

**Critical analysis of the implementation of the Primary  
Health Care Strategy implementation and framing of issues  
for the next phase**

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## **Critical analysis of the implementation of the Primary Health Care Strategy implementation and framing of issues for the next phase**

### **Executive Summary**

#### **Introduction**

This paper represents the first part of a two-stage project 'Where Next for Primary Health Care Development in New Zealand?' that was undertaken by Judith Smith, Visiting Academic Fellow in the Sector Capability and Innovation Directorate of the Ministry of Health during 2008-2009. The project's two elements were as follows:

- an initial phase entailing critical synthesis and analysis of PHCS implementation to date and a framing of the key issues that faced this sector in 2008 and beyond; and
- a second phase that sought to identify options for how primary health care provider development might go forward in New Zealand .

This paper is based on synthesis of existing analysis of the Primary Health Care Strategy (the Strategy) and its implementation, framed within the author's assessment of this material. In addition, 30 interviews with national primary health care stakeholders were undertaken in order to explore the background to, implementation of, and progress associated with the Strategy.

#### **The Primary Health Care Strategy**

The Primary Health Care Strategy was based on two core academic traditions within primary health care research:

- the importance of **strong and effective person-focused primary health care service provision** as the crucial level for care continuity, co-ordination and integration within a health system (after Barbara Starfield, 1998)
- the **importance of primary health care as a fundamental approach to health and community development**, and hence in reducing inequalities and improving health (after WHO Alma Ata, 1978)

The analysis set out in this paper is based on an assertion that within the Primary Health Care Strategy, the focus on a health development paradigm of primary health care was predominant as the organising principle for the Strategy and its implementation. This made great sense given the problems that the Strategy was seeking to address in relation to inequalities in health, in access to primary health care services, and a need for greater community participation in health.

It is argued here the Starfield vision of ensuring strong and comprehensive primary care services based on the principle of people receiving continuous, co-ordinated and comprehensive first-contact care has not always received the attention during Strategy implementation that was apparently intended. This assertion is made not on the basis of how funding has been allocated (for the majority of new primary health care funding has gone towards reducing the cost of access to first-contact care) but rather in relation to *how* the Strategy has been implemented (e.g. the ways in which it has been able to engage and influence general practice and other providers), and where

the most impact appears to have been made (e.g. in reducing the cost of access to services, but not being able to lever significant change in models of care at practice and provider level).

International and national evidence on patient views of primary health care indicate that New Zealand scores well (for those who are able to access such care), with timely access to in- and out-of-hours services, longer consultation times, and a sense of involvement in care decisions. This suggests that New Zealand has a strong base of primary health care provision upon which to build as it seeks to extend its primary health care services in line with Starfield's vision.

### **Reflecting on implementation of the Primary Health Care Strategy**

The Strategy was, by its own admission, intended as a vision to be interpreted locally, rather than a detailed national implementation plan. Progress made in relation to the six key directions set out in the Strategy is reviewed below.

#### **Work with communities and enrolled populations**

Population registration is now in place throughout New Zealand, providing the foundation for activity focused on reducing health inequalities and improving public health. Likewise, 80 primary health organisations (PHOs) have been put in place and almost all of the population is registered with a PHO. However, the extent to which the population is aware of PHO functions and services as suggested in the Strategy is open to question, and it seems that people continue to relate first and foremost to their general practice or community provider. PHOs have involved communities in their governance arrangements and are clear about their responsibility to work with communities and the enrolled population in order to try and improve health. The main challenge however is the extent to which PHOs have the actual levers available to them to bring about change in service provision for communities and the enrolled population.

#### **Identify and remove health inequalities**

The identification of health inequalities is a key focus for PHOs and district health boards (DHBs), and this issue is regarded by the health system as a core national health priority. There is evidence of improvement in health outcomes in New Zealand over the past decade, together with better rates of immunisation (an indicator that was a key concern prior to the Strategy), and a reduction in inequalities associated with ethnicity in this regard. It is however too early to say whether the Strategy itself has contributed directly to what appears to be a slowing in the rate of increase of health inequalities in New Zealand.

#### **Offer access to comprehensive services to improve, maintain and restore people's health**

Sufficient attention has not been paid to specifying, with the different professions and providers, what different models of comprehensive primary health care services might look like and how they might be realised. The Strategy was ambiguous in relation to the role and functions of PHOs and this compromises PHOs' ability to assume a strong role in leading change in primary care. Reducing the cost of access to first-contact care has been a key area of success within Strategy implementation – the challenge now is how to sustain this and continue to address inequalities in access. The use of capitation as the basis for allocation of government funding for primary

health care has helped to embed a population approach to local planning and funding, but the continuation of significant patient co-payments, together with partial contracting between the government and general practice, means that the potential gains of capitation in respect of a different model of service have largely gone unrealised. There have been many innovations in service provision, but they have not been evaluated and disseminated in a systematic manner. The relationship between the government and general practice was often fraught during Strategy implementation, and clinical involvement in PHOs varies significantly as a result.

#### **Co-ordinate care across service areas**

The Strategy set out an ambitious set of aspirations related to the co-ordination of health services within and from primary care, but these need much more attention in the next phase if desired models of integrated care are to come about. PHOs have however used new funding available to them to extend services aimed at better care co-ordination, for example for people with long-term conditions, and they have made progress in developing joint health programmes and initiatives with inter-sectoral partners. International evidence on effective primary care suggests that strong general practice that assures a longitudinal and personal connection between patients and their GP or nurse is critical to co-ordination of services within and beyond the health system. This entails a system where practices are effectively connected (by IT and other management and professional relationships) to a wider range of local diagnostic, allied health care, welfare and public health services. In the New Zealand context, the issue of people having to pay for some services can act as a barrier to the practice performing the role of overall co-ordinator of services.

#### **Develop the primary health care workforce**

Whereas in 2001 the Strategy asserted that New Zealand had sufficient GPs and practice nurses (although not distributed appropriately), by 2008, there was national consensus about a shortage of health workforce. Given the known importance of strong first-contact primary health care services in enabling effective co-ordination of an individual's care, there is a need for national leadership in respect of specifying what primary health care services should look like, with associated minimum standards. Without this, it will be difficult to hold DHBs to account for availability and standards of primary health care. There is evidence of innovation in the development of the primary health care workforce in New Zealand, but concerns remain about the evaluation and spread of such innovation. If new models of integrated primary health care are to be put in place (or where in existence, supported and extended), there is a need for PHOs to have a clearer role in relation to service development, along with appropriate levers and incentives.

#### **Continuously improve quality using good information**

The development of patient enrolment has provided a crucial information platform for public health and primary health care interventions. The PHO Performance Management Programme represents an initial attempt to develop national standards for primary health care services, albeit that it focuses on PHOs rather than providers and as such lacks clarity about how practice/provider level performance is to be assessed and incentivised. There is potential to use the PHO Performance Management Programme and the Ten Health Targets to develop a more sophisticated approach to the assessment of quality and performance. This could build on existing professional and community accreditation programmes. What is crucial is that clarity

is achieved about the level of the system where performance is to be measured and rewarded (practice, IPA/primary care network, PHO, or DHB).

### **Challenges for the next phase**

Based on this analysis of Strategy implementation, these are the challenges for the next phase:

#### **1) Rebalancing the Primary Health Care Strategy**

There is a need for a refreshed Primary Health Care Strategy that ensures attention to the development and extension of first-contact services and a setting out of the direction for the next phase of implementation. As part of this, it might be helpful to work with primary health care stakeholders to paint a picture of what primary health care might look like in New Zealand in say ten to twenty years. Long-term planning such as this needs to take place within the wider context of strategy for the whole New Zealand health care system, making sure that primary care develops to meet the expectations set by national and regional plans for clinical services and networks. This vision for primary care is also needed for the general population who struggle to recognise the scope and potential of primary health care. In doing this, it might be helpful to include a set of national desired outcomes for primary care, and the articulation of ‘simple rules’ for how actors in the system will work together.

#### **2) Working with primary care professionals to plan and implement change**

There is an opportunity to build on the strengths of New Zealand primary care by assuring a ‘medical or primary care home’ within plans for the next phase. In taking forward the Primary Health Care Strategy, *how* the process is developed and managed is as important as what is put in place. With funding roll-outs complete, there is a window of opportunity to frame a new and more constructive relationship with general practice, NGOs, DHBs and other players in the primary health care system. The challenge is to enable strong community *and* clinical leadership of the next phase of change within primary health care. Furthermore, national PHO organisations need to be fully involved in primary care planning alongside clinical leaders.

#### **3) Clarifying the role and functions of a PHO**

There is a need to clarify the role and functions of a PHO within the health system. This could include work to establish a typology of PHOs, accepting that they are a diverse constituency and as such, may have different areas of responsibility and focus appropriate to their form. In any work to pilot different models of integrated primary health care, there should be attention to exploring how the PHO role might operate in different contexts to enable learning about ‘types’ of PHO. PHOs might in future choose to be primary care provider networks, or global planners and funders of primary care for a defined locality – options such as these could be explored within pilot projects. As the future role and function of PHOs is explored, there is a need to determine how far it is important that people have a choice of PHO, and how this relates to people’s ability to exercise choice of primary care practice.

#### **4) Testing out different models of service provision and funding**

PHOs find themselves constrained in relation to exerting influence over local practices and other providers, largely on account of primary care funding arrangements that continue to require a significant patient co-payment direct to the practitioner. There is a need for national debate about the nature of the co-payment

for general practice, in order to inform future policy about primary care funding and provision. The time is ripe to explore a range of different service models within primary care, including the funding and organisational arrangements that might enable these to be developed by PHOs, IPAs, and providers. In testing out such service and funding models, consideration should be given to exploring new approaches to pooled or locality funding of primary health care, along with contracting and budget-holding by PHOs and/or primary care networks. A range of devolved models of service provision and funding calls for a performance framework that can assure value for money and quality of care nationally.

#### **5) Setting out the expectations of DHBs in relation to developing primary health care**

There is a need for a restatement of the role and expectations of DHBs in relation to implementing the Strategy, in parallel to clarifying the role of the PHO. This needs to include an exploration of the pros and cons of DHBs continuing to provide community health services and whether these services should move into PHO management or funding/contracting. A requirement for joint planning between DHBs and PHOs might be helpful in signaling the joint responsibility for Strategy implementation. The performance management framework for DHBs need to emphasise and incentivise the importance of making progress with Strategy implementation, and DHBs need to be closely involved in developing plans for the next phase of Strategy implementation.

#### **6) Strengthening management and leadership within primary health care**

There is a need for a management and organisational development plan to be put in place to support the next phase of Strategy implementation. This needs to explore and address the present and future needs for general and clinical management in primary care, at practice, PHO and DHB levels. Such programmes will require funding and long-term commitment to support, network and develop those managing a significant and far-reaching change within the New Zealand health system.

#### **7) Evaluating and learning from the experience of implementation**

The analysis by Jonathan Lomas of evaluation and spread of innovation in the New Zealand health system could be used as the basis for developing a stronger framework for evaluating and disseminating change and innovation within primary health care. A review of existing research and evaluation capacity, together with an assessment of current projects under way or completed, would be an important first step in determining a more strategic approach to evaluation and implementation of innovations (where they are proven to be effective). Different approaches to 'linkage and exchange' could be trialled as part of the next stage of Strategy implementation, drawing on the experience of Canada, UK and elsewhere.

### **Conclusion**

To conclude, what is needed in the next phase of development is:

- The setting out for the health sector and the population of a vision for effective primary health care services, including a stronger focus on the development of first-contact services as the core co-ordinator of people's health care, within in an overarching framework of seeking to improve health and reduce inequalities.

- A commitment to work in a more inclusive and collaborative manner with general practice, NGOs, and all other primary care stakeholders as policy is shaped and implemented in a way that builds on the strengths of current provision.
- Work to clarify the current and potential role and functions of PHOs, including the development of plans for how they might assume a more extended role as primary care networks and/or as holders of global budgets for primary and community care services.
- The development of streamlined and different approaches to primary care funding that enable the testing out of new models of integrated primary and community care, within primary care networks.
- A restatement of the role and expectations of DHBs in relation to implementing the Strategy, including in respect of funding, planning, community service provision, and performance management, and how they relate to other actors such as PHOs and community health providers.
- A plan for how management and organisational development support will be provided to the process of strengthening and changing primary and community health care to meet the health and workforce challenges ahead.
- A commitment to evaluate new organisational and service developments in primary care, and to explore new ways of connecting research and practice, drawing on international experience of 'linkage and exchange'.

