



MANATŪ HAUORA

# National Forum: Primary Health Care Organisations

*New Zealand Case Study*

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**CENTRAL GOVERNMENT**  
Minister of Health



**21 DISTRICT HEALTH BOARDS**

Buy with Service Agreements

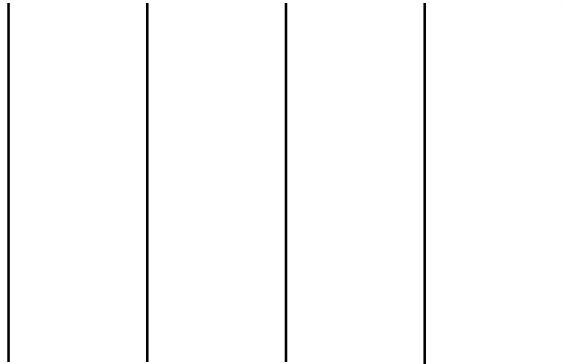
Internal agreements

**Other Providers**  
(for profit or not for profit private or community ownership, voluntary, welfare)

- Private pharmacy, laboratory, & imaging
- Primary care – GPs, Allied Health, Midwives
- Private hospital services
- Community services
  - Disability support
  - Mental health

District Health Board provider arm

- Public hospitals
- Some community services
- Assessment & rehabilitation



Health and disability support services

**Users of New Zealand health and disability support services**

## Primary Health Care – general practice aspects

### **New Zealand has:**

- 3,200 General Practitioners (GP: Population ratio 1:1300)
- 8,500 (approx) Practice/community nurses
- 1100 Practices
  
- Almost all New Zealanders have a regular doctor (GP) –a “gatekeeper” to the broader system
- Most practices are owner operated, for profit, small businesses and function within larger groupings/networks
- People enjoy very good same day access

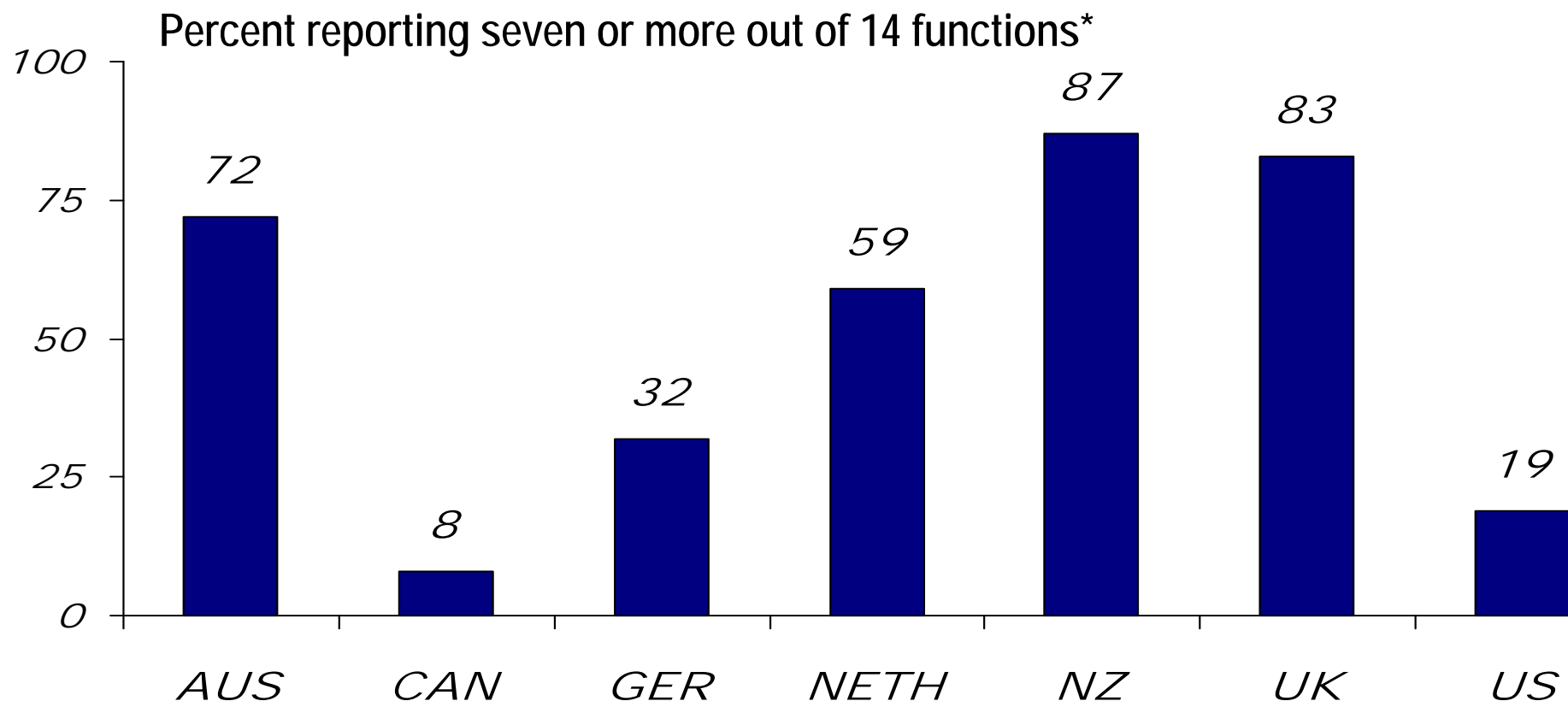
### **Prior to 2002 general practice received**

- Up to 50% of its revenue from government, largely (targeted) fee-for-service
- The rest of their revenue came from patient co-payments, and
- 50% of adults paid full consultation cost (no govt subsidy)

## Length of Time with Regular Doctor/Place of Care

	AUS	CAN	NZ	UK	US
Has Regular Doctor/Place (%)	<b>94</b>	<b>95</b>	<b>97</b>	<b>99</b>	<b>91</b>
2 years or less (%)	<b>22</b>	<b>20</b>	<b>21</b>	<b>18</b>	<b>29</b>
3 - 5 years (%)	<b>22</b>	<b>21</b>	<b>20</b>	<b>17</b>	<b>25</b>
<b>More than 5 years (%)</b>	<b>50</b>	<b>53</b>	<b>56</b>	<b>63</b>	<b>37</b>
No regular doctor/place (%)	<b>5</b>	<b>5</b>	<b>3</b>	<b>1</b>	<b>9</b>

## Primary Care Practices with Advanced Information Capacity



\* Count of 14: EMR, EMR access other doctors, outside office, patient; routine use electronic ordering tests, prescriptions, access test results, access hospital records; computer for reminders, Rx alerts, prompt tests results; easy to list diagnosis, medications, patients due for care.

