with their communities, and with their District Health Board. They will also need to consider what changes to make to their organisational arrangements, and will plan how to prepare themselves for the new tasks and services that will be needed.

District Health Boards and primary health care providers should support communities and interested individuals to be involved with primary health care developments, so that the future system can understand and address people's needs and priorities.

Appendix One:

Primary Health Care Reference Group

The Ministry of Health has the task of developing a definitive primary health care strategy for Government approval, building on the Minister of Health's discussion document *The Future Shape of Primary Health Care*.

Terms of Reference

The reference group will assist the Ministry of Health in this task by:

Commenting on the summary of submissions;

With reference to the discussion document, the submissions and the sector, commenting on the implications of the strategy as it is developed;

Engaging with the sector and sharing ideas, while recognising that some documents which members will see will require confidentiality.

Membership

Dr Win Bennett (Chair), Manager, Ministry of Health

Bridget Allan, CEO, Hokianga Health Enterprise Trust

Patsi Davies, Consumer Perspective/Consumer Rights Researcher, Hamilton

Barbara Docherty, Goodfellow Unit, General Practice and Primary health Care, Auckland University

Dianne Gibson, Ngati Porou Hauora

Karen Guilliland, National Director, New Zealand College of Midwives

Liz McElhinney, CEO, Ko Te Poumanawa Oranga

Allan Moffit, General Practitioner, East Health

Debbie Ryan, Southseas Healthcare Ltd

Dr Branko Sijnja, General Practitioner, Clutha Health First

Appendix Two

Definition of Primary Health Care - Drawn up by the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978:

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

RELEASED UNDER THE OFFICIAL INFORMATION ACT

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To be completed...

Pincus, 1998;

Baum, 1999;

McCarthy, 1998,

Malcolm, 1999

- (Lieu et al 1994)
- (Howie 1999)
- (Gulbrandson et al 1997)
- (Hjortdahl et al 1991)
- (Becker et al 1974)
- (Weiss et al 1996)
- (Flint 1987).

Gribben 1992, 1996;

Ministry of Health 1999;

Waldergrave 1999; Barnett 1998; Barnett 2000) (Saltman and Figuras 1997

Guthrie 2000

Ministry of Health 2000



CABINET

2025-02-0-6
(v2)
CAB (00) M 41/6

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Minister of Health

COPIES TO:

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Deputy Prime Minister
Minister of Finance
Minister for Accident Insurance
Minister of Social Services and Employment
(MSP)
Associate Minister of Maori Affairs
(Hon Sandra Lee)
Associate Minister of Finance
(Hon Trevor Mallard)
Minister of State Services
Minister of Maori Affairs
Minister of Pacific Island Affairs
Minister of Women's Affairs
Minister of Youth Affairs
Associate Minister of Health
(Hon Tariana Turia)
Hon Phillida Bunkle
Secretary, SPH

Primary Health Care Strategy

Reference: CAB (00) 814; SPH (00) M 33/6

At the meeting on 11 December 2000, following reference from the Cabinet Social Policy and Health Committee (SPH), Cabinet:

- a **noted** that the Primary Health Care Strategy attached to the submission under CAB (00) 814 has been completed following extensive public consultation, with input from a sector reference group and from other Government agencies;
- b **noted** the advice of the Minister of Health that a number of editorial changes had been made to the discussion document following consideration at SPH;
- c **invited** the Minister of Health to release the Primary Health Care Strategy in January 2001, following the release of the New Zealand Health Strategy;

- d **directed** the Ministry of Health to put together, as a matter of urgency, a detailed transition plan, with implementation options, for the development of the publicly funded primary care sector, in line with the principles in the Primary Care Strategy.

A handwritten signature in black ink, appearing to read 'Harvinder Singh'.

Secretary of the Cabinet

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

Minimum Requirements for Primary Health Organisations

**Hon Annette King
Minister of Health
November 2001**

Primary Health Care Strategy



I am very pleased to release this set of minimum requirements for Primary Health Organisations (PHOs).

These requirements are important for getting started on the Primary Health Care Strategy that I released in February this year. District Health Boards, communities and primary health care providers have been eagerly awaiting this information to help them plan for the future.

Providers and communities must be able to move at their own pace. Some are close to being PHOs already, others have further to go. They need to be able to find the best local arrangements to achieve the Strategy's vision and their key relationship will be with the District Health Board. The requirements deliberately leave room for such a variety of approaches.

I expect to be able to make some announcements fairly soon about how Government plans to fund the Strategy so that people can get the services they need to improve, maintain and restore their health. Of particular concern and urgency are those high-need groups that have been missing out and they will be the first to move.

The Ministry of Health has an extensive work programme to provide District Health Boards with the support, guidance and essential building blocks for getting the Strategy going. The Ministry will shortly be releasing a companion set of guidelines to accompany these minimum requirements. The guidelines will contain tools and ideas so that groups can learn from what has gone before and consider a range of possible choices.

I am confident that effective PHOs will grow from and build on the existing strengths of general practitioners, nurses, community and other health workers. Māori providers, Pacific providers, Independent Practice Associations and other organisations can all evolve into PHOs. They will not be an extra layer of bureaucracy.