This critique is intended as a challenging overview of Strategy implementation to date, together with a framing of issues for the next stage. The Strategy has been at once radical, as evinced by its backing of a community development and population health approach to primary care, and also conservative, in its focus on using government funding to try and reduce co-payments through a subsidy, rather than a contracting approach.

What is clear from the interviews carried out for this analysis is that across the spectrum of primary health care stakeholders in New Zealand, there is a real appetite to move forward and explore in a more collaborative and negotiated manner the potential for different models of care (with associated funding and business models) that will put New Zealand primary health care in a position to meet the twin challenges of rising incidence of long-term conditions and constrained workforce supply. The challenge is to learn from the process of implementing the Strategy to date, attending to the issues related to the lack of an overall implementation plan, the existence of fraught relationships, unclear organisational roles, and inadequate incentives, whilst building on the evident progress associated with developing primary care infrastructure, addressing inequalities in health access and status, and making primary care a key actor in the wider health system. If this challenge is met, New Zealand's Primary Health Care Strategy will indeed have been radical, successful and of international note.

## **Acknowledgements**

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The work contained in this paper was carried out during a secondment from the University of Birmingham to the Ministry of Health. The author was asked to carry out this project in order to inform Ministry of Health thinking about next steps in this policy area. The views expressed in this paper are however those of the author alone, and do not represent Ministry of Health policy.

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**London, March 2009**

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### **Introduction**

This paper represents the first part of a two-stage project 'Where Next for Primary Health Care Development in New Zealand?' that was undertaken during a one-year secondment as Visiting Academic Fellow in the Sector Capability and Innovation Directorate of the New Zealand Ministry of Health.

The project's two elements were as follows:

- an initial phase entailing critical analysis of Primary Health Care Strategy (PHCS, or the Strategy) implementation and a framing of key issues facing this sector in 2009 and beyond; and
- a second phase that sought to identify options for the development of primary and community health services in New Zealand .

In this first paper, an overview is given of the aims and objectives of the Strategy, in the context it was developed. This is followed by an assessment of the extent to which the aims and objectives of the Strategy have been met over the period 2001-2008, based on synthesis of existing research, evaluation and policy analysis material. This assessment is then used as the basis for identifying the challenges facing the health sector as it takes the Strategy into its next phase of implementation, along with an exploration of how existing policy mechanisms could be used in order to meet these challenges, and where new ones might be required.

### **Methods**

This work represents synthesis of analysis of the Primary Health Care Strategy and its implementation, framed within the author's assessment of this material. Thirty interviews with national primary health care stakeholders were undertaken (e.g. Ministry of Health officials, GP Leaders' Forum, Health Care Aotearoa, PHO Alliance, PHONZ, primary health care nurse leaders, and academics who have followed the Primary Health Care Strategy implementation closely), in order to explore the background to, implementation of, and progress associated with the Strategy.

### **The Primary Health Care Strategy**

During the late 1990s, there was considerable debate within New Zealand about the problems associated with primary health care provision, and exploration of options for addressing these issues (e.g. Malcolm, 1996; Brown and Crampton, 1997; Crampton and Brown, 1998; Gribben and Coster, 1999; Cumming and Mays, 1999; Crengle, 1999; Malcolm et al, 1999). Discussion centred on the significant inequalities in access to primary health care experienced by some population groups, along with health outcome indicators that appeared to result, at least in part, from these disparities in access to care, and the different ways in which New Zealand might change policy in order to address these problems.

The Primary Health Care Strategy was published by the Minister of Health, Hon Annette King, in February 2001, following prior publication of a discussion document about the future of primary health care in 2000 (King, 2000). The Strategy set out a 'five to ten years new vision' that was intended to enable 'a strong primary health care system [...] central to improving the health of New Zealanders and, in particular, tackling inequalities in health' (King, 2001, pvii). The specific vision was as follows:

'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 reduce health inequalities between different groups.' (King, 2001, pvii)

This vision statement clearly reflects the two traditions within primary health care that underpinned the development of the Strategy. Firstly, **the importance of strong and effective primary health care services as the bedrock of a health system**, this being considered a requirement if health outcomes are to be maximised, and costs kept under control (Starfield, 1998, pp8-9). Starfield defined primary health care as being:

'that level of a health service system that provides entry into the system for all new needs and problems, provides person-focused (not disease-oriented) care over time, provides care for all but very uncommon or unusual conditions, and coordinates or integrates care provided elsewhere by others. It thus is defined as a set of functions that, in combination, are unique to primary care'

Starfield also emphasised (op cit, p9) primary care as an approach that forms the basis for the work of other levels in the health system:

'Primary care addresses the most common problems in the community by providing preventive, curative, and rehabilitative services to maximize health and well being. [...] It is care that organizes and rationalizes the deployment of all resources, basic as well as specialized, directed at promoting, maintaining, and improving health'.

The second academic tradition that underpinned the Strategy was one that (in common with Starfield's emphasis on a wider role for primary care) regards **primary health care as a fundamental approach to health development**, this being grounded in the World Health Organisation Alma Ata declaration on primary care (WHO, 1978). This tradition, as explained by Smith (2006, p117) holds that primary health care comprises all those elements of care and community development that enable people to lead healthy and meaningful lives:

'A view of primary healthcare as an approach to health development holds that it is central and foremost within a healthcare system, comprising all those activities and conditions that go towards ensuring the public health. 'Primary' therefore implies that this area of care is fundamental, essential and closest to people's everyday lives and experiences.'

The Strategy (King, 2001, p1) drew on both the Starfield (strong person-centred primary health care services) and the Alma Ata (primary health care as an approach to health development) traditions when setting out what the Strategy was expecting primary health services to include:

- 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, and pharmacy services that include advice as well as medications; and
- first-level services for certain conditions (such as maternity, family planning and sexual health services, and dentistry) or those using particular therapies (such as physiotherapy, chiropractic and osteopathy services, traditional healers and alternative healers).

Arguably, within the Strategy, the focus on a population health (as opposed to patient health) paradigm of primary health care was predominant as the organising principle for the Strategy, something which made great sense in the context of the problems the Strategy was seeking to address. Indeed, over time, the term 'population health' has consistently been used within health policy and management to describe the desired focus of the health sector when seeking to implement the Strategy. The desire for population health to guide Strategy implementation was set out as follows:

‘The vision involves a new direction for primary health care with a greater emphasis on population health and the role of 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.’  
(King, 2001, pvii)

In this way, the Strategy was clearly intended as a framework within which to implement the government's wider aims related to health, including a desire to reduce inequalities, improve access to primary health care services within the spirit of Starfield's definition, and foster greater community participation in health.

When analysing implementation of the Strategy, it is asserted in this paper that the Starfield vision of ensuring strong and comprehensive primary care services based on the principle of people receiving continuous, co-ordinated and comprehensive first-contact care did not always receive the attention that was intended. This assertion is made not on the basis of how funding was allocated (for the majority of new primary health care funding has gone towards reducing the cost of access to first-contact care) but rather in relation to *how* the Strategy has been implemented (e.g. the ways in which it has been able to engage and influence general practice and other providers, or not), and where the most impact appears to have been made (e.g. in reducing the cost of access to services, but not being able to lever significant change in models of care), as will be explored in the section on Strategy implementation below.

## **Primary health care provision in New Zealand**

Before examining the implementation of the Strategy, it is important to take stock of where New Zealand sits in relation to international comparisons of primary health care services, and also to examine what it was that policy makers were seeking to address when they developed the Strategy in 1999-2000.

In relation to the first point about international comparisons, New Zealand's primary care services measure up well, for example within surveys of general practice services carried out by the Commonwealth Fund. In a recent report (Schoen et al, 2007) of adults' experiences of health care in seven countries (Australia, Canada, Germany, the Netherlands, New Zealand, the United Kingdom and the United States) the following observations were made about New Zealand's primary care system:

- public views of primary care have grown steadily more positive in the last decade;
- cost-related access rates, although still a key issue by international comparisons, have improved since 2004;
- access to doctors by telephone during practice hours, and by email, is an area where New Zealand scores highly in comparative terms;
- New Zealanders are among the most likely to receive same-day appointments and likewise report easy access to after-hours services;
- they are most likely to feel that their doctor tells them about treatment options and involves them in decisions about their care; and
- New Zealand rates highly in relation to the doctor or someone in the practice co-ordinating care from other places.

The findings from this study suggest that, for New Zealanders who are able to afford it and otherwise feel able to access it, the experience of primary care is largely positive, with timely access to in- and out-of-hours services, longer consultation times than in other countries, and a sense of involvement in care decisions being key positive factors. This last point is summarised by the authors of the paper as follows:

‘The strongly positive experiences reported by Australian and New Zealand adults indicate that having more time to spend with patients makes a difference’ (Schoen et al, 2007 p733).

The study suggests that in relation to Starfield's analysis of what makes for strong primary health care, New Zealand scores well in relation to person-focused care over time (with people reporting a 'medical home', a practice to which they feel they belong), and relatively well for co-ordinating care. Concern remains about cost being a barrier to access to care for some people, and as with all the countries in the study, the overall challenge is:

‘how to integrate care in an era of specialization and shortages of family care physicians. Achieving better care co-ordination will likely require designs

that include a mix of formally integrated organizations, co-locating or sharing services, and connecting through information systems. Aging populations and medical science advances will likely require workforce as well as system innovations to improve health and meet population needs.’ (Schoen et al, 2007, p733)

In relation to the second point of this section about the problems that the Strategy was seeking to address in 1999-2000, these were concerned with the relatively high cost of access to first-contact general practice services in New Zealand (namely the level of patient co-payments), the evident inequalities in access to primary health care experienced by specific disadvantaged population groups, and the fragmented nature of the primary health care provider system. In other words, whilst New Zealand primary health care has tended to measure up well in international comparisons in relation to the quality of service, in 1999-2000, this was only the case for those who felt able (for financial or other reasons) to access the service.

In a paper in 1999 commissioned as part of the process of developing ideas for the Strategy, Malcolm et al set out what they considered to be the issues facing primary health care:

- its peripheral and fragmented role in contrast to the well-organised power and status of the hospital;
- uncertain and often confrontational relationship with government;
- a lack of clear identity and consensus on how it might best be organised;
- major inequities in the distribution of primary medical care and related services, reflecting the ‘inverse care law’ (Tudor-Hart, 1971) that those most of need in care are those least likely to receive it;
- significant financial and other barriers to access; and
- uncontrolled growth, with demand-driven funding.

Malcolm et al’s 1999 analysis reveals the extent to which there were concerns about primary health care both in relation to its function as a provider of first-contact services (after Starfield, 1998), and more broadly in respect of the population’s access to care and primary health care’s place in the wider health system (after Alma Ata, 1978).

Gribben and Coster (1999), in a paper commissioned by the National Health Committee as part of a series to examine evidence of benefit of population-based approaches to primary health care, made a pressing case for the need for investment in primary health care services in New Zealand, citing the country’s position within the OECD in spending the highest proportion on hospital (as opposed to primary health care) services, and also in having relatively poor health outcomes:

‘New Zealand’s health status statistics do it little credit. Where we once led the world in life expectancy and infant mortality we are now near the bottom

of the league tables. Our immunization rates are so low that we now bear the dubious distinction of being an exporter of infectious diseases.’ (Gribben and Coster, 1999, p118)

Gribben and Coster went on to assert (p118-119) that:

‘when one considers that our most pressing health problems are best tackled by primary health care or public health strategies (for example, by reducing smoking, improving nutrition, increasing our immunization rates and preventing rheumatic fever) the argument for transferring resources to primary care and public health becomes compelling.’

It is clear that in 1999-2000, New Zealand primary care was in need of investment and reform. In relation to both first-contact care in general practice where reform was needed to enable better and lower cost access, and broader public health areas such as reducing health inequalities, improving immunisation rates, and enabling more effective disease prevention, primary health care was considered to be the part of the health system needing urgent and far-reaching attention.

In the next section of this paper, an examination is made of how far the implementation of the Primary Health Care Strategy has enabled the concerns identified in 1999-2000 to be addressed.

