The public and private interface in New Zealand primary health care

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Introduction

We are currently 18 months into the implementation of the New Zealand Primary Health Care Strategy. Implementation of the Strategy has highlighted the different roles and responsibilities within the sector, as well as creating new ones.

This paper argues that in the New Zealand context, greater attention needs to be paid to this public/private relationship especially in primary health care. This traditional partnering process needs much more explicit attention, with formal principles and actions of partnership to be negotiated. Such a framework could facilitate retaining the engagement of the private sector, stabilise the provision of primary health care, strengthen the stability of the workforce and ultimately meet the goals of the Primary Health Care Strategy.

Global overview: public/private partnerships

There is a global trend of governments attempting to re-orientate health care that was traditionally focused upon hospital care, to an emphasis on primary and population-based health care. This makes both health and economic sense – leading to growing attention by policy makers to primary care and to greater recognition of the importance of such an approach. International health care reform has also led to a growth in public/private partnerships. In New Zealand primary care, Primary Health Organisations could provide the appropriate vehicle for this interface.

In 1987 the World Bank recommended that Governments *'Encourage the management sector (including non-profit groups, private physicians, pharmacists and other health practitioners) to provide health services for which consumers are willing to pay.*"[1] Furthermore, in its 1993 World Development Report, the bank recommended that Governments shift elements of service provision from the public to the private, for-profit sector.[2] Whilst there has been considerable focus upon financing and delivery, there has been little scrutiny of how the public sector inter-relates with private sector providers, and the impact that this relationship has on successful implementation of policies and meeting health outcomes.

A 1991 report by the World Health Organization[3] noted inequities of access for consumers to private sector providers. It also noted how many providers operate in both sectors and called for the recognition of contextual differences in the provision of global (health) policy advice.

There is recognition that the public sector is shaped by private actors. The tension, however, will be in the differences of values, roles and responsibilities that each party holds. Tensions can arise from both practical and philosophical difference. Governments all over the world engage with the private sector. New Zealand is no exception. Often the private sector boosts the capacity of the public sector to deliver services. It is important to recognise the respective sectors' differing drivers. The public or government sector will seek to regulate or control its perceived risks, whereas in order to foster competition and innovation, the private sector will ideally seek less control or regulation. In addition to this inherent tension, there is the issue of capital provision and who manages and carries actual risk.

The New Zealand context: implementation of the primary care strategy

Since 1938, New Zealand has had a free, nationalised secondary service and a subsidised private primary care system. This primary care system is unusual, more reflective of a developing country rather than a developed one. New Zealand's traditional 'fee-for-service' has created barriers to accessing primary care for those most at risk, namely the most socio-economically disadvantaged. Low-income countries generally have a weak capacity to raise public revenues, so therefore private expenditure becomes more important. In these countries, the poor have more out-of-pocket expenditure. There is an ongoing tension of how to manage the pro-rich bias that public subsidies can provide when better resourcing a health system.[4] New Zealand is currently moving to a capitated system, and moving away from the subsidy of fee for service, although patient co-payments remain part of the financ-

ing of the system and, in particular, some providers. Ultimately, the question will be the level of New Zealand's resources and ability to finance the system. This mixed system can present solutions to managing some of these problems.

The relationships and dynamics of the sector have changed considerably in recent years. Twenty-one District Health Boards (traditionally responsible for secondary care) have now been established to hold responsibility for the health of their populations. They identify health need and oversee secondary, primary and population health services.

Primary Health Organisations (PHOs) have been established, within which new primary health and population-based health services are provided. They must:

- Provide a minimum set of essential population-based services
- Work with groups in their populations which have poor health or are missing out on services to address their needs
- Demonstrate they are working with other providers in their regions to ensure services are coordinated around the needs of their enrolled populations
- Use a national enrolment system to enrol people through primary providers
- Demonstrate that their communities and consumers are involved in their governing processes and the organisation 'is responsive to their community'
- Demonstrate that all practitioners and providers can influence decision-making processes
- Be not for profit bodies with full and open accountabilities for the use of public funds, and quality and effectiveness of services.

Underpinning this change is that whilst additional funding is to be provided to primary care, it is only available through capitated funding to PHOs.

The minimum requirements for PHOs still have a significant impact upon the public/private partnership between the general practitioner and other stakeholders in the sector.

The public/private mix in health care expenditure

Until now, 30 per cent of primary health care is government subsidised; the balance is funded through private co-payments, health insurance and Accident Compensation payments. In 2001, public sources of vote health in New Zealand were 76.7 per cent (down from 82.4% in 1989) and private sources 23.3 per cent (up from 17.6% in 1989).[5] Levels and types of funding into general practice will now vary further, especially during this time of transition, as general practitioners become members of PHOs. In turn PHOs will be eligible for the different types of funding available to primary health care. There has been a signalled intention that primary health care in New Zealand will be of very low cost to all consumers within 10 years. However issues of political stability and continuity of policy direction will significantly influence this outcome.