I look forward with great interest to seeing PHOs develop up and down the country over the next few years.

A handwritten signature in black ink, reading 'Annette King'. The signature is fluid and cursive, with the first name 'Annette' written in a larger, more prominent script than the last name 'King'.

Hon Annette King
Minister of Health

Minimum Requirements for Primary Health Organisations

INTRODUCTION

Implementing the Primary Health Care Strategy is a key first step towards achieving the goals set out in the New Zealand Health Strategy. The Primary Health Care Strategy aims to improve health and reduce health inequalities by moving to a system where services are co-ordinated around the needs of a defined group of people. Primary Health Organisations (PHOs) will be organisations of providers working with their communities to achieve this.

The process for fully implementing the Strategy is to be an evolutionary one over the next few years building on the strengths of the existing services provided by general practitioners, nurses, community health workers and others.

Many of these practitioners operate under existing organisational arrangements such as IPAs, Maori Provider Organisations, rural trusts and so on. Implementing the Strategy means that DHBs will work with these organisations and their communities in order to find the best way locally to set up Primary Health Organisations.

KEY POINTS ABOUT PHOs

The Strategy (page 5) notes key points about PHOs as follows.

- ▶ Primary Health Organisations will be funded by District Health Boards for the provision of a set of essential primary health care services to those people who are enrolled.
- ▶ At a minimum, these services will include approaches directed towards improving and maintaining the health of the population, as well as first-line services to restore people's health when they are unwell.
- ▶ Primary Health Organisations will be required to involve their communities in their governing processes. They must also show that they are responsive to communities' priorities and needs.
- ▶ Primary Health Organisations must demonstrate that all their providers and practitioners can influence the organisation's decision-making, rather than one group being dominant.
- ▶ Primary Health Organisations will be not-for-profit bodies and will be required to be fully and

openly accountable for all public funds that they receive.

- ▶ While primary health care practitioners will be encouraged to join Primary Health Organisations, membership will be voluntary.

MINIMUM REQUIREMENTS

The main focus is on achieving results in terms of better health, reduced health inequalities and easier access to services. The following minimum requirements set the parameters within which DHBs and local groups will find their own best answers. DHBs will decide whether an organisation is meeting the minimum requirements both in terms of services delivered and its overall structure and governance before allowing it to become a Primary Health Organisation. A set of national guidelines will be distributed to assist DHBs, primary providers and their communities with tools and ideas for PHO establishment and meeting minimum requirements. The process of establishing a PHO will reflect the principles of the Treaty of Waitangi – partnership, participation and protection.

WHAT A PHO WILL DO

► *PHOs will aim to improve and maintain the health of their populations and restore people's health when they are unwell. They will provide at least a minimum set of essential population-based and personal first-line services.*

DHBs are required, under national service coverage specifications, to ensure people have access to a set of primary health care services. The service agreements they enter with PHOs will specify these services in more detail. The agreements will include associated requirements such as understanding their population, information systems, coordination, and management of referred services within a budget. They will set out expectations about availability, affordability, quality, and cultural competence. For example, PHOs which include rural communities will need to ensure equitable and effective access to primary health care services within their rural communities or within acceptable travel times.

► *PHOs will be required to work with those groups in their populations (for example, Maori, Pacific and lower income groups) that have poor health or are missing out on services to address their needs.*

The DHB must be satisfied that the PHO's planning, prioritisation and service delivery will contribute to a reduction in health inequalities.

► *PHOs must demonstrate that they are working with other providers within their regions to ensure that services are co-ordinated around the needs of their enrolled populations.*

The DHB must be satisfied that PHOs demonstrate they are working with other providers as appropriate to co-ordinate care for their enrolled populations in ways that best meet the needs of their communities.

KEY CONSIDERATIONS WHEN ESTABLISHING A PHO

► *DHBs will use a national formula to fund PHOs according to their enrolled populations*

A formula is being developed nationally so that funding will reflect characteristics of the

population that determine their need for primary health care services. The formula will cover the minimum essential services – DHBs may choose to enter other arrangements for other services.

► *PHOs will use a national enrolment system to enrol people through primary providers*

People will only be able to enrol with one PHO at any time. They will usually enrol at the level of the general practice or primary health clinic. A nationally agreed set of rules will set out people's and providers' rights and responsibilities and will establish requirements for information collection and protection.

► *PHOs must demonstrate that their communities, iwi and consumers are involved in their governing processes and that the PHO is responsive to its community*

The DHB must be satisfied that community participation in PHO governance is genuine and gives the communities a meaningful voice. In addition, DHBs will require PHOs to show how they respond to their communities.

► *PHOs must demonstrate how all their providers and practitioners can influence the organisation's decision-making.*

The DHB must be satisfied that PHOs seek the views of providers and practitioners and have sufficient processes to ensure that decisions take account of the range of views.

► *PHOs are to be not-for-profit bodies with full and open accountability for the use of public funds and the quality and effectiveness of services.*

Before an organisation can become a PHO, the DHB will need to be sure that the organisation has a suitable not-for-profit status and that the requirements for reporting and disclosure will allow the DHB and the public to fully understand the use of public funds and the quality and effectiveness of services in order to evaluate the results.