### **The implementation of the Primary Health Care Strategy**

The Primary Health Care Strategy was, by its own admission, intended as a ‘new vision for primary health care’, rather than a detailed implementation plan for the health sector. This fact was acknowledged as follows:

‘It [the PHCS] 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.’ (King, 2001, p.ix)

This setting out of a broad vision for primary health care, and explicit acknowledgement of a desire to hold back from prescribing details of implementation, are important signals of what emerged as a permissive policy implementation context, one that focused on approaches such as setting out ‘key directions’ and ‘minimum requirements’, rather than specific instructions about exactly what was to be implemented where, when and how.

In the Strategy itself (King, 2001, p27), mechanisms for implementation were identified as follows:

- funding agreements and accountability documents for district health board performance;

- Ministry of Health toolkits and policy guidelines for district health board contracting with providers, including the development of plans for primary health care;
- training and communication about best practice; and
- the development by providers and their organisations of relationships with their communities and district health board.

It is of note that the setting out of the overall approach emphasised the importance of involvement and collaboration with the primary health care sector, for arguably, the issue of involvement and engagement of some key parts of primary health care provision (most notably general practitioners) has been one of the areas of failure of the Strategy's implementation. This issue is returned to later in this paper.

First of all, however, an examination is made of the specific aims of the Strategy and the extent to which these were achieved over the period 2001-2008. These 'aims' cannot be considered as objectives, for they were not set out in a specific and measurable form in 2001, reflecting the aspirational and evolutionary nature of how the Strategy was taken forward.

The six 'key directions for achieving the vision and new arrangements' in the Strategy were as follows:

- 1) work with local communities and enrolled populations;
- 2) identify and remove health inequalities;
- 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; and
- 6) continuously improve quality using good information.

For each key direction, a number of actions were identified, some for achievement by primary health organisations (PHOs) and district health boards (DHBs), others by providers, and some by the Ministry of Health. The key directions and associated actions were revisited and assessed by the Ministry of Health in 2005-2006 within a Primary Health Care Strategy Implementation Project. This project resulted in a Primary Health Care Strategy Implementation Work Programme for the period 2006-2010 that set out (Ministry of Health, 2006):

- new oversight arrangements for a 'new way of working' for the Ministry of Health and DHBs with regards to the implementation of the Strategy;
- a view of where primary health care needed to be in 2010 in order to deliver on the vision of the Strategy; and

- a work programme setting out what needed to be done to deliver on the goals of the Strategy by 2010.

In preparing the analysis set out in this paper, the original directions and actions set out in the Strategy were reviewed, along with the review made by the Ministry of Health during the 2006 implementation project, evidence from evaluation studies and academic commentary, and taking into account the views expressed in recent discussions with thirty primary health care stakeholders. The analysis is organised within the six key directions of the Strategy, and then summarised into an overall review of implementation to date.

### **1) Work with local communities and enrolled populations**

Eighty primary health organisations (PHOs) are in place across New Zealand, and all of them appear to involve local communities within their governing processes. The extent to which PHOs have been comfortable with developing community participation is reported to vary (Neuwelt et al, 2005; Hefford et al, 2005) and how far community members have influence on PHO decisions and direction also appears to differ across PHOs (Barnett et al, forthcoming).

The development of registration within the primary health care system was considered a fundamental requirement if the issues facing New Zealand primary health care in 1999-2000 were to be addressed (Gribben and Coster, 1999; Cumming and Mays, 1999; Crampton and Cumming, 1999). For example, the public health actions required in relation to screening and immunisation called for accurate and extensive population registers to be put in place. In 2008, almost all the New Zealand population was enrolled with a PHO, meaning that registration now forms a cornerstone of the primary health care system. It should however be noted that PHO registers have yet to be used to their full extent in relation to public health interventions and that there have been other initiatives, such as the development of a national immunisation register, that have enabled parallel progress in this area.

It is argued by most commentators that people consider themselves first and foremost to be registered with a primary health care provider (usually a general practice), and that public awareness of the role and functions of PHOs is low. This is of significance because the Strategy asserted that people should be able to choose their PHO on the basis of the services it offered for them. Evidence from recent research does however suggest that people are gaining awareness of PHOs, and to some extent, their functions (Phoenix Research, 2008). What is less clear is how far PHOs are regarded as visible and significant local organisations that are able to 'place-shape' and hence be regarded as important local institutions that assure and protect health (Glasby, 2006; Lyons, 2006). Likewise, there is uncertainty as to whether people experience the degree of information about PHOs and local services that was envisaged in the Strategy as follows:

'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' (King, 2001, p9).

People retain their right to change practice or provider at any time and without having to give an explanation. What is much less clear is how far people have any sense of choice of PHO (or of having been given any choice about this in the first place), or indeed of what a PHO might be able to offer them by way of services, information, community involvement and so forth.

From research carried out as part of the five-year national evaluation of the Strategy, it is clear that PHOs regard the requirement to involve and work with communities as fundamental to their purpose, and that they have put in place a range of mechanisms in order to facilitate this (Cumming et al, 2005; Barnett et al, forthcoming). PHOs similarly report a strong sense of responsibility for an enrolled population and for seeking to improve the health of that population and reduce inequalities that may exist in relation to the health status of different groups within the population. What is less clear is how far PHOs are actually able to use the register of enrolled people to implement strategies for health improvement at provider and practice level.

Arguably, PHOs should relate to a distinct geographical locality in order to enable effective locality planning and funding of services for a particular population. However, to move to such an approach (which does in fact exist in some areas of New Zealand where PHOs are geographically defined and do not have overlapping membership) would remove the potential for people to exercise choice of PHO. This again begs the question of how far people identify with a PHO, rather than with a particular practice or provider. This issue of a need to clarify what a PHO is and does is returned to later in the paper.

The key conclusions related to progress with this first Strategy direction about local communities and enrolled populations are:

Population registration is now in place, providing the foundation for activity focused on public health interventions such as immunisation and screening.

Primary health organisations (PHOs) are in place across New Zealand and almost all of the population is registered with a PHO.

The extent to which the population is aware of PHO functions and services is open to question, and it appears that people continue to relate first and foremost to a particular practice or provider.

PHOs have involved communities in their governance arrangements, although the extent of such influence appears variable.

PHOs are clear about their responsibility to work with communities and the enrolled population in order to try and improve health.

The extent to which PHOs have the levers to bring about change for communities and the enrolled population remains in some doubt.

## **2) Identify and remove health inequalities**

PHOs appear to be very attuned to the assessment of local health needs, and the requirement to address health inequalities (Cumming et al, 2005; Smith and Mays,

2007; Barnett et al, forthcoming). A striking feature of the New Zealand health system is the widespread awareness among managers, clinicians and board members of health inequalities, the social injustice associated with these, and the legislative mandate on district health boards to seek to address these (Chambers, 2008). However, in the Ministry of Health's assessment of progress with Strategy implementation in 2005-2006, the authors noted (Ministry of Health, 2006, p12) that even for 2010 'it will be too early to see the gap in life expectancy narrowing' and suggested a range of proxy measures such as statin utilisation and HBA1c levels that, if examined by high needs populations, would demonstrate the degree to which health inequalities were being addressed.

Recent analysis of indicators of health status suggests that inequalities in health are being addressed in New Zealand, and in particular some of those indicators that were of particular concern to commentators in 1999-2000. For example, infant mortality is dropping for both the Maori and total population – the Maori rate dropped from 11.5 per 1000 live births in 1996 to 6.6 per 1000 in 2005 (43%), while the total rate declined 28% in the same period (Ministry of Health, 2008). In relation to life expectancy, this has risen by 3.5 years for males and 2.2 for females over the period 1998 to 2007 (Ministry of Health, 2008). What is not known however, is how far any of this can be related to the Primary Health Care Strategy and its implementation.

In the most recent report from the evaluation of the Primary Health Care Strategy (Cumming and Gribben, 2007) it is noted that reductions in fees for first-contact general practice services are benefitting Maori and Pacific peoples more than other ethnic groups. Fees for these groups have probably fallen more quickly as a result of new funding for first-contact care being allocated initially to high-needs ('access') practices ahead of other ('interim') practices. When utilisation of general practice services is examined however, increases in usage appear to be similar across ethnic groups with no apparent additional benefit for Maori and Pacific people (Cumming and Gribben, 2007).

Childhood immunisation levels were an area of particular concern when the Strategy was first developed (Gribben and Coster, 1999). The Table 1 below illustrates the progress that has been made in this respect over the past decade, particularly in relation to the change in levels achieved for Maori and Pacific children.

*Table 1: Percentage of children fully immunised at age 2 years in New Zealand, 1991-2005 (source: Ministry of Health)*

	1991/92 National Survey	1996 North Survey	Health	2005 National Survey
European	-	72.3		80.1
Maori	42	44.6		69
Pacific	45	53.1		80.7
Overall	<60	63.1		77.4

As noted earlier, there is evidence at a macro level to suggest that inequalities in health may have stopped increasing or even started to have decline, probably as a result of economic expansion and wider social policy reforms (Blakely et al, 2007). A

major longitudinal study of ethnic and socioeconomic trends in mortality from the University of Otago reported in 2007 drew the following conclusions:

‘from 1996-99 to 2001-04, for both ethnic and income groups, relative inequality appears to have largely stabilised and absolute inequality may have begun to decline. The possible convergence of mortality rates represents a turnaround from the previous trend’ (Blakely et al, 2007, pxix).

The researchers pointed out that it was not possible to quantify the contribution of specific social, economic, public health and health services policies (including the PHCS) to ‘this apparent change in trajectory of health inequalities’, and underlined the importance of continuing tracking of trends in mortality, along with research targeted at trying to understand reasons for any changes in mortality.

The Blakely et al research suggests that PHOs and DHBs have been seeking to improve health within a supportive socio-economic context, even if it is not possible to assert with any certainty that their health planning and funding efforts have as yet had a direct effect on health outcomes.

This highlights a need for detailed analysis of health status and outcomes at a local, as well as national, level. New Zealand is rich in epidemiological data, and the acid test for DHBs and PHOs will be how effectively they are able to use such data in their health planning, funding and monitoring work, and hence demonstrate local progress with this particular goal of the Primary Health Care Strategy.

The key conclusions related to progress with this second Strategy direction related to inequalities are:

The identification of health inequalities is a key focus for PHOs and DHBs, and this issue is regarded by the health system as a core national health priority.

There is evidence of stabilisation or improvement in health inequalities in New Zealand over the past decade, including in relation to infant mortality and life expectancy.

There is evidence of improvement in rates of immunisation (an indicator that was a key concern prior to the Primary Health Care Strategy), and in a reduction in inequalities associated with ethnicity in this regard.

It is too early to say whether the Strategy itself, including the activities of PHOs, has contributed directly to what appears to be a slowing in the rate of increase of health inequalities in New Zealand.

Local and national studies of health status, and where possible, of the connection between specific health policy and management interventions and health outcomes, will be critical to demonstrating progress with this area of Strategy implementation.

### **3) Offer access to comprehensive services to improve, maintain and restore people's health**

This key direction in the Strategy draws on Starfield's view of effective primary health care in calling for improved access to a comprehensive range of health services that are concerned with health improvement. It implicitly suggests that PHOs will use their role as local enrolment organisations to develop an improved range of local services that are tailored to the health needs of that local population. It seeks to address two of the issues that Malcolm et al identified in their critique of New Zealand primary health care in 1999: the existence of significant barriers to access to primary health care for some people; and inequity in the distribution and availability of primary medical care and related services.

#### *Specifying the range of primary health care services*

A crucial question to be posed in relation to the issue of enabling access to a comprehensive range of services is: has work been done to determine what such a range of services might look like, and what organisational models should be used in order to deliver the services? A frequent anecdotal criticism of Strategy implementation, and one that was made in a number of interviews for this paper, is that the standard New Zealand experience of general practice (a 15-minute consultation with a GP) has not largely changed since 2001.

This begs four questions: firstly, if New Zealand general practice fares well in international comparisons as was noted earlier, to what extent is that a problem? It may not be the length of the consultation that is the main issue, but rather the extent to which consultations are used in relation to preventive as well as reactive care. Secondly, it calls for detailed work to establish what different models of primary health care, including developments of the 'standard general practice' should (or already in some cases do) look like, and which models might be appropriate to certain people or populations. Thirdly, it raises the issue of how far a capitation funding approach is being used to shift the paradigm of primary health care towards a more preventative and population focus. Fourthly, how can PHOs carry out effective health service planning and development for a locality when they do not necessarily have a clear geographical remit, and where practices can change PHO if unhappy about a PHO seeking to exert a greater influence on its providers?