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Out of pocket expenses for consumers is internationally recognised as one of the greatest barriers to access to health care. The New Zealand Government has identified this as one of the key issues underpinning its strategic direction in health policy. However, it is worth noting that in health systems globally, public out-of-pocket expenses grow in relation to the lowering of national income; in other words, the lower income the country, the greater out-of-pocket expenses for the consumer.

Issues

There is a broad range of issues arising from the implementation of the Primary Care Strategy. The following are identified for their relevance to the private/public interface.

1. DHBs started to contract with PHOs with considerable variation; the resulting outcome has been a shifting of hospital/DHB risk and responsibility on to primary care and in particular, general practice.
2. Minimal funding was allocated for infrastructure development, quality, information technology and governance capacity building.
3. Compliance and administrative demands ballooned for providers, with development of enrolment registers, information technology compatibility issues.
4. Government information technology and capacity were inadequate and underdeveloped for reporting and payment requirements – compromising provider viability.
5. Graduated funding introduction increased funding for those most at need, at risk populations became low-cost access PHOs while other PHOs took the interim funding formula. This created inequalities in boundaries, with instability of provider viability, pepper-potting, and patients leaving general practices to enrol with another down the road.
6. Some general practitioners are concerned about PHO governance requirements; where others in governance make strategic decisions directly affecting their (the GP's) future. (The practitioner may be carrying personal financial risk such as capital investments, mortgages on homes to finance health services which are now affected by public governance requirements.)
7. The gaps in knowledge and expertise of those in governance making strategic decisions affecting practices.[6]

It is important to note that the majority of these issues are related to the administration, contracting and reporting of service provision, rather than the delivery of the service to the patient per se. In addition, a lack of implementation planning, including addressing key infrastructure issues, imposes the assumption that the private sector – in this case individual practitioners – will pick up the additional costs. The current structure also needs to proactively address ongoing development of quality infrastructures in a sustainable and cohesive way, rather than focusing just on indicators.

The structure has considerable potential to undermine provider viability, add time and compliance demands. This in turn, has considerable workforce implications. The College's recent membership survey of its members indicates that compliance costs and current working conditions is having a significant impact upon general practitioners' intentions to continue in general practice.[7] There is mounting evidence that new recruits into general practice avoid private business arrangements and graduate towards employed, salaried positions.[8]

Where to from here?

In order to stabilise the primary care workforce, and achieve the intended outcomes of the Primary Care Strategy, it is essential that the interface between the private and public sector be more robustly and explicitly addressed. Primary Health Organisations, whilst retaining their not-for-profit status, have the potential to provide a legitimate interface between public and private sector provision and resourcing of care.

Explicit principles of engagement are an important beginning point. There are international examples of principles of engagement between public and private actors at development and international aid levels. There is no reason why such an approach could not be applied at a more local level.

For instance, principles of engagement could require all crown agencies to pay particular attention to both policy development and contracting.

In the area of policy the questions that should be routinely addressed could include:

- How is this policy to be implemented?
- Which stakeholders are to be involved?
- Who is responsible for the administration, measurement and reporting of the process? What is the potential impact upon the sector?
- What resources and infrastructure will be required?
- Who will meet the cost of these resources and infrastructure? – In the short, medium and long term?
- What are the different visions, intentions and drivers of the parties involved? And how can these be reconciled?
- What is the impact upon employment and professional relationships? How are these to be addressed?
- What outcomes are to be expected to be achieved and within what timeframes?
- Who carries risk? What is the nature of this risk? How is the risk managed?

In the implementation and service delivery, funding is channelled through PHOs, which would then have an agreed framework that addresses these same areas. This provides a framework that explicitly identifies provider accountability, risk, cost visibility and cost sharing, services types and sites, and recognises both private and public provision.

It is questionable whether New Zealand has the resources to provide full public services. The foundations of primary health care have been firmly planted in the private sector. We have, however, moved to a mixed model of delivery. By recognising, resourcing and supporting such a framework, we would be far more likely to be able to address underlying tensions and the risks that create barriers to successful implementation of the Primary Care Strategy. It is therefore critical that such a framework is developed as soon as possible and explicit models of engagement become an essential part of any Government policy development, or contracting process with non-government providers.

This also has the potential to validate different approaches to service provision, provide more transparency, develop explicit quality frameworks and promote greater collaboration. Finally negotiated, explicit private/public partnerships in the delivery of primary health care have the potential to depoliticise the process and provide sustainable relationships and positive health outcomes.

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