THE IMPLICATIONS OF THE 2001 PRIMARY HEALTH CARE STRATEGY FOR PROVIDERS AND CONSUMERS

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ABSTRACT

AIM AND RESEARCH QUESTION

To discuss *The Primary Health Care Strategy* (King, 2001) and its implications for providers and consumers. The research question is: What are the implications of the 2001 Primary Health Care Strategy for providers and consumers

METHODOLOGY

Applied policy qualitative analysis using the 'framework' approach. This non-contact approach involved generating data from the strategy document by identifying themes that related to the research question, coding the data according to the themes and then mapping and interpreting the data. The process involved a systematic but flexible approach to determine the meaning, relevance and connections of the data and the themes. The themes of 'provider' and 'consumer' were identified a priori and guided the process to identify the three key themes of funding, services and skills. Part way through the process two further categories were identified in order to fully answer the research question. These included: Implications of the strategy for consumers; and implications of the strategy for providers. A theoretical framework informed the discussion for both categories.

RESULTS

The findings demonstrate that the strategy has significant implications for providers and consumers. It shows that the vision and the key directions outlined by King (2001) are achievable but require a different process than that outlined in the document. The findings suggest that the most effective way to achieve these are to: Target disadvantaged groups and providers who are willing to work with those groups; strengthen nursing's professional identity by establishing primary health care nursing models; assign nurses the responsibility to deliver population health activities; and address the structures and payment mechanisms in General Practice.

ACKNOWLEDGEMENTS

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CHAPTER ONE – INTRODUCTION TO THE STUDY

In February 2001, the Honourable Annette King, Minister of Health for the Labour Government, released *The Primary Health Care Strategy*. *The Primary Health Care Strategy* (to be referred to as 'the strategy') is a key part of an overall framework aimed at achieving a health system for the people of New Zealand that will help to reduce the health inequalities that exist and to ensure that health services are directed to achieve the greatest benefits for the population (King, 2001). The *Primary Health Care Strategy* sets out King's vision for primary health care to be achieved over the next five to ten years. King's vision involves a direction for primary health care with a greater emphasis on population health and the role of the community, health promotion and preventive care, the need to involve a range of professionals and the advantages of funding based on population needs rather than fees for service (King, 2001, p. viii).

In order to achieve the vision, King (2001) outlines six key directions which involve primary health care moving to a system where services will be organised around the needs of the population. This system will involve local structures to be established which will be known as Primary Health Organisations (PHOs), and which will be funded by District Health Boards. The funding mechanism referred to as 'population-based' funding is viewed by King (2001), as the fairest way to allocate funding to ensure the needs of the population are served. King (2001) claims that "when funds are not tied to particular numbers of services or types of practitioners there are no barriers to using the most appropriate health practitioner in each situation" (p.14). This study will highlight the significant implications this strategy has for providers[1] and consumers[2]. Qualitative document analysis will be used.

The topic for this study fully emerged when the researcher was employed by the Health Funding Authority in the Change Management team, and was assigned the role of Project Manager for Primary Care. During this period she was seconded to the Ministry of Health's Primary Health Care Reference Group advising and assisting in the development of the strategy. This role involved providing expert advice by commenting on the summary of submissions; commenting on the implications of the strategy as it developed; and engaging with the sector, and sharing ideas within recognised constraints relating to confidential information (King, 2001). This situation changed when the researcher moved on from being an employee with the Health

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[1] The term provider will be used throughout the study and will relate to those groups that have direct or indirect responsibilities for providing primary health care services. This will largely include District health Boards, Primary Health Organisations and health practitioners.

Funding Authority, with particular ideas about the strategy, to someone who looks back on her involvement in the development of the strategy using it as an academic research frame.

King (2001), in her strategy provides details of the way the vision will be achieved and acknowledges that it will involve a period of change. The researcher believes, however that the significance of the change has not been taken into account. While the strategy formulates a number of principles that are expected to ensure "a stable and constructive transition" (p.27) it lacks a specific and detailed implementation plan and instead delegates that responsibility to the newly formed District Health Boards. This lack of a detailed implementation plan, combined with her earlier experience in roles related to primary health care led the researcher to identify her research problem – *'What are the implications of the 2001 Primary Health Care strategy for providers and consumers?'*

For the purpose of this study it is important to declare the researcher's experience in primary health care roles, particularly her role within the Health Funding Authority. Throughout her career the researcher has had a number of different roles located in primary health care settings. These roles included that of Public Health Nurse, Independent Nurse Practitioner, and more latterly in the Health Funding Authority (HFA), and for a short time in the Ministry of Health. This role involved purchasing, funding and policy development related to primary care services. One of her key assignments in the HFA, as noted above, was to project manage the development and implementation of a national primary care contract. This also led to her secondment to the primary health care strategy reference group. The last two experiences have left the researcher with an interest in primary health care and its interface with the rest of the health sector. In particular, it was during the development of the strategy that the researcher developed insight to understand the impact on General Practice, which, will be argued, is the lynchpin of primary care.

This is of particular significance in relation to King's (2001) strategy which signals a radical shift from the current medically driven primary care service[3] to a new primary health care environment. A part of this process involves a new system, as described above, which involves new structures – PHOs – through which primary health care services will be funded and provided. This implies a change that potentially impacts on the current Independent Practitioner Associations (IPAs) the majority of General Practitioners (GPs) belong to[4]. The strategy

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[2] The term consumers will refer to individuals, groups or communities who are potential or actual recipients of primary health care services
[3] The differences between primary care and primary health care are described below
[4] see below and Chapter 2 for description of IPAs

appears to assume that this radical shift, as outlined by King (2001), will be accepted and fully implemented by all providers of primary health care.

This study will argue that the providers who will be most affected by the strategy will be those involved in the current primary care setting (GPs and Practice Nurses) and to a lesser degree, other nurses currently involved in the provision of primary health care services. Therefore the discussions relating to the implications of the strategy for providers, will focus on GPs and primary (health) care nurses. It is acknowledged that there are other providers, such as midwives, physiotherapists and pharmacists, involved in the provision of primary health care, but they will not be included in the discussion in this study.

METHODOLOGY

The decision to apply the research methodology of qualitative document analysis emerged as a result of a number of considerations. Firstly, because of her role in developing the strategy, the researcher decided that it would be of benefit to examine the meaning and relevance of the strategy document using a formal analytical process Secondly, the researcher identified the 'framework approach', a methodology that has been used by the Social and Community Planning Research Unit, in the United Kingdom, to conduct applied qualitative policy research (Ritchie & Spencer, 1994). Frequently in applied policy research, document analysis is used as either a part of or for the entire project. For this study, document analysis will be the only methodology applied. Thirdly, policy analysis is usually targeted to provide answers to assist in greater understanding of the issues, and so it was considered an appropriate and useful methodology to apply to this study (Ritchie & Spencer, 1994). The study therefore could be viewed as useful to providers as they commence the change to achieve the directions outlined by King (2001).