What appears to have been missing from Strategy implementation was detailed work with 'mainstream providers' to explore how they wanted to develop (or were already developing) new approaches to service delivery and health promotion. In other words, there does not seem to have been a concerted attempt to specify what the government was looking for in terms of primary health care provision in return for significant new investment of public funds, nor to engage professionals in such a process of service specification and design. Furthermore, there was little attempt to address *how* new patterns of care might be brought into being.

The desired characteristics of a PHO (strong community governance, not-for-profit status, focus on population health) and the manner in which funding was rolled out (universal application of capitation funding via PHOs) implicitly signalled a move towards a government-funded primary health care system, and one that would be community-governed in the spirit of the Alma Ata declaration (WHO, 1978). There does not however appear to have been a forum (or thirst) for a national debate about

how to strengthen and extend general practice within the framework of the Strategy, nor any attempt to analyse the incentives within the general practice system. Instead, government pressed on with roll-outs of funding intended to reduce co-payments in general practice and, via capitation funding, hoped there would be a shift towards a more multidisciplinary and preventative model of care delivery.

#### *Clarifying the role of a PHO*

From a reading of the list of actions in the Strategy about enabling access to comprehensive services, it is not clear what was intended as the role of a PHO. The DHB is identified as being expected to fund 'essential' primary health care services 'whether through Primary Health Organisations or by alternative arrangements'. PHOs are signalled as 'not-for-profit entities [that] will be able to contract for services from private, for-profit providers' and as organisations that 'will be encouraged to develop innovative ways of providing services that people can afford' (King, 2001, p17). This suggests that DHBs were to be the statutory funder of core primary health care services for a population, with some of that funding going to PHOs who would in turn contract with providers (and by implication practices) whilst the rest of the funding would go direct to other providers.

This lack of clarity about the functions of PHOs, and overlap with those of DHBs, recurs as a theme in evaluation studies (e.g. Cumming et al, 2005; Croxson et al, 2009; Gauld, 2008) and in interviews carried out for this paper. Given the ambiguity about the PHO role in the original Strategy, it is not surprising that PHOs have evolved into a diverse set of organisations that vary considerably in relation to size, function, position in the local health system, and apparent extent of influence over the provision of primary health care services. This ambiguity, whilst on the one hand a means of enabling flexible development of PHOs appropriate to local needs, history and relationships, could on the other be an explanation for why Strategy implementation was focused on setting up organisational infrastructure and rolling out new funding, and much less on the development of new models of care at practice level. This could be because it proved easier to set up PHOs and roll out new funding, rather than engaging in more sophisticated Strategy implementation through processes of purchasing and contracting that could have enabled greater change in service provision in return for new investment.

#### *Reducing the cost of access to first-contact care*

The allocation of new funding, and in particular the reduction in cost of access to first-contact services has arguably been the area of Strategy implementation where most progress has been made. The cost of access to general practice has (for the time being – its sustainability is questionable) reduced (Cumming et al, 2005; Cumming and Gribben, 2007), and fewer people now report that cost has prohibited them from seeking medical attention (Schoen et al, 2007; New Zealand Health Survey 2006/07). Utilisation of primary health care services has increased over the same period and for almost all population groups (Cumming and Gribben, 2007).

It should however be noted that given the universal approach to the allocation of new resource for reducing the cost of access to primary health care (albeit that new resources went to high needs populations ahead of others), it is not surprising that some of the largest financial gains in relation to reduced general practice fees have accrued to people not regarded as having high needs, something that potentially runs

counter to the high level aim of the Strategy in relation to reducing inequalities. This reflects a policy that was universal rather than targeted in its approach to implementation.

It should be noted however that over a quarter of the New Zealand population is now enrolled in primary care services that guarantee 'very low cost access' to primary care. These practices have, in effect, accepted a cap on the co-payment they charge patients, in return for additional capitation funding. Whether \$15.50 is 'very low cost' for people in high needs populations is debatable, although clearly in many cases much lower than has traditionally been the case. A further challenge for the next phase of Strategy implementation is to determine how to maintain lower fee levels, and along with this, to debate what an 'ideal' fee might look like, and to continue to address what inhibits some people from accessing general practice services.

*Using capitation funding to shift the model of care*

In 1999, in a paper examining the potential impact of shifting to capitation funding in primary care in New Zealand, Cumming and Mays highlighted the risks of assuming automatic benefits from such a move. They asserted that without putting in place other changes such as stronger contracts with practices, and incentives to avoid cost-shifting by referral to secondary care, benefits were likely to be limited. They suggested that other things being equal, a shift to using capitation for the allocation of government funding would enable a more population-based approach to care, and an improvement in the distribution of resources towards higher needs PHOs. As noted earlier, a population health focus to health planning and funding has permeated the New Zealand health system, thus confirming Cumming and Mays' prediction.

How far the allocation of primary care funding now better reflects need is open to question. Whereas subsidies of general practice fees were targeted to high needs people prior to 2001 (or at least to those who made visits to practices), this is now made available to all population groups (via a capitation payment to the practice or provider for all those people registered with the practice/PHO), and evaluation shows that higher income groups have experienced the most significant decreases in fees (Cumming and Gribben, 2007).

Probably the most important factor to note when examining how far capitation funding has enabled a change in the focus of general practice away from 'see and treat' towards a more preventative approach, is the continuing existence of patient co-payments. Gribben and Coster warned in 1999:

'In theory, capitation reduces incentives to over-service that fee-for-service funding encourages, and encourages preventative health care and health promotion. The extent to which this outcome is financially encouraged depends on the level of patient co-payment. If providers derive significant income from co-payments, the benefit of capitation is lost. Co-payments should be as low as possible, and preferably zero.' (Gribben and Coster, 1999, p125).

As will be seen from the analysis set out below, the extent to which service models and approach have changed at provider level is open to question. This is due in part to the incomplete contracting process that accompanies the allocation of the majority

of new money put into primary care since 2001 (Croxson et al, 2009). Croxson et al's analysis asserts that despite the existence of a contract between DHBs and PHOs for the allocation of capitation funding, it remains unclear as to whether funding is being passed to practices and practitioners in the form of capitation, and how far providers feel obliged to change their approach to care in line with what is intended by a capitation funding system. They argue that as well as contracts being incomplete, there is a lack of incentives that actually impact on decision makers (GPs).

This incomplete process of contracting, together with the continuing existence of co-payments, has meant that there have been few levers available to PHOs, or the health system more generally, to incentivise or monitor change within primary care provision. A performance programme for PHOs was introduced in 2006, but the fact that this has a limited range of indicators, is applied to PHOs and yet relies on practice activity and performance, and (as noted later in this paper) has appeared to lack support from leaders of general practice, means that the programme has yet to report a significant impact in relation developing primary care service delivery.

The warnings sounded by academics in 1999 about the need for integrated policy and economic incentives when seeking to bring about change in general practice (on the basis of international research evidence about the incentive effects of capitation, fee-for-service, and patient co-payment funding) appear to have been borne out in the implementation of the PHCS in New Zealand.

#### *Innovations in service delivery in primary health care*

There have however been many innovations in primary health care service delivery resulting from the implementation of the Strategy and the emergence of PHOs. Some of these are documented in publications such as Cumming et al, 2005; Ministry of Health, 2005; CBG Research, 2006; Primary Health Care Nurse Innovation Evaluation Team, 2007, DHB and PHO annual reports, and have been showcased at conferences such as the Primary Health Care Focus events in 2002 and 2005.

What is less clear is how far such innovations have been evaluated in a systematic manner, or what attempts have been made to disseminate these across local, regional and national levels of the health system. In a recent commentary on the New Zealand health system, Lomas (2008) noted that innovation abounds, yet lacks focus, with little co-ordinated evaluation capacity. He also called for more extensive application of change management principles at a local level, viewing this as critical to effective implementation of innovations.

It is clear that PHOs have been able to bring about change to the range of local primary health care provision, albeit that questions remain as to how extensive this has been, especially in relation to changing what happens within providers funded by the PHO, as opposed to services developed directly by PHOs.

Firstly, it is striking how far PHOs have enabled the promulgation of a philosophy of primary health as an approach to developing population health (namely in the Alma Ata tradition). Many of their reported achievements are firmly located within what might be termed the health promotion and population health paradigm, enabling the provision of services not traditionally associated with primary medical care. This

focus is likely to be encouraged by both the national direction set by the Strategy, and by having community involvement at PHO board level.

Secondly, PHOs have played a key role in developing services that seek to connect up different parts of the primary health care system, and also link in with wider inter-sectoral provision. How far such services are well-integrated into practices and other community providers, and hence result in joined-up care for individual consumers remains open to question, and this is explored in the section on service co-ordination below.

#### *Clinical involvement in PHOs*

Whilst PHO membership was in theory voluntary for GPs and practices, in reality, if they wanted to access government funding for first-contact care, they had to join a PHO. This meant that for some practices and their organised networks (e.g independent practitioner associations [IPAs]), PHO development and membership was entered into as a pragmatic and somewhat reluctant response to a set of policy mechanisms, and not an enthusiastic decision to form new organisations for the development of local services. Indeed, in many cases, the IPAs joining or becoming PHOs believed that they were already successful developers of primary care, and resented the need to adapt their organisational form to the new institutional arrangements put in place by government.

An ‘elephant in the room’ in relation to Strategy implementation has been the fraught and conflicted relationship between the government and general practice, this being particularly played out through the ‘fees issue’, the process of rolling out new funding to PHOs and providers. The ‘fees issue’ has been described in recent academic analysis (Crosson et al, 2009) as having been a ‘metaphor for so much else in the New Zealand primary health care system’. The authors of this analysis assert that in the absence of clearer and more complete contractual arrangements between government and general practice, and given an apparent failure to engage general practice in Strategy implementation, frustration got enacted through the process of negotiating detail of how to roll out new money for primary health care. The ‘fees issue’ thus became a metaphor for a fear of control by the state and a desire for professional autonomy (on the part of GPs) and for a desire for increased patient access and lower fees (on the part of government).

Despite these significant tensions between general practice and the government in relation to Strategy implementation, it is evident that in many PHOs, effective clinical engagement and leadership at the local level is enabling service change and development, and many examples were quoted in interviews carried out for this paper. What is not so clear is how far such initiatives are widespread across the country. It would be interesting to explore whether PHOs that have been able to work constructively with IPAs having a history of effective clinical engagement, thus incorporating this clinical engagement with a more population health-focused approach, have been more able to bring about changes to services at provider level than some of the PHOs that were created specifically as part of Strategy implementation. Furthermore, given the often tense and conflicted relationship between the government and general practice during implementation of the Strategy, it is likely that this lack of partnership working at a national level has sometimes affected clinical-managerial relationships at a local level within PHOs.

Within some PHOs, it is sometimes suggested that managers and boards find it easier to focus on service development that is concerned with health promotion and other activities at PHO (rather than provider) level, preferring to enact this type of work than having to tackle practices about their approach to service delivery. Indeed, this begs the question as to how far PHOs regard themselves as having a role in clinical, as well as community, governance of primary health care locally. Evaluation evidence points to a mix of interpretations about the PHO role in clinical governance and service provision, with some PHO board and managers seeing as a core function, and others seeing it as something outside their remit (Barnett et al, forthcoming; Smith and Cumming, forthcoming). This again underlines the extent to which the ambiguity in PHO role has led to divergent interpretation of PHO functions at a local level.

The key conclusions related to progress with this third Strategy direction related to comprehensive primary health care services are:

There has not been sufficient attention paid to specifying, with the different professions and providers, what different models of comprehensive primary health care services might look like and how they might be realised.

The Primary Health Care Strategy was ambiguous in relation to the role and functions of PHOs and that ambiguity continues to compromise PHOs' ability to assume a strong role in leading change within local health systems.

Reducing the cost of access to first-contact care has been a key area of success within Strategy implementation – the challenge is how to sustain that progress and continue to address inequalities in access.

The use of capitation as the basis for allocation of government funding for primary health care has helped to embed a population approach to local planning and funding.

The continuation of significant patient co-payments alongside capitation funding, together with partial contracting between the government and general practice, means that the potential gains of capitation in respect of a different model of service have gone largely unrealised.

