The Lancet Global Health
Commission on
Financing Primary Health Care

Aotearoa New Zealand's Primary Health Care Strategy: Equity Enhancing in Policy and in Practice?

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WORKING PAPER 6

JANUARY 2022

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Lancet Global Health Commission on Financing Primary Health Care

The Lancet Global Health Commission Financing Primary Health Care (2020 – 2022) is committed to drawing on robust, evidence-based knowledge to generate useful findings and actionable recommendations to inform decisions made by governments and partners that shape the effective financing of primary health care. Our work is focused on enhancing, protecting and enabling the appropriate resourcing of primary health care as a critical engine for the achievement of universal health coverage.

Country case studies

The Commission organised 10 case studies. Each country lead consultant and team undertook a scoping review to identify 'hot topics' in the financing of PHC in the respective countries. The teams then chose a 'deep dive' topic on which to undertake primary research. The 10 case studies were undertaken in: Brazil, Chile, China, Estonia, Ethiopia, Finland, Ghana, India, New Zealand and the Philippines.

Funding

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

Suggested citation

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

Acknowledgements

Report edited and formatted by Becky Wolfe.

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Table of contents

Acronyms

ASH	Ambulatory Sensitive Hospitalisation
CHE	Crown Health Enterprises
CSC	Community Services Card
DHB	District Health Board
FFS	Fee-for-service
GP	General Practitioner
GPC	General Practice
HUHC	High Use Health Card
HP	Health Promotion
IFHC	Integrated Family Health Centre
IPA	Independent Practitioner Association
IPIF	Integrated Performance and Incentive Framework
NZHS	New Zealand Health Survey
PHC	Primary Health Care
PHCS	Primary Health Care Strategy
PHO	Primary Health Organisations
PSAAP	Primary Health Organisation Service Agreement Amendment Protocol
RHA	Regional Health Authority
SIA	Services to Improve Access
SLM	System Level Measures Programme
VLCA	Very Low Cost Access (scheme)

Executive Summary

In 2001, the Aotearoa New Zealand (A/NZ) government released a Primary Health Care Strategy (PHCS), aimed at enhancing the role that primary health care (PHC) plays in health care, improving health, and reducing inequities in health. The Strategy included: providing additional funding to reduce user charges and to extend PHC services; establishing Primary Health Organisations (PHOs) as meso-level organisations to support the development of PHC; changing the government's financing from fee-for-service payments for visits to general practitioners (GPs) to capitation payments via PHOs; and establishing a PHO performance programme to improve quality of care.

This paper assesses how the government roll out of new funding, the new capitation formula, and aspects of the PHO performance programme, supported its goals of reducing inequities in access to care and in health. The paper notes that the PHCS has changed some foundational aspects of PHC in A/NZ and some of these do promote better equity. The potential of the PHCS was demonstrated in its early years, but progress has stalled, and a new approach is needed 20 years on.

Box 1: Key lessons for a greater equity orientation

- Recognise that it is extremely difficult to reform health care service delivery; it requires a sustained approach to change.
- Consider how existing models of care work for key populations – fund and pilot new models of care and support their spread if evaluations show they are successful. Consider who provides services, their 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.
- Set priorities and use new funding to get the priority changes needed to make equity gains.
- Recognise that 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, consider how continued fee-for-service user charges alongside government capitation payments may blunt capitation payment incentives.
- Carefully consider policies needed to ensure the supply of desired services – make investment in needed workforces (e.g., indigenous Māori and Pacific workforces, nursing, mental health counsellors, health coaches) and support other needed infrastructure (e.g., integrated centres).
- Monitor and evaluate continually (including ensuring that key data are available to measure change).

1. Introduction

In 2001, the Aotearoa[1] New Zealand (A/NZ) government introduced and began to implement a Primary Health Care Strategy (PHCS), aimed at significantly strengthening the role of primary health care (PHC) services in the health system. This paper explores key aspects of the PHCS, its implementation, and the extent to which implementation in practice has supported the policy goal of reducing inequities in health. The paper focuses on the roll out of new funding, the adoption of a weighted capitation formula to fund PHC, and the PHO performance programme. It aims to provide detailed information on the complex arrangements that were developed to support the PHCS, and lessons learned from the A/NZ experience for other countries.

In Section 2, the paper sets out the background to PHC policy in A/NZ until the year 2000. Section 3 sets out, in broad terms, the introduction of PHCS in 2001, and how the PHCS policy evolved up to 2021. Section 4 provides further detail on the roll out of new funding, the capitation funding formula and the PHO performance programme; assesses the extent to which these have been equity-enhancing; and examines changes in these features that have occurred up to 2021. Section 5 explores the impact of key aspects of the PHCS through an equity lens, drawing on published sources and a number of key indicators. Section 6 draws overall conclusions on the equity-enhancing nature of the PHCS and its implementation in A/NZ and considers the lessons learned from the A/NZ experience.

The paper focuses on the arrangements for adults. Analyses of the policy changes and impacts for children are available here (Jeffreys M, Smiler K et al. 2022[2]). A goal of enhanced integration (or co-ordination) – across PHC services, and between PHC and secondary services (hospital care) – was also a key part of the PHCS; that too is discussed elsewhere (Cumming, Middleton et al. 2021[3]) Another area that is not considered in depth is that of Whānau Ora, an Indigenous philosophy and programme that supports a more holistic approach to health and social development goals for high needs families, or whānau; it too has been described and analysed elsewhere (Boulton, Tamehana et al. 2013, Smith, Moore et al. 2019).

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[1] 'Aotearoa' is a Māori name for New Zealand. Māori are the Indigenous population of Aotearoa New Zealand. They came to the country in the 14th Century. A Treaty was signed by the Crown (Queen Victoria) and Māori iwi (tribal) leaders in 1840; see Waitangi Tribunal (2020). Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry. Wellington, Waitangi Tribunal for a recent report on Hauora (health).

[2] https://www.sciencedirect.com/science/article/pii/S2352827322000234

[3] https://www.ijic.org/articles/10.5334/ijic.5679/

2. Background – Primary Health Care Policy Prior to the 2000s

1935-1990

The key financing and organisational arrangements for PHC in A/NZ go back to the 1930s, when a Labour (left-leaning) government campaigned on introducing free, integrated, comprehensive health care for the entire population. During the late 1930s and early 1940s, the government was able to introduce free hospital, maternity, and mental health care, largely delivered via publicly owned hospitals. But general practitioners (GPs) fought hard against the funding and capitation proposals suggested for PHC. In the end, GPs remained as independent small businesses (known as general practices (GPCs)), with their services partially funded by a universal, fee-for-service (FFS) government subsidy, with GPs also retaining the right to charge service users fees on top of the government subsidy. At that point, government subsidies covered around 75% of the cost of a GP visit (Primary Care Working Group on General Practice Sustainability 2015).

As a result, PHC remained very much in the background for policy and funding when compared to hospital services, which developed quickly with new funding, new infrastructure, and new technologies over the next four decades. For many years, the government subsidy for GP visits stayed at the same dollar level, while the user charges increased. By 1986, the subsidy was funding around 20%-30% of GP income (at $1.35 for an adult; $3.30 for beneficiaries, the chronically ill and the elderly; and $11.20 for children; with higher rates for after-hours consultations) (Primary Care Working Group on General Practice Sustainability 2015).