THE PRIMARY HEALTH CARE STRATEGY - THE CONTEXT IN RELATION TO THE STUDY

The release of the strategy in February 2001, coincided with the restructuring of the health sector in response to *The New Zealand Public Health and Disability Act, 2000*. This Act dissolved the Health Funding Authority (HFA) and replaced it with twenty-one District Health Boards (DHBs). They were, tasked with the responsibility for assessing the health and disability needs of their communities, and managing resources and service delivery to meet these needs. The Ministry of Health (MOH) would support the DHBs through its regulating, funding and monitoring role (King, 2001). Thus, the Primary Health Care strategy was released in the midst of significant change, where newly established DHBs were grappling with their responsibilities and, in particular, the added responsibility for funding and providing primary health care services. Up until this most recent reform, primary health care had been funded by the Health Funding Authority through a range of different contracts and with a number of different providers. Services for primary care had predominantly been contracted through organisations known as Independent Practitioner Associations (IPAs) while population services had mainly been contracted through the Hospital and Health Service (HHS) providers. In the new environment primary health care services (including primary care and population health services, commonly referred to as public health services) would be contracted and funded through new and different organisations to be known as Primary Health Organisations (PHOs).

The literature review will show this reform process was one of many that has been implemented over the last ten years with varying successes and failures. It will reveal that the government for some time has attempted to improve primary health care in line with the *Ottawa Charter for Health Promotion* (Health and Welfare Canada, 1986). Malcolm (1993) reported that throughout the health reforms of the 1990s, the focus was on supporting primary medical care to the detriment of primary health care. This can be attributed in part to the confusion that exists within the health sector between the terms 'primary care' and 'primary health care' with both frequently being used interchangeably. King (2001) refers to the definition drawn up at Alma-Ata in 1978. This definition bases primary health care in "practical, scientifically sound, culturally appropriate methods that is [sic]:

-Universally acceptable to people in their communities

-Involves community participation

-Integral to, and a central function of, New Zealand's health system

-The first level of contact with our health system" (p.1).

Primary health care within this definition is much broader than primary care which can be described best as primary medical care, consistent with care and services usually provided by a General Practitioner (Carryer et al., 1999). For this study, the term primary health care will refer to the broader definition as described in King (2001). Primary care or primary medical care will be used to refer to those services currently provided by a General Practitioner (GP) or a Practice Nurse and which are typically the first point of contact where people enter the health care system (Stanhope & Lancaster, 1996).

THE AIM OF THE STUDY

The aim of the study is to discuss the implications of *The 2001 Primary Health Care Strategy* (King, 2001) and its implications for providers and consumers. It will demonstrate that the government's 2001 strategy document, outlining the changes to the way services are provided and funded, will have a major impact on both groups. Discussions will be related to population-based funding as the key to enable the changes required by King (2001); the range and change to skills and services; and the implications of the strategy for both providers and consumers. The literature will show, that despite previous attempts to introduce population based funding, there has been considerable resistance by primary care providers (GPs) to accept it, thus maintaining the status quo of the predominant fee-for-service payment mechanism[5]. This resistance is viewed as a means of continuing a primary medical care model where funding is directed to specific practitioners (GPs) creating barriers for effective utilisation of other practitioners (Carryer et al., 1999).

The potential for better utilisation of primary health care nurses will be explored in response to the strategy's explicit reference to the critical role for primary health care nursing (p.23). This role for nursing is supported by many nursing leaders who, while acknowledging that effective delivery of primary health care requires a range of different skills and practitioners, recommend that nursing has practitioners with the skills and knowledge that are particularly applicable to primary health care settings (Carryer et al., 1999).

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[5] Refer to Chapter 2 for discussion related to funding mechanisms

Another key concept that emerges from the strategy is the emphasis on effective coordination and a collaborative multidisciplinary approach. The concept of multidisciplinary teams has been difficult to implement in the past, partly due to barriers relating to the way services are funded, but also due to issues relating to role ambiguity and confusion around professional identities. The literature will demonstrate some of the barriers that currently exist in relation to this. Later discussion on the implications of the strategy for providers, in Chapter 7, will be informed by the work of Williams (2000) which focuses on issues of role boundaries and professional identities for medicine and nursing. The focus of the discussion relating to the implications of the strategy for consumers will be located within a community development model. Characteristics of this model are reflected by King (2001) in particular in relation to involving communities in primary health care activities and as an effective way to address the inequalities of health that exist.

OUTLINE OF THE STUDY

The introduction chapter is followed by the first part of the study, the literature review that locates the research in an international and national context. Chapter 2 provides an overview of international health reform over the last ten years and then takes a closer look at the impact of reform in New Zealand. It continues by reviewing the different models of primary care in New Zealand including General Practice, Maori and Pacific primary care services and third sector primary care. It compares primary care and the role of GP with other countries. The chapter provides a brief overview of different payment mechanisms used in primary care, including fee-for-service, capitation, bulk funding, salary and co-payments.

Chapter 3 reviews the range of primary health care nursing providers who contribute to primary health care in NZ. It traces their history and provides an overview of their roles. The second section focuses on some of the issues confronting primary health care nursing and links some of the key issues that emerged in chapter 2.

Chapter 4 outlines the methodological and theoretical approaches applied to this study. It discusses the rationale applied to reach the decision to use qualitative document analysis applying the 'framework' approach. It notes that the researcher's employment changed once the study had commenced. This change meant that some of the constraints that had been identified at the start of the study no longer applied. The chapter will outline William's (2000) concern for identifying and managing the different professional identities in order to realise the potential

for primary care. Her concepts will be applied to inform the discussion in chapter 7, which focuses specifically on the implications of the strategy for providers. Chapter 4 will also include an overview of the model of community development that will be applied to inform the discussion in chapter 8, which is related to the implications of the strategy for consumers. This model reflects the characteristics of a population health focus and issues related to health inequities and represent a way of achieving the direction as outlined by King (2001) in her strategy.

Chapters 5 and 6 relate to the 3 key themes following the 'framework approach'. Chapter 5 discusses funding as an overarching and key feature of the strategy. The discussion will include the strengths and weaknesses of the population-based funding approach. This discussion will demonstrate that successful implementation of the strategy is dependant on providers accepting population-based funding. It highlights the implications of this method of funding for both providers and consumers.

Chapter 6 discusses the remaining 2 themes. The first section focuses on the services that are outlined in the strategy. The second section discusses the skills required of providers/practitioners in order to provide the services. The implications of both themes are discussed in relation to providers and consumers.

Chapter 7 and 8 demonstrate the deductive nature of the 'framework' approach, which allows for new categories to be derived partway through the analysis (Pope, Ziebland & Mays, 2000). During the analysis of the 3 key themes, it became apparent that there were specific implications emerging for both providers and consumers.

Chapter 7 discusses the specific implications of the strategy for providers. It considers the data from a much broader perspective than is taken when considering the implications in relation to the 3 themes. The discussion is informed by the work of Williams (2000), as noted above, because of her focus on nurses' and doctors' responses when confronted with policy change and/or health reform. These conditions, similar to the strategy, impact on professional identities and roles. The key is to understand and address them in order to move forward.

Chapter 8 discusses the implications of the strategy for consumers. The discussion is informed by taking a community development model, as noted above, and applying its characteristics to the population health focus of the strategy based on a community development model.