There have been many innovations in service provision, but they have not been evaluated and disseminated in a systematic manner.

The relationship between the government and general practice has often been fraught and conflicted during the period of Strategy implementation.

Clinical involvement in PHOs varies significantly and has sometimes been hampered by a tense national relationship between the government and general practice.

There is variability in the extent to which PHOs consider themselves to have a role in clinical, as well as community, governance of local primary health care services.

#### **4) Co-ordinate care across service areas**

This key direction, like the previous one related to comprehensive primary care services, draws directly on Starfield's definition of what constitutes effective primary health care. In its interpretation within the Primary Health Care Strategy, co-ordination encompassed multi-sectoral action across different areas of health and social welfare provision, multidisciplinary team-working within primary care, the development of better integration between primary and secondary care, co-ordination between primary care and public health services, partnership working across health, mental health and disability sectors, and appropriate co-ordination for specific population groups. This key direction is thus far-reaching, complex, and extremely ambitious, placing very significant expectations upon PHOs, practices and other providers.

It is not therefore surprising that in evaluation and commentary upon Strategy implementation, co-ordination and team-working are often mentioned as areas of relative lack of progress, along with concern about lack of leverage of change in service models at provider level. In a report of the evaluation of the Strategy (Cumming et al, 2005), the issue of co-ordination did not emerge as a theme in its own right. However, within commentary on practice level changes, the importance of finding ways of effecting change within all practices (whether high needs or not) was highlighted as critical to the achievement of wider Strategy goals related to teamwork and co-ordination:

‘It is at the practice level that the development of a team approach, with an expansion of the categories included in the team, takes effect. Similarly, advocacy for individual patients, either with secondary health services or with other agencies, originates with the discovery of need during a consultation. And the consultation is the starting point for individual approaches to prevention and lifestyle change. Furthermore, such need exists among the patients of all practices and the Strategy implies that it should be met at whatever practice people choose to attend’. (Cumming et al, 2005, p31)

This confirms the importance for PHOs of finding levers and incentives to bring about change at practice level, particularly in relation to the co-ordination of care for patients with complex needs, such as where people have a number of long-term conditions and hence need care from a range of agencies within and beyond the public health system. Of particular note in the New Zealand health system is the need to explore the role of co-payments for general practice care and how they impact on the potential to deliver integrated care for individuals across a wide range of providers operating within different business models.

PHOs are using new sources of funding such as Care Plus and Services to Improve Access in order to develop a wider range of primary health care provision, and to try and better co-ordinate care for specific patient and population groups. Evidence from evaluation of Care Plus (Gribben, 2007) and of the Strategy overall (Cumming and Gribben, 2007; Primary Health Care Nurse Innovation Evaluation Team, 2007) points to an increase in the number of nurse consultations within primary health care, and of the emergence of different models of care that seek to better co-ordinate services for people with complex needs. PHOs are also establishing much stronger inter-sectoral links, and examples abound of initiatives to improve health that have been funded by

PHOs in partnership with territorial authorities, non-governmental organisations (NGOs), Work and Income New Zealand (WINZ) and others.

What is not clear however is the extent to which the largest element of new funding for primary health care, that for first-contact care, is being used in order to develop more effective co-ordination in key areas of need in the New Zealand health system, namely after-hours primary health care, long-term conditions management, and at the interface between primary and secondary care.

Data collected in the 2006/07 New Zealand Health Survey (Ministry of Health, 2008) confirm the fact that a majority of the population have a recognised single care-giver within primary care and that they are usually able to consult the same person. Ninety per cent reported not having changed primary care provider in the past year and 80% reported seeing the same GP each time they visited the practice, although the issue of how far that care-giver co-ordinates care was not explored in any depth beyond the issue of follow-up discussions after a visit to a medical specialist (these being experienced in 40% of cases where a person had been to see a medical specialist recently). Commonwealth Fund survey research findings (Schoen et al, 2007) likewise underlined the importance to New Zealanders of a 'medical home' that can co-ordinate care, and, as noted earlier in this paper, New Zealand rates relatively highly in terms of the doctor knowing the patient's history and being available to co-ordinate care.

Critique of the Primary Health Care Strategy often centres (as does this paper to some extent) on the need for more change at practice level in order to bring about more multidisciplinary working and better care co-ordination. What an examination of international comparative data on the performance of New Zealand primary care (as measured in public satisfaction surveys) provides is a caution about not throwing the baby out with the bathwater when asserting a need for extensive change and new models of care. New Zealand primary health care measures up well by international standards (with the exception of enabling access to all population groups), and, as in Starfield's analysis, the connection of an individual with 'their' GP or nurse represents an effective means of care co-ordination and sense of belonging for a patient struggling to find their way through a complex web of services.

It appears therefore that when seeking to bring about stronger co-ordination within the New Zealand primary health care system, there is a need to take account of both the Alma Ata *and* Starfield perspectives on primary health care. Firstly, there is a need to ensure that all groups within the population have good access to primary care at practice level, and that there is a strong connection between an individual and a known care-giver, be that a GP, nurse or community health worker. Secondly, that known care-giver needs to have strong support from the local health system (practice, PHO, NGO, DHB community health staff, etc.) in having access to a wide range of other diagnostic, allied health care, public health and welfare services, supported by information and other management infrastructure. Only with this rooting of an individual with a practice or other provider (in a 'medical [or primary health] home') can an Alma Ata vision of strong primary care as the fulcrum of a community health system be realisable in New Zealand.

In short, it is perhaps at times fashionable in New Zealand to point a finger at general practice and accuse it of not having adapted to 'the Strategy approach to care'. But perhaps this misses the point. Strong and effective person-centred general practice is critical to the type of primary health care envisaged in the Strategy, or at least it is in a country that has a primary care system built on a model of professional general practice. The challenge for New Zealand is how to use the existing funding and business models to further strengthen primary health care, enable it to access and co-ordinate a wider range of community-based services, and crucially, in a way that enables all the population to feel able and willing to benefit from such care and co-ordination, and not just those who are able to pay for it. Put another way, it will be important to make sure that whilst striving to enable access to primary health care for those currently unable or unwilling to access it (e.g. because of inability to pay, or their transient lifestyle, or some other reason such as cultural alienation or mistrust of professionals), the quality of primary health care provision currently enjoyed by many New Zealanders is not compromised.

The key conclusions related to progress with this fourth Strategy direction about co-ordination are:

The Strategy set out a far-reaching and ambitious set of aspirations related to the co-ordination of health services within and from primary care.

Analysis and commentary on Strategy implementation often cites care co-ordination as an area needing more attention in the next phase, with criticism tending to focus on general practice not having changed its model of care.

PHOs have however used the new funding available to them to extend services aimed at better care co-ordination, for example for people with long-term conditions.

PHOs have also made significant progress in developing joint health programmes and initiatives with inter-sectoral partners.

International evidence on effective primary health care suggests that strong general practice that assures a longitudinal and personal connection between patients and their GP or nurse is critical to co-ordination of services within and beyond the health system.

What this entails is a system whereby practices are effectively connected (by IT and other management and professional relationships) to a wider range of local diagnostic, care, welfare and public health services.

In the New Zealand context, the issue of people having to pay for some services (e.g. GP and practice nurse visits) can act as a barrier to the practice performing the role of overall co-ordinator of services, if people hold back from using their practice, or choose to access other (free) services first, such as the emergency department.

This reinforces the need for the next phase of implementation of the Strategy to focus on exploring models of care that seek to better co-ordinate and integrate services for patients, based on strong general practice, yet operating within a broader population health approach.

### **5) Develop the primary health care workforce**

The Primary Health Care Strategy asserted that New Zealand had, in 2001, broadly sufficient GPs and primary care nurses, but that these were not distributed according to need (King, 2001, p22). In 2008, the situation has changed, and Ministry of Health and professional organisations are in agreement about workforce becoming an ever more pressing issue for the health system, as supply of doctors, nurses and other professionals becomes more challenging. As noted in the previous section, stronger care co-ordination and integration will, among other things, require effective and well-supported general practice, and this raises an issue about where the doctors and nurses who will increasingly co-ordinate and deliver care will come from, and how they will be trained and used.

The Strategy identified a need for ‘explicit minimum standards for availability of first-contact services’, in order that DHBs would know what they were expected to achieve. It is unclear whether this work has been carried out, and it may be that the ambiguous nature of the PHO role referred to earlier in this paper was the reason for this not having happened, for it remains unclear as to who the responsible agency is in this regard. The Strategy talked elsewhere about PHOs having a key role in developing a comprehensive range of services locally, but then implied that for workforce planning purposes, DHBs were the accountable agency. DHBs are the clearly accountable statutory body for ensuring access to local health services – what has not been so clear is who is responsible for planning and developing extended and better integrated primary and community health care provision as described in the Strategy.

In a recent report to the Minister of Health about overcoming barriers to change and innovation in primary health care workforce development, the Workforce Taskforce (2008) set out five barriers to primary health care workforce effectiveness:

- the funding model (suggesting that funding needed to be realigned to enable innovation);
- organisational structures (arguing a need for capital investment to enable expansion and training);
- professional leadership (calling for stronger professional leadership and clinical governance);
- training (making a number of recommendations about changes required in professional and management training, including on a multidisciplinary basis); and
- quality improvement (calling for a national framework for quality improvement in primary health care).

The workforce report echoed evaluation studies of Strategy implementation in its analysis of the current position of primary health care in New Zealand, and exposition of the reasons why service development, more effective co-ordination and so forth had yet to be achieved. It does not however explore issues such as how future models of care might look (and hence what workforce may be required), nor does it set out data about the primary health care workforce and how it is comprised, and the pressures it faces. It would appear that an opportunity to describe future primary

health care service models, specify minimum service standards and assess the workforce implications of this may have been missed.

What is clear is that given increasing national concern about the availability of workforce for the health sector, there is a need for clarity about what the primary care sector should be delivering, who should manage that process (DHBs, PHOs, IPAs or others) and what service models and staffing will be required. Around this needs to be wrapped a system of performance management that holds DHBs to account for the meeting of those standards at a local level. Furthermore, consideration will need to be given to how, in turn, DHBs hold PHOs to account for making appropriate changes to the use of primary health care workforce at provider level.

There is evidence in New Zealand of innovation in the development of primary health care workforce, including work to strengthen and extend nursing practice, as witnessed in the DHB-wide approach to nursing development and innovation within Mid-Central DHB. As with other areas explored within this paper, what is not so clear is how such developments are being evaluated in a systematic manner, now what performance management levers are in place to ensure that effective developments are rolled out.

At a time when primary health care is being looked to as a key locus of care delivery and co-ordination within new models of care being designed to meet the future challenges of an ageing population made up of many people living with long-term conditions, the availability of workforce is constrained, and innovations in the use of that workforce appear to be variable nationally. Furthermore, PHOs appear to lack the levers to bring about new models of integrated care within providers (or networks of providers). DHBs arguably have such levers in respect of their own provider arm services, and where they contract with NGO and other providers for primary health care, but this still leaves a question about how changes in the use of workforce can be leveraged within general practice.

The key conclusions related to progress with this fifth Strategy direction on workforce are:

Whereas in 2001 the Strategy asserted that New Zealand had sufficient GPs and practice nurses (although not distributed appropriately), by 2008, there was national consensus about a shortage of health workforce and of a need for more radical approaches to planning and organising services and roles in the future.

Given the known importance of strong first-contact primary care services in enabling effective co-ordination of an individual's care, there is a need for national leadership in respect of specifying what primary health care services should look like, with associated minimum standards.

Without such a specification of minimum standards for primary health care provision, it will be difficult to hold DHBs to account for the availability and standards of primary health care.

There is evidence of innovation in the development of the primary health care workforce in New Zealand, but concerns remain about the evaluation and spread of such innovation and workforce development across DHBs and PHOs.

If new models of integrated primary health care are to be put in place (or where in existence, supported and extended), there is a need for PHOs to have a clearer role in relation to service development, along with appropriate levers and incentives.

The national performance management framework needs to support the development of stronger first-contact primary care that co-ordinates wider health care needs and services.