# The health system pressures

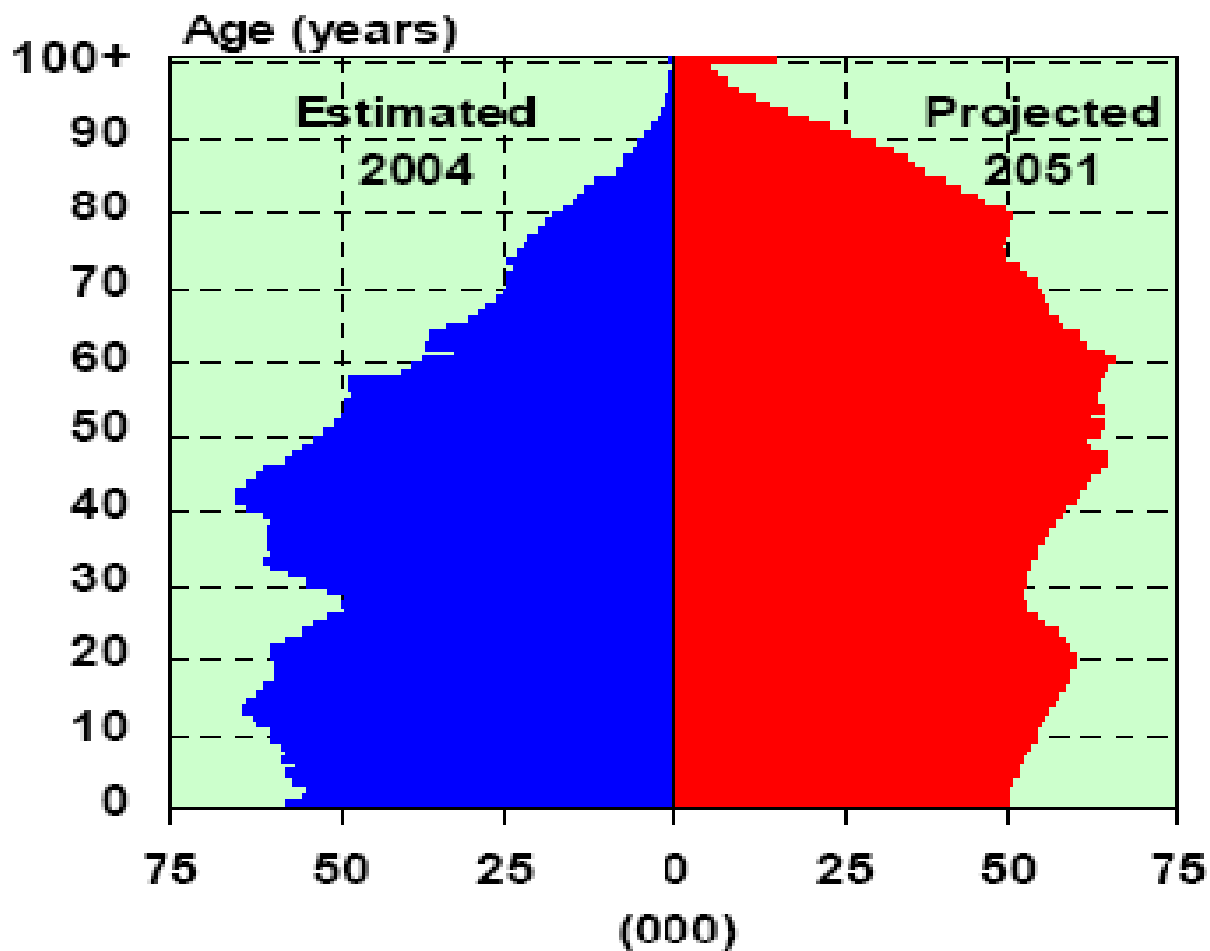
## Current pressures:

- Health inequalities – access barriers, more chronic disease and the inverse care law
- Workforce shortages - widespread
- Funding – recent increases in Vote Health are not sustainable
- Safety and quality – unexplained variability in performance
- Decisions in the national interest