Chapter 9 discusses the findings that emerge out of each of the analysis chapters and relates these to the literature. Significant developments that impact this study, and that have occurred since the release of the strategy, are highlighted. The chapter highlights the constraints to successful implementation of the strategy and recommends an approach that takes into account the significance of the changes required of both providers and consumers. It will note the challenges faced by providers as they struggle to implement the strategy in the midst of restructuring the health sector for the fourth time in ten years, and where the primary health care strategy is only one of a number of strategies to be implemented.

Chapter 10 provides the conclusion to the study, reviewing the methodology and its strengths and limitations. It includes some recommendations for further research and actions related to practice.

CHAPTER TWO – PRIMARY CARE – THE INTERNATIONAL PERSPECTIVE OF THE PAST TEN YEARS

INTRODUCTION

Over the last ten years in particular, public sector health reform has been constant for many western countries. Longley (1996) suggests that in fact it is not just in health, but that government functions as a whole, are being redefined, not just at a central government level but equally at local government level. This has been particularly noticeable in the United Kingdom (UK) and New Zealand (NZ) and to a lesser extent in Canada, Australia and the United States of America (USA).

The main focus of change for health over the past ten years, has included the devolvement of decision making; the separation of policy making from service delivery; use of the private sector for public services; and a greater emphasis on quality of services while controlling costs (Longley, 1996). This focus on change in the health sector has largely been due to the enormous number and diversity of services, along with the development of technology that has changed the consumer's expectations regarding access to health care issues. Economic, political and ideological pressures have added to this (Ilaffe & Munroe, 2000).

Contracting has been instigated as a vehicle to purchase and subsequently deliver services, and decisions have largely been based on economic rationalisation (Brown, 1996). For primary care in particular, the focus on economics and rationalisation as the basis for change has been in direct opposition to the views of international organisations such as the World Health Organisation (WHO). Instead such organisations advocate for reform to be focused in primary care (Maynard & Bloor, 1995) due to the significant evidence of its effectiveness in improving health outcomes (Malcolm, 1999; Pincus et al, 1998.; Shi, 1997; Starfield, 1992).

Prior to 1996 a less ideological approach has been the driving force behind the reforms, resulting in providers competing for business, and a new generation of managers resulting in a devalued role for health professionals particularly in relation to decision making; and fragmentation of services. In the UK, under the Thatcher government, reform has been described as 'big bang' (Ham, 1997), where between 1989 and 1996 the National Health

Service (NHS) was transformed and central government planning gave way to networks. Ham describes the reforms in NZ and Israel as taking a similar 'big bang' approach. By contrast, reform in Holland and Germany has been incremental, while Sweden is described as approaching reform through a bottom up approach where county councils have set the pace and the role of national government is less important. In the USA, Ham (1997) notes, rapid change continues to occur but he describes it as reform without reform.

This chapter will discuss the reform process that occurred in countries such as NZ, the UK, USA, and Australia with specific reference to its impact on primary care. The first section provides an international perspective of reform. Section two outlines the impact for NZ and provides the reader with a broad overview of the way that primary care is funded. The NZ section includes a discussion on the range of models of primary care, specifically for Maori and Pacific people, and for disadvantaged groups which have emerged through the reform process. It provides an overview of the impact of reform on Public Health and the delivery of public health services. Chapter 3 will discuss the roles of the Public Health Nurses, the main providers of public health, in more detail.

INTERNATIONAL PERSPECTIVE

United Kingdom

Like most developed countries, the UK has consistently developed health policies to allocate (usually scarce) resources by determining access to care, either through willingness or ability to pay, or by need (Maynard & Bloor, 1995). This is compounded by the principle of cost containment, which has dominated health reform through the 1990s and which resulted in decision makers being pressurised to make rational choices based on knowledge.

In the UK, from 1948, the National Health Service (NHS) was run through regional authorities. Primary care however had its own equivalent of the District Health Authorities which paid GPs on the basis of the number of registered patients and gave them an administration fee which contributed to the cost of their premises and to pay staff. GP's continued to receive the fee-for-service subsidy[6] as well.

It was the *National Health System and Community Care Act* (1990) that introduced the purchaser/provider split, and the decision of the Thatcher government to develop a competitive model. This split was expected to enable a more independent assessment of population needs and priorities and would enable providers to compete with each other for contracts (Atkin & Lunt, 1997). While the role of the Regional Health Authorities (RHAs) was maintained as planners and distributors of funding, the number of them was reduced by 1996 (Atkin & Lunt, 1997).

A fundamental aspect of the NHS reforms was to shift the focus of health care from secondary to primary care, with a focus on providing care in the community. A population health focus was reinforced. The founding of the Family Health Service Authorities supported this shift along with delegating the responsibility of contracting GPs to deliver medical services for their population (Atkin & Lunt, 1997). To this end, in April 1991, the General Practitioner Fundholding Scheme was established, essentially enabling larger practices to opt to manage their own budgets and to purchase some hospital services as well as diagnostic tests and pharmaceuticals. Practitioner contracts introduced incentives for a range of preventative initiatives and primary care providers were encouraged to provide health education and promotion services.

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[6] Refer to NZ section below for definition of the different funding mechanism

Further change was signalled for primary care with the release of the White Paper (National Health Service, 1998). For primary care the paper focused on a delivery model that was to be developed over the next ten years. In particular it noted the important role of primary care and emphasised the key role of primary care professionals (doctors and nurses). They were considered the health care provider's best placed to understand the needs of individuals as s whole. By 1999 primary health groups had been established with responsibilities for defined populations (Bojke et al., 2001). The groups included NHS trusts, primary care groups and other primary care professionals working in partnership with local authorities and other local health interest groups accepting the devolvement of responsibility and decision-making at a local level (Bojke et al., 2001). This model was expected to encourage those organisations that had previously competed with each other, to work cooperatively and with a focus on treating people according to need. This approach was expected to increase flexibility and achieve improved integration - a contrast to the previous split which had resulted in fragmented services and poor strategic coordination (Bojke et al., 2001).

The contracting approach was changed with annual contracts being replaced with longer funding agreements. National service frameworks would require local teams of GPs and community nurses to work together in primary care groups to provide responsive, accessible and seamless care. A new system of clinical governance would ensure that clinical standards would be met and reinforced through continuous improvement activities. Primary care groups would have devolved responsibility for a budget that would cover most aspects of care (Department of Health, 1997).

Two key findings have emerged regarding this new service framework, from a study carried out by the Public Health Alliance (1998). The first finding highlighted that simply putting groups of people together required some effort being directed into finding new ways to genuinely involve all members of the group working effectively together. The second highlighted that management and organisational culture was shown to be unsupportive of population health initiatives. The study (Public Health Alliance, 1998), recommended that population health activities could not just be 'added on to' primary care and that it must be integral to the strategic development of primary health care.

There are risks associated with devolving responsibility for planning and providing health services to regional and local offices. While the intent is to focus on improved coordination and collaboration, there is the potential for it to result in a lack of coherence and duplication compounded by an increase in bureaucracy and management tiers. By contrast it is argued by

some that local decisions result in a reduction of geographic inequalities, improved integration of services and more coherently planned services (Higgins, 1999). This has yet to be evaluated.

