

Improving Health for New Zealanders by Investing in Primary Health Care

DECEMBER 2000



**NATIONAL ADVISORY COMMITTEE
ON HEALTH AND DISABILITY**

HUNGA KAITITIRO I TE HAUORA O TE TANGATA

National Health Committee
P O Box 5013
Wellington
Tel (04) 495 4413
Fax (04) 495 4401

ISBN 0-478-10490-1 (Booklet)
ISBN 0-478-10491-X (Internet)

This document is available on the National Health Committee web site:
<http://www.nhc.govt.nz>

EXECUTIVE SUMMARY

The National Health Committee provides independent advice to the Minister of Health on the kinds and relative priorities of health and disability support services that should be publicly funded. This report is the Committee's advice to the Minister on primary health care and is the culmination of work on two specific issues:

- how primary health care can reduce health inequalities by reaching individuals and groups in communities who are disadvantaged and currently underserved
- how primary health care can best achieve improvements in health outcomes for communities through population-based approaches.

The report is based on evidence about effective primary health care in New Zealand and international literature and the growing number of successful initiatives occurring around New Zealand. It does not cover every aspect of primary health care and is separate from the Ministry of Health's primary health care strategy. However, many of the conclusions in this report are consistent with the primary health care strategy, reflecting the importance of population-based approaches and reducing health inequalities.

This report recommends significant changes for primary health care in New Zealand. Effective implementation of its recommendations will require leadership, clear policy directions and co-operation between the Government, District Health Boards and primary care providers. The Ministry of Health's proposed primary health care strategy will start this process, which needs to be supported by adequate investment and workforce development.

What is primary health care?

Primary health care (PHC) is an approach to health care that includes a range of services designed to keep people well, from promotion of health and screening for disease to assessment, diagnosis, treatment and rehabilitation. The services provide first level contact that is universally accessible by self-referral and have a strong emphasis on working with communities and individuals to improve their health.

The role of primary health care in reducing health inequalities

- A significant proportion of hospitalisations and premature death in New Zealand can be prevented through good PHC.
- There is international research showing that PHC has an independent effect on improving health status and reducing health inequalities.
- There is sufficient evidence to show that providing free access to PHC services reduces the barrier of cost for low-income families and contributes to more timely and equitable access to both primary and secondary care.

NATIONAL HEALTH COMMITTEE

- The following act as barriers to PHC contributing to reducing health inequalities in New Zealand:
 1. the predominance of fee-for-service (FFS) payment for general practice services
 2. public funding for PHC not being allocated on the basis of need
 3. significant co-payments for many groups discouraging them from accessing PHC
 4. the provision of ineffective services to some population groups
 5. effective services not being provided to people most likely to benefit.

Population-based approaches to primary health care

- A population-based approach consists of organised action to promote and protect the health of identified groups and reduce inequalities between groups.
- Many PHC organisations in New Zealand are already encompassing population-based approaches.
- The following issues need special consideration to help extend the use of population-based approaches in PHC in New Zealand:
 1. the level and system of public-funding of PHC; a relatively small proportion of PHC in New Zealand is publicly funded compared with similar countries, while FFS payments provide limited incentives for population-based approaches
 2. an environment and incentives that encourage interdisciplinary team approaches to be used much more widely.
- The current level of public funding of PHC is insufficient to promote population-based approaches and ensure that PHC providers can lead improvements in population health and the reduction of health inequalities.

Conclusions

- Genuine action to address health inequalities needs to take into account broader social, cultural and economic factors, which are the principal determinants of health.
- Reorienting the New Zealand health system towards a focus on health promotion, early intervention and disease prevention will require a greater emphasis on PHC. In addition, PHC itself will need to continue to develop towards population-based approaches and accountability for health outcomes.
- Evidence suggests prevention initiatives, early detection and improved disease management, which should be the key focus of PHC, are more likely to benefit those with poorer health. It appears that good PHC disproportionately improves the health of socioeconomically disadvantaged people and will help reduce health inequalities in New Zealand.

- In order to help to reduce health inequalities, PHC in New Zealand should:
 1. adopt a broad approach, working with communities and individuals to improve their health
 2. address the broader social, cultural and economic determinants of health where possible
 3. be allocated public funding based on the level of need of the population served
 4. minimise access barriers, in particular cost and cultural barriers
 5. ensure effective interventions are delivered to people most likely to benefit.
- The Committee believes that population-based approaches in PHC should be fostered, as they will contribute to improving the health of the whole population and can help to reduce health inequalities.
- The Committee has identified five key actions to strengthen population-based approaches in primary health care.
 1. A focus by District Health Boards and primary health care providers on population health outcomes and mechanisms to ensure accountability for improving health and reducing health inequalities.
 2. An interdisciplinary approach within a structure that has a community health focus. This will require the development of organisational capability, particularly management capability, for delivering population-based health care.
 3. Funding levels and mechanisms that promote population-based approaches, distribution of resources according to need and accountability for outcomes.
 4. A 'whole sector focus' on a broad PHC approach with a shift in focus and authority away from secondary care.
 5. The collection of sufficiently detailed data on population health needs and systems that prioritise and monitor population-based initiatives for outcomes, equity and quality.

Recommendations

1. *The Government should support the orientation of the whole sector towards a broad primary health care approach with a focus on health promotion, early intervention and disease prevention.*
2. *The Government should preferentially invest in primary health care services with the intention of moving to fully-funded care over the next five years.*
3. *Funding of primary health care should be largely through capitation in order to support population-based approaches, rapidly address existing inequities in funding and improve accountability for better health outcomes.*
4. *Primary health care organisations should be funded to deliver essential services to their enrolled population through interdisciplinary teams.*
5. *Workforce initiatives should be funded and implemented to train primary health care practitioners to work in the new environment.*

CONTENTS

Executive Summary	3
1 Introduction	7
1.1 What is the National Health Committee’s interest in primary health care?	7
1.2 What is primary health care?	8
2 Process	9
3 Reducing health inequalities through primary health care	10
3.1 Can the health sector reduce health inequalities?	10
3.2 What is the evidence that primary health care can help to reduce health inequalities?	11
3.3 Reducing health inequalities in New Zealand: the way forward for primary health care	12
3.3.1 A broad primary health care approach and addressing social cultural and economic determinants	13
3.3.2 Allocation of resources according to need: distribution of primary health care practitioners and funding	13
3.3.3 Minimising the cost barrier: co-payments for primary care	13
3.3.4 Effective interventions: providing high quality of care	14
4 Population-based approaches in primary care	15
4.1 What is meant by a population-based approach?	15
4.2 What is the international experience with population-based approaches in primary care?	16
4.3 Primary health care and population-based approaches in New Zealand	20
4.4 Key issues to address to enhance population-based approaches	20
4.4.1 Funding of primary health care in New Zealand	20
4.4.2 Promoting team approaches	22
4.5 Summary: enhancing population-based approaches in primary health care	23
5 Discussion	24
5.1 The primary health care team	24
5.2 Funding	25
6 Conclusions and recommendations	27
6.1 A broad primary health care approach	27
6.2 Funding	28
6.3 A team approach to primary health care	30
6.4 Workforce training and quality	30
References	31
Appendix 1: Organisations and individuals who made submissions or met with secretariat members	35

1 INTRODUCTION

1.1 What is the National Health Committee's interest in primary health care?

One of the functions of the National Health Committee (NHC) is to "advise the Minister of Health on measures that would deliver the greatest benefit to the health of the population and groups of the population, with particular regard to groups at risk or disadvantage, having regard to available resources" (King 2000). In June 1998 the Committee identified a range of social, cultural and economic factors as the principal determinants of health and identified actions required to reduce health inequalities (NHC 1998). The Committee also acknowledged the important role of publicly funded health services, which can and should:

- take the lead in promoting equity in health by striving for equity of access to both treatment and preventive services
- use those resources devoted to health care to achieve the greatest possible benefit to overall population health
- give high priority to improving the health of groups with the worst health status
- be able to respond to the health care needs of different social groups
- take the lead in encouraging a wider and more strategic approach to developing policies that benefit the population's health as a whole (NHC 1998).

The Committee's interest in primary health care (PHC) arises from the following compelling issues:

1. well documented health inequalities in New Zealand, which highlight an urgent need to take action to address inequalities in health
2. evidence that a good proportion of the illness and premature death in New Zealand is potentially preventable by health sector intervention
3. evidence for inequities in access to primary medical services and subsequently to publicly-funded 'flow-on' services including laboratory services and pharmaceuticals
4. a stated commitment by successive New Zealand Governments to a greater focus on health promotion and disease prevention in the publicly-funded health system
5. a planned shift to District Health Boards (DHBs) in which the joint funding and hospital care provision roles of the new DHBs presents a risk that hospitals may become the focus of the DHBs at the expense of PHC.