## Which will intensify.....

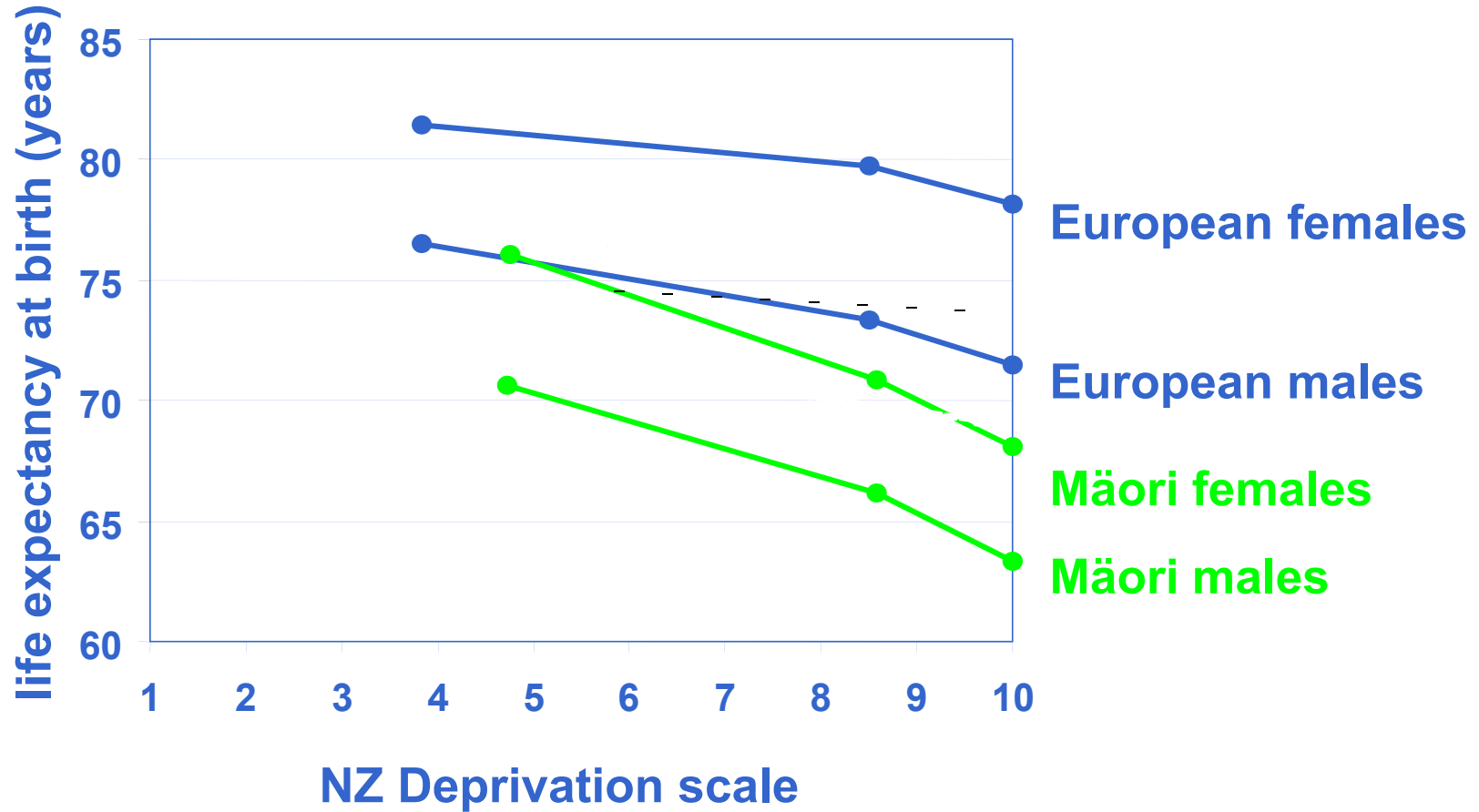
- Managing within the available funding;
- Population growth, redistribution and ageing;
- Increasing risk and prevalence of long term conditions;
- Risk of a second wave of health inequalities associated with obesity;
- Effective utilisation of the available workforce;
- Effective application of technological advances; and
- Rising consumer expectations

# Age Distribution of Population



Statistics New Zealand, March 2006

# Life Expectancy by Ethnicity and Deprivation



# Primary Health Care Strategy (2001)

## Aims

- Better health for all
- Reduced health inequalities
- More emphasis on population health
- Better access to primary health care services
- Co-ordination, continuity, collaboration
- Community participation
- Primary health care fully involved in health system

## Primary Health Organisations (PHOs)

### Minimum Requirements:

- Deliver minimum service package
- Work with groups with poor health
- Co-ordinate care with other providers
- Apply enrolment rules
- Involve communities, and Maori
- Enable all provider groups to influence decisions
- Be not-for-profit with full and open accountability
- Use capitation funding formula

## PHO funding

- \$2.2 billion over 7 years, from 2002
- Capitation (universal), paid through PHOs
  - Annual adjustment to retain value
- Low cost prescriptions
  - reduced from \$15 to \$3
- Practices receive blended funding
  - Capitation from govt (& some incentive payments)
  - Fees for service from patients

## What's been achieved?

80 PHOs established since 2002 – diversity ++

>4.1m people enrolled – and patient satisfaction remains high, by international comparisons

### Access

- 50% reduction in schedule fees
- Very low cost access – 1.2m New Zealanders
- Children < 6 years – 78% free
- Cheaper pharmaceuticals for all
- Greater use of services

