

**Purchasing
Primary Health Care
Provided In
General Practice**

March 2002

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Foreword

The vast majority of us visit a doctor or health centre at some time to deal with a health problem that is worrying us. Some of us will need to make frequent visits, and the doctor may play a significant part in our lives.

These initial contacts with the health system are known as primary health care. However, few of us know the complicated funding and purchasing arrangements that underpin these consultations and how the arrangements have developed – particularly over the last 10 years. This report provides explanation and analysis of what the arrangements look like now.

As the basis for the report, we examined the historical development of state funding and purchasing of primary health care. We have found a great deal that does not meet our expectations – for example, we found ineffective needs assessment and monitoring and no strong accountability.

However, we do not see it as constructive to concentrate unduly on the past. Rather, we see our report as:

- a resource for people in the health sector – especially District Health Boards – that will help them understand the current arrangements and learn from the past; and
- a basis for future actions that are set out in our extensive recommendations.

Because public spending on health care is such a significant part of the Government's annual budget, it is a topic in which we will be taking a continuing close interest.

D J D Macdonald

8 March 2002

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Glossary of Terms

Budget Management	A notional budget that is negotiated with a Primary Care Organisation, from which its General Practitioner members are expected to meet the costs of a range of services provided to their patients. These services could include pharmaceuticals, laboratory and other diagnostic tests, and elective (i.e. non-emergency) surgery.
Capitation Funding	A fixed annual sum paid to a General Practitioner for every patient registered with the General Practitioner, regardless of the number of times that a patient is seen during the year. The rate of funding is generally formula-based – to allow for the different levels of need of different populations.
Fee for Service	A scheduled fee paid to a General Practitioner for each consultation or service provided to a patient eligible for the subsidy.
General Medical Services	Services provided in general practice which the Government subsidises – defined as “all proper and necessary consultations provided to the individual patients of a General Practitioner, either personally or by a locum or other approved arrangement”. ¹ The services include: <ul style="list-style-type: none">• family planning and pregnancy services;• “Well child” services; and• health education about lifestyle risk factors and chronic diseases.
General Practice	A team of health providers (including General Practitioners and practice nurses) of comprehensive primary health care.
General Practitioner (GP)	An appropriately qualified medical graduate who has particular knowledge and skills to provide continuing comprehensive primary medical care.
Independent Practitioner Association	Association of General Practitioners set up, in response to the Health and Disability Services Act 1993, as an infrastructure for their provider side of primary health care contracting. The associations are generally established as limited liability companies or trusts and most are owned by the General Practitioner members. (Refer to Appendix 1 on pages 128-129 for a complete list.)

¹ This definition is taken from the Notice issued pursuant to section 88 of the New Zealand Public Health and Disability Act 2000.

Primary Care Organisation (PCO)

Organisation that General Practitioners collectively set up, in response to the Health and Disability Services Act 1993, as an infrastructure for their provider side of primary health care contracting. There are four main types – Independent Practitioner Association, “loose network”, community-owned organisation, and smaller contracting practice. (These are further described in Figure 7 on page 40 and Appendix 3 on pages 131-132.)

Primary Health Care

The first level of contact that individuals, the family, and community have with the national health system. The care given is therefore general (i.e. not specialist), comprehensive (covers physical and mental well-being, and includes both preventative care as well as medical treatment), continuing (in that an individual often visits and establishes an ongoing relationship with a particular general practice), and accessible.

Purchaser

The authority responsible for assessing need and purchasing (by contracts with providers) the appropriate services to meet those needs, and monitoring the delivery of the services. Purchasers have changed over the past decade, as follows:

up to 1993	the Ministry of Health
1993 to 1997	4 Regional Health Authorities
1997 to 1998	the Transitional Health Authority
1998 to 2000	the Health Funding Authority
from 2001	21 District Health Boards.

Although the purchasers have changed as described, the principles for purchasing are the same (see paragraph 2.25 on page 39).

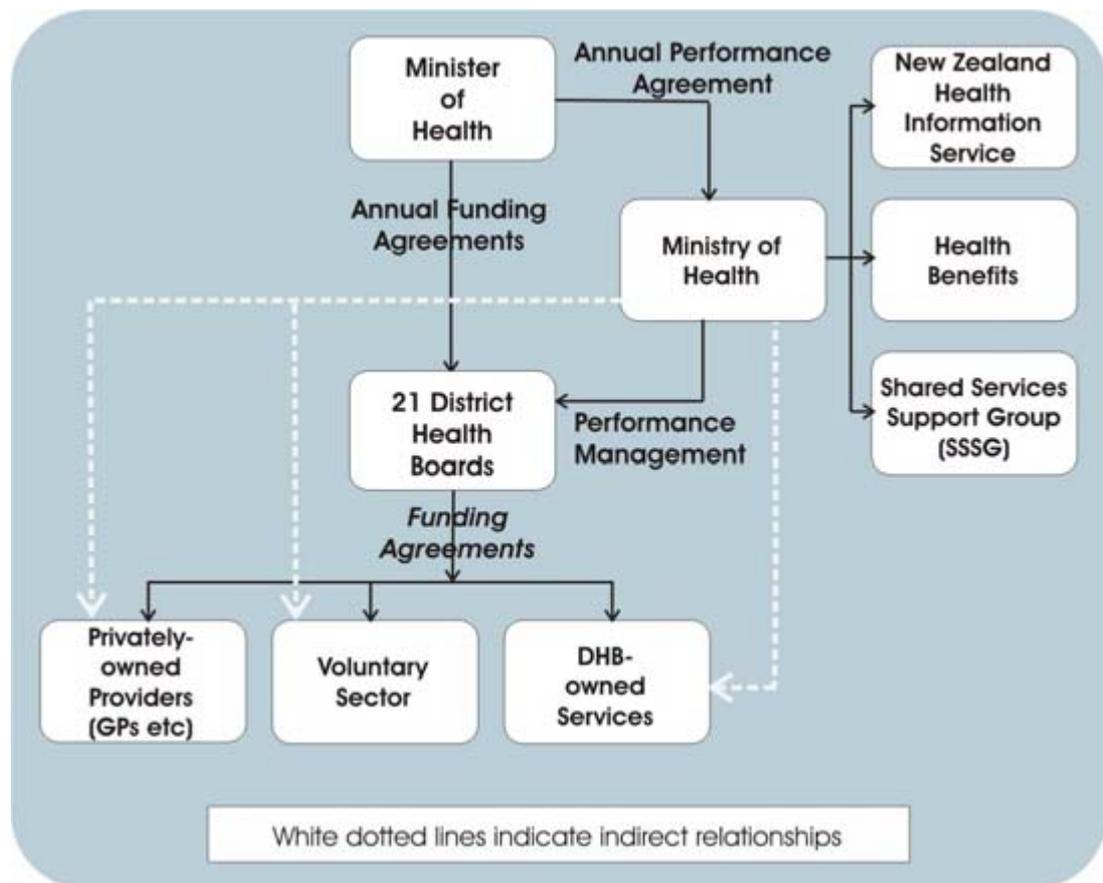
Shared Services Support Group (SSSG)

A national processing centre and information repository. It provides the infrastructure to manage approximately 6500 contracts and its responsibilities include contract administration, monitoring, and payments.

Sole Practitioner

A General Practitioner who has not joined a Primary Care Organisation. The General Practitioner’s contractual relationship with the purchaser is through the Notice issued under section 88 of the New Zealand Public Health and Disability Act 2000. (See also Appendix 3 on pages 131-132.)

Structure of the Public Health Sector



Regional Administrative Structure

The geographical areas of the four former Regional Health Authorities have been retained as the regional administrative areas of (successively) the Transitional Health Authority, the Health Funding Authority, and the Ministry of Health.

In this report we refer to each area and its administration by the appropriate geographic abbreviation – Northern, Midland, Central, and Southern. The coverage of each area is indicated on the map below.



Summary

What is Primary Health Care?

Primary health care –

...is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.²

A significant component of primary health care in New Zealand is *General Medical Services* provided by General Practitioners (GPs) working within General Practice.

In 2000-01 funding for health provision cost the New Zealand taxpayer \$6,974 million, of which \$1,954 million³ was spent on primary health care through...

- subsidies of General Medical Services, including practice nurses;
- subsidies of pharmaceuticals dispensed in the community;
- referrals for diagnostic services such as blood tests;
- community-based maternity services; and
- community mental health services.

Figure 1 on page 12 shows Government expenditure on primary health care in relation to other components of health spending in 2000-01.

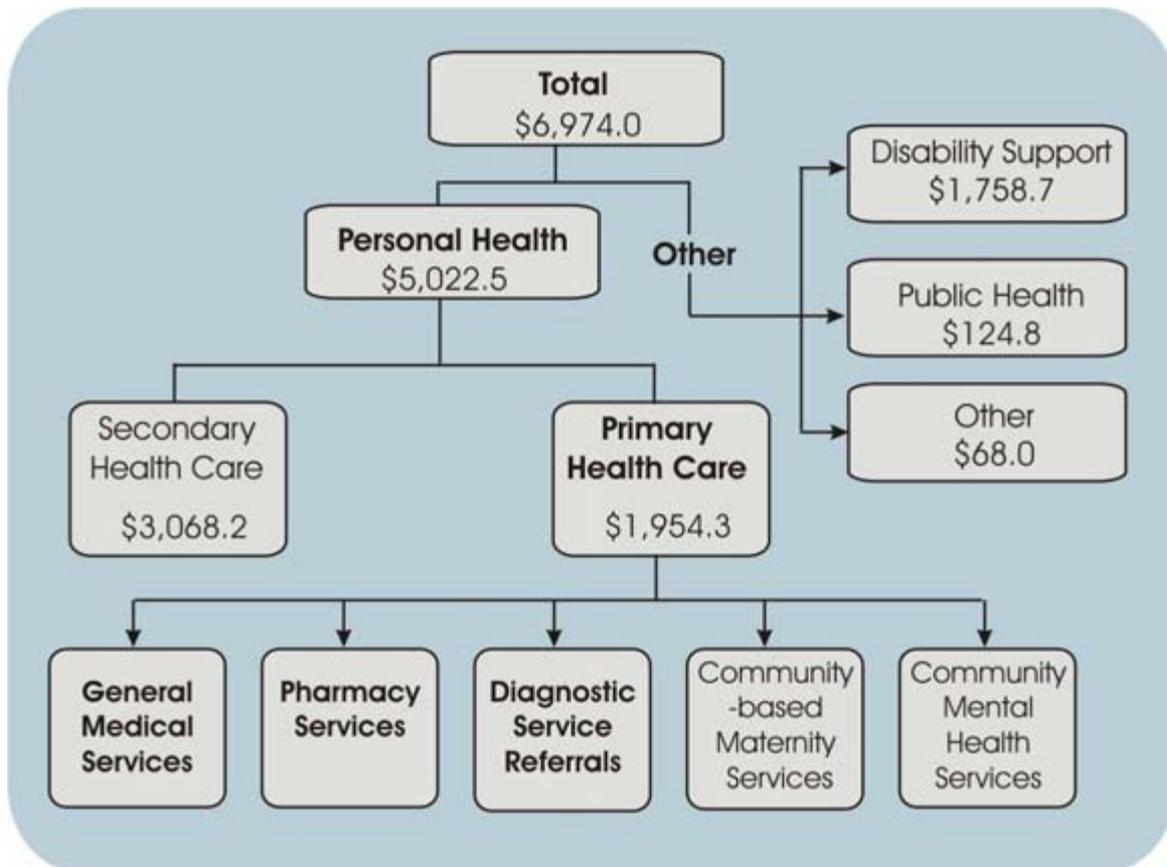
In this report we focus on three major elements of primary health care:

- *General Medical Services*; which include GP consultations that may lead to
- prescribing medicines (*pharmacy services*); and
- *referrals for tests to assist in diagnosis* – such as laboratory testing of blood samples.

² International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978.

³ Our best estimate – see paragraph 2.11 on page 36.

Figure 1
 Government Expenditure on Health Care 2000-01
 (\$million)



General Medical Services subsidies...

... are paid for eligible patients, and are designed to prevent cost from deterring people from using primary health care services. Subsidies therefore target:

- people on low incomes (including beneficiaries) who are entitled to a Community Services Card;
- high users of health services who are entitled to a High Use Health Card; and
- children who receive a subsidy according to their age, Community Services Card or High Use Health Card status.

The subsidies do not necessarily cover the whole cost of a GP consultation. GPs may also charge a *co-payment* (an amount over and above the subsidised amount), which the patient is required to pay. The co-payment varies between GPs, but generally represents the difference between the amount paid by a non-subsidised patient and the government subsidy.

Pharmaceutical subsidies...

... are paid to pharmacists for pharmaceutical items. Everyone pays a Government prescription charge, except for items for children under six (which are free). Patients are also charged any difference between the actual cost of the prescribed item and the government subsidy applied to it.⁴

Diagnostic tests...

... are generally subsidised in full for all patients.

What did we do?

We examined the extent to which *purchasing* of primary health care:

- is based on an assessment of health needs; and
- supports the effective and efficient *provision* of primary health care.

We focused on the role of the various organisations acting as *purchasers*⁵ before the creation of 21 District Health Boards (DHBs) on 1 January 2001 (under the New Zealand Public Health and Disability Act 2000). Accordingly, our report provides an assessment of the state of primary health care purchasing inherited by the DHBs.

We also make observations on the capability of *Primary Care Organisations* (PCOs). These are organisations that GPs collectively set up in response to the Health and Disability Services Act 1993, as an infrastructure for their *provider* side of primary health care contracting.⁶ We do not audit these organisations – our observations on them are based on our discussions with practitioners and with organisations with extensive experience of primary health care.

We set out a number of lessons for the Ministry of Health (the Ministry) and DHBs. Our recommendations focus on issues that we believe they need to address, and note the action required to promote the Government's policy for developing primary health care.

We structured our examination around the seven key features of good purchasing practice as described in Figure 2 on page 15. Our findings and detailed recommendations for each of the features are set out in Parts 3 to 9 of this report.

⁴ Community Services Card holders pay a reduced prescription charge plus any cost difference. In addition, there is a Pharmaceutical Subsidy Card available from pharmacists for people and families that pay more than 20 prescription charges in one year. This card entitles the holder to a reduced prescription charge after 20 prescriptions (excluding prescriptions for children under six), and no charge after 20 prescriptions if the holder also has a Community Services Card.

⁵ We explain the term *purchaser* in the Glossary of Terms on page 8. We use the term throughout this report to refer to the various authorities that have been and are now responsible for purchasing primary health care, except in particular instances where we wish to refer to specific purchasers (such as the Regional Health Authorities).

⁶ There are currently more than 70 PCOs. A complete list is provided in Appendix 1 on pages 128-129.

Overall Conclusions

The arrangements for purchasing primary health care are not based on a comprehensive assessment of health needs, and, in our view, fall well short of what is needed to ensure the provision of effective and efficient services.

This situation has arisen for two broad reasons. First, changes that purchasers have been able to make have inevitably been constrained by the need to take existing arrangements as the starting point – particularly in respect of primary health care funding. Incentives, including financial incentives, have been required to effect change. New money that is potentially available to effect change has been limited by cost pressures and competing priorities across the health sector.

Another key factor has been the frequent changes in the organisation of the health sector – the creation of 21 DHBs was the third significant restructuring of the health sector since the Health and Disability Services Act 1993 came into effect. Continuous organisational change has made it difficult for purchasers of primary health care to:

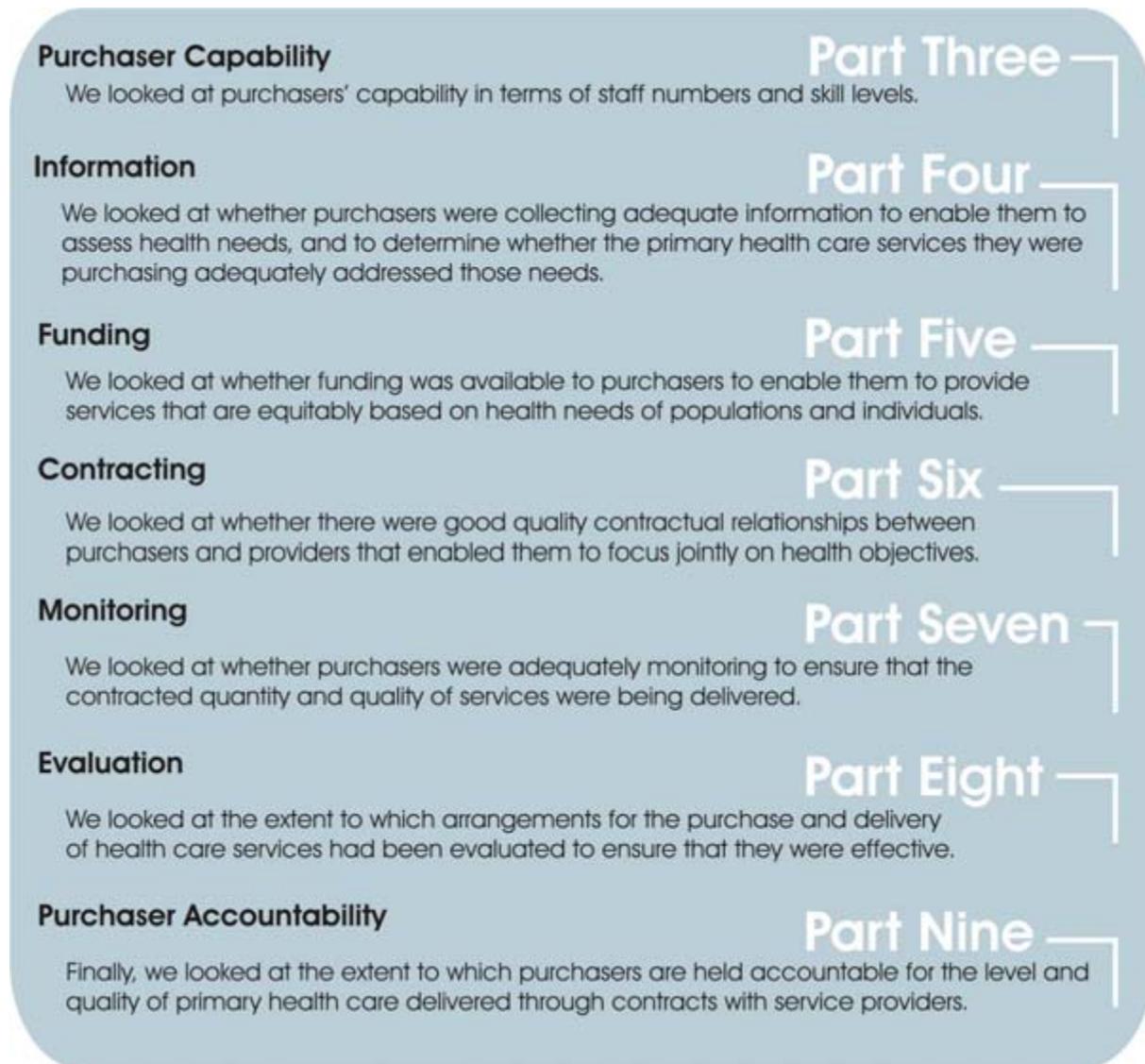
- retain and develop staff capabilities, skills, and experience in purchasing primary health care;
- build and maintain institutional knowledge in relation to the purchase of primary health care services;
- identify and collect useful information on primary health care needs, services, and outcomes; and
- establish systems – including better systems for primary health care funding, monitoring, and accountability – to support partnerships with primary health care providers to improve services and, ultimately, the health of patients.

In our view, the health sector would benefit from a period of stability to allow effective purchasing capability for primary health care to develop, and to make progress to improve the effectiveness and efficiency of primary health care service delivery. The fact that service provision has continued to function as well as it has reflects, to a large degree, the goodwill and tenacity of health professionals working in the primary health care sector. We found a high level of commitment among providers in the sector to developing good relationships with the DHBs.

Key Findings

Our key findings are set out in the following paragraphs related to each of what we consider to be the seven key features of good practice for purchasing health care described in Figure 2 on the opposite page.

*Figure 2
Seven Key Features of Good Practice
for Purchasing Health Care*



Purchaser Capability

Purchasers have struggled to develop and maintain the human resource capability needed for effective purchasing of primary health care.

Locality managers of the former Health Funding Authority (HFA) had a key role in purchasing primary health care. However, this staff group experienced high turnover. Lack of continuity limited purchasers' opportunities to develop institutional knowledge and an understanding of the complex primary health care sector. It also limited the scope to build close relationships with PCOs.

At the same time, the HFA set itself the task of developing, negotiating and implementing a standard national contract. This task was complex and time-consuming, and absorbed a great deal of the HFA's efforts.

The HFA considered the development of a national contract to be a key priority to help achieve greater consistency and transparency in place of the various contracts previously agreed by the four RHAs – both between different geographical areas and with different PCOs. However, this priority limited the resources available to develop other capabilities, such as locality teams' work with providers to develop quality specifications and monitoring of service delivery.

PCOs have developed their contracting capability as providers of primary health care.

In order to achieve effective contracting outcomes, both purchasers and providers should ideally have comparable resources and capability that enable them to negotiate from positions of similar strength.

Generally, PCOs have been successful in developing their capability to undertake contracting. Even so, different PCOs are at different stages of development – partly reflecting the resources that have been available to them.

These differing capabilities have resulted in varying contracting outcomes, and differences in funding, that at least partly reflect the relative negotiating strength of the purchaser and of particular PCOs.

Information

The information collected by the Ministry and purchasers is insufficient to enable them to adequately identify the level and type of services required.

To effectively purchase primary health care, the purchaser needs to know about the people for whom care is being purchased – including their age, gender, ethnicity, deprivation, and health status (as these factors influence the amount and type of health care that will be required).

The Ministry collects information on the volumes and cost of services delivered – but this kind of information provides little indication of the current health needs of the population. Little information is collected about people who rarely or never visit a GP. And purchasers do not collect the kind of information that would indicate health needs – such as the number of people suffering chronic diseases like diabetes and asthma, and the severity of their condition.

Some PCOs collect information on the health status of the populations registered with their GPs. However, the information varies as they collect it on their own initiative.

As a result, consistent data on health status across populations is not available to the purchasers to enable them to assess health needs and determine whether the primary health care they are purchasing adequately addresses those needs.

Funding

Currently, there is no national formula for funding primary health care – although a national formula is being developed.

Without a national funding formula, it is difficult to systematically target those people with the poorest health and independence status. It is also difficult to ensure that people with the same condition have access to the same level of service in different parts of the country.

Uneven access to funding creates different health care opportunities between communities.

The different funding methods in operation have resulted in different levels of funding being available to address local needs – such as sexual health programmes, programmes for the elderly, and community nurses attached to schools. This uneven access has been compounded by the funding of many local programmes out of “savings”.⁷ For some PCOs, there has been less opportunity to make savings.

The Government subsidises access to General Medical Services provided by and through GPs.

Subsidies for low-income earners, high users, and children are designed to ensure that the cost does not deter people from using primary health care services. However, GPs may charge a co-payment over and above the subsidised amount, and this co-payment may deter some people.

The Ministry is currently reviewing the Community Service Card regime.

Contracting

In the absence of national contracting objectives, priorities or guidelines, purchasers have negotiated varied contracts that have the potential to contribute to differing health care outcomes between communities.

The RHAs (that operated from 1993 to 1997) had considerable freedom to develop new approaches to contracting. The nature of the negotiations therefore varied between and within regions, and resulted in some PCOs negotiating contracts with more favourable terms than others. The HFA thus inherited a range of different contracts, and large numbers of GPs were also still operating under arrangements that pre-dated these contracts.

⁷

For some expenditure, PCOs are given notional budgets. Where the actual expenditure is less than the notional budget, the PCO is able to retain a portion of the difference as “savings” which can be used to fund local programmes.

When the HFA was established in 1997, one of its aims was to standardise contracts and the contracting process. Many PCOs signed a standard national contract in 1999. The contract continues to allow considerable flexibility – Part 3 of the contract (the Service Delivery Agreement) varies between different PCOs.

Varying contracting outcomes have a lasting effect on the equitable provision of, and access to, primary health care services. Once contracts have been negotiated and budgets set, it becomes difficult for the purchaser to shift funding from one area to another. Locality managers have been responsible for negotiating and managing primary health care contracts. Given the complex contracting environment, we would have expected them to be supported by guidelines, priorities, or objectives as to how they should go about negotiations for primary health care. Generally, however, such guidance was not available.

In our view, the unsystematic way in which contracting has been undertaken has been partly responsible for the inconsistent access to types and levels of services between different areas and PCOs.

The contracts focus on the legal relationships between purchasers and providers, rather than on the joint achievement of agreed health objectives and the quality of services being purchased. Accordingly, the contractual relationships between purchasers and providers have been an obstacle to the two parties focusing jointly on health objectives.

The contracts agreed with most PCOs are generally over 100 pages long and have been written with a view to covering every possible eventuality. Representatives of the PCOs we visited told us that they would favour shorter contracts that focused on a genuine partnership between the purchaser and provider and included:

- the objectives and outcomes that the purchaser and provider wish to achieve; and
- the responsibilities of each party to ensure that the agreed objectives are achieved.

There needs to be more engagement on quality issues.

Quality specifications in the contracts we examined referred to guidance and specifications that were still being developed. Purchasers and PCOs had not produced any quality specifications through their joint efforts, though some PCOs had independently developed quality specifications to help their GP members improve the quality of care provided to patients.

Monitoring

Effective monitoring is limited to the audit of GPs' claims and capitation payments.

Health Benefits⁸ has in place arrangements for auditing GPs' claims for subsidy, and for testing capitation (per head) payments against patient registers.