In November 1998, the Committee consulted with the sector about how best to contribute to the PHC debate. A small group of people with knowledge of and experience in PHC settings helped develop a work programme. The group identified areas where the Committee could 'add value', which were considered along with previous work by the Health Funding Authority (HFA), Ministry of Health, other Government departments and the research community.

NATIONAL HEALTH COMMITTEE

Taking this advice into account, the Committee identified the following two terms of reference for its PHC work programme:

- *To examine how primary health care can reduce inequalities by reaching individuals and groups in communities who are disadvantaged and currently underserved*
- *To determine how primary health care can best achieve improvements in health outcomes for communities through population-based approaches.*

1.2 What is primary health care?

PHC services have been identified as essential to improving health and reducing health inequalities. Good PHC allows timely, community-based access to effective and appropriate prevention, diagnostic, treatment and support services, helping people to enjoy the best possible health and independence and minimising unnecessary use of secondary care services. As identified in the draft New Zealand Health Strategy, “Primary health care will be critical to improving health and closing the gaps in health status between Māori and Pacific peoples and other New Zealanders” (Minister of Health 2000).

The World Health Organization (WHO) defines PHC as:

- a level of care that is the first point of contact with the health system, based on a philosophy of equity and social justice
- a strategy concerned with intersectoral collaboration
- a set of activities that includes basic clinical services (WHO 1978).

Starfield (1998) identifies four essential features of primary care:

- first point of contact
- long-term relationship with patients
- comprehensive nature of services
- co-ordination of services.

These definitions imply a broad agenda including:

- the analysis of structural social and economic determinants of ill health and service delivery driven by effective and equitable needs assessment
- advocacy on broader social issues where they relate to health outcomes
- supporting the empowerment of groups with poor health status through community development and similar participatory processes.

In New Zealand, PHC should also be considered within the context of the principles of the Treaty of Waitangi; partnership, protection and participation.

Primary health care (PHC) is an approach to health care that includes a range of services designed to keep people well, from promotion of health and screening for disease to assessment, diagnosis, treatment and rehabilitation. The services provide first level contact that is universally accessible by self-referral and have a strong emphasis on working with communities and individuals to improve their health.

2 PROCESS

The NHC commissioned six discussion papers to foster debate on the terms of reference. Independent authors were asked to examine the issues from a number of perspectives to:

- describe different models of PHC and evidence of what works in different localities for different population groups
- determine the most effective PHC funding mechanisms that could best facilitate improvement in health status, particularly for disadvantaged groups
- describe how current models of PHC and their funding systems can best achieve improvement in health outcomes through population-based approaches.

The six papers covered:

- primary care models for delivering population-based health outcomes (Coster and Gribben 1999)
- third sector PHC (Crampton 1999)
- locating nursing in PHC (Carryer et al 1999)
- Māori primary care services (Crengle 1999)
- PHC for Pacific people (Tukuitonga 1999)
- funding population-based PHC in New Zealand (Cumming 1999).¹

These papers were widely distributed for comment in September 1999. Fifty-nine written submissions were received and 40 face-to-face meetings were held with professional organisations, providers and consumer representatives between October 1999 and February 2000.² An extensive literature search was also undertaken.³

In addition, the Committee has been working closely with the Ministry of Health on the development of the PHC strategy where it relates to population approaches and reducing inequalities.

It should be noted that general medical practice has been central to the delivery of primary care services in New Zealand and many other countries. Therefore, much of the current evidence around the funding of primary care relates to care delivered by general practitioners (GPs).

¹ These papers are available on the NHC website <http://www.nhc.govt.nz>

² Appendix 1 lists the individuals and groups who made submissions or met with secretariat members.

³ A more extensive background paper incorporating the literature review and an analysis of the submissions will be made available on the NHC website <http://www.nhc.govt.nz>

3 REDUCING HEALTH INEQUALITIES THROUGH PRIMARY HEALTH CARE

The extent and significance of health inequalities between ethnic and socioeconomic groups in New Zealand are now well documented (Ministry of Health 1999a). Improvement in the health status of the New Zealand population as a whole will not be achieved without reducing these inequalities.

Not all health inequalities are avoidable (NHC 1998). The Committee's interest lies in avoidable health inequalities because these imply potential inequities. The focus of this report is about what PHC can do to improve equity of outcome (health status) as the Committee considers this an important goal for publicly funded health care. One essential element of this is improving equity of access to PHC services.

There have also been a number of international reports on health inequalities with well-researched strategies to reduce these inequalities. Recurrent themes in these reports are:

- addressing the broader social and economic determinants of health as part of PHC
- a focus on promoting good health
- improving access to early intervention and prevention
- building partnerships with communities and local providers. (Acheson 1998; Health Canada 1999; US Department of Health and Human Services 2000).

Clearly, these themes imply that PHC has a leading role within the health sector in responding to health inequalities.

3.1 Can the health sector reduce health inequalities?

Reducing inequalities in health primarily means addressing structural social and economic factors. Policies in non-health sectors such as education, housing, transport and employment are essential to improving health in population groups with poor health status.

Yet there is also potential for the health sector to prevent excess morbidity and early mortality in population groups with the worst health status. Estimates of 'avoidable' morbidity and mortality have been made recently, based on responsiveness to health sector interventions that are currently available, including population-based and individual-based preventive interventions (Ministry of Health 1999b). The data suggest that there were approximately 9000 potentially avoidable early deaths per year in 1996 and 1997, which is about 70 percent of all deaths occurring in people under 75 years of age. In people aged 0 to 74 years, there are much higher rates of avoidable death among Māori (2.5 times) and Pacific people (1.9 times) than in European/other New Zealanders. In addition, almost a third of all hospitalisations in the 0 to 74 age group were considered potentially avoidable through health promotion or effective PHC.

3.2 What is the evidence that primary health care can help to reduce health inequalities?

Overall, an estimated 78 percent of avoidable early deaths in New Zealand in 1996-97 were a result of health problems that could either be prevented in the first place or would have been amenable to early intervention (primary avoidable mortality (PAM) and secondary avoidable mortality (SAM), see Table 1 below). These are both situations where primary care should have a leading role, as PHC practitioners are in a position to identify people at high risk and help them make lifestyle changes or treat conditions early before complications develop. In addition, more effective PHC could have reduced the number of avoidable hospital admissions by two thirds. Given that the rate of both avoidable hospitalisations and avoidable deaths are two to three times higher among particular populations, e.g. Māori, ethnic minorities, people living in deprived neighbourhoods, there is considerable scope for PHC to reduce health inequalities.

Table 1 – Avoidable deaths, ages 0–74, average of 1996 and 1997

	Number of deaths	Age-standardised rate per 100,000	Percentage of total deaths in 0-74 age group	Percentage of avoidable deaths
Avoidable mortality	9025	223	70	100
PAM	4741	116	37	53
SAM	2302	56	18	26
TAM	1982	50	15	22
Unavoidable mortality	3861	94	30	
Total mortality	12,886	316	100	

Source: Ministry of Health 1999a p 316.

Primary avoidable mortality (PAM) — conditions that are preventable, whether through individual behaviour change (lifestyle modification) or population level intervention (healthy public policy). The condition is prevented before it develops by addressing its risk or protective factors: This constitutes ‘primary prevention’.

Secondary avoidable mortality (SAM) — conditions that respond to early detection and intervention, typically in a PHC setting. As well as clinical preventive services such as cancer screening, it includes chronic disease management intended to delay the progression of diseases such as diabetes or the recurrence of events such as heart attacks or strokes (for example, through the monitoring and management of high blood pressure). This approach constitutes ‘secondary prevention’.

Tertiary avoidable mortality (TAM) — conditions whose case fatality rate can be significantly reduced by existing medical or surgical treatments (typically, but not necessarily, in a hospital setting), even when the disease process is fully developed. This constitutes ‘tertiary prevention’.

NATIONAL HEALTH COMMITTEE

The role of PHC is supported by international research showing an independent effect of PHC on improving health status and reducing health inequalities (Starfield 1994; Shi 1997). Other research shows that PHC may mitigate (though not prevent) the adverse effect of income inequality on health status (Bunker et al 1994; Lantz et al 1998; Shi et al 1999). Countries oriented towards a strong primary care infrastructure achieve better health outcomes, as assessed by a variety of measures (Starfield 1994; Shi 1997; Lantz et al 1998; Bunker et al 1994; Shi et al 1999). It appears that it is not the number of primary care doctors that matter but the way resources are distributed and clear specification of roles (Starfield 1996).

Research by Starfield (1996) suggests that countries oriented towards a strong PHC infrastructure tend to achieve better health outcomes. PHC in these countries is characterised by:

- more equitable distribution of resources
- fewer barriers to access (such as co-payments)
- choice of primary care provider
- long-term relationships between patients, families, communities and providers
- integration of services (Starfield 1996).