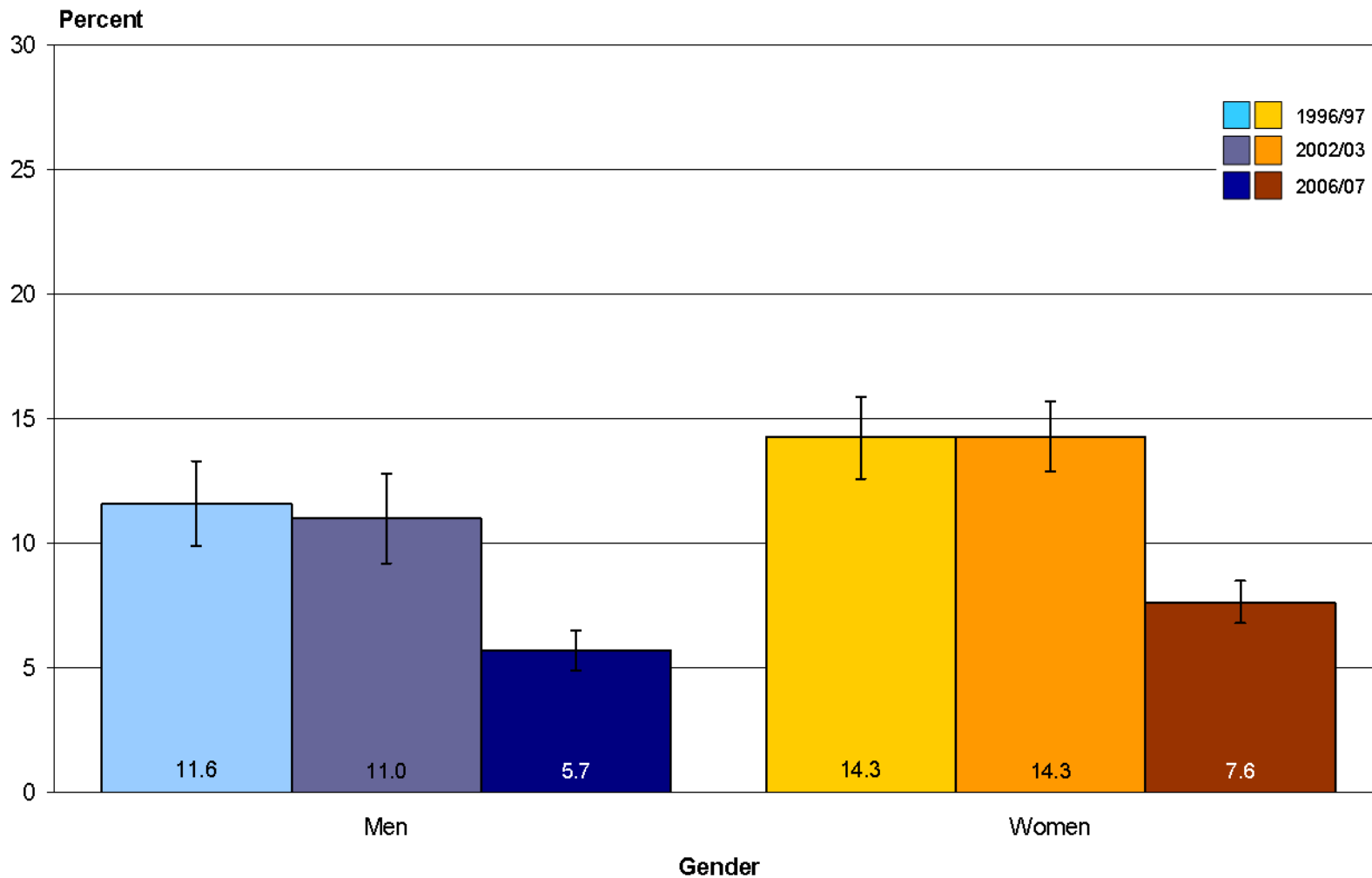
### Services

- More focus on chronic conditions
- Innovative new approaches, and greater use of nurses

### Improving performance

- Practice accreditation – Cornerstone/Te Wana
- PHO Performance Programme – overall improvement, but significant variation
- Health Targets

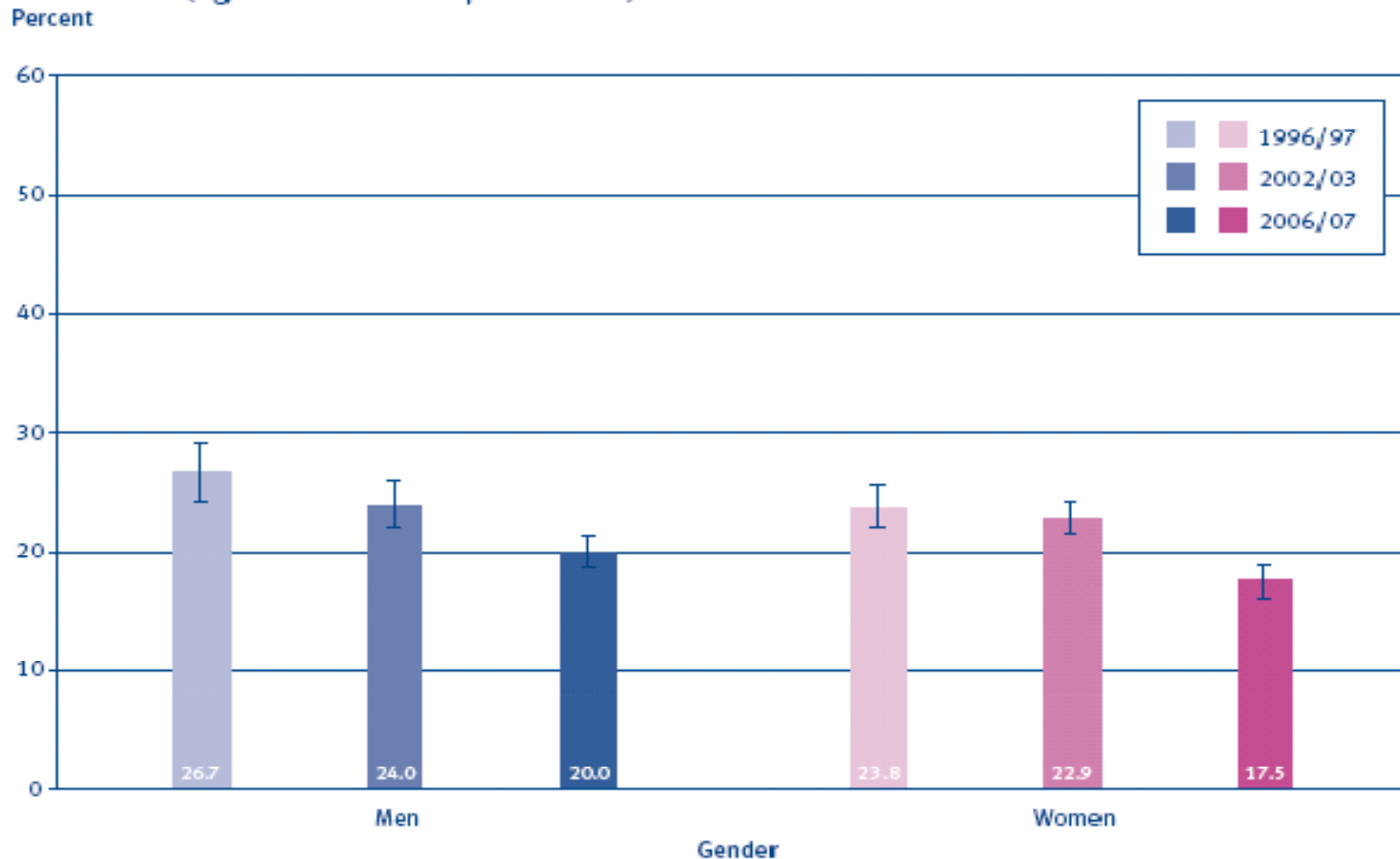
# Unmet need for GP services (any reason), adults by gender



NZ Health Survey, 1996/97, 2002/03, 2006/07

# Trends in smoking 1996-2007 (NZ Health Survey)

Figure 2.29: Daily smoking for adults, by gender, 1996/97, 2002/03 and 2006/07  
(age standardised prevalence)



Better, sooner, more convenient



# Diabetes

Population studies suggest

- 66% of Europeans with diabetes have been diagnosed
- 75% of Maori
- 83% of Pacific

70% had a free annual check (100,000 in total)