It was repeatedly recognised that the user charges for GP visits were a major barrier to access, especially for Māori, Pacific peoples, and those in lower income groups. The charges were seen as contributing to poor PHC access, over-use of free hospital emergency department services (EDs)[4], people becoming sicker and then being admitted to hospital late, and worsening health inequities (New Zealand Government 1969; New Zealand Government, 1974; Health Benefits Review 1986). Inequities in the A/NZ context means unfair differences in access to and the use of health services, and in health status (Poynter, Hamblin et al. 2017).

There were some examples in A/NZ of different arrangements for PHC. For example, for some time there were 12 Special Areas, in very rural locations, with staff employed by the Ministry of Health. Several medical centres began to be paid via capitation payments from the late 1970s, including Otumoetai (Seddon, Reinken et al. 1985), Ropata, and Karori medical centres. Finally, a number of Union Health Centres developed during the 1970s. These were also funded via capitation and offered cheaper services with stronger links with social services and with nurses providing much of the care. However, these arrangements remained limited (McGrath 1989).

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[4] In A/NZ, hospital EDs are part of District Health Boards or DHBs, which have overall capped funding. Thus, hospital EDs do not have financial incentives to encourage over-use; rather, DHBs often remind people to seek GP care first rather than just turning up a at a free hospital ED.

Box 2: Primary Health Care in Aotearoa New Zealand 1935-1990

Foundations

- A single central government Minister of Health oversees health policy and most health funding, supported by the Ministry of Health
- Little attention is paid to PHC in policy, although numerous reports emphasised that PHC arrangements in A/NZ could be improved to deliver better, and more equitable, health
- There is limited accountability of PHC providers for the funding they receive (i.e., there is passive funding[5] of PHC by central government)

Resource mobilisation and allocation

- PHC service delivery is generally limited to GP visits; there is no formal, defined package of care
- Financing of health care is via general taxation, which also funds other government services, offering a low-cost form of financing for health[6]
- Finances for health are pooled at central government level, enabling governments to allocate financing to health care to best meet health needs (i.e., to prioritise spending)
- Finances for PHC are allocated on a FFS basis for GP visits, i.e., promoting productivity (visits), with financing from both government and service users on a FFS basis

Financial and non-financial incentives

- PHC providers are incentivised to i) locate in more populated areas and in areas with higher incomes; ii) deliver more visits/consultations; and iii) set service user charges at levels that the market could bear – taking into account ability and willingness to pay; service user charges are not regulated
- There is significant provider autonomy
- Access to PHC is particularly dependent on ability to pay service user charges, leading to significant barriers to access to care and a likely over-use of hospital services, i.e., there are significant inequities in access to care leading to significant inequities in health

Organisation

- There is a highly skilled GP workforce, supported by practice nurses (via a practice nurse subsidy which is extended from rural areas to the whole country in 1977)
- There are highly fragmented services, with GPs as gatekeepers/referrers into other parts of the health system (e.g., to pharmacies for prescriptions, to hospitals for specialist care)

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[5] Passive funding is the allocation of government funding for services via e.g a fee for a standard service, based on claims from health care providers. It contrasts with active purchasing, where a government or its agents make strategic decisions about what to fund, use contracts to lay out the services that should be provided (potentially including guidelines for particular care), and enforce those contracts.

[6] There is no tagged tax for health in A/NZ.

1990s

By the early 1990s, the standard $NZ 1.35 per GP visit government subsidy was funding only around 20%-30% of total GP fees (Primary Care Working Group on General Practice Sustainability 2015). A National Party (conservative) government, brought to power in late 1989, undertook two major reviews of the health system during 1990/91 (alongside other social policy reviews).

From one review (focused on government 'benefits'), it was decided to change the universal financing arrangement for PHC to a targeted arrangement. This was done to focus spending on higher needs groups. The changes saw the introduction of a Community Services Card (CSC) for those on lower incomes. Those holding such a card would be entitled to subsidised GP care, while those not holding a card would pay the full cost of GP care themselves (Shipley 1991). A major concern with this approach was whether all those eligible would take up their cards; and this did indeed eventuate as a major problem, with one study finding only 72% of those eligible for the CSC were holding one in some communities (Parks 1996). A High Use Health Card (HUHC) was also introduced to reduce the cost of GP services for those not eligible for a CSC, but who required frequent visits (12 or more in the previous year) (Cumming, McDonald et al. 2014).

A second review focused on the financing and organisation of the health system as a whole (Upton 1991). This led to major health system reforms, undertaken between mid-1991 and mid-1993. These reforms established a purchaser-provider split or 'quasi'-market. Four new geographically based Regional Health Authorities (RHAs) were established as stand-alone active purchasers, and publicly owned hospitals were reorganised into 23 Crown Health Enterprises (CHEs), which were to generate surpluses for reallocation back into the health system. All health care providers (including CHEs and GPs) were to be funded through formal contracts, and all providers (including privately owned hospitals) could compete for contracts with the RHAs[7]. Thus, PHC providers moved onto new, formal contracts. These reforms resulted in several key developments in PHC (Barnett 2003).

First, GPCs and others established new representative organisations (Independent Practitioner Associations or IPAs) that contracted with purchasers on their behalf, as a means of ensuring GPCs had negotiating power with the RHAs. IPAs made it easier for purchasers to contract for PHC services by reducing the number of contracts. IPAs also better supported backroom functions, quality improvement including via peer activities, and could allocate resources across GPCs where a single GPC might not be able to support specialised roles (e.g., asthma nurses). IPAs also supported an interest in a wider role for PHC amongst some GPC providers.

Second, each RHA developed some new funding arrangements for PHC. There was a shift to capitation payments in some parts of the country (with 22% of GPs on capitated payments by 2001 (Crampton, Sutton et al. 2002)); some referred services budgets were set up to encourage lower pharmaceuticals and laboratory expenditure (Kirk, Barnett et al. 2002); and, in one case, a global budget covered all PHC services within a lump sum (Kirk, Barnett et al. 2002).

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[7] At this point, privately owned hospitals would be competing with publicly owned CHEs to deliver some specific hospital services (such as elective services). GPCs would likely hold contracts for a range of standard services but be able to compete for specialised PHC services (such as sexual health services).

Overall, however, these reforms were expensive to implement, highly controversial, and did not always lead to the desired outcomes (e.g., major savings in CHEs did not eventuate and waiting lists grew rather than reduced) (Ashton 1999, Cumming 2013). National Party-led governments introduced multiple policy changes and provided millions of dollars to the health sector to try to the overcome challenges to the new system. Thus, in the mid-1990s, CHEs became Hospital and Health Services, and were no longer required to generate a surplus; and in the late 1990s, the four RHAs were amalgamated into a single national Health Funding Authority, designed to improve national consistency and streamline contracting arrangements (Ashton 1999, Cumming 2013).

At the same time, there was growing international interest in strengthening PHC, based in part on new research suggesting that a stronger PHC system could result in reduced overall expenditure, better health, and reduced inequities (Starfield 1992, Starfield 1994, Starfield 1996, Grant, Forrest et al. 1997, Starfield 1998, Shi and Starfield 2000). A number of A/NZ reports (Health Funding Authority 1998, Coster and Gribben 1999, Crampton 1999, Crengle 1999, Cumming 1999, National Health Committee 2000) reflected on this international research and suggested that PHC should play a stronger role in health care and health.