Primary Care in the UK is similar to the NZ model, where individuals choose a GP for their first contact care, assessment, treatment and management of acute and chronic disease and referral to secondary services or specialist care, where appropriate. Like NZ, the GPs in the UK acts as gatekeeper to specialist and secondary services (Starfield, 1998). Some GPs will provide home visits and some provide care for people in nursing homes – known in NZ as Rest Homes and/or residential care. Their work is generally biomedical in nature. GPs in the UK are self-employed but have contracts (funding agreements) with the National Health System (NHS) for managing the health of all people registered with them. They are paid through a mix of fee for service and capitation payments (Koperski et al., 1999).

Australia

Primary health care in Australia, at both a federal and state level, focuses on the provision of services which promote, maintain and restore health. The Australian health care system, including primary care, has much in common with the NZ system. An individual will choose a GP for first point of contact care, management of common conditions, and ongoing maintenance of health problems. GPs themselves, argue that their role is wider than this and includes coordination of patient benefits as well as education regarding prevention and health promotion (Anderson, 1986). Reform in Australia, unlike the USA, UK and NZ, has been focused more on incremental reform as a way of strengthening primary care. The first wave of reform in the 1990s to impact primary care was the establishment of a *General Practice Strategy* (1991). Its purpose was to assist general practice reassert its role within the Australian health system and to ensure the provision of a high quality of care (Bolem, 1996). This strategy included two key programmes. The first programme involved providing financial support to develop infrastructure and projects for groups referred to as divisions of general practice. These divisions are not dissimilar to the NZ IPAs, in that they are self-managed entities formed on a geographical basis (Wilton & Smith, 1999). Funding is in the form of fee for service along with block grants. The second of the key programmes was in the form of a payment supplement for GPs who met the criteria demonstrating that they provided a more comprehensive range of services. This was an attempt to move away from the predominant fee for service funding mechanism and to encourage population health activities. A review of general practice (Commonwealth of Australia, 1998) recommended the need to further enhance the population health role of GPs in cooperation with public health networks. Similar to the UK and the USA, it was found that GPs needed specific training in population-based approaches.

More recently, policy changes have attempted to achieve cost containment and improve cost effectiveness within the primary care sector. One such reform has involved the introduction of coordinated care trials (Wilton & Smith, 1997). These trials have attempted to coordinate services for specific groups of patients using bulk funding rather than fee-for-service payments. A significant feature of the trials was the inclusion of other health services such as pharmaceutical, community, allied health as well as hospital impatient and outpatient services.

Unlike NZ and the UK, Australia has not implemented budget holding initiatives designed to manage the increase in pharmaceutical costs and to cap the level of overall public expenditure (Malcolm & Powell, 1996). Wilton and Smith (1996) suggest that the piecemeal reforms to date in Australia have not addressed the core problems facing primary care and budget holding needs to be considered. Alford (2000) reinforces this and notes that primary health services are uncoordinated and fragmented, resulting in duplication, wastage's and difficulties for people accessing services. Despite these more negative aspects, it has resulted in a change in the way General Practice has been organised, delivered and remunerated over the past decade (Commonwealth of Australia, 1998).

The reforms of 1999 have made an attempt to address these issues with a more political and economic focus, replacing the welfare model of service delivery with a more market oriented model (Alford, 2000). This has included splitting the roles of purchaser and provider and contracting for services. A population-based funding regime was also included in the proposals. These most recent proposed changes have aligned Australia more closely with the more radical reforms undertaken in NZ, UK and the USA.

United States of America

The USA model of primary care is generally very different from that of the UK and NZ, except for the fact that it is referred to as general practice. It has a stronger medical focus and consumers generally have their own secondary service providers instead of GPs, resulting in a much higher use of physicians. Primary care is comprised of teams including physicians, practice nurses and physician assistants which have emerged as a result of roller coaster change through the 1990s (Mullan, 1998). The teams are described by Koperski et al (1997), as poorly developed and dominated by physicians who utilise the other team members as handmaidens. Michel (1997) would suggest this practice of using nurses as handmaidens is not dissimilar to NZ where she describes the use of practice nurses by GPs in a similar way. Despite this, the establishment of the teams has demonstrated an endeavour to strengthen primary care.

By 1994 principles such as integration of health services, clinician accountability and a focus on addressing personal health needs in partnership with patients had been established, along with a concept of practicing in the context of the family and the community. As a result, over the past ten years primary care has gained prominence, particularly in terms of achieving outcomes in relation to health (Mullan, 1998). While there were reported successes of primary medical care practitioners embracing some health promotion and prevention activities, such as cervical screening and immunisation, other aspects have not been embraced to the same degree (US Preventive Services Taskforce, 1996). This issue is a particular challenge for those practitioners who have not received population health training. It is further constrained by the fee-for-service payments, which encourage limited consultation times in order to increase the volume of patients that can be seen in a day. Health education, a major component of population health, takes time and does not fit within a fee-for-service funding structure. The US Preventive Services Taskforce (1996) noted that population health and in particular, health education, is an activity that could be picked up by Nurse Practitioners. This will be discussed further in the following chapter.

Starfield (1998) argues the need for a strong primary health care infrastructure in order to integrate population health services with primary care. This includes addressing issues associated with effective use of resources, such as nurses; addressing roles and role boundaries; and reducing barriers such as co-payments.

Unlike NZ and the UK, the USA had undergone less constant policy change until the early 1990s when Clinton's health plan was introduced. The plan was introduced with overriding goals including the accomplishment of quality and cost control as well as improved access to services (Williamson, 1994). This required significant restructuring of the health industry. The plan however was dumped and replaced with the managed care system (Mullan, 1998). Managed care in the US has meant that managers have more say over physicians in determining care, and the health insurer controls and /or coordinates the use of health services in order to contain costs. It is within this managed care system that primary care and in particular, the physician, has attained the critical gatekeeping role, particularly controlling referrals to secondary care. While the main focus, as has been noted, is to contain costs, Starfield (1998) comments on some of the more positive aspects of managed care. She suggests that it encourages improved coordination of care due to the more formal links between the levels of care (primary and secondary), and better communication due to enhanced electronic communication. There are risks associated with managed care as it can segregate well populations from less healthy, lower socio-economic groups through the enrolment process,

thus reducing access to primary care services for these groups (Starfield, 1998). Koperski et al (1997) note that despite the potential for managed care to improve coordination, in reality the USA has no coherent policy for developing primary care whose system is currently "dispersed, uncoordinated and fragile" (p.319).

NEW ZEALAND - REFORM AND PRIMARY CARE

It was the National Government in 1991, in line with the 1989 Public Finance Act, who made the decision to split the purchaser/provider roles in health service provision and in 1993 enacted the *Health and Disability Services Act*. This resulted in the establishment of 4 regional health authorities which were each assigned the total health budget for their regions, along with a responsibility to purchase services to best meet the needs of the people. Details of how that should happen were reflected in the government's health policy statement (Upton, 1991) and which would become referred to as the Green and White paper.

The Green and White paper focused on the need for a more integrated approach to managing total health care. It described the health system as suffering from poor communication and coordination and costly duplication of services all compounded by fragmented funding. In particular the paper stated that the government planned to "encourage better coordination in the management of total health care across general practice, other community - based services and hospital services" (Upton, 1991, p.41). People's choices of different styles of health care would be improved by allowing, for example, more services to be delivered by nurse practitioners and other health professionals as well as doctors. This would make it easier for all those groups to deliver more health promotion and education.