## **6) Continuously improve quality using good information**

The Primary Health Care Strategy talked about the importance of robust information systems to support implementation, yet held back from being specific as to how the connection would be made between information collection, data analysis, and performance improvement. Indeed, the Strategy acknowledged its evolutionary nature, revealing a degree of discomfort about an approach that might suggest pressure for national standards or consistency of provision:

‘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 final arrangements are effective and acceptable.’  
(King, 2001, p26)

Strategy implementation has built upon New Zealand general practice’s early adoption of information technology (Ministry of Health, 2005) and has, via PHO enrolment, developed a national register of the population as a basis for capitation funding and other public health programmes such as screening and immunisation. In this way, an information platform has been put in place to support the addressing of key concerns that led to the development of the Strategy in the first place.

One of the main areas where information collection is being connected with performance monitoring (and a desire for quality improvement) is through the PHO Performance Management Programme. This programme comprises a set of indicators that are applied to PHOs, and which are linked with a financial payment to the PHO where indicators are achieved. There has been significant debate about the programme and the extent to which professional groups have been involved in its development and governance, along with a call from some quarters for a programme that more explicitly focuses on practice/provider level performance and incentivises that accordingly (e.g. QI4GP, 2007). The programme is currently subject to evaluation, which may lead to further policy recommendations in this regard.

The Ministry of Health has also introduced Ten Health Targets (Minister of Health, 2007) as a framework for performance assessment in the health system, and a majority of these apply to primary health care services. Some commentators assert that there is potential for the Ten Health Targets and the PHO Performance

Management Programme to be developed into a more integrated performance framework for primary health care. In theory, this could be used to underpin a clearer role for PHOs in developing services at provider level, supported by incentives that make sense for providers of different professional and community backgrounds.

In respect of information and performance improvement in primary health care, significant work has been carried out at national level to determine an approach for the future, based on an analysis of case studies in primary care as set out in the Key Directions report (Field and Gandar, 2007). It would seem that for primary health care, the most pressing issue is to develop a clear sense of priorities for the next overall phase of Strategy implementation, accompanied by clarification of the role and functions of the key players (in particular PHOs, DHBs and the Ministry of Health), and the creation of policy settings that enable the negotiation and incentivisation of change at primary health care provider level. Only when this initial work has been done, and an appropriately supportive performance framework been put in place, can information investment and development take place.

As noted earlier, primary care services in New Zealand score well by international comparisons of quality (or at least in relation to patient satisfaction, e.g. Schoen et al, 2007). Many practices and community providers now subject themselves to formal accreditation via programmes such as Cornerstone (Royal New Zealand College of General Practitioners) and Te Wana (Healthcare Aotearoa). Research evidence would support the extension of approaches such as these in support of national primary health care standards, and, where appropriate, linked with financial incentives to enable a degree of 'pay for performance' in addition to capitation and patient co-payments. The question remains however as to the level within the system at which such standards and performance assessment should be applied: practice; primary care network/IPA; PHO; or DHB?

The key conclusions related to progress with this sixth Strategy direction relating to quality improvement and information are:

The Primary Health Care Strategy acknowledged the need for quality improvement in primary health care but held back from advocating a particular national approach.

The development of patient enrolment has provided a crucial information platform for public health and primary health care interventions.

The PHO Performance Management Programme represents an initial attempt to develop national standards for primary health care services, albeit that it focuses on PHOs rather than practices and lacks clarity about how practice/provider level performance is to be assessed and incentivised.

There is potential to use the PHO Performance Management Programme and the Ten Health Targets to develop a more sophisticated approach to the assessment of quality and performance at provider level. This could build on existing professional and community accreditation programmes and standards. What is crucial is that clarity is gained about where in the system performance is actually measured and rewarded (Practice, IPA/primary care network, PHO or DHB).

## **Discussion: challenges for the next phase**

In this section, conclusions are drawn about implementation of the Primary Health Care Strategy. These are then used as the basis for identifying challenges facing the health sector as it takes the Strategy forward, along with an exploration of how existing policy mechanisms could be used, and where additional ones might be required.

### *Overall focus of the Strategy*

The Primary Health Care Strategy was founded on two primary care traditions: one that regards primary health care as an approach to health and community development (Alma Ata); and the other that considers primary health care to be a crucial level within the health system where personal care is delivered by a known care-giver in a continuous, co-ordinated and longitudinal manner (Starfield). During implementation of the Strategy, the former tradition arguably took precedence, sometimes at the expense of the second. This is evident from the primary focus on reducing inequalities in (and the cost of) access to care, whilst apparently struggling to negotiate and develop extended and strengthened models of first-contact primary health care that are more population-focused and fit for meeting the challenges of long-term conditions and workforce pressures within New Zealand.

The focus on reducing health inequalities and on developing a population health approach made complete sense in the context of the fundamental health issues faced by New Zealand in the late 1990s, issues that the Strategy was intended to address. Given the historical development of primary care funding in New Zealand, it was difficult for government to work with general practice to address the issue of patient co-payments and how this would relate to a shift to capitation funding. This appeared to result in the profession being 'worked around', and to the existence of what have been called (Croxon et al, 2009) 'partial contracts' with providers. This all seems to have contributed to the existence of a fraught relationship between government and general practice (one that had been problematic for decades prior to the development of the Strategy), and probably to there being insufficient time and energy left to focus on to how to strengthen, extend and refocus first-contact care.

Furthermore, the lack of an implementation plan for the Strategy clearly contributed to the confusion about role and functions of key organisational actors such as PHOs, and impeded the development of effective mechanisms and incentives to bring about desired change with primary care providers.

### *Achievements of the Strategy*

Key achievements within Strategy implementation include the creation of a national system of population enrolment which provides a platform for public health and other health improvement interventions, and the establishment of 80 primary health organisations that provide a local focus for service development and funding. As mentioned above, the investment of significant new money in reducing the cost of access to first-contact services represents a major achievement, as does the fact that over a quarter of New Zealanders now have access to 'very low cost' services which have a guaranteed maximum fee.

Inequalities in health, a major focus of the Strategy, appear to be stabilising or even reducing (Blakely et al, 2007), and whilst it is impossible to say that this is a direct

result of reforms to primary care, it clearly presents an important and encouraging context within which to take forward the next phase of primary health care development in New Zealand.

At a local level, PHOs and providers have put in place innovative schemes to develop a greater range of preventive and population health-focused services, albeit that evaluation and dissemination of such achievements has been limited and hence detailed assessment of this is not currently possible. What is clear however is that the Strategy has become embedded in the health system, along with a strong sense of the importance of primary care and the need for a population health approach to planning and funding.

### *Challenges remaining*

On the other side of the balance sheet, much more remains to be done in relation to strengthening and extending first-contact primary health care services, enabling them to meet the challenges of an ageing population, a rise in the levels of chronic disease, and ever scarcer workforce supply. There is a need for policy makers to work closely with primary health care professions in specifying models of care and determining what funding, workforce, and other policy mechanisms are required if such models are to be enacted within the New Zealand health system.

A key inhibitor of this service development work at practice level currently is the ambiguity in relation to the role of PHOs. The precise functions of PHOs have never been set out in a clear and coherent manner, and hence PHOs exist as a very diverse range of organisations. There is now an opportunity for national leadership by the Ministry of Health and primary health care representative organisations to set out what a PHO (or different types of PHO) should be within the health system, and to connect this to the vital work that is required in relation to specifying and enacting the development of stronger and more extended primary health care services. This might entail analysis of different existing types of PHOs (perhaps building on recent work that has been carried out by the Strategy Implementation Joint Work Programme), and setting out what these 'types' mean in practice, together with suggestions about potential form and function for the future.

In taking forward work to specify and enact new models of care, within a context of a sharper definition of the role of a PHO (or PHOs), the time is now ripe to pilot different approaches to delivering better integrated care. This could entail the selection of a range of PHOs (varying in size, history, management arrangements, and geography) within which existing or emerging models of integrated primary health care could be identified as test-beds of the next phase of Strategy implementation. Possible elements to the pilot sites could include: pooled funding for primary health care (Care Plus, Services to improve access, first-contact capitation, etc); budget-holding by practices and providers for specific services, referrals or clinical conditions; the use of alternative contracts between PHOs and practices; and new approaches to funding primary health care premises development.

Given the complexity of organisational and funding arrangements currently in place within the primary health care sector in New Zealand, piloting would appear to be a logical way forward in relation to testing out some different ways of doing things. A number of pilot projects within differing geographical, demographic, and PHO

organisational contexts would enable an exploration some of the intended and unintended consequences that emerge when change is implemented in what Sibthorpe et al (2004) have called the 'massively entangled' relationships of primary health care systems. In this way, some of the ambiguity and fraught relationships experienced during Strategy implementation thus far might be avoided, or at least explored in fewer settings prior to national roll-out. Indeed, piloting might indicate that certain approaches to funding, organisation and so forth are appropriate for some settings, but not for others.

Critical to such an approach would be effective community *and* clinical leadership of pilot projects. For too long, general practice has often felt marginalised by Strategy implementation, and a reframing of the relationship between the profession and government would represent an important first step towards 'doing things differently' in the next phase of Strategy implementation. This would require courage on the part of Ministry of Health officials and similarly on the part of leaders of general practice, along with clarification of mutual expectations, and would test the extent to which stakeholders are prepared to move beyond some of the confrontation and tension of previous years.

A reframing of the relationship in this way would entail difficult discussion and exploration of business models in primary health care, and consideration of how different funding mixes might work in different settings and for specific areas of care. The challenge is to try and engage in such debate in a way that focuses on the health needs of New Zealanders, and that recognises that all primary care stakeholders find themselves standing on a shared 'burning platform' when workforce issues, the needs of the ageing population, increased demand for acute services, and the rise in prevalence of long-term conditions are projected forwards into the future.

In short, what is needed for the next phase of implementation is system-level attention to the main issues raised in this paper:

- a stronger focus on the development of first-contact services as the core co-ordinator of people's health care, within in an overarching framework of seeking to improve health and reduce inequalities;
- the setting out of a vision of what strong primary health care services that focus on health improvement should look like, along with specification of what people should expect of primary health care;
- work to clarify the roles of different organisational actors in the system – practices, PHOs, DHBs, national professional organisations, and Ministry of Health;
- the testing out of new models of care, possibly within pilot projects, in order to explore different approaches to funding and provision; and
- the development of information and performance management systems that can enable and support such an approach.

### *The process for making change*

As important as the ‘what’ of scoping the next phase of Strategy implementation, as set out in the previous paragraph, is being clear about ‘how’ the different actors in the health system will work together when doing this strategic thinking, planning, and implementation. Given the tense nature of the ‘fees issue’ during Strategy implementation discussed above, and the observations about a degree of ambiguity in the implementation of some elements of the Strategy, it is now time to discuss and refine *how* primary care development in New Zealand is carried out, as well as attending to *what* needs to be done.

In the next phase of Strategy implementation, it might be appropriate for the different actors to explore (and hopefully agree) a set of simple rules that will guide behaviour and relationships. Processes for collecting data and enabling feedback loops will also be important, so that different actors can hold one another to account for how the process of change evolves. As Sibthorpe et al (2004) pointed out, relationships in primary health systems are highly complex and, as an overseas observer, it sometimes appears that this is particularly the case in a smaller population and health policy and management community such as New Zealand. It is not surprising that Strategy implementation has been complicated and often difficult, for bringing about change in health systems is hard work that entails conflict, debate, compromises, and setbacks on the journey towards improved health and services.

In the section below, specific challenges are set out in relation to what this analysis of Strategy implementation suggests in relation to how primary health care might be further developed in the next phase.

### **1) Rebalancing the Primary Health Care Strategy**

There is a need for the Ministry of Health, along with clinical and community leaders, to set out a refreshed vision for the Primary Health Care Strategy, taking into account the experience of the past seven years, and focusing plans in a way that responds to criticisms of implementation to date, and sustains and builds on the achievements of the Strategy.

This could include work to paint a picture of what primary health care in New Zealand might look like in say ten or twenty years’ time, and the minimum standards and service entitlements within primary care. This is needed both within the health system and also for the wider population who struggle to recognise the scope and potential of primary health care. In doing this scoping work, there is a need to address both strands of the Strategy’s intent, namely primary health care as an approach to population health development, and primary health care as the ‘medical home’ that co-ordinates care for patients. Furthermore, such planning work needs to take place within the wider context of health strategy development for New Zealand, ensuring that primary care plans in a way that means it will be able to meet the expectations put on it by the wider development of regional and national clinical services.