Box 3: Primary Health Care in Aotearoa New Zealand 1990s

Foundations

- A single central government Minister of Health oversees health policy and most health funding, supported by a Ministry of Health
- Growing attention is paid to PHC in policy, with financing changes in the early 1990s to promote equity of access through targeted subsidies, and key reports emphasising that PHC arrangements in A/NZ could be improved to deliver better, and more equitable, outcomes
- Greater accountability of PHC providers for the funding they received via contracts

Resource mobilisation and allocation

- PHC service delivery is generally still limited to GP visits; there is no formal package of care for service users but there is more specificity of the services GPs/GPCs should deliver in contracts
- There is continued financing of health care via general taxation
- Financing for health care continues to be pooled at central government level, enabling governments to allocate financing to health care to best meet health needs
- Financing for PHC continues largely on a fee-for-service basis for GP visits, i.e. promoting productivity (visits), but there are new arrangements developing in some parts of the country, using capitation and budgets to incentivise different behaviours (see below)

Financial and non-financial incentives

- PHC providers largely continue to be incentivised as in earlier years; although there were some new arrangements providing different incentives via capitation (to keep people well), referred services contracts (to reduce spending on referred services) and a block contract (to offer more flexible service delivery while keeping within a capped budget)
- There continues to be significant provider autonomy, but there are more contractual and performance obligations
- There is a change from universal to targeted funding designed to enable better access for those with higher needs, promoting better equity
- Access to PHC is likely to improve for those with CSCs and HUHCs, but for others, access continues to be particularly dependent on ability to pay service user charges set by GPs/GPCs; i.e., there remain significant inequities in access to care leading to significant inequities in health

Organisation

- There is a highly skilled GP/GPC workforce, increasingly supported by nurses
- Services remain highly fragmented

3. The Primary Health Care Strategy

This section sets out the details of the PHCS at a high level and identifies key changes that have occurred in PHC policy up to 2021. Section 4 (below) will discuss key PHCS arrangements in more depth from an equity perspective.

2000–2008

In late 1999, a Labour-led coalition government came to power, overturning the 1990s reforms, and establishing 21 (now 20) geographically based District Health Boards (DHBs), responsible for the health of their communities, and running their own hospitals, public health, and health services (e.g., community-based mental health care). DHBs are funded via a population-based funding formula[8] that includes age, gender, ethnicity, deprivation[9], rurality, unmet need, and funding for overseas visitors (Penno, Audas et al. 2012). These reforms were designed to remove most of the quasi-market arrangements introduced during the 1990s, although some elements remained, including (initially) an internal separation of purchasing and provision within some DHBs, and the on-going use of contracting for PHC and community services.

In 2000, as the DHBs were being established, the government released a New Zealand Health Strategy to guide the health sector's priorities (King 2000). In 2001, it released a Primary Health Care Strategy (PHCS) (King 2001), the first major policy emphasising PHC since central government took over the financing and responsibility for health care in the 1930s. The PHCS built on international evidence that a strong PHC system would likely lead to better health, reduced inequities in health, and overall lower expenditure on health, including through reduced hospital admissions (Starfield 1992, Starfield 1994, Starfield 1996, Grant, Forrest et al. 1997, Starfield 1998, Shi and Starfield 2000).

The PHCS involved a number of major changes to PHC policy. First, there was to be significant new funding allocated to PHC, to i) reduce user charges to lessen the role of cost as a barrier to access; and ii) expand PHC services, including, for example, through out-reach services or longer opening hours, as well as through new ways of delivering services, such as through more nursing services, and an expansion of the PHC team to include e.g., social workers.

Second, the government sought the development of new not-for-profit Primary Health Organisations (PHOs) as meso-level organisations – sitting between DHBs and PHC providers – to oversee PHC for enrollees. These built on the IPAs that developed during the 1990s (as noted above) but would be not-for-profit and would involve local communities and a wider range of providers in their governance and decision-making. PHC providers could choose whether to join a PHO or not, but those who did not, would not be able to obtain new funding and offer reduced fees for consultations.

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[8] This is a weighted per capita formula covering those residing in a district. The PHC capitation formula is also a weighted per capita payment, but it applies to those who formally enrol with a GPC, with GPCs competing against each other for enrollees.

[9] Deprivation is measured by an NZDep area measure, that takes into account socio-economic factors such as household income, employment, qualifications, etc. Atkinson, J., C. Salmond and P. Crampton (2014). NZDep2013 Index of Deprivation. Wellington, University of Otago. There are 10 deciles, 1 being the least deprived and 10 being the most deprived; at times, these are reported as five quintile groups, 1 covering deciles 1-2 (the least deprived), and 5 covering deciles 9-10 (the most deprived).

Third, people would now formally be enrolled with a PHO. This would allow a shift from government funding via FFS to funding via capitation and enable greater accountability for the achievement of key targets, through having a formal enrolment list and being able to measure population denominators (see below on the performance management programme). In practice, drawing on already existing processes where people registered with a particular GPC, people formally enrolled via a GPC which in turned joined a PHO. Formal enrolment would also support greater continuity of care, through people having a formal first port of call for health services.

Fourth, government funding changed from targeted FFS for GP services to universal weighted capitation at the PHO level. The shift back to universal funding would ensure all New Zealanders would receive subsidised care, while the move to capitation was designed to better control government financing in PHC (as expenditure would no longer grow as a result of increases in utilisation and FFS payments); encourage a focus on keeping people well; and support the development of a range of services not dependent on people seeing a GP (e.g., nursing services).

Finally, in 2006, the government introduced a PHO Performance Programme, designed to improve quality of care and better hold PHC to account for the achievement of key goals.

It is worth noting that PHC arrangements are negotiated via a national Primary Health Organisation Service Agreement Amendment Protocol (PSAAP), with representatives from all DHBs, PHOs, GPCs, and the Ministry of Health. PHC funding flows through DHBs, who pass on key funding streams to PHOs. Thus, PHC funding is effectively ring-fenced, although DHBs can allocate their other resources to PHC if they so wish.

By 2009, it would be noted that the PHCS was strongly supported throughout the health sector, and that it had arguably met early key goals via the establishment of PHOs, virtually full enrolment of the population in PHOs, the allocation of significant amounts of new funding, a shift to capitation, a reduction in the charges people paid, and an increase in utilisation, especially of nursing services in GPCs (Raymont and Cumming 2013, Raymont, Cumming et al. 2013).

However, far less had been achieved in terms of developing new models of care, with most care continuing to be delivered in much the same way it always had – that is, via 15-minute GP consultations. New models of care might have included more multi-disciplinary team and preventive approaches to care, with PHC providers taking on a greater role in co-ordinating care (Smith 2009). It was thus argued that there was a need for a stronger focus on a vision for, and collaborative implementation of, new models of integrated/co-ordinated care, along with evaluation to support the spread of the more successful models (Smith 2009).

2009-2017

There was a change of government in late 2008, to a National-Party-led coalition government. The National Party had gone into the 2008 election critiquing the lack of progress with the PHCS (especially the slow development of new models of care), and promising more personalised care, delivered closer to home, with an expansion of PHC services and more integrated/co-ordinated service delivery, including through new Integrated Family Health Centres (IFHCs) (Ryall 2007). At the same time, the Global Financial Crisis hit, and although A/NZ was not as adversely affected as other countries, economic growth did slow (Ng and Bollard 2012). Health expenditure in A/NZ grew far more slowly over the next few years (Cumming 2017).