Primary Care, in particular, was most affected by the reform processes, starting with the change to the funding body. Up until that time primary care services had been subsidised through the Department of Health with a subsidy level varying from between 0 – 100% and with the expectation that users of the services would pay part charges and thus contribute to the costs of some of those services. The subsidy, historically, has been paid to general practitioners (GPs) on a fee-for-service basis – a more detailed description of this will be outlined later – however the Green and White paper recommended that payment mechanisms, through contracts for services, should start to change. Upton (1991) described this mechanism for payment as a "procedure based medical care payment" (p.49), and stated that he wanted it changed to that of a capitated payment method. This, it was believed, would alter the perverse incentives that existed

in the fee for service payment mechanism and which were reflected in overservicing, a focus on less complex cases and inhibited or inappropriate use of other health providers (Crengle, 1999). Instead, it was expected that a capitation method of payment would encourage teamwork and enable more attention to be given to health promotion (Cumming, 1999).

However by 1996, despite the recommendations outlined in the Green and White paper, there had been little movement towards achieving a change in funding mechanisms and only 20% of GPs were being funded through capitation arrangements (Coster & Gribben, 1999). By 1998 further reform had taken place and the 4 regional health authorities had merged to form one national body, the Health Funding Authority. Again, the issue of funding mechanisms was raised with GPs, with the development of a proposal to implement capitation nationally in the form of population based funding (Health Funding Authority, 1998). This never progressed as GPs were concerned, as they had been all the way along, that they might be financially disadvantaged. Thus the proposal was rejected (Coster & Gribben, 1999).

Then in 1999, the general elections resulted in a change of government. The newly elected Labour led Coalition Government announced its decision to disband the Health Funding Authority and establish District Health Boards (DHBs), thus reversing the funder/provider split that had been recommended so strongly back in the early 1990s (Howden-Chapman & Ashton, 1994). These DHBs are similar to the old Area Health Boards that existed in 1989 under the Labour government. The most significant difference between the two structures is that the DHBs are responsible for both purchasing and providing services for people in their region, including primary care (French, Old & Healy, 2000).

General Practice has for some time been central to the delivery of publicly funded primary care in NZ with GPs remaining a core element in service provision (National Health Committee, 2000). It is also the largest recipient of funding for primary care services and furthermore it is argued by some that primary care is in fact dominated by primary medical providers (Tukuitonga, 1999). Over the last ten years the most significant development in relation to General Practice has been the development of Independent Practitioner Associations (IPAs). Simultaneously GPs moved away from working in sole practitioner situations to small group practices generally comprising a team of GPs, Practice Nurses, receptionist(s) and a Practice Manager. Today there are only approximately 27% of GPs working in sole practices with the remainder working in group practices (New Zealand Health Information Service, 2000). For IPAs, their development was largely in response to an *Auckland Uniservices Report* (1992) and occurred at about the same time that the 4 RHAs were established. They have emerged as

groupings of doctors who have formed to act as umbrella organisations to take contracts through the funding body for the provision of a range of primary care services (Coster & Gribben, 1999). What this served to do what to position them well for any future contracts and funding opportunities, establish them as lobbying bodies and subsequently disadvantage many other existing and potential service providers such as nurses. This was in spite of the recommendation in the Green and White paper (1991) which discussed the potential for the development of other service providers, in particular nurse practitioners. It must also be noted that the development of IPAs was largely achieved through significant financial support from the regional health authorities (Coster & Gribben, 1999). This has not gone unnoticed by other primary care providers and nurses argue strongly that GPs have been significantly advantaged through contracting efforts, which they have rarely been eligible for (Ministerial Taskforce on Nursing, 1998).

By 1996, there were forty-two IPAs but, as noted above, there was little movement towards any change in funding and payment mechanisms. Fee-for-service subsidies remained dominant. Over the following three years some consolidation in the number if IPAs occurred and as a result of amalgamation there was a resulting increase in the number of GPs per IPA. By 1999 IPAs were able to demonstrate that through some of the contracts that they had been awarded for services, such as budget holding for pharmaceuticals and laboratory tests, they had been able to achieve savings. This enabled them to develop additional services for patients as well as provide continuing medical education for their GPs and develop information systems (Coster & Gribben, 1999).

The role of the General Practitioner

Historically, primary care internationally has been characterised by the type of practitioner providing the service – the GP (Starfield, 1998). The GP is typically the first point of contact into the health system through self-referral for a specific health episode generally in reaction to an acute or chronic health need. The emphasis is mainly on the curative aspects of medical care (Carryer et al., 1999). In order to carry out the consultation the GP must be skilled in diagnosis and treatment modalities for both life threatening and chronic diseases. As well they need to be proficient in managing a wide range of minor problems for a cross section of patients of all ages. GPs also have a significant gate-keeping role, as noted above, and hold the responsibility for referring patients to specialist services where required (Jeffreys & Sach, 1983). Their role and responsibilities are not only general in nature but also quite diffuse. This role, generically described, would not differ significantly throughout the western world. .

Funding for General Practice

This section will describe the funding mechanisms for General Practice in NZ, however the descriptions of the mechanisms for fee for service and capitation are applicable to other countries that utilise those same payment mechanisms. GPs working in General Practice receive government subsidies for GP care, pharmaceuticals and laboratory tests along with variable levels of patient co-payments depending on the fees set by the GP. The funding arrangements vary from a fee-for-service model to capitation – a method of payment that had been proposed, as earlier mentioned, throughout the reform process and gradually introduced in some areas of NZ over the past few years. Both mechanisms of payment have been exposed to criticism and support with benefits and disadvantages identified for both.

Fee for Service

A fee-for-service subsidy involves the payment of a predetermined subsidy to the GP, from the health funder, in return for a consultation with a patient who is either the holder of a community services card or a child under the age of six years. A fee-for-service system tends to result in short visits and presents a risk of attracting additional visits in order to maximise the amount received. The more people the GPs see, the more they get paid. Because the fees are tagged specifically to a GP consult it tends to discourage the use of other and possibly more cost-effective providers (Cumming, 1999). Starfield (1992) notes that this is the most common method of payment for primary care in most western countries. In NZ this method of payment is received by approximately 85% of GPs (French et al., 2001).

Capitation

Capitation on the other hand involves providers being paid a "per head" amount for a given period for all the people enrolled or registered with them. The payments can be adjusted according to the type and range of services and for the type of population that is being served. The risk with this type of payment is that the GP may provide less care than is required may be delivered in order to improve or maintain health. By contrast it provides a strong incentive for providers to try and keep their population group healthy by providing preventive care, health education and health promotion. It predicts cash flow and also allows for more flexible use of resources such as nurses. (Cumming, 1999). French et al. 2001) reinforce the latter and suggests that this would free GPs to assume more complex work. French et al (2001) query whether GPs would retain the right to charge a fee-for-service, or co-payment, within a capitation-funding model. Approximately 15% of NZ GPs are remunerated in this way (French et al., 2001).

