General practitioners in primary health organisations:

Policy victims or policy leaders?

Pauline Barnett, Department of Public Health and General Practice, Christchurch School of Medicine and Health Sciences, University of Otago.

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***Pauline Barnett** is a senior lecturer in health policy and management in The Department of Public Health and General Practice at the Christchurch School of Medicine and Health Sciences. She is a social scientist with degrees from Cambridge University, Indiana University and the University of Otago. Her research interests are in health sector policy and restructuring, particlarly relating to governance issues and primary care.*

Over the last 15 years there have been greater changes to the primary care sector than at any time since the 1930s. The direct relationship between general practitioners and the state has changed from a doctor reimbursed on a direct basis for individual services, to a relationship mediated by a collective contract with health funders through GPs' own organisations, the independent practitioner associations (IPAs), to GP organisations becoming sub-contractors through primary health organisations (PHOs) and district health boards (DHBs). The speed at which these policy changes have been enacted has been remarkable, given the lack of major policy innovation over the preceding decades. Many GPs have seen themselves as 'policy victims', either responding 'on the hoof' to a turbulent environment, such as the health reforms of the 1990s, or reacting to policies (such as the Primary Health Care Strategy) handed down from government. So have GPs been policy victims? Or have they been significant players themselves? To answer this question I will first discuss some key ideas about the formation of policy and then briefly examine the circumstances leading to the introduction of the Primary Health Care Strategy, including changing ideas about primary care and the readiness of the local health environment for change. This will allow some conclusions about the role of GPs in health policy and whether they have been policy victims or policy leaders.

Frameworks for health policy

Policy: 'the messy reality'

Much has been written about different ways of making policy, the nature of policy decision-making and the pre-conditions for good implementation. However, despite best efforts to bring scientific analysis to policy making, most authors acknowledge that policy-making is uncertain, political, unpredictable and often has unintended consequences. One observation is that policy making is a 'messy reality',[1] although this is not necessarily the model that policy theorists, ministers of health or senior officials prefer. One of the reasons for this 'messy reality' is that it is highly influenced by the social, cultural, economic and political environment. Understanding the forces at work, being able to 'read' the environment and work with it are critical. Keeping this in mind, there are, among a host of policy models,[2,3] two important views of the policy process that can help us interpret what has happened to primary care policy in recent decades: the rationalist model and the stakeholder model.

Rationalist model

This model represents the view of how policy officials and governments prefer policy to be made: systematically and based on expert analysis. A rational analysis of the issues is followed by a rational set of proposals which are enacted in a systematic way. Policy goals are never value free, of course, but once the goals are decided then the pursuit of the policy ideally follows a set of systematic steps. This view of the policy process is particularly important when areas of high investment are at stake. For example, a casual approach is not possible if decisions need to

be made about energy policy (e.g. developing nuclear power) or putting a man on the moon. Nor can decisions be made in an incremental or partial way if major structural changes are intended, for example, the establishment of the NHS, or health reform in New Zealand. When trying to do something large, an 'all or nothing' approach is usually the preferred strategy. In these circumstances governments and experts are the main players. These 'experts' are unlikely to include key participants, such as health professionals and other interest groups, but technocrats, economists and theorists.

Stakeholder model

The rationalist model does not readily accommodate divergent views, but the stakeholder model acknowledges that there are different perspectives on particular policy issues and tries to make this a strength. Most western democracies like to think that they pursue a stakeholder model that reflects a 'pluralist' approach, permitting many parties and interest groups to participate in negotiating policy decisions. However, as we all know, not all players have equal power in such negotiations, and some groups or interests may be able to participate only minimally. Until recently, for example, consumer groups were not key participants in health policy-making. Where there are unequal power relationships, and where some interest groups occupy a sufficiently powerful position that they cannot be ignored, this tends to lead to a 'corporatist' version of the stakeholder model, whereby some groups are recognised as 'insiders', always to be consulted and to be part of the policy making process.

Historically in New Zealand the medical profession has been part of a corporatist framework in making policy alongside the state. On the few occasions that governments have sought to impose an alternative approach, excluding the profession from the development of policy or making decisions counter to its interests, there has been sharp resistance and government goals have not been successfully achieved (such as 1938 Social Security legislation or the 1975 White Paper on Health) or there were unintended consequences (e.g. the Nurses Amendment Act 1990).

The corporatist model reflects underlying power relationships and structural influences, tending to reinforce the status quo and resist change. It is a clear alternative to both the rationalist and wider stakeholder models, but for ambitious governments rarely provides opportunities for major change.