Monitoring of service delivery is not effective.

Purchasers' monitoring of the provision of primary health care services is poor. PCOs are required to provide data on the services that their members provide, but told us that purchasers rarely explained why they wanted the data or what it was to be used for. We found little evidence that the data was being used to monitor services or to provide feedback to service providers.

Purchasers were also not monitoring whether, or to what extent, individual GPs or PCOs audit the standard of clinical care provided to patients.

Clinical audit⁹ is the responsibility of health care professionals. We expected clinical audits of primary health care to be carried out by providers (by individual GPs and PCOs) and monitored by the purchaser. To varying degrees, GPs and PCOs were undertaking clinical audits. However, we found that the purchasers were not monitoring the amount or nature of any clinical audit being undertaken.

Evaluation

Evaluation of the effectiveness of primary health care purchasing and provision has been limited.

In November 1999, the Treasury and the Ministry commissioned a joint review of the development of PCOs.¹⁰ The review did not seek to assess the effectiveness of PCOs as a vehicle for the delivery of primary health care. However, it identified major areas requiring development – for example, to make funding more equitable, and to improve information, community participation and governance.

The special arrangements negotiated with the Christchurch-based PCO *Pegasus Health Limited (Pegasus Health)* are being evaluated. The evaluation

⁸ Health Benefits is now part of the Ministry. It was originally a company set up by the four RHAs to process pharmaceutical claims, the majority of General Medical Services claims, and other claims for services (such as practice nurses).

⁹ Clinical audit is a process whereby doctors, nurses and other health care professionals systematically review, and where necessary make changes to, the care and treatment they provide to patients. The purpose of clinical audit is to improve the quality of patient care by such audits becoming routine practice for all health care professionals.

¹⁰ *The Development of Primary Care Organisations in New Zealand*, November 1999 – Professor Laurence Malcolm, Lyn Wright, Pauline Barnett. A review undertaken for Treasury and the Ministry of Health. ISBN 0-478-23597-6 (Booklet); ISBN 0-478-23598-4 (Internet).

is examining the impact of these arrangements – including access to services, service quality and responsiveness, and the resource implications of extending the arrangements to other parts of the country.

We expected that local programmes provided by PCOs would be evaluated to establish their effectiveness, ongoing value, and potential for delivery in other areas. We found that programmes were only occasionally evaluated.

Purchaser Accountability

Our assessment of accountability focused on the HFA's documents because these were the most recent available reports at the time of our examination. They also provide the starting point for the development of accountability arrangements for the 21 DHBs. We concluded that the HFA's performance measures for primary health care were not adequate to enable assessment of its performance for the quantity and quality of services purchased.

To enable assessment of its performance for the services purchased, the purchaser needs to detail:

- the specific types and levels of services to be provided;
- the intended impacts of these services; and
- the indicators that will be measured to determine that the intended impacts are achieved.

However, the performance measures for primary health care that the HFA presented in its 1999-2000 Annual Report were broad and lacked specific, measurable targets. Instead, the measures focused on systems, processes, and structures that the HFA was developing or had put in place. The measures were of limited value in terms of accountability for services provided, or their impact on health.

The same measures were used in the quarterly reports of the HFA to the Ministry. This meant that the Ministry did not receive sufficient information to enable it to effectively monitor the purchasing of primary health care undertaken by the HFA.

Our Recommendations for the Ministry and DHBs

The context for our recommendations is...

- The over-arching strategy for health services that was set out in *The New Zealand Health Strategy*, published in December 2000.¹¹ This strategy identifies the Government's key priority objectives, and highlights five

¹¹ ISBN 0-478-23993-9 (Book); ISBN 0-478-23994-7 (Internet).

service areas – of which primary health care is one – for the short to medium term.

- The specific strategy for primary health care – *The Primary Health Care Strategy* – that was released in February 2001.¹² This strategy emphasises:
 - population health and the role of the community;
 - health promotion and preventative care;
 - the need to involve a range of health professionals; and
 - funding based on population needs rather than fees for service.
- The 21 DHBs established by the New Zealand Public Health and Disability Act 2000, which are responsible for:
 - investigating, assessing and monitoring the health status of their geographically defined populations;
 - providing, or arranging for the provision of, health services to their resident populations; and
 - monitoring the delivery of the services and the performance of service providers.

In the following paragraphs we provide a summary of our recommendations, which are set out in full at the end of the corresponding parts of this report.

Purchaser Capability

DHBs would benefit from a period of stability to enable them to build institutional knowledge and purchasing capability, and to develop relationships with primary health care providers.

The Ministry should monitor DHB capability.

Information

Both the Ministry and the DHBs need data to assess health status and health need.

DHBs (under the direction of the Ministry, to provide national consistency) should consult and agree with providers on the data to be collected, who should collect it, and how it will be used and fed back to providers.

¹² ISBN 0-478-24306-5 (Booklet); ISBN 0-478-24307-3 (Internet).

The Ministry and DHBs should ensure that they make good use of the information that is available from PCOs. The Ministry should work closely with bodies such as The Royal New Zealand College of General Practitioners and the Independent Practitioner Association Council of New Zealand (the IPA Council) to make national information on health needs more consistently available.

Funding

More consistent funding arrangements should continue to be developed on the basis of population health needs.

Any new arrangements should also take account of past experience of capitation and be developed in consultation with people who understand the delivery of primary health care.

The Ministry should select a funding formula that is relatively simple and straightforward to administer. It should also ensure that there are information systems capable of underpinning the formula.

Where there is an exceptional health need not reflected in the formula, DHBs should consider a separate funding arrangement.

Contracting

The current form of the contract needs to be reviewed.

The contract should reflect the public law context in which it operates, with the object of avoiding an unduly legalistic approach and keeping compliance costs to a minimum. It should focus on:

- the health objectives, outputs and outcomes that the primary health care providers and purchasers wish to achieve;
- the responsibilities of each party for securing the desired achievements; and
- the obligations to Parliament and the public to report on how effectively and efficiently funds are spent to achieve the desired objectives, outputs and outcomes.

Purchasers and providers should engage more with each other on quality matters in primary health care.

Monitoring

The Ministry should establish the information and capability needed to monitor primary health care providers, taking account of the views and

expertise of key stakeholders and interested parties (including DHBs, PCOs and bodies such as The Royal New Zealand College of General Practitioners and the IPA Council).

The Ministry should ensure that the various monitoring responsibilities are clearly defined.

DHBs should engage with providers on the clinical audits they undertake, and develop their capability to a point where they can influence the choice of clinical audits to ensure that clinical audit programmes reflect the DHB's health and purchasing priorities.

Evaluation

Models of service delivery need to be more comprehensively evaluated, starting with the most important and least evaluated to date.

This will require collection of information on arrangements and programmes being operated locally in order to identify those with potential to be extended to other parts of the country.

The Ministry should maintain oversight of important evaluations.

Purchaser Accountability

Health care purchasing needs to incorporate a performance measurement system that results in the quantity and quality of health care being purchased by DHBs being measured and reported on.

This will require:

- relevant and reliable information;
- a culture change from relatively straightforward measurement of systems and processes to providing reviews of health outcomes (and/or inputs, outputs and behaviours likely to lead to good health outcomes); and
- Ministry involvement – as the funder, guardian and promoter of *The New Zealand Health Strategy* and as supporter to the DHBs.

Part One

What We Looked At

Scope of Our Examination

- 1.1 We examined the extent to which *purchasing* of primary health care:
- is based on an assessment of health needs; and
 - supports the effective and efficient *provision* of primary health care.
- 1.2 We structured our examination around seven key features of good practice for purchasing health care, as described in Figure 2 on page 15. Our findings and recommendations on each feature are set out respectively in Parts 3 to 9 of this report. Each Part sets out in detail:
- our expectations;
 - our key findings in relation to our expectations, and the evidence supporting our findings; and
 - recommended future actions.
- 1.3 Primary health care is a large topic. In order to keep our examination to a manageable size, we chose not to undertake specific work in a number of key areas. Prominent among the exclusions to our scope are:
- the work that GPs undertake on behalf of the Accident Compensation Corporation; and
 - Maori health and the specific primary health care response to Maori health needs.
- 1.4 We are currently considering the various options and priorities for including Maori health in our future work programme, and we are planning to start a study of case management in the Accident Compensation Corporation later this year.

Why Did We Look at Health Care Provided in General Practice?

- 1.5 We chose the provision of primary health care in general practice because:
- Most people see GPs as an important part of health care...**
- 1.6 Generally, a GP consultation is the first point of contact for people with the health system.
- 1.7 Of approximately \$1,954 million spent on primary health care services in 2000-01, we estimate from available information that more than half was spent or initiated in general practice.

General practice was significantly affected by the Health and Disability Services Act 1993...

- 1.8 GPs established Primary Care Organisations (PCOs) as a specific response to the new contracting environment established by the Health and Disability Services Act 1993. Other providers (such as hospitals) had to develop new contractual arrangements and management information systems too, but in the main they were able to do this within their existing organisations.

The contracting arrangements are complex...

- 1.9 As explained in Part 6 on pages 85-93, the arrangements for contracting for primary health care provided or initiated by GPs are complex. We believe that the results of our examination have the potential to assist District Health Boards (DHBs) in undertaking their roles as purchasers, and we recommend improvements to current arrangements.

Our Information Sources

- 1.10 We reviewed both national and international literature on primary health care. In addition, we examined reports and documents produced by:
- the Ministry of Health (the Ministry);
 - the former Health Funding Authority (HFA); and
 - the PCOs we visited.
- 1.11 Our examination of documents was extensive. Nevertheless, we were confronted with difficulty in gaining access to some key HFA documentation that some former HFA staff considered would have provided us with a more complete picture of primary health care purchasing up to the time the HFA was disestablished. The documentation concerned included:
- complete sets of minutes of the HFA Board and its Purchase Board (we were shown papers of the two boards, but they were not assembled in a way that enabled us to identify and locate specific papers on primary health care, or to be sure that the papers we were shown were complete); and
 - papers documenting the HFA's work to develop the Primary Health Care Strategy, which the Ministry published in February 2001, shortly after the HFA was disestablished.
- 1.12 Since completing our examination, the Ministry has begun to index the papers of the HFA Purchase Board to make them more readily accessible and useable.

1.13

We met and interviewed Ministry and former HFA staff, primary care providers, and other people with extensive experience of primary health care. The people we interviewed were:

- Ministry staff – including the Deputy Director-General (Personal Health) and the Project Manager for Service Development;
- the General Manager, and benefit payments and audit staff of Health Benefits (which is now part of the Ministry);
- staff of the Shared Services Support Group, which is the Ministry’s contract management and monitoring branch;
- staff of the Ministry’s New Zealand Health Information Service;
- former staff of the HFA;
- six locality managers based in the four regional administrative offices – Northern, Midland, Central (two), and Southern (two) – who have the role of contract manager;
- the Chief Executives and contract managers from a sample (four in Northern, two in Midland, three in Central, and two in Southern) of Independent Practitioner Associations and Community Health Organisations (both are types of PCO);
- a sole practitioner GP and a GP member of an Independent Practitioner Association;
- the Chief Executive of the Independent Practitioner Association Council of New Zealand (the IPA Council);
- representatives of The Royal New Zealand College of General Practitioners¹³; and
- academics – including two Chairs of General Practice and a Professor in Community Health.

1.14

The interview evidence we collected was highly consistent – even though it came from people with different backgrounds and perspectives. Coupled with the documentary evidence (and notwithstanding the difficulty with the HFA documentation), we have a high degree of confidence in the evidential basis of our findings and recommendations.

¹³

Approximately 95% of all New Zealand GPs are members of the Royal College, which is the national body in New Zealand concerned with standards of general practice and education for GPs.

Part Two

Primary Health Care – An Outline

2.1 In this part we describe the primary health care services provided in general practice. We answer the following questions:

- What is primary health care?
- Who pays for primary health care?
- Who purchases primary health care?
- What are Primary Care Organisations?
- How does the New Zealand Public Health and Disability Act 2000 affect primary health care?
- What else is new?

What is Primary Health Care?

2.2 Primary health care –

*...is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.*¹⁴

2.3 The specialist care given to people in public hospitals, hospices or community treatment centres is called secondary health care. It includes all hospital operating costs, including laboratories, hospital-dispensed medicines, nursing, ambulance services and administration. Figure 3 on page 34 sets out the main features of primary health care and compares them with secondary health care.

2.4 A person may obtain primary health care services in a number of ways. For example:

- Where the person experiences a medical problem and is looking for advice on how to treat it. Depending on the nature of the problem, the person may seek advice from a pharmacist, the mobile nursing service (if available in their area), a district nurse, a medical centre, or a GP.
- By way of a specific service – such as maternity, family planning and sexual health services.
- By way of a specific service following a general consultation. For instance, diagnostic tests (such as blood tests) may be required to determine the extent of the problem, medication may be prescribed, or an x-ray may be required.

¹⁴ International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978.

Figure 3
Main Features of Primary Health Care and Differences
Compared with Secondary Health Care¹⁵

Primary Health Care is:	Secondary Health Care is:
<ul style="list-style-type: none"> • Generalist • Holistic • Continuing • Comprehensive 	<ul style="list-style-type: none"> • Specialist • Most often focused on one set of problems • Episodic • Limited in scope
<p>The defining feature of primary health care is that primary health care professionals are collectively accountable for the provision of generalist, comprehensive, continuing and accessible care.</p>	

2.5 In addition, *The Primary Health Care Strategy*¹⁶ sets out a broader definition of primary health care services that has been increasingly accepted in the health sector in recent years and includes:

- health professionals participating in communities and working with community groups to improve the health of people in the community; and
- health improvement and preventative services – such as, health education and counselling, disease prevention, and screening.

2.6 GPs are generally the first point of contact for people wishing to consult a health professional about a health problem.

2.7 The Government refers to the services for which it is prepared to subsidise general practice as “General Medical Services”, which include the services illustrated in Figure 4 on the opposite page.

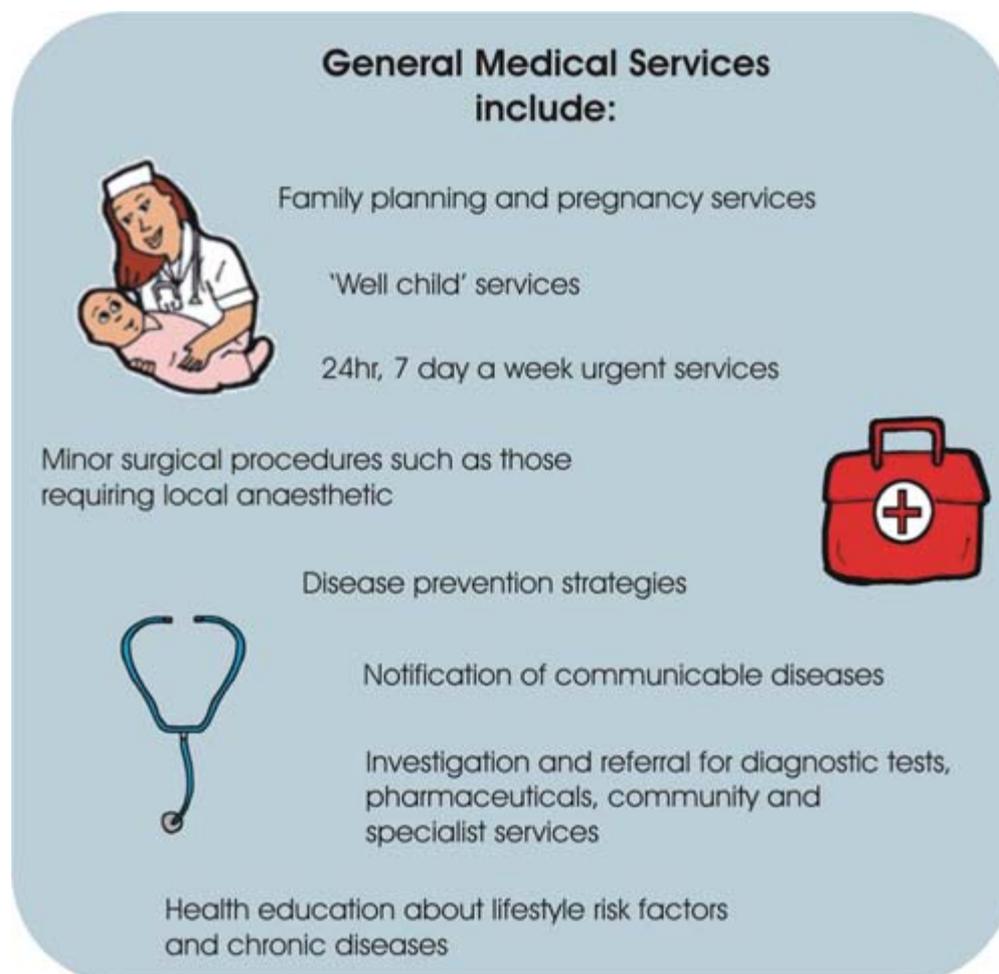
2.8 An important feature of the provision of General Medical Services is that most GPs are independent contractors – they are not employed by any public sector organisation. Some GPs are salaried employees of non-Government organisations such as Union Health Clinics.

2.9 As independent contractors, GPs also often employ other people – such as nurses and receptionists – to help in providing General Medical Services to their patients.

¹⁵ Source: Malcolm and others – see footnote 10 on page 19.

¹⁶ Announced by the Minister of Health in February 2001.

Figure 4
An Illustration of General Medical Services



Who Pays for Primary Health Care?

2.10 Authenticated information on actual Government spending for particular health services is not readily available – as we said in a report to Parliament last year.¹⁷ However, in its 2000-01 Annual Report¹⁸ the Ministry reported the following non-departmental expenditure out of Vote Health on funding for:

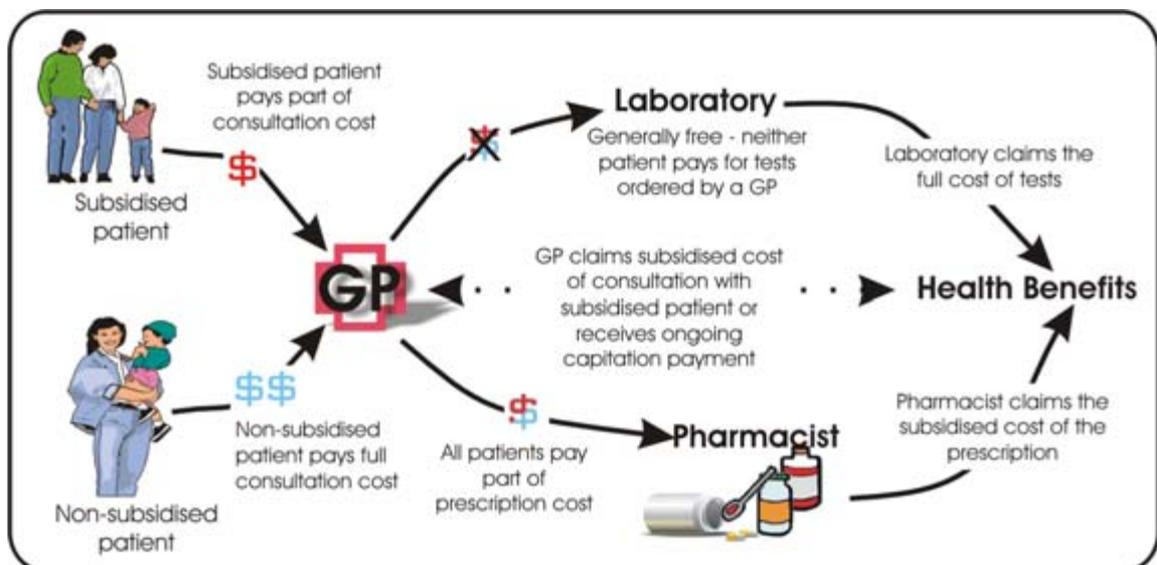
	<i>\$million</i>
Personal Health Services (Output Classes O1-O4)	5,022.5
Disability Support Services (Output Classes O5-O8)	1,758.7
Public Health Service Purchasing (Output Class O9)	124.8
Management and other services (Output Classes O10-O14)	68.0

¹⁷ Under the heading "Lack of Information About Health Activities Funded Through Non-departmental Output Classes", parliamentary paper B.29[01b], 2001, pages 72-75.

¹⁸ Parliamentary paper E.10, 2001, page 107.

- 2.11 As Figure 1 on page 12 shows, primary health care is a sub-group of Personal Health Services. Our best estimate of the division of the spending of \$5,022.5 million for Personal Health Services in 2000-01 (based on the division of spending in an earlier year – 1998-99) is \$1,954.3 million for primary health care and \$3,068.2 million for secondary health care.
- 2.12 What the Government pays for primary health care – through subsidising patient visits and treatment costs – is only part of the cost of the services provided. The patient or (if insured) their insurance company meets the remainder of the cost, which is estimated at \$760 million.
- 2.13 Figure 5 below shows how the costs are divided between the Government and patients for GP consultations, prescriptions, and test referrals. It illustrates that, although the funds that GPs receive directly relate only to General Medical Services, GPs also initiate other expenditure by prescribing medicines and by ordering tests. GP behaviour therefore has a major influence on the subsidy costs incurred by the Government.

*Figure 5
GP Consultations, Prescribing, and Test Referrals:
Who Pays for What?*



- 2.14 Public funding of primary health care is spent on:
- subsidies of General Medical Services and the cost of practice nurses;
 - pharmaceuticals dispensed in the community;
 - referrals for diagnostic services (such as blood tests);

- community-based specialist services;
- community-based maternity services; and
- community mental health services.

2.15 GPs also participate in public health related programmes¹⁹ – for which they are paid out of public funding for Public Health Services (see Figure 1 on page 12 and paragraph 2.10 on page 35).

The Government pays a subsidy for services provided to eligible patients...

2.16 The eligibility criteria for subsidised services are designed to ensure that cost does not deter people from using primary health care services. The subsidies therefore target:

- people on low incomes (including beneficiaries), who are entitled to a **Community Services Card**;
- high users of health services, who are entitled to a **High Use Health Card**; and
- children who receive a subsidy according to their age, or Community Services Card or High Use Health Card status.

2.17 A Community Services Card entitles the holder to subsidies for GP visits and to larger subsidies for prescription medicines than for non-cardholders. As at 1 July 2001, over one-third of adults²⁰ had a Community Services Card.

2.18 Figure 6 on the next page analyses adult Community Services Card holders by reason for eligibility. However, a number of people eligible for the card do not apply for one – the Ministry has estimated that one-fifth of eligible people do not hold a Community Services Card.

2.19 A High Use Health Card is designed to ensure that people with chronic conditions do not face excessive health care costs. Eligibility for this card is determined on the basis of the number of visits to the GP, and does not depend on the person's income. As with the Community Services Card, the holder is entitled to subsidies for GP visits and larger subsidies for prescription medicines. The Ministry has estimated that four-fifths of those eligible for a High Use Health Card do not have one.

¹⁹ The programmes include:

- immunisation (for the prevention of disease);
- smoking cessation (to reduce risks associated with unhealthy behaviours);
- sexual health services (to maintain and improve sexual and reproductive health);
- mammography and cervical screening (to identify disease through screening); and
- health education and lifestyle counselling (to aid better management of diseases such as asthma and diabetes).

²⁰ The total number of adults on which this statement is based was taken from *the National Population Estimates: June 2001 quarter* – persons aged 15 and over – published by Statistics New Zealand.

Figure 6
Adults Holding a Community Services Card, by Reason (as at 1 July 2001)

Reason for having a Card	No. of Adults	%
Receiving an income tested benefit	499,445	44
Receiving state superannuation	329,585	29
Receiving family assistance	132,822	12
On a low income with no dependants	107,974	9
On a low income with dependants	29,301	3
Receiving a residential subsidy	22,721	2
Receiving a war veteran's pension	5,669	1
TOTAL	1,127,517	

- 2.20 From July 1997, for children under six the Government increased the subsidy paid for all GP visits and removed pharmaceutical charges. The expectation was that these steps would result in near-universal access to free medical care for such children.
- 2.21 GPs are able to charge their patients a sum of money (called a *co-payment*) over and above the subsidy paid by the Government. The cost of consulting a GP may therefore remain a deterrent for some people.
- 2.22 Depending on their contract with the purchaser, GPs are able to claim subsidies for the General Medical Services they provide in two main ways:
- A payment in the form of a *fee for service* for each patient seen who is eligible for subsidised care.
 - A fixed payment for each of the patients registered with the GP, regardless of the number of times any patient is seen – these are known as *capitation*²¹ payments. Capitation funding is described in more detail in paragraphs 5.17 to 5.24 on pages 72-73.

²¹ Capitation was originally introduced in 1941, but very few GPs accepted it. It was used more widely in the 1980s – mainly by the Union Health Clinics, and then was widely promoted by the Midland RHA.

- 2.23 The rates of fee-for-service payments in 2001 are set out in Appendix 2 on page 130.

Who Purchases Primary Health Care?

The Health and Disability Services Act 1993 established a “funder”, “purchaser”, and “provider” relationship...

- 2.24 As will be apparent from the preceding paragraphs, primary health care services are **paid for** by up to three parties:

- the Government;
- the patient; and
- the patient’s insurer (if any) – which may include the Accident Compensation Corporation.

- 2.25 Who **purchases** the services to be paid for is a different matter. The model that is still used – although some of the parties have changed – is that established by the Health and Disability Services Act 1993. That Act set up the four RHAs as purchasers of health services that entered into a funding agreement with the Crown (the *funder* of subsidies and other health service costs). As the *purchasers*, the RHAs were responsible for:

- assessing the need for services in their regions;
- purchasing from health service providers (through contracts) appropriate services to meet those needs; and
- monitoring the delivery of the services.