Budget Holding

Pharmaceuticals and laboratory services are funded through budget holding arrangements where a provider is paid a budget for a nominated period of service delivery. The risk with this sort of funding is that if more services are delivered than are funded for, the providers do not receive more funding. In other words the providers carry the risk of going over budget so have a strong incentive to stay within budget or reduce their ordering and make savings. These savings may then be used for additional services. Currently in NZ, this form of budget holding is nominal only and the risk is generally shared between the provider and the funder. However the common practice has been that the funders have usually covered additional costs above and beyond the budgets (Cumming, 1999).

Salary

In this method of payment, the GP receives a fixed sum from the health funder for their professional services (Starfield, 1992). The GP is usually not self employed. Health Care Aoteoroa (HCA), a large provider of primary health care services throughout NZ, is a good example of an organisation that employs GPs and other health professionals and reimburses them for the services they provide by means of a salary (Crampton, 1999).

Co-payments

The requirement for people to meet some or all of their primary care costs has been a part of government policy for some time. For low income people and children this requirement has been partially alleviated throughout the 1990s with targeted benefits aimed to improve access to primary care services and pharmaceuticals. This was achieved through benefits such as the introduction of community services and high user health cards to lower income people and the free services for children under 6 years of age. In turn, as highlighted above, this entitles the GP to the GMS subsidy. This targeted approach is different from other countries that have enforced statutory insurance (Hindle & Perkins,2000). This results in the insurance company either reimbursing the GP or the patient directly for services (Starfield, 1992). In NZ the targeted groups are still required to pay an additional fee-for-service to the GP. Cumming (1999), in her role as a health economist, puts patient co-payments into perspective. Her view is that co-payments have a tendency to impede attempts to improve access to health or to promote a population based approach to care particularly for lower socio-economic groups who already have poorer health status than their more well off counterparts. This is reinforced by the National Health Committee (2000) who note that evidence suggests that co-payments selectively reduce access to services for low income people and probably contribute to the

inequities in the distribution of public funding for primary care services. Because the co-payment is payable at the time of the visit, low income people tend to either not seek services or utilise the emergency department at public hospitals.

Other Models of Primary Care in New Zealand

General Practice, while being viewed as the mainstream provider for primary care services, is not the only model of care that is established in New Zealand and the National Health Committee in its report (2000) notes that alternative models, in particular, Maori and Pacific models should continue to be supported.

Models of Primary Care for Maori

Maori have been involved in the provision of primary care and public health since the early 1900s. Since the 1970s, Maori health initiatives have slowly increased, largely due to the political action directed to reaffirming the Treaty of Waitangi. Throughout the period between 1984 and 1994 there was increasing recognition of Maori rights, the establishment of Maori health committees and recognition of Maori health as a health gain priority area (Crengle, 1999).

In 1991 the government announced a programme of health reform which offered significant opportunities for Maori in health service provision (Upton, 1991). This included the development and management of Maori health programmes and services with particular emphasis on health promotion and education. More importantly it meant that Maori solutions would be developed to address Maori problems with the assistance of government funding. As a result of this, contracts were offered by funding authorities, throughout the period of the 1990s, to Maori providers for defined services. These usually encompassed general practice and health promotion and screening to specific services such as well child (Durie, 1998). As a result of this activity through the 1990s there are now over three hundred Maori health service providers, most of whom provide primary health care services (Crengle, 1999). These are commonly referred to as services 'for Maori, by Maori', are generally Iwi or tribal based, and many of them are funded on a capitation basis providing them with a degree of autonomy and some ability to risk share. This then enables them to provide services in a more flexible way with health centres and mobile clinics on marae and in other settings (Durie, 1998).

Despite this development, HFA data in the mid 1990s, show that disadvantaged groups such as Maori remained underserved contributing to their poorer health status and greater use of hospitals (Malcolm, 2000). This is described as 'inverse law' where those people who have the greatest need have less access to health care (French et al., 2001). This situation is also reflected in rural communities who are frequently comprised of lower socio-economic groups. This situation has led to the development of nurse-led services in Northland. Over the years these have grown to include medical practitioners (Carryer et al., 1999). Now there is a mix of services, some with general practitioners as an integral part of the services, and some where there is assurance that patients can access a doctor if required.

A further recent development has seen the growth of Maori Integrated Organisations (MICOs) who are beginning to act as purchaser/ contract managers. Crengle (1999) describes them as still being in their formative stage but that ultimately they should develop the capability to assume purchasing and monitoring responsibilities for all Maori health for their region.

Pacific primary health services

Pacific health services have also developed in response to health reform. For Pacific people financial, language and cultural barriers combined with a perception that mainstream services are inappropriately delivered to their people, has seen them over-represented in hospital discharge statistics for conditions which are frequently preventable (Tukuitonga, 2000). This situation is compounded by an over representation of their population in adverse socio-economic circumstances caused through unemployment, overcrowding and poor quality housing (Tukuitonga, 1998). Thus, in response to this and in line with opportunities presented through the health reforms of the 1990s, a number of 'by Pacific for Pacific' models of health care have emerged. By 1999 there were thirty Pacific owned health providers along with a lesser number of churches who due to the significant role they have in the community, were contracted to provide health education and promotion programmes (French et al., 2001).

The majority of these models are based in Auckland with services focused on prevention programmes and the provision of primary care. This is largely due to the high rates of hospitalisation for communicable disease, accidents and injury as well as for chronic disease (Ministry of Health, 1999). They are generally community focused, community owned and operated. They are funded through the existing funding arrangements that are available to all general practitioners throughout the country and include a mix of fee for service, bulk funding and some additional project funds (Tukuitonga, 1999). Their funding opportunities have not

included the specific workforce and provider development funding that Maori providers received.

Pacific health providers also differ somewhat from Maori in their approach to providing health services for Pacific people. While Maori strongly believe in services 'for Maori by Maori', Pacific providers acknowledge that their models of care cannot meet the entire needs of their population, largely due to a paucity of trained Pacific health professionals. In fact a considerable number of staff, particularly GPs who are employed within their service models, are not Pacific. This lack of appropriately trained Pacific health professionals places some pressure on mainstream providers to provide services in a way that make them acceptable to Pacific people in order to manage the demand on the 'by Pacific, for Pacific' models of care (Tukuitonga, 1999).

Third sector primary care

A third and different model again has been growing over the past ten years in NZ and is referred to as 'Third Sector' primary health care. It is a term applied internationally to describe organisations that are non-government and non-profit. In New Zealand, in particular, they have taken on a specific role to address the health care needs of vulnerable groups (Crampton, 1999). They started to have significant presence in the late 1980s with the establishment of the Union Health Centres, as a response to the trade union movement's commitment to respond to the demands of its members for affordable high quality care (Crampton, 1999). Throughout the 1990s they developed further as alternatives to traditional primary care arrangements (Shipley, 1995). They are frequently Iwi based, have a strong emphasis on providing primary care and population focused services for low-income people and on working bi-culturally. Funding is largely achieved through public health funding (Crampton, 1999).