In addition, countries with strong PHC-led systems have lower overall health care costs, and where PHC is strong, its effect is greatest in areas of low income (Starfield 1996). Starfield asserts that relatively wealthy people are little influenced by public funding for primary care, and where funding is increased the first to benefit are the poor. In addition, where a country has strong primary care, specialist availability and increasing funding of secondary care appear to make little additional difference to health outcomes.

Starfield's findings have implications for the proportion of public spending that is allocated to PHC. They also point to the need to distribute PHC funding in ways that optimise the availability of appropriate services and personnel for people with the poorest health.

3.3 Reducing health inequalities in New Zealand: the way forward for primary health care

In order to help to reduce health inequalities, the Committee considers that PHC in New Zealand should:

1. adopt a broad approach, working with communities and individuals to improve their health
2. address the broader social, cultural and economic determinants of health where possible
3. be allocated public funding based on the level of need of the population served
4. minimise access barriers, in particular cost and cultural barriers
5. ensure effective interventions are delivered to people most likely to benefit.

3.3.1 A broad primary health care approach and addressing social cultural and economic determinants

A broad PHC approach maximises opportunities for prevention, early intervention and effective disease management both through the provision of accessible, appropriate and effective services and through engaging local communities in the planning, delivery and evaluation of their health care services. Population-based approaches, which are discussed in Section 4, are essential to achieving this.

This approach includes the capacity to respond to broader factors impacting on the health of individuals and communities. PHC has an important role in addressing the social, cultural and economic determinants of health for individuals and populations. Health professionals will need to broaden their approach beyond advocacy for improved access and increase their capacity to address the structural determinants that affect health outcomes (Pincus et al 1998).

3.3.2 Allocation of resources according to need: distribution of primary health care practitioners and funding

New Zealand's fee-for-service (FFS) funding system for primary care encourages service providers to locate in areas where there are more people and fewer socioeconomically disadvantaged groups. The resulting uneven distribution of practitioners exacerbates inequities in access and funding and thus disadvantages rural people and poorer communities. Other funding mechanisms such as capitation may make the distribution of resources more equitable but are unlikely, on their own, to stop practitioners preferentially locating in well-populated and wealthy areas.

There is some evidence in New Zealand of inequities in the distribution of public funds for general practice and 'flow-on' services. A study in the Auckland region showed that, when subsidies for general medical services (GMS), prescribed pharmaceuticals and community laboratory tests are included, people from the most deprived areas get significantly less public funding than people from less deprived areas (Malcolm et al 1999).

In addition, primary care is the 'gate-keeper' for secondary care services and inequitable access to primary care services can result in inequitable access to secondary care, in particular for elective procedures. There is evidence for inequitable access to secondary care services in New Zealand. Health Funding Authority analyses demonstrate lower rates of intervention for several common elective procedures in Māori than would be expected by their level of need, compared with non-Māori (HFA 1999).

3.3.3 Minimising the cost barrier: co-payments for primary care

New Zealand has relatively high levels of co-payments for primary care compared with other OECD countries (the reasons for this are discussed in Section 4.4.1). In part, the rationale for co-payments (for both primary care visits and pharmaceuticals) is to discourage excess or frivolous use. However, a reasonable proportion of primary care visits are provider-generated, especially follow-up visits (Starfield 1998). Putting

NATIONAL HEALTH COMMITTEE

barriers in the way of people needing services is an unfair way of discouraging over-utilisation. Evidence clearly shows that people with genuine need for health care are as discouraged from seeking care as people who are less needy (Rasell 1995).

Therefore, co-payments:

- are arguably ineffective in reducing costs (in fact, they may increase costs because of provider-induced demand) (Fahs 1992)
- interfere with the receipt of necessary care
- heighten inequity by preferentially disadvantaging people who need care the most, i.e. people with chronic diseases and socioeconomically disadvantaged groups (Saltman and Figueras 1998).

As a result of significant co-payments, cost acts as a barrier to accessing primary care for some groups in New Zealand (Dixon et al 1994; Barnett and Coyle 1998; Barnett 2000; Waldegrave et al 1999). Community services cards (CSC) assist many people on low incomes to access GP services effectively (Ministry of Health 1999). However, there is evidence that a significant number of eligible people do not have a CSC (Gribben 1996; Parks 1996), while some people who do not meet the eligibility criteria for a CSC may also struggle. The corollary of this is inequities in access to 'flow-on' services including laboratory services and pharmaceuticals. However, cost is not the only important barrier. Income alone does not explain the relatively lower use of GP services by Māori; cultural factors may play a significant role (Scott et al in press).

The combination of financial barriers to access and unequal distribution of primary care practitioners and resources makes it difficult for socioeconomically disadvantaged population groups to access PHC. In addition, rural residents and people living in some provincial towns in New Zealand are experiencing deterioration in the availability of primary care services, notably general practice. Taken together, these different factors set the stage for inequities in publicly-funded PHC provision, which need to be addressed.

3.3.4 Effective interventions: providing high quality of care

To reduce inequalities in health outcomes, attention also needs to be paid to the quality of care received by different population groups. While disparities in resource use in New Zealand are partly due to access barriers, they are also in part a result of differences in the process and delivery of health care to people from different socioeconomic and cultural backgrounds. For instance, many Pacific people prefer a health-related consultation to be with the whole family rather than the individual patient. The pathways through which socioeconomic and cultural factors have an influence are complex and include patient characteristics such as education, knowledge, literacy and health beliefs, ethnic concordance between professional and patient, and professional attitudes and bias.

An important starting point is to ensure more equal access to effective services and to reduce the use of ineffective services. There are a number of initiatives underway to help move practice towards effective interventions, e.g. evidence-based practice guidelines. These initiatives need continued support and development.

4 POPULATION-BASED APPROACHES IN PRIMARY CARE

Health inequalities call for urgent action within the health sector to integrate patient-centred and population-based health initiatives to improve health status (Freyman 1989; Lee 1994; Thier 1992). There is growing interest in population-based approaches as a basis for action to improve health and reduce health inequalities. In many New Zealand communities, action is already being taken and there are many exciting population-based initiatives in PHC, some within a community development framework (Ministry of Health 1998; IPA Network 2000).

4.1 What is meant by a population-based approach?

A population-based approach consists of organised responses to promote and protect the health of identified groups and reduce inequalities between groups. It is explicit in acknowledging that socioeconomic conditions are key factors in determining people's health and that social inequalities produce a gradient in health status, with the most disadvantaged individuals and groups experiencing the worst health outcomes.

Population-based approaches do not replace but rather complement high quality care for individual patients. They provide the framework within which high quality and equitable care can be provided to individuals and groups of people.

Essential elements for effective population-based approaches in PHC include:

- description and comparison of the health of different population groups
- identification and measurement of risks to the health of population groups based on quantitative and qualitative information
- a system of keeping track of people for regular preventive care
- provision of effective and comprehensive PHC services for individuals and their families, including educational, preventive, screening, treatment, rehabilitation and follow-up
- assessment of the effectiveness of health-related interventions designed to promote health, prevent illness or injury, or maximise independence in those with illness
- implementation, monitoring and evaluation of these interventions
- mechanisms for enabling and supporting community action, including funding and technical support, to target priority health problems
- linkage of the components of the health sector and other sectors that allow the above activities to occur (Towler 1999; Tukuitonga 1999).

Population-based approaches are not synonymous with universal (as opposed to targeted) provision of services. Some population-based approaches will be 'universal' in nature, e.g. immunisation, but may include targeted strategies for certain population groups, e.g. community vaccinators for children not reached by clinic-based

immunisation. Other population-based services may be designed and targeted to specific population groups, e.g. marae-based smoking cessation programmes for Māori, school-based sexual health services.

The NHC considers a population-based approach to primary health care to imply care delivered to groups (however defined), although specific components of a service may be provided to individuals. This approach requires defining community needs and delivering effective services to meet those needs in appropriate settings including marae, homes, schools, and workplaces. Services include health promotion, disease prevention programmes and disease management initiatives that enable people to make individual and collective choices to improve their health.

4.2 What is the international experience with population-based approaches in primary care?

Internationally, a number of countries are encouraging PHC services to adopt a population-based approach to improve the health of the population overall and reduce inequalities between groups. This section summarises key international discussion of and experience with population-based approaches. It identifies what value this approach adds as well as factors that enhance or inhibit a population-based approach.

United Kingdom

Since the early 1990s, the National Health Service (NHS) contract with GPs has provided incentives for the development of general practice-based health promotion and disease prevention programmes.

Experience suggests that:

- the contracts have facilitated the expansion of health promotion and disease prevention services (Le Touze and Calnan 1996)
- many programmes have failed to target those most at risk of ill health (Gilliam et al 1996).
- there are difficulties regarding monitoring and accountability (Baeza and Calnan 1998).
- there is evidence that communities most at risk of ill health tend to experience the least satisfactory access to prevention services (Birmingham Health Authority 1995).

These authors all conclude that funding of PHC should be allocated on the basis of need to assist with addressing inequalities in PHC. Thus, population-based approaches are insufficient on their own to reduce health inequalities and need to be supported by equitable funding.