- 2.26 The four RHAs were disestablished on 30 June 1997 and their functions were transferred to the Transitional Health Authority. The HFA replaced the Transitional Health Authority on 1 January 1998. The HFA was disestablished from 1 January 2001 and its functions divided between the Ministry and 21 DHBs.

What Are Primary Care Organisations?

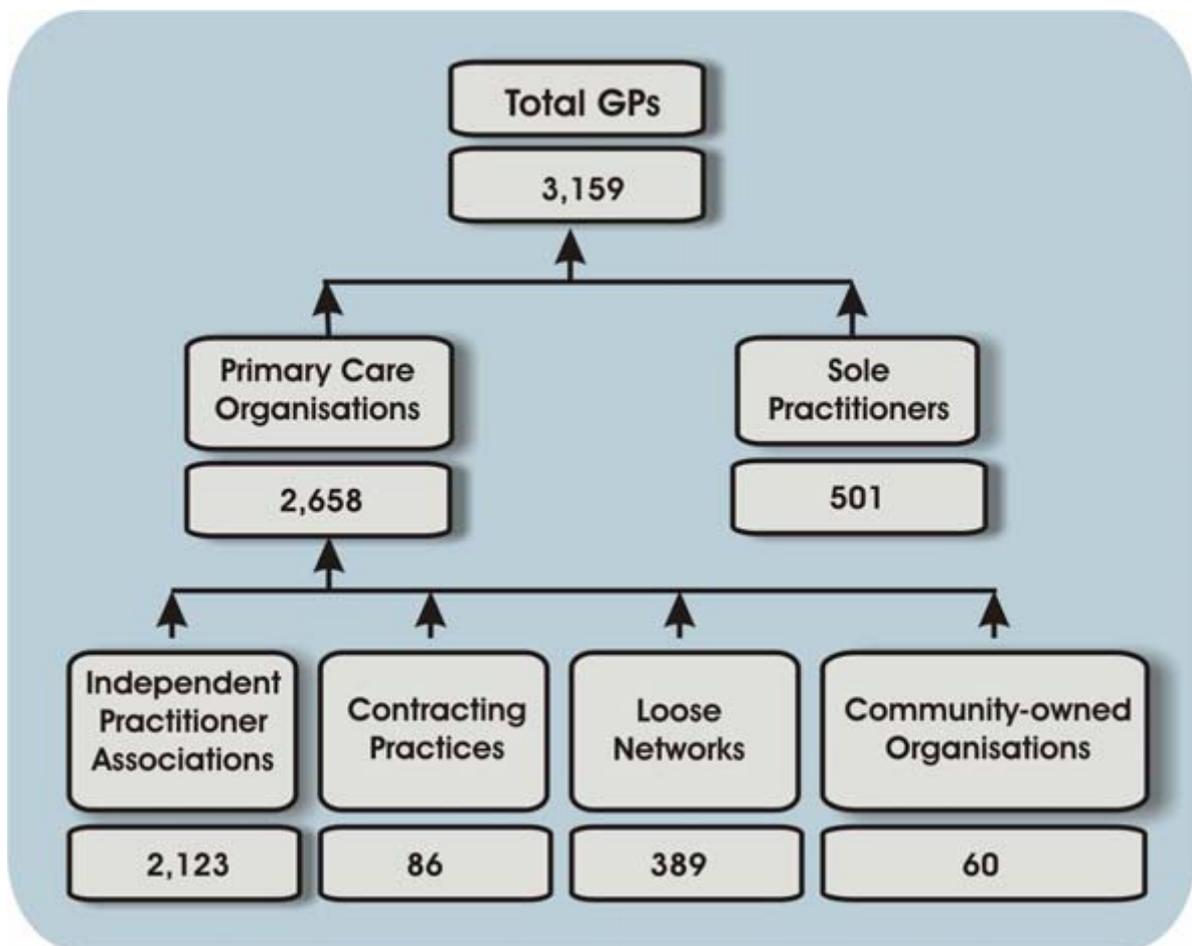
- 2.27 The RHAs encouraged the development of PCOs, in which GPs came together for the purpose of entering into a contractual arrangement with the purchaser for the provision of services. The RHAs saw the development of PCOs as a means of facilitating their contractual relationships with GPs:

- the RHAs could negotiate service agreements with groups rather than individual GPs, making the contracting process more efficient;

- the PCOs provided a framework for consultation with GPs on management of demand-driven expenditure; and
- the PCOs provided a means of potentially introducing population-based budgets.

2.28 Each of the RHAs took independent approaches in encouraging PCOs to develop. PCOs vary widely in size, ownership structure, and geographical coverage (and coverage often overlaps). GP membership of a PCO is voluntary, but by November 1999 84% of GPs had chosen to become a member. The numbers of participating GPs are shown in Figure 7 below.

*Figure 7
GP Membership of Primary Care Organisations
(as at November 1999)*



(Source: Malcolm and others – see footnote 10 on page 19.)

- 2.29 PCOs have different ownership structures and approaches to contracting, but can be grouped into four main categories²²:
- Independent Practitioner Associations;
 - smaller contracting practices;
 - community-owned organisations; and
 - loose networks.
- 2.30 Each type of PCO is explained further in Appendix 3 on pages 131-132.
- 2.31 PCOs undertake different roles for their GP members. Generally, however, they:
- negotiate annual service agreements with the purchaser;
 - identify local health needs and seek funding for local programmes to meet them;
 - arrange for continuing education of GP members – which often includes setting up a peer review process in relation to drug prescribing and other quality systems; and
 - provide comparative performance information on the activities of their members to the purchaser – which involves establishing IT systems and databases among their GP members.
- 2.32 In some instances, the PCO manages budgets and capitation fees for GP members.
- 2.33 PCOs are funded from a variety of sources – including the Government, individual shareholders, and/or the community. The amount of Government funding that they receive depends on the level of management services they provide. Since 1998, PCOs that were involved in helping GP members to manage their prescribing and referrals for laboratory tests have received \$6,300 a year for each GP member over 0.2 of a full-time equivalent.
- 2.34 PCOs not involved in these activities receive a lower sum. For example, CareNet (a loose network) was paid \$1,000 a year for each GP member.

²² We have adopted the classifications used in the publication *The Development of Primary Care Organisations in New Zealand* (see footnote 10 on page 19).

Effect of the New Zealand Public Health and Disability Act 2000

- 2.35 The objectives and functions of DHBs are specified in sections 22 and 23 (respectively) of the New Zealand Public Health and Disability Act 2000. We describe DHBs' functions in some detail in Appendix 4 on pages 133-134.
- 2.36 DHBs enter into funding agreements with the Ministry to fund health and disability support services, which they either deliver themselves or arrange for other providers to do so. Briefly, DHBs can be described as being responsible for:
- investigating, assessing, and monitoring the health status of their geographically defined populations;
 - providing, or arranging for the provision of, health services to their resident populations; and
 - monitoring the delivery of the services and the performance of service providers.

What Else is New?

A New Strategic Focus

- 2.37 The Ministry set out an overarching strategy for health services in the *New Zealand Health Strategy*, published in December 2000. This strategy identifies the Government's key priority objectives, and highlights five service areas – of which primary health care is one – on which the Government wishes the health sector to concentrate in the short-to-medium term.
- 2.38 The strategy will be implemented:
- by developing toolkits to identify the actions that different types of organisations or providers can take to address priority objectives;
 - by developing more detailed action-orientated strategies for specific health issues, services or population groups; and
 - through performance and/or funding agreements with the Ministry, DHBs and providers.
- 2.39 Specific strategies have been developed for primary health care, disability and mental health.
- 2.40 The Primary Health Care Strategy was released in February 2001, and emphasises:
- population health and the role of the community;

- health promotion and preventative care;
- involving a range of health professionals; and
- funding based on population needs rather than fees for services.

2.41 The strategy envisages the creation of multi-disciplinary, not-for-profit Primary Health Organisations (PHOs) that would aim to improve and maintain the health of enrolled populations using population-based funding. The Ministry is in the process of developing more detailed policy for the creation of PHOs, in consultation with bodies including DHBs and PCOs. The Ministry envisages that many existing PCOs can evolve into PHOs.

A New Set of Guidelines for Contracting

2.42 In May 2001, the Treasury issued *Guidelines for Contracting with Non-Government Organisations for Services Sought by the Crown*.²³ The guidelines –

... are intended to encourage the use of better contracting practices by all departments and Crown entities involved in negotiating arrangements with non-Government organisations for the provision of services that support the Government's objectives.

2.43 We would expect health sector contracting practices to compare favourably with these guidelines.

²³ ISBN 0-478-1181-4.

Part Three

Purchaser Capability

What We Looked At

- 3.1 *We looked at purchasers' capability in terms of people available to fulfil the purchasers' role in purchasing effective and efficient care to meet health needs. We expected that purchasers would build and maintain sufficient capability – both in terms of the numbers of staff and their skills and competence – to:*
- *understand the contracting environment for the delivery of primary health care; and*
 - *develop effective relationships with GPs and PCOs.*

Understanding the Contracting Environment

- 3.2 In general, the purchasers did not have a sufficient understanding of the contracting environment for the delivery of primary health care. Three factors appeared to have contributed to this.
- Successive re-organisations have reduced the time available to build organisational capability.
 - High staff turnover among locality managers, partly resulting from frequent organisational change, had limited the opportunity to develop managers' capabilities to interact effectively with GPs and PCOs.
 - We found evidence of a general lack of experience and knowledge of primary health care and how it is delivered among locality managers and other staff responsible for contracting.

High Staff Turnover

- 3.3 We sought data from the Ministry on staff turnover and retention, and on staff employed in purchasing primary health care who had experience of the primary health care sector. However, the Ministry was unable to supply this data.
- 3.4 We therefore had to rely on other evidence – but the evidence and views we collected were consistent and compelling. The locality managers and the staff from PCOs whom we spoke to all suggested that staff turnover was high, and had been a problem over a number of years in all except one region – Midland – which appeared to have had less difficulty retaining staff for longer periods. In one region we were told that out of ten staff employed by the RHA to purchase health services, only two remained when the HFA was formed and one subsequently left.

Lack of Staff with Experience in Primary Health Care

- 3.5 At the time of our examination, most locality managers had a contract management background, and few had experience of primary health care – though for some of the contracts with the larger PCOs, such as *Pegasus Health* and *First Health*, locality managers had drawn on the expertise of the HFA’s national primary care team.
- 3.6 The Ministry estimated that around 15 of its staff had primary health care experience, and eight of these had gained their experience in providing primary health care – two as GPs, three as pharmacists, two as nurses, and one as a manager.
- 3.7 The staff working for PCOs usually have primary health care experience – for example, in nursing, pharmacy, or physiotherapy.

Developing Effective Relationships

- 3.8 The high staff turnover and lack of staff with primary health care experience appear to have hindered the development of effective relationships between the purchasers and PCOs. For example, GPs and staff in PCOs reported having to “educate” a succession of new locality managers about the realities of primary health care.
- 3.9 PCOs and locality managers both found little opportunity to develop a partnership, because of the effort needed to put a basic contract in place. The need to finalise annual contracts made it more likely that relationships would become strained rather than co-operative.
- 3.10 We observed – and our observations were confirmed by people with long-term experience of the primary health care sector – risks of “provider capture”²⁴, because of the large gaps in capability and knowledge between purchasers and providers of primary health care. However, sometimes the knowledge gap had a different effect – resulting in a “take it or leave it” approach by purchasers to contracting with primary health care providers that was also not conducive to the development of constructive relationships.
- 3.11 A large amount of time and effort was also required to replace the lost institutional knowledge in understanding the various contracts – time that might otherwise have been used to develop relationships with providers.
- 3.12 Under these circumstances, PCOs told us that they found limited opportunities for involving purchasers in developing primary health care services.
- 3.13 Some locality managers had wider responsibilities than others. For example, locality managers in Midland had been appointed as contract managers for the primary health care sector alone. Locality managers in other regions usually had a broader portfolio of responsibilities, which included hospital contracts.

²⁴ That is, where the provider exercises the dominant influence in the contracting relationship.

- 3.14 Locality managers with hospital contracts could find themselves with little time available to develop relationships with PCOs. The wider portfolios – primary and secondary – could provide the opportunity for better co-ordination of purchasing between the primary and secondary sectors, although we found only limited evidence of this actually happening.
- 3.15 Purchasers have little information on primary health care services and needs – as further discussed in Part 4 on pages 51-65. On the other hand, PCOs have a detailed understanding of primary health care, and some also have good information on services and the health needs of their GPs’ patients. This gap further increases the difference in the capability of purchasers and providers in negotiating contracts for primary health care.
- 3.16 Generally, PCOs have relatively well-established capability. However, no-one is currently monitoring GP availability in any detail, although the issue is of increasing concern among those involved in providing primary health care. We found anecdotal evidence of shortages of GPs in some areas, particularly rural areas, which could lead to capability issues in future.

Recommended Future Action

- 3.17 DHBs would benefit from a period of stability to enable them to build institutional knowledge and purchasing capability, and to develop relationships with primary health care providers.
- 3.18 DHBs particularly need to:
- assess staff capability (and the capability of any contractors – including those undertaking shared services on behalf of more than one DHB);
 - achieve a balance between contract management skills and an understanding of the primary health care sector – through staff development, recruitment, and secondments;
 - support their staff in:
 - building knowledge of primary health care; and
 - creating effective relationships with providers of primary health care; and
 - review and monitor the capability of their primary health care providers – drawing on the providers’ experience and working with them to identify issues and develop solutions.
- 3.19 The Ministry should monitor DHBs’ capability – such as by requiring DHBs to measure and provide information to the Ministry on turnover of key staff and retention of key skills.

Part Four

Information

What We Looked At

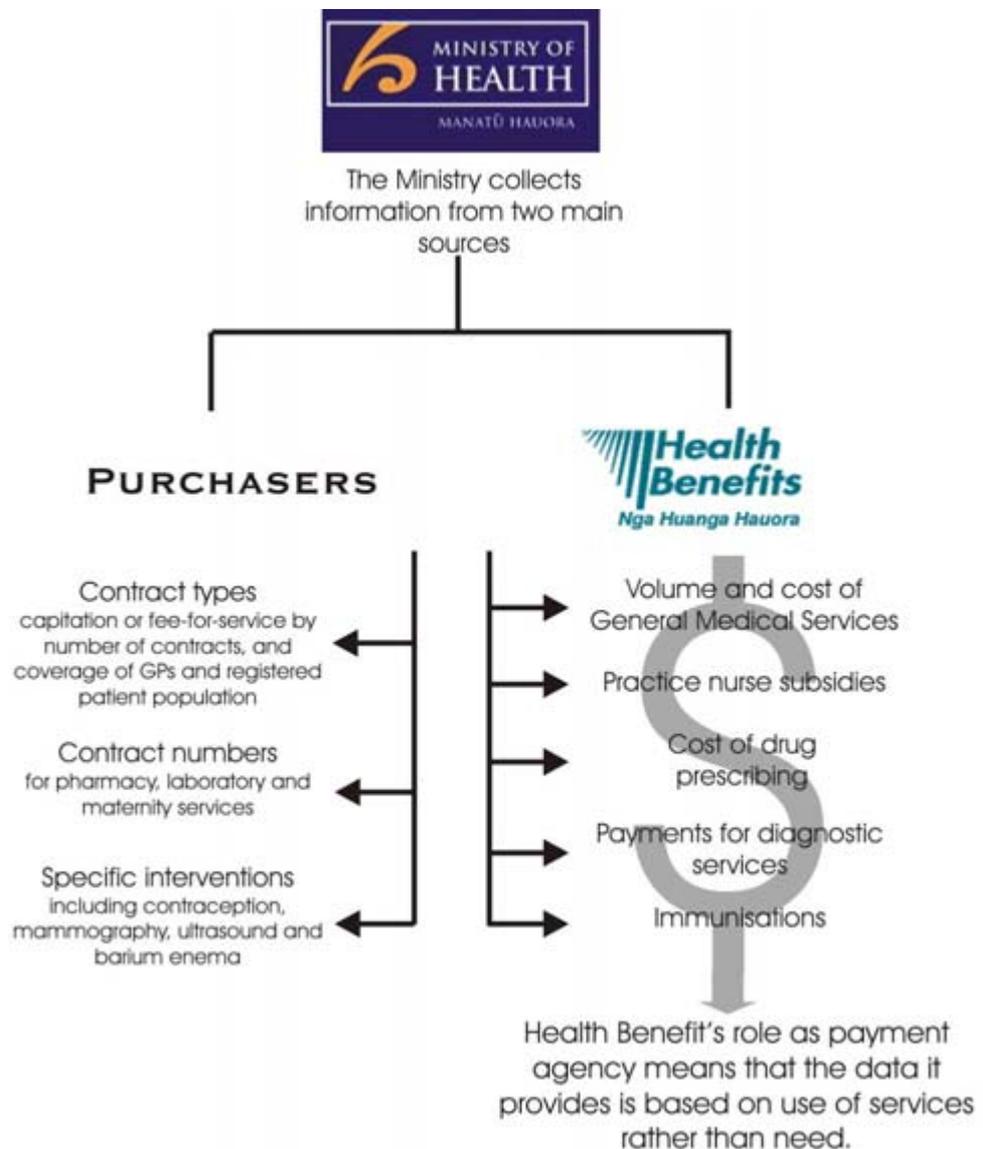
- 4.1 *We looked at whether purchasers were collecting adequate information to enable them to assess health needs and to determine whether the primary health care they were purchasing adequately addressed those needs.*
- 4.2 *Examples of information on a local basis that we expected to find included:*
- *key demographic data, such as age, sex, and ethnicity;*
 - *the number of people eligible for subsidised care; and*
 - *indicators of the population's disease status – for example, the numbers of people suffering from diabetes, cardiovascular disease, or asthma, which are conditions for which first-line treatment is typically provided in a primary health care setting.*

Information Held by the Funder and Purchasers

- 4.3 To effectively purchase primary health care, a purchaser needs to know about the people for whom care is being purchased – including age, gender, ethnicity, and deprivation,²⁵ because these factors influence the amount and type of health care that will be required.
- 4.4 For example, the young, the old, and women tend to access primary health care frequently, and some ethnic groups have relatively poor health status or are more susceptible to particular health problems. People who live in poorer areas generally have higher health needs.
- 4.5 Neither the Ministry nor the HFA was collecting sufficient information to adequately identify the level and type of services needed for GP-based primary health care. Information that the HFA collected was limited to population characteristics, and was intended to support the payment of rural bonuses and consideration of applications from potential new GPs. It included:
- distance, travelling times, and services provided by rural GPs;
 - the ratio of GPs to the population in defined areas; and
 - the match between population characteristics (e.g. gender and ethnicity) and the GPs serving the area.

²⁵ The deprivation index is a measure of the social and economic disadvantage relative to the society to which an individual or group belongs. The index used in New Zealand statistically combines nine socio-economic variables from the Census for small areas, known as meshblocks, which have a median of 90 people. The scores are grouped into deciles, with decile 1 comprising the least deprived 10% of meshblocks, and decile 10 the most deprived.

Figure 8
 GP-related Primary Health Care Information
 Collected By The Ministry



4.6 Figure 8 above illustrates the GP-based primary health care information collected by the Ministry. It shows that the information about contracts provides only very broad details of the contracts that have been let with primary health care providers. And the payments information provided by Health Benefits reflects the historical use of primary health care and (therefore) provides only a weak indicator of current health needs of populations, because:

- there is not necessarily a correlation between the number of GP visits and the level of ill health in a population – indeed, people who take the greatest

care of their health may also be the most likely to visit their GP, and people with the greatest health need may be less likely to attend;²⁶

- people who are eligible for subsidised care but who do not take up their entitlement are not taken into account; and
- the kind of global cost and activity information collected provides little indication of the type and level of illness in the population.

4.7 For many conditions, it is important to know the prevalence and severity of illness among the people with the condition so as to be able to:

- identify undiagnosed chronic disease;
- control or slow the progress of chronic disease in the population; and
- identify and plan for future health needs.

4.8 Figure 9 on page 56 illustrates how this information is important in respect of a specific disease – diabetes. The Ministry’s priority health areas include chronic diseases such as diabetes, asthma, and congestive heart conditions. However, it has not systematically collected national data on these diseases, and we found that data collected locally was held only at a local level.

Information Initiatives

4.9 We consider that the Ministry has some promising information initiatives at the development stage.

4.10 The New Zealand Health Information Service (the Health Information Service) is responsible for the collection and dissemination of health-related information. This responsibility includes providing appropriate databases, but to date the database focus has been on secondary rather than primary health care information. At the time of our examination the Ministry was establishing an immunisation database, which the Health Information Service is responsible for. The deadline for the completion of the database was 1 July 2001 so that DHBs could use the data for their estimates.

4.11 The immunisation database is intended to record the immunisations that children have had and whether they are being immunised at the right age, as an indicator of the effectiveness of the immunisation programme. It is also intended to provide information to GPs to help them assess their immunisation practice.

²⁶

It has been established in a number of research studies that people living in more deprived areas have relatively high rates of hospitalisation and relatively high mortality and morbidity (ill health). This applies to all ages, for both genders, and all ethnic groups. Research also indicates that more deprived populations tend to make relatively low use of primary health care.

Figure 9
Why It Is Important to Have Information
On Diabetes Health Needs

Diagnosing diabetes early is important, because the risk of serious diabetes-related illness (including blindness, lower limb disease, heart disease, stroke and kidney failure) can be reduced by lifestyle measures such as:

- ➔ good diet (e.g. low in saturated fat and high in fruit and vegetables)
- ➔ appropriate level of exercise (e.g. for people with a good general level of health, a minimum 30 minutes a day of moderate-intensity physical activity)

It is therefore important to know people have diabetes, but:

205,000+ New Zealanders are estimated by prevalence surveys to have diabetes.
but only

105,000 people have been identified as having diabetes according to available evidence

therefore a further

100,000+ people may possibly have diabetes and are not being treated because they do not know they have it.

These people will not be receiving advice and treatment that could help them avoid potentially serious future illness. The prevalence of adult onset diabetes is increasing in New Zealand - and is predicted to double by 2011. The burden of diabetes and diabetes-related illness will therefore increase significantly.

\$249 million is an estimate of the current annual cost of treating complications and renal failure as result of diabetes, in addition to the human cost.

The Ministry and DHBs need data on numbers of people with diabetes and the severity of their condition to plan for treatment of severe diabetes-related illnesses, including:

- ➔ renal dialysis
- ➔ amputations
- ➔ treatments to prevent blindness
- ➔ management of heart attack and stroke

- 4.12 The database is based on claims for subsidies paid by Health Benefits and is not yet complete. One reason is that no claims are made to Health Benefits for measles and flu vaccinations given as part of the national public health programme rather than as General Medical Services.
- 4.13 The Health Information Service, under contract from PHARMAC²⁷, operates a pharmaceutical database known as *pharmhouse*. The data for *pharmhouse* is also extracted from claims (by pharmacists) that are paid by Health Benefits.

²⁷ PHARMAC is responsible for managing Government-funded subsidisation of medicines and promoting the responsible use of pharmaceuticals. PHARMAC was first established in 1993 as a company wholly owned by the four RHAs. It is now a Crown entity in its own right.

The data starts from 1992 and includes details of the drug supplied, the National Health Index²⁸ number of the patient prescribed the drug, the GP prescriber, and the pharmacist who dispensed the drug.

4.14 The Ministry, PHARMAC, and *Pegasus Health*²⁹ have access to *pharmhouse*. The DHBs and other PCOs can request data from PHARMAC, the Health Information Service and/or Health Benefits. PHARMAC said that the DHBs and other PCOs may soon also have access to *pharmhouse*, but that an understanding of the database is needed to interpret the data. PHARMAC is working closely with the Health Information Service to address this issue.

4.15 PCOs (especially those operating in Northern) have concerns about the quality of the *pharmhouse* data for 1999-2000 and 2000-01, and the effect that it had on the calculation of PCOs' "savings". The Ministry and the IPA Council³⁰ examined the concerns about the database and found:

- weaknesses in the model developed by the HFA – including difficulties with correctly reflecting changing GP memberships of PCOs;
- anomalies in how the data is obtained and stored (e.g. coding to “doctor zero”, which was related to problems with electronic claiming by pharmacies); and
- lack of direct access to the data for PCOs to enable them to validate the data and use it to monitor prescribing practice.

4.16 Since February 2001, the Health Information Service has also operated the Laboratory Claims Data Warehouse which provides data on laboratory testing. Again the data derives from the payments made by Health Benefits, and includes:

- the laboratory;
- the type of test;
- the referring GP or nurse; and
- the patient's National Health Index number.

4.17 The laboratory data is largely complete. Data for GP members of *Pegasus Health* has to be added separately because the Pegasus Global Budget (explained in Figure 15 on page 78) directly meets the cost of laboratory tests that those members order.

²⁸ The Health Information Service is working on a National Health Index to provide a mechanism to uniquely identify health care users. It will enable exchange between different information systems while protecting privacy. The Index could potentially provide comprehensive information on health needs, both nationally and by area. There is still a great deal of work to be done to develop the Index, including resolution of basic matters such as wide-scale duplication of patient numbers.

²⁹ *Pegasus Health* is a PCO. It has access to the database because of its different funding arrangements, as described in Figure 15 on page 78.

³⁰ The IPA Council represents the majority of, but not all, PCOs.

- 4.18 The Health Information Service was to have developed a database of General Medical Services data, but the work was not continued because of the poor quality of the data available.

