



## **New Zealand's Primary Health Care Strategy: what are the costs and how likely are the benefits?**

Antony Raymont and Jacqueline Cumming

Major changes are occurring in primary healthcare organisation in New Zealand. The Government is implementing a Primary Health Care Strategy, which foresees that:

'People will be part of local primary health care services that improve their health, keep them well, are easy to get to and co-ordinate their ongoing care. Primary health care services will focus on better health for the population, and actively work to reduce health inequalities between different groups.'<sup>1</sup>

Primary Health Organisations (PHOs) will be the vehicle used to implement these changes; they will have access to management funding and will be rewarded for achieving budgets via a new system of performance management now under development.<sup>2</sup> The first PHOs were established in July 2002 and by April 2003 thirty four PHOs were in operation.<sup>3</sup>

User charges for primary care in New Zealand are among the highest in OECD countries and create a significant barrier to access, particularly for those on lower incomes or with higher healthcare needs. Under the Strategy, additional funding is being made available by the Government to enable a reduction in these charges. This funding is currently being targeted towards high-need populations through the use of the 'Access' formula and around 700 000 New Zealanders can now access care with lower user charges.<sup>3</sup> In practice, all those enrolled in Access-formula-funded PHOs are eligible for lower charges and within the next ten years the Government aims to make primary care cheaper for all New Zealanders.

In addition to reduced economic barriers to primary care, key components of the Strategy are: community participation in primary care, with the potential to improve acceptability, effectiveness, efficiency, coverage and equity of resource allocation, as well as greater self-reliance;<sup>4</sup> a population-based approach, with an increasing focus on prevention, screening and health promotion;<sup>5,6</sup> better targeting of resources using a needs-based funding formula;<sup>7</sup> better coordination of services; a multi-disciplinary work force; and better information coupled with a stronger performance management framework to improve quality of care.

The paper by Robinson in this issue of the NZMJ estimates the likely cost to the New Zealand Government of providing universally free primary medical care.<sup>8</sup> Robinson makes his estimates using results from the Rand Health Insurance Experiment (Rand HIE) undertaken in the United States during the late 1970s, coupled with New Zealand health expenditure data. Robinson includes in his calculation:

- Rand HIE estimates of differences in utilisation of services related to the proportion of the primary care fee paid by the user;
- estimates of the GP consultation fee currently charged in New Zealand;

- estimates of the additional costs related to referred services (medicines, diagnostic tests and additional hospital admissions).

He estimates the costs of free care to be between \$349 million and \$922 million, with a 'best' estimate of between \$435 million and \$592 million.

There are reasons to suggest that the increase in primary care service utilisation in New Zealand (and the costs to the Government) will not be at the high end of Robinson's estimates. It seems likely that, for many, some user fee will continue to be charged and that the increase in visits will not be as high as estimated using the Rand HIE free care data. There is also the possibility that limited capacity will constrain the increase in primary care visits; Robinson points to supply, morale and workload issues for doctors in primary care. On the other hand, the Strategy envisages an increase in the use of other healthcare professional skills that may reduce such constraints.

In the Rand HIE, individual providers were paid on a fee-for-service basis; thus, there were economic incentives to deliver as much care as possible. There is evidence that providers do react to financial incentives, with a higher number of visits received when they are paid on a fee-for-service basis.<sup>9</sup> Robinson notes that providers' incentives to control the number of visits may increase where they are paid on a capitation basis. New Zealand's Primary Health Care Strategy does involve a shift to capitation, but at the PHO level. Thus, PHOs will have financial incentives to control utilisation, but as long as providers continue to be paid on a pure fee-for-service basis their own incentives will be to maximise the number of patients they see.

Beyond estimates of the likely increase in primary care visits, it is unclear what effect cheaper primary care will have on rates and costs of hospital admissions. In the Rand HIE study, there were higher rates of utilisation of hospital services for those paying lower user charges. But the New Zealand policy will hope to reduce hospital admissions, in particular ambulatory sensitive admissions that might be avoided through improved primary care. Capitation does encourage referrals outside the capitated budget, and this may lead to cost-shifting and increased costs for medicines, laboratory tests and Accident Compensation Corporation (ACC) payments, as well as hospital budgets.

Robinson's estimates of the costs to the Government of implementing cheaper primary care do not include the cost of implementing the Primary Health Care Strategy as a whole, with additional expenditure required for management costs, new health promotion expenditure and PHO performance monitoring costs. Similarly, Robinson does not account for the decrease in payment by individuals, which will reduce the cost to society as a whole for primary care.

The best guess at the cost for the New Zealand Government in reducing user charges – around \$600 million per annum – shows that the full implementation of cheaper primary care is expensive. This represents 7.9% of the current \$7.584 billion public expenditure on healthcare.<sup>10</sup> The key issue is the extent of the benefit that will result.

Economic theory suggests that the new economic incentives associated with the development of PHOs may deliver the outcomes desired by the Government, ie, a population health focus, a shift in the mix of skills used in primary care delivery, improved access to care for disadvantaged populations and improved incentives to

keep expenditure within limits.<sup>7,9</sup> International research shows that nurse practitioner services provide benefits to consumers and the health sector, and improve health outcomes in a cost-effective way,<sup>11,12</sup> but beyond this there is very little research that categorically shows that the changes envisaged will lead to improved health status.<sup>9</sup> Further, the extent to which we can predict what might happen in New Zealand on the basis of international research is complicated by the different policy, organisational and service delivery contexts that exist here.

Given the dearth of evidence, evaluation of the Strategy as proposed by the Health Research Council, the Ministry of Health and the ACC<sup>13</sup> is of particular importance. A number of evaluations of primary care groups and trusts (PCG/Ts) have been undertaken in the UK and are relevant here. Two separate evaluations have commented on the significant development time required to establish organisations, the lack of management resources (money and skills), and slow progress towards involving users and the community in service development. GPs have tended to dominate decision making and, while nursing viewpoints are valued, nurses have not felt fully included in decision making. Relationships with health authorities have at times been tense.<sup>14,15</sup> It is likely that the evaluation of the Strategy in New Zealand will uncover similar issues.

The evaluation tender documentation focuses on the process of implementation of the Strategy (the changes in structure). Of equal importance is the evaluation of changes in: the experience of healthcare users; utilisation rates by service type; the distribution of funding related to different population groups; the cost of different services; and population health status, including avoidable hospital care. Finally, the long-term outcome of the changes in primary healthcare are likely to depend on adequate monitoring with timely feedback where desired changes are slow to develop.

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