- No ethnic/age/gender differential

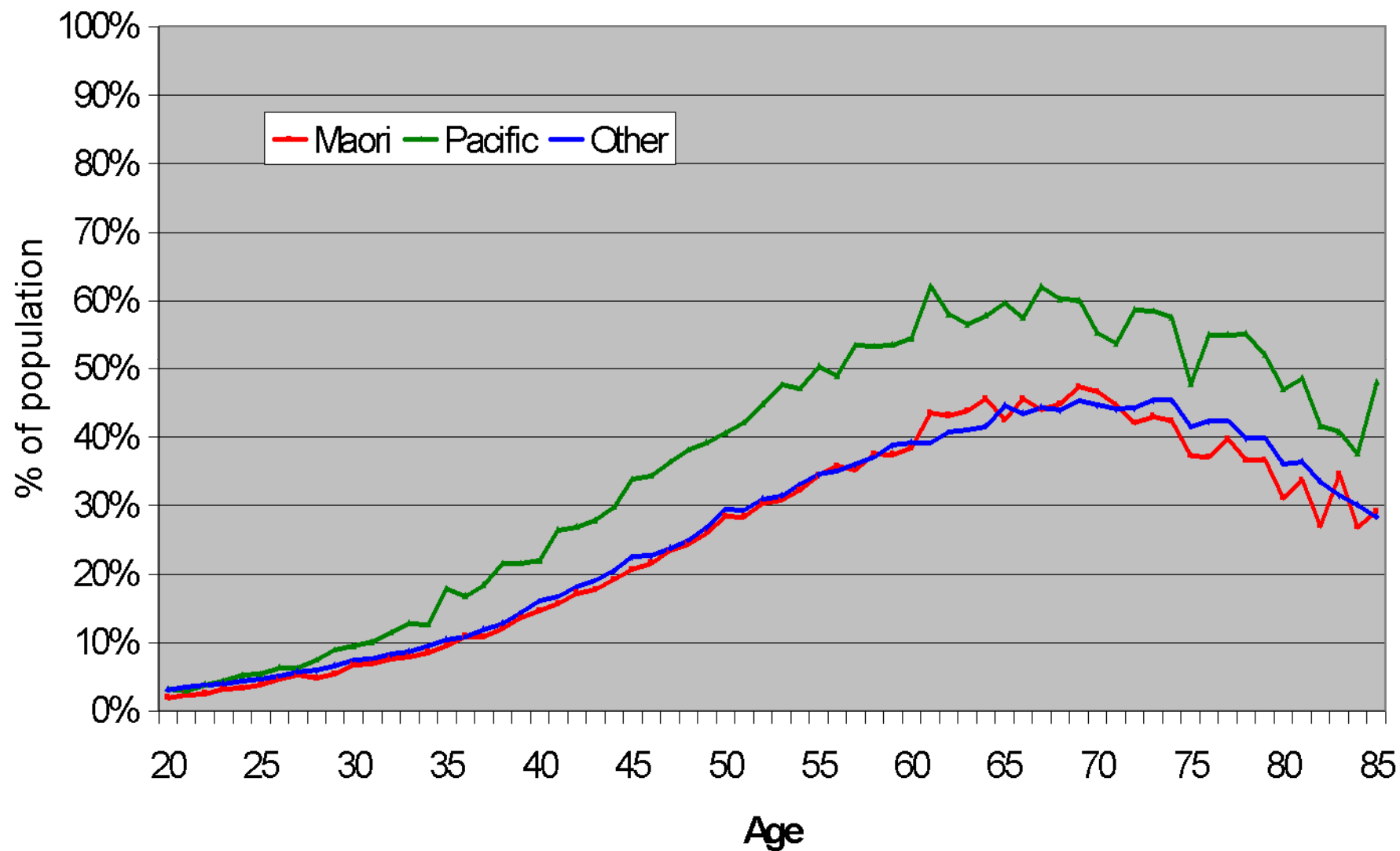
Number of people on statins has dramatically increased

- No ethnic differential

Diabetes control similar to that in US academic centres

- Some ethnic differential

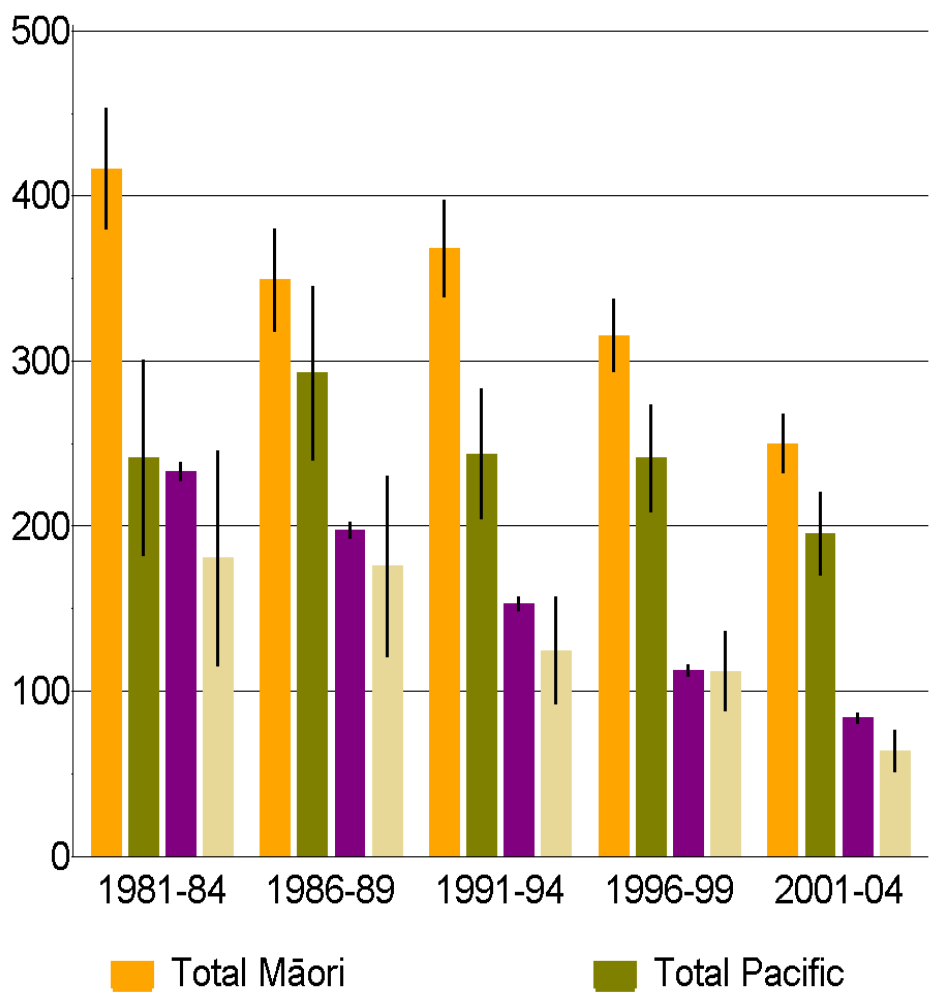
## People with Laboratory Tests for CVD risk assesment in 2008 (tests includes sceening for diabetes)



