Radical reforms for primary health care in New Zealand

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Financial, social and political forces have combined to produce radical reforms in New Zealand’s health system. These are characterized by decentralized management; the integration of services that have traditionally been kept separate, such as the hospital and the community, and public and personal health; and focusing on the population rather than institutions as the basis of the system. These changes are accompanied by a shift of emphasis from secondary towards primary health care.

New Zealand has a population of 3.5 million, of which nearly 12% is of Maori descent. Public sector restructuring and deregulation over the last decade has led to a dramatic change in New Zealand’s economic performance, with an annual growth rate in gross domestic product in 1994 of over 6%, and inflation of 1.6%.

Health services are funded largely from central government taxation which, together with other sources of finance such as social welfare and local authorities, paid for 80.6% of the total in 1992. This reflects a trend towards privatization of health expenditure since 1980, when 88% was paid for by the government.

Historical background

New Zealand brought in a comprehensive system of social security in the 1940s, and this led to a progressive expansion of social services. By the late 1970s it was becoming obvious that New Zealand’s standard of living, from being one of the highest in the world in the early 1950s, had slipped substantially, in comparison with most of the other OECD countries. Major social as well as economic forces were demanding change. These included the challenge of an increasingly disaffected Maori population, the rise of the women’s movement, concerns about the environment, and increasing unemployment.

In 1984 there was a change of government, which marked the beginning of a process of radical change which is still going on today. It is characterized by the abolition of subsidies, and the deregulation, “corporatization” and privatization of almost all the commercial functions of the government. In 1989 area health boards, established in 1983, became fully operational. In the same year, 10 national health goals, each with specific targets, were set by the government under the New Zealand Health Charter. The 14 area health boards were required to monitor the health status of their populations and implement the national goals and targets within their own areas.

A possibly unique feature of the New Zealand health system has been the development
of the service management approach, in which the service rather than the institution is seen as the fundamental organizational framework of the health system. In this kind of health system the basic unit is not the hospital or other organizational entity, but the population. Under the general manager of the area health board, service managers for clinical service divisions were no longer limited by the traditional hospital and community services boundaries but could manage services across boundaries as needed.

The government elected in 1990 announced an even more radical reform in 1991 (1), based on the separation of purchasers (four new regional health authorities) from providers. Major reasons for doing this included the massive government budget deficit and a desire to cut government expenditure, increasing waiting lists for elective surgery, and the apparent failure of publicly provided health services to achieve adequate accessibility and integration. Four groups of providers were envisaged. Firstly there would be crown health enterprises (belonging to the government), largely replacing the existing area health boards. Secondly, community trusts could be formed in which small rural communities could opt to manage their own hospital and related services. Thirdly, private general practitioners would have services purchased from them by regional health authorities instead of being funded centrally as they were in the fee-for-service system. Fourthly, voluntary nongovernmental organizations would provide services, mainly for people with disabilities.

In July 1993 the four regional health authorities became responsible for purchasing all the personal health and disability support services required in their regions. In the same year, a Public Health Commission was established, to be responsible for purchasing population-based public health services still largely provided by the crown health enterprises. The Department of Health became the Ministry Health in July 1993 after placing almost all its provider functions in other agencies. A new Core Services Committee advises the Minister on health priorities.

Towards a system based on primary health care

Over the past two decades there has been a progressive shift from secondary to primary care. This has been speeded up in the last two years with the current reform process which integrates both primary and secondary funding under the regional health authorities. Despite the early ambivalence of many general practitioners towards contracts, a significant number of them have seen the potential of advancing the development of primary health care through contracting with regional health authorities.

A number of primary care pilot projects were established in 1991, most of which had a budget-holding approach to the management of primary care resources and were related to similar experiments in the United Kingdom. This led to the establishment of an increasing number of independent practice associations throughout the country. Some 40 have now been formed, and cover possibly half of the total number of general practitioners. Although still in the early stages, this devel-
opment provides for the progressive build-up of collective accountability arrangements amongst general practitioners for the provision of their services. These include alternatives to fee-for-service payments, the practice of patient registration, accountability for quality of care, information systems, and progressive budget-holding for laboratory, pharmaceuticals and secondary care services.

The most advanced example of this development is the Pegasus Medical Group in Christchurch. Its 195 members include almost all general practitioners in the city, and it is paying its members under contract through the Southern Regional Health Authority for medical services, maternity, immunization and other related subsidies. It has already successfully established budget-holding for laboratory services with major savings, and followed this up with a similar project for pharmaceuticals in early 1995. Its services cover some 300,000 population and its goals include building up the standards and quality of general practice, shifting the balance of services from secondary to primary care and improving the health status of the people of Christchurch. Similar developments are occurring in other independent practice associations.

A range of other primary care initiatives have also been fostered and stimulated by the current reform process. For example, Te Oranganui, a charitable trust formed by the Maori tribal groupings in the Wanganui area, has established a health centre which has enrolled over 5000 people in 12 months. It is moving progressively into budget-holding for the provision of a comprehensive primary health care service, including contracts with local general practitioners. It is also complementing primary medical care with culturally appropriate health promotion services.

**International relevance**

It may be relatively easy for small countries such as New Zealand to implement major health reforms, but some aspects of its experience could be of significance for any country trying to ensure that its health services work properly.

In particular, the following lessons can be drawn from New Zealand’s experience.

- It is necessary to shift the emphasis in health services from inputs to outputs and outcomes. The importance of separating the purchasers from the providers is that it makes it practical to think in terms of achieving value for money in the health services. Their value can be determined by whether they are improving the health status of their populations. New Zealand’s regional health authorities now have a specific responsibility to achieve health gains by focusing on the defined health needs of their populations.

- The principle of integrated and capped population-based funding has been applied successfully. Population-based funding of area health boards resulted in a less than 1% annual inflation-adjusted growth in the health budget over the decade of 1982–92. This can be compared with the previous 6.1% annual growth in the open-ended fee-for-service primary medical care expenditure. It illustrates the comparative advantage of the regional health authorities with their fully integrated, capped budgets.
The trend is towards greater accountability of doctors for decentralized decision-making within these capped budgets. The model of service management has gone beyond hospitals and become an epidemiologically based system of accountability. It is also now involving general practitioners through the independent practice associations. A distinctive feature of this approach is that it includes other disciplines in a general management model rather than a clinical directorate model as appears to be typical of other countries.

Primary health care should be a managed service entity. The replacement of the hospital by services is the key to this organizational development (2). Similar developments might be occurring in the USA and the United Kingdom, but in both those countries the primary care services are doctor dominated, not particularly focused on the population, and not part of any planned or integrated system.

Much can be achieved by integrating public health with personal health services through a population-based provider entity such as an area health board. Despite their commercial emphasis, the crown health enterprises have included both public health and personal health services in the range of services they provide, and find this consistent with their focus on population. Attempts to disentangle public health from personal health services have conspicuously failed and have been strongly resisted by all concerned, including providers of personal health care services.

We may conclude that New Zealand's health reforms over the last few years illustrate some fundamental shifts in the planning and provision of health services which are likely to have significance for many aspects of international health work, including ways of achieving Health for All by the year 2000 through primary health care.

References

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**Forging a new global partnership**

Achieving sustainable development requires protecting the rights of local people to control their own resources – whether it be forests, fish, or minerals. Yet nations and people everywhere are also discovering that if we are to master today's transnational challenges, a wider role for international institutions is inevitable. It is thus a paradox of our time that effective governance requires control being simultaneously passed down to local communities and up to international institutions.