A review of population-based approaches in PHC undertaken in the UK highlighted barriers that hampered the development of more community-oriented activities and

services and identified those factors that had proved important in supporting their development (Birmingham Public Health Alliance. 1998) (See Table 2 below). The review concluded that population health cannot simply be ‘added on’ to PHC services. Rather it must be integral to the strategic development of PHC if the strengths of this approach are to be successful.

Table 2 – Developing a population-based approach in primary health care

BARRIERS TO ACCESS	ENABLING FACTORS
<ul style="list-style-type: none"> • Primary care generally perceived as primary medical care leading to emphasis on health as an individual concern rather than a community issue. • Primary care and public health practitioners lack confidence to address inequities. • Genuine participation by local people in health viewed as helpful but problematic to achieve. • Short-term funding and inappropriate time scales unhelpful. Good relationships and an understanding of communities takes time to develop. • Disease focused outcome measures may take years to become significant and hinder innovations that seek to improve overall health and well-being rather than to control a specific disease process. 	<ul style="list-style-type: none"> • Committed individuals important to success of project but often lack sustainable organisational support. • Project workers provide bridging role between local people and primary care. • Control over resources (funding, professional and personal skills). • Supportive organisational strategies, such as jointly funded posts, imaginative and facilitative management and established corporate structures. • A history of community participation and collaboration over a number of years increases effectiveness of participation in health related activities.

Source: Public Health Alliance 1998

Evaluation studies of the UK Total Purchasing Pilots highlight three reasons why their PHC models overall have not generally led to a more population-based approach:

- under-developed organisational capabilities for promoting population-based health
- inadequate assessment of population-based needs (Killoran 1999); locality-based or district-wide collaborations, often with the health authority playing a key role, appeared to have been more likely to develop a health needs assessment capacity than independent fund-holding organisations (Smith et al 1997)
- organisational and managerial culture did not support population health approaches (Marks and Hunter 1998).

NATIONAL HEALTH COMMITTEE

Canada

Based on Canadian experience, several reports conclude that the WHO Health for All policy can only be achieved through the integration of health promotion, disease prevention and PHC (Advisory Committee on Population Health 1994; Health Canada 1986; Canadian PHA 1997). The reports suggest that implementing a population-based approach requires a change in the way Canadian PHC is funded, organised and delivered. The key changes required include:

- working in partnerships at a variety of levels
- building in accountability
- making policy choices informed by evidence
- reallocating resources, including power and authority away from professional groups to people and communities.

USA

A review of over 500 initiatives in the United States in the mid-1990s (Lasker 1997) documented six types of benefits from collaboration between clinical medicine and population health. They are:

- improving services by co-ordinating care for individuals
- improving access to care by establishing frameworks to provide services for the uninsured
- improving the quality and cost-effectiveness of services by applying a population perspective to medical practice
- using clinical practice to identify and address community health problems
- strengthening health promotion and health protection by mobilising community resources
- shaping the future direction of the health system by collaborating around policy, training and research.

There are published reports in the United States of primary medical care practitioners practising 'wellness' successfully, i.e. basic preventive care and chronic disease management, but they are exceptions (Downs 1981; Fletcher 1983; Wechsler et al 1983; Wagner et al 1996). Some aspects of preventive medicine, such as cervical screening and immunisation, have been embraced more fully than others.

Research indicates that planning and providing care for geographically defined communities poses a challenge for practitioners of individual patient care (Nutting 1987; Greenlick 1992; Nutting et al 1991). Such an approach involves teamwork, developing information systems, and designing, modifying, prioritising, and monitoring population-based programmes. Personal motivation to carry out population-based programmes has also been noted to be highly relevant to successful outcomes (Anderson 1993; Taplin et al 1998).

Overall, studies suggest that although many primary medical care practitioners are aware of the importance of some risk behaviours, e.g. smoking and alcohol use, most do not inquire routinely about a wide variety of significant risks. Moreover, practitioners who have attempted health education or intervention have felt their efforts to be moderately successful at best. Most report that they lack the knowledge and skills to intervene effectively but remain interested in acquiring these skills. Finally, many express interest in better referral networks and financial reimbursement for health promotion.

Many PHC practitioners report that the lack of financial reimbursement for health promotion activities is a major problem. In the US many health maintenance organisations (HMO) and independent practice associations (IPA) are now paying for prevention and risk-reduction activities. Results of these programmes suggest that such activities may not be very cost-effective from the perspective of the HMO or IPA. However, evaluation of these programmes is difficult as the benefits may not be realised for many years.

Australia

Many general practitioners in Australia have taken a broader population health role over the last decade, particularly through the Divisions of General Practice and university departments of general practice. The 1998 review of general practice in Australia recommended further enhancing the population health role of general practitioners through the Divisions of General Practice, in close co-operation with existing public health networks.

Three important changes supporting the population health role of GPs in Australia have been:

- funding for the establishment of the Divisions of General Practice (equivalent in some respects to IPAs in New Zealand)
- funding for general practice-based research
- the establishment of support and evaluation resource units.

A survey of Australian GPs regarding enhancing their population focus found:

- the quality of existing population health work within general practice is very variable; GPs indicated a need for specific training in population-based approaches to health promotion and health maintenance.
- some interest in broader roles such as health advocacy, liaison with population health agencies and greater participation in state or national surveillance activities
- extensive support for priority setting for population (public) health programmes at national level, informed by all available evidence prior to these programmes or related services being taken up by GPs (Towler 1999).

Some GPs felt that expanding their role could also be seen as threatening to existing public health medicine specialists.

4.3 Primary health care and population-based approaches in New Zealand

As in the countries surveyed above, PHC in New Zealand is still largely synonymous with general practice and much of the information on access, funding and other issues relates to general practice. The Committee supports the shift to increased teamwork that is occurring in New Zealand general practice services.

Many professional groups also support this wider interpretation. The recent formation of a College of Primary Care by the Royal New Zealand College of General Practitioners (RNZCGP) and the practice nurse branch of the New Zealand Nurses Organisation is a step towards a broader PHC approach.

The RNZCGP acknowledges the tension between the provision of personal and population health services in improving the health of communities, but emphasises that health promotion, prevention and screening are essential components of general practice (RNZCGP 1999). The College recommends that population-based approaches should continue to be adopted in tandem with personal care services to improve health outcomes.

The issues for GPs in New Zealand in attempting to focus effectively on preventive care have been well summarised by Foote (2000). He observes that health-conserving behaviour tends to be a middle class habit and that GPs tend to be “preaching to the converted.” He also notes that patients requiring time for preventive care, emotional support, and more complex disease management are heavily disadvantaged, i.e. the ‘inverse care’ law applies.

There are a number of population health initiatives in PHC underway in New Zealand. However, little long-term evaluation of these initiatives has been carried out, often because sufficient time has not yet elapsed. Many of these initiatives are documented in the NHC’s background paper and in previous Ministry publications (Ministry of Health 1998; Minister of Health 2000b).

4.4 Key issues to address to enhance population-based approaches

The Committee has identified two issues that need to be addressed to widen the adoption of population-based approaches in PHC:

- the level and system of public funding of PHC
- ways to promote team approaches.

4.4.1 Funding of primary health care in New Zealand

New Zealand spends a lower proportion of total health expenditure on PHC than many OECD countries. It is one of few OECD countries where people pay significant co-payments for primary care. There is also evidence that New Zealand spends a larger proportion of its health budget on hospital services than most other OECD countries (Anderson 1998).

A relatively low proportion (40 percent) of generalist PHC, and thereby access to the rest of the health system, is funded through Vote:Health in New Zealand.⁴ This does not send the signal that PHC is integral to achieving the broader goals of the publicly-funded health system. It also limits possibilities for distributing PHC resources according to need, encouraging a focus on health promotion and disease prevention, and improving the accountability of PHC for broader population health goals.

In contrast, hospital services are largely publicly funded,⁵ which gives hospitals much greater leverage over new funding each year in order to maintain a reasonable level of service free of charge. There is clear evidence that this acts to divert resources away from primary care; there was a real increase in total publicly-funded health expenditure of 22 percent between 1990/91 and 1997/98, compared with a 17 percent increase in expenditure on primary services and no real increase in expenditure on GMS during the same period (Ministry of Health 2000).

The reasons for the current level of public funding for primary care are complex but are largely historical. Patient co-payments have been present for much of the last 60 years. In the early 1940s patients paid around one-quarter to one-third of the total fee charged by GPs (Hay 1989; New Zealand Government 1974). However, there were no increases in the subsidies paid to GPs until 1972. Even with the 1972 increase, Government subsidies covered only around one-third (New Zealand Government 1974) to one-half of GP fees (Hay 1989). The current level of co-payments is due mostly to the failure of the GMS to keep pace with inflation. Erosion of the value of Government subsidies underlies GPs' concerns about preserving the right to charge a co-payment.⁶

Evidence suggests that co-payments are selectively reducing access to PHC for low-income people who are more likely, as a group, to have higher need. This situation probably contributes to the demonstrated inequities in the distribution of public funding for primary care services, including public subsidies for laboratory and pharmaceutical services.