A Ministerial Review panel reported in 2009, noting the financial challenges faced by the health sector as costs rose while health spending increased at a much slower pace than during the 2000s. Key recommendations aimed to reduce bureaucracy, improve frontline health services, and improve value-for-money (Ministerial Review Group 2009). With respect to PHC, this resulted in a number of changes in policy, albeit still within the ambit of the PHCS. The new government sought a reduction in the number of PHOs to strengthen the system's ability to plan services, improve capability and capacity in bringing about change in service delivery, and reduce administrative costs. As a result, the number of PHOs fell from 82 in 2008 to 32 in 2011 (Brooking 2018) and further to 30 in 2017[10].

The government also supported nine business cases, which involved the merging of some PHOs and collaborative arrangements with DHBs through new 'Alliances', where DHBs and PHOs work together jointly on planning and service delivery reform. Particular emphasis was also placed on developing IFHCs, which would co-locate PHC services and an expanded range of services to be delivered in PHC settings (e.g., specialist assessments by GPs, minor surgery, chronic care, increased nursing, and allied health); deliver more seamless care; and include appropriate social services.

Around 2011/12, changes were also made to the PHO Performance Programme, linking it more strongly with DHB targets, and removing the assessment of improvements for high needs versus other population groups. Work began on what would become the Integrated Performance and Incentive Framework (IPIF), which in turn became the System Level Measures Programme (SLM) (see below for more detail).

From 2013, the government required all DHBs to establish Alliances (Gauld 2014), which, at the very least, had to involve district PHOs, but should also involve other community providers and groups. DHBs remained the decision-making authority in terms of funding and implementing change.

In 2016, there was a refresh of the New Zealand Health Strategy (Ministry of Health 2016), including a roadmap of actions (Ministry of Health 2016). The Refresh emphasised the need for the health system to become more people-powered; deliver more services closer to home; deliver high value and high performance; support a team approach; and make use of smart systems. It largely reiterated the direction of the PHCS for PHC care.

2017-2020

A Labour-led coalition government came to power at the end of 2017. In a major expansion of the scope of PHC services, in its 2019 budget, the government began the formal introduction of PHC mental health services for those with mild-to-moderate mental distress, providing funding to support trained mental health workers across PHC services

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[10] One district – South Canterbury – has no PHO, with the DHB fulfilling PHO functions.

(Adern 2019). It also began to fund health coaches in PHC settings, designed to emphasise wellbeing (Cassie 2020).

Following concerns over the overall performance of the sector (including rising DHB deficits as the rate of increase in funding slowed while the population grew, and slow change in the models of care delivered by PHC providers), the government established a review of the health and disability system.

In the Interim Report released in 2019, key issues raised relating to PHC included: inconsistencies in coverage and funding across PHC services; significant user charges continuing to act as barriers to access; and the lack of progress with key aspects of the PHCS, including in relation to engaging widely with communities and developing new models of care (Health and Disability System Review 2019). The final report set out recommendations for a full restructure of the health system, with a new organisation, Health NZ, to oversee health services policy and delivery; fewer DHBs (between eight and 12) working with Health NZ; no mandated PHOs; an increased focus on locality planning and service delivery and services that better meet the needs of local communities; and a new Māori Health Authority to oversee Māori health (which may or may not have commissioning responsibilities) (Health and Disability System Review 2020).

With a Labour government re-elected at the end of 2020, key changes based on the Health and Disability Review are currently being implemented, with the new system to commence on 1 July 2022. Key changes include the abolition of DHBs, which are to be taken over by a single national organisation (Health NZ). A new Maori Health Authority will focus on Maori health and will have funding to commission services. PHOs currently have no formal role in the system and work is underway on localities.

Box 4: Primary Health Care in Aotearoa New Zealand 2000-2020

Foundations

- A single central government Minister of Health oversees health policy and most health funding, supported by Ministry of Health
- Significant attention is paid to PHC in policy, with a PHCS and significant new funding for PHC
- Continued accountability of PHC providers for the funding they received via contracts, with a PHO performance programme introduced in 2006

Resource mobilisation and allocation

- PHC service delivery increasingly involves GPs and nurses; there is no formal package of care for service users but there is more specificity in contracts
- There is continued financing of health care through general taxation
- Financing for health continues to be pooled at central government level, enabling governments to allocate financing to health care to best meet health needs
- There is a change from targeted government funding of GP visits to universal financing via a weighted capitation payment paid to PHOs, i) promoting wellness, and ii) providing more equitable funding to support those who enrol rather than just those who use services; but, on the other hand, continuing to allow funding from FFS user charges that iii) promote productivity and visits but that iv) also retain cost barriers to access to PHC care

Financial and non-financial incentives

- PHC providers are incentivised to i) locate in more populated areas and in areas with higher incomes; ii) deliver care that promotes wellness but also visits/consultations through FFS user charges; and iii) charge the fees that the market can bear (i.e., ability and willingness to pay); with capitation now funding a larger proportion of income
- There remains significant provider autonomy, but there are increased contractual and performance obligations, including through a PHO performance programme
- There is new funding to reduce the user charges people pay, but the change from targeted funding to universal funding would see those who were better off experiencing greater reductions in fees
- Access to PHC continues to be dependent on ability to pay user charges billed by GPs, leading to significant barriers to access to care and a likely over-use of hospital services, i.e., there are significant inequities in access to care leading to significant inequities in health, albeit new funding attenuated these effects

Organisation

- There continues to be a highly skilled GP workforce, increasingly supported by nurses
- There continue to be highly fragmented services, with GPs as gatekeepers/referrers into other parts of the health system, but with a policy focus on integration/co-ordination and more initiatives aimed at integration (e.g., IFHCs)

4. The Primary Health Care Strategy and its Implementation: An Equity-Enhancing Strategy?

A key goal of the PHCS was to improve equity – in particular, to improve the health of Māori, Pacific peoples, and those on lower incomes, and to reduce inequities in health for these populations compared to the European NZ population. However, no formal intervention logic was ever produced to show how the PHCS would in fact lead to reductions in inequities in health.

In theory, new governance arrangements, new funding and funding arrangements, more flexibility in service delivery, and more accountability for performance, could all support reduced inequities over time. For example, the PHCS included the ability for Māori and Pacific to self-govern via their own PHOs or to become partners in PHO governance, and this change might lead to more appropriate services to meet the needs of Māori and Pacific peoples. The new capitation formula could provide a greater proportion of funding for those with higher needs, while also enabling funding to be allocated to support all those enrolled rather than just all those who attend consultations. The change from FFS for a GP visit to capitation could encourage new ways of delivering services, such as through greater use of nurses and the ability to deliver services via outreach clinics. Accountability for performance through a PHO performance programme might support greater equity by rewarding faster improvements in the health of those with the greater needs compared with more healthy populations. On the other hand, a shift from targeted to universal funding would be unlikely to support a reduction in inequities, as those with higher incomes would benefit most from new funding and, overall, whether or not the PHCS would succeed in reducing inequities would depend on how the reforms were implemented in practice. The sections below focus on the implementation of key aspects of the PHCS: the rolling out of new funding; capitation and the capitation formula; and the PHO performance programme, and the implications of each for improving equity.