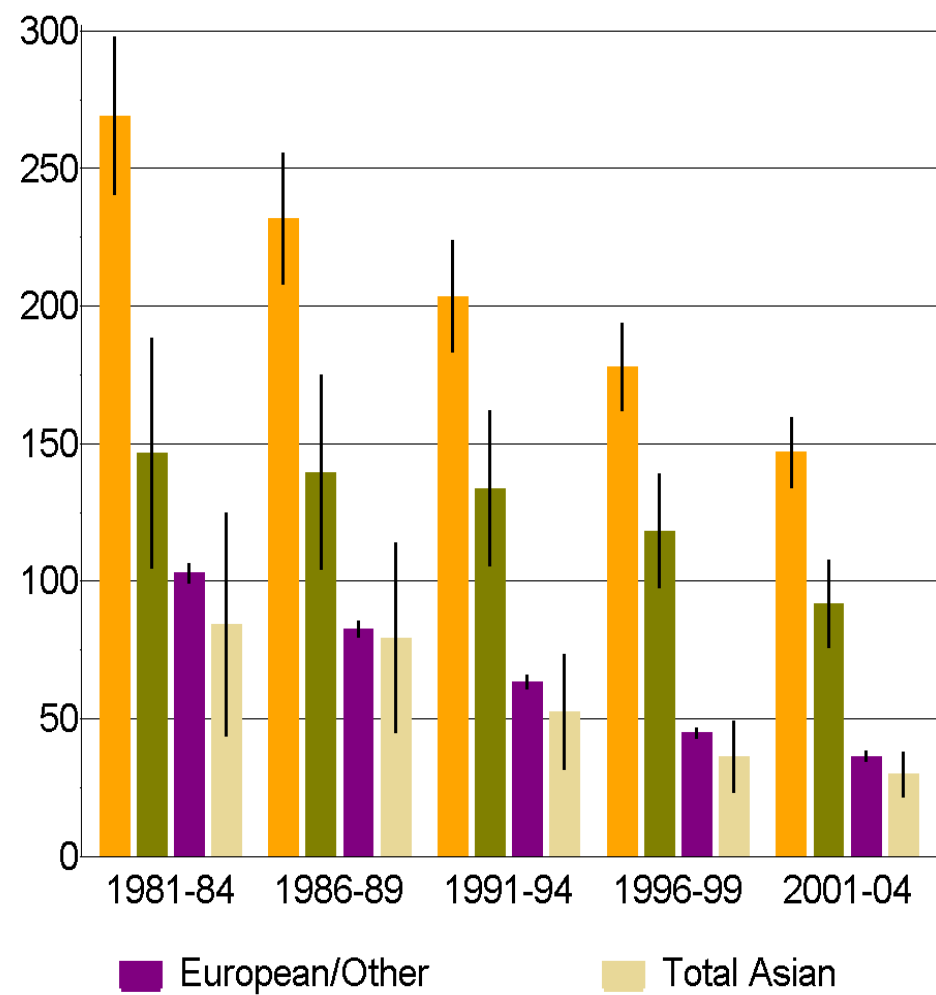
# CVD mortality rates by ethnicity, 1-74 yrs