There is increasing acceptance and use of capitation to fund PHC in New Zealand (Malcolm 1999; NZCPHC 2000). Capitation may encourage population-based approaches and a greater emphasis on prevention. It has also been shown to lead to increased delegation to nurses and other non-medical PHC providers, improving accountability for outcomes and facilitation from an 'illness' to a 'wellness' model.

⁴ Once ACC and other Government agency funding is included, the overall percentage of general practice income from public funding is 60 percent (Ministry of Health 2000, p 63).

⁵ Virtually 100 percent of health care in public institutions is publicly funded, and 85 percent of health care in both public and private institutions overall is publicly-funded (Ministry of Health 2000, p62).

⁶ Experience with the introduction of 'free' GP visits for children under 6 years suggests that if GPs are comfortable with the level of public subsidy of consultations, then few practitioners will charge a co-payment even if they are able to. However, it is worth noting that the level of funding for such visits (\$32.50) has not increased since the scheme commenced in 1997, even to keep pace with inflation. This tends to reinforce the desire of GPs to retain the right to charge a co-payment, even if they are largely happy with the level of subsidy.

NATIONAL HEALTH COMMITTEE

However, capitation can lead to under-servicing for people from lower socioeconomic groups through adverse selection and 'cream skimming'. This is more likely to occur if a shift to capitation occurs while significant co-payments still exist.

Māori, Pacific and other community-owned primary care providers are already beginning to provide broad or extended PHC services, e.g. with GPs, practice nurses, community nurses, school nurses, well-child services, social workers, traditional healers, and health promotion and disease management programmes. Currently, this type of service provision is possible only by 'cobbling' together multiple contracts and has high associated transaction costs.

4.4.2 Promoting team approaches

A key feature of effective PHC is providers working together and co-operating with minimal fragmentation from the consumer's perspective. Interdisciplinary teamwork is increasingly a feature of health care in New Zealand, particularly in hospital settings where the institutional nature of care is conducive to such teamwork.

PHC providers should be able to provide a range of 'essential' services to their enrolled population, either directly or through an established relationship with another provider. This implies co-operation and teamwork focused on improving the health status of the population for which the PHC organisation has responsibility. Working in teams, which might be 'virtual' teams in some respects, is also essential for quality assurance and continuity of care.

As previously highlighted, general medical practice has been central to the delivery of publicly-funded primary care in New Zealand to date and interdisciplinary teamwork has been difficult to establish. This has been due in part to the funding of general practice consultations through a FFS system and providing subsidies for doctors to employ practice nurses. GPs will remain a core element of PHC in the future but their roles will change.

Teamwork needs to be fostered by approaches that make better use of all the different expertise in the team and encourage communication rather than overlap, omission or division (NZCPHC 2000). It will take time to move to a truly team-based approach with greater sharing of power and resources. However, a move to a broader PHC approach, predicated on interdisciplinary teamwork among professionals, also calls for a sharing of power and resources in a true partnership between professionals and communities. This would see the community involved in the governance of PHC organisations and sharing decision-making about how funding should best be spent in that community.

4.5 Summary: enhancing population-based approaches in primary health care

The Committee believes that population-based approaches in PHC should be fostered, as they will contribute to improving the health of the whole population and can help to reduce health inequalities. Based on its research and consultation, the Committee has identified five key actions to strengthen population-based approaches in primary care. These actions are also necessary to enhance action to reduce health inequalities in PHC .

1. A focus by District Health Boards and primary health care providers on population health outcomes and mechanisms to ensure accountability for improving health and reducing health inequalities.
2. An interdisciplinary approach within a structure that has a community health focus. This will require the development of organisational capability, particularly management capability, for delivering population-based health care.
3. Funding levels and mechanisms that promote population-based approaches, distribution of resources according to need and accountability for outcomes.
4. A 'whole sector focus' on a broad PHC approach with a shift in focus and authority away from secondary care.
5. The collection of sufficiently detailed data on population health needs and systems that prioritise and monitor population-based initiatives for outcomes, equity and quality.

The current barriers to population-based approaches in PHC are similar to those that limit its ability to help reduce health inequalities. Addressing key issues, in particular funding and interdisciplinary teamwork, will assist in achieving a greater focus on health promotion and disease prevention and the greater goals of improved outcomes and reduced health inequalities.

5 DISCUSSION

Health inequalities and inefficiencies in health service delivery call for greater emphasis on PHC that focuses on health promotion, early intervention and disease prevention. Through clinical preventive practices, PHC practitioners can help individuals lead healthy lives; through community-driven population services, PHC practitioners can help whole communities become healthier (Cashman et al 1999). Early intervention and disease prevention services are the two key population services that function explicitly as the bridge between the health of the individual and the health of the community.

Evidence suggests prevention initiatives, early detection and improved disease management, which should be the key focus of PHC, are more likely to benefit those with poorer health; therefore, they will help to reduce health inequalities. An orientation towards PHC is highly congruent with the direction that successive New Zealand governments have signalled for health care in New Zealand. This strongly supports the case for orienting the New Zealand health sector towards PHC.

5.1 The primary health care team

While much of the evidence and discussion of primary health care in this report relates to general practice, the Committee envisages the PHC team as inclusive of a range of practitioners. The key to effectively involving many different practitioners is interdisciplinary teamwork, which implies practitioners bringing their different knowledge and skills together for the benefit of individuals and communities.

An essential requirement of the 'primary health care team' is that it be managed well at both the organisational and the care levels. The team must be co-ordinated to support the delivery of effective primary care to its community. Roles within the team need to be defined but there also needs to be flexibility so that different circumstances that arise in the community can be addressed most appropriately. The size and makeup of the team also need to be flexible.

The effective implementation of the changes to PHC called for in this report will require extra support in rural areas, particularly acknowledgement of and action to address:

- the stresses New Zealand's rural primary care workforce face
- the inadequacy of rural primary care infrastructure in many areas.

An important requirement of the PHC team is training. The responsibility on primary care professionals to assist in the training of undergraduate and graduate students needs to be reflected in remuneration arrangements built into the capitated system.

The following issues are relevant in deciding what the PHC team might look like.

1. PHC organisations need to have specific strategies to target populations, particularly those with poorer health status and this will require the innovative

use of different practitioners. For example, a PHC organisation might use salaried nurses to track down and deliver services such as immunisation and screening to people who are not accessing clinic-based services.

2. The different and specialised roles of PHC practitioners need to be understood.⁷ The knowledge and skills of the PHC nursing workforce and other non-medical professionals need to be better recognised and used within PHC structures. The interdisciplinary nature of PHC teams should be reflected in organisational governance and management.
3. Funding arrangements influence whether and how PHC providers involve a range of professional groups. FFS payment for GP services can work against the appropriate use of nurses, in particular for health promotion activities. A mix of different funding approaches may be needed to enable teamwork to occur.

5.2 Funding

There is no perfect system for funding PHC and there will always be trade-offs. However, both the level of public funding for PHC and the way in which PHC services are funded have a major impact on the extent to which PHC can contribute to helping reduce health inequalities.

There is good evidence that providing free access to primary care services largely reduces the barrier of cost for low-income families and contributes to more timely and equitable access to secondary care. Given the stated intention to shift towards a greater focus on health promotion and disease prevention, a confusing message is currently being sent by the existence of co-payments for primary care while secondary care is largely free.

The Committee's research suggests that capitation funding for PHC is more likely than FFS to encourage population-based approaches, enhance a team approach and improve accountability for population health outcomes. While changes in practice, e.g. towards a population-based approach, may take time, at the very least capitation should lead to a better distribution of resources towards those population groups that currently have low rates of primary care service utilisation (and expenditure) but often have higher needs (Cumming 1999).

Capitation funding should be paid to PHC organisations, which then make their own remuneration arrangements with individual providers and practitioners for the provision of comprehensive primary care services to their enrolled population groups.

⁷ These practitioners include doctors (general practitioners, public health medicine and medical specialists), nurses (practice nurses, public health nurses, district nurses, palliative care nurses, community mental health nurses, dental nurses, Plunket nurses and midwives), pharmacists, community health workers (including Māori and Pacific health workers), alternative medicine practitioners and traditional Māori and Pacific healers, mental health professionals (psychologists, counsellors), social workers, dental health practitioners, allied health professionals (including physiotherapists, occupational therapists, podiatrists, chiropractors, optometrists, and dieticians) home care workers, support personnel (administrators, ambulance and emergency service workers, laboratory technicians, imaging technicians, radiology technologists) and many others.

NATIONAL HEALTH COMMITTEE

Enrolment with a PHC organisation will help ensure the more equitable distribution of funding. Establishment and infrastructure development grants for new and existing providers respectively, particularly for Māori, Pacific and other community-owned providers, are also required to help address existing inequities.