Rolling out new funding

A key set of steps in implementing the PHCS related to how new funding would be rolled out. Although the economy was doing very well at the time, the government's promise of spending an additional $2.2 billion over seven years on PHC (Raymont and Cumming 2013) could not occur all at once. Hence, it was decided that new funding would be rolled out gradually, in practice over five years between 2002-2007.

'Access PHOs', or GPCs within PHOs, were determined to be those working with higher needs populations, i.e., where 50% or more of the enrolled population were Māori, Pacific or those living in the more deprived areas (NZDep 9 or 10). Some flexibility was to be provided to ensure high needs could be met, and in some cases, entire districts would be deemed high need. Access PHOs would be funded at a higher capitation rate right from their formal establishment, enabling them to reduce the user charges their enrollees paid and to expand services immediately. They would be held accountable for keeping user charges below a certain level, although not all the new funding was expected to be allocated to reducing user charges, recognising that some PHOs and practices were already struggling financially. User charges would no longer reflect CSC (i.e. family income) status, but it was recognised that charges probably would differ by age.

Providing funding for the highest-needs groups in this way can be seen as equity-enhancing, depending on the actual make-up of those in Access PHOs (see below).

Other PHOs and practices were 'Interim'; so-called as the funding levels that would apply to them were to be temporary, until new funding was provided to raise capitation funding to the same level as Access PHOs and practices. New funding to reduce user charges in Interim PHOs and practices was then rolled out over 5 years, age group by age group: for children under six in 2002; for 6-17 year olds in October 2003; for older people (>65) in July 2004; for 18-24 year olds in July 2005; for 45-64 year olds in July 2006; and, finally, for 25-44 year olds in July 2007. This too was an equity-enhancing approach, in that those who use more services were those in Interim practices to receive new funding first. However, an early problem was how to ensure all the new money went to actually reducing user charges (Raymont, Cumming et al. 2013); the government eventually introduced fees reviews policies (still in place today) to try to ensure much of the new funding did indeed support reduced charges and better access to care (see below).

Capitation funding and formula

Another set of key steps towards enhancing equity was the capitation formula itself. Theoretically, capitation funding formula are vital tools in ensuring that funding arrangements are fair and that they provide the incentives desired by government. Formula that do not adequately adjust for need make it difficult for health service organisations to deliver the necessary care to those enrolled with them, and put the organisations themselves at financial risk. Poorly weighted formula also present incentives for health service organisations to 'cream-skim' or select better risks through the enrolment process, and/or to skimp on care, including encouraging higher risks to leave and seek care elsewhere.

The main funding provided to PHOs and then to be provided to practices, is for 'First Contact' or 'First Level' services' (i.e., support, promotion, diagnosis and treatment services in GPCs), which initially made up around 80% of funding for PHC going through PHOs. The initial Access funding formula was weighted based on age, gender, and high user health card (HUHC) status (previously held by those with 12 or more visits per annum).

The formula was based on:

- national average general practice utilisation rates (from 1998/1999);
- a payment of $35 per visit for under 6s and $25 per visit for all others; and
- amounts corresponding to the previous practice nurse subsidy, distributed in proportion to general practice utilisation rates for each age/sex group.

Prior to the introduction of the PHCS, subsidies for GP services were set at:

- $32.50 for children 0-5
- $15 and $20 for young people aged 6-17 not holding a CSC or HUHC and those holding a CSC or HUHC respectively
- $15 for adults holding a CSC or HUHC, and
- $0 for adults without a CSC or HUHC (Raymont, Cumming et al. 2013).

Thus, the PHCS was providing an additional payment of:

- $2.50 per visit for children under 6

- $10 and $5 per visit for young people aged 6-17 without a CSC or HUHC
- $10 per visit for those adults holding a CSC or HUHC, and
- a new $25 subsidy for those adults without a CSC or HUHC.

It is this that shows how the shift from targeting to a universal subsidy would benefit those with higher incomes more, at least on a per visit basis.

Unfortunately, from an equity perspective, neither ethnicity nor deprivation were included in the PHC formula. This seems to have originally been planned, given that both independently affect access to care (Hefford, Crampton et al. 2005). However, the limited data that were available showed similar rates of GP utilisation for all groups, in spite of known higher needs for some groups (as measured, for example, by hospitalisations and premature mortality (Hefford, Crampton et al. 2005)), especially for Māori and Pacific peoples. This suggested that there was significant unmet PHC need in some communities, that would be bedded in should existing utilisation rates be used to determine the capitation funding formula. Instead, the government introduced additional funding for Services to Improve Access (SIA) and Health Promotion (HP), both of which had weightings in the formula for ethnicity and deprivation.

SIA was the second funding pool, aimed at improving access for those with higher needs. The weightings for high needs people in Access PHOs/practices were: 1 for non-Māori, non-Pacific people living in deprivation deciles 1-8 (the less deprived areas); 1.2 for Māori or Pacific peoples in those same deciles; 1.2 for non-Māori, non-Pacific peoples living in deprivation deciles 9 and 10 (the most deprived areas); and 1.4 for Māori or Pacific peoples living in deprivation deciles 9 and 10. SIA funding was to be provided to PHOs, rather than practices, and hence was calculated as the weighted sums multiplied by the base formula less the funding that would be provided if only the base funding were provided. PHOs were to submit plans to their DHB on how they would improve access before the funding could be spent. The funding would support, for example, community workers, well clinics or mobile outreach nursing services (Hefford, Crampton et al. 2005).

The third funding pool was for HP services, set at $2 per capita, with higher weightings for high needs groups e.g., a Māori or Pacific person in NZ Dep 9 and 10 would earn $2.80 for the PHO. This funding was also allocated to PHOs. DHBs would agree with PHOs on this spending, with DHBs also consulting with public health agencies on the best ways of allocating this funding. It would cover, for example, smoking cessation services, physical activity and healthy eating programmes, or suicide awareness programmes (Hefford, Crampton et al. 2005).

The fourth funding pool was to cover those with HUHCs; those who visited a GP 12 or more times in the previous year. This was also based on $35 per visit for under 6s and $25 per visit for others, leading to significant increases in funding for these groups, given their high numbers of visits.

For Interim PHOs and practices, the funding formula for first contact services continued to include CSC as a weighting mechanism (CSC or no CSC), and would be based on existing rates to begin with. As new funding was to be provided to Interim PHOs and practices, the CSC would be phased out as a funding mechanism (over a 10-year period). The formula for SIA and HP services were the same as for Access PHOs and practices, supporting

Interim PHOs and practices to improve access to services and expand HP activities, and more fairly distributing funding from an individual or family perspective (Hefford, Crampton et al. 2005).

In addition, funding was to be provided to all PHOs to support the establishment of PHOs; management tasks within PHOs, with higher per capita funding for smaller PHOs; rural services, to support recruitment and retention and reasonable rosters for after-hours care; and quality payments (eventually, the PHO performance programme).

A range of other services, such as extended nursing services, enhanced mental health services, and services for refugees, would also be supported via targeted initiatives and/or through DHB funding.

