

# **The Future Shape of Primary Health Care**

**A Discussion Document**

Hon Annette King  
Minister of Health

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# Foreword

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



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

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

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

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

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

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

A handwritten signature in black ink that reads "Annette King". The signature is written in a cursive, flowing style.

Hon Annette King  
MINISTER OF HEALTH

# Feedback

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

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

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

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

Comments on any aspects of the document are welcomed. The questions overleaf cover some specific issues where comment is sought. Comment on other issues is welcome.

It would be helpful where possible if submissions are presented according to the questions or according to specific chapters of the discussion document.

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

faxed:   (04) 496 2342

e-mailed:                                      PHCS\_Consult@moh.govt.nz

This document is also posted on the Ministry of Health web site. Submissions can be made via the Internet:

[www.moh.govt.nz/primarycare.html](http://www.moh.govt.nz/primarycare.html)

**The closing date for submissions is Friday 26 May 2000.**

### **Question 1**

This document proposes a primary health care system that pays more attention to the health of populations by way of primary care organisations that deliver a defined range of services at defined levels of quality to a defined population (page 20).

Please comment on this proposal. For example, will this approach improve people's health?

### **Question 2**

This paper proposes that, in order to improve the population approach to health, people be encouraged to affiliate with one primary care organisation (page 22) and, in order to improve continuity of care, to nominate a preferred practitioner or practice within the organisation.

Please comment on this proposal. For example, what do you think of this move to affiliation, how would people be encouraged to affiliate, and how should the system operate?

### **Question 3**

This paper proposes that primary care organisations be required to have representation from service users, the community and practitioners (page 24).

Please comment on this proposal. For example, how can effective representation be achieved?

### **Question 4**

This paper lists a variety of primary health care services that people need (page 13).

Please comment on this proposal. For example, what do you think about this list of services? Which ones would you include in the services that all primary care organisations would be expected to cover? Are there some that should never be covered by a primary care organisation?

### **Question 5**

This paper proposes that there should be nationally consistent rules for availability (page 21) and affordability (page 25) of first-line primary health care services.

Please comment on this proposal. For example, do you agree on the need for nationally consistent rules and, if so, how they should be specified?

### **Question 6**

This paper proposes that primary care organisations be funded to provide a specified set of services on the basis of the characteristics of their affiliated population rather than according to the number of services they provide (page 24).

Please comment on this proposal. For example, do you support this method of funding? If so what difficulties do you see, if not, what alternatives do you suggest?

## Question 7

This paper proposes greater co-ordination of services (page 22) in primary health care, between primary and secondary care, and between health and other relevant sectors.

Please comment on this proposal. For example, is improving coordination an important role for primary health care? How do you see the proposed roles of District Health Boards and primary care organisations working?

## Question 8

This paper proposes that the special relationship between the Crown and Māori should be reflected in service agreements with primary health care providers and organisations (page 23).

Please comment on this proposal. For example, how well would this proposal meet the needs of Māori and reflect their special relationship with the Crown?

## 9 Other issues

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

- roles and responsibilities of District Health Boards in relation to primary health care (page 19)
- particular issues relating to mental health, disability support services, and other particular service areas
- issues relating to particular professional groups
- the future of primary health care services that are currently not funded
- requirements for quality
- the expectation that more information on self-help will be easily available for people to use
- workforce and training
- greater emphasis on information systems
- confidentiality issues.



# Summary

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This document is a first step in finalising arrangements for primary health care as part of the New Zealand Health Strategy. The Minister of Health is seeking submissions from all those interested in improving New Zealand's health system. The Feedback section (page v) identifies a number of questions and key issues on which specific comment is sought and details the process for making your views known. These views will be taken into account in further development of the New Zealand Health Strategy.

Chapter 1 (page 1) describes the future health system and where primary health care will fit. Chapters 2 to 4 (pages 3 to 19) present detailed proposals for primary health care: first explaining why we need clearer direction for primary health care, then describing the characteristics of the proposed primary health care system, and finally how the system will operate and the changes that will be required.

## **Chapter 1: The Future Health System (page 1)**

Chapter 1 sets primary health care within the context of the Government's future vision for New Zealand's health system. It explains what the New Zealand health system of the future will aim to achieve and what changes will be involved. The New Zealand Health Strategy will be the key document guiding developments. It will be accompanied by structural changes to the health service by widening the Ministry of Health's roles and establishing District Health Boards. Primary health care will be central to the future system.

### **New Zealand's future health system (page 1)**

The Government is introducing changes to the New Zealand health system to ensure that it achieves very good health and independence for all New Zealanders, to ensure people have fair access to services regardless of their ability to pay, and to provide a high-performing system in which people can have confidence.

The system will be non-commercial with open and accountable decision-making processes.

### **New Zealand Health Strategy and the System's Organisation (page 1)**

The New Zealand Health Strategy will set out overall goals and objectives for the country's health.

The health sector will be reorganised with new roles for the Ministry of Health and the establishment of District Health Boards. These Boards will have overall responsibility for identifying and meeting the health needs of people in their District.

### **Primary health care in the future health system (page 2)**

Primary health care is the first level of contact with the health system. It involves working with communities and emphasises health as well as illness. A variety of health workers provide primary health care services.

Primary health care will be central to achieving the aims of the future health system.

## **Chapter 2: Why Do We Need a Clear Direction for Primary Health Care? (page 3)**

This chapter explains why a clearer direction for primary health care is a key part of the new direction for New Zealand's health system. A strong primary health care system can address many of the key health problems that are facing New Zealand. As well as addressing current problems, however, the system needs to be designed in the light of future changes and challenges. A clear direction for primary health care is also essential to guide recent developments and to show which ones will be helpful in the future and which ones need to change or stop.

### **Problems that must be addressed (page 3)**

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

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

### **Changes that will affect primary health care (page 5)**

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

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

### **Aligning primary health care with the future direction (page 7)**

The organisation and delivery of primary health care services have been evolving over several years. Many changes are consistent with the Government's aims and the vision for the future. Some of these changes, however, have occurred in a piecemeal way and have been available only to certain groups of the population. Other developments in the last decade will not fit with the new direction so it is important that there is a clear statement of that direction.

Inappropriate approaches include those that emphasise competition and secrecy, those where public funds are applied to personal or shareholder profit rather than for improving health, and any where private health insurers are owners or governors of organisations managing large blocks of public primary care funds. Nor is it appropriate in the health system to have

organisations that lack meaningful involvement by their community or that are dominated by one professional group to the exclusion of other important practitioners.

Positive primary health care developments that are discussed are:

- new primary care organisations that have improved primary health care's ability to fully participate in the future health service, including Māori groups, rural community trusts, some urban trusts, Pacific providers, and various groupings set up by general practitioners
- the changing roles and boundaries for many primary health care practitioners including GPs, nurses, pharmacists, and midwives
- the increase in the number and variety of Māori primary health care providers and the emergence of Māori Development Organisations
- a growth of Pacific providers
- greater emphasis on mental health in the community and in the role of primary health care in providing services
- the changing perception of disability and alterations in disability support services delivered in the community
- a growing emphasis on population-based services: matching care to community needs and greater attention to health improvement and disease prevention as well as early intervention
- the development of links between communities and primary health care providers
- increased co-ordination and integration between primary health care and other parts of health and other relevant sectors such as education and social welfare.

### **Chapter 3: Primary Health Care in the Future (page 13)**

The proposals for primary health care in this paper are a significant evolution from current arrangements. Primary health care will have the nine key characteristics described below.

#### **Deliver on New Zealand's health goals and District Health Board plans (page 13)**

Primary health care should be fully integrated into the health system and play a key part in its development. The New Zealand Health Strategy will set goals for the health system and, working to these goals, District Health Boards will assess people's needs and develop District Plans. Primary health care providers will have service agreements with District Health Boards.

#### **Reflect the needs of those it serves (page 14)**

A key change will be the move from a system that is mainly focused on responding to individuals who seek care to one that actively ensures that services meet the needs of the population. This will place more emphasis on health education, disease prevention, early intervention, supporting self-care and support for those with ongoing problems.

#### **Provide comprehensive services to maintain, restore and improve people's health (page 14)**

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

To improve health outcomes, primary health care providers must put more emphasis on health promotion and disease prevention. Immunisation is a key example. To do this, accountability

based on evidence about what works, appropriate incentives and good accountability methods will be needed.

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

### **Provide appropriate and accessible services (page 15)**

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

- Some rural areas have difficulty attracting and retaining primary health care providers. There will be nationally consistent rules about availability of first contact services.
- Māori and some people on low incomes appear to consult less frequently than their health status would suggest is necessary. This may help explain New Zealand's high rate of avoidable hospitalisations.

### **Ensure effective co-ordination of care (page 16)**

From an individual's perspective, care should be provided by the most appropriate practitioners in the most appropriate setting. Effective co-ordination should ensure consistent advice, avoidance of duplication of treatment, effective distribution of resources among providers, and systems that prevent people 'falling through the cracks' between different providers. Greater co-ordination would improve the quality of service and reduce confusion for users.

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

Many of the health problems that New Zealand faces are concentrated in areas of deprivation. Greater co-ordination is needed between the sectors, for example, health and housing, which influence wellbeing. Primary care has an important role to play in co-ordinating these services by using techniques such as case management and by facilitating communication.

### **Provide continuity of care over time and across episodes of ill health (page 17)**

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

### **Be of the highest quality consistent with available resources (page 17)**

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

### **Ensure that resources are fairly distributed according to need (page 18)**

Public resources for District Health Boards should be distributed differentially across the country according to a measure of the needs of the population. At present there is some evidence that, because funds are allocated according to the number of services provided, those in more deprived areas (and therefore those with greater need) are actually getting fewer rather than more resources.

### **Acknowledge and respond to the special relationship between Māori and the Crown (page 18)**

Healthy whānau, hapū and iwi are critical to the future of Māori development. Primary health care with an emphasis on wellbeing, community, and disease prevention has a critical role to play in improving Māori health status and advancing Māori development. Māori providers have a key role in ensuring Māori responsive services, but all services must plan to meet Māori need in an acceptable fashion.

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

## **Chapter 4: How the System Will Work (page 19)**

This chapter briefly discusses new plans and structures proposed for the country's health services. It then considers within this context the organisation, services and funding needed to achieve the proposed new primary health care system.

### **Roles and structures in the new health service (page 19)**

Under the New Zealand Public Health Services and Health Reforms (transfer and transitional provisions) Bill to be introduced later this year, the Ministry of Health will monitor the state of the country's health, manage health policy advice, and fund and regulate the health sector. Up to 22 District Health Boards will be established with responsibilities for assessing health needs, establishing strategic and operational plans, funding primary care and disability services, and providing public health, hospital and some community services.

Boards will have a Hospital Governance Committee and a Primary Care Advisory Committee. The Primary Care Advisory Committee will be involved with ensuring all people in the District have the primary care services to meet their needs and will advise the Board about funding and maintaining relationships with and between many different providers and provider organisations.