Health promotion and disease prevention are activities traditionally funded through public (population) health. However, a greater focus on these activities in primary care does not imply that funding should be shifted from public health. Public health activities remain central to improving population health and reducing health inequalities. In addition, public health practitioners have many of the skills required to plan and implement population-based initiatives. It is likely that the public health sector will need strengthening to assist PHC to continue to shift its focus towards health promotion and disease prevention.

6 CONCLUSIONS AND RECOMMENDATIONS

Having considered international experience and feedback from submissions and consultation in New Zealand, the NHC has reached the following conclusions and identified several key actions that will promote a population-based approach and contribute to reducing inequalities through PHC .

6.1 A broad primary health care approach

1. The Ministry of Health should promote a policy environment that orients the health sector towards a broad PHC approach.
2. A systematic approach to quality in PHC should be developed, with monitoring of appropriate indicators to determine progress towards improving population health goals and reducing health inequalities. Good information collection, analysis and feedback will support effective monitoring. There are difficulties associated with monitoring on the basis of outcomes (Cumming and Scott 1998), so useful and reliable process indicators need to be agreed upon and monitored in addition to outcomes.
3. District Health Boards should have accountability for a defined population, assessment of population needs and development of programmes to meet these needs. Alternative models of PHC service delivery, in particular Māori and Pacific providers, should continue to be supported and new services promoted to address the health needs of specific population groups.
4. PHC organisations should provide or have direct access to the following 'essential' services and features:
 - community participation and involvement in organisational governance
 - health needs assessment and population-based planning with community input
 - first-level care for acute medical problems and injuries
 - first-level care for specific health issues, e.g. family planning, maternity care, diabetic foot care, community-based stroke rehabilitation, which should be within the continuum of primary care even if they continue to be funded separately from PHC organisations.
 - personalised advice on disease prevention and self-care
 - effective chronic disease management including relevant disease risk-factor screening and early intervention and a focus on keeping people out of hospital
 - population-based interventions delivered to individuals, e.g. immunisation
 - a commitment to the principles of the Treaty of Waitangi and services provided in accordance with these principles, i.e. participation at all levels, partnership in service delivery and culturally appropriate practices (Minister of Health 2000a)
 - culturally appropriate services for different ethnic groups

NATIONAL HEALTH COMMITTEE

- the ability to respond to issues in other sectors that are impacting on the health of individuals or communities, e.g. housing problems, benefit entitlements
 - opportunities for individuals and families to contribute to health promotion strategies and initiatives to improve community health and reduce health inequalities
 - the capacity to work with organisations in other sectors such as local Government, transport, welfare, housing and education to advocate for changes that will improve the health of their enrolled population.
5. PHC providers need to develop and maintain lists of the people who regularly seek care and advice from them. While people should be encouraged to enrol with a PHC provider of their choice, this should not restrict them from seeking advice from another provider when appropriate. Processes for dealing with such 'casual' visits should be administratively easy and not penalise individuals or organisations.
6. PHC providers should develop effective working partnerships with all professional groups and with:
- Māori groups relevant to improving the health of Māori in the local population
 - other relevant organisations, e.g. local authorities
 - the community, particularly through community development approaches.

Recommendation

The Government should support the orientation of the whole sector towards a broad primary health care approach with a focus on health promotion, early intervention and disease prevention.

6.2 Funding

1. Public funding of PHC in New Zealand should aim to:
- foster a health care system that has a focus on prevention, promotion and early intervention
 - encourage population-based approaches
 - improve accountability of primary health organisations for population health outcomes
 - contribute to reducing health inequalities
 - ensure that people, especially low income people and families, have access to essential primary care without a significant cost barrier
 - minimise any tendency for inappropriate use of acute hospital services and make it easier to provide care in community settings without shifting costs onto the patient

- enable the PHC team to assist in the training of undergraduate and graduate students.
2. The current level of public funding for PHC is not sufficient to achieve the above objectives. Reallocating current GMS, practice nurse and capitation funding or changing the method of funding, e.g. to capitation, are likely to have only a marginal benefit. The objectives can be achieved through preferential investment of a proportion of the 'sustainable funding pathway' money into PHC each year, without necessarily injecting more money into the health budget. Investment in PHC is an investment in future population health and is unlikely to result in a decrease in the use of hospital services over the next five to ten years. A shift initially from acute to elective secondary care services is likely owing to improved access to primary care and the consequent increased referral for elective services that are part of good disease management. Funding for these services needs to be sufficiently flexible to accommodate this shift. In the long term, better health promotion and disease prevention through PHC will ensure more appropriate and cost-effective use of acute and elective secondary care services.
 3. It is paramount that public funding of PHC services is allocated on the basis of need. This implies that all PHC funding should be distributed through a capitation formula that includes a measure of deprivation in addition to age and ethnicity and acknowledges the additional costs of rural provision. Any increase in public funding for PHC is likely to be incremental. Additional investment in PHC should be targeted in the first instance at services provided to people in socioeconomically disadvantaged groups and at supporting the infrastructure in many rural communities.
 4. Any increases in public funding of PHC should be tied to specific services. As part of this, well-evaluated demonstration projects should be used to trial and assess the cost-effectiveness of population-based approaches in PHC.

Recommendations

The Government should preferentially invest in primary health care services with the intention of moving to fully-funded care over the next five years.

Funding of primary health care should be largely through capitation in order to support population-based approaches, rapidly address existing inequities in funding and improve accountability for better health outcomes.

6.3 A team approach to primary health care

1. Funding for primary care providers should encourage a team approach to the organisation and delivery of services. There should be flexibility in the actual ways in which professionals are paid by PHC organisations. There is increasing acceptance of salaried practice among GPs and a range of options should be explored for funding specific providers, e.g. a base salary plus FFS payments for some services and/or performance payments to all PHC team members or achieving certain targets.
2. PHC organisations will require a combination of people including clinicians, community workers, population health practitioners, managers and support staff. PHC teams should be characterised by:
 - management that fosters a team approach and utilises the range of skills necessary to provide the 'essential' services described above
 - opportunities for continuing education for all members
 - an understanding of and responsiveness to both the principles of the Treaty of Waitangi and cultural issues in the whole population served
 - participation in health-related community development and intersectoral initiatives.

Recommendation

Primary health care organisations should be funded to deliver essential services to their enrolled population through interdisciplinary teams.

6.4 Workforce training and quality

1. Orientation towards a population-based approach will require training and workforce development for practitioners working both in PHC and secondary care organisations. Training should be part of undergraduate core curricula for all PHC professionals as well as continuing education, credentialing and re-accreditation programmes and should contain modules such as preventive medicine and health promotion.
2. Specific funding should be tagged for training PHC teams to develop and implement quality improvement programmes.
3. Specific funding should be tagged for PHC teams to assist in the training of undergraduate and graduate students.

Recommendation

Workforce initiatives should be funded and implemented to train primary health care practitioners to work in the new environment.

REFERENCES

- Acheson D. 1998. *Independent Inquiry into Inequalities in Health: Report*. London: Stationery Office.
- Advisory Committee on Population Health. 1994. *Strategies for Population Health: Investing in the health of Canadians*. Prepared by the Federal, Provincial and Territorial Advisory Committee on Population Health for the Meeting of the Ministers of Health Halifax, Nova Scotia, September 14–15, 1994. Ottawa: Health Canada.
- Anderson GF. 1998. *Multinational Comparison of Health Care, Expenditures, Coverage and Outcomes*. Washington DC: The Commonwealth Fund.
- Anderson LK. 1993. Teams: group process, success and barriers. *Journal of Nursing Administration* 23: 15–19.
- Baeza J, Calnan M. 1998. Beating the bands? *Health Service Journal* 109: 26–7.
- Barnett JR, Coyle P. 1998. Social inequality and general practitioner utilisation: assessing the effects of financial barriers on the use of care by low income groups. *New Zealand Medical Journal* 111: 66–70.
- Barnett JR. 2000. Geographic perspectives on hospital restructuring and its impacts in New Zealand. *New Zealand Medical Journal* 113: 125–8.
- Birmingham Health Authority. 1995. *Birmingham Public Health Report: Closing the gap*. Birmingham: North Birmingham Health Authority.
- Birmingham Public Health Alliance. 1998. *Beyond Acheson: An agenda for the new public health*. Birmingham: Public Health Alliance.
- Bunker JP, Frazier HS, Mosteller F. 1994. Improving health: measuring the effects of medical care. *Milbank Quarterly* 72: 225–8.
- Canadian PHA. 1997. *The Canadian Experience of Intersectoral Collaboration for Health Gains*. Ottawa: Canadian Public Health Association.
- Carrier J, Dignam D, Horsburgh M, et al. 1999. *Locating Nursing in Primary Health Care: A report for the National Health Committee*. Wellington: National Health Committee/National Advisory Committee on Health and Disability.
- Cashman SB, Anderson RJ, Weisbuch JB, et al. 1999. Carrying out the Medicine/Public Health Initiative: the roles of preventive medicine and community-responsive care. *Academic Medicine* 74: 473–83.
- Coster G, Gribben B. 1999. *Primary Care Models for Delivering Population Based Health Outcomes: Discussion paper for the National Health Committee*. Wellington: National Health Committee/National Advisory Committee on Health and Disability.
- Crampton P. 1999. *Third Sector Primary Health Care: A report prepared for the National Health Committee*. Wellington: National Health Committee/National Advisory Committee on Health and Disability.
- Crengle S. 1999. *Māori Primary Care Services: A report prepared for the National Health Committee*. Wellington: National Health Committee/National Advisory Committee on Health and Disability.
- Cumming J. 1999. *Funding Population Based Primary Health Care in New Zealand: A report prepared for the National Health Committee*. Wellington: National Health Committee/National Advisory Committee on Health and Disability.
- Cumming J, Scott C. 1998. The Role of Outputs and Outcomes in Purchaser Accountability: reflecting on New Zealand experiences. *Health Policy* 46: 53–68
- Dixon F, Watt J, Thompson R, et al. 1994. The influence of increased health care costs on general practitioner consultations and prescription collection. *New Zealand Medical Journal* 107: 353–5.