Two key points are worth noting here. The first is that first contact capitation funding is provided to PHOs; it is then generally thought to flow then onto practices using the same formula (Croxson, Smith et al. 2009). However, practices may not necessarily allocate funding in the same ways to those working in the practice (some may be salaried, for example), nor to practice partners/owners. The second point is that the FFS arrangements for user charges continue in the A/NZ health sector, albeit they now make up a smaller proportion of funding. Thus, it cannot be said that PHC funding in A/NZ is totally based on capitation, and hence the funding arrangements are not guaranteed to provide capitation incentives at the practice level.

PHO Performance Programme

The PHO performance programme can be seen to be a crucial means by which PHOs and practices are held accountable for the achievement of key goals, and as being particularly necessary where there is capitation funding, as a means of reducing incentives to skimp on care and encourage higher-needs (or cost) people to dis-enrol. The programme was, however, contested, as some felt that it should led from general practice. After a long development process (Smith and Cumming 2017, Smith 2018), it set key targets for a range of indicators, including, amongst others, immunisations for children aged under 2 and flu vaccinations in the over 65 age group, breast and cervical cancer screening, cardiovascular risk assessments, diabetes detection and follow up, and smoking status, each to be measured for both the relevant general population *and for high needs groups*, with a view to reducing inequities in those indicators over time. The overall funding available through the programme was, however, tiny compared with all PHC funding ($23m) (Brooking 2018). By July 2007, all PHOs had joined the programme.

Over time, the programme did see improvements in the key indicators, often (but not always) with higher rates of increases amongst high needs groups for some indicators, reducing inequities over time (to 2011) (bpacnz 2011). With improvements in data, clinical governance and population-based initiatives, the programme was seen to be worth the investment, although smaller PHOs found it a challenge to implement (Brooking 2018).

Controversies and changes over time

There was widespread support for the PHCS; however, various controversies have arisen over its implementation and there have been a number of key changes in policies over time.

First, with general practice raising concerns over how to support people needing extended care within the overall context of a generic capitation formula, the government introduced, from April 2004, Care Plus. Care Plus provided additional funding (around 10%) to work more intensively with around 5% of the population (including those with HUHCs) needing particularly intensive services. This funding would support: low or reduced cost access; continuity of care through a Care Plan jointly developed with the patient and ongoing support through pre-planned regular reviews; and advice on self-management (Ministry of Health 2004). Funding was to be allocated to PHOs as they joined the programme, with 50% up front, and the remainder allocated when PHOs met particular levels of expected enrolments (Ministry of Health 2004).

Second, by funding entire PHOs or practices at different rates using generic proxies for high needs (age and gender), the targeting that occurs within key formula are not exact, meaning that some people are covered by higher needs funding arrangements, but do not have higher needs themselves; while some who have higher needs miss out on higher needs funding as they belong to a PHO or practice that does not receive funding at a higher needs rate. Initial analyses showed that 41% of those in Access PHOs or practices were not in the high priority target groups. This problem would, however, resolve once new funding was rolled out to Interim PHO and practices (Hefford, Crampton et al. 2005).

Third, the formula was based on the number of visits in 1998/99 (Brooking 2018), and the average number of visits was expected to, and indeed was, rising. The government promised that reviews of the formula would take place fairly soon after the roll out of new funding began. Thus, a 2006 Expert Advisory Group review of the funding formula suggested that changes needed to be made to the funding formula to update capitation rates arising from now higher utilisation rates and to better meet the needs of high needs groups. Despite having considerable support, the government decided not to change the formula, in part based on advice that any changes within existing budgets would create winners and losers (GPs/GPCs serving more wealthy groups would lose while those serving high needs groups would win – if total funding were not increased at the same time) and may lead to a loss of support amongst key groups for the PHCS (Brooking 2018). Instead, new funding was allocated to rural services, a Very Low Cost Access (VLCA) scheme (see below), innovations in nursing and mental health, and a PHO Performance Management Programme (Brooking 2018).

Fourth, as a result of the above review, the VLCA scheme was introduced in 2006. It was to fund low user charges for whole practice populations by providing a top-up to base capitation rates, so long as all adults were charged the same low user charge, and there were zero fees for children aged under six. Charges were to be capped (which in 2006 was $0 for children, $10 for those aged 6-17, and $15 for adults). From 1 October 2009, as expenditure on the VLCA scheme ballooned, with almost 30% of practices joining (Brooking 2018), the rules were changed and only those with 50% or more high needs populations could be a part of the scheme.

Thus, the emphasis shifted from a universal low charge mechanism to one looking to better support access for those with higher needs (Primary Care Working Group on General Practice Sustainability 2015) and to ensure that PHOs and practices offering low charges were better financially supported (Brooking 2018). The scheme would, however, have the same population coverage issues as the Access funding arrangements; and indeed, analyses showed a high number (44%) of high needs people were in non-VLCA practices, while only 56% of those in VLCA practices were high needs. The 2009 VLCA version of the scheme was also viewed as having introduced a high degree of unfairness into the funding of practices, as practices can only join if they have 50% or more of their populations high need; these practices, those who took it up before the restrictions in 2009, and those who now fall below the original requirements but are still in the scheme, are seen to be at a competitive advantage compared to practices not in the scheme (Primary Care Working Group on General Practice Sustainability 2015).

Fifth, concerns were raised early on over the extent to which new funding was in fact leading to reduced user charges (Raymont, Cumming et al. 2013). Very soon, a user charges review process was put in place where it was felt that charges were rising faster than desirable. This process linked with a key promise made by the government when implementing the PHCS – that government funding rates would increase regularly to cover rises in costs over time. (This promise was necessary due to previous governments not indexing subsidy payments to cost increases, leading to ever-rising user charges for service users.) Adjustments were initially made based on the consumer price index (based on price rises for a weighted basket of consumer goods). Later, an annual cost assessment process was developed by which an annual agreed increase in charges was presented by the government, with increases varying depending on the proportion of funding a practice receives from capitation (i.e., higher increases are allowed for practices with a higher proportion of funding from capitation). A fees' review process would apply should charges rise above that rate. This regulation of user charges is viewed as a problem by many. Despite government promises, annual charge increases are below the level of general inflation, and the proportion of funding through user charges is increasing. This is seen to be at odds with government policy desirous of ensuring charges stay low (Primary Care Working Group on General Practice Sustainability 2015). In addition, as the emphasis has been on increases in charges over time, the process is seen as disadvantaging those who had low charges to begin with and who now cannot increase their charges without undergoing a review (Primary Care Working Group on General Practice Sustainability 2015).

Sixth, regular concerns have been raised over the adequacy of funding in general, but also over the sustainability of some practices, particularly those serving higher needs groups, who often faced not only working with those with high needs, but also higher proportions of funding coming from capitation and limited ability to charge for services (Brown and Underwood 2013, National Hauora Coalition 2016). The VLCA scheme was introduced in part to deal with this issue, rewarding those PHOs and practices that keep charges low with new funding to support low charges. Following a further review that raised major concerns over the sustainability of practices serving high needs communities, in 2013, the government allocated $4m to support practices most in need, and provided funding, for two years, for graduate nurses to work in high needs practices (Brooking 2018).