There will be specific protections to ensure that resources are not directed to secondary care at the expense of primary health care and the long-term health of the community.

### **Primary Care Organisations (page 20)**

The proposed primary health care system involves most primary health care providers being part of primary care organisations that are paid to deliver a defined range of services at defined levels of quality to an affiliated population.

#### **Forms of primary care organisations (page 20)**

Various organisational forms are possible and many acceptable forms exist now, but all primary care organisations must:

- have meaningful representation from patients and/or their communities in governance processes
- have representation from the range of health providers in the organisation
- be not-for-profit organisations
- be fully and openly accountable for public funds and ensure that any surpluses are used to improve health status or increase access to agreed health services.

#### **Relationships with the District Health Board (page 20)**

Boards will cover a geographic district. To ensure that people receive primary health care they will have service arrangements with primary care organisations and will encourage everyone in their catchment area to affiliate with a primary care organisation of their choice.

#### **Services that primary care organisations will provide (page 21)**

The Government will expect primary health care providers to offer a nationally specified range of services. Consistent levels of access (including availability and affordability) will be set and quality standards agreed. Certain primary health services such as maternity care, well-child care and many mental health services are at present often provided by providers that are not a part of a first-contact provider organisation and District Health Boards will continue to fund such separate provision.

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

#### **Affiliation (page 22)**

People will be encouraged to make a free choice of the available primary care organisations, formally affiliate with their chosen organisation, and nominate a preferred practitioner or practice within the organisation. They will be entitled to change providers without difficulty and, although they will only affiliate with one organisation at a time, they will be free to seek care elsewhere, for example for a second opinion, when sensitive problems are involved.

#### **Meeting the needs of the affiliated population (page 23)**

District Health Boards will assess needs of those living in the District but will take account of primary care organisations' views and information in their planning processes. Primary care organisations will be taking responsibility for primary health care services to a population and must plan their services to achieve targets and goals and meet the needs of the people they serve.

#### **Responsiveness to Māori (page 23)**

The Government will expect primary health care providers and their organisations to show continued acceptance of, and responsiveness to, the Treaty of Waitangi. The Treaty must be reflected within service agreements between the District Health Boards and primary care organisations.

### **Involvement of the population, those who use services, and practitioners (page 24)**

The Government will require all primary care organisations to have some formal representation on governance processes from services users, the community and the range of practitioners within the organisation.

### **Information (page 24)**

Having responsibility for services to an affiliated population will increase the need for good information systems within primary care organisations.

### **Funding and paying for primary health care services (page 24)**

The issues and changes discussed in this discussion document will impact on and be influenced by future funding arrangements.

- Primary care organisations will be funded for taking responsibility for a defined population, rather than for delivering specific items of service. Certain services (such as GP care and pharmaceuticals) may be bundled together as at present and the mix may be extended in future. The added requirements on organisations to take a population based approach will mean additional work that will need to be compensated. Further work will be needed to quantify costs and identify how they are to be funded.
- Certain services will be dealt with separately from those services provided by all primary care organisations. Services such as maternity, well-child, and sexual health services may be provided by other organisations or practitioners, with separate funding arrangements. This would ensure, for example, that women continue to have the choice of independent midwifery services that has been available since the Nurses Amendment Act 1990.
- Primary health care providers may still charge some users for access to first contact services as they do at present. The Government will ensure that such charges are not a barrier to people getting the care they need. Providers will be required to document their compliance with measures to ensure affordability.

### **Other issues**

There are a number of other issues that will need to be addressed in order to implement the proposals in this paper. They include:

- involving key players and managing changes
- the costs of change
- workforce
- information.





# Chapter 1: The Future Health System

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This chapter sets primary health care within the context of the Government's future vision for New Zealand's health system.

## **New Zealand's future health system**

The future health system will:

- aim for very good health and independence for all New Zealanders
- ensure people have fair access to services regardless of their ability to pay
- provide a high-performing system in which people can have confidence.

These aims will be achieved by:

- reducing disparities between the health of different groups
- meeting the needs of communities
- involving communities in decisions about their local health services
- giving priority to promoting health and preventing disease
- making sure that resources for health are used effectively.

There will be some significant changes though they will be achieved by building forward rather than wholesale replacement of the current health system.

The Government is restoring a non-commercial system with emphasis on health and the provision of quality health services.

Decision taking at all levels will once again be an open and publicly accountable process.

## **New Zealand Health Strategy and the System's Organisation**

The Government is developing a New Zealand Health Strategy in consultation with the public and people working in the health sector.

The Strategy will set out overall goals and objectives for the country's health and guide how the system operates to ensure consistency in availability, access, appropriateness and quality.

This paper on primary health care is the first part in the development of the New Zealand Health Strategy and responses to this paper will be incorporated into consultation around the New Zealand Health Strategy.

Some significant changes will also occur to the structures and operations of the health service. These involve changes to the Ministry of Health and the establishment of District Health Boards. More detail of these changes is given in Chapter 4 (page 19).

## **Primary health care in the future health system**

### **What is meant by primary health care?**

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

### **Primary health care will be central to the future health system**

Primary health care will be central to achieving the aims of the future health system.

Primary health care is delivered close to communities and is the key to improving and maintaining health through education, counselling and disease prevention.

As the first level of contact that individuals have with the system, primary health care providers can make a significant difference not just in treating illness, but also in supporting people to care for themselves and their families, improving wellness, preventing illness, and supporting those with long-term problems.

The future health system will involve groups of primary health care providers taking on responsibility for actively addressing the health needs of defined groups of people rather than reacting only when people are unwell and seek help.

Within our health system, appropriate primary health care services must be available to all people regardless of who they are, where they live, what their income is, or what problems they may have.

In future, primary health care providers and their organisations will work closely with the Primary Health Advisory Committees of District Health Boards. This discussion document sets out proposals for how that interaction will be managed, what the roles will be, and how services can be better organised and funded.

## Chapter 2: Why Do We Need a Clear Direction for Primary Health Care?

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This chapter explains why a clearer direction for primary health care is a key part of the new direction for New Zealand's health system. A strong primary health care system can address many of the key health problems that are facing New Zealand. As well as addressing current problems, however, the system needs to be designed in the light of future changes and challenges. A clear direction for primary health care is also essential to guide and build on recent developments, to show which ones will be helpful in the future and to identify the few that need to change or stop.

### Problems that must be addressed

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

#### Disparities in health status

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

Although Māori health status has increased significantly over the last 10–20 years it remains lower than that of non-Māori New Zealanders. Māori life expectancy at birth is eight years less than that of non-Māori. Māori experience a higher prevalence of most diseases, especially diabetes, cardiovascular disease and respiratory diseases. The rates of sudden infant death syndrome (SIDS) is five times higher among Māori than non-Māori. Young Māori men have high rates of unintentional injuries.<sup>1</sup>

Pacific peoples also have a lower health status on average than other population groups. The reasons for low health status are complex, and are related to a variety of factors including levels of economic activity, poor levels of educational attainment, and housing. The inability of health and other social services to meet the needs of their patients and clients and, in some cases, cultural 'inappropriateness' are also important.

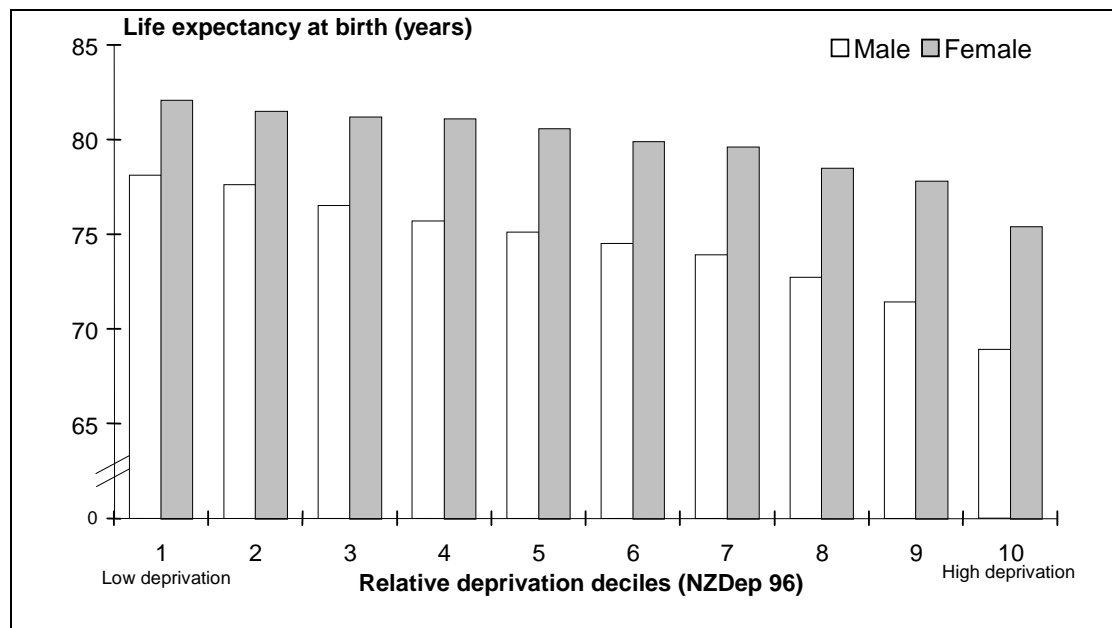
Figure 1 shows the relationship between socioeconomic group (as shown by New Zealand deprivation scores) and life expectancy. For males, life expectancy at birth varies from 68.9 years for the most deprived to 78.1 years for the least – a difference of 9.2 years. For

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<sup>1</sup> Ministry of Health briefing for the incoming Minister 1999: Māori health.

females, a similar relationship exists, with a difference of 6.7 years of life expectancy between the highest and lowest groups.

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



Source: Ministry of Health 2000

### Preventable illness

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

### Avoidable hospitalisations

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

### Barriers in accessing primary health care services

Primary health care services are the most frequently used health services. The Ministry of Health's nationwide health survey for 1996/97 showed that 80 percent of New Zealanders visited a GP at least once at year. In the same period, 44 percent visited a pharmacist (for health advice or to obtain medicines), 25 percent a nurse or midwife, 14 percent a physiotherapist, and less than 10 percent visited other types of primary health care practitioners (Ministry of Health 1999a). This pattern of use had changed little from the previous survey in 1992/93 (Ministries of Health and Statistics 1993).

General practice services (general practitioners and practice nurses) are the most commonly used services. Government funding of general practice was \$276 million in 1997/98. When the subsidies paid for prescribed medicines and diagnostic tests are included, a total of \$1.2 billion

was spent (Ministry of Health 1999b). It is important to look at whether these funds are reaching people with the greatest need.