Information on Population Health Status

- 4.19 In April 1999 the Ministry published information about the health status of the population in *Taking the Pulse – The 1996/97 New Zealand Health Survey*.³¹ This report presented an overview of the second nationally representative survey of the health status and health service utilisation of New Zealanders. It was built on the previous 1992/93 Health Survey (the Household Health Survey) by improving the content and methodology, and by extending the scope of the survey.
- 4.20 The 1996/97 survey is useful in monitoring the health-related risk factors, health status, and health service utilisation over time – providing information on:
- selected health-risk behaviours (e.g. smoking, physical inactivity, and alcohol use);
 - health status – including self-reported physical and mental health, the prevalence of selected conditions (asthma, diabetes), and the incidence of injuries;
 - utilisation of health services and prescriptions; and
 - individuals' experience and knowledge of health services, their satisfaction levels, and barriers to obtaining health services.
- 4.21 More recently, in November 2001, the Ministry published *The Health and Independence Report*.³² This report:
- looks at changes to the health and disability sector over the last decade; and
 - brings together information on health expenditure, trends in health sector workforce development, activity and outcomes in relation to personal and family health services (which includes primary health care), disability support services, mental health services, public health services, Maori health, and over the health and disability sector as a whole.
- 4.22 Although largely focused on hospitals, the report contains some material that is directly relevant to primary care – including the following:

³¹ ISBN 0-478-23511-9 (document); ISBN 0-478-23512-7 (Internet).
³² ISBN 0-478-26266-3 (book); ISBN 0-478-26267-1 (Internet).

- There has been a relative increase in preventable hospitalisations for conditions that could be treated through primary health care. The most likely reasons given for this increase are –
 - changes in incentives to refer on or admit patients to hospital;
 - a rise in the prevalence of chronic conditions; and/or
 - the failure of primary health care to reach certain sectors of the population.
- The national immunisation coverage in 1998 was assessed at approximately 10% lower than reported in 1996.
- The number of preventable hospitalisations for children has risen steadily since 1998-99 – by an average of 9.2% a year. Hospitalisations for vaccine-preventable disease have increased by 12.1% a year since 1996-97.

4.23 The report is intended to be used by health planners, health service providers, community groups, and others who work or have an interest in the health and disability sector.

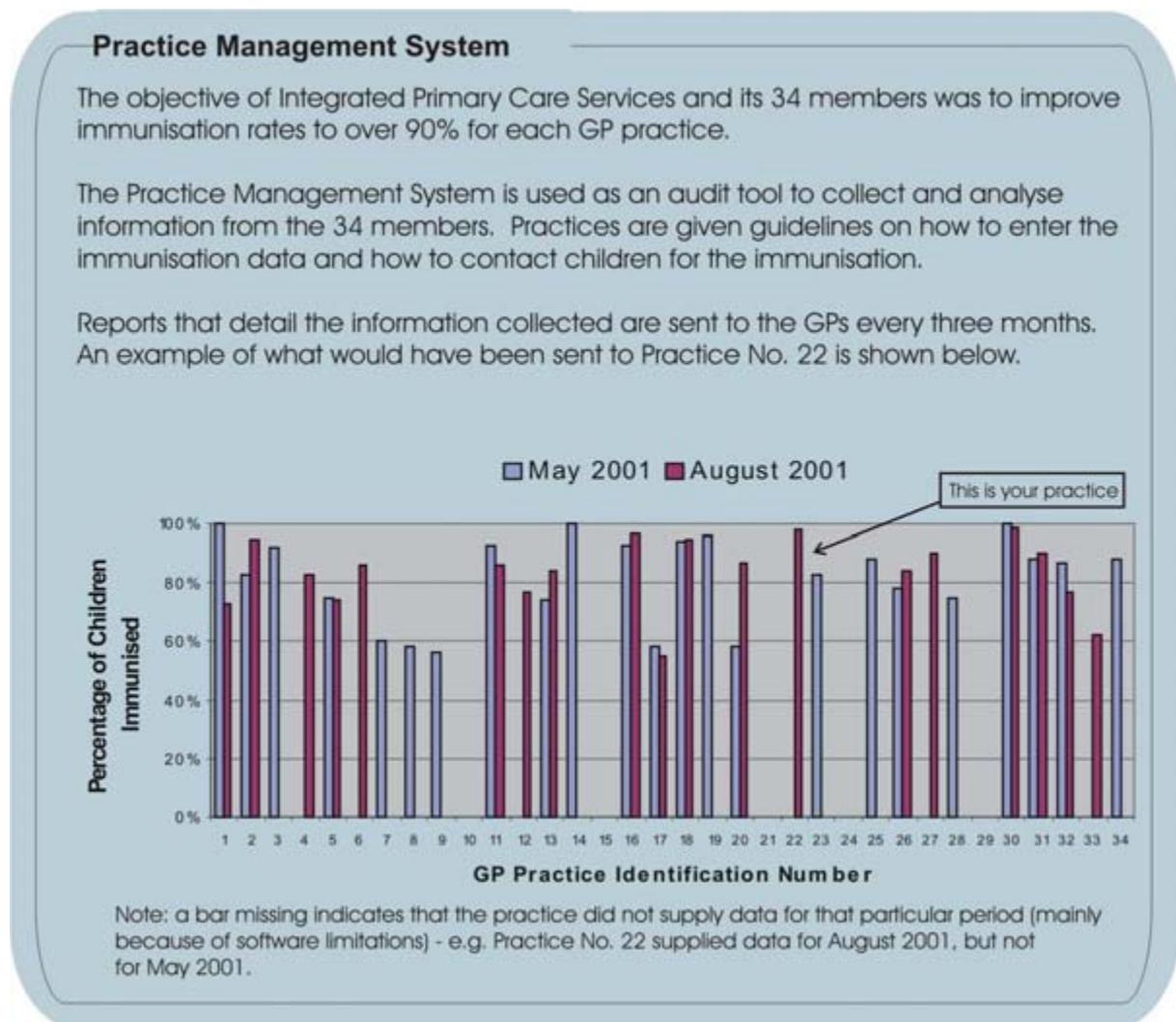
Information Held by Providers

- 4.24 GPs' computer systems can be used to record comprehensive information on patient ill health and treatments. Individual GPs may hold useful information on the health status of their registered patients – for example, on the level and severity of chronic diseases like diabetes and asthma.
- 4.25 PCOs have promoted the quality and usefulness of GP-held data by more extensive use of computer-based clinical information systems. Current estimates suggest that approximately 70% of GP practices that have information technology obtain their software from the same company. Of the other 30%, 10% each use two other companies, and the remaining 10% use a range of other sources.
- 4.26 Individual PCOs' and GP practices' use of data and systems also varies, with some having developed relatively sophisticated arrangements. These differences are the product of a number of factors, including:
- The extent to which PCOs and GPs themselves have a use for information about their patient population – where funding is on a capitation basis, there is an incentive to collect population data and to have systems for ensuring that the data is correct.
 - Where and when the PCO was set up – some of the first PCOs received special grants for information systems development and computerisation for their GP members. The amount and purpose of the funding offered varied both between and within RHAs.

Information to Assess and Improve Performance

- 4.27 The more developed PCOs use and analyse information and data from their GP members to help the GPs to compare and improve their performance. Figure 10 below illustrates an example of what one PCO (*Integrated Primary Care Services*) gives to its GP members to show them how their immunisation rates compare to those of other GP members' practices.

Figure 10
Example of Comparative Performance Information



GP Reporting of Health Status and Service Use

4.28 As an example of GP reporting, one PCO (*First Health*) requires its GP members to report annually on (among other things):

- the demographic profile of their patient population;
- the clinical profile of their patient population, including incidence of disease; and
- workload data – i.e. patients’ use of the services.

4.29 This kind of reporting by GPs is designed to:

- improve and standardise data collection, analysis, and interpretation of the health status of the patient population;
- facilitate comparisons of health status between different populations, and analysis of relative changes over time;
- identify the incidence of conditions that are preventable or can be managed most effectively in a primary care setting; and
- produce better information to support national health goals – for example, to improve Maori health.

Analysis of Health Needs by PCOs

4.30 Some PCOs have undertaken broad analyses of health need across their populations to help target the services that their GP members provide. For example, *First Health* uses the GPs’ registers of their patients’ age and sex and the 1996 Census data (which provides information on deprivation levels in different areas) to illustrate the population characteristics in each of its eight networks. Its analysis uses indicators such as age, ethnicity, Card status, and deprivation.

4.31 *First Health* has found, for example, that:

- In some areas, the Maori and Polynesian populations have higher proportions of people who do not hold a Community Services Card or a High Use Health Card, yet appear to be entitled to subsidised care.
- There are wide differences between ethnic groups in the rate of take-up of some services – such as influenza immunisations for the over 65s – by different categories of eligible people.

- 4.32 Needs assessment as a PCO function is formally part of the Global Budget arrangement of *Pegasus Health* (see Figure 15 on page 78).
- 4.33 The data that a PCO provides to a purchaser depends on the extent of the management services and information that the PCO has contracted to provide. The reporting requirements can thus vary from one PCO to another. Where the PCO covers a large geographical area, it may have different reporting requirements on behalf of the groups of GPs located in the different areas of the former RHAs.
- 4.34 The types of information usually requested are: immunisation, incidence of diabetes and asthma and, less frequently, smoking cessation, cervical screening and checks for melanoma.
- 4.35 Details of some reporting requirements are provided in Appendix 5 on pages 135-136.
- 4.36 PCOs submit the data to the Ministry's Shared Services Support Group where it is entered onto a database. Paper copies of summary reports are then sent to the purchaser dealing with the PCO concerned. There is no national collation of this data – which would in any case be incomplete, because of the inconsistent data requirements described above.
- 4.37 The PCOs we spoke to questioned the usefulness of some of the data sought. For example, some PCOs are required to report the percentage of patients with, say, asthma. Others are required to report both actual numbers and the percentage of the patient population. Information solely on the percentage of population is of limited value – since it could be reporting any number of people with the disease, depending on the size of the base population.
- 4.38 The Research Unit of The Royal New Zealand College of General Practitioners is separately collecting computerised patient records from participating GPs. The collected records are being used to identify clinical associations between demography, and use of primary and secondary health care for non-identifiable individuals. The Unit is also looking at methods of coding data to make it easier to establish the reasons for patient visits and the treatment given.
- 4.39 The Unit has compared the patient records submitted (the *study population*) with the population as a whole, in terms of demography (age, gender, ethnicity, socio-economic status, geographical location) and secondary care (admission type, bed stays, diagnostic categories). It has found that the study population is representative of the total population except in respect of the geographical location.³³ The results of this work may be used in future to test the soundness of any population-based funding formula.

³³ The proportions of the study population come from: Northern 21.4%; Midland 34.0%; Central 7.6%; Southern 37.0%.

The WAVE Report

4.40 In December 2000 the Director-General of Health, in consultation with DHBNZ³⁴, appointed an Advisory Board to facilitate the development and acceptance by the health sector of an Information Management and Technology plan. The project was subsequently renamed *WAVE* – Working to Add Value through E-information.

4.41 The project is intended to improve health outcomes through effective use of health information at the least cost to the health sector. The project involved substantial work to review the gaps between current and best practice, and to generate a plan to bridge the gaps, across eight work streams:

- strategy;
- knowledge;
- electronic health records;
- data architecture;
- privacy;
- systems infrastructure;
- investment; and
- organisation design.

4.42 The WAVE report's top ten priorities included the need to “gather primary care information”, and to “fix up pharmacy and laboratory data and provide primary care with access”. The report outlined concerns similar to those that we have expressed in this report. For example, the WAVE report stated that:

Health providers are collecting large amounts of data, yet important information on ethnicity or health status is not being captured. The collected data is stored in a variety of databases but not fed back and is, therefore, of only limited use. No organisation currently has a mandate (or resources) to mine existing health care data sets systematically. Lack of links...between databases makes research at the population health level difficult. Most IPAs mine data sets held by their member GPs, but to varying degrees.

...

Lack of information – about what happens in primary care, the quality and effectiveness of services and, most significantly, lack of information to support any contracting that might help the sector move away from the traditional institutional boundaries.

³⁴

District Health Boards New Zealand, the representative body of DHBs.

...

The limitations in pharmaceuticals and laboratory expenditure are so significant that the implementation of the primary care strategy, implementation of capitation and efficient management of referred services is not possible. At the moment DHBs and providers are expected to take responsibility for funding or managing contracts, yet cannot account for their spending.

- 4.43 We understand that the Ministry is currently considering the recommendations of the WAVE report.

Recommended Future Action

- 4.44 Both the Ministry and DHBs need data to help assess health status and health need. *The Health and Independence Report* (published in November 2001) on the whole health and disability sector (see paragraph 4.21 on page 58), provides a useful starting point and source of national information to DHBs developing their own local arrangements.

- 4.45 The Ministry should collect comprehensive and reliable data to assist it in:

- allocating funding between different DHBs and health services;
- overseeing and assessing DHB performance in meeting health needs; and
- evaluating the effectiveness of health policies and programmes.

- 4.46 DHBs should collect comprehensive and reliable data to assist them in:

- identifying and purchasing services to address the health needs of the population;
- monitoring service delivery; and
- evaluating whether the services purchased effectively address the identified health needs.

- 4.47 It is also important that DHBs (under the direction of the Ministry, to provide national consistency):

- consult with GPs and PCOs about data in which they have a common interest;
- agree on the data to be collected, who is best placed to collect it, and its intended use; and
- provide PCOs and GPs with the results of any comparative analysis that would be useful to them.

- 4.48 DHBs' information requirements should be consistent in order to:
- support analysis above the level of a single DHB; and
 - ensure that PCOs with a reporting relationship to more than one DHB are required to meet only one set of information requirements.
- 4.49 The Ministry should work closely with bodies such as The Royal New Zealand College of General Practitioners and the IPA Council in the interests of making national information on health needs more consistently available.
- 4.50 Many GPs hold useful information on health status, treatment, and treatment outcomes. The information and reporting structure needs to be further developed – such as through standard systems software and coding structures – to facilitate the provision of consistent information. The PCOs already provide an infrastructure to help make this happen – they and their member GPs generally seek the same information needed by purchasers.
- 4.51 In the short term, this infrastructure would support a “bottom-up” approach to information collection and analysis (making good use of information from GPs) while the Health Information Service proceeds with the longer-term project for a national health database based on a National Health Index number. Some large obstacles must be overcome to successfully implement this longer-term project.
- 4.52 The WAVE report contains important, relevant analysis and recommendations on a range of matters – including the use of information held by GPs and the development of the national health database. The Ministry should:
- give the report serious and detailed consideration;
 - provide a rationale for accepting or rejecting particular recommendations; and
 - publish an action plan and timetable for implementing the recommendations that it accepts.

Part Five

Funding

What We Looked At

- 5.1 *We looked at whether funding was available to purchasers to enable them to provide services that are equitably based on the health needs of populations and individuals.*
- 5.2 *We defined “equity” in terms of how health needs assessment, evaluations of effectiveness, and Government policies and priorities are used to fairly determine:*
- *the share of Vote Health allocated to broad service areas – personal health, disability support, and public health;*
 - *the allocation of personal health funding to regions (now 21 DHBs – which receive funding for both personal health and disability support services);*
 - *the share of personal health funding allocated to primary health care (rather than secondary, tertiary and disability support services);*
 - *the allocation of funding to various providers, services, and programmes; and*
 - *the allocation of funding in relation to the needs of individuals.*

The Principle of Equity

- 5.3 *Equity was one of the key principles³⁵ used by the HFA in making decisions, determining priorities, and allocating resources. The HFA applied the principle mainly in terms of equity of outcome – that is, priority should be given to the services most likely to improve the health and independence of those with the poorest health and lowest independence status.*
- 5.4 The HFA also recognised the importance of *horizontal* equity, i.e. equal treatment of equals. Horizontal equity implies, for example, that people in any part of the country with the same condition will have access to the same level of service.

³⁵

Other principles were:

- *effectiveness* – in terms of desired outcomes, such as reduced pain or prevention of premature death;
- *cost* – the total cost, including flow-on effects, related to maximum possible health gain;
- *Maori health* – encouragement of Maori participation in providing and using services; and
- *acceptability* – the expectations and values of New Zealanders.

Sharing the Available Funds

- 5.5 In practice, the allocation of Vote Health funds between the broad service areas, the share of the personal health budget between regions, and the allocation between primary and secondary health care, are based on the historical cost of these services. An allowance for any anticipated increases is also based on historical trends. The use of historical information in this way reflects the fact that there has been insufficient data to base allocations on “health needs”.
- 5.6 The Ministry and the Treasury are working on a funding formula that is intended to lead to a more equitable distribution of funding (for all services, not just primary health care) based on the health needs of DHBs’ populations. As currently envisaged, the formula will take into account:
- population size and demography;
 - unmet needs and challenges in reducing disparities between population groups; and
 - adjustments for rural factors and overseas visitors.
- 5.7 The funding formula will not be introduced until 2003-04, by which time the DHBs will have responsibility for all (or almost all) services. In the meantime, the funding will continue to be allocated to DHBs on the existing basis.

Equity of Access for Patients

- 5.8 For primary health care, subsidised access to cardholders (see paragraph 2.16 on page 37) and subsidised consultations for children under 6 are available irrespective of the method of funding for General Medical Services (capitation or fee for service – paragraph 2.22 on page 38). This policy is designed to improve the usage of General Medical Services by people on low incomes and people whose state of health obliges them to make high use of the services. These concessions are universally available, thereby achieving a degree of horizontal equity.
- 5.9 GPs can charge cardholder patients a co-payment. The co-payment would be much less than the full cost, but may still be sufficient to deter some people from obtaining General Medical Services.
- 5.10 The Ministry is currently reviewing the future of the Community Services Card. The review is being undertaken in the context of the Primary Health Care Strategy (see paragraphs 2.40 and 2.41 on pages 42-43), which includes the principles of “improving health” and “reducing health inequalities”.

Funding Methods

5.11 Equitable *funding* of General Medical Services requires a consistent method of allocating funds that takes account of the health needs of the population. However, as we explain in Part 4, comprehensive information on health needs for primary health care that would support such a method is not currently available.

5.12 Primary health care funding has historically been demand-driven, in that GPs were paid for the specific services they provided. Most GPs are still subject to arrangements³⁶ that enable them to claim:

- a fee for each consultation with patients eligible for subsidy (a “fee for service” – paragraph 2.22 on page 38);
- a practice nurse subsidy;
- where applicable, a rural bonus; and
- an immunisation service subsidy.

5.13 GPs also prescribe pharmaceuticals, order laboratory tests, and refer patients to specialists. These services are either wholly or partly paid for from Vote Health. Pharmacists and laboratories claim directly for subsidies for prescribed pharmaceuticals and the cost of laboratory tests, under arrangements that do not make the GP routinely aware of the cost of prescribed treatments and referrals.

5.14 The fee-for-service arrangements therefore provide little *financial* incentive for GPs to manage the numbers of patient visits, the volume of pharmaceuticals prescribed, or the number of laboratory tests ordered. The arrangements also provide purchasers with little information about what GPs actually do.

With the advent of the Health and Disability Services Act 1993, two main approaches were developed to manage demand-driven expenditure...

5.15 From 1993 two main approaches were developed to manage demand-driven expenditure:

- capitation funding for General Medical Services; and

³⁶ Section 51 of the Health and Disability Services Act 1993 (replaced from 1 January 2001 by section 88 of the New Zealand Public Health and Disability Act 2000) provided for the Crown or its agent (in the case of the 1993 Act, the RHAs and later the HFA; in the case of the 2000 Act, the DHBs) to give notice of the terms and conditions on which they will make payment to any person(s). A provider (in this case a GP) who accepts a payment is deemed to have accepted the notified terms and conditions. These notices are intended to keep transaction costs down by reducing the number of contracts. They are primarily used for the purposes of multiple providers of particular services, such as GPs and pharmacists.

- budget management for referred services (diagnostic tests and pharmaceuticals).

5.16 Different RHAs gave priority to different approaches. Of the four RHAs, three (Northern, Central and Southern) placed an emphasis on budget management of referred services – intending to develop capitation funding for General Medical Services at a later date. As a result, Northern has the highest number of GPs on budget management contracts in the country. Midland developed contracts based on capitation funding of General Medical Services before developing budget management, and has the highest number of GPs on capitation funding.

Capitation Funding of General Medical Services

5.17 In relation to controlling the amount spent on General Medical Services, some PCOs were encouraged to agree to *capitation* funding. Capitation funding budgets are generally formula-based – to allow for the different levels of need of different populations. For example, where a GP has a relatively high number of patients who are entitled to subsidised or free consultations, the GP might expect to receive a relatively high rate of capitation payment.

5.18 Capitation funding is intended to encourage GPs to focus on promoting the health of their registered patients – such as by providing advice on diet and smoking – and to be more discriminating in deciding whether they need to see patients themselves. For example, where a consultation with a practice nurse might be more appropriate:

- a fee for service creates a financial *disincentive* for the GP to refer the patient eligible for subsidy to the nurse, because the GP is paid the fee only by seeing the patient her/himself; whereas
- under capitation funding that disincentive does not exist.

5.19 Most patients are still charged a consultation fee (i.e. a co-payment), so that capitation funding does not remove all elements of the financial incentives and disincentives associated with a fee for service.

5.20 The majority of GPs – whether or not they are PCO members – still operate under the fee-for-service arrangement for General Medical Services. The Ministry was unable to provide precise figures for the current pattern of funding, but from the data available it estimated that the relevant percentages are as follows:

- 72% of GPs operate under fee for service – and receive 60% of the available funds for General Medical Services; and
- 28% of GPs receive capitation payments – and receive 40% of the available funds for General Medical Services.

- 5.21 Whether a GP is paid for General Medical Services by capitation payment or fee for service can make a big difference to the subsidy funding available to them – depending on the characteristics of their local population, as indicated by the example provided in Figure 11 below.

Figure 11
Potential Impact of Capitation Funding in
One Primary Care Organisation – South Med Limited

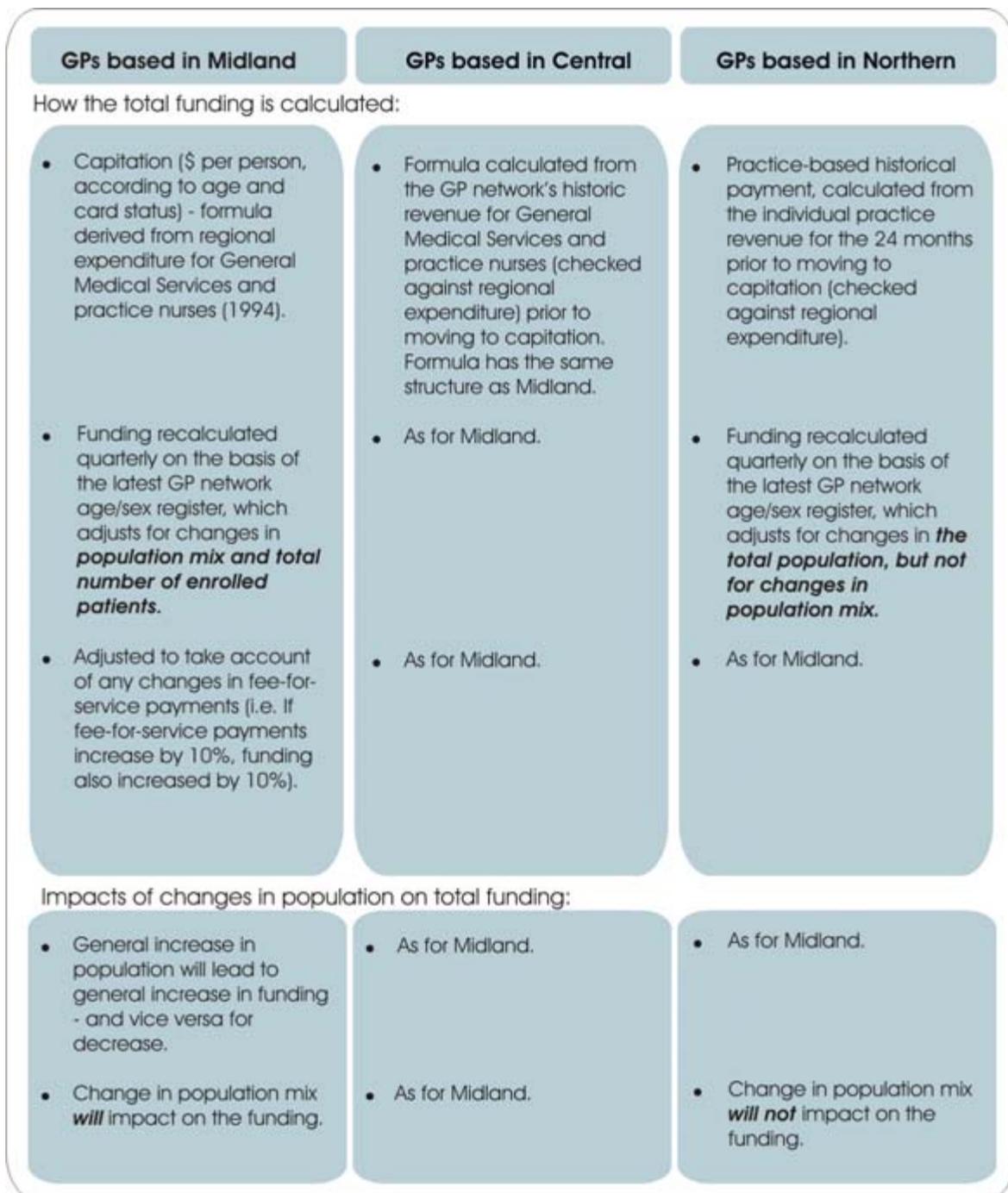
South Med Limited, based predominantly in South Auckland, has been discussing capitation funding for its GP members with purchasers since 1994. It has also looked at joining **First Health**, which would bring it within that organisation's capitation arrangements.