Seventh, the PHO Performance Programme underwent a series of changes. A first change, in 2011/12, included the removal of reporting on differences between high and low needs groups (Brooking 2018). Between 2012 and 2017, work was done to develop an Integrated Performance and Incentive Framework (IPIF) that would set higher level goals for the system, better link DHB targets with PHO performance and encourage a more collaborative, quality-improvement-focused performance framework, with both national and local components (Expert Advisory Group 2014). That in turn developed into the System Level Measures (SLM) programme, introduced from July 2016. The programme focuses on achieving key outcomes (ambulatory sensitive hospitalisation rates for 0-4 year olds; acute hospital bed days per capita; patient experience of care; amenable mortality rates; babies in smoke-free households; and youth access to health services). The aim was to encourage a collaborative, quality improvement approach overseen by Alliances, with districts able to identify key contributory measures that they will work towards improving through specific actions and initiatives (Chalmers, Ashton et al. 2017). The overall programme is guided by the Triple Aim – to improve the quality, safety and experience of care; to improve the health and equity for all populations; and to strive for best value for public health system resources. Equity is embedded throughout the programme.

Eighth, in 2015, a Primary Care Working Group on General Practice Sustainability reported on on-going concerns, as noted above, recommending, amongst other things, that the capitation formula for first contact services be reworked with new consultation rates, and the CSC be reinstated into the formula, with the VLCA formula to include CSC status, ethnicity and deprivation so that all individual high needs service users would benefit wherever they were enrolled. The group also recommended that fee regulation apply only for those eligible for lower user charges, with all practices given the ability to charge non high needs service users a fee 'commensurate with service' (Primary Care Working Group on General Practice Sustainability 2015).

Ninth, the Waitangi Tribunal – where claimed breaches of *Te Tiriti o Waitangi* are heard – has been hearing claims with regards to PHC from Māori since 2016 and has recently reported back its findings. It found multiple breaches of *Te Tiriti* by the Crown, noting:

> *'the legislative and policy framework of the primary health care system fails to address adequately the severe health inequities experienced by Māori. Further, the Crown failed to lead and direct the primary health care system in a way that adequately supported and resourced Māori to design and provide for their own wellbeing through designing and delivering primary health care to Māori. The Crown's failures prejudicially affect the ability of Māori to sustain their health and wellbeing 'failing to design and administer the current PHC system to actively address persistent Māori health inequities' (Waitangi Tribunal 2020, p.161).*

Key concerns focused on a lack of Māori governance and partnership in decision-making with Māori across the health system, inadequate funding for Māori-led PHOs and practices to support reductions in inequities, and a lack of accountability across the system to ensure key organisations work to reduce inequities in health, and to spend resources allocated for Māori health on Māori health.

The Waitangi Tribunal has recommended, amongst other things, a stronger legislative framework to recognise and provide for *Te Tiriti* principles across the health sector, a stand-alone Māori Primary Health Authority, an assessment of the underfunding of Māori PHOs and providers, a reassessment of the PHC funding formula, and consideration of stronger accountability arrangements relating to Māori health across the sector (Waitangi Tribunal 2020). The government has announced the establishment of a new Māori Health Authority and work continues on the other issues raised by the Tribunal.

Finally, in December 2018, the government re-introduced the CSC back into funding arrangements for PHC, with those holding CSCs now eligible for higher levels of capitation, with new funding available to support higher capitation payments for those practices willing to agree to keep user charges at the same level as VLCA practices.

5. Impacts

There is limited evidence about the extent to which the PHCS has achieved its key goals, especially over the longer term, and in particular whether or not key changes have led to reductions in inequities. Analyses are hampered by there being no single, national PHC database with which to monitor and evaluate change. Key achievements, based on published data, are set out below.

Enrolments

It was noted above that the shift to capitation would be equity-enhancing via changing funding arrangements to support all those enrolled in PHOs, as opposed to funding only those who had consultations (with GPs). High levels of enrolment were achieved within a short space of time, and across all population groups. Little attention has been paid recently to enrolments, however, and a new analysis shows increases in the proportion of people not enrolled over time, and differences in enrolment rates across the country and by population group, with Māori having lower rates of enrolment than European New Zealanders, young people 15-24 having the lowest enrolment rates, and higher enrolment rates in more affluent areas. The researchers suggest that more needs to be done to ensure that people can enrol, have funding provided to support their care, and pay lower charges (Irurzun-Lopez, Jeffreys et al. 2021).

User Charges

Between 2001/02 and 2006/07, the charges that people paid when using PHC services generally fell following the allocation of new funding to PHC. For example, adults aged 45-64 were paying an average $27.62 and $19.27 in 2001/02 in Interim and Access practices respectively; by 2007, these had fallen to $23.90 and $13.91 respectively (Raymont, Cumming et al. 2013). Charges did not fall, however, to the extent of the new funding. Those without CSCs, unsurprisingly, saw the greatest falls in the fees paid. However, even by the end of the roll-out of new funding, background increases in fees were seeing fees above their initial levels for some groups (e.g., those aged 65 and over). Access charges remained lower than Interim charges throughout the period (Raymont, Cumming et al. 2013).

Since new funding has been fully rolled out to all by mid-2007, there have been regular increases in the capitation rate each year, and a number of policies and new funding to keep charges low, including, those noted above i.e. Care Plus, 2004; VLCA, 2006 with limits on which GPCs can join in 2009; new funding to support GPCs supporting lower charges, 2013; and funding to reduce charges for those with CSCs, 2018. Analyses of NZHS data show the median fee paid (in $NZ 2018) rose from $24 in 1996/97 to $35 in 2002/03, remaining static to 2006/07, before rising to $38 in 2011/12, falling slightly and rising again in 2014/15, and sitting at $39 in the 2016/17 NZHS (Jeffreys, Irurzun Lopez et al. 2020).

Unmet Need

For the immediate years following the release of the PHCS in 2002/03 to 2006/7[11], national New Zealand Health Survey (NZHS) data show large decreases in overall unmet need for

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[11] Data for 2002/03 and 2006/07 are reported separately from data from 2011/12 on (when the survey became an annual survey), due to differences in the survey questions.

GP services, i.e., not being able to: afford to see a GP, get an appointment within 24 hours, get transport, or get childcare. The data show a similar, but not as large, decrease for Māori; and a significant decrease in the proportion of adults who reported an unmet need for GP services due to cost from 6.3% to 1.8% (a 71% decline), with a slightly lower decrease for Māori from 10.8% to 4.1% (a 62% decline) (Ministry of Health, various years).

In 2002/03, after adjustment for age, the main reason for unmet need for GP services for men was 'cost', but in 2006/07 the main reason for unmet need had become 'didn't want to make a fuss / couldn't be bothered' and 'unable to get an appointment soon enough or at a suitable time'. For Māori, cost remained the main reason for unmet need in 2006/07. Thus, in the early years of the PHCS, there were reductions in unmet need, but they were not as great for Māori as they were for the European NZ population (Ministry of Health, various years).

Between 2011/12 and 2019/20[12], the data show overall unmet need rising: rates of unmet need overall now sit at 31%, and are particularly high for Māori (42.6%), for Māori women (50.2%), and for Pacific women (42.2%). Rates of unmet need due to cost, however, were generally stable across the period, although they increased for European NZ men and decreased for Māori women. These rates sit at 13.5% across the whole population but are particularly high for Māori at 20.5%; Māori women at 24.1% and Pacific women at 21.4%. When comparing ratios of unmet need due to cost over time, these improved for women compared with men over time; they improved for Māori compared with non-Māori between 2011/12 and 2014/15 before worsening again to 2018/19 and improving a small amount between 2018/19 and 2019/20; they worsened for Pacific peoples to 2018/19 before improving between 2018/19 and 2019/20; and they worsened for those in NZDep 5 compared with those in NZDep 1 between 2011/12 and 2014/15, and improving to 2018/19 and again to 2019/20 (Ministry of Health, various years).