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

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

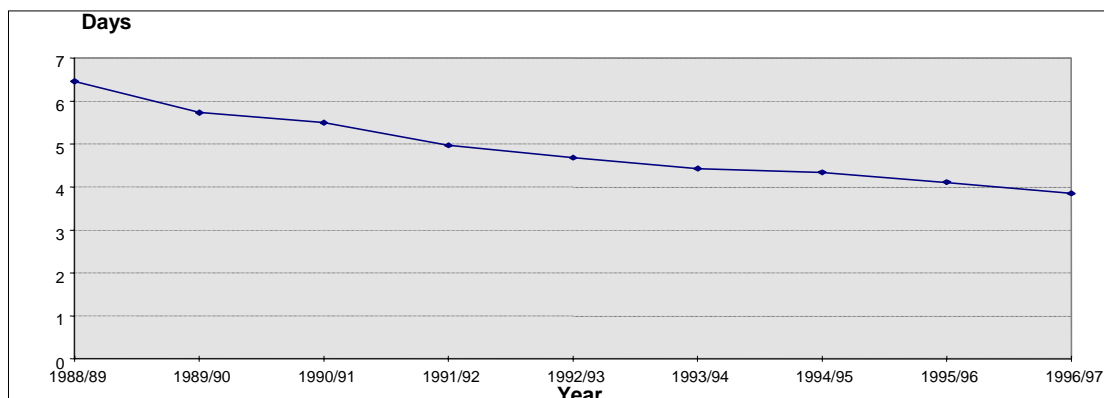
## Changes in society that will affect primary health care

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

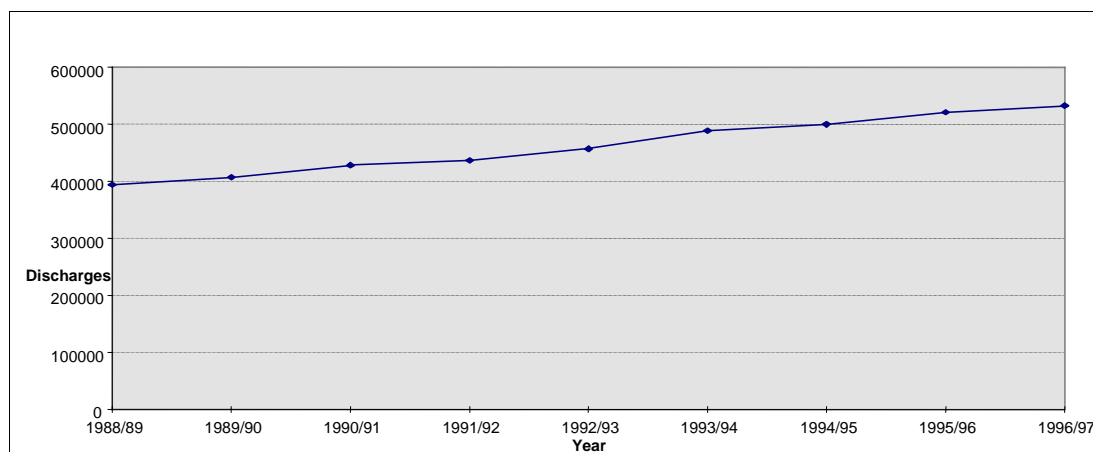
### Ongoing change in where care is provided

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

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



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



### **Demographic and social factors**

In common with similar nations, New Zealand is slowly moving towards an ageing population. There is evidence that older people will become relatively more healthy. However, there will be an increasingly large group of people who display complex multi-system problems at a more advanced age (over 85).

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

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

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

### **Epidemiological factors**

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

### **Technical advances**

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

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

## **Aligning primary health care with the future direction**

The organisation and delivery of primary health care services have been evolving over several years. Many changes are consistent with the Government's aims and the vision for the future. Some of these changes, however, have occurred in a piecemeal way and have only been available to certain groups of the population. Other developments in the last decade will not fit with the new direction so it is important that there is a clear statement of that direction.

Some recent developments are outlined below. Other changes are described in greater detail in Appendix 1 (page 27).

Some developments during the mid-nineties set up providers to compete against other providers. Instead of collaborative approaches that emphasised sharing of good ideas, some organisations tried to guard their innovations in case competitors gained a commercial advantage. This culture alienated many who were working in the health professions and damaged previous working relationships. Commercial secrecy made it difficult to judge the effectiveness of new initiatives.

Somewhere between 5 and 10 percent of the contracts with primary care organisations operated with profit as a key incentive. These involved organisations carrying the financial risk of a fixed budget and being entitled to retain profits for the organisation's use.

Some mooted primary health care developments over the last five years pursued the idea that private, primary care organisations should hold a budget to purchase services from public hospitals. Such arrangements raise many questions about accountability, security of access to care when needed, the integrity of the public health system, and the appropriate role for primary health care providers. Similarly, it is not appropriate in the New Zealand health system that private health insurance companies own or govern primary care organisations that manage or distribute large blocks of public funding.

Many developments in the way that primary health care is organised and delivered have improved its ability to fully participate in the future health service and to deliver on the vision for the future. Such primary care organisations include Māori groups, rural community trusts, urban trusts, Pacific providers, and various groupings set up by general practitioners.

A strong 'third sector' of non-Government, not-for-profit organisations with strong community focus and ownership has emerged (Crampton 1999). These include some organisations that provide primary medical and nursing services, health services provided by Māori, and various patient support groups. Other organisational developments include the emergence of rural trusts, nurse led organisations, midwifery groups and Pacific peoples provider organisations.

Responses to the health needs of Māori have led to Māori provider development and Māori workforce development. These developments have also enhanced the responsiveness of mainstream health services, promoted intersectoral initiatives and encouraged the development of co-ordinated or integrated care developments. Māori provider development has been actively fostered through initiatives such as the Māori Provider Development Scheme.

Approximately 80 percent of GPs now belong to a primary care organisation (Malcolm 1999). The most common type of such organisation is an Independent Practitioner Association (IPA). There are various different ownership, governance and management arrangements with some being companies, others incorporated societies, non-profit trusts, or partnerships. Malcolm reports that almost all IPAs are opposed to the concept of retaining savings from their budgets as personal profits.

Another significant change in primary health care provision is the growth in the number of practitioners who receive their Government funds according to the number of subsidised patients they have registered rather than by a fee for every service they provide services to these patients. Such capitation arrangements were first introduced some years ago (Seddon et al 1985) but have grown in recent years until now some 15 percent of practitioners are paid that way (Ministry of Health 1998).

A range of primary care organisations with various organisational forms has grown up over recent years. Some of these forms will need to change in order to be consistent with future directions that put emphasis on a broader view of health and the importance of community involvement. Many organisations at present have no provision for community input and only limited opportunities for feedback or complaint from those using the services. Even where organisations have adopted a trust status it is unclear whether community representation has a significant impact on governance or direction. Similarly, a majority of the large primary care organisations have an inappropriate dominance by doctors both in their ownership and governance.

### **The changing role of primary health care practitioners**

The 1990s saw many changes in the roles and tasks of primary health care practitioners.

GPs were affected by the shift of some work from hospital to community, the advent of new technologies and an increasing emphasis on preventive care and health education activities. The release of guidelines for clinical performance, new quality and professional standards, and increased information and administrative requirements all impacted on workload.

Nurses have taken increasing responsibility in many primary health care practices and now sometimes lead primary care initiatives. Some have established themselves as independent nurse practitioners. Many new initiatives focusing on health education, disease prevention and management of chronic conditions have largely depended upon nurses. Moves to develop nurse prescribing will further develop the nursing role in primary health care.

Pharmacists found their role as providers of information on pharmaceuticals and self-care increasing. There was a rapid increase in the number of independent midwives following the Nurses Amendment Act 1990 that permitted them to practise independently.

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

### **New ways of delivering services for Māori**

The number of independent Māori providers delivering health services targeted to Māori has increased tenfold over the last five years and there are now 240 providers. Māori providers include iwi providers, those that have emerged from within mainstream health providers, those providers built by Māori health practitioners, and community-based Māori social service providers.



Services provided by Māori providers include those focusing on health promotion and education, general medical services, nursing services, primary mental health services, disability support services, traditional healing services, and intervention services.

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

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

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

Many Māori organisations operate across traditional health sector boundaries to co-ordinate a range of social services and economic development initiatives for their populations. This co-ordinated cross-sectoral approach provides a base for integrated service delivery and opportunities to address some of the wider determinants of health.

Some Māori organisations have been working closely with the Government funder in the decision making about allocating resources to improve the delivery of services to Māori. The funder has also had a number of 'Treaty relationship' agreements with iwi organisations to ensure decision making reflects Māori needs and preferences, and to inform Māori communities about health and disability issues.

A recent development has been the emergence of Māori Development Organisations, with specific responsibilities for achieving specified Māori health gain priorities, co-ordinating service delivery, and working with Māori providers to build their capacity to deliver comprehensive high quality services to Māori, and with mainstream providers to increase their responsiveness to Māori.

Māori Development Organisations and other Māori health organisations are beginning to define the populations that they serve by encouraging people to register with the organisation. The planned next step is for those organisations to negotiate service agreements with the Government funder to take responsibility for a range of primary health care services to achieve health gain for those populations.

This increased participation is beginning to show dividends in improving access to services for Māori and more effective service delivery, not only by Māori providers themselves but also by mainstream services within those communities.

### **The delivery of services for Pacific peoples**

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

## **Changes in primary health care for people with mental health problems**

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

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

## **New ways of delivering disability support services**

Having a disability is not the same as being sick. Nowadays disability support services are mostly being delivered in the community. There has been an increased role for voluntary organisations, home support workers and home care services.

People with disabilities require an approach that integrates medical interventions with the delivery of broader social and disability support services. This increases the skills demanded of primary health care providers and a related emphasis on increased training.

As is the case with mental health services, many different services and providers are involved with individuals needing disability support. There has been an increase in the co-ordination between these services though more is needed.

## **Developing a population-based approach**

Increasingly primary health care providers are involved in providing services for defined populations. Most primary health care provider organisations can now identify the populations that they serve and are starting to provide a range of population-based services. IPAs tend to define their populations by consolidating the lists of patients who attend the general practices that they cover. Māori groups directly register patients and members of the relevant iwi. Rural trusts tend to operate according to a geographic catchment area and build up registers of all those living in the area.

However the populations are established, these organisations offer various population-based approaches. These include various efforts to describe the health care needs by, for example, maintaining disease registers. Māori providers usually focus on directly contacting whānau and hapū to provide health education and identify people in need of health care. Other groups are beginning to operate similar local initiatives such as school based health clinics to contact hard to reach individuals.

## **Building links with the community**

At present only a few primary care organisations, mostly in the 'third sector' (see page 28) are owned by their communities, or include patient or community representatives on the organisation's governing bodies. However, IPAs are increasingly developing links with their local communities in various ways. This includes activities such as taking part in public meetings, regular written communication with patients, and surveying community views. Some IPAs are also developing more formal links with Local Government or finding other ways to establish community and patient 'voice' on their organisations.