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### CVD 1-74 yrs Males



### CVD 1-74 yrs Females

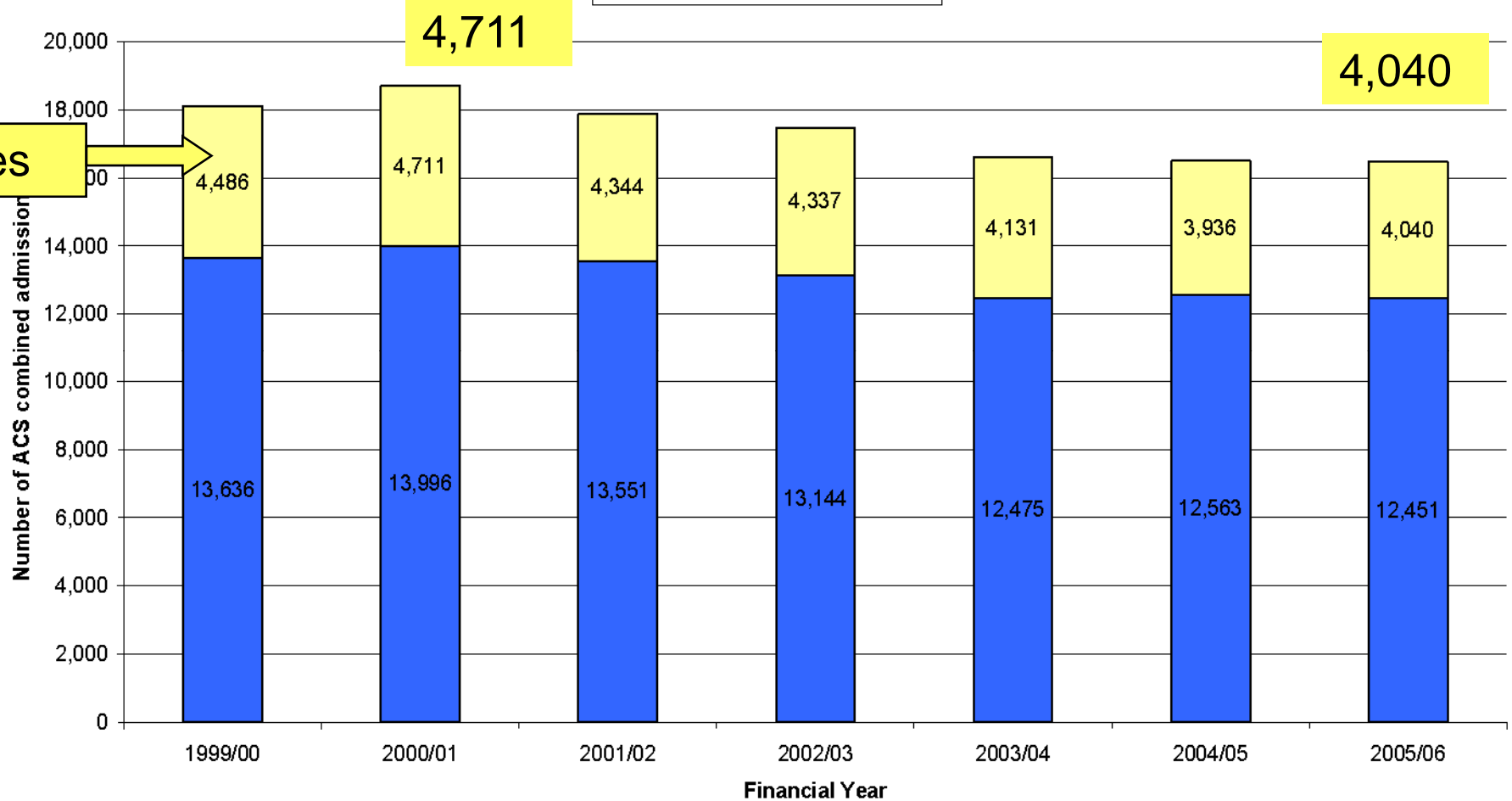


# Acute Coronary Syndrome...

## ACS admission

STEMI, Non-STEMI, Unstable Angina

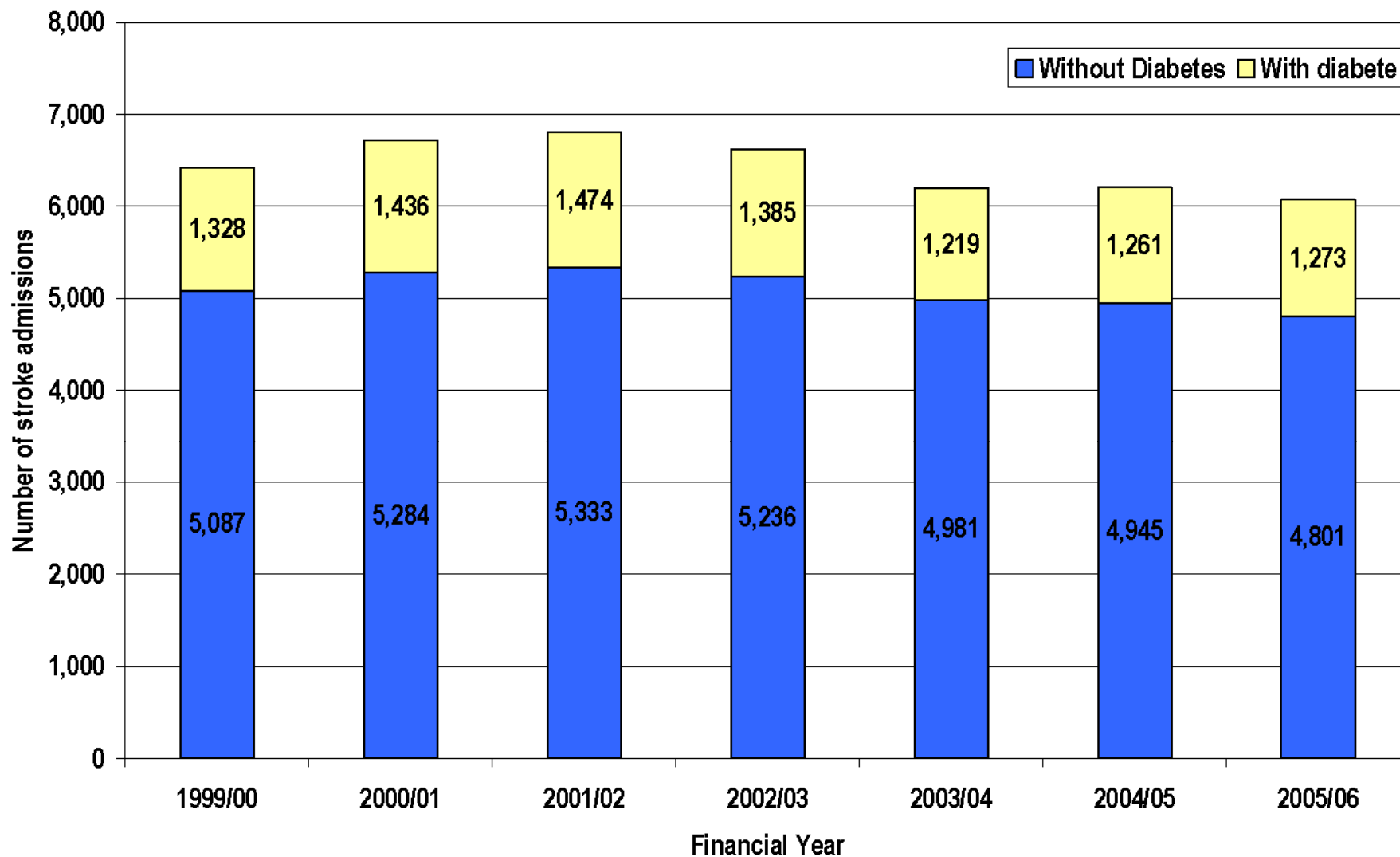
Without diabetes With diabetes



Diabetes

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# Other CVD events...stroke



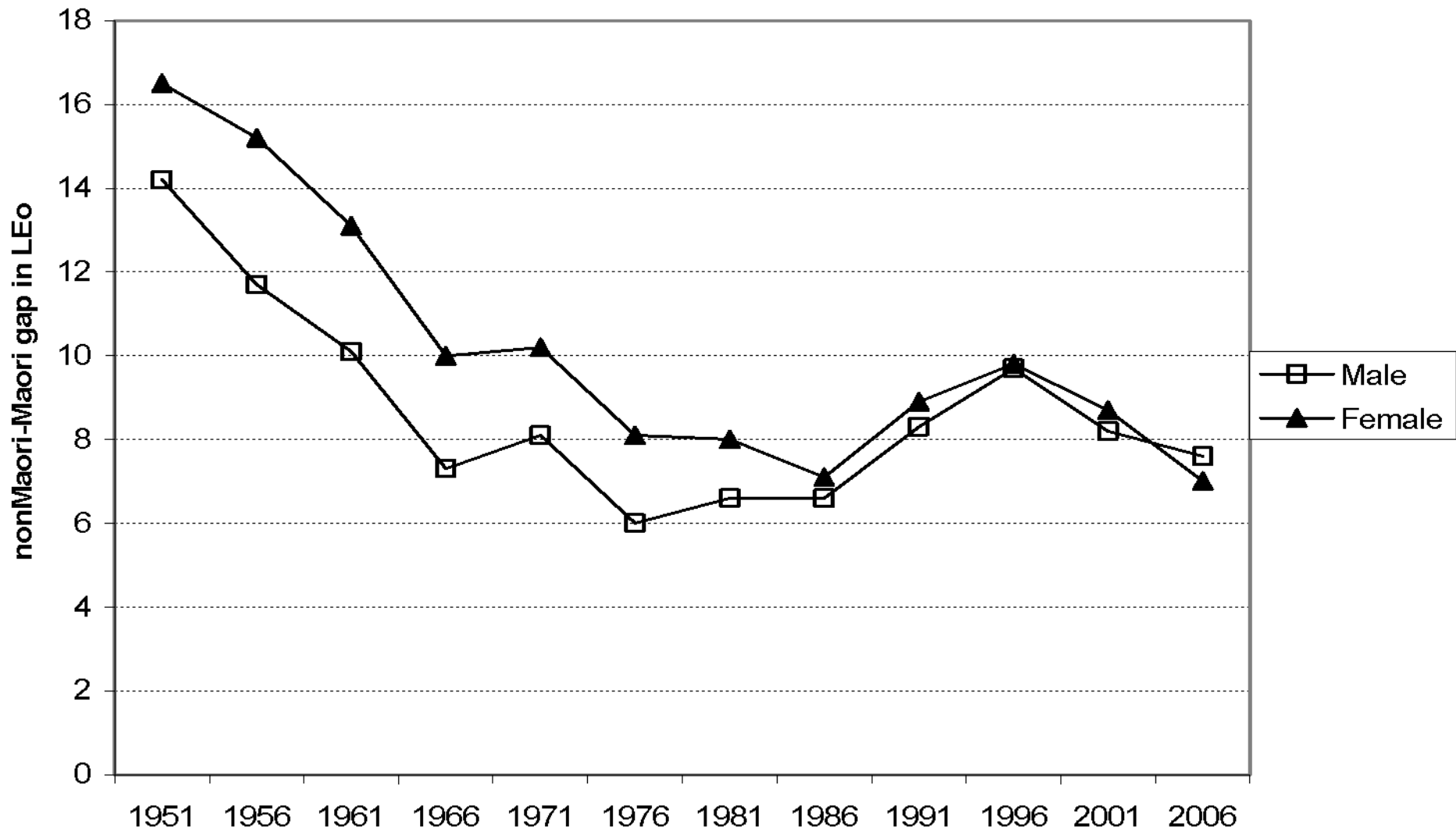
# Capital & Coast DHB

## Can demonstrate:

- Increasing numbers of GPs and Practice Nurses since 2001 – with the greatest increase being in very low fees practices
- Increased utilisation rates
- An increase of 9% (since 2007) in the % of 2 year old children fully immunised
- Declining trends in ED attendance rates, since 2005, for people enrolled with PHOs
- Diabetes - flat or decreasing numbers of admissions, despite increased numbers of people with diabetes
- ASH admissions have declined, particularly for people enrolled with PHOs

Primary Health Care in C & C DHB  
Final Report June 2009

# Life expectancy gap between Māori and non-Māori (1951 – 2006)



Better, sooner, more convenient

## PHO Diversity

### Size

Enrolled populations 3,500 – 350,000

50% of PHOs have <20,000 people (13% of total population)

20% of NZ's population enrolled with the two largest PHOs

### Governance

Usual size 5 – 9 members

Community members 24% of all board members nationally

Maori 24%

GPs 20%

Practice nurses 10%

Other providers 10%

Smith, J. & Cumming, J (2009)  
Taking the temperature of Primary Health Organisations; A  
briefing paper.  
Wellington, Health Services Research Centre

## PHO Diversity

### **Their role – the views of PHO Managers**

- Strategic planner of primary health care
- Funder of primary health care
- General practice support
- Provider development
- Community development
- Inter-sectoral work
- Direct provider of services

### **A critical area of difference**

- 48% see their role as direct provision of primary health care services
- 52% do not see this as a PHO function

## In summary

PHOs have reached something of a watershed.

We now have a primary health care infrastructure in place that's achieved some of the aims of the PHCS

- an enrolled population
- with improved access to services
- more focus on chronic disease
- and on health inequalities,
- as well as community engagement

.....but they seem constrained in their ability to bring about significant change to the model of service delivery in primary care