Public Health

Public health services have been a part of mainstream health care since the *1983 Area Health Board Act* and generally refer to activities to prevent disease, prolong life and promote health (French et al., 2001). This changed in 1991, when it was determined through the Green and White paper (Upton, 1991) that personal and public health services would be purchased separately and that a Public Health Commission would be responsible for purchasing public health services. This according to Upton (address to the *Health Promotion Forum*, Auckland, 24 October, 1991), demonstrated the importance that the government placed on public health and health promotion activities. This separation of public health from personal health services is viewed as difficult as many personal health providers, and in particular primary care

providers, provide some elements of public health such as screening (Bandaranake, 1994). This concern is highlighted in the discussions related to the roles of nursing working in primary care settings[7]. It was also in contrast to the emphasis placed on integration of primary and secondary services in the Green and White paper (Upton, 1991).

In 1993 a report released by the Public Health Commission, in compliance with its requirement by the 1993 *Health and Disability Services Act*, described the health status of New Zealanders and attributed their low health status not just to people's lifestyles but also to the government's economic and social policies. The intent, therefore, of Upton (1991) to maintain a public health focus through the establishment of a separate structure and the subsequent disestablishment of the Public health Commission resulted in a loss of focus on the health status of New Zealanders and an emphasis on health expenditure (Finlayson, 1996).

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[7] See Chapter 3 re Practice Nurses and Public Health Nurses

CONCLUSION

The above discussion has highlighted the constancy of health reform over the past ten years, whether it has been incremental in nature such as in Australia and Europe or more radical as in the UK, USA and NZ. The driving forces have largely been economic and political, as governments have struggled to contain rising costs and increasing demand for services. The approaches taken have been diverse, ranging from introducing policy to address the barriers to care, to policy that changes the incentives to provide services. In particular this has included attempts internationally, with variable success, to encourage primary care to encompass population health activities. The need for GPs to receive additional training in population health activities is raised as an issue, as well as concern that population health can not just be 'added on' to primary care (Commonwealth of Australia, 1998). Starfield (1998) summarises the approaches by noting that whatever the approach, all countries face similar challenges " to provide services in an effective, efficient and equitable manner" (p.101).

Splitting the role of purchaser and provider was fundamental to most of the policies, providing a framework for establishing competition and the adoption of a market driven approach. Through this market driven approach, particularly in NZ, primary care and GPs have been encouraged to become more accountable through competition and contracting for services as well as being more responsive and flexible to consumers needs (Howden-Chapman & Ashton, 1994). Both providers and funders have appeared to have more of a concern for managing costs.

Considerable time (and funding) has also been directed to the establishment of the IPAs. While this has been a significant shift for GPs who were more used to functioning as autonomous practitioners, it has done little to shift funding mechanisms, which were proposed by Upton (1991). As a consequence, the benefits that Upton (1991) proposed would emerge from a more flexible payment mechanism, such as captitation, have not been realised. Fee-for-service payments remain the dominant mechanism, maintaining the status quo of the dominant primary care model, with the GP as the lead practitioner. GPs in NZ, like their international colleagues, are commonly self employed and although fee-for-service remains dominant there is a mix that includes capitation and private fees (Koperski et al., 1997).

The models of primary care or more appropriately, primary medical care, are similar in many western countries and have been briefly described. In general, individuals within a population

will choose a general practitioner for their first contact care; assessment, treatment and management of acute and chronic disease; referral to secondary services or specialist care where the GP acts as the gatekeeper (Starfield, 1998). The work of the GP to date has been biomedical in nature with a focus on technical and curative care rather than preventive or community oriented (Johnstone, 1995). This is despite attempts through reform, as noted above, to try and get GPs more involved in the provision of population health services.

Collaboration and teamwork between doctors and nurses has varied internationally with the UK and the USA leading the western countries in this area. Over the past few years it has increasingly become an issue in relation to effectiveness and efficiency of service delivery yet it has been slow to progress particularly in NZ. Evidence from the UK suggests that getting groups to work effectively together takes more than just forming them into a group (Public Health Alliance, 1998). Despite this, teamwork is seen as integral to successful integration of population health activities into existing primary health care services. The literature starts to highlight potential roles for nurses, particularly when barriers such as fee-for-service payments are replaced with capitation funding models (Cumming, 1999; French et al., 2001). Barriers such as the funding mechanism and the dominance of the GP continue to inhibit progress.

New models of primary care, as a result of Maori and Pacific provider development have emerged have emerged over the past few years in response to the reforms, highlighting a transition from the traditional, or mainstream, primary care model that dominates in NZ. Their models reflect more of a population focus where they provide services ranging from first contact through to health promotion and education. Services are frequently mobile and provided in settings that are more accessible to their consumer group.

Therefore, while for NZ in particular, the past ten years of reform have made significant attempts to change primary care both through service delivery and funding there has been little progress. The emphasis remains in a primary medical model with little evidence of a population health focus or any desire on the behalf of GPs to change.

The following chapter will address the role of nurses working in primary care and primary health care settings in NZ.

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CHAPTER ONE – INTRODUCTION TO THE STUDY

In February 2001, the Honourable Annette King, Minister of Health for the Labour Government, released *The Primary Health Care Strategy*. *The Primary Health Care Strategy* (to be referred to as 'the strategy') is a key part of an overall framework aimed at achieving a health system for the people of New Zealand that will help to reduce the health inequalities that exist and to ensure that health services are directed to achieve the greatest benefits for the population (King, 2001). The *Primary Health Care Strategy* sets out King's vision for primary health care to be achieved over the next five to ten years. King's vision involves a direction for primary health care with a greater emphasis on population health and the role of the community, health promotion and preventive care, the need to involve a range of professionals and the advantages of funding based on population needs rather than fees for service (King, 2001, p. viii).

In order to achieve the vision, King (2001) outlines six key directions which involve primary health care moving to a system where services will be organised around the needs of the population. This system will involve local structures to be established which will be known as Primary Health Organisations (PHOs), and which will be funded by District Health Boards. The funding mechanism referred to as 'population-based' funding is viewed by King (2001), as the fairest way to allocate funding to ensure the needs of the population are served. King (2001) claims that "when funds are not tied to particular numbers of services or types of practitioners there are no barriers to using the most appropriate health practitioner in each situation" (p.14). This study will highlight the significant implications this strategy has for providers[1] and consumers[2]. Qualitative document analysis will be used.

The topic for this study fully emerged when the researcher was employed by the Health Funding Authority in the Change Management team, and was assigned the role of Project Manager for Primary Care. During this period she was seconded to the Ministry of Health's Primary Health Care Reference Group advising and assisting in the development of the strategy. This role involved providing expert advice by commenting on the summary of submissions; commenting on the implications of the strategy as it developed; and engaging with the sector, and sharing ideas within recognised constraints relating to confidential information (King, 2001). This situation changed when the researcher moved on from being an employee with the Health

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[1] The term provider will be used throughout the study and will relate to those groups that have direct or indirect responsibilities for providing primary health care services. This will largely include District health Boards, Primary Health Organisations and health practitioners.

Funding Authority, with particular ideas about the strategy, to someone who looks back on her involvement in the development of the strategy using it as an academic research frame.