Setting the policy agenda

Perhaps even more important than the type of decision model used is the question of how particular issues actually reach the policy agenda. This clearly depends on the general political environment. A useful analysis by Kingdon[4] suggests that there are rarely any genuinely new policy issues and ideas, just the right moment when there is conjunction of three separate 'streams' within the environment: problems long identified; a range of possible solutions; and the presence of organised participants or stakeholders. These three 'streams' exist with lives of their own within the environment, but if there is a key moment when they come together then a 'policy window' occurs that permits action and change. This key moment can arise through changes in the environment (a new minister? a crisis in the system? new evidence? sudden media attention?).

Work by Lewis and Consedine[5] in Australia in the early 1990s showed how different groups became important over time in setting the policy agenda. Their research in the early 1990s showed the most important policy players were medically trained, but were working in academia, bureaucracies, or public teaching hospitals. These groups can be considered the 'corporate elite' of medicine, and largely excluded front-line providers. This, of course, is another variation of the Orwellian aphorism, that 'some are more equal than others'. In the later part of the period studied by Lewis and Consedine the influence of even the medical elite was lessened as economists became more dominant in setting the policy agenda.

Antecedents of the PHC strategy and PHOs

If we examine both the content of and the decision-making around the Primary Health Care Strategy, and the positioning of key players, we can understand it best in terms of both the rationalist model and the Kingdon concept of a policy window.

The vision: Declaration of Alma Ata 1978

The rationalist approach relies on a strong policy vision, encapsulated in the Strategy document. Quite explicitly the Strategy (p.1) acknowledges the WHO Declaration of Alma Ata (1978), a set of ideas that largely languished in western countries for the subsequent two decades but has gradually been gaining credence. The key elements of the Declaration are both service related and organisational. For example, the service aspects, that primary care is essential care, point of first contact, etc. are hardly contentious and reflect established best practice. The organisational implications of the Declaration of Alma Ata, however, were more challenging, and included three key elements that were not necessarily understood or well received by either policy makers or practitioners:

- a public health or population focus (including addressing inequalities);
- community participation in care; and
- the central place of primary health care in health systems.

These concepts redefined primary care, in theory at least, by maintaining the core features of family-centred practice, but adding these important organisational components.

Organisational implications: a poor fit with general practice?

If we examine the three organisational themes of the Alma Ata Declaration, it is easy to see why they did not resonate particularly with general practice of the 1980s, but equally easy to see how such ideas could become incorporated into a model of primary care as circumstances changed.

The population focus

General practice has had a long tradition of flirting with public health ideas, with early experiments internationally, including the Peckham Pioneer Health Centre in the 1920s and 1930s, and work in South Africa in the 1940s and 1950s on *'community oriented primary care'*[6] and in New Zealand the work of the Maori Councils around 1900. Later New Zealand initiatives of the 1980s and 1990s in population approaches were exemplified by some larger general practices with capitation contracts and by the services of HealthCare Aotearoa. A particularly significant step internationally, of course, was Tudor Hart's demonstration that general practice was a setting for public health work.[7] It is ironic that it was general practice that first articulated the key public health paradigm on the relationship between health and social and economic inequalities that has underpinned population health since the early 1980s.

So why did public health approaches not 'catch-on' widely in primary care in New Zealand? First, public health relies on *'organised efforts'*,[8] but the individualised culture of general practice and the fee-for-service system precluded such a collective approach. Public health also requires sophisticated information systems, but without an 'organised effort' and strategic resourcing this was impossible. Research into disease management systems in managed care organisations in the US have been producing evidence for over a decade of the power of such systems to manage the care of population groups. The more organised primary care sector in the UK, for example, has also been mobilised, first through fund-holding and then through primary care trusts to undertake the high-level public health role as a funder of services. Recent research in the UK[9] demonstrates the high level of aggregation among primary care organisations required for effective funding roles.

It has only been since GPs formed their own collective groups, the IPAs, that the significance of population-based information systems has been demonstrated in New Zealand.[10] Similarly, the formation of IPAs has allowed GPs to relate to like-minded organisations, both statutory and non-government that are also wary of the budgetary and political power of hospital and specialist services, recognise the limits of technology and appreciate the opportunities for prevention.