## Primary Health Care Strategy Budget (2007/08)

Funding Stream	\$million	% of total budget
First contact	520	64%
Services to improve access	39	5%
Health promotion	9	1%
Management fee	32	4%
Care Plus	30	4%
Performance payments	29	4%
Rural health	13	1.5%
Mental health	7	1%

## Next steps

### “Better, Sooner, More Convenient Primary Health Care”

#### Includes

- A focus on clinical engagement and leadership
- Shifting more services into local communities e.g diagnostics, first specialist assessments, allied health services
- Enhanced access e.g walk-ins, nurse-led clinics
- PHOs and general practice to have a greater role coordinating care
- Enhanced role for nurses e.g as case managers for at-risk families
- Establishment of Integrated Family Health Centres
- And more focus on consolidation – PHOs and practices

## This builds on.....

### **Primary Health Care Strategy (MoH 2001)**

- But with a greater focus on personal health delivery

### **Now More than Ever (WHO Report 2008)**

- Universal coverage, Service delivery reforms, Public policy reforms, Leadership reforms

### **Size Matters, Making GP Services Fit for Purpose**

(Prof Paul Corrigan 2005)

## The Approach

### **Significant development through an annual EOI process**

- Enables early movers
- Builds on clinical leadership
- And is large scale – up to 30% of population

### **The opportunity**

- To have global budgets, delegated funding for a range of referred services and a broader range of services
- A different contract, relationship based, and focussed more on outcomes
- Greater transparency – a learning environment

### **Existing arrangements continue**

- Participation in subsequent waves an option

## EOI - eligibility

### **Primary health care providers, organisations or networks that:**

- Have capability and capacity for large scale change
- Use integrated, coordinated and multi-disciplinary approaches
- Support devolution of secondary services to primary health care
- Able to deliver services to a population of 50,000+, or smaller populations from a significant geographical location.

## EOI - assessment criteria

- The size of the potential benefits – especially in relation to national health priorities
- Organisational capability and capacity for large scale change
- Strength of relationships

**“You don’t need an engine when you  
have the wind in your sails”**

Paul Bate 2004



## Further information:

Ministry of Health

<http://www.moh.govt.nz/primaryhealthcare>

Health Services Research Centre, Victoria University

<http://www.victoria.ac.nz/hsrc/>