South Med Limited has assessed that, because of the area's relatively low income population, some of its GP members might expect to receive around **\$30,000 each a year in extra funding for General Medical Services** if they moved from fee for service to certain methods of capitation funding.

The purchaser asked **South Med Limited** to remain for the time being with the current arrangements, on the basis that a national capitation formula was planned to be in operation by the year 2000. However, this was not achieved and there is currently no date for introducing a national capitation formula.

- 5.22 For those GPs receiving capitation payments, there is no national consistency in funding. The locally-negotiated formulas are still those that were historically agreed with different PCOs and across different geographical areas.
- 5.23 The inconsistency can apply even to single PCOs. For example, *First Health* has GP members from areas in the North Island extending from Northland south to Hawke's Bay and Taranaki. Its GPs are therefore spread over Northern, Central, and Midland, and are subject to different locally-negotiated formulas.
- 5.24 How the amount of capitation funding available to each of these three groups of GPs is calculated is explained in Figure 12 on page 74. The calculations illustrate that the formula used directly affects the size of the amount of funding relative to the patient population over time. The formula only indirectly affects the amounts paid to member GPs – the distribution to individual GPs is managed by the PCO and may be adjusted to reflect the numbers of different types of patients on each GP's patient list.

Figure 12
 Three Capitation Formulas Applied to
 One Primary Care Organisation – First Health

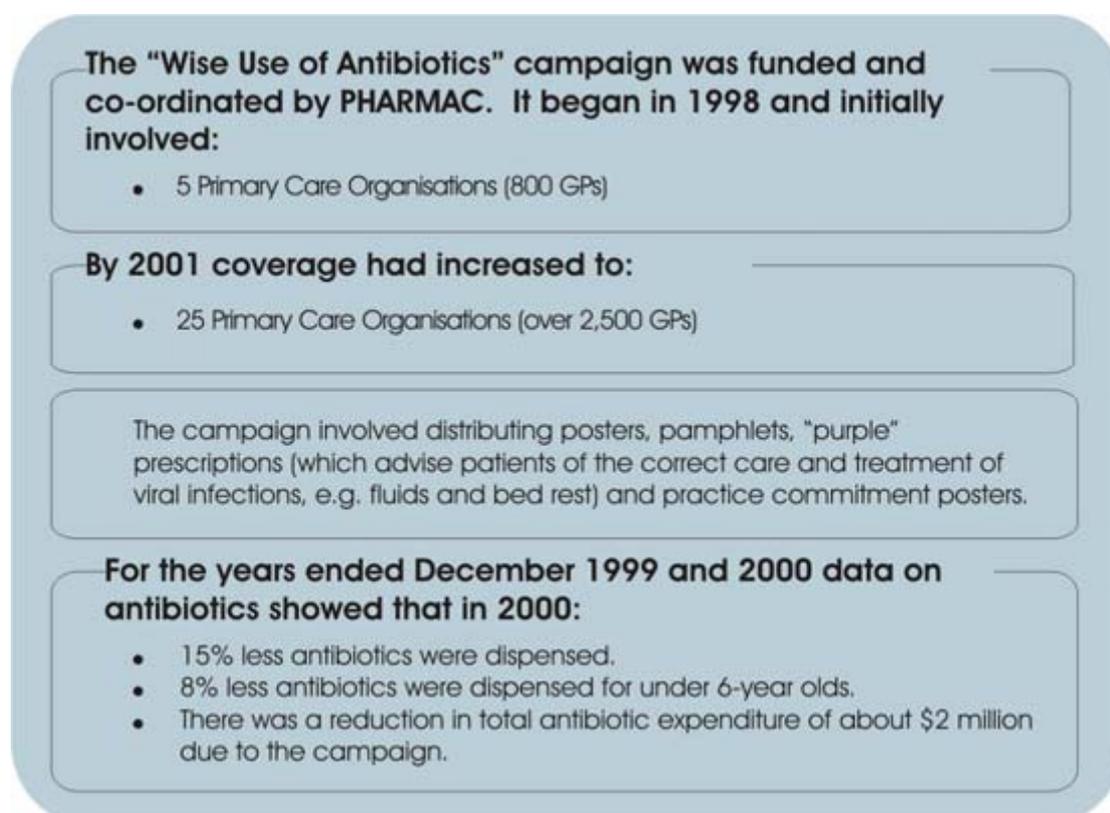


Budget Management

5.25 On average, each GP generates approximately \$200,000–\$225,000 a year of publicly-funded health care costs through their prescribing and referrals for diagnostic testing. The *budget management* arrangements are intended to increase GPs' awareness of, and involvement in, the financial costs of their clinical decisions.

- 5.26 By June 1997, 71% of GPs were in a budget management arrangement, whereby purchasers negotiate a *notional* budget with PCOs, out of which their GP members are expected to meet the costs of a range of services provided to their patients. These services could include pharmaceuticals, laboratory and other diagnostic tests, and elective (i.e. non-emergency) surgery.
- 5.27 The budgets are described as “notional” (or “indicative”) because the expenditure risk – should the actual cost exceed the notional budget – usually remains with the purchaser, who continues to meet any additional costs.³⁷ However, as an incentive to the GPs, a percentage of any “savings” – that is, where actual expenditure is below the notional budgeted amount – is retained by the PCO.
- 5.28 According to records held by the Ministry, savings on pharmaceuticals for the year to 30 June 2001 amounted to \$5.7 million, and savings on diagnostic expenditure were much less, at \$97,500. These figures exclude any savings made by three PCOs – *Pegasus Health* (see Figure 15 on page 78), *First Health*, and *Hokianga* – because the figures are not available to the Ministry.

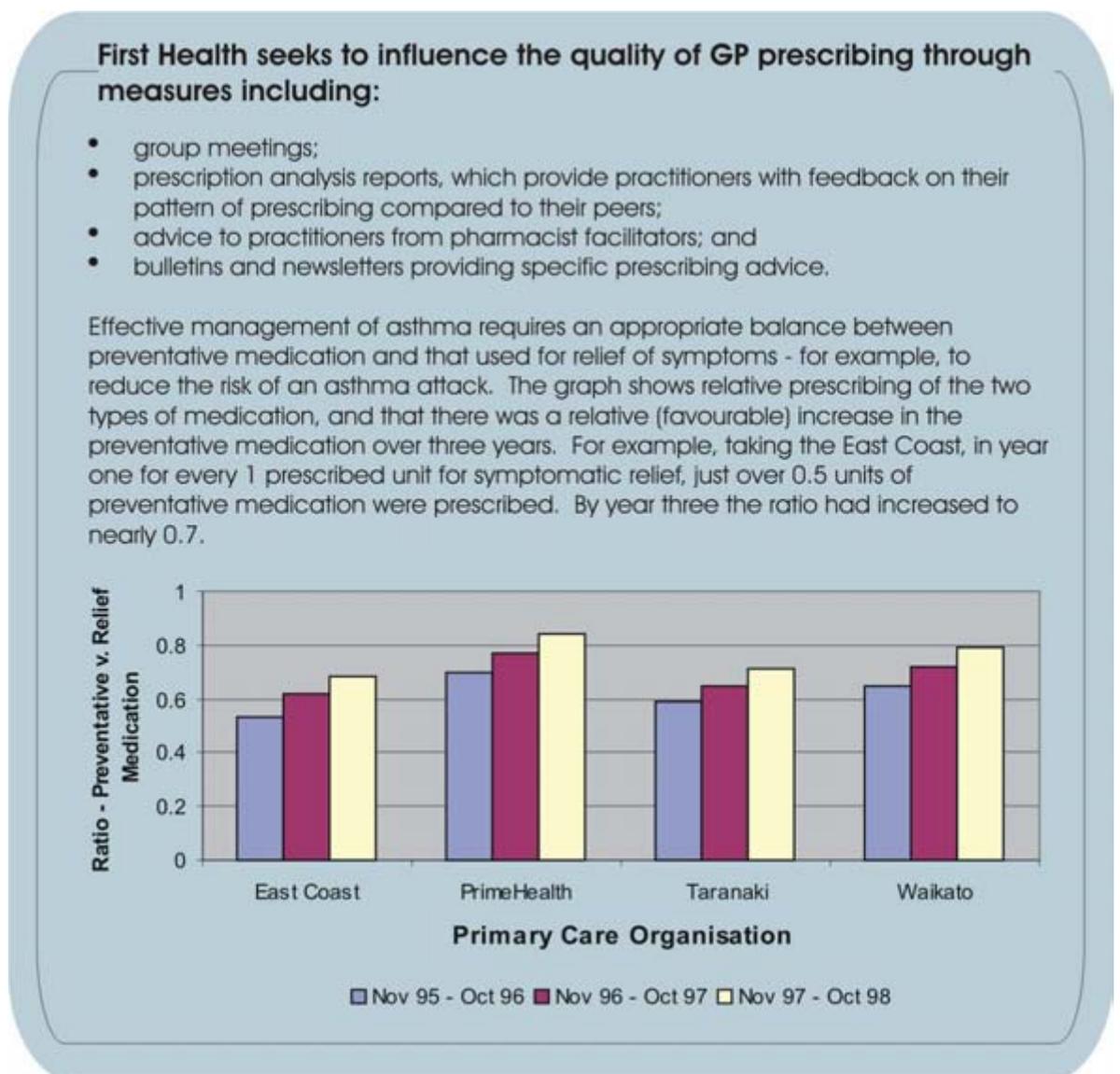
Figure 13
Reducing the Cost of Pharmaceuticals



³⁷ *First Health* operates a very different arrangement in that its budgets are “at risk”, i.e. *First Health* takes on the demand-side risk for its contracted providers.

- 5.29 A number of PCOs suggested that there might have been scope for still greater improvements through budget management – and in prescribing practices in particular – if they had had better and more timely access to comparative information, including by GP. Other PCOs suggested that budget management would have been more successful if purchasers had agreed budgets with PCOs consistently before the start of each contracting period.
- 5.30 Figure 13 on page 75 provides an example of how PCOs, working with PHARMAC, reduced the costs of prescribing one type of drug – antibiotics.
- 5.31 Figure 14 below illustrates improved prescribing practices in one large PCO, *First Health*. *First Health* also provides education about the appropriate absolute dosages of the medications, and supports this with feedback to its practitioners of comparative dosage data when this is available.

*Figure 14
Improving Prescribing Practice*



- 5.32 Subject to the purchaser's approval, a PCO may use any savings on pharmaceuticals to pay for:
- administration or infrastructure for new initiatives;
 - activities such as continuing education of GP members; and
 - providing local programmes such as sexual health programmes, programmes for the elderly, and community nurses attached to schools.
- 5.33 In some cases, savings have been used to reduce the co-payments required from patients.
- 5.34 A markedly different arrangement was negotiated in Southern with the PCO *Pegasus Health*. The main features of the arrangement – the Pegasus Global Budget, which covers General Medical Services and a range of referred services – are outlined in Figure 15 on page 78.

Funding of Additional Local Programmes

- 5.35 Many parts of the country have some additional programmes in primary health care designed to address specific health needs. Examples include:
- clinics in schools;
 - Marae-based GPs; and
 - pneumococcal vaccination of patients with chronic obstructive pulmonary disease.
- 5.36 However, the availability of such programmes has tended to depend on the availability of funding rather than any assessment of relative local needs. The type of contract operated between the purchaser and the PCO has, in turn, dictated availability of funding. More specifically, the extent to which individual PCOs that operate budget management have been able to make “savings” has been a determining factor, because savings are the main source of funding for these extra services.
- 5.37 There are three main ways that a PCO can make savings:
- Where the PCO chooses a budget management arrangement for pharmaceutical and laboratory expenditure, it is normally entitled under its contract to retain half or more of any savings.

continued at the top of page 79

Figure 15
The Pegasus Global Budget

Pegasus Health (formerly Pegasus Medical Group), established in 1992, represents 226 (more than 80%) Christchurch GPs, caring for 290,000 patients. It is a not-for-profit charitable company.



In 1999, the Health Funding Authority wished to quit its existing contract with Pegasus Health. The pharmaceutical contract had two years to run, but was favourable to Pegasus Health to an extent that was well beyond contracts available to other Primary Care Organisations. The Health Funding Authority and Pegasus Health negotiated a new contract.

The significant differences between the new contract with Pegasus Health and contracts with other Primary Care Organisations are the scope and extent of the funding and the way in which the funding is managed:

- The Global Budget is treated as a single fund to be used to meet all costs. Through its control of the Global Budget, Pegasus is able to allocate funds to those programmes (detailed in an agreed service plan) that it considers will best meet local needs.
- The baseline for the Pegasus Global Budget is \$73 million - including \$38 million for pharmaceuticals, \$9 million for laboratories, \$19 million for General Medical Services (including practice nurse subsidy) \$0.6 million for existing programmes, \$3 million for projects and services and \$1.4 million for administration. The budget is adjusted annually for volume changes (e.g. patient population, GP members) and changes in national forecast pharmaceutical expenditure.
- The Global Budget also includes \$3 million for managing acute demand (\$2 million in the first year). This income is "at risk" from the second year, and retention is dependent on success in managing the demand and subject to certain secondary care targets for reduced activity being met.
- Pegasus Health is the payment agent for its GP members and most referred services, e.g. laboratory diagnostics. The responsibility to monitor and audit payments also lies with Pegasus Health.
- Pegasus Health employs 70 staff in management, development and practice support roles - around half are directly involved in clinical support of GPs and practice nurses. All costs are ultimately met from the Global Budget.
- Pegasus Health is responsible for collecting and analysing data on health and community needs and identifying those needs that are best dealt with by GPs.
- Pegasus Health retains all savings from the Global Budget. It is required to produce an annual Global Budget Report that accounts for income and expenditure, but not for accumulated reserves. As at 30 June 2000, the total reserves of Pegasus Health were \$22.5 million - this included \$3.9 million arising from Global Budget income. For the years 30 June 2000 and 30 June 2001, Pegasus Health reported surpluses transferred to reserves of \$3.6 million and \$3.2 million (the latter including rebates, refunds and prior year adjustments) respectively. This money is available for Pegasus Health to spend on continuing Global Budget activity.
- The contract term was 27 months from 1 July 1999, extendable for a further nine months subject to satisfactory review of Pegasus Health performance against key performance indicators on developing, implementing, and evaluating a range of health-related services alongside its GP members. The Ministry engaged a contractor to undertake the review which was completed in July 2001, and found that Pegasus met 87% of the indicators, against a requirement to meet at least 70%. The contract was extended.
- The Pegasus Global Budget is being independently reviewed (see paragraph 8.7 on page 110).

- Where General Medical Services are being paid for by capitation funding, savings can accrue to individual practices if the actual costs of subsidised General Medical Services are lower than total Government funding. Lower costs may arise (for example) from using a wider range of health professionals or from lower patient visits or treatment needs as a result of effective health promotion activities.
- The Global Budget contract (see Figure 15 on page 78) combines principles of traditional budget management and capitation funding at a PCO level.

5.38 The availability of funds from savings is uneven because:

- not all PCOs have been offered capitation;
- for those offered capitation, the funding formula used depended on their geographical location;
- not all PCOs were offered budget management;
- not all PCOs had access to support tools such as up-to-date IT systems and timely expenditure data to influence behaviour;
- GPs who are independent or belong to loose networks (28% of all GPs in 1999) neither receive capitation funding nor operate budget management; and
- notional budgets for pharmaceuticals and laboratory services were based on historical use, so those areas where prescribing and laboratory referrals had historically been higher were allocated larger budgets, and therefore found making savings easier.

5.39 As a general rule, budgets that are set in relation to historical spending (rather than some measure of current health need) disadvantage poorer communities. Research evidence has shown that those populations in greatest need are those upon whom expenditure is least.³⁸ In those areas – from a health improvement perspective – PCOs might be looking to encourage increased patient contacts and increased prescribing, subject to identifying specific treatments and drugs that appear to be under-identified and under-prescribed.

³⁸ For example: *Towards A Comprehensive Demand-side Strategy for Pharmaceutical Management in New Zealand*, Professor Laurence Malcolm, July 2001.

Figure 16
Expenditure By Three Primary Care Organisations

Integrated Primary Care Services - West Auckland			Pegasus Health - Christchurch		
No. of GPs		91	No. of GPs		226
No. of Patients		125,000	No. of Patients		290,000
Ratio		1 GP to 1,374 patients	Ratio		1 GP to 1,283 patients
Expenditure	\$/patient	\$	Expenditure	\$/patient	\$
General Medical Services	54	6,800,604	General Medical Services	61	17,740,041
Pharmaceuticals	108	13,478,523	Pharmaceuticals	121	34,959,297
Diagnostic Services	26	3,302,860	Diagnostic Services	23	6,785,778
Practice and Administration -		\$/GP	Practice and Administration -		\$/GP
Practice Education	838	76,271	Practice Education	5,679	1,283,542
Information Technology	785	71,467	Information Technology	11,371	2,569,891
Practice Development	848	77,151	Practice Development	3,359	759,211
Corporate & Administration	5,600	509,608	Corporate & Administration	8,081	1,826,348
Local Initiatives comprising -			Local Initiatives comprising -		
Community Dietary Clinics		20,000	Population Health and Prevention		347,969
Terminal Care Visits		100,000	Health Promotion		306,026
Primary Options Acute Management		30,000	Patient Enrolment		9,622
Sub-specialisation Training		40,000	Immunisation		481,734
			Pneumovax		133,384
Total Local Initiatives		\$190,000	Smoking Cessation		261,717
		\$1.52/patient	Mammography		328,812
			Under 21s Sexual Health		604,296
			Maori Health		8,062
			Health Education		290,880
			Special Situation Benefit		119,704
			Hardship Fund		48,154
			Diabetes		12,157
			National Waiting Times		36,373
			Community Care Project		389,383
			After Hours Services		59,857
			Interim Funding Project		49,356
			Integrated Care		28,112
			Elder Care Canterbury		135,820
			Child Health		87,072
			GP in Emergency Department		34,707
			Surgical Care Project		96,736
			Access to ECHO		17,535
			GP Minor Surgery		1,419
			Mental Health		66,596
			Prescribing Review		12,765
			Counselling Project		26,022
			Palliative Care		8,324
			Sexual Abuse		10,511
			Maternity		20,688
			GP Design Team		12,613
			Call Line		21,686
Total Local Initiatives		\$447,355	Total Local Initiatives		\$4,068,092
		\$3.20/patient			\$14.03/patient
Wellington Independent Practice Association					
No. of GPs		112			
No. of Patients		140,000			
Ratio		1 GP to 1,250 patients			
Expenditure	\$/patient	\$			
General Medical Services	41	5,758,677			
Pharmaceuticals	108	15,187,822			
Diagnostic Services	30	4,171,487			
Practice and Administration -		\$/GP			
Practice Education	1,304	146,000			
Information Technology	1,045	117,000			
Practice Development	464	52,000			
Corporate & Administration	3,420	383,000			
Local Initiatives comprising -					
Diabetes		132,956			
Mental Health		103,648			
Models of Care		138,187			
School Clinics		47,759			
Preferred Medicines		14,743			
Socio-economic Status		10,062			
Total Local Initiatives		\$447,355			
		\$3.20/patient			

Pharmaceutical expenditure is based on reimbursement cost. The above data is the most comparable we could obtain, but, because of different mark-up and management fee structures between regions, the figures shown may not be strictly comparable. A similar caveat applies to the patient data because different PCOs may take different approaches to calculating patient rolls. The "Practice and Administration" figures for Pegasus include indirect expenses incurred in supporting development and delivery of local initiatives.

5.40 This historical basis for budgeting can lead to wide differences in the services offered to patients, depending on:

- the extent to which the PCO that a GP belongs to has been able to make and retain savings; and
- the terms of the contracts, which may be difficult to alter.

5.41 Figure 16 on the previous page illustrates the expenditure (for the year ended 30 June 2000) of three PCOs that offer different services to their patients. One of the three, *Pegasus Health*, is funded on the basis of the markedly different arrangements described in Figure 15 on page 78. The *Pegasus* Global Budget includes funding for GP-based initiatives for health promotion and improved integrated care (integration, that is, between primary and secondary health care). The local initiatives provided by *Pegasus Health* include:

- certain post-operative care for patients provided in general practice rather than the hospital outpatient clinic;
- a five-bed observation unit staffed 24 hours a day to provide an alternative to hospital admission for some categories of patients;
- extended care at home or rest home, led by the patient's own GP team and providing a Mobile Extended Care Support Unit for diagnostic support;
- arrangements to encourage frequent attenders at the hospital's emergency department to make appropriate use of general practice; and
- free sexual health consultations to under 21s (since extended to people aged under 25).

Development of Population-based Funding

5.42 There is currently no national needs-based formula for funding primary health care. However, a national contract signed by PCOs in 2000 (see paragraphs 6.3 to 6.5 on page 87) signalled the Government's intention to develop national formula for primary health care that will take account of health needs indicators (such as population deprivation).

5.43 The HFA had undertaken some related work to develop, test and deliberate on approaches to capitation payments to GPs for General Medical Services and practice nurse services. This work resulted in the development of three formulas:

- one was similar to the current Midland formula (Figure 12 on page 74); and

- the other two used the New Zealand Deprivation Index as a measure of socio-economic status, and one of these also used the Community Services Card and High Use Health Card as such measures.

5.44 The HFA modelled the formulas using a large sample of patient registers – showing the effects of the formulas by region, demographic groups, and PCOs. For all three formulas, a common effect of applying them was shown to be a shift of funds from the more affluent to relatively deprived areas. More specific results included:

- net losses to Southern and net gains to Central;
- increases in funding of up to 14% for the most deprived areas; and
- areas with high numbers of Community Service Card holders gaining most from the formula that included the New Zealand Deprivation Index as a variable.

5.45 The Ministry has concluded that its preferred formula is the one that includes both the New Zealand Deprivation Index and the numbers of Community Services/High Use Health Card holders. The Ministry is still considering how the model can take account of ethnicity.

5.46 In addition, the Ministry is looking at how new funding announced in December 2001³⁹ can be further targeted at communities with the greatest level of deprivation.

Population-based Funding – Views of Providers

5.47 Those PCOs that we spoke to supported in principle population-based funding and a consistent capitation funding model for General Medical Services. However, they had reservations about the practicality of the national formula being developed. In particular:

- Compulsory patient enrolment – or at least much wider enrolment than currently – would be essential for effective implementation of a population-based formula. However, the Primary Health Care Strategy (paragraphs 2.40 and 2.41 on pages 42-43) envisages continuing with voluntary enrolment.
- PCOs were concerned that the proposed formula might prove too complex to administer. It is more complex than those used for the Pegasus Global Budget and in other areas (including Midland and Central). They favoured starting with the Midland model and developing the formula over time. The DHBs and PCOs in Northern are reviewing their capitation funding and budget management arrangements with a view to adopting a simpler model as an interim measure before moving to a national formula.

³⁹ Ministry of Health press release – 10 December 2001.

- Full application of a national funding formula would require additional funding for primary health care for currently unmet needs – for example, to provide increased access to groups with high health needs who currently tend to make low use of primary health care (see Figure 11 on page 73).

Recommended Future Action

5.48 A number of principles should underpin future funding of General Medical Services:

- A more consistent funding model should continue to be developed on the basis of population health needs, as a means of improving the ability to meet the policy objective of equity.
- The Ministry should be clear about its goals in terms of equity, and the associated cost. A nationally consistent funding formula should increase equity, but is likely to be more expensive than current arrangements – unless large transfers of resources are made between different parts of the country.
- The Ministry should identify all key success factors relevant to its preferred funding approach. Where an important policy area such as compulsory registration of patients is a key success factor for the preferred approach, the feasibility of that approach (should the key success factor not be in place) needs to be reviewed.
- Funding mechanisms should take account of their costs to both purchasers and providers, and the need for both to have information systems and infrastructures capable of underpinning them. A complex formula could prove difficult for both to administer, and would make little sense if it were based on data of variable quality.
- As long as different funding formulas are still being used locally, PCOs covering more than one purchaser's area will continue to incur higher administrative costs than if they had only a single formula to administer.
- Any new funding arrangements should take full account of past experience of capitation funding, and be developed in consultation with people who understand the delivery of primary health care. The piloting of the proposed national funding formula using a sample of patient registers (paragraph 5.44 on pages 81-82) is an important step.
- A relatively simple national formula would be unlikely to fully reflect all major health needs. DHBs should identify and assess any exceptional local health needs, and the extent to which they are already reflected in the funding formula. Where they are not sufficiently reflected, they should consider a separate funding arrangement for an additional service – based on an assessment of need and potential health gain from providing the service.

Part 6

Contracting

What We Looked At

- 6.1 *We looked at whether there were good-quality contractual relationships between purchasers and providers that enabled both parties to focus jointly on health objectives. These relationships, and the contracts supporting them, should also secure agreement on:*
- *quantity and quality of services to be provided; and*
 - *how the quantity and quality of services will be measured.*

What Are the Contractual Arrangements?