NATIONAL HEALTH COMMITTEE

- Downs CR. 1981. Michigan physicians learning health promotion makes them more effective. *Michigan Medicine* 80: 579, 581, 586.
- Fahs MC. 1992. Physician response to the United Mine Workers' cost-sharing program: the other side of the coin. *Health Services Research* 27: 25–45.
- Fletcher DJ. 1983. Wellness: the grand tradition of medicine. *Postgraduate Medicine* 73: 87–9, 92.
- Foote S. 2000. Right idea, wrong model: why general practitioners are not succeeding with preventive care. *New Zealand Medical Journal* 113: 148–9.
- Freymann JG. 1989. The public's health care paradigm is shifting: medicine must swing with it. *Journal of General Internal Medicine* 4: 313–9.
- Gillam S, McCartney P, Thorogood M. 1996. Health promotion in primary care. *British Medical Journal* 312: 324–5.
- Greenlick MR. 1992. Educating physicians for population-based clinical practice. *Journal of the American Medical Association* 267: 1645–8.
- Gribben B. 1996. The community services card and utilisation of general practitioner services. *New Zealand Medical Journal* 109: 103–5.
- Hay I. 1989. *The Caring Commodity: The provision of health care in New Zealand*. Auckland: Oxford University Press.
- Health Canada. 1986. *Achieving Health for All: A framework for health promotion*. Ottawa: Health Canada.
- Health Canada. 1999. *Toward a Healthy Future: Second report on the health of Canadians*. Prepared by the Federal, Provincial and Territorial Advisory Committee on Population Health for the Meeting with Ministers of Health, Charlottetown, P.E.I., September 1999. Ottawa: Health Canada.
- HFA. 1999. *Population and Gap*. Wellington: Māori Health Operating Group, Health Funding Authority.
- Howden-Chapman P, Tobias M (eds). 1999. *Social Inequalities in Health: New Zealand 1999*. Wellington: Ministry of Health.
- IPA Network. 2000. *Presentation Summaries from IPA Network Meeting 19–20 February 2000, Wellington*. Wellington: IPA Network.
- Killoran A. 1999. *Total Purchasing: A step towards new primary care organisations*. London: Kings Fund Publishing.
- King A. 2000. Memorandum to Cabinet Social Policy and Health Committee: Other agencies: Appropriate corporate form and functions of: NZ Blood Service; PHARMAC; Health Benefits Ltd; National Health Committee; Residual Health Management Unit. CAB (00) M 15/3B. <http://www.executive.govt.nz/minister/king/memoranda2/agencies>
- Lantz PM, House JS, Lepkowski JM, et al. 1998. Socioeconomic factors, health behaviours, and mortality: results from a nationally representative prospective study of US adults. *Journal of the American Medical Association* 279: 1703–8.
- Lasker R. 1997. *Medicine and Public Health: The power of collaboration*. New York: New York Academy of Medicine.
- Lee P. 1994. Models of excellence. *Lancet* 344: 1484–6.
- Le Touze S, Calnan M. 1996. The banding scheme for health promotion in general practice. *Health Trends* 28: 100–5.
- Mackenbach JP, Kunst AE, Cavelaars AE, et al. 1997. Socioeconomic inequalities in morbidity and mortality in western Europe. *Lancet* 349: 1655–60.

NATIONAL HEALTH COMMITTEE

- Malcolm L, Wright L, Barnett P. 1999. *The Development of Primary Care Organisations in New Zealand: A review undertaken for Treasury and the Ministry of Health*. Wellington: Ministry of Health.
- Marks I, Hunter D. 1998. *The Development of Primary Health Care Groups: policy into practice*. Birmingham: National Health Service Confederation.
- Minister of Health. 2000a. *The New Zealand Health Strategy: discussion document*. Wellington: Ministry of Health.
- Minister of Health. 2000b. *The Future Shape of Primary Health Care: a discussion document*. Wellington: Ministry of Health.
- Ministry of Health. 1998. *Action for Health and Independence: Bridging the gap between actions and outcomes: Proceedings of a conference held in Wellington, October 15–17, 1998*. Wellington: Ministry of Health.
- Ministry of Health. 1999a. *Our Health, Our Future: Hauora pakari, koiora roa: The health of New Zealanders 1999*. Wellington: Ministry of Health.
- Ministry of Health. 1999b. *Taking the Pulse: The 1996/97 New Zealand health survey*. Wellington: Ministry of Health.
- Ministry of Health. 2000. *Health Expenditure Trends in New Zealand 1980–99*. Wellington: Ministry of Health.
- National Forum on Health. 1996. *What determines health? Summaries of a series of papers on the determinants of health*. Ottawa: National Forum on Health.
- NHC. 1998. *The Social, Cultural and Economic Determinants of Health: Action to improve health*. Wellington: National Health Committee.
- New Zealand Government. 1974. *A Health Service for New Zealand*. A white paper prepared by the Department of Health. Wellington: Government Print.
- Nutting PA. 1987. Population-based family practice: the next challenge of primary care. *Journal of Family Practice* 24: 83–8.
- Nutting PA, Nagle J, Dudley T. 1991. Epidemiology and practice management: an example of community-oriented primary care. *Family Medicine* 23: 218–26.
- NZCPHC. 2000. *Working Together in Primary Health Care: Discussion document*. Wellington: New Zealand College of Primary Health Care.
- Parks C. 1996. *A Study of Community Services Cards in Five Primary Health Care Practices in the Auckland Region*. Auckland: Department of Community Health, University of Auckland.
- Pincus T, Esther R, DeWalt DA, et al. 1998. Social conditions and self management are more powerful determinants of health than access to care. *Annals of Internal Medicine* 129: 406–11.
- Pomare E. 1995. *Hauora: Māori standards of health III: A study of the years 1970–1991*. Wellington: Eru Pomare Māori Health Research Centre, Wellington School of Medicine.
- Rasell ME. 1995. Cost sharing in health insurance: a re-examination. *New England Journal of Medicine* 332: 1164–8.
- RNZCGP. 1999. *General Practice into the Future. A primary care strategy*. Report of the Presidential Task Force, occasional paper number 5. Wellington: Royal New Zealand College of General Practitioners.
- Saltman RB, Figueras J. 1998. Analyzing the evidence on European health care reforms. *Health Affairs (Millwood)* 17(2): 85–108.
- Scott K, Marwick J, Crampton P. *Utilisation of general practitioner services in New Zealand and its relationship with income, ethnicity and government subsidy*. Soc Sci Med, in press.