Such exploratory work about primary health care futures should take place in a collaborative manner involving a range of stakeholders from the primary health care sector and professions. For example, this could include: setting out overall desired outcomes related to primary care; signaling the ‘simple rules’ or principles by which Strategy implementation will be guided and monitored; clarifying the role and

functions of PHOs (and DHBs in relation to primary health care); specifying a core set of primary health care services that DHBs will be expected to ensure for local people; and setting out details of how models of integrated primary health care will be designed, piloted and evaluated in partnership with funders, providers and practices.

The Ministry also needs to set out how it will support implementation of the next phase of the Strategy via funding arrangements, development support, and a performance framework that includes appropriate organisational and professional incentives.

There is a need for a refreshed Primary Health Care Strategy that sets direction for the next phase, builds on achievements to date, and attends to the extension and strengthening of primary care services.

As part of this, it might be helpful to work with primary health care stakeholders to paint a picture of what primary health care could look like in say ten to twenty years.

This could include the development of desired outcomes for primary care, along with 'simple rules' about how Strategy implementation will be guided and monitored.

This is needed both within the health system and also within the wider population who struggle to recognise the scope and potential of primary health care.

An indication of how new models of care are to be designed, piloted, supported and evaluated is needed, along with information about the funding and organisational arrangements to underpin change.

## **2) Working with primary care professionals to plan and implement change**

New Zealand primary health care scores highly in international comparisons focused on patient satisfaction, and therefore there is a need to avoid throwing the baby out with the bathwater when exploring ways in which new models of care might be developed. Given Starfield's (1998) analysis of the role and importance of first-contact care within a health system, it would make sense to adopt a policy development perspective that regards general practice (and other first-contact providers such as NGOs, community organisations) as the core of the primary health system, namely the 'medical [or primary care] home'. Work could then be undertaken with representatives of these groups to develop models of care that can address system-wide issues such as how to care for people with long-term conditions and assure a sustainable workforce.

General practice leaders report having felt marginalised in the process of developing the Strategy, and then feeling similarly excluded during its implementation. There is an irony in this in that many people interviewed for this paper felt that general practice had had undue attention within the process of Strategy implementation, in particular in relation to the negotiation of funding roll-outs. However, the implicit desire to see IPAs disappear (as evinced by the lack of articulation of a role for them in the Strategy), and to try and erode the co-payment/fee in general practice (as illustrated by the approach to rolling out new funding and the introduction of schemes that entail a fee cap), clearly added further tension into the relationship.

There is now an opportunity for the relationship between government and general practice to be reframed now that the funding roll-out process has been completed, a new leadership team is in place at the Ministry of Health, a new government has been elected, and general practice leaders are signaling a strong desire to be included in the next phase of planning and service development.

Indeed, a reframing of the relationship is crucial if New Zealand is to make real progress in developing and implementing new models of care and workforce to meet future challenges. Given the strong international evidence about the importance of clinical engagement and leadership in bringing about change in health systems (e.g. Pettigrew et al, 1992; Iles and Sutherland, 2001), placing such leadership at the heart of policy development is a vital prerequisite to the next stage of Strategy development and implementation.

It is important to emphasise that this is not a case of clinical engagement instead of community participation, it is about having 'both and'. Just as evidence supports the need for clinical engagement in bringing about change within health systems, so it points to a need for robust community participation, particularly when seeking to develop and strengthen community and primary health care services (e.g. Barnes and McIver, 1999; Gillam and Miller, 1997; Bayer et al, 1999; Epstein et al, 2002; Thurman et al, 2007).

Furthermore, national PHO leaders and organisations need to be fully involved in planning of primary care development alongside clinical leaders, for without this, there is a real risk of disenfranchising another community of interest when seeking to draw clinical leaders more clearly into national and regional planning arrangements.

There is a need to ensure that a 'medical or primary care home' is at the centre of primary care policy, building on the strengths of New Zealand's general practice and primary care system.

In taking forward the Primary Health Care Strategy, *how* the process is developed and managed is as important as what is put in place, in particular in respect of how general practice is involved in planning and implementation.

With funding roll-outs complete, there is a window of opportunity to frame a new and more constructive relationship with general practice, NGOs, DHBs and other players in the primary health care system.

The challenge is to enable strong community *and* clinical leadership of the next phase of change within primary health care.

National PHO leaders and organisations should be fully involved in planning of primary care development alongside clinical leaders.

### **3) Clarifying the role and functions of a PHO**

Ambiguity about the role and functions of a PHO has dogged Strategy implementation. Debate about administrative and management costs will always question the need for 80 local health care organisations in a population of 4 million, unless the role of PHOs is clearly specified in relation to that of DHBs, general

practices and other providers. There is therefore a need for clarification and (re)statement of the role and purpose of a PHO. If it is decided that these organisations are needed in the future (e.g. for planning and funding primary care, undertaking service development, contracting for primary care from practices and other providers, being accountable for clinical and community governance), then their rationale needs spelling out clearly, including how their role inter-relates with that of DHBs, IPAs and others, and perhaps with a new set of minimum requirements.

There is a range of different types of PHOs in place in New Zealand, differing in size, function, management arrangements, service development priorities, relationship with practices, and so forth (Smith and Cumming, forthcoming). As noted above, perhaps it is time to acknowledge this within policy and to categorise PHOs within a typology, each type having an indicative set of functions and responsibilities, supported by minimum requirements.

Within such an approach which acknowledged the diversity of size, function and focus of PHOs, pilots could then be developed. These could for example test out how a PHO might hold a global budget for certain referred (diagnostic and other allied/community health) or secondary care services, to enable better co-ordinated services for people registered with the PHO and living with long-term conditions. Alternatively, a PHO might use its global budget to contract with some of its practices and other providers to enable a wider range of services to be delivered into local practices. Some PHOs might elect to be a primary care provider network, operating under contract to the DHB and drawing together a number of practices and other providers, whilst others might want to assume more of a locality purchasing/planning and funding role, contracting with practices and other providers.

Within any exploration of the role and functions of a PHO, it will be necessary to examine how important it is that people have an actual or theoretical choice of which PHO they belong to. Whilst some commentators argue for locality based PHOs where there is no overlap between populations (as is the case in a number of DHB areas), others assert the importance of having different PHOs within an area and hence enabling people to choose a particular type of PHO, for example a by Maori for Maori provider or a Pacific health practice. However, it is debatable how far people recognise that they have a choice of PHO, the generally accepted view being that having a choice of primary care practice or provider is what matters to people, rather than choice of PHO.

There is a pressing need to clarify the role and functions of a PHO within the health system.

This could entail work to establish a typology of PHOs, accepting that they are a diverse constituency and as such, may have different areas of responsibility and focus appropriate to their form.

In any work to pilot different models of integrated primary health care, there should be attention to exploring how the PHO role can operate in different contexts to enable learning about 'types' of PHO.

PHOs might in future choose to be primary care provider networks, or global planners and funders of primary care for a defined locality – options such as these could be explored within pilot projects.

As the future role and function of PHOs is explored, there is a need to determine how far it is important that people have a choice of PHO, and how this relates to people's ability to exercise choice of primary care practice.

#### **4) Enabling PHOs to lever change within providers**

The ambiguity of PHO role represents one of the key blocks to progress in the New Zealand primary health care system. Furthermore, PHOs find themselves with their arms effectively tied behind their backs, unable to use capitation funding to shape service delivery at practice level, given the continuing presence of significant patient co-payments, and the lack of contractual mechanisms to specify and lever service changes (Cumming and Mays, 1999; Gribben and Coster, 1999; Mays and Blick, 2008).

The nature of the co-payment in primary care will need to be debated within New Zealand at some point, in order to determine what the 'ideal' fee (if any) should be and how it will be assured from a fiscal point of view. Without such debate and analysis, it is difficult to see how the lower-fees environment developed in recent years can be sustained or extended. In a system with increasing calls for primary health care to be the main co-ordinator of more extensive care for people with long-term conditions, the nature of the GP fee needs to be debated, and an exploration made of alternative funding models that both enable the known benefits of capitation and the flexibility of some fee-for-service and performance payments (for an exploration of possible blended payment models, see Mays and Blick, 2008). It would seem appropriate that in any piloting of new models of integrated primary and community health care, a range of contract and funding options should be tested out, where professionals are interested in a business model other than the traditional general practice fee-for-service approach.

The time appears to be ripe to explore different models of integrated primary and community health services within New Zealand. This needs to include an examination of different funding and organisational arrangements, and in particular how PHOs might be enabled to perform a more active role as funders and developers of primary care provision locally. There will not be a one-size-fits-all solution in New Zealand, due to the diversity of providers within the health system and the focus on community-based approaches.

Potential approaches to be explored include: the allocation of global primary and community health care budgets to PHOs so that they can then purchase (or deliver) care for their enrolled population; the development of primary care networks (possibly based on IPAs or community trusts) that would take on contracts to deliver (or sub-contract for) specific areas of care for the local enrolled population; and the amalgamation of primary care funding streams into a single pool to be allocated by a PHO (or primary care network) to its practices within a contract specifying desired service standards and outcomes. The sorts of services that PHOs might assume budgets for could include services for long-term conditions such as diabetes and asthma, home nursing care for frail older people, and after-hours medical services.

This would be likely to entail PHOs or primary care networks holding budgets for DH-provided as well as practice-based primary care services – an issue that seems important to explore as part of the development of new models of community and primary health care.

Given that diversity of service model and funding approach appears to be accepted as appropriate in the New Zealand context, there will be a need for a performance framework that can assure value for money and quality of care, and allow for comparisons to be made across PHOs and DHBs. In a publicly funded health system where people look to government to assure minimum standards of health care provision, such a performance framework is essential, and arguably, data about the performance of providers and PHOs should be publicly available to the taxpayers who fund services.

PHOs find themselves constrained in relation to exerting influence over local practices and other providers, largely on account of primary care funding arrangements that continue to require a significant patient co-payment direct to the practitioner.

There is a need for national debate about the nature of the co-payment for general practice, in order to inform future policy about primary care funding and provision.

The time is ripe to explore a range of different service models within primary care, including the funding and organisational arrangements that might enable these to be developed by PHOs, IPAs, and providers.

In testing out such service and funding models, consideration should be given to exploring new approaches to pooled or locality funding of primary health care, along with contracting and budget-holding by PHOs and/or primary care networks.

A range of devolved models of service provision and funding calls for a performance framework that can assure value for money and quality of care nationally.

##### **5) Setting out the expectations of DHBs in relation to developing primary care**

Within the New Zealand health system, district health board (DHBs) have statutory responsibility for improving the health of their local population and reducing inequalities in health status. They are the core funder and planner of health services, and provider of last resort where people find themselves otherwise unable to access services. As such, in any refocusing of the role and function of PHOs, there needs to be parallel attention to what this means for the role of DHBs, and how they will be held to account for making progress with Strategy implementation.

In research exploring the implementation of the Strategy (e.g. Cumming et al, 2005; Gauld and Mays, 2006; Gauld, 2008; Smith et al, 2008; Barnett et al, forthcoming) a concern about the role and remit of the DHB regarding primary health care planning and development recurs. This critique typically focuses on a number of factors explored earlier in this paper: the lack of clarity of role of the PHO and whether or not it is a planner/funder, developer of provision, or something else; how DHBs can therefore carry out joint planning with PHOs, in a context of ambiguous roles, and also in some cases with PHOs that are based on communities of provider interests

rather than geographical communities; the variable performance of DHBs in relation to how far they have been able to focus on primary health care rather than being captured by secondary care concerns; and the complex system of primary health care funding and accountability that rests on a framework of partial contracting, and suffers from the tensions in government-general practice relationships.

This analysis suggests a need for clarification of the expectations of DHBs in respect of primary care funding, planning and performance management. Furthermore, it would be helpful to now explore the pros and cons of moving DHB-managed community services from DHBs into PHOs as envisaged in the Strategy, or alternatively, ways in which PHOs might fund and contract for such services as part of developing new models of integrated primary and community health services. Only if DHBs understand their own role in regard to planning, funding and provision of primary care, along with that of PHOs, can change be brought about in a coherent and planned manner. Critical to this is the information collection and performance framework within primary health care. As a response to oft-cited concern about secondary care capture of DHB planning and funding, it might make sense to put an element of DHB funding at risk if it does not achieve specific primary health care performance targets.

It would also be possible to require DHBs to develop plans for local Strategy implementation in collaboration with their PHOs (whilst this already happens in some places, it is not universal), demonstrating how they have engaged both community and clinical interests.

