Aotearoa New Zealand's Primary Health Care Strategy

Equity-enhancing in Policy and in Practice?

The Lancet Global Health Commission on Financing Primary Health Care

SYNOPSIS

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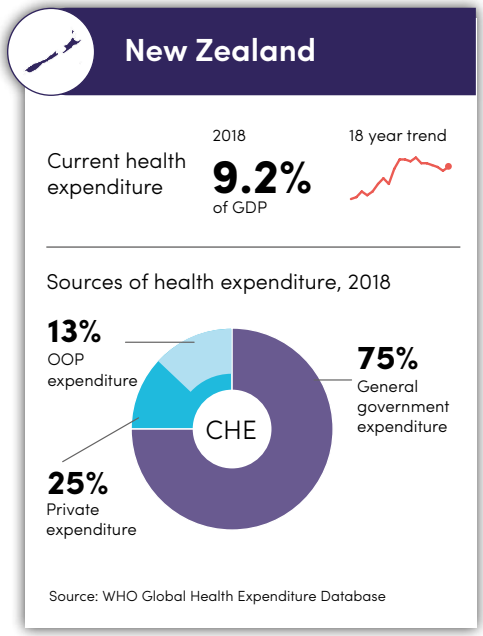
In 2001, the Aotearoa New Zealand (A/NZ) government launched an ambitious Primary Health Care (PHC) strategy, which aimed to expand PHC services and reduce inequities in access to health care and health outcomes, particularly for Māori, Pacific peoples, and those on lower incomes. The Strategy included a significant increase in funding allocated to PHC, and a shift in provider financing arrangements from fee-for-service (FFS) to capitation. Primary Health Organisations (PHOs) were introduced to allocate government funding to service providers and support the development of PHC. This paper explores key aspects of the PHC Strategy and the extent to which its implementation over the past 20 years has supported the policy goal of reducing inequities in health.



NEW FUNDING ARRANGEMENTS AIM TO REDUCE FINANCIAL BARRIERS TO CARE AND INEQUITIES

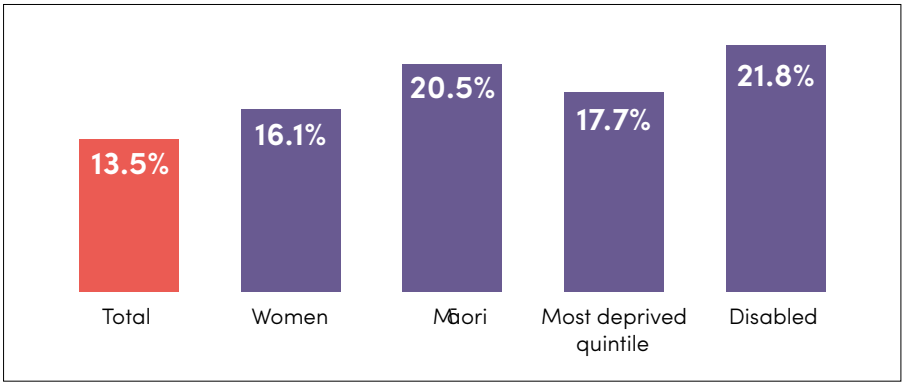
An important component of the Strategy was to change the way that PHC services were financed. Prior to 2001, financing was largely on a FFS basis, with the government subsidising care for those on lower incomes. The introduction of PHC strategy brought with it a change from targeted government funding for general practitioner (GP) visits to universal, weighted, capitation paid to PHOs. The move to capitation was designed to ensure that all New Zealanders would receive subsidised care and to encourage providers to focus on preventative health care. Also, as part of the Strategy, in 2006, the government introduced a PHO Performance Programme that aimed to improve the quality of care and better hold providers to account for the achievement of key goals. The Strategy continues to be amended under the current government with additional funding for mental health and wellbeing services in recent years.