NATIONAL HEALTH COMMITTEE

- Shi L. 1997. Health care spending, delivery, and outcome in developed countries: a cross-national comparison. *American Journal of Medical Quality* 12: 83–93.
- Shi L, Starfield B, Kennedy B, et al. 1999. Income inequality, primary care, and health indicators. *Journal of Family Practice* 48: 275–284.
- Smith J, Bamford M, Ham C, et al. 1999. *Beyond Fundholding: A mosaic of primary care led commissioning and provision in the West Midlands*. A research project funded by the West Midlands Regional Office of the NHS Executive. Birmingham: University of Birmingham, Health Services Management Centre.
- Starfield B. 1994. Is primary care essential? *Lancet* 344: 1129–33.
- Starfield B. 1996. Public health and primary care: a framework for proposed linkages. *American Journal of Public Health* 86: 1365–9.
- Starfield B. 1998. *Primary Care: Balancing health needs, services, and technology*. New York: Oxford University Press.
- Taplin S, Galvin MS, Payne T, et al. 1998. Putting population-based care into practice: real option or rhetoric? *Journal of the American Board of Family Practice* 11: 116–26.
- Their S. 1992. Public health and medicine: the need for marital counselling: future of public health in the Commonwealth. Paper presented at the annual meeting of the Massachusetts Public Health Association, Waltham, MA, September, 1992.
- Towler B. 1999. *Enhancing The Population Health Role Of General Practitioners*. Canberra: Department of Health and Aged Care.
- Tukuitonga C. 1999. *Primary Healthcare for Pacific People in New Zealand: Discussion paper for the National Health Committee*. Wellington: National Health Committee.
- US Department of Health and Human Services. *Healthy People 2010: Understanding and improving health*. 2000. Washington DC: US Department of Health and Human Services.
- Wagner EH, Austin BT, Von Korff M. 1996. Organising care for patients with chronic illness. *Milbank Quarterly* 74: 511–44.
- Waldegrave C, King P, Stuart S. 1999. *The Monetary Constraints and Consumer Behaviour in New Zealand Low Income Households*. Lower Hutt: The Family Centre Social Policy Research Unit.
- Wechsler H, Levine S, Idelson RK, et al. 1983. The physician's role in health promotion: a survey of primary care practitioners. *New England Journal of Medicine* 308: 97–100.
- WHO. 1978. *Primary Health Care: Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978*. Geneva: World Health Organization.

APPENDIX 1 – ORGANISATIONS AND INDIVIDUALS WHO MADE SUBMISSIONS OR MET WITH SECRETARIAT MEMBERS

Organisations

NAME		ORGANISATION
Anne	Allan-Moetaua	Porirua Union Health Service
Raylene	Andrews	IPCS
Eileen	Austin	NZNO
Paul	Baigent	Royal New Zealand Plunket Society (Inc.)
Anna	Bailey	Health Star Pacifica
Tim	Bailey-Gibson	Carenet
Anita	Bain	NZNO
Kim	Bannister	RNZCGP
David	Benson-Pope	Planning and Environment Committee, Dunedin City Council
Susan	Bowness	Christchurch South Health Centre
Susan	Bramley	Health Waikato
Gaye	Brodie	Hamilton East Medical Centre (Pinnacle)
John	Broughton	Ngai Tahu, Maori Health Research Unit
Chris	Bullen	A+ Public Health
Margaret	Cain	NZNO
Shelley	Campbell	New Traditions, Health Waikato
Michelle	Cleary	Northland Health
Sandra	Coney	Woman's Health Action
Rob	Cooper	HFA Auckland
Rob	Cooper	HFA Auckland
Clare	Copland	Pegasus Medical Group
Gregor	Coster	IPCS
Allie	Crombie	Hutt Union & Community Health Service
Louise	Croot	Healthcare Otago Limited
Paul	Dadson	MPO
Phillippa	Davies	Pharmacy Guild of NZ Inc
Peter	Didsbury	Procure
Barbara	Docherty	Auckland School of Medicine
Gail	Donald	Wai-Health
Claire	Doole	Waitemata Health
Sue	Dow	Northland Health
Betty	Dunn	NZNO
Julia	Ebbett	The Doctors IPA
Christina	Edmonds	Northland Health
Lynne	Edmonds	Auckland Healthcare
Alec	Ekeroma	South Auckland Health
Rosemary	Englefield	Papanui Medical Centre
Nancy	Fithian	PHA
Karen	Flegg	RNZCGP
Lesley	Frederikson	NZAO

NATIONAL HEALTH COMMITTEE

NAME		ORGANISATION
Shelley	Frost	Pegasus Medical Group
Euan	Galloway	Pharmacy Guild of NZ Inc
Diane	Gibson	Ngati Porou Hauora
Barbara	Glenie	NCWNZ
Peter	Glensor	Health Care Aotearoa
David	Graham	Health Waikato
Alan	Greenslade	IPCS
Gill	Greer	FPA NZ
Waveny	Grenell	Pegasus Medical Group
Moana	Hadfield	Ngati Porou Hauora Inc
Glenyse	Hargraves	NZNO, PHN Section
Aroha	Hudson	Nga Ngaru Hauora O Aotearoa
Anne	Inglis	Far North Area Health Services
Peter	Jansen	Te ORA
Lannes	Johnson	IPCS
Sheryl	Jury	South Auckland Health
Sharon	Lambert	Nga Ngaru Hauora O Aotearoa
Michael	Lamont	Mangere Health Services Trust
Susan	Lancaster	Waitemata Health
Nushka	Lange	NZNO, PHN Section
Martin	London	Christchurch School of Medicine
Laurence	Malcolm	Aotearoa Health
Tony	Mansefield	Procure
Lyvia	Marsden	Nga Ngaru Hauora O Aotearoa
Tom	Marshall	Procure
Don	Matheson	HFA
Paul	McCormack	Pegasus Medical Group
Ross	McCormick	Auckland School of Medicine
Morehu	McDonald	South Auckland Primary Care Services
Sean	McGarry	Wai-Health
Fran	McGrath	Ministry Of Health
Judy	McHardy	Far North Area Health Services
Cameron	McIvor	NZMA
Wayne	McLean	Raukura Hauora O Tainui
Lloyd	Millar	Wai-Health
Annette	Milligan	Nelson Independent Nursing Practice Ltd
Annette	Milligan	College of Nurses, Aotearoa (NZ) Inc
Cathy	Mitchell	NZNO, Practice Nurse Section
Brent	Morrissey	Otara Union Health Centre
Filipo	Motulalo	Langimalie Clinic
Catherine	Nelson	Newtown Union Health Service
John	Newman	Westkids
Chris	O'Brien Woods	Crown Public Health
Cathy	O'Malley	WIPA Ltd
Hugh	Oliver	NZNO
Judith	Parnell	Australasian Faculty of Public Health Medicine

NATIONAL HEALTH COMMITTEE

NAME		ORGANISATION
Jane	Patterson	NZMA
Teuila	Percival	Middlemore Hospital
Carmel	Peteru	Hutt Valley Health
Lyndsay	Randall	Waitemata Health
Reg	Ratahi	Wai-Health
Gill	Regan	Newtown Union Health Service
Gloria	Reid	Northland Health Ltd
Jewel	Reti	Northland Health Ltd
Ruth	Richards	HFA Christchurch Office
Sheila	Robinson	Northhealth, Whangarei
Marty	Rogers	Nga Ngaru Hauora O Aotearoa
Jean	Ross	Centre for Rural Health
Debbie	Ryan	South Seas
Jorgen	Schousboe	Pegasus Medical Group
Wini	Schwass	Mangere Health Centre
Martin	Sears	Pegasus Medical Group
Hugh	Senior	Unitec Institute of Technology
Gabrielle	Sexton Rosewarne	Northland Health Ltd
Nicolette	Sheridan	South Auckland Integration pilots
Jonathan	Simon	First Health
Margaret	Southwick	Whitireia Community Polytech
Carla	Staniland	Wai-Health
Tatiana	Stebakova	IPCS
Maureen	Stringer	NZNO, Practice Nurse Section
Phyllis	Taylor	A+ Public Health
Gwen	Te Pania-Palmer	Auckland
Carol	Thomas	NZNO, PHN Section
Carol	Thomas	Waitemata Health
Michelle	Thomson	Northland Health Limited
Murray	Thomson	Dept of Oral Health, University of Otago
Les	Toop	Pegasus Medical Group
Michael	Trousselot	Pegasus Medical Group
Sue	Turner	Crown Public Health, Christchurch
Olivia	Tusa	Hutt Valley Health
James	Tuwhare	Otara Union Health Service
Rhema	Vaithianathan	University of Auckland
Petra	van den Munckhof	Newtown Union Health Service
Sally	Wagener	NZNO, PHN Section
Erin	Ward	Northland Health
Ralph	Wiles	NZMA
Daniel	Williams	Crown Public Health
Deirdre	Williams	Child and Family Service
Mark	Wills	Procure
Betty	Wilson	Healthcare Otago
Margaret	Wing	Waitaki District Health Services
Dell	Wood	Health Waikato
Gerald	Young	Procure

NATIONAL HEALTH COMMITTEE

Individuals

NAME

Karen	Adams
Jacqueline	Allen
Simon	Baker
Elmar	Beekman
Jan	Bryant
Lester	Calder
Marianne	Cameron
Ronda	Cleland Weiss
Joy	Comley
Margaret	Connell
Sheryl	Corbett
Raina	Elley
Matea	Gillies
George	Gray
Tiwini	Hemi
Ginny	Hinton
David	Jansen
Nathan	Joseph
Andrew	Lindsay
Anne	Lingard
Merian	Litchfield
Siloma	Masina
John	Mein
Michelle	Meyer
Joy	Millar
Jean	Mitaera
Guy	Naden
Pat	Ngata
Patrick	O'Connor
Chris	Shelton
Mary	Stevens
Ngaamo	Thompson
Iunita	Vaofusi
Jacqui	Westren