## **Increasing co-ordination and integration of care**

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

services, lack of continuity of care and confusion for the patient. Increasingly primary health care providers are seeking to co-ordinate services to reduce the likelihood of this happening. Some developments bring together providers working with a particular sub-population such as children or the elderly. Others focus on improving the management of certain chronic condition such as diabetes. Such co-ordination usually involves primary and secondary care providers as well as community workers and volunteers. Some groups are developing links with other sectors, for example, education and housing, which can impact on a person's wellbeing.



## Chapter 3: Primary Health Care in the Future

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The proposals for primary health care in this paper are a significant evolution from current arrangements. The key features can be understood in terms of nine characteristics.

Primary health care will:

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

Each of these characteristics is described in detail below.

### **Deliver on health goals and District Health Board plans**

Primary health care is 'an integral part of the country's health system, of which it is the central function and main focus' (World Health Organization 1978). One of its key characteristics, therefore, is to be fully integrated into the country's overall health system. This means that primary health care will play a key part in the future health system for the country as set out by the New Zealand Health Strategy and, at district level, as laid down in District Health Board plans.

The New Zealand Health Strategy will set out overall goals, objectives and targets for the health system. The Strategy will also indicate certain sector performance measures to ensure consistency in availability, access, appropriateness and quality. Initially these measures will be based upon existing measures but they may, over time, be revised.

District Health Boards will have the task of assessing health and support needs for those living in their District. They will do this through a variety of means including analysis of available data sources, consulting providers and others with expert knowledge and conducting specific surveys. Boards will then draw up longer-term strategic plans in full consultation with their communities. They will also prepare annual operational plans. The Board's primary health advisory committee will be a key source of advice when drawing up plans. This process will allow the views of primary health care and disability service providers to be incorporated into the Board's planning processes.

Boards will enter into service agreements with health care providers for the delivery of services according to detailed annual plans. Where provider organisations have established a history of providing a suitable quality service that makes effective use of resources and improves health status, Boards will be able to enter into longer-term funding arrangements with them.

## **Reflect the needs of those it serves**

At present many primary health care providers only provide services when patients contact them. Primary health care providers are not required to address the needs of those who do not consult. Indeed no provider organisation clearly carries this responsibility for the population. There is no explicit targeting of individuals who are not seen by the system but who may be those in greatest need of the services it offers.

Primary health care at its most effective reflects and caters for the needs of the population it serves, takes account of local priorities, and assumes a degree of responsibility for community health outcomes and for those who miss out. This will be a key requirement of future primary health care arrangements.

How this increased emphasis for primary health care providers to meet the needs of their population will align with the roles and relationships of District Health Boards is further discussed in Chapter 4.

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

People need primary health care services that take a broad view, covering physical (taha tinana), mental (taha hinengaro), social (taha whānau) and spiritual (taha wairua) aspects. The services needed are listed below though they may not all be provided directly from a single primary care organisation:

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

To improve health and independence outcomes, primary health care providers will be expected to put more emphasis on health promotion and disease prevention. Evidence shows that primary health care can play an effective part both in large scale screening and preventive programmes (Smale et al 1996) and in effecting some change in people's lifestyle choices (Ashenden et al 1997). However, at present there is significant variation between the preventive activities that different providers and individual practitioners provide (Williams et al 1999). Achieving a greater emphasis on these activities will involve attention being paid to them in service

agreements, including clearer specifications based on evidence about what works, appropriate incentive arrangements, and good accountability methods.

Services will include education, information and support for people to self-manage minor illness where appropriate – or to manage within the family/whānau. As modern technology makes more information directly accessible, some people may manage more problems by themselves. Some information services are already operating (Plunketline), and others are being tested (Healthline). Development of such services is an international trend.

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

However, primary health care also covers services for a range of situations that are more narrowly focused. These are services directed towards a particular sub-group (for example, well child services and primary level maternity care), or particular types of services (such as physiotherapy, psychotherapy, counselling, family planning advice and sexual health care). Covering this range of services requires a particular set of skills that are often outside the competence of the generalist practitioner. There will be careful specifications and protections to ensure that people will be able to continue to receive these services from current providers rather than being obliged to receive them all from one organisation. At the same time there is a need for better links between these more narrowly focused services and the rest of primary care.

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

## **Provide appropriate and accessible services**

Achieving the vision of fully developed primary health care will mean paying attention to how easily people are able to access services. Barriers that need to be considered relate to availability (number and distribution of services), affordability and acceptability (including cultural appropriateness).

Most people at present seem to be able to access generalist first contact services when they need them (Ministry of Health 1999a). However, some people *do* face barriers and poor availability of these general services and other primary health care services.

For example, while the overall ratio of patients to GPs in New Zealand is average compared with OECD countries (OECD 1999), there are some rural (and indeed some urban) areas that have difficulty in attracting and retaining health practitioners.

New Zealand rates for ambulatory care (GP and hospital outpatient visits) are in the lower third of OECD countries (OECD 1999). There are indications of cultural and cost barriers for some New Zealanders wishing to see GPs. Although Māori and Pacific peoples consult as frequently as other ethnic groups overall, this is less frequently than one would expect. When adjustment is made for the population's age, income and health status, Māori consult less frequently than would be expected (Scott et al 2000). People with lower incomes tend to be under-represented in the group who visit the doctor only once or twice a year (after adjustment for other factors).

Lower income and Māori and Pacific peoples also report higher rates of not seeing doctors when needed because of cost (Ministry of Health 1999a).

These findings suggest utilisation does not always reflect need and they may partly explain our high rates of avoidable hospitalisations (Ministry of Health 2000). They suggest that affordability, access and cultural barriers mean that some people who are usually fairly healthy (and infrequent users of GP services) are not getting help early enough when they do develop symptoms.

## **Ensure effective co-ordination of care**

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

Effective co-ordination should help ensure:

- early identification of issues
- consistent advice
- no duplication of tests and treatments
- that resources across various providers of care are used most effectively to improve the health of the individual and for members of the wider population
- that people/patients do not miss services if they 'fall through the cracks' between providers
- consistent and compatible information flows.

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

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

Many of the health problems New Zealand faces are concentrated in areas of deprivation and are also driven by factors outside the health sector. More co-ordination is needed between health services and other sectors such as education, housing, justice and welfare. Primary health care providers would have a key role in organising this co-ordination using techniques such as case



management, facilitating communication between various agencies, and brokering services for individuals and families.

As documented at the hui Te Ara Whakamua (Te Puni Kōkiri 1994), Māori working within the health sector believe that the economic, cultural (including land and tino rangatiratanga), education and employment factors which impact on the health of an individual and their whānau must be addressed when considering their health and wellbeing. Maximising the wellbeing and health of Māori requires attention to these determinants, and health gain cannot be separated from positive Māori development (Crengle 1999).

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

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

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

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

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

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

## **Be of the highest quality consistent with available resources**

People should have access to a primary health care system that provides the highest quality of care within the resources that are available. New Zealanders should be confident that quality standards are consistent across the country and do not vary between providers.

Ensuring quality should be a normal part of professional work. Clinical governance (the involvement of clinicians in managing each other's clinical decisions) is becoming more accepted as part of primary health care delivery. Practice should be based on the best available evidence. Best practice guidelines already exist in many areas of primary health care practice and they help make evidence readily available to practitioners (and to patients who wish to use

it) at the time clinical decisions are made. If practitioners have information comparing their clinical practices to those of colleagues and to the best evidence they can use it to determine where changes should be made to improve quality of care.

## **Ensure resources are fairly distributed according to need**

The basic principle here is that public resources should be distributed differentially across the country according to a measure of the needs of the population. This will ensure that those areas that have the highest levels of health need (for example, South Auckland or East Cape) receive proportionately more resources than those with less need. At present much primary health care funding is paid out according to the number of services provided and there is some evidence that the ‘inverse care law’ applies: expenditure is less in those areas with high needs and highest in the more affluent parts of the country (National Health Committee 1999b).

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

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

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

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

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

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

## Chapter 4: How the System Will Work

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This chapter first sets the context for implementing primary health care proposals by briefly discussing the coming changes to the way the country's health services will operate. It then considers the organisation, services and funding needed to achieve the proposed new primary health care system.

### Roles and structures in the new health service

The New Zealand Health Service will be re-organised over the next two years. Under the New Zealand Public Health Services and Health Reforms (transfer and transitional provisions) Bill to be introduced later this year, the Ministry of Health will monitor the country's health, manage health policy advice, and fund and regulate the health sector.

Up to 22 District Health Boards will be established with a majority of elected members.

The Boards will have responsibilities for:

- assessing the health and support needs of those living in their District
- establishing strategic and operational plans
- building and maintaining relationships with a range of providers
- funding various primary health care and disability support services
- providing a range of health services including public health services, hospital services, and some community services.

Boards will have at least two committees: a Hospital Governance Committee that will separate off the governance of the public hospital, and a Primary Care Advisory Committee.

The Primary Care Advisory Committee will be the key advisory body to ensure that the people in the District receive primary health care and disability services that meet their needs. Because of the nature of primary health care, this committee will be focusing on ways to improve, maintain and restore health of individuals and communities. It will advise the Board on funding decisions and be involved with maintaining relationships with and between many different primary health care providers and provider organisations.

As well as hospital and public health services, District Health Boards will also take over from existing Hospital and Health Services responsibility for the provision of a number of services in the community such as district nursing, community mental health services, some immunisation and other preventive care services, and a range of specific therapy services.

It will be important that Boards act impartially in any decisions or advice about the appropriate mix of primary and secondary care services for their populations. Fears have been expressed that the immediacy of demand for secondary services could lead to pressure to direct resources to secondary rather than primary health care – to the detriment of the health of the population in the longer term. District Health Boards will be subject to specific requirements to guard against such tendencies.

## Organising the provision of primary health care

The characteristics of good primary health care that were detailed in the Chapter 3 will be achieved by establishing:

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

It is proposed that the key unit for providing the range of primary health care services that people need will be the primary care organisation. The next sections consider aspects of these organisations.

### Primary care organisations

#### The form of primary care organisations

Various types of organisation may be suitable to achieve the proposals in this paper. They may vary according to the characteristics of the affiliated population (for example, urban or rural, Māori or Pākehā), or to the way that providers have been organised in the past (for example, practitioners employed in larger groups as opposed to multiple small and independent practices).

A range of different organisational forms has developed over recent years. Different forms have different strengths and no particular one will be mandatory. There will, however, be some rules about organisations with which District Health Boards have funding arrangements.

Primary care organisations must:

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

#### Relationships with the District Health Boards

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

The District Health Boards will also, at least initially, be a provider of some community services and, especially in some rural areas, of first contact primary health care. Over time it may be that this provision of community and primary services will either expand or diminish depending upon local needs and the success or otherwise of local primary care organisations.