Consultation Rates

Between, 2002 and 2007, consultation rates rose for those aged 18 and over, especially amongst the elderly. Consultation rates were seen to increase for those with CSCs in Interim practices and older adults (45+) in Access practices, for Māori (especially those aged 45 and over) and for Asian groups (especially those aged 18-25 and 45+). Worryingly, consultation rates had fallen for Pacific peoples (Raymont, Cumming et al. 2013).

A sophisticated econometric analysis was undertaken using NZHS data from 2002/03, 2006/07, and 2011/16. This showed that between 2002/03 and 2006/07, the proportion of people visiting doctors increased for some groups (men, European New Zealanders, and those on middle incomes), but with a reduction in the average number of visits, and the data suggesting that the increase in the proportion of people consulting doctors might have come from those in good or better health. The proportions visiting a doctor and the average number of consultations fell, however, between 2011/12 and 2015/16, especially amongst young adults (18-24) (Thomson, 2019).

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[12] Data for the 2019/20 survey covered a 9 month period only as a result of COVID-19; interviewing stopped in March 2020.

Disparities in the proportions of people visiting a doctor and consultation rates for Māori reduced at first, but then increased in the later study periods. High-income groups were most likely to visit a doctor, but the gap between richest and poorest fell by 2006/07, and by 2011/12, the number of visits varied only for those in the most deprived quintile, compared to the last deprived quintile. Those with chronic conditions also made more use of GP services, following the introduction of the PHCS and Care Plus, but in later years, this service utilisation dropped off (Thomson 2019).

Ministry of Health national administration data show that between 2008/09 and 2015/16, GP consultation rates per person increased for both high needs and non-high-needs groups, from an average of 2.9 to an average of 3. Nurse consultations increased from an average of 0.3 to 0.7 for non-high-needs groups and from 0.5 to 0.9 for high needs groups. Thus, consultation rates have increased by the same amounts for high needs groups as for others but are a little higher for high needs groups as a result of their higher average number of nurse visits (Ministry of Health, personal communication).

Emergency Department Use

National New Zealand Health Survey data show a large increase in ED use between 2006/07 and 2011/12 and to 2019/20, from 8.5% of adults using services to 13.6% to 14.9%, with even larger increases for Māori (10.4% to 20.7% to 21.4%), and Pacific rising from 9.1% to 14.9% to 20.5%. Thus, the PHCS does not appear to have affected ED rates and rates have stabilised during the 2010s (Ministry of Health, various years).

Hospitalisations

Ambulatory Sensitive Hospitalisation (ASH) rates are those (largely acute or urgent) hospitalisations that are thought to be reduceable through good care delivered in PHC settings, and it might be expected that such rates would fall over time as PHC services improved. One study has examined the impact of the PHCS on ASH rates between 2001 and 2009. The analyses found that there is some evidence of falling ASH rates in the first few years of the PHCS (to 2004) for some groups in the population, especially children and older people and in particular with respect to vaccine preventable ASH rates. However, rates increased again after around 2004, and rose particularly for Pacific peoples and those in higher deprivation areas. Both deprivation and ethnic inequities in ASH rates increased, although the latter not as much as the former. The paper concluded that ASH rates did not fall as a result of the PHCS, and that changes to funding and access, on their own, will not contribute to reducing ASH (Milne, Parker et al. 2015).

6. Conclusion

The A/NZ PHCS in 2001 was ambitious in its goals, aiming to transform PHC and strengthen its role in health care and health. It also aimed to reduce inequities in health care and in health. The fact that there could be a national PHCS, and significant new funding, arises in part from key foundational features of the A/NZ health system; that is, that a central government is by far the largest financier/funder of health care, and that it can allocate resources to key priorities as a matter of national policy. Significant new funding has been allocated to PHC in dollar terms. The PHCS itself, by distinguishing between different types of PHOs and practices, also enabled the government to first allocate funding to PHOs working with higher needs populations, rolling out funding increases over time.

New PHCS funding was to be allocated through PHOs using a weighted capitation formula that needed to be fair so that PHOs and practices delivering services to high needs populations could provide adequate care and be financially sustainable, but that also aimed to keep user charges low for high needs groups. The largest proportion of funding was, however, insufficiently weighted for ethnicity and deprivation, and although separate funding for SIA and HP was more fairly weighted, that funding makes up only a small proportion of total PHC funding. Despite on-going concerns and a number of reviews, the formula itself has not changed. Rather, many *ad hoc* changes have been made. As noted above, these have focused on supporting lower fees for those in particular PHOs and practices (via VLCA funding), shoring up the finances of organisations delivering care to higher needs groups, and, most recently, reintroducing the CSC back into play, enabling all those families on low incomes with CSCs, and in GPCs that have signed up to the scheme, to be able to access lower cost care. The result is a set of funding arrangements that are confusing to all.

Early analyses suggested that the PHCS may assist the government in achieving some of its key goals, with almost universal rates of enrolment, reduced user charges, increasing rates of consultations, and improvements in services delivered via the PHO performance programme, including for some higher needs groups. Longer term, however, the momentum of the PHCS was not able to be sustained, in part due to changes in government, and in part due to the Global Financial Crisis, which arguably robbed the country of the opportunity to continue to strengthen PHC services. The data show that governments have supported the PHC sector to the extent that overall rates of unmet need have been stable over time, but it is of concern that these rates are not falling, and that other barriers to care have increased significantly instead. Also of concern is that inequities have barely shifted over time with respect to unmet need.

Capitation on its own was always unlikely on its own to lead to significant changes in the model of care provided in A/NZ, although it has led to a significant increase in the use of nurses. Rather, new models of care needed to be designed, tested and costed, and supported in particular for higher needs groups. This is particularly about the scope of services provided by PHC providers, and the funding needed to support wider scopes of services is likely to be significant (General Practice New Zealand 2019). Expanding Whānau Ora is a further way forward in terms of better meeting the needs of key population groups (Boulton, Tamehana et al. 2013, Smith, Moore et al. 2019).

Moving beyond where A/NZ is now firstly requires attention to the issues raised by the Waitangi Tribunal, in particular addressing issues relating to legislative mandates, governance, and appropriate funding for Māori, in order to significantly reduce inequities. Secondly, attention needs to be paid more broadly to the governance of PHC service delivery organisations, to better bring in community views and ensure services meet needs appropriately. Third, there is a need to revisit the scope of services delivered in PHC. Fourth, the government needs to work closely with community and PHC groups working with high needs populations to build their capacity and capability further. Finally, governments will need to balance ongoing financial support of mainstream services delivering universal care with the development of alternatives for higher needs populations. Upcoming changes to the structural arrangements in the A/NZ health sector may support this, with a plan for more locality planning, but there is also a major risk that the reforms slow progress even further, as new agencies are established, new plans are developed, and new relationships built as the reforms bed in. Particular attention needs to be paid to continuing developments in PHC if A/NZ is not to reflect again in five years' time that little progress has been made.

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