In any work that takes place to clarify the role of a PHO (or of different types of PHO), there needs to be parallel exploration of what this will mean for the DHB role, including in relation to different sorts of PHO. For example, if a PHO assumes responsibility for pooled funding for its local population for some or all primary and community services (and perhaps some referred and secondary care services), detail will be required as to how a DHB should hold that planning and funding activity to account. In other cases where a PHO is largely a provider organisation, the DHB's role might be defined as the planner and funder of primary health care, assuming responsibility for contracting with the PHO as a provider alongside other provider organisations.

DHBs are a core element in the New Zealand health system and are the most visible and accountable health funding and management bodies in the eyes of the public. Their directly elected nature also places them in a central governance position. As such, any development of the Primary Health Care Strategy that seeks to test out new models of service provision, explore different funding arrangements, and refocus the role and functions of PHOs, needs to address critically the DHB role and capacity. Related to this is a need to involve DHB stakeholders in planning how Strategy implementation goes forward, learning from their experience to date of working with PHOs to implement the Strategy, and identifying where changes are required in order to enable DHBs to play their role in further developing primary health care that is fit for the challenges ahead.

There is a need for a restatement of the role and expectations of DHBs in relation to implementing the Primary Health Care Strategy, including in respect of funding, planning and performance management.

Any restatement of the role of the DHB in respect of primary care needs to take place in parallel to the clarification of the role and functions of a PHO.

Such work needs to include an exploration of the pros and cons of DHBs remaining the providers of community health services, and whether the time is ripe for such services to move into PHO management, or alternatively to be funded and contracted for by PHOs.

A requirement for joint planning between DHBs and PHOs would be helpful in signaling joint responsibility for Strategy implementation.

The performance management framework for DHBs need to emphasise and incentivise the importance of making progress with Strategy implementation.

DHBs need to be closely involved in developing plans for the next phase of Strategy implementation.

#### **6) Strengthening management and leadership within primary care**

The implementation of the Strategy, as evident from the analysis in this paper, has been complex and challenging, especially given the intricacies of the New Zealand primary health funding system. This has grown more complicated as a result of the shift to capitation funding whilst at the same time retaining a system of co-payments, along with the putting in place of a number of ring-fenced funding schemes for long-term conditions, services to improve access, health promotion and mental health. The process of managing such a system, and dealing with intended and unintended consequences, calls for a high level of management skill, particularly in respect of the management of relationships and change.

In a complex health system with 21 DHBs and 80 PHOs it is likely that scarce health management capacity is often stretched thinly across organisations, and this may be a further contributory factor to the lack of progress in changing service models and care co-ordination at provider level.

The need for stronger and more focused management capacity has emerged in interviews carried out for this analysis, and has recurred in evaluations of the Strategy (Cumming et al, 2003; Cumming et al, 2005). Work to clarify the role and functions of PHOs, and in parallel of DHBs in regard to primary health care, will enable an assessment to be made locally and nationally of the management and organisational development requirements of the primary care sector, especially in relation to plans to extend primary and community health care to assume a stronger role in areas such as co-ordinating care for people with long-term conditions.

Such an assessment of capacity and capability should not be confined to PHOs, but also extended to include that vital but often overlooked group of practice management, along with the primary care planning and funding managers within DHBs. Furthermore, if clinical engagement and leadership within primary health care

are to be regarded as equally important as community participation and leadership, there will be a need for attention to be given to the funding and design of management development interventions and support for the clinicians who are leading, or would like to be involved in leading, the next phase of Strategy implementation at local, and at national level.

It is striking that within Strategy implementation, the issue of management, leadership and organisational development appears to have received relatively little attention, in comparison with how much energy has gone into the process of negotiating funding roll-outs and the shaping of programmes at PHO level. For such a radical change programme within a complex health system (and a system that faces significant workforce pressures, including in relation to management capacity) it is crucial that an assessment is made of management and organisational development needs, and programmes and other interventions put in place to make sure such needs are met and that scarce management resource is maximised and retained within the system.

There is a need for a management and organisational development plan to be put in place to support the next phase of Strategy implementation.

This needs to explore and address the present and future needs for general and clinical management in primary care, at practice, PHO and DHB levels.

Such programmes will require funding and long-term commitment to support, network and develop those managing a significant and far-reaching change within the New Zealand health system.

## **7) Evaluating and learning from the experience of implementation**

A theme running through this analysis has been the presence of significant service and workforce innovation within the New Zealand health system, yet a lack of systematic evaluation and sharing of that innovation. In a country of 4 million, it is striking how difficult the health system seems to find the evaluation and sharing of innovation. Although the devolved approach to service planning and delivery has clear merits, in this regard it appears to inhibit the scrutiny and sharing of service development, and at times, local diversity almost appears to be used as an excuse for not learning from the experience of others elsewhere in the country.

Innovation can be a positive thing within a health system, but it is important to note that just because something is new, it may not be effective or worth continuing. Only with proper evaluation in relation to impact on services, health, staff, and the wider health system can robust decisions be made about sustaining innovations. This point was made strongly by Jonathan Lomas in his assessment of innovation and change with in the New Zealand health system (Lomas, 2008) and there is a need to explore how Lomas' recommendations can form part of rebalancing and taking forward implementation of the Primary Health Care Strategy.

This is likely to include a review of national and local studies of the Strategy, and an examination by funders, researchers, policy makers, managers, clinicians and other primary health care stakeholders of what form of evaluation and/or action research might be helpful in informing the next phase of Strategy implementation.

Academia as well as funders and policy makers will need to think through its future role in this regard, for, as pointed out by Lomas, useful rigorous evaluation of service innovations, designed in such a way as to enable effective dissemination and implementation, will call for new methodological approaches and a different relationship between researchers and practitioners. There is much to learn in this regard from experience in Canada, the UK and Australia where different approaches to policy and service evaluation have been put in place as part of 'linkage and exchange' activity related to primary health (and other) care.

The analysis by Jonathan Lomas of evaluation and spread of innovation in the New Zealand health system could be used as the basis for developing a stronger framework for evaluating and disseminating change and innovation within primary health care.

A review of existing research and evaluation capacity, together with an assessment of current projects under way or completed, would be an important first step in determining a more strategic approach to evaluation and implementation of innovations (where they are proven to be effective).

Different approaches to 'linkage and exchange' could be trialled as part of the next stage of Strategy implementation, drawing on the experience of Canada, the UK and elsewhere.

## Conclusions

### *Development of the Strategy*

The Primary Health Care Strategy was ambitious, far-reaching, and designed to be a means by which primary care in New Zealand would be re-oriented away from what had been seen as a patient/individual focused system towards one that was more concerned with the health of populations (and more akin to the Alma Ata vision of primary care). It was also designed to strengthen the role of primary care in the wider health system, seeking to enable improved access to a wider range of community-based care provided or co-ordinated by a known practice or care-giver (drawing on the work of Barbara Starfield).

### *Implementation of the Strategy*

The lack of detail about implementation in the Strategy had two main effects: firstly, a permissive policy environment that led to diverse arrangements across the country and a culture of local innovation and service development; and secondly, ambiguity in relation to the role and functions of key organisational players such as PHOs and DHBs. This set the scene for a precarious process of change that focused much attention on funding roll-outs, and a conflicted relationship between the government and general practice, yet avoided tackling core issues within the New Zealand primary health care institutional arrangements, namely the continuing presence of general practice co-payments, and the lack of contractual leverage between PHOs and practices.

Of the actions set out in the Strategy, reducing the cost of access to services apparently received most policy attention, and hence is where most change has been identified. Arguably, in a policy context that was deliberately permissive, where a decision was taken to shift from a targeted approach to GP fee subsidies to one where

funding was allocated on a universal basis with the intention (or rather hope, for there was no clear contractual mechanism to assure this) of reducing overall patient co-payments, it is not surprising that the changes to funding of first-contact care quickly became the main focus of Strategy implementation.

By far the largest element of government funding allocated to primary health care during Strategy implementation has been this funding for first-contact care. Herein lies the central flaw in the process of Strategy implementation – a failure to address the need for clear incentives and levers in respect of the allocation of new funding, or in other words to put in place robust accountability arrangements for the public money, and hence have a means by which value for money for the new investment could be realised. The government was clearly unwilling to raise the possibility of a contract between government and general practice and thus the process by which new money was allocated become the forum where long-standing tensions and mistrust between government and general practice were played out through the ‘fees issue’, which, as noted earlier, became a metaphor for so much else within the implementation of the Strategy.

This lack of a ‘deal’ with general practice, along with the use of universal funding roll-outs to push forward Strategy implementation, had three main consequences. Firstly, it enabled the core infrastructure changes envisaged in the Strategy to be put in place, in particular the establishment of PHOs across the country and the allocation of new funding for a range of primary care programmes. Secondly, it has however fundamentally prevented many PHOs from being able to lever or incentivise significant change at provider and practice level. And thirdly, ‘hearts and minds’ within some areas of general practice have yet to be won over to the intentions and approach of the Strategy.

The failure to properly explain the relationship between PHOs and providers to whom they allocate funding added to the fundamental lack of clarity about what PHOs could be expected to achieve in relation to assuring and developing local primary health care services. It also meant that practices and their IPAs or trusts, who had previously been able to negotiate contracts for local service developments, found themselves in a less clear planning and funding environment, without the incentives to take forward primary care development work they had engaged in during the 1990s. They felt disgruntled that policy implementation that on the face of it assured the survival of their organisations, in reality meant that they had to adapt to a quite different policy environment that appeared not to acknowledge their experience and potential. This effectively weakened many PHOs and, whilst PHOs have, as noted earlier, made a range of service improvements nationally, the potential for more widespread and sustained change at practice and provider level has yet to be realised.

#### *Next steps for the Strategy*

This takes us to the question of where next for primary care in New Zealand. Based on the analysis of Strategy implementation set out in this paper, what is needed in the next phase of development of primary care policy is:

- The setting out for the health sector and the population of a vision for effective primary health care services, including a stronger focus on the development of first-contact services as the core co-ordinator of people's health care, within in an overarching framework of seeking to improve health and reduce inequalities.
- A commitment to work in a more inclusive and collaborative manner with general practice, NGOs, and all other primary care stakeholders as policy is shaped and implemented in a way that builds on the strengths of current provision.
- Work to clarify the current and potential role and functions of PHOs, including the development of plans for how they might assume a more extended role as primary care networks and/or as holders of global budgets for primary and community care services.
- The development of streamlined and different approaches to primary care funding that enable the testing out of new models of integrated primary and community care, within primary care networks.
- A restatement of the role and expectations of DHBs in relation to implementing the Strategy, including in respect of funding, planning, community service provision, and performance management, and how they relate to other actors such as PHOs and community health providers.
- A plan for how management and organisational development support will be provided to the process of strengthening and changing primary and community health care to meet the health and workforce challenges ahead.
- A commitment to evaluate new organisational and service developments in primary care, and to explore new ways of connecting research and practice, drawing on international experience of 'linkage and exchange'.

### *Summary*

This critique is not intended as a portent of gloom and doom, but as a challenging overview of Strategy implementation to date, together with a framing of issues for the next stage. The Strategy has been at once radical, as evinced by its backing of a community development and population health approach to primary care, and also conservative, in its focus on using government funding to try and reduce co-payments through a subsidy, rather than a contracting approach. An assessment of the Strategy's achievements points to progress in reducing the cost of access and increasing utilisation of services, yet to concerns about how far such changes are sustainable in the longer term, given the contested nature of the implementation process, and absence of organizational incentives and levers to bring about more profound change in how services are delivered within practices.

What is clear from the interviews carried out for this analysis is that across the spectrum of primary health care stakeholders in New Zealand, there is a real appetite to move forward and explore in a more collaborative and negotiated manner the potential for different models of care (with associated funding and business models) that will put New Zealand primary health care in a position to meet the twin

challenges of rising incidence of long-term conditions and constrained workforce supply.

The challenge is to learn from the process of implementing the Strategy to date, attending to the issues related to lack of an overall implementation plan, the existence of fraught relationships, unclear organisational roles, and inadequate incentives, whilst building on the evident progress associated with developing primary care infrastructure, addressing inequalities in health access and status, and making primary care a key actor in the wider health system. If this challenge is met, New Zealand's Primary Health Care Strategy will indeed have been radical, successful and of international note.

**Judith Smith**  
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