#### Building the capacity for Māori participation

Māori capacity for participating in the health and disability sector must continue to be built upon, and Māori communities must continue to be empowered to provide for their own health

needs. Encouraging effective relationships between District Health Boards and Māori (including good information, communication in good faith and opportunities for dialogue) will provide the strong base needed for effective improvements in Māori health outcomes. This will in turn lead to reduced health disparities between Māori and other New Zealanders. As mentioned further below it will also be critical to increase the responsiveness of mainstream providers to Māori and to build intersectoral linkages outside health services to address wider determinants of health.

### **Services that primary care organisations will provide**

The Government will expect primary health care providers to offer a specified range of services. Levels of access (including availability and affordability) will be set and quality standards agreed nationally.

Primary health care provider organisations will have service agreements with their District Health Board. There will be a nationally agreed set of services including health education, disease prevention, support for self-care, diagnosis, treatment, ongoing care, rehabilitation and referral (as detailed on page 14).

Organisations will usually supply a range of first contact advice and treatment services, and individual preventive services. Certain primary health services such as maternity care, well-child care and many mental health services are at present often provided by providers that are not a part of a first contact provider organisation. The District Health Board will continue to fund such separate provision. In the future Boards may choose to move to more co-ordinated arrangements where providers and the community agree to do so.

There will also be nationally consistent levels of access to primary health care services. National specifications will set down expected levels of availability for first-line services. This will mean that all people, especially those living in smaller and more remote communities, will have certainty of what they can expect.

District Health Boards may choose to go beyond the nationally agreed minima. This might, for example, be to address particular community needs, to move services from the hospital to the community, or to develop more integration among providers. Similarly, communities or providers may wish to propose new initiatives. Such developments would need to be in addition to the minimum service and would either have to be provided within the existing budget and/or would require negotiation and agreement with the District Health Board. Such district by district variations will only be allowed within clear national parameters so as to maintain an acceptable level of national consistency.

### **Quality of services**

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

### **Co-ordination of services**

District Health Boards will have responsibility for most health and disability support services in their districts and will receive funding for primary as well as secondary health services. They

will be in a position to organise and fund services in the most appropriate way and the most appropriate place and to shift funds around the health system.

District Health Boards will be seeking to increase co-ordination between various agencies in health and other sectors. Strong primary care organisations that take responsibility for co-ordinating a range of services needed by their affiliated populations and that work closely with other providers will help ensure services are provided in the best way. Over time, and in consultation with the community and providers, Boards may decide to widen the range of primary health care services that are included in arrangements with primary care organisations. However, Boards will not devolve the funding of secondary care services to primary care organisations.

Co-ordination may often entail primary health care provider organisations working with other provider agencies. In future, primary health care could become a strong advocate for local community development in health and related areas such as education, social welfare, housing, and justice, which often have major impact on health status.

Certain areas of New Zealand have higher levels of deprivation. These will need a more intensive approach to address underlying causes of poor health status. Population-based funding must be sufficiently sensitive to variations in local conditions to reflect the extra needs of such communities. Administrative systems also need to be responsive to enable agencies from various sectors (not just health) to work more effectively together to achieve particular common goals. The Government will support more integrated and targeted approaches in these areas (as is already beginning in South Auckland, and Porirua/Kapiti).

### **Information transfer and sharing**

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

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

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

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

### **Defining the population that organisations serve: affiliation**

A population-based primary health care system links providers of services to groups of people. The organisation will then be funded and held to account by the District Health Board for ensuring people get primary health care services as agreed with the Board.

Individuals will be encouraged to affiliate with a primary care organisation of their choice. The Government, District Health Boards, primary and secondary provider organisations and community groups will all be involved in explaining the reasons for such a system and helping to ensure that it occurs.

Affiliation needs to be with the organisation so they can take a population approach and be funded accordingly. This will probably be the mechanism those organisations that are based around a community will prefer anyway. For example, Māori primary health care providers

have already built up lists of the people in their populations by working directly with iwi, hapū and whānau.

On the other hand, continuity of care is best served by a more personal relationship with a particular practitioner or small practice team that knows the individual. Most people in New Zealand can already identify a family doctor or general practice and they may choose to affiliate with the organisation that the practice belongs to.

A mechanism to ensure continuity for both the population and the individual would be to encourage people to affiliate themselves with an organisation and also identify a preferred practice or practitioner belonging to the organisation. While initial affiliation lists might be built up from the existing lists of organisations or practices, it is proposed that, over a period of two or three years, organisations would be required to ensure that each individual had made an active and fully informed choice.

Other details that will need to be finalised include how to deal with family members, what the rules are about maintaining and updating lists, how people's affiliation will be recorded and who can have access to that information.

While strongly encouraged for the reasons already outlined, people will not be obliged to affiliate. Similarly, while it is expected that over time all generalist first contact practitioners will join primary care organisations or some form of network to enable them to be fully involved in primary health care provision, this will not be obligatory.

It is anticipated that most individuals will receive most of their primary care services from the provider they affiliate with or from others associated with that provider's organisation. The system must, however, not only allow free choice when affiliating and the ability to change without difficulty, but also allow people to have choice of provider for second opinions, sensitive conditions and problems. Moreover, some primary services may not be part of the defined set of services that are included in the agreement with the organisation. For example, this will be normally the case for maternity services.

### **Meeting the needs of the affiliated population**

The District Health Board will be responsible for assessing needs of those in the District. Primary care organisations will, however, be dealing with a smaller population than the District and will be in a good position to know about some aspects of affiliated people. Districts will take account of primary care organisation views and information in their planning processes.

Primary care organisations must plan their own services to achieve the targets and goals that are set by the district and to meet the needs of the people they serve. Similarly, individual practitioners and practices in a larger organisation will address the needs of the individuals and families who have nominated them as preferred practitioner or provider. Many primary health care providers have already started this process by keeping registers of people who are at risk of, or living with, conditions such as diabetes.

### **Responsiveness to Māori**

The Government will expect primary health care providers and their organisations to show continued acceptance of, and responsiveness to, the Treaty of Waitangi. The Treaty must be reflected within service agreements between the District Health Board and primary care organisations.

Many Māori continue to use mainstream health services. Conversely some are reluctant to use services because those services are not provided in a culturally sensitive or appropriate manner.

New primary health care arrangements are critical to meeting the needs of Māori. It will be particularly crucial to ensure that ethnicity is accurately recorded when people affiliate. Both Māori primary health care providers and mainstream providers will then be better able to work closely with Māori communities to meet their needs.

### **Involvement of the population, those who use services, and practitioners**

Primary care organisations will be expected to encourage relationships between the community and the primary health care system. While there are various ways the community and the primary health system can interrelate, the Government will require all organisations to have some formal and meaningful representation within the organisation's governance processes from services users, the community, and the range of practitioners working in the organisation.

### **Information**

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

## **Funding and paying for primary health care services**

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

### **Pay organisations for taking responsibility for a defined population, rather than for delivering specific items of service**

This will require a system for funding according to the relative needs of the population served. Under such a needs-based system, a fixed amount of public money is allocated for each patient covered regardless of the number or volume of services provided to people.

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

The services to be provided will be set down in agreements between the District Health Board and primary care organisations. Current arrangements that bundle funding for the services provided by GPs and practice nurses with the prescriptions and laboratory tests they order need careful and consistent specification. Further services, particularly preventive care services such as immunisation, may be added in future.

Taking responsibility for a defined population may mean additional work for current primary health care providers. Where this is so it will be specified in contracts and appropriately recompensed. Better and earlier primary care may result in reduced expenditure on hospital services later though sometimes the benefit will be improved health rather than reduced costs. Extra costs may in fact be involved, especially in the short term. Further work to quantify fiscal impacts will be needed before planning the pace of the strategy's implementation.

Not all primary care organisations will provide the comprehensive range of primary health care services that people need. Some services such as maternity, well-child, and sexual health services may be provided by other organisations or practitioners.



Funding for these services will therefore be possible as a separate item. This, for example, will ensure that women continue to have the choice of independent midwifery services that has been available since the Nurses Amendment Act 1990.

### **Ensuring that people can afford primary care services**

Primary health care providers may still charge some users for access to first contact services as they do at present. The Government's objective will be to ensure that such charges are not a barrier to people getting the care they need.

Whether individual practitioners receive public funding according to the number of people affiliated or as a fee for each service, their service agreements will require that they continue to reduce the fees they charge for those in the Government's priority population groups. In particular, free access for children under six will continue to be a requirement with reduced fees targeted to older children, low-income adults and high health service users. Similarly the Government will continue to ensure that such groups of people pay less for prescribed medications.

Maternity services will be publicly funded at no charge to women. Similarly well-child, sexual health, and the primary mental health services that are not charged for at the moment will continue to be free of charge.

Where charges for primary health care services remain, more attention will be given to ensuring people know about their entitlement to reduced fees. Current arrangements appear to leave an affordability barrier for some people and may need review. There is also evidence (Gribben 1996) of incomplete uptake of entitlement to reduced charges, which may reach significant levels in some communities.

Providers will be expected to document their compliance with measures to assure affordability.

### **Other issues**

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

#### **Workforce**

This document presents a view of the future shape of primary health care. However, the pace of technological change in health care is such that some changes may impact on us sooner than that. In addition many areas need to be planned for and implemented much sooner, for example, training and workforce issues need to reflect the fact that it can take up to 10 years to train some health care professionals. The Government is establishing a Health Workforce Advisory Committee to co-ordinate the workforce skill needs of the sector with the provision of appropriate training and education.

#### **Information**

Any changes in primary health care need to be accompanied by appropriate developments in information technology and systems to enable the vision to become a reality. Collection of accurate and up-to-date information on affiliated populations is imperative.

## **Managing and funding change**

The achievement of a new primary health care system clearly involves a period of change. Some changes will occur soon, some will take several years. A focused change management process is needed to ensure that primary health care service users and practitioners are fully informed and encouraged to play an active part in achieving the proposals outlined in this discussion document.

It is particularly important that momentum around some recent gains is not lost during the transition phase. This is an imperative for the Government especially in regard to Māori health gains.

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

## Appendix 1: Recent Trends in Primary Health Care

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

Many of the changes to primary health care have developed in a piecemeal way or they have only been available to certain groups of the population. Moreover, changes sometimes overlap or conflict, and various groups have called for a clear statement of direction.

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

### **The development of new forms of primary health care provision**

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

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

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

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

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

### **Independent Provider Associations (IPAs) and other GP associations**

GPs have formed larger organisational groups called Independent Provider Associations (IPAs). The first IPAs were established in about 1992 and by 1999 there were some 32 IPAs in New

Zealand with more than 2000 members. Most cover small areas in larger centres, though some (such as Southlink, Pinnacle and First Health) cover far wider geographical areas. In addition there are nearly 100 GPs in 10 smaller contracting practices, approximately 400 in loose networks, and some 60 who are members of 'third sector' providers (see below). In all, over 80 percent of GPs are members of some type of primary care organisation (Malcolm 1999). They provide care for an estimated 3.1 million patients, approximately 85 percent of the population.