- 6.2 From 1993, the RHAs began to work with PCOs to develop and negotiate new contractual arrangements. Each RHA operated independently, which had the advantage of allowing innovation. However, it also led to a range of differences, particularly in respect of funding (which, as described in Part 5, can affect the services available to patients). The HFA therefore inherited arrangements with a range of infrastructures, contracts and incentives.
- 6.3 One of the aims of the HFA was to make contracting between the regions more consistent. To this end, it set about negotiating a standard national contract specifying the terms and conditions on which the purchaser would contract with the PCO for the provision of services.
- 6.4 A national primary care team mainly undertook the negotiations for the national contract. The team approach enabled some pooling of primary health care knowledge and expertise, thereby mitigating the capability problems experienced in relation to local contracting that we described in Part 3 (paragraphs 3.2 to 3.16 on pages 47-49). PCOs facilitated the negotiations by establishing a national body – the Independent Practitioner Association Council, which represents the majority of, but not all, PCOs.
- 6.5 There are a number of types of PCO (as indicated in Appendix 1 on pages 128-129). Many PCOs signed the HFA's standard national contract in 1999. Nevertheless, differences still exist in relation to:
- the method of claiming for General Medical Services (capitation or fee for service);
 - whether GPs operate budget management for expenditure on pharmaceuticals and diagnostic tests; and
 - what services additional to General Medical Services that GP members of PCOs provide.

6.6 Therefore, the arrangements for contracting for primary health care provided by GPs remain complex. The complexity arises out of the fact that there are different types of organisations, they provide different management services, and they operate under different types of contract and funding. Few people would be aware of the consequences of these differences for the services likely to be available to them when they register with a GP.

The Form of Contract

6.7 In a normal commercial situation, parties' rights and obligations are determined by the nature of their contractual relationship. Health care is also purchased using a contracting model, but there are other critical influences on the relationships between the parties – most importantly, legislation and public expectations about accountability for the use of taxpayer funds.

6.8 Purchasers' contracting with PCOs closely follows the commercial contracting model. Most contracts are over 100 pages long and have been written with a view to covering every possible eventuality.

6.9 Many PCO staff admitted to us that they had not read the whole document. Several said that HFA staff had suggested that they ignore sections not applicable to them. The PCO staff considered this approach undermined the credibility of the contract. They generally favoured a much shorter contract reflecting a partnership relationship between themselves and the purchaser.

6.10 The contracts are between the purchaser and the PCO, but they also contain terms which:

- the PCO is required to insert into its contracts with its GP members; and
- enable the purchaser to take enforcement action against GPs.

6.11 The contracts are also designed for PCOs whose GP members have their own patient registers. But the contracts do not fit well with community-owned PCOs, which hold their patient registers centrally. These PCOs were concerned that this could have implications for ownership of the patient register where a GP leaves the PCO.

6.12 The contracts are in three parts:

- a Head Agreement;
- General Terms; and
- a Service Delivery Agreement.

6.13 The first two parts are the same for all signatory PCOs.

Service Delivery Agreements

- 6.14 The Service Delivery Agreement generally remains in force for one year. It covers General Medical Services funding and (where relevant) notional budgets for budget management for prescribing and laboratory services, and details of any additional services to be provided. The HFA's work on a national contract (see paragraphs 6.3 to 6.5 on page 87) achieved some improvements in consistency, such as common descriptions of services.
- 6.15 However, there are a number of problems with the Service Delivery Agreements, as described in the following three paragraphs.
- 6.16 First, the short duration of the agreement – exacerbated by negotiations that can take 3 to 6 months and the effort that such negotiations require – reduces the time available to develop local programmes and assist GPs to improve their practices. The burden of annual renegotiation is not helped by the high turnover of locality managers that we describe in Part 3 (paragraphs 3.2 to 3.4 on page 47) – with new managers needing time to become familiar with previous negotiations before they begin a new round.
- 6.17 Inclusion in the agreement of detailed administrative requirements also lengthens the contract with material that could just as easily be agreed outside the contracting process. This would mean that alterations would not require a change to the contract. One reason given for such detailed contracts was the high turnover of locality managers – with PCOs wanting to formalise details because of likely key personnel changes in the future.
- 6.18 Important agreement terms – such as funding approaches and provisions for retaining savings – differ widely between PCOs. These differences are the product of an inconsistent approach by locality managers in negotiating the agreements, given that they were working without clear objectives or guidelines to support their negotiations. Figure 17 on the following page illustrates the terms of agreements with three PCOs – two with similar terms and one (*Pegasus Health*) for which the terms are very different.

Quantity and Quality of Services

- 6.19 The concept of quantity of services provided is relatively straightforward – for example, the capitation funding model envisages that GPs will provide all required General Medical Services for certain numbers of patients.
- 6.20 However, the contracts we examined lacked focus on the quality of services. The contracts required GPs belonging to PCOs to comply with the guidance of The Royal New Zealand College of General Practitioners (the RNZCGP). But the specified guidance was still being developed in a initiative that was partly funded by the HFA.

Figure 17
Key Features of the Service Delivery Agreements
with Three Primary Care Organisations

Wellington Independent Practice Association	First Health	Pegasus Health
		
<ul style="list-style-type: none"> • One year agreement 	<ul style="list-style-type: none"> • One year agreement 	<ul style="list-style-type: none"> • 27 months from 1 July 1999, extended for a further 9 months subject to satisfactory evaluation
<ul style="list-style-type: none"> • Termination with 12 months written notice or 6 months if part of agreement terminated 	<ul style="list-style-type: none"> • Termination with 12 months written notice or 6 months if part of agreement terminated 	<ul style="list-style-type: none"> • No termination prior to end of term
<ul style="list-style-type: none"> • Provision to re-negotiate service schedules 	<ul style="list-style-type: none"> • Provision to re-negotiate service schedules 	<ul style="list-style-type: none"> • No provision to re-negotiate service schedules
<ul style="list-style-type: none"> • Provision for purchaser to withhold payment in certain circumstances 	<ul style="list-style-type: none"> • Provision for purchaser to withhold payment in certain circumstances 	<ul style="list-style-type: none"> • No provision for purchaser to withhold payment
<ul style="list-style-type: none"> • Purchaser responsible for claims and information audits 	<ul style="list-style-type: none"> • Purchaser responsible for claims and information audits 	<ul style="list-style-type: none"> • Provider (i.e. Pegasus Health) responsible for claims and information audits
<ul style="list-style-type: none"> • Fee for service for General Medical Services • Fee for service for practice nurse subsidy, plus subsidy according to sessions provided • Fee for service for immunisations 	<ul style="list-style-type: none"> • Capitation funding for General Medical Services with fee for service for casual patients • Capitation-related practice nurse subsidy, plus subsidy according to sessions provided • Fee for service for immunisations 	<ul style="list-style-type: none"> • All services funded through Global Budget negotiated with the purchaser - includes funding for pharmaceuticals, laboratories and maternity, and agreed local programmes (see Figure 15). The components of the budget cannot be readily separated.

6.21 At the time of our examination the RNZCGP was testing its *Practice Accreditation* process for general practice. The accreditation deals with:

- factors affecting patients;
- environmental processes;
- practice systems;
- patient and practice information management;

- quality assurance; and
 - professional development and assessment processes.
- 6.22 The RNZCGP is currently exploring how to spread the take-up of the accreditation process, together with measures to ensure that it is adequately funded.
- 6.23 The contracts also required the HFA to work with PCOs to define and agree quality specifications for areas such as quality management, employee training, and clinical audit. We were unable to find examples of such activities involving the HFA.
- 6.24 However, some PCOs were developing initiatives relating to quality of services independently of the purchaser and outside the contract. For example, *Health Care Aotearoa* has developed quality standards and an accreditation programme for community services. These standards are broader and not specific to general practice, but they are being used by some PCOs to help practice staff to focus on achieving high-quality teamwork and close community links.
- 6.25 This accreditation programme has been discussed and agreed with the RNZCGP. Both the programme and the awarding of accreditation (through the Australian Quality Improvement Council – involving education and internal assessment, on-site review, feedback, and improvement actions) are also available to non-members of *Health Care Aotearoa*.
- 6.26 We provide further examples of PCOs’ work on quality of services in Part 7 on *Monitoring* (paragraphs 7.15 to 7.22 on pages 99-101).
- 6.27 One PCO we visited (*South Link Health*) considered that its contract for maternity services provided a good model for the type of contract that would also work well for General Medical Services. Figure 18 on the following page sets out the main elements of the contract.

Recommended Future Action

- 6.28 Contracting arrangements should reflect strategic health objectives. For example:
- If the objectives envisage a consistent standard of certain types of health care, the contracting arrangements need to be designed to achieve this – with appropriate, consistent guidance to those negotiating the contracts.
 - Many PCOs are innovative. There is no reason why a more consistent contracting approach cannot continue to support innovation within the framework of strategic health objectives – with an emphasis on services to meet high-priority health needs and activities that (if effective) may be extended to other patient populations.

Figure 18
 Example of a Contract Style That Might Suit
 Primary Health Care Contracting

The contract is the **Maternity Services Agreement with South Link Health**. Key features of the contract are:

- ★ it is relatively short and concise
- ★ it sets out clearly the relationships between the parties
- ★ the position of **South Link Health** and that of its members in relation to the agreement is clear
- ★ general provisions cover important matters - such as the process for amending the agreement, disagreement resolution, compensation, access to premises and records, and compliance with the Treaty of Waitangi
- ★ purchase list and payment terms are clear
- ★ service specifications refer to components of the service
- ★ organisational quality standards deal with important matters - such as hygiene and relationships with patients, including dealing with complaints
- ★ requirements for information systems and reporting are clearly set out.



6.29 The current form of contract needs to be reviewed, taking account of the views of locality managers and PCOs. Any such review needs to be undertaken in a cost-effective way, avoiding duplication of costs among DHBs.

6.30 The primary health care contract should reflect the public law context in which it operates, with the objects of avoiding an unduly legalistic approach and keeping compliance costs to a necessary minimum. The contract (or contracts) should focus on:

- health objectives, outcomes, and outputs that primary health care providers and the purchasers wish to achieve;
- the responsibilities of each party for securing the proposed achievements;
- how performance will be assessed; and
- the obligations to Parliament and the public to report on how effectively and efficiently funds are spent to achieve health outcomes.

- 6.31 It is important that contracts reflect the relationship between the purchaser and the PCO, the structure of the PCO, and how the PCO relates to its members. A review of the current contract should also consider the term of the Service Delivery Agreement – including the feasibility of a term for PCOs that extends beyond one year.
- 6.32 Purchasers and providers should engage more with each other on quality of service matters. PCOs, their GP members, and professional organisations are concerned with improvements in quality. DHBs (assisted by the Ministry) need to increase and broaden their participation in quality matters in primary health care. A number of key principles should guide the engagement:
- The respective roles of purchasers and providers in relation to quality of services should be made clear.
 - Both parties should address themselves to the whole range of quality assurance processes being operated – so as to develop a shared understanding of quality monitoring and improvement.
 - The Ministry should provide a way for work being done within New Zealand to be shared among different purchasers and providers – so as to maximise the benefits of good practice.
 - The Ministry should draw on international practice (where appropriate) to promote progress with the introduction of quality of service initiatives, since a lot of innovative work is being done internationally on the improvement of primary health care services.
 - DHBs should develop a strategy on quality of primary health care that is based on a clear understanding of general practice and draws on national and local priorities for meeting health needs. The strategy should guide all aspects of its approach to quality improvement – including targeted and consistent data collection for focused analysis.
 - Clinical audit should form part of the quality strategy, which we discuss further in Part 7 (paragraphs 7.19 to 7.27 on pages 100-104).

Part 7

Monitoring

What We Looked At

7.1 *We looked at the evidence of whether purchasers were adequately monitoring the contracted quantity and quality of services being delivered.*

7.2 *Purchasers can monitor service delivery in two main ways:*

- *by undertaking the monitoring themselves by seeking and auditing information provided by PCOs; or*
- *by requiring the PCOs to undertake the monitoring directly, with sufficient review of the monitoring by purchasers to ensure that it is being properly carried out.*

Monitoring Quantity

7.3 The main source of information for monitoring the quantity of services is Health Benefits. Health Benefits audits the validity of the claims it receives, including the validity of capitation payments based on numbers of registered patients.

7.4 We examined the methodology used for these audits in 1997 and found it to be largely effective.⁴⁰ Health Benefits staff whom we spoke to for the purpose of this examination were concerned about the gaps in coverage of their data. The concern stemmed from the fact that Health Benefits was not receiving data on General Medical Services consultations from some practices with capitation funding (because the GPs concerned are not able to claim the cost of visits).

7.5 Since completing our field work, a new requirement to supply this information to Health Benefits has been established. One exception to this requirement is *Pegasus Health*. Under the terms of its contract, *Pegasus Health* itself (not Health Benefits) is responsible for undertaking claims and information audits of its practitioners. This is subject to:

- *Pegasus Health* adopting an equivalent programme to that used by Health Benefits for identifying dishonesty or fraud among practitioners;
- *Pegasus Health* obtaining the purchaser's approval to the programme and reporting requirements; and
- the purchaser retaining the right to undertake the audit itself if there is good reason to believe that patient care or patient rights are compromised by practitioners' failure to meet the terms of the contract.

7.6 Though the purchasers have approved the programme and reporting used by *Pegasus Health*, the Ministry confirmed that the extent to which *Pegasus Health* is undertaking the programme has not been independently reviewed.

⁴⁰ *Health Benefits – Detecting and Preventing Invalid Claims – Fourth Report for 1997, parliamentary paper B.29[97d], pages 43-60.*

- 7.7 As we discuss in Part 4 (paragraph 4.6 on pages 54-55 and Figure 8 on page 54), the information collected by Health Benefits focuses on services provided and claimed for. The information provides a measure of take-up of services, but is not intended to be an indicator of either health needs or outcomes.
- 7.8 In addition to the payment data (as we also explain in Part 4), PCOs are required to submit data and narrative reports on their contracts to the Shared Services Support Group. We have outlined the problems with this information and the limited use made of it (paragraphs 4.33 to 4.37 on page 62).
- 7.9 In practice, there has been minimal monitoring of the services provided in primary health care. The HFA attributed its poor performance to the time and effort required to develop a standard national contract (paragraph 6.3 on page 87). Service monitoring was to have been properly established as part of the implementation of this contract.

Monitoring Quality

- 7.10 Locality managers and PCO staff meet periodically to discuss services. These meetings also offer a potential opportunity to discuss the quality of services provided. The frequency of these meetings varied between areas. In some cases, they were held solely for negotiating contracts. In others, locality managers attended meetings monthly.
- 7.11 It is not clear to what extent these meetings enabled purchasers to review the quality of services delivered – although the PCOs considered the meetings were useful. However, the PCOs saw their main value in ensuring that locality managers understood the primary health care sector and gained an insight of local health needs from practitioners.
- 7.12 The data collected by the Shared Services Support Group includes disease state management data (such as the information on diabetes outlined in Appendix 5 on pages 135-136) that would be useful in assessing health needs. We found little evidence of purchasers using this information, and no evidence of it being examined at a national level.

Future Monitoring by DHBs

- 7.13 A review (by the Ministry's internal audit team – reported in July 2001) of audit and monitoring functions across the health sector concluded that current audit functions lacked a consistent approach and did not represent an effective and efficient use of resources. Our examination supports this conclusion. The internal audit report:
- identified risks associated with the transition to 21 DHBs, including capacity to perform audit and monitoring functions, especially in the short term; and

- noted the importance of ensuring –

...a smooth hand-over of audit and monitoring responsibilities to District Health Boards without loss of expert knowledge about individual providers and about audit and monitoring methods.

7.14 When we consulted The Royal New Zealand College of General Practitioners on the draft of this report, the RNZCGP noted that it shared these concerns. Knowledge about general practice and primary health care within DHBs will inevitably guide their future approaches to primary health care purchasing. The RNZCGP said that establishing the existing level of knowledge was difficult, and that it was concerned about “the level of knowledge and information reaching DHBs which will guide their approach to purchasing primary health care”.

Monitoring by PCOs

7.15 PCOs’ monitoring of their own member GPs is directed mainly to what is required to manage notional budgets. This involves elements of quality monitoring – such as through reviews of prescribing by:

- using information supplied by PHARMAC;
- providing GPs with reports comparing their prescribing with the prescribing patterns of other GP members; and
- visiting GPs to discuss prescribing practices and issues.

7.16 However, PCOs in Northern were unable to perform this kind of review, since PHARMAC was unable to provide them with accurate prescribing data relating to their members.⁴¹ Northern PCOs’ monitoring, therefore, focused mainly on the achievement of local programmes.

7.17 Generally, PCOs also organise continuing medical education for their members and facilitate groups of GPs for the purpose of peer review of individual clinical practice.

7.18 Figure 19 on page 100 outlines the comprehensive monitoring arrangements that *First Health* has established. The arrangements:

- include features of continuous improvement designed to support GP members in improving the care they provide to patients; and
- are underpinned by the requirement for GPs to produce annual quality reports that include indicators of the health needs of the patient population.

⁴¹ Northern was the most affected by the problems with the *pharmhouse* database described in paragraph 4.15 on page 57.

Figure 19
First Health's *Monitoring of Behalf of its GP Members*



First Health has developed monitoring arrangements comprising:

- **12 performance targets** that were agreed with the Health Funding Authority:
 - child immunisations;
 - influenza vaccination;
 - cervical screening;
 - breast screening;
 - cardiac disease prevention;
 - suicide prevention;
 - hypertension (high blood pressure) management;
 - practice nurse development;
 - consumer satisfaction;
 - quality reporting;
 - information collection; and
 - management of patient registers.
- A **clinical management committee** within each GP network that selects which targets should be measured, reflecting the characteristics of the patient population - **its health needs** and highest priority **health outcomes**.
- Practices working with the **network co-ordinator** (a member of staff of the PCO) towards **meeting their targets** and monitoring whether they have been met.
- Further analysis by PCO staff to compare the **performance of different GP networks**, and to discuss with them the results of these analyses with a focus on understanding local circumstances and how difficulties can be overcome to improve performance, using the experience of other GP networks.

Clinical Audit

7.19 Purchase contracts generally make PCOs responsible for clinical audit among their GP members. The purpose of clinical audit – as part of routine practice for all health care professionals – is to improve the quality of patient care. Clinical audit seeks to –

...improve the quality and outcome of patient care through structured peer review whereby clinicians examine their practices and results against agreed standards and modify their practice where indicated.⁴²

7.20 The HFA did not look at whether PCOs were undertaking clinical audit. We found instances of clinical audit being undertaken – for example, clinical audits of diabetes management in Midland and Northern.

⁴² *Clinical Audit in the NHS*, UK National Health Service Executive, 1996.

- 7.21 Best practice in diabetes management is well documented, making it a good subject for clinical audit. The audits in Midland and Northern involved checking the medical files of diabetic patients to ensure that the treatment and management of their diabetes was appropriate.
- 7.22 Figure 20 below and Figures 21 and 22 on the next two pages provide examples of clinical audits of, respectively:
- diabetes care, undertaken by *South Med Limited*;
 - prescribing for geriatric patients, undertaken by *Wellington Independent Practice Association Limited*; and
 - the treatment of bronchiolitis (cough and wheeze) in children under the age of one year, undertaken by *South Med Limited*.

*Figure 20
A Clinical Audit of Diabetes Care*

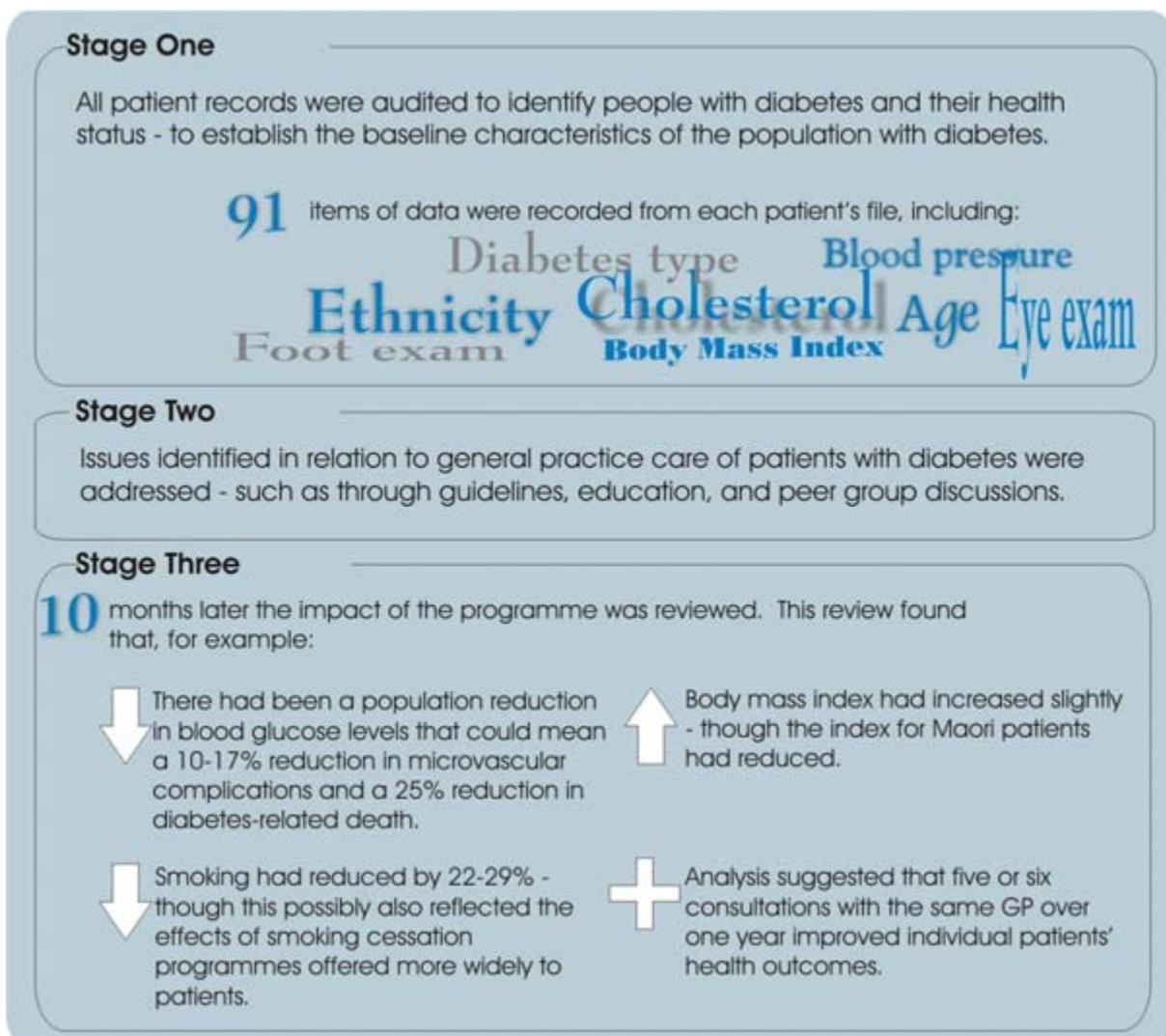


Figure 21
A Clinical Audit of Prescribing for Geriatric Patients

Why audit prescribing for geriatric patients?

- 1 The elderly are particularly vulnerable to adverse drug effects and drug interactions because of changes in the body as people get older.
- 2 The elderly also tend to be prescribed a range of different medicines because they suffer from more different kinds of illness and disease.
- 3 Every medicine that the elderly are prescribed therefore needs to be both necessary and appropriate for the individual.
- 4 While some adverse effects have minimal consequences, others result in hospitalisations, falls, and fractures - serious consequences that are likely to result in loss of independence. Such effects are also costly for the country.

The audit

A clinical audit of geriatric prescribing was developed by the Wellington Independent Practice Association in 1998-99 and approved by The Royal New Zealand College of General Practitioners. The audit was repeated in 1999-2000.

Purpose of the audit

- to focus attention on prescribing for geriatric patients;
- to identify any recurring problems to be addressed by continuing education; and
- to reinforce the need for:
 - ➔ regular review of each prescribed drug - to check that the patient still needs it and that it is still working;
 - ➔ monitoring those drugs that require it;
 - ➔ monitoring of the patient's renal function; and
 - ➔ other biochemical and clinical monitoring as necessary.