In theory, the capitation formula, alongside other measures introduced in the Strategy, could support reduced inequities by providing a greater proportion of funding for people with higher needs, whilst also enabling funding to be allocated to support all those enrolled, rather than only for people who attend consultations. In practice, however, the main formula used to determine levels of funding allocated to population groups did not include ethnicity or deprivation, despite higher health care needs for these groups.

IMPLEMENTATION IN PRACTICE – THE CHALLENGE OF ACHIEVING LONG TERM CHANGE

The paper finds limited evidence on the extent to which the Strategy achieved its key goals and whether changes led to reductions in inequities. Early analyses suggested that the PHCS may have helped the government achieve almost universal rates of enrolment, reduced user charges, increased rates of consultations, and improvements in services delivered via the PHO performance programme. Longer term, however, the momentum of the PHCS has not been sustained. In recent years there have been increases in the proportion of people not enrolled in PHC, with lower enrolment rates

Figure 1: Proportion of adults who were unable to visit a GP due to cost in 2019/2020



Source: Country case study

amongst Māori compared to European New Zealanders, and in less affluent areas. Inequities with respect to unmet need for health care have also persisted (see figure 1). Access to PHC continues to be dependent on users' ability to pay GP charges, leading to significant barriers to care and a likely over-use of hospitals.

MOVING FORWARD – THE NEED FOR NEW MODELS OF CARE AND A RENEWED FOCUS ON ADDRESSING INEQUITIES

On its own, capitation was unlikely to lead to significant changes in the way that PHC was provided in A/NZ, although it has led to a large increase in the use of nurses. Moving forward, new models of care, e.g., multi-disciplinary teams to increase the scope of services and more preventive approaches to care, need to be designed, tested, costed, and supported.

To meaningfully reduce inequities in health care, especially for Māori, the government must pay greater attention to higher needs populations, and consider, specifically, the recommendations of the Waitangi Tribunal to address issues relating to legislative mandates, governance, and appropriate funding for Māori.

Related to this is the need to better incorporate community views in the design and delivery of PHC services to ensure that they are appropriate to meet their healthcare needs. It is important that the government balances ongoing financial support of mainstream services delivering universal care with the development of alternatives for higher needs populations.

LESSONS LEARNED

1. **Successful reform of health care service delivery requires a sustained approach to change.** Recognise that it is extremely difficult to reform health care service delivery.
2. **Consider how existing models of care work for key populations.** Fund and pilot new models of care and support their rollout if evaluations show they are successful. Consider: who provides services, the emphasis on curative vs preventive care or on key health issues, where services are located (in local clinics, in community settings such as marae or schools), how much support there is for self-care, the scope of services (e.g., mental health, dental health, social services), and the integration/co-ordination role.
3. **Set priorities and use new funding to get the priority changes needed to make equity gains.**
4. **A move from a fee-for-service to a capitation arrangement on its own will not necessarily lead to significant changes in service delivery or in models of care.** For example, continued fee-for-service user charges alongside government capitation payments may blunt capitation payment incentives.
5. **Carefully consider policies needed to ensure the supply of desired services.** Invest in needed workforces (e.g., nursing, mental health counsellors, health coaches) and support essential infrastructure (e.g., integrated centres).
6. **Monitor and evaluate continually,** including ensuring that key data are available to measure change.

This synopsis is based on one of 10 country case-studies written for the Lancet Global Health Commission on Financing Primary Health Care:

Cumming J. Aotearoa New Zealand's Primary Health Care Strategy: Equity Enhancing in Policy and Practice? *Lancet Global Health Commission on Financing Primary Health Care.* Working Paper No. 6. 2022

Funding: This work was funded by a grant from the Bill & Melinda Gates Foundation. However, the views expressed in the synopses are those of the authors and do not necessarily reflect the views or policies of BMGF.

Suggested citation: Cumming J. Synopsis: Aotearoa New Zealand's Primary Health Care Strategy: Equity Enhancing in Policy and Practice? *Lancet Global Health Commission on Financing Primary Health Care.* 2022