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

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

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

### **'Third sector' primary health care**

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

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

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

## **Māori organisations**

There has been a desire among Māori for greater autonomy in health service delivery and a number of providers, both iwi-based and operated by urban Māori authorities, have been developed. Services include marae-based clinics, health education and support organisations for mothers, people with mental disabilities, etc.

## **Pacific organisations**

A smaller number of providers for Pacific peoples have emerged. Many of these are focused around the delivery of support, prevention and education services for mothers and children. These developments are further described in separate sections below.

## **Other new forms of provider organisations**

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

In the 1980s most support services for people with disabilities were provided by Area Health Boards, large non-profit organisations and small voluntary organisations. The disability support reforms provided the opportunity for the development of support-service organisations. Some of these are private organisations or non-profit organisations employing staff to provide services to those who qualify for these services (see the disability section on page 37).

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

## **The changing role of primary health care practitioners**

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

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

### **General practitioners**

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

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

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

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

## **Nurses**

Nurses have had a long history of contributing to population-based and primary health care in New Zealand. Throughout the 1990s there were significant changes which have affected the way nurses practice (Carrier 1999). These changes can be attributed partly to the movement to graduate entry level of nursing, demand from nurses for post-graduate education, expectation of nurses and those of the communities they serve has risen, changing roles with medical practitioners and the effect of the contractual service environment.

Primary health care nursing involves making use of the ability of community members to establish their goals, strategies and priorities for health. The focus of the nursing services is not only on essential first contact activities but also on health promotion and community developments. It involves processes such as: community and family assessment, community participation, action and partnerships, home visiting, surveillance and monitoring.

Nurses have contributed to primary health care services through independent contracts directly from the funder for nurse-led clinics, through general practice services as practice nurses, and through Hospital and Health Services as district, public health nurses and community nurse specialists. They also work through non-government agencies and providers such as the Royal New Zealand Plunket Society, the Family Planning Association, Nurse Maude, the Asthma and Respiratory Foundation, and Māori, Pacific and mental health community providers.

Nurses have experienced frustration as they have seen many of the services they have been educated to offer in relation to primary health care fragmented, and have had little ability to influence the service they can deliver in current provider organisational structures.

There are approximately 5745 nurses currently working in community services, including approximately 3100 practice nurses. In some practices the nurse's role is restricted. In others it is extensive, especially where practices are funded by capitation and/or actively pursue team-working and an increased and autonomous role for nurses. Although capitation of these

practices has increased (Ministry of Health 1998), it is uncertain whether the role of practice nurses will change significantly in future without accompanying attitudinal and power shifts in practices (Ministerial Taskforce on Nursing 1998).

Some new initiatives have a significant potential to widen the accessibility of primary health care nursing practice. These include Healthline (a telephone advice and triage system) and the passing of legislation that will allow selected nurses to prescribe.

The Ministerial Taskforce on Nursing (1998) made recommendations for changes that will further broaden the scope of nurses' contribution in primary health care. Realising this potential requires models of primary health care delivery to embrace the multi-disciplinary and community development nature of service, where intersectoral relationships, and collaborative partnerships are the foundation stones.

### **Pharmacists**

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

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

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

### **Midwives**

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

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

During the first half of the 1990s some 20 percent of women chose care from a midwife while up to 60 percent had both a midwife and a GP. New arrangements were introduced in 1996 whereby women had to nominate a lead carer and since then, many GPs have ceased to be

involved as lead carers. The latest data (July–September 1999)<sup>2</sup> shows that independent midwives are lead carers for 60 percent of births and are also probably the main practitioner for many of those where the hospital is lead carer (5 percent).

### **Other primary practitioners**

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

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

More than 10 percent of people see opticians and physiotherapists once or more in a year. Fewer than 10 percent had seen one of the practitioners listed in the New Zealand Health Survey in the previous 12 months. It is difficult to determine whether use of these practitioners has changed over the decade (Ministry of Health 1999a).

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

## **New ways of delivering services for Māori**

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

### **Māori health a priority**

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

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

- greater Māori participation at all levels of the health sector

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<sup>2</sup> Information provided to the Ministry of Health by the HFA, based on Health Benefits Ltd claims data.

<sup>3</sup> Ministry of Health briefing for the incoming Minister 1999: Māori health.



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

### **Māori providers**

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

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

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

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

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

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

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

- Te Raukura Hauora o Tainui has attracted over 3600 patients who previously did not have consistent arrangements for health care.
- A Wellington School of Medicine study in Wairarapa indicated that asthma control by Māori participants improved significantly as a result of marae-based asthma clinics.
- Use of Te Atiawa Runanga Medical Trust primary health services has resulted in a 30–50 percent reduction in hospitalisation rates for respiratory problems at Taranaki Healthcare; the same practice was successful in controlling diabetes in many patients through diet alone.
- In those regions where it is active Tipu Ora has achieved immunisation rates well above the national average for Māori babies.

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

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

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

## **The delivery of services for Pacific peoples**

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

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

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

### **Use of services**

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

Research and anecdotal evidence suggest that an increased availability of Pacific 'friendly' services could improve access to primary health care services (Tukuitonga 1999). At present Pacific peoples are more likely to access secondary services than other population groups and they have a high rate of hospitalisation.

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

- increasing the training and numbers of Pacific providers
- contracting Pacific programmes for Pacific peoples
- developing alliances between Pacific and mainstream and/or Māori services
- encouraging mainstream services to be more 'Pacific friendly'

- improving intersectoral communication
- community empowerment
- comprehensive evaluation and research.

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

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

### **Challenges for the future**

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

## **Changes in primary health care for people with mental health problems**

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

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

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

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

In 1996 the Mason Report (Mason 1996) recommended a substantial increase in the funding for mental health services, the establishment of a Mental Health Commission to monitor changes, work to improve community understanding, and a strengthening of the mental health workforce. As a result of this funding increase there have been significant changes in secondary mental

health care, and an awareness of the need for improved provision of mental health care in the primary sector. Areas where further changes are needed have also been identified. An extension to this funding in order to meet the goals of the original report is being explored at present.

### **Increased emphasis on education, prevention and early intervention**

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

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

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

### **Increasing the role of general practice in providing mental health services**

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

Failure to recognise 50 percent or more of mental health problems in general practice has been described elsewhere (Simon et al 1999) and New Zealand GPs recognise these problems. The National Health Committee has responded by producing a series of guidelines for the management of depression, anxiety and drug and alcohol problems for GPs and other primary health care workers to use (National Health Committee 1996, 1998, 1999a, 1999b; National Health Committee and Ministry of Education 1998). The Royal New Zealand College of General Practitioners (1999) also recently released guidelines for primary health care providers for the detection and management of young people at risk from suicide.

### **Increasing the number and expertise of Māori mental health care providers**

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

### **Co-operation and integration of mental health services**

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

An increasing number of mental health providers have become aware of the need for more co-operation and integration between the specialist mental health services and primary health

care. A growing number of primary health care providers have begun to work more closely with secondary services, which enables them to confidently provide primary health care for people with severe mental health disorders. Examples of this include the Newtown Union Health Clinic, the Wellington Primary and Secondary Mental Health Liaison Programme, and the Shared Care Project in Hawke's Bay.

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

### **Recent progress**

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

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

### **New ways of delivering disability support**

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

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

### **The disability sector**

The disability sector is complex and diverse. It is often characterised as consisting of five broad groupings of people: those with an intellectual, psychiatric, physical, sensory or age-related<sup>4</sup> disability. In a survey conducted during 1996/97, 20 percent of respondents (equating to approximately 702,000 people nationally) reported a disability resulting in some functional and/or role limitation. Approximately half of these reported needing assistance either intermittently or continuously.

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<sup>4</sup> Generally refers to people over the age of 65 years.

## **Disability support services**

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

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

## **Some recent changes in disability support services**

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

- the emergence of more home support agencies providing more household management and personal care services<sup>5</sup>
- some not-for-profit agencies extending their range of services (for example, some CCS branches now contract for specialised needs assessment for children)
- some increase in respite care or relief of caregivers
- an increase in daycare services
- consideration of individualised funding packages for individuals to purchase their own support packages
- a greater number of people with complex disabilities being cared for in the community following deinstitutionalisation.

## **The relationship between the disability support sector and health sector**

### **Integration of health and disability services**

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

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

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

- The Elder Care Canterbury initiative [[www.know.govt.nz](http://www.know.govt.nz)] which began in July 1997 involves integration of programmes across public hospitals in the area, community support agencies, primary health care providers (and their IPAs) and voluntary services.

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<sup>5</sup> Household management includes help such as cleaning and laundry. Personal care includes help with eating, dressing and other daily activities.

This project involves combining funding from several streams, including a sub-project to integrate services funded by ACC. The focus is on integrating services through improving relationships among providers and between providers and the community.

- DSS services are under-utilised by Māori with disabilities and their whānau, and Māori-for-Māori disability services have been slow to become established. Tainui is an example where iwi social services provide integrated health and disability support services to address Māori aspirations for an holistic service.

### **Unique health needs**

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

### **Workforce**

The DSS reforms have created a high demand for responsive health and disability practitioners, and for skilled support workers. There has been a significant increase in the number of household management and personal care workers. Consideration is also being given to personal care workers or assistants performing some of the tasks previously undertaken by district nurses and other health practitioners. Some concern has been raised recently, particularly by the nursing profession (College of Nurses Aotearoa et al 1999), over the level of skill, training and supervision of some personal care workers. Workforce concerns also include a shortage of health professionals with specialist skills (for example, paediatricians with skills to diagnose and assess children with autistic spectrum disorder).

## **Developing a population-based approach**

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

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

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

Most New Zealanders can identify a source of primary medical care where they most commonly seek treatment (Ministry of Health 1997). Over the last decade most general practices have built up lists of the patients to whom they regularly give treatment. Keeping such lists has been

considered a mark of good practice for many years.<sup>6</sup> The availability of such links between patients and practices has made a population approach feasible and has been an important tool in the growth of primary care organisations such as IPAs (Malcolm 1999).

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

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

Other primary health care providers take various different population approaches. For example, public health nurses have an important role in monitoring the health of people living in defined neighbourhoods or whose children attend certain schools. Plunket and Tipu Ora provide well-child services, family advice and support to all families in an area.

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

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

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

## **Building links with the community**

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

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

Primary health care providers have communicated with and consulted their communities in various ways. Some IPAs market their 'brand' through their member practices, especially where there is more than one IPA in the area. Others publicise new services or improved access they

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<sup>6</sup> Royal New Zealand College of General Practitioners.



have provided from savings on budget holding or new initiatives funds. Other primary health care groups that have informed potential clients about their services include midwife groups, disability support organisations, and independent nurse practitioners (McClellan et al 1988).