Audit method

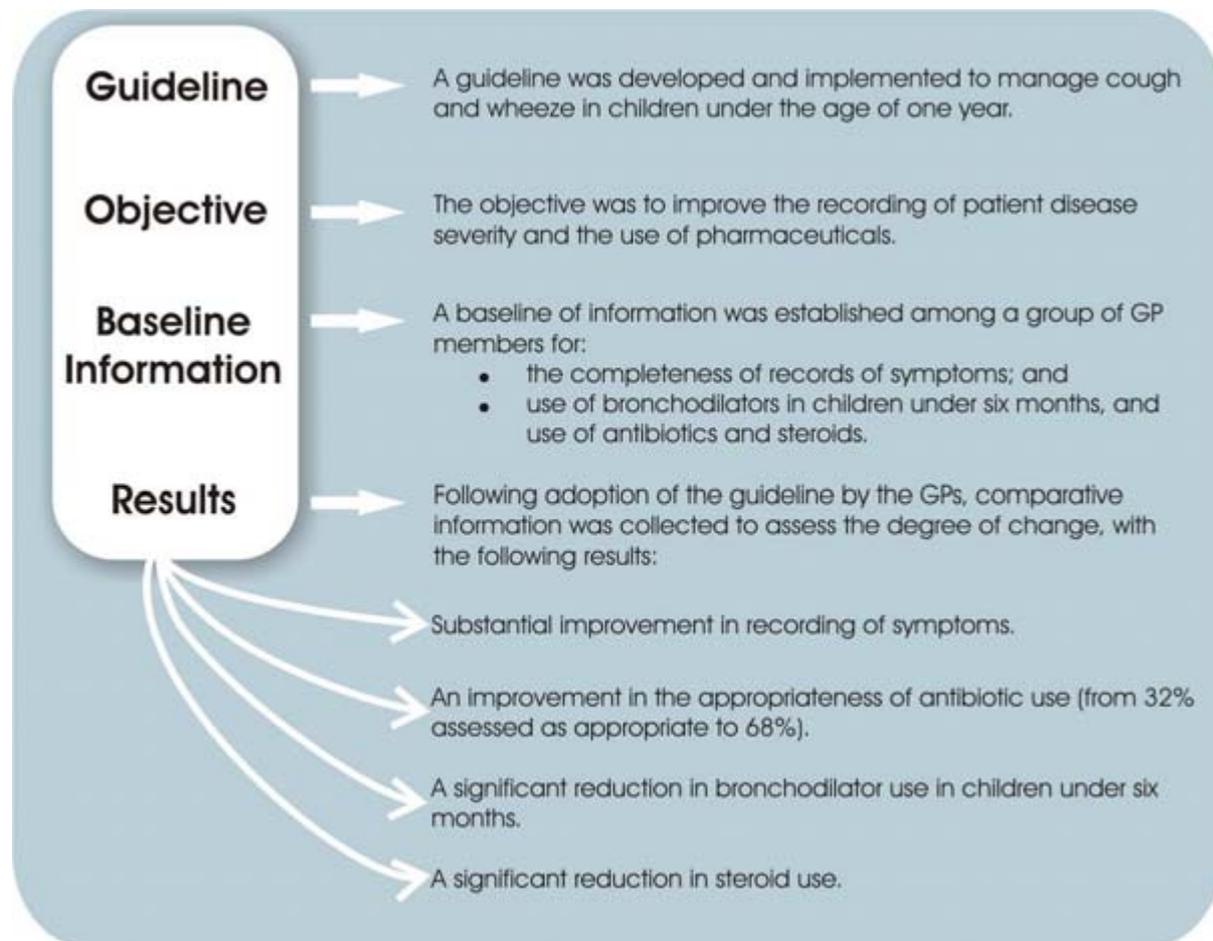
Each GP was asked to audit 10 patients who were 65 years or older who were currently taking 4 or more medicines. If a GP did not have 10 patients who met these criteria, WIPA audited all that qualified.

Each medicine regime was reviewed for drug interactions.

Resulting actions

- ➔ written comments about their audits sent to each GP, together with a bulletin on Geriatric Prescribing;
- ➔ continuing education workshops held;
- ➔ audited case discussions held by GPs in peer groups; and
- ➔ a pharmacist facilitator discussed results with GPs.

Figure 22
A Clinical Audit of the Treatment of Bronchiolitis



Privacy Considerations

7.23 A common concern expressed to us related to patient privacy and confidentiality. Many clinical audits involve examination of the appropriateness of the treatment given to individual patients, so a detailed examination of their medical records is an essential part of the process. It was suggested that the application of privacy rules might prevent clinical audits.

7.24 This issue was raised in the report of the WAVE project (paragraphs 4.40 to 4.43 on pages 63-64), which suggested that privacy legislation needed to be better understood by the health sector. It stated that:

There are many misconceptions: the [privacy] legislation is not about keeping things private or 'secret' but, instead, about ensuring information is used consistently with the purpose for which it was obtained and that it is understood by those from whom it was obtained. The Privacy Act is often blamed, incorrectly, for the withholding of information when this has nothing to do with the legislation...

- 7.25 The report’s recommendations included measures to improve awareness of privacy and correct application of privacy and confidentiality principles.
- 7.26 We raised the issue of privacy directly with the Privacy Commissioner. He pointed out that “health agencies” (which include, among other bodies, both PCOs and GPs) are subject to the Health Information Privacy Code in respect of health information.⁴³ The Code sets out clear rules relating to health information that are applicable to clinical audits. We reviewed the Code and concluded that it allows for clinical audits, so long as those undertaking the audits correctly apply the Code.
- 7.27 But the Health Information Privacy Code applies not just to clinical audits. It applies to all activities of health agencies involving the collection, use, and disclosure of personal health information. To operate most effectively within the Code, PCOs and GPs therefore also need to communicate clearly to patients their policies concerning personal health information.

Recommended Future Action

- 7.28 We believe that past difficulties in building and maintaining knowledge and experience of primary health care purchasing are strongly associated with the failure of the purchasers to make progress in developing meaningful monitoring. It is important to address this risk in the new environment. We make the following recommendations.
- 7.29 The Ministry should establish the information and capability needed to monitor primary health care providers. It should do so alongside an information and capability assessment for other purposes, e.g. health needs assessment. The Ministry should take account of the views and expertise of key stakeholders/interested parties (such as DHBs and PCOs) and bodies such as the RNZCGP and the IPA Council.
- 7.30 The Ministry should ensure that the various monitoring responsibilities are clear. As far as possible, monitoring should take place close to service delivery – but with the important proviso that monitoring and audit expertise should not be diminished by breaking the expertise up into non-viable units. Where a PCO is responsible for claims and information audits of its practitioner members (as with *Pegasus Health*), the purchaser should regularly assess whether the audits are undertaken and, if so, that they are effective.
- 7.31 Some PCOs have taken steps to monitor the performance of their own members. Where these arrangements are working well, a DHB’s monitoring activity should focus on ensuring that the PCO’s monitoring is reliable, and on using the results to improve its own purchasing strategy and capability.

⁴³ The Health Information Privacy Code 1994 applies to health information about identifiable individuals collected or held by health agencies. The rules of the Code are enforceable by complaining to the Privacy Commissioner and (if necessary) in legal proceedings before the Complaints Review Tribunal. There may be financial and other consequences for agencies that breach these rules.

- 7.32 DHBs should engage with providers on the clinical audits they undertake. A DHB needs to develop its own capability to the point where it can influence the choice of clinical audits to ensure that clinical audit programmes reflect the DHB's health and purchasing priorities.
- 7.33 DHBs, PCOs and GPs should work together to ensure that fears about patient privacy do not prevent effective audits of clinical care being carried out. And all those involved should ensure that clinical audits are undertaken in a manner that complies with the rules of the Health Information Privacy Code relating to personal health information, so that patients can be assured that their medical records are safe.
- 7.34 The Ministry should establish how it can best help DHBs to make progress. For example, it might facilitate sharing of information on improvements and innovations in monitoring and clinical audit.

Part Eight

Evaluation

What We Looked At

- 8.1 *We looked at the extent to which arrangements for the purchase and delivery of health care services had been evaluated to ensure that the arrangements were effective. In the context of primary health care, the arrangements that should be evaluated include:*
- *allocation of funding between General Medical Services, local programmes, and national programmes, relative to identified health needs;*
 - *the purchasing function; and*
 - *the role of PCOs as “managers” of primary health care provision.*
- 8.2 *We also expected that key primary health care programmes would be evaluated to establish whether they addressed identified health needs, and whether the programmes should be replicated in other areas.*

Evaluation of Service Delivery

- 8.3 There has been limited evaluation of the purchase and delivery of health care services – notwithstanding the introduction in recent years of alternative funding approaches (e.g. capitation) and structures (e.g. the replacement of the four RHAs with the HFA).
- 8.4 The Treasury and the Ministry did commission a joint review of the development of PCOs.⁴⁴ The purpose of the review included:
- to develop a descriptive overview, classification, and preliminary analysis of PCOs;
 - to identify the gaps in information needed to evaluate PCOs; and
 - to provide insights into the possible future of PCOs within the New Zealand health system.
- 8.5 The review identified major areas requiring development, including:
- implementation of population-based funding and capitation, as a way of addressing major inequities in primary health care utilisation and expenditure between areas;
 - better information and information systems;
 - greater community participation; and
 - improved governance and management.

⁴⁴ *The Development of Primary Care Organisations In New Zealand* (see footnote 10 on page 19).

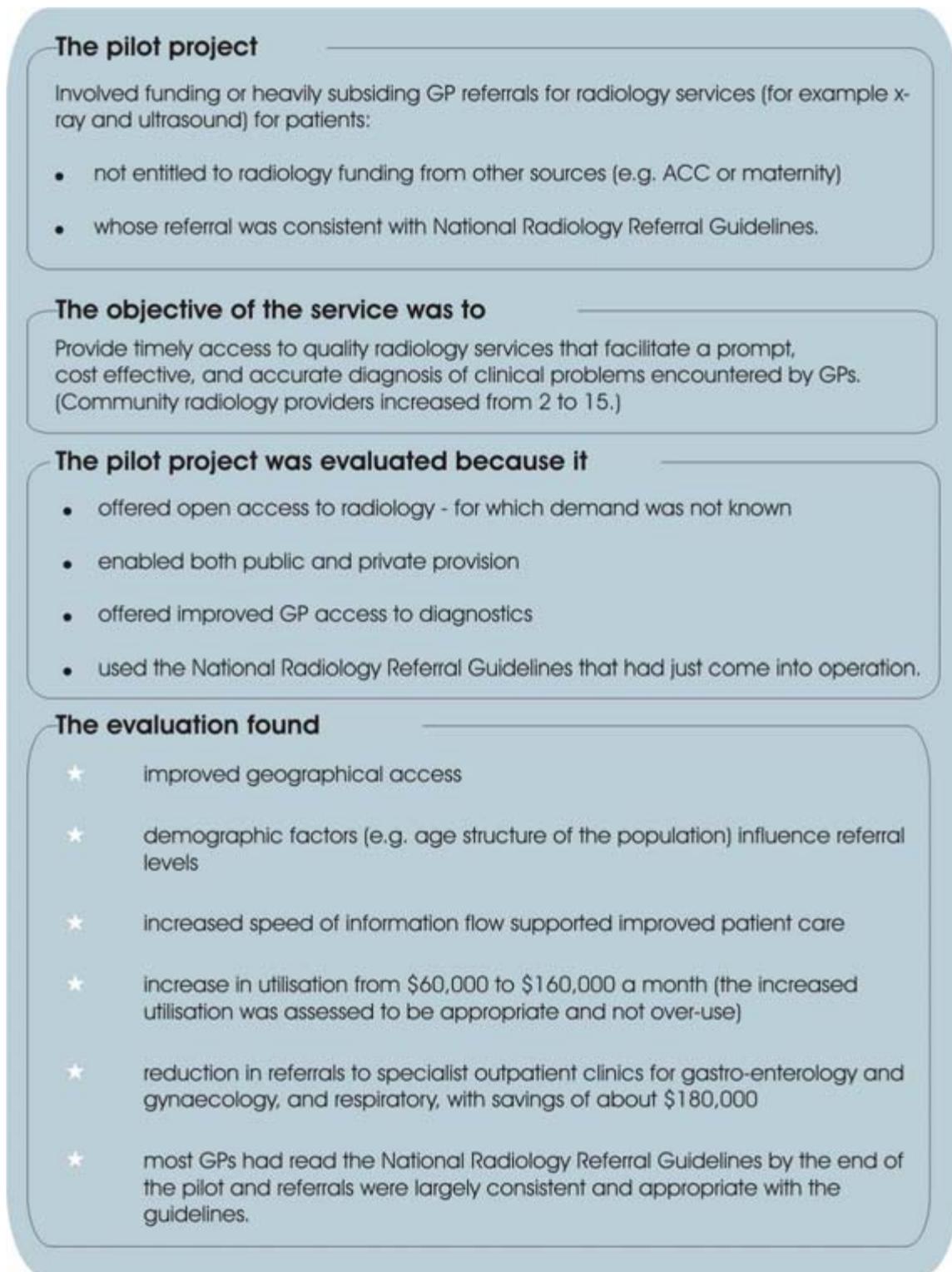
- 8.6 The review recommended a national health care strategy to reinforce the need for, and the opportunity to establish, a national primary health care policy and strategy. Both strategies have since been developed (see paragraphs 2.37 to 2.41 on pages 42-43). The review also suggested a need for a national strategy to promote a major expansion of research, development and evaluation in primary health care.
- 8.7 The *Pegasus* Global Budget (see Figure 15 on page 78) was put in place partly as an experiment to determine whether the arrangement should be more widely adopted. A team from New Zealand Health Technology Assessment (a research unit of the University of Otago) is evaluating the arrangement. The evaluation is examining effects of devolving purchasing to *Pegasus*, including the impacts on:
- the ability of people to obtain the care that they need from *Pegasus* members;
 - the quality of services provided, and how changes in service quality affect demand for hospital services and clinical management of diseases;
 - responsiveness to the needs of the community;
 - equity of funding; and
 - ability to measure, monitor and improve population health status.
- 8.8 The evaluation is also assessing the effectiveness of the Global Budget model and the resource implications of extending the model to other areas of health.
- 8.9 In April 2001, the evaluation team produced an interim report detailing work in progress. At that stage the team was able to give some indications of activity trends since the start of the Global Budget, but it was too early to make any firm assessment of impacts.
- 8.10 The Ministry has passed the responsibility for managing and co-ordinating the evaluation to the Canterbury DHB as the entity responsible for the whole of the *Pegasus Health* contract. However, because of its potentially wider implications for delivery of primary health care in other parts of the country, we expected the Ministry to maintain a close oversight and interest in the evaluation. We were therefore concerned that (when we asked) the Ministry was unaware of what progress was being made with the evaluation.

Evaluation of Programmes

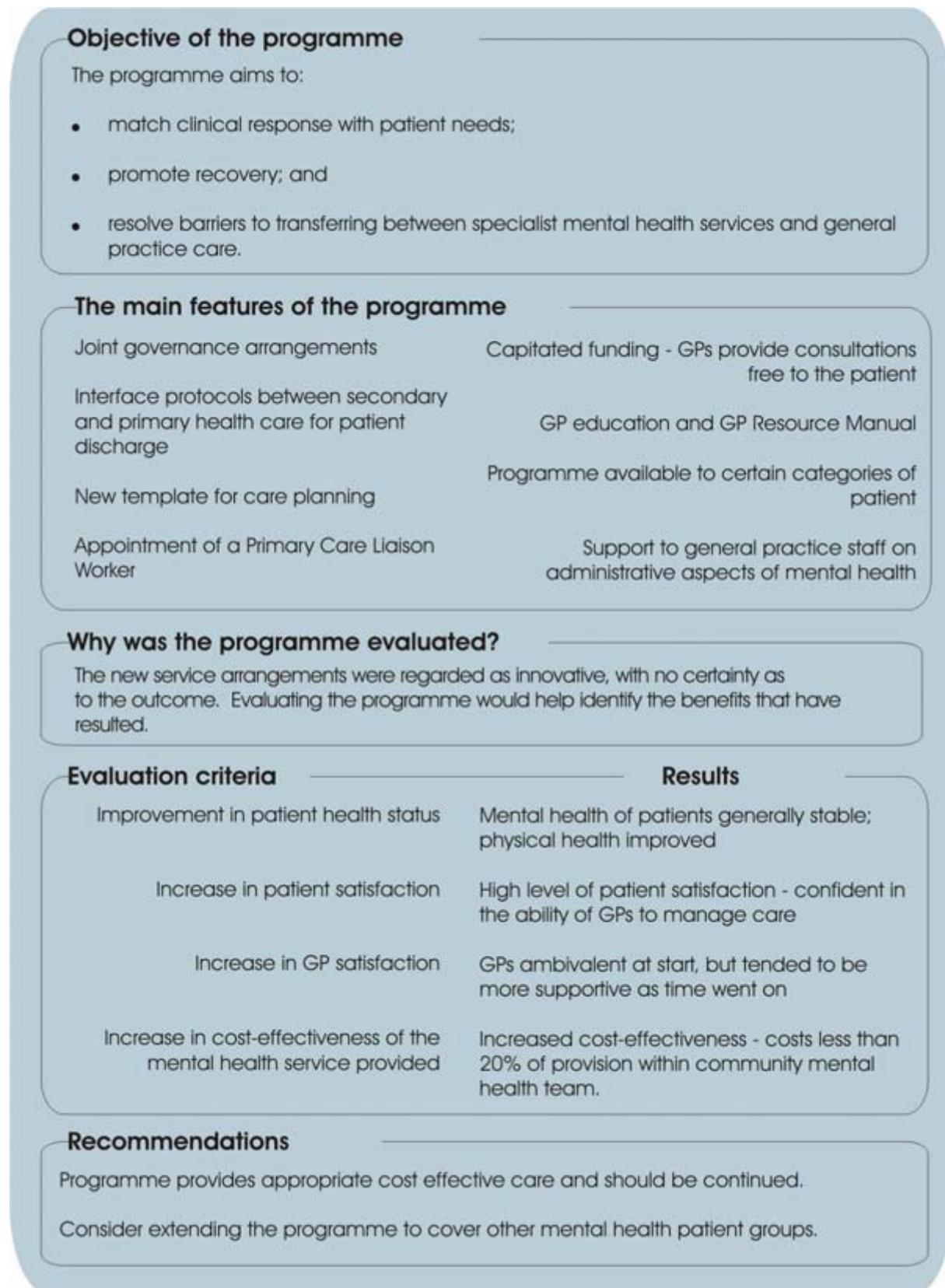
- 8.11 It is important to identify programmes that have the potential to improve patient care and (therefore) should be considered for application by other PCOs or in other parts of the country. Programmes are only occasionally evaluated.

8.12 Some locality managers held limited data on programme results, but were not using it. Figure 23 below and Figure 24 on the following page illustrate two evaluations of primary health care programmes that *Wellington Independent Practice Association Limited* undertook.

Figure 23
An Evaluation of Community Radiology Services



*Figure 24
An Evaluation of the Primary Care Mental Health Programme*



Recommended Future Action

- 8.13 Arrangements for the purchase and delivery of health care services need to be more comprehensively evaluated, starting with the most important and least evaluated to date.
- 8.14 The purchasing function is both important and under-evaluated, and should be a priority for evaluation in the near future.
- 8.15 The Ministry should maintain effective oversight of important evaluations – especially where the arrangements or programmes being evaluated have the potential to be extended to other parts of the country.
- 8.16 Information on arrangements and programmes should be collected to enable them to be evaluated to see how well they are working, and whether they should be extended to other areas. Some PCOs are already providing support for this kind of assessment and should be encouraged to develop this capability further.

Part Nine

Purchaser Accountability

What We Looked At

- 9.1 *We looked at the extent to which the HFA had been held accountable for the level and quality of primary health care. More specifically, we expected that:*
- *the HFA would have been held accountable for the type, level, and quality of primary health care that it purchased; and*
 - *the Ministry would monitor the results of the HFA's purchasing.*
- 9.2 *We focused on the HFA's formal accountability documents because these were the most recent available at the time of our examination. The documents also provide the starting point for the development of accountability arrangements for the 21 DHBs.*

Accountability Arrangements of the Health Funding Authority

- 9.3 In this section we discuss five key accountability documents of the HFA. The purpose and relationship between these documents is illustrated in Figure 25 on page 118.
- 9.4 We examined the following HFA accountability documents for references to statements of intentions and reported performance in the purchase of primary health care services:
- the Annual Report for the year ended 30 June 2000;
 - the Statement of Intent for 2000-01; and
 - the Ministry's first quarterly monitoring report for 2000-01.

HFA Annual Report for the Year Ended 30 June 2000

- 9.5 We reviewed the Statement of Service Performance in the 1999-2000 Annual Report that sets out how the Statement of Intent has been implemented.

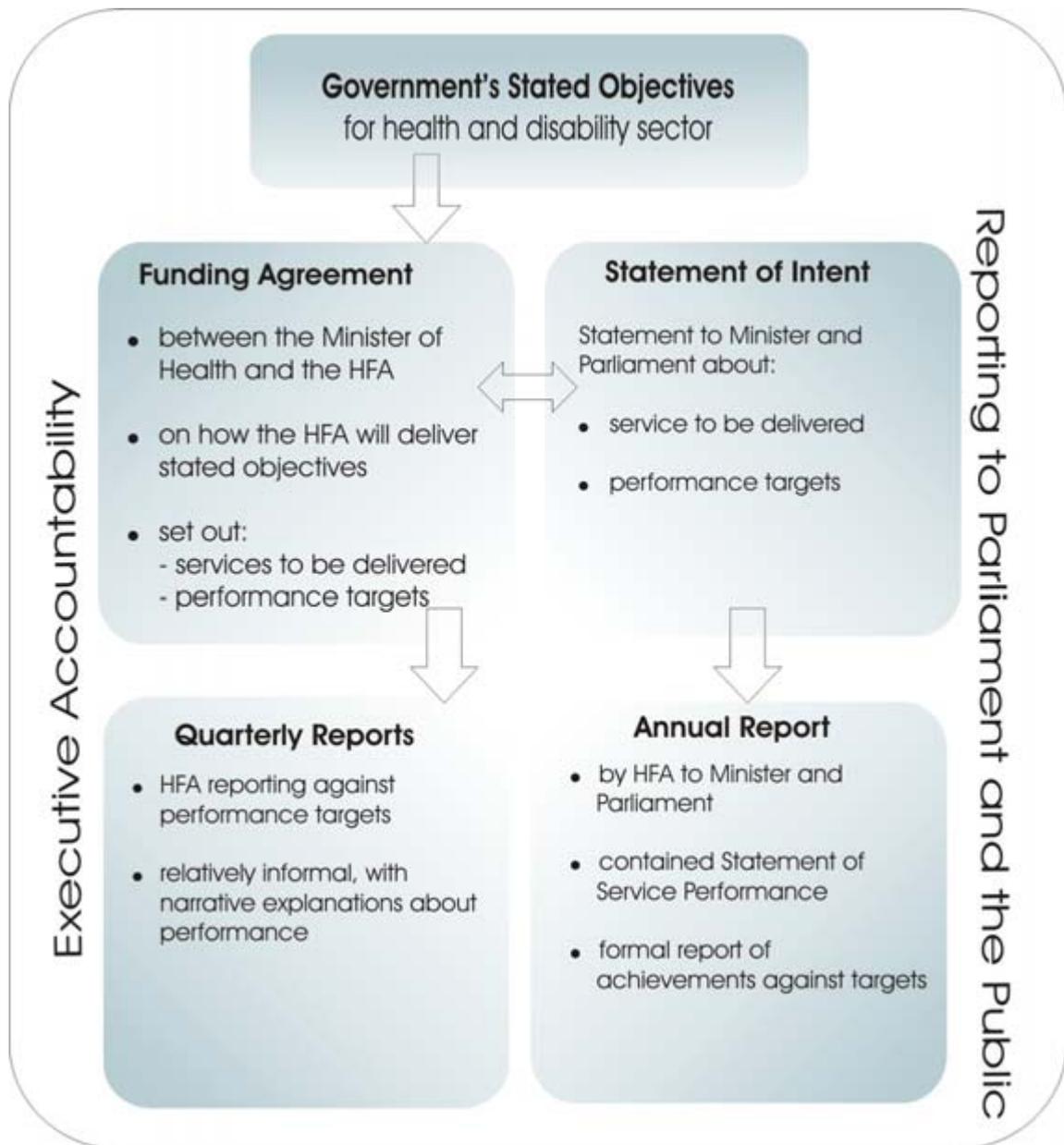
Achievement of Objectives

- 9.6 The Government's Statement of Objectives – and in turn the Funding Agreement and the 1999-2000 Statement of Intent – identified 15 areas for specific health focus by the HFA.⁴⁵ Most of these were relevant to primary

⁴⁵ Improving the Health of New Zealanders, Maori health, mental health, waiting times for elective surgery, Pacific health, rural people's health, children's health, young people's health, women's health, older persons' health, disability support services, diabetes, oral health, sexual and reproductive health, and migrants and refugees. The HFA also had two organisation-related objectives: acknowledging the special relationship between Maori and the Crown, and statement of owner's expectations.

health care. However, few contained measures of service delivery performance for primary health care.

Figure 25
Accountability Arrangements of the Health Funding Authority



9.7 One objective – *Improving the Health of New Zealanders* – was broken down into four sub-objectives for the HFA, of which the following two were most relevant to primary health care:

- to continue work on developing longer-term funding arrangements; and
- to evaluate the integrated care demonstration projects.

- 9.8 We assessed the usefulness of any performance measures specified and the HFA's reporting against those two sub-objectives.
- 9.9 The HFA expressed the sub-objective in relation to the development of long-term funding arrangements in general, non-measurable terms:
- The key focus for 1999-2000 is for the HFA to build on relationships with providers to move toward relational contracting and continuous improvement of purchase frameworks with particular emphasis on the hospital sector.*
- 9.10 No reference was made to promoting a national funding formula, or measures and targets against which the Ministry might have assessed the HFA's long-term funding arrangements.
- 9.11 The HFA reported on achievements under this sub-objective in the *non-hospital* sector in the following terms:
- The HFA has continued to work on developing longer-term funding arrangements designed to enable providing organisations to better plan their service delivery.*
- 9.12 Very broad statements of this kind – without measures to illustrate the scale and speed of progress – provide only limited information to Parliament and the public about the HFA's discharge of its role as purchaser of health services. The statement also made no reference to the development of a national primary care contract, even though the HFA told us that this had been a key priority over a number of years.
- 9.13 The sub-objective on integrated care (which encompasses primary health care) had a performance target to –
- ...support the ongoing evaluation of the integrated care national demonstration projects to assess how different forms of service delivery can affect the quality and cost effectiveness of health care delivery...*
- 9.14 The Annual Report stated that the performance target had been achieved in full. The basis for this statement was that nine out of an original 11 integrated care projects were still running and being evaluated. However, the report only stated the services concerned (elderly care, child health, diabetes, asthma and congestive heart conditions) and project locations (Northland, Auckland, Waikato and Canterbury). No information was provided on how these projects related to, and the impact that they might have on, the purchase of primary health care services.
- 9.15 We examined the remaining objectives for information on performance and achievements in primary health care. Overall, the objectives are not (on their own) especially challenging, in that they are very broad and are not sufficiently specific to enable the services to be monitored and measured. We give some examples in the following paragraphs.