Community participation

The Primary Health Care Strategy inserted ideas of a particular type of participation into primary care, the concept of community governance. It is of interest that the ideas of community participation in the Alma Ata model for primary health care were developed by a New Zealander, Ken Newell, later to be Professor of Community Health in Wellington. In the 1970s Ken Newell worked for WHO and authored an important book *Health by the People*[11] which provided a basis for developing thinking on primary care.†

'Community involvement' is often perceived as a '1970s' notion, representing an attempt to translate the protest, rebellion and activism of the 1960s into changes to power structures. In health, both the second wave of feminism, with its emphasis on reproductive rights, and action around the rights of psychiatric patients played particular parts in challenging the power of medicine. Although there have been notable shifts in patient-doctor relationships in the subsequent decades and more responsiveness overall to users of health services, this was generally not translated into governance, at least in western countries.

Exceptions of course have, again in New Zealand, been the development of HealthCare Aotearoa and the emergence of community trusts in the 1990s. In general these were seen as peripheral to mainstream primary care, but suited to the special needs of rural, Maori and disadvantaged communities. Initiatives in some IPAs from the late 1990s[10] to engage more formally with local communities may have developed eventually into more shared governance arrangements.

However, with respect to community governance, there have been larger forces at work. Internationally there has been frustration with the lack of responsiveness on the part of governments, bureaucracies and specialist agencies to the preferences of the wider community. There is strong reaction to the role of 'experts' and lack of consultation. This situation is characterised as a 'democratic deficit' and is reflected in the opportunities taken by communities to reject the decisions of elites. Both the support for MMP in New Zealand in 1993 and the recent (June 2005) rejection by French and Dutch voters of the European Constitution reflect public mistrust of corporate experts and political arrogance as much as a vote on the merits of the issue. It was this wider trend that contributed to the reinstatement, after the 1999 election, of elected local representation in New Zealand health services and underpins the efforts to 'democratise' governance arrangements for primary health organisations.

† *I am indebted for this information to Dr George Salmond who gave permission for use of details of the background to the Alma Ata Declaration from his presentation to the Canterbury Public Health Association Regional Seminar in 2003.*

Central place of primary care in health systems

The centrality of primary care to health systems was a key plank of the Alma Ata Declaration. Initially this concept did not find favour in New Zealand policy circles or those of most western countries, other than the UK where there were efforts to develop a 'primary care-led NHS' from the early 1990s. Attempts to reorientate health services away from their traditional focus on hospital and specialist services was an important element of the Ottawa Charter for Health Promotion (1986) but, again, there was initially little progress in developing a greater focus on either public health or primary care in New Zealand. This is hardly surprising; there was little evidence for the effectiveness of a health system centred on primary care, and the leadership from the general practice sector was pre-occupied throughout the 1980s with reacting, with some success, to policy changes from the Labour Government.

The 1990s, however, saw two important developments: first, the emergence of evidence for the system-level effectiveness of primary care and, second, a creative and proactive approach from GP leadership to the policy vacuum of the early years of the Health Reforms (1991–94). The work of Starfield and colleagues[12,13] has been important in confirming the importance of a primary care focus for the effective performance of health systems, and, more recently, a systematic review of the literature[14] has confirmed that overall improvements in population health outcomes is related to the strength of primary care. There is also no doubt that GP leadership in the 1990s in New Zealand harboured the view, despite feeling disempowered and marginalised, that there was potential for a primary care leadership role in the overall health system. I quote from a series of interviews with IPA leaders in 1997:

A systematic review of the literature has confirmed that overall improvements in population health outcomes is related to the strength of primary care

'...we need recognition of primary care as a key part of the health system that can provide some leadership.'

'...primary care should develop as the hub of the health services.'

Despite the constraints of the 1990s, the view that there was a significant leadership potential for primary care at system level was promoted strongly through IPAs and IPAC. The IPAC website reports over 200 new projects, many of them formally engaging other health organisations or taking a broad perspective of the primary care role.

Discussion

The policy models set out above suggest that the introduction of the Primary Health Care Strategy was a rationalist process, without serious stakeholder engagement, with GPs seen as 'policy victims'. However, taking a longer term view and using Kingdon's model of problems, solutions and players coming together at a 'policy window', it is possible to argue that through the 1980s and early 1990s there was increasing recognition of Alma Ata concepts and that stakeholder (GP) perspectives were becoming increasingly aligned with those of policy makers, even if the policy process itself left something to be desired.

Through the changing political environment and the initiatives of GPs themselves, many primary care organisations were poised to take further steps in engaging in a population health approach, becoming increasingly engaged in community governance, and taking a leadership role within the wider system. IPAs and other PCOs had already staked out much of this territory and, by establishing new organisations, created a ready environment for the 'policy window' provided by a new minister. GPs in all senses were the policy leaders that made the Primary Health Care Strategy possible. Its success, or otherwise, is also likely to rely, in the end, on that leadership.

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