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

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

## **Increasing co-ordination and integration of care**

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

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

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

As a result:

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

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

Recent developments and ideas range across a spectrum. At one end are initiatives that are developing better co-ordination and communication between separate providers, with no plans to alter funding arrangements. A number of integrated care pilots are at this end of the spectrum.

A good example is the cardiac failure project between a Christchurch general practice, some specialist community nurses and the hospital department of cardiology.

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

## Targeting those in need

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

### Targeted subsidies for accessing general practice and pharmaceuticals

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

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

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

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

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

The most likely conclusion from these somewhat variant findings is that most people on low incomes who have a Community Services Card can afford to see a GP when needed. However, there are some for whom the costs they face, even with a subsidy (a \$20–\$30 GP fee plus some prescription fees and other costs such as transport, childcare and opportunity costs) are still too

great a barrier. There are other people who, while eligible for a card, do not have one (or do not use it).

### **Other initiatives that target primary health care to particular groups**

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

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

A number of services have been developed that are focused on the needs of people on low incomes. The Union Health Clinics (McGrath 1989) were an initiative that received early funding, and more recently Health Care Aotearoa has received support for the establishment of new centres targeting low income people (Crampton 1999). These practices are funded according to their enrolled population rather than by the number of services that doctors provide, and this has allowed more innovative use of other providers such as nurses, with an accompanying reduction of the costs of providing and accessing some services (Cumming 1999).

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

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

For mental health there are two specific issues that need to be addressed to ensure that appropriate primary health care services are available to the 20 percent of the population who have mental health problems. Firstly, GPs in particular have commented that current funding models do not address the much longer time needed to carry out a comprehensive mental health assessment. This results in a lack of acknowledgement, identification and treatment of mental health problems. The second issue compounds the first, namely, the lack of subsidies for people with mental health problems to access providers other than GPs. For example, a person with a Community Services Card who is suffering from depression cannot use that card when seeing a psychologist, and so is restrained from what may be the most appropriate treatment through the uneven subsidy structure. It is noteworthy that these restrictions do not apply to ACC clients.

### **Addressing inequitable distribution of primary health care funding**

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

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

# Appendix 2: Selected Primary Health Care Statistics

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## Introduction

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

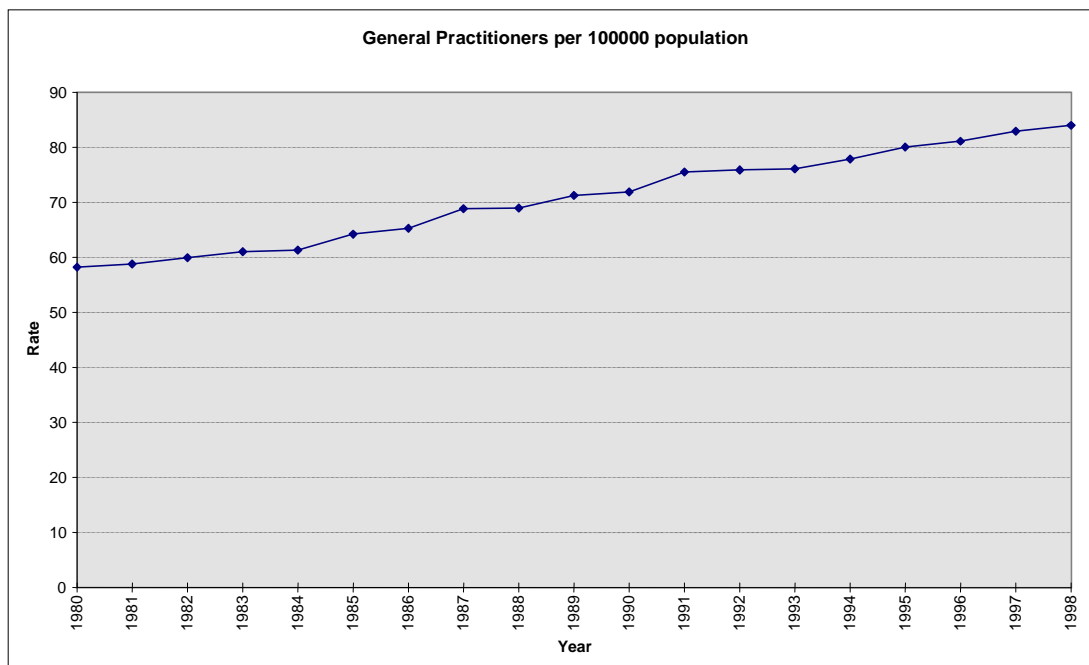
It should be noted that data are not necessarily available in a consistent format across all professions or time periods. Where necessary, explanatory notes have been included. Where possible for activity figures, rates per 100 000 population have been used to take account of population changes while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

## General practitioners

### Numbers

The total number of GPs in New Zealand has risen consistently over the last two decades. Figure 4 shows the number of GPs per 100 000 population.

**Figure 4: General practitioners per 100 000 population**



Source: New Zealand Health Information Service

Note: Numbers include part-time working.

## Utilisation

The recently produced findings of the New Zealand Health Survey (Ministry of Health 1999a) shows that GPs are the most consulted primary health care provider, with approximately 80 percent of adults and children having seen a GP at least once in the previous 12 months.

Some of the key points relating to utilisation of GPs are given below.

- Women (84 percent) are more likely to see a GP than males (74 percent) and they are also more likely to visit doctors more often than men.
- Children, particularly those under five, are heavier users of GP services than adolescents and adults under 65.
- People over 65 are more likely than younger adults to see a doctor, and do so more frequently than younger adults.
- Income is not significant in determining the likelihood of a person seeing a GP at all. However, those in the lowest income groups were likely to visit a GP more often and people from more deprived areas (regardless of income)<sup>7</sup> were more likely to visit a GP six times or more.
- There is little difference in the number of Europeans (81 percent), Māori (75 percent) and Pacific peoples (79 percent) who visited a GP over the previous 12 months. However, people from other ethnic groups (62 percent) were considerably less likely to have done so.
- Adults (90 percent) and children under 15 (87 percent) with a disability were more likely to see a GP than the total population (Department of Statistics 1998).
- Eleven percent of men and 14 percent of women had not visited a GP at least once in the previous 12 months when they felt they needed to. They were most likely to be young (15–24 years), from deprived areas on low family incomes, Māori or Pacific peoples.
- Reasons people gave for not consulting a GP included cost, being unable to find a suitable time or being able to spare the time. Children were less likely to miss an appointment than adults.

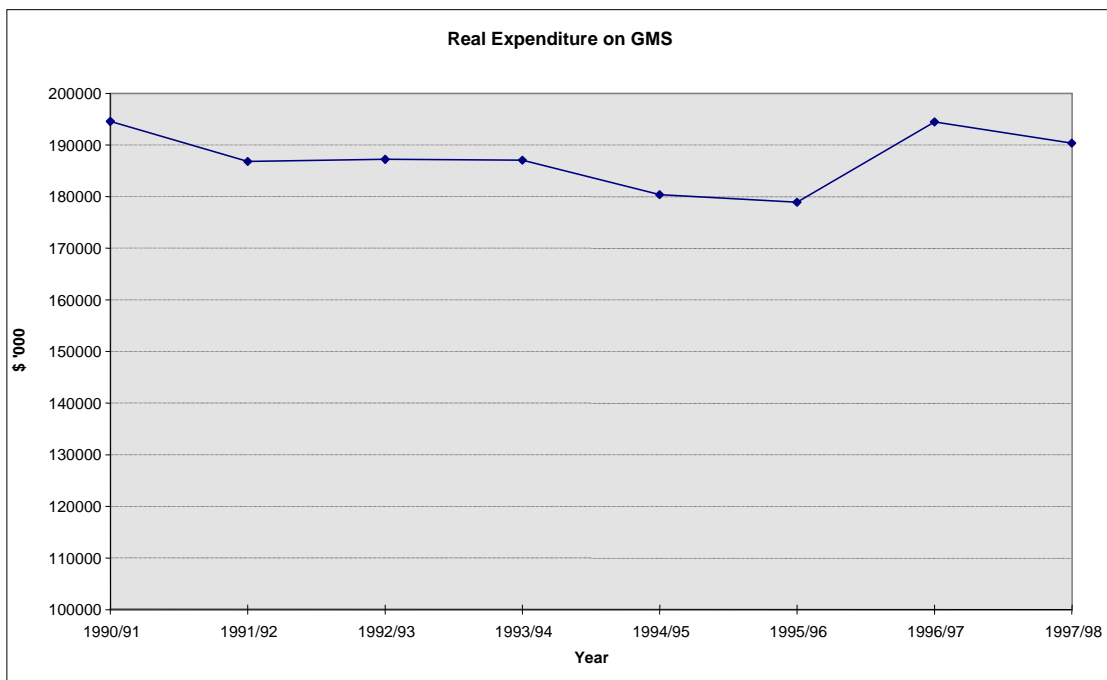
## Funding

Real expenditure on general medical services (GMS) is shown in Figure 5. It can be seen that expenditure in real terms has fallen slightly over the last 10 years although there have been some peaks and troughs.

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<sup>7</sup> This is calculated using the NZDep96 score which is a measure of the level of deprivation in an area calculated using factors such as the proportion of people on some form of benefit.

**Figure 5: Real expenditure on general medical services**



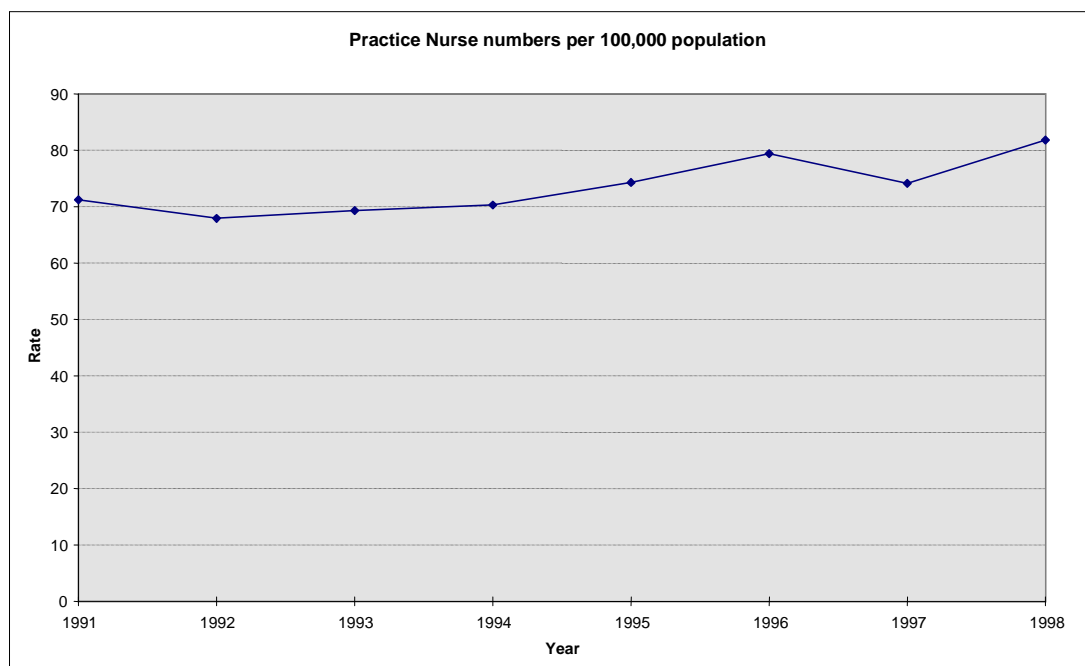
Source: Ministry of Health 1999

## Practice nurses

### Numbers

As with GPs the number of practice nurses has consistently risen. Data are available for the last decade and these are given in Figure 6 below. In terms of absolute numbers this represents a rise from 2404 in 1991 to 3077 in 1998.