- 9.16 The **Maori health objective** is to purchase services in Maori health gain areas.⁴⁶ There were no details of the specific types and levels of services to be provided to Maori; nor the intended impact of these services.
- 9.17 The reporting of the results of a smoking cessation pilot programme for Maori women (in which 2500 had enrolled against a target of 2000) provided an isolated instance of the use of a measurable target. Information on the numbers of women who had stopped smoking as a result of the programme would have been still more useful.
- 9.18 For the **diabetes objective**, the performance targets made no reference to the current health status of the population or the level of improvement being sought. Nor was a target set to newly identify the numbers of diabetes sufferers – despite the known connection between early diagnosis and effective treatment of this serious disease.
- 9.19 However, for **Maori health** an important achievement was reported, with all Maori primary health care providers having agreed to provide free annual checks for people with diabetes.
- 9.20 For the **Pacific health objective**, \$700,000 was spent on the general development of Pacific providers. The focus of this funding was health promotion and early intervention. However, without details of the health priority areas, and the areas in which providers would be trained, it was difficult to see what was being purchased with these funds.
- 9.21 Most of the measures and targets that were set involved processes being established rather than the health care being purchased or the desired outcome. For example, for **rural people’s health**:
- The objective included completing the contracting for a Rural Practice Support Scheme. This was partly achieved in that funding had been allocated, standard contracts had been sent to providers, and three out of 13 contracts had been signed.
 - The HFA also reported that it had established a Rural GP network, which had developed a scale for reallocating the rural subsidy allocated to GPs operating in rural areas.
- 9.22 Any information on rural health matters is not unimportant. However, since a desired outcome is to improve rural people’s access to GP-based health care, other measures – such as the change in numbers of GPs working in areas assessed as needing improved access – would have been useful.
- 9.23 Some objectives that we expected to include measures for primary health care had no such measures. For example, under **Children’s Health**, there were no measures relating to the role of GP-based care in prompt identification of meningococcal disease.

⁴⁶ These are smoking, immunisation, diabetes, oral health, hearing, asthma, injury prevention, and mental health.

- 9.24 The Statement of Owner’s Expectations (which the Ministry prepared) for the HFA, reflected the Government’s ownership interest in the HFA. It contained the following sub-objectives relevant to primary health care:
- to have the capability to meet other objectives and to support the transfer of functions to the DHBs;
 - to purchase, monitor, and ensure delivery of services to meet agreed coverage and access requirements; and
 - to complete Service Agreements.
- 9.25 We examined the performance measures and reporting of achievements in relation to the Statement of Owner’s Expectations. Our conclusion is that what was reported did not provide a clear picture of actual performance.
- 9.26 For example, the capability measures focused on systems, processes and structure, and gave little indication of their impact. As a result, the Annual Report lacked meaningful information for readers who had an interest in the HFA’s capability.
- 9.27 Another example is the most recent re-organisation that clearly had a marked impact on the HFA’s skill base. The Annual Report identified in general terms those most affected by the re-organisation and described strategies to address the effects on them:
- Staff capability issues are most acutely felt in the Personal Health, Maori Health, and Mental Health Operating Groups, and are being managed by a combination of reprioritisation, tightening the focus on key work, reallocating work, and recruiting on fixed-term contracts (or as permanents, where the role transfers to the Ministry of Health), and by working more closely with staff from the Ministry of Health on joint projects.*
- 9.28 However, without specific measures such as staff turnover, movements in and out of key positions, and losses and gains in specific skills, it would have been difficult to tell just how serious the situation was. (The Ministry was unable to provide us with this kind of data to assist our assessment of HFA capability – see Part 3 on pages 45-49.) The report also lacked data or information about the effect that the staffing problems had had on the services being purchased – such as what programmes had been delayed because of the staffing problems.
- 9.29 The sub-objective *Purchase, Monitor and Ensure Delivery of Services to meet Agreed Coverage and Access Requirements* included a target requiring the HFA to ensure that there were *systems and processes in place to identify, report and act on material exceptions in the delivery of service coverage*. The sub-objective is recorded in the Annual Report as having been “achieved in full” – the basis for this assessment being that:

- *all performance reports from providers are being logged and acknowledged within two days, most within 24 hours;*
- *overdue reports are being regularly followed up by letter from monitoring officers and non-compliance against reporting requirements being escalated to locality managers as appropriate;*
- *HFA Operating Group staff members identify and act on information that identifies variance from purchase agreement requirements;*
- *aggregated reports have been developed and are produced at the end of each reporting period by monitoring officers from the HFA's Shared Services Support Group and forwarded to the relevant locality managers.*

HFA General Managers are required to ensure service coverage is fulfilled in their service area.

- 9.30 These statements largely describe administrative processes that do not, in themselves, give assurance that providers are actually providing the contracted service. Logging of performance reports and follow-up of overdue reports is not sufficient to establish that the performance targets have been achieved. As we explain in Part 7 on pages 95-105 (at least in relation to primary health care) monitoring of the quantity and quality of services provided is not well done.

HFA Statement of Intent for 2000-01

- 9.31 The Statement of Intent for the HFA's final year of operation (2000-01) largely mirrored the format and content of the statement for the previous year. However, it did contain a new section on *Primary Care Services* under the objective *Improving the health of New Zealanders*. The new section provided some details of systems and processes being developed in primary health care – including:
- modelling population-based funding formulas and testing them against patient registers – to provide a basis for moving towards more equitable funding;
 - aligning service specifications with capitation models;
 - advancing work that supports primary health care related recommendations of the Nursing Taskforce; and
 - engaging all sector participants on the development of the Primary Health Care Strategy (published in February 2001).

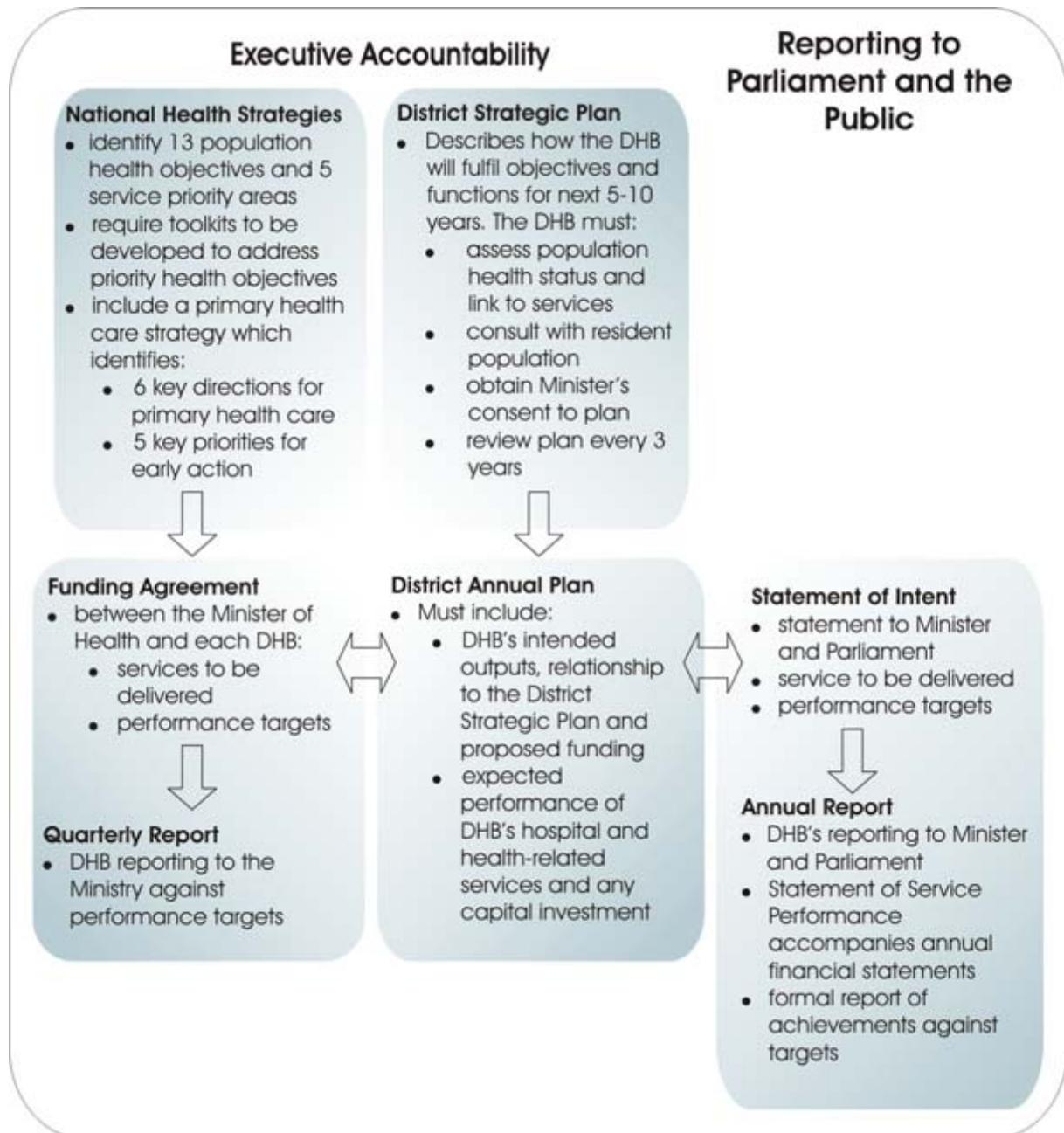
The Ministry's First Quarterly Monitoring Report for 2000-01

- 9.32 The Ministry's first quarterly report for 2000-01 records its monitoring of the HFA against the Funding Agreement. It follows the same format as the Annual Report.
- 9.33 The report noted that the primary health care objective (see paragraph 9.31 above) was "substantially achieved".
- 9.34 To meet the objective of reducing the incidence and impact of diabetes the HFA envisaged that Local Diabetes Teams established in the previous year would complete local diabetes plans – identifying priorities for improving local diabetes management in the first quarter of the financial year. This target was "not achieved". But such plans (once available) should provide the basis for improving diabetes care.
- 9.35 The report noted that three Independent Practitioner Associations in Auckland still had not reached agreement with the HFA on providing a service for free annual reviews of diabetes patients. However, the report did not explain why this was the case.
- 9.36 There was a similar lack of explanation relating to laboratory expenditure, which had exceeded budget by \$6.4 million (16.5%). The excess was attributed to increased utilisation, but (again) why that was so was not explained.

DHB Accountability Arrangements

- 9.37 Figure 26 on page 124 illustrates the accountability arrangements for the 21 DHBs. They are similar to the previous arrangements for the HFA (see Figure 25 on page 118) – requiring an annual Funding Agreement, Statement of Intent, and Annual Report (including a Statement of Service Performance).
- 9.38 New strategic elements have been added to the accountability framework for DHBs, with the provision for national health strategies and the requirement for DHBs to produce district strategic plans for the next 5-10 years, and district annual plans.
- 9.39 These additional strategic elements are intended to provide a clearer national contracting framework, particularly because the DHBs have been given a local purchasing role. Our examination has shown how the previous four regional structures led to fragmentation of arrangements for funding primary health care (see paragraphs 5.15, 5.16 and 5.20 to 5.24 on pages 71-73). The creation of 21 DHBs poses the risk that further fragmentation could occur unless there is firm strategic direction at a national level on important matters of health policy.

Figure 26
 Accountability Arrangements for District Health Boards



9.40 Initially, the DHBs are inheriting services and contracts for their respective regions as established by the HFA. The 5-10 year strategic plan proposals are to be based on assessments of population health status and needs, on which the DHB must consult its community.

9.41 The Ministry and DHBs have agreed on the following performance measures in relation to primary health care:

- The number of new or expiring GP agreements (contracts), and the number of these that use the national agreement (contract) – as a measure of the uptake of the national agreement.
- The number and percentage of contracted providers with a Maori Health plan that has been agreed with the funder.

9.42 As with most of the measures under the HFA regime, these measures focus on processes and are of limited use in measuring DHB performance. The measures make no mention of the amount and quality of the health care to be purchased, and the impact that the care purchased is intended to have on the health status of the DHB's population.

9.43 A recent review of the framework for DHBs' Statement of Service Performance recognised that the current framework is relatively conservative.⁴⁷ This conservatism reflected the fact that the DHBs had only recently been created and were only just beginning to develop their own policies and procedures. The review emphasised that the framework should be developed over time, and should eventually focus on changing the determinants of health and health outcomes in the area.

Recommended Future Action

9.44 Our analysis of accountability reporting is relevant to health care purchasing generally, not only to primary health care. Our recommendations are similarly relevant to publicly-funded health care as a whole.

9.45 Health care purchasing needs to incorporate a performance measurement system that results in the quantity and quality of health care purchased by DHBs (including care provided by DHBs or their agents) being measured and reported on. The Ministry and DHBs need to recognise that this transition will require significant effort and resources. It needs to be managed well and in a timely way to support the intended DHB focus on the health of their local populations.

9.46 To manage the transition, a number of obstacles need to be overcome. One key obstacle is the lack of relevant and reliable information to make the assessments that are necessary to measure the performance of the health system in a meaningful way. Another is the culture change that will be required to support a move from relatively straightforward measurement of systems and processes to arrangements that review health outcomes, and/or inputs, outputs and behaviours likely to lead to good health outcomes.

9.47 We do not believe that the size of the task should stand in the way of early implementation. For example, lack of relevant, reliable information to support a particular performance measure should not be put forward as a reason for not imposing the measure if it is important to the achievement of health objectives.

⁴⁷

Review by Arthur Andersen, reported July 2001; commissioned collectively by DHBs.

Instead, introducing the measure should be used to drive the provision of the necessary information.

9.48 The Ministry and the DHBs should give priority to jointly developing performance measures as a basis for evaluating achievements. The Ministry needs to be involved:

- as the funder;
- as the guardian and promoter of the New Zealand Health Strategy; and
- as supporter to DHBs, which will need to significantly develop capability to manage the complexities of performance reporting in health care.

9.49 In establishing an effective performance measurement regime, the Ministry and DHBs should consider in particular:

- work already undertaken by providers – DHBs and providers will need to discuss and agree meaningful performance measures in developing a partnership relationship (as we discuss in Part 6 – e.g. paragraphs 6.30 to 6.32 on pages 92-93);
- international work on performance measurement of health systems, including measures already in use in some countries; and
- the need to measure indicators of the experience of patients of the health system – both their direct experience of health care and how the wider health system affects the quantity and quality of their lives.

Appendices

Appendix 1

Primary Care Organisations as at 1 August 1999

Primary Care Organisation	Region
Independent Practitioner Associations	
Bay Health Ltd	Northern
Comprehensive Health Services Ltd	Northern
Dargaville	Northern
EastHealth Services Ltd	Northern
First Health & <i>PrimeHealth</i>	Northern, Midland, Southern
Integrated Primary Care Services	Northern
Kaikohe IPA	Northern
Mangere Health Resources Trust	Northern
Procure (Central, North and South)	Northern
Pukekohe Health Services	Northern
South-Med Ltd	Northern
Westview Medical Centre	Northern
Whangarei Health Care Ltd	Northern
Whangaroa Health Services Trust	Northern
Pinnacle	Midland
Rotorua General Practice Group	Midland
Hawkes Bay Independent Providers Association “Paradigm”	Central
Karori/Ropata IPA	Central
Hutt Valley IPA (now Kowhai IPA)	Central
Manawatu IPA Ltd	Central
Progressive Health (NZ) Inc	Central
The Doctors (Hawkes Bay)	Central
Upper Hutt Medical Centre IPA	Central
Tararua IPA	Central
Wellington Independent Practice Association Ltd (now Greater Wellington Health Trust)	Central
Christchurch South Health Centre	Southern
Hurunui-Kaikoura Rural Health Ltd	Southern
Marlborough GPs Society	Southern
Papanui Medical Centre	Southern
Pegasus Medical Group (now Pegasus Health Limited)	Southern
Selwyn Rural Health	Southern
South Link Health	Southern
National Primary Care Network (“Caretnet”) includes Nelson Clearing House	New Zealand wide
Health Care Aotearoa	39 members New Zealand wide – as listed on the next page
Other Providers	
Hokianga Health Enterprise Trust	Northern
Pasifika Health Care	Northern
Tongan Health Society	Northern
South Seas Health Group	Northern
Maori providers ⁴⁸	New Zealand wide

⁴⁸ There are over 220 Maori health providers. Some contract directly with the purchaser and others are under the umbrella of *Health Care Aotearoa*.

Members of Health Care Aotearoa (as at November 2000)	
Maori Comprehensive Care Providers	
Hauora Hokianga	Northern
Ngati Whatua o Orakei Health Centre	Northern
Te Rununga o Whaingaroa	Northern
Whakawhiti Ora Pai	Northern
Ngati Awa Social and Health Services	Midland
Ngati Porou Hauora	Midland
Ngati Rangi Community Health Centre	Midland
Ngati Ruanui Health Centre	Midland
Tamaranui Kokiri Trust	Midland
Te Atiawa Health Runanga Medical Trust	Midland
Te Rohe Potae o Rereahu Maniopoto Trust	Midland
Turanga Health	Midland
Kahungunu Executive	Central
Kahungunu Taiwhenua ki Wairarapa	Central
Kahungunu Taiwhenua o Heretaunga	Central
Ngati Toa Rangatira	Central
Te Kotuku Hauora o Rangitikei	Central
Te Runanga o Nga Maata Waka	Southern
Community Comprehensive Care Providers	
Auckland Peoples Centre	Northern
Te Puawaitanga Health Care Centre Otangarei Trust	Northern
Waiheke Health Trust	Northern
Wellington Peoples Resource Centre	Central
Union Health Providers	
Hauora o Puketapapa – Roskill Union & Community Health	Northern
Otahuhu Union Health Centre	Northern
Otara Health Centre	Northern
Waitakere Union Health Centre	Northern
Hutt Union & Community Health Service	Central
Newtown Union Health Service	Central
Porirua Union & Community Health Service	Central
Christchurch Union & Community Health Centre	Southern
Specialised Service Providers	
Piritahi Marae	Northern
Putea o Pua	Northern
Kaute Pasifika	Midland
Nga Maia o Te Tairawhiti	Midland
Puangi Hau	Midland
PaCH – Pacific Community Health	Central
Te Huringa Health	Central
Pacific Islands Health Professionals Association	Southern
Pacific Trust Canterbury	Southern

Appendix 2

Schedule of Fees for General Medical Services

Payments in respect of consultations for General Medical Services provided to eligible persons are as follows:

	<i>\$(GST incl)/ eligible person</i>
Child, under 6 years of age*	32.50
Holder of a current Community Services Card	15.00
Dependent child, 6 years of age or over, of a holder of a Community Services Card	20.00
Holder of a current High Use Health Card who is not a child	15.00
Holder of a current High Use Health Card who is a child 6 years of age or over	20.00
Child who is not within a category specified above	15.00
Six-week check of baby (provided in accordance with the Tamariki Ora schedule)	32.50

No payment can be claimed (or made) arising from personal injury caused by accident and/or medical misadventure, or otherwise entitling a patient to cover under the Accident Insurance Act 1998.

- * The HFA expected that, from 1 July 1997, GPs would not charge a co-payment for most consultations between the hours of 8am and 8pm, 7 days a week. The HFA believed that this would result in near-universal access to free medical care for children under six.

Appendix 3

Types of Contracting Entity

There are five different types of contracting entity.

Sole Practitioner

By sole practitioner we mean a GP who has elected to stay on the section 88 Notice (previously the section 51 Notice). GPs in this category:

- do not negotiate;
- their services and fees are set out in the Notice; and
- they are alone – they do not form part of a wider network.

PCOs – of which there are four main types⁴⁹

Independent Practitioner Association

Independent Practitioner Associations form the largest group. They are generally established as limited liability companies or trusts and most are owned by GPs.

There is considerable diversity in how Independent Practitioner Associations operate, but generally they act as umbrella organisations which negotiate contracts with the purchaser on behalf of their members for the provision of a wide range of primary health care services (including General Medical Services provided by GPs).

Loose Network

Loose networks are the second largest group and function as a provider organisation. They enable GPs not belonging to an Independent Practitioner Association to consult and deal collectively with the purchaser.

The GPs and practices that belong to these groups are unwilling to enter into budget management contracts, with members advocating the fee-for-service model. Instead, they tend to have special purpose contracts – for example, to provide communication between members, develop local practice guidelines, and co-ordinate immunisation programmes.

⁴⁹

We have adopted the same classifications and extracted the figures used in the publication *The Development of Primary Care Organisations in New Zealand* – see footnote 10 on page 19.

CareNet is the largest of these groups and is a national primary health care network.

Community-owned Organisation

The Ministry promoted community-owned organisations as a means of providing health care to vulnerable communities. They are non-government, non-profit-making organisations with a strong community focus. Providers such as iwi health service groups and other community groups (e.g. Union Health Clinics) are established in a variety of ways including incorporated societies, charitable trusts and limited liability companies. They provide legal, financial and management support for their members, and are usually managed by a committee of service providers, community and patient representatives.

The key features of these organisations are that they:

- are non-profit organisations;
- usually employ salaried staff including GPs;
- serve very disadvantaged populations with high health need;
- provide care for high proportions of Maori and Pacific Island peoples;
- deal with a high level of health need, leading to prolonged consultations;
- are community driven and owned;
- provide services that are subsidised with community funding;
- tend to have a population with low uptake of the Community Services Card, resulting in disadvantage in both capitated and General Medical Services funding; and
- have a high patient/GP ratio (usually over 2000 patients per GP).

Smaller Contracting Practice

Smaller contracting practices are usually GP-owned, though some are set up as limited liability companies and as community trusts which have a contract with the funder to manage their own resources (for laboratory and pharmaceuticals), clinical activity and quality standards.

Appendix 4

Functions of District Health Boards

(as set out in section 23 of the New Zealand Public Health and Disability Act 2000)

For the purpose of pursuing its objectives, each DHB has the following functions:

- (a) to ensure the provision of services for its resident population and for other people as specified in its Crown funding agreement:
- (b) to actively investigate, facilitate, sponsor, and develop co-operative and collaborative arrangements with persons in the health and disability sector or in any other sector to improve, promote, and protect the health of people, and to promote the inclusion and participation in society and independence of people with disabilities:
- (c) to issue relevant information to the resident population, persons in the health and disability sector, and persons in any other sector working to improve, promote, and protect the health of people for the purposes of paragraphs (a) and (b):
- (d) to establish and maintain processes to enable Maori to participate in, and contribute to, strategies for Maori health improvement:
- (e) to continue to foster the development of Maori capacity for participating in the health and disability sector and for providing for the needs of Maori:
- (f) to provide relevant information to Maori for the purposes of paragraphs (d) and (e):
- (g) to regularly investigate, assess, and monitor the health status of its resident population, any factors that the DHB believes may adversely affect the health status of that population, and the needs of that population for services:
- (h) to promote the reduction of adverse social and environmental effects on the health of people and communities:
- (i) to monitor the delivery and performance of services by it and by persons engaged by it to provide or arrange for the provision of services:
- (j) to participate, where appropriate, in the training of health professionals and other workers in the health and disability sector:

- (k) to provide information to the Minister for the purposes of policy development, planning, and monitoring in relation to the performance of the DHB and to the health and disability support needs of New Zealanders:
- (l) to provide, or arrange for the provision of, services on behalf of the Crown or any Crown entity within the meaning of the Public Finance Act 1989:
- (m) to collaborate with pre-schools and schools within its geographical area on the fostering of health promotion and on disease prevention programmes:
- (n) to perform any other functions it is for the time being given by or under any enactment, or authorised to perform by the Minister by written notice to the board of the DHB after consultation with it.

Appendix 5

Reporting Requirements

The following is a sample of the type of information that some PCOs are required by the purchase contract to report on (see paragraphs 4.33 to 4.35 on page 62):

- **Immunisation** – percentage, or (depending on the contract) number, of children in the practice population –
 - requiring immunisation;
 - immunised on time;
 - fully immunised by age 2;
 - presented late for immunisation; and
 - for whom immunisation has been declined.

- **Cervical cancer** – percentage or number of women aged 20-70 within the practice population:
 - on the National Cervical Screening Register; and
 - of those on the Register, who have had a smear test within the last 3 years.

- **Asthma** – number of patients on age/sex register with asthma; and of the patients on the age/sex register the proportion:
 - with asthma;
 - who receive asthma education;
 - who have a written asthma action plan; and
 - who visit the Emergency Department/are admitted to hospital.

- **Diabetes** –
 - total number of patients on register and the percentage of patients on the register relative to the entire practice register;
 - the number of diabetic patients with HBA1c<8.5;
 - percentage of an agreed sample of patient records kept (5 diabetic patients per GP) which show that 80% of the diagnostic methods listed have been undertaken on the sample group of patients under 75 years of age, on the register at least 50% of the time;
 - percentage of practices with a practice nurse who has taken extra diabetes education; and
 - percentage of practices that have conducted a consumer survey on satisfaction with care, and results.

- **Melanoma spot check** –
 - number of spot check clinics and coverage of the Independent Practitioner/Practice population;
 - number of melanomas diagnosed and percentage of melanomas detected at a thickness level of 0.76mm or less; and
 - number and type of other skin cancers detected.

- **Smoking cessation** – for smokers identified from the disease registers of each GP practice, provide smoking cessation messages and provide assistance and follow up to those who have indicated that they want to quit:
 - the baseline number of people in each of the target group identified as smokers;
 - the number in each target group who have received smoking cessation advice;
 - the number in each target group who have stopped smoking completely; and
 - the number in each target group who have received smoking cessation advice and continue to smoke, but have reduced their smoking by at least 50%, and have sustained this reduction for more than three months.

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