**Figure 6: Practice nurse numbers per 100 000 population**



Source: New Zealand Health Information Service

### Utilisation

Patients see a practice nurse either as part of a consultation with a GP or independently. The New Zealand Health Survey (Ministry of Health 1999a) found the following key messages:

- just under a quarter of respondents reported that they had seen a nurse<sup>8</sup> in the previous 12 months
- women (28 percent) were more likely than men (18 percent) to have seen a nurse in this time
- 18 percent of people had seen a practice nurse without seeing a doctor at the same time
- children were more likely to see nurses than older adults
- nearly a third of adults and children with disabilities had seen a nurse in the previous 12 months.

In a Midland survey, a quarter of respondents reported that they had consulted a nurse without seeing a doctor at the same time. On over half of these occasions the nurse was a practice nurse. Other nurses consulted included Plunket nurses (18 percent), public health or school nurses (14 percent) and district nurses (10 percent) (Sceats 1995).

### Funding

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

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<sup>8</sup> This includes practice nurses, midwives, district nurses, public health nurses and Plunket nurses.

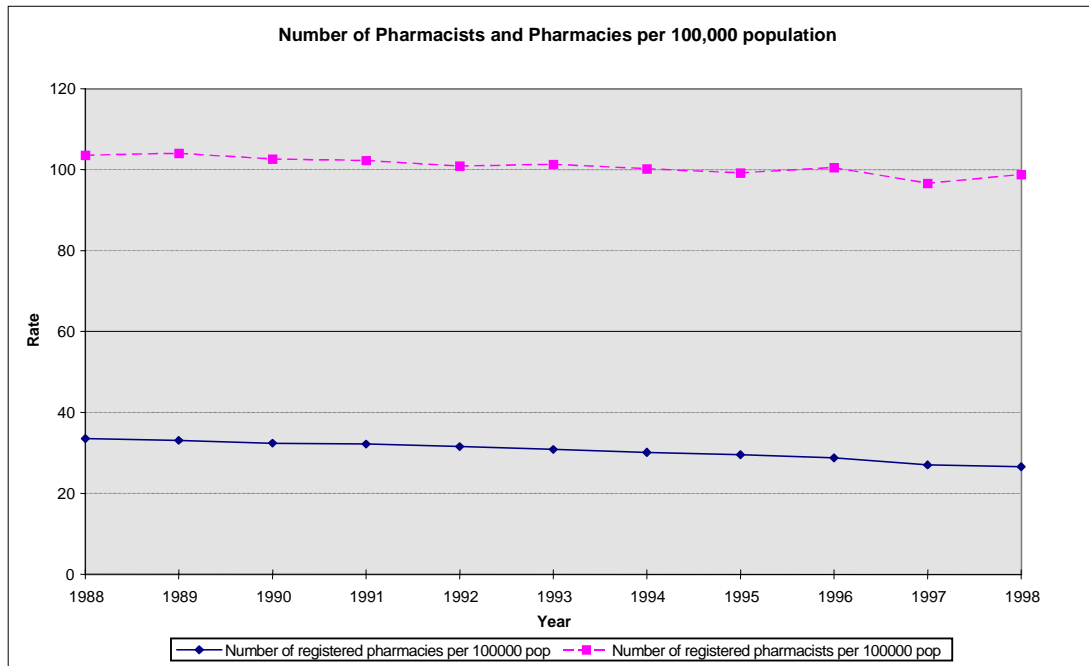


# Pharmacists

## Numbers

Figures are collected on both the number of pharmacies and the number of pharmacists within New Zealand. These figures are given in Figure 7 as a rate per 100 000 population.

**Figure 7: Registered pharmacists and pharmacies per 100 000 population**



Source: Pharmaceutical Society of New Zealand 1998

## Utilisation

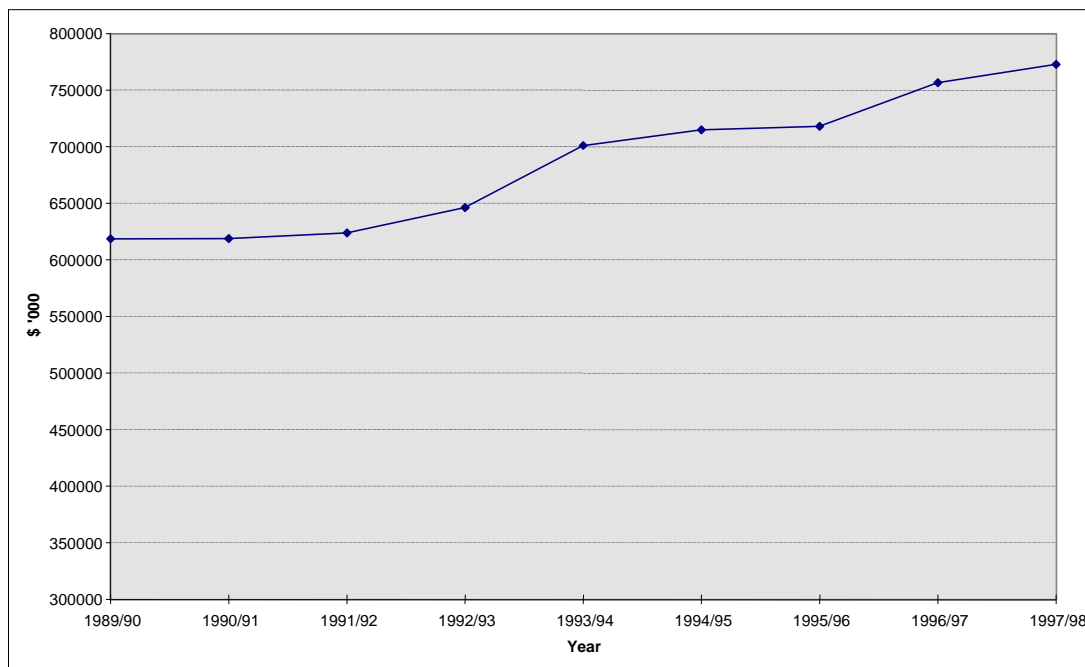
Other than GPs (and others in a general practice), pharmacists are the health practitioner that people are most likely to see. Reasons for doing so include picking up a prescription, seeking health advice and purchasing medicines not on the schedule. The New Zealand Health Survey indicates that in the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

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

## Funding

Expenditure on pharmaceuticals by individuals includes both over-the-counter and prescription purchases. The Government expenditure on pharmaceuticals, which represents the subsidy paid by the Government, is shown in real terms in Figure 8.

**Figure 8: Real expenditure on pharmaceuticals**



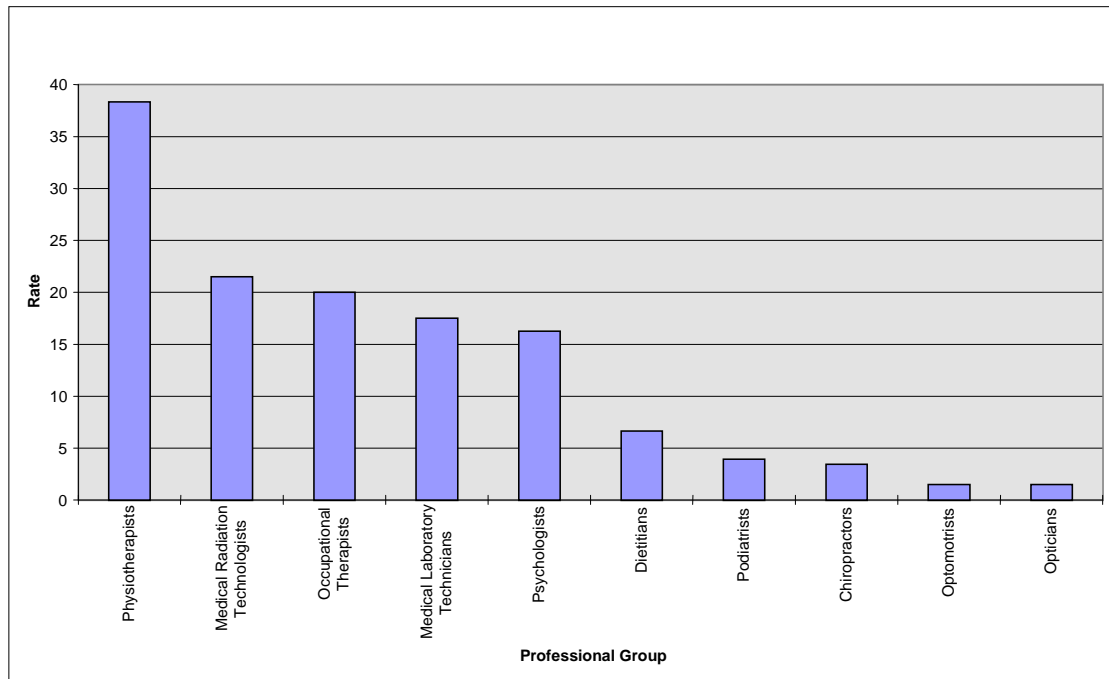
## Other primary health care providers

### Numbers

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

It is difficult to get accurate information on other primary health care providers in New Zealand because of the range of providers. Information from an annual survey of certain professional groups is available, but the accuracy depends on the response rate to the survey. For this reason time series data have not been included in this section. Rates per 100 000 population for 1998 are shown in Figure 9.

**Figure 9: Primary health care staff groups: rates per 100 000 population 1998**



Source: New Zealand Health Information Service

### Utilisation

Apart from dentists, people rarely see other health care providers, mainly because the reasons for doing so are usually fairly specific. Some of the relevant findings from the New Zealand Health Survey (Ministry of Health 1999a) are that in the previous 12 months:

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

## Appendix 3: References

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