King (2001), in her strategy provides details of the way the vision will be achieved and acknowledges that it will involve a period of change. The researcher believes, however that the significance of the change has not been taken into account. While the strategy formulates a number of principles that are expected to ensure "a stable and constructive transition" (p.27) it lacks a specific and detailed implementation plan and instead delegates that responsibility to the newly formed District Health Boards. This lack of a detailed implementation plan, combined with her earlier experience in roles related to primary health care led the researcher to identify her research problem – *'What are the implications of the 2001 Primary Health Care strategy for providers and consumers?'*

For the purpose of this study it is important to declare the researcher's experience in primary health care roles, particularly her role within the Health Funding Authority. Throughout her career the researcher has had a number of different roles located in primary health care settings. These roles included that of Public Health Nurse, Independent Nurse Practitioner, and more latterly in the Health Funding Authority (HFA), and for a short time in the Ministry of Health. This role involved purchasing, funding and policy development related to primary care services. One of her key assignments in the HFA, as noted above, was to project manage the development and implementation of a national primary care contract. This also led to her secondment to the primary health care strategy reference group. The last two experiences have left the researcher with an interest in primary health care and its interface with the rest of the health sector. In particular, it was during the development of the strategy that the researcher developed insight to understand the impact on General Practice, which, will be argued, is the lynchpin of primary care.

This is of particular significance in relation to King's (2001) strategy which signals a radical shift from the current medically driven primary care service[3] to a new primary health care environment. A part of this process involves a new system, as described above, which involves new structures – PHOs – through which primary health care services will be funded and provided. This implies a change that potentially impacts on the current Independent Practitioner Associations (IPAs) the majority of General Practitioners (GPs) belong to[4]. The strategy

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[2] The term consumers will refer to individuals, groups or communities who are potential or actual recipients of primary health care services
[3] The differences between primary care and primary health care are described below
[4] see below and Chapter 2 for description of IPAs

appears to assume that this radical shift, as outlined by King (2001), will be accepted and fully implemented by all providers of primary health care.

This study will argue that the providers who will be most affected by the strategy will be those involved in the current primary care setting (GPs and Practice Nurses) and to a lesser degree, other nurses currently involved in the provision of primary health care services. Therefore the discussions relating to the implications of the strategy for providers, will focus on GPs and primary (health) care nurses. It is acknowledged that there are other providers, such as midwives, physiotherapists and pharmacists, involved in the provision of primary health care, but they will not be included in the discussion in this study.

METHODOLOGY

The decision to apply the research methodology of qualitative document analysis emerged as a result of a number of considerations. Firstly, because of her role in developing the strategy, the researcher decided that it would be of benefit to examine the meaning and relevance of the strategy document using a formal analytical process Secondly, the researcher identified the 'framework approach', a methodology that has been used by the Social and Community Planning Research Unit, in the United Kingdom, to conduct applied qualitative policy research (Ritchie & Spencer, 1994). Frequently in applied policy research, document analysis is used as either a part of or for the entire project. For this study, document analysis will be the only methodology applied. Thirdly, policy analysis is usually targeted to provide answers to assist in greater understanding of the issues, and so it was considered an appropriate and useful methodology to apply to this study (Ritchie & Spencer, 1994). The study therefore could be viewed as useful to providers as they commence the change to achieve the directions outlined by King (2001).

THE PRIMARY HEALTH CARE STRATEGY - THE CONTEXT IN RELATION TO THE STUDY

The release of the strategy in February 2001, coincided with the restructuring of the health sector in response to *The New Zealand Public Health and Disability Act, 2000.* This Act dissolved the Health Funding Authority (HFA) and replaced it with twenty-one District Health Boards (DHBs). They were, tasked with the responsibility for assessing the health and disability needs of their communities, and managing resources and service delivery to meet these needs. The Ministry of Health (MOH) would support the DHBs through its regulating, funding and monitoring role (King, 2001). Thus, the Primary Health Care strategy was released in the midst of significant change, where newly established DHBs were grappling with their responsibilities and, in particular, the added responsibility for funding and providing primary health care services. Up until this most recent reform, primary health care had been funded by the Health Funding Authority through a range of different contracts and with a number of different providers. Services for primary care had predominantly been contracted through organisations known as Independent Practitioner Associations (IPAs) while population services had mainly been contracted through the Hospital and Health Service (HHS) providers. In the new environment primary health care services (including primary care and population health services, commonly referred to as public health services) would be contracted and funded through new and different organisations to be known as Primary Health Organisations (PHOs).

The literature review will show this reform process was one of many that has been implemented over the last ten years with varying successes and failures. It will reveal that the government for some time has attempted to improve primary health care in line with the *Ottawa Charter for Health Promotion* (Health and Welfare Canada, 1986). Malcolm (1993) reported that throughout the health reforms of the 1990s, the focus was on supporting primary medical care to the detriment of primary health care. This can be attributed in part to the confusion that exists within the health sector between the terms 'primary care' and 'primary health care' with both frequently being used interchangeably. King (2001) refers to the definition drawn up at Alma-Ata in 1978. This definition bases primary health care in "practical, scientifically sound, culturally appropriate methods that is [sic]:

-Universally acceptable to people in their communities

-Involves community participation

-Integral to, and a central function of, New Zealand's health system

-The first level of contact with our health system" (p.1).

Primary health care within this definition is much broader than primary care which can be described best as primary medical care, consistent with care and services usually provided by a General Practitioner (Carryer et al., 1999). For this study, the term primary health care will refer to the broader definition as described in King (2001). Primary care or primary medical care will be used to refer to those services currently provided by a General Practitioner (GP) or a Practice Nurse and which are typically the first point of contact where people enter the health care system (Stanhope & Lancaster, 1996).

THE AIM OF THE STUDY

The aim of the study is to discuss the implications of *The 2001 Primary Health Care Strategy* (King, 2001) and its implications for providers and consumers. It will demonstrate that the government's 2001 strategy document, outlining the changes to the way services are provided and funded, will have a major impact on both groups. Discussions will be related to population-based funding as the key to enable the changes required by King (2001); the range and change to skills and services; and the implications of the strategy for both providers and consumers. The literature will show, that despite previous attempts to introduce population based funding, there has been considerable resistance by primary care providers (GPs) to accept it, thus maintaining the status quo of the predominant fee-for-service payment mechanism[5]. This resistance is viewed as a means of continuing a primary medical care model where funding is directed to specific practitioners (GPs) creating barriers for effective utilisation of other practitioners (Carryer et al., 1999).

The potential for better utilisation of primary health care nurses will be explored in response to the strategy's explicit reference to the critical role for primary health care nursing (p.23). This role for nursing is supported by many nursing leaders who, while acknowledging that effective delivery of primary health care requires a range of different skills and practitioners, recommend that nursing has practitioners with the skills and knowledge that are particularly applicable to primary health care settings (Carryer et al., 1999).

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[5] Refer to Chapter 2 for discussion related to funding mechanisms

Another key concept that emerges from the strategy is the emphasis on effective coordination and a collaborative multidisciplinary approach. The concept of multidisciplinary teams has been difficult to implement in the past, partly due to barriers relating to the way services are funded, but also due to issues relating to role ambiguity and confusion around professional identities. The literature will demonstrate some of the barriers that currently exist in relation to this. Later discussion on the implications of the strategy for providers, in Chapter 7, will be informed by the work of Williams (2000) which focuses on issues of role boundaries and professional identities for medicine and nursing. The focus of the discussion relating to the implications of the strategy for consumers will be located within a community development model. Characteristics of this model are reflected by King (2001) in particular in relation to involving communities in primary health care activities and as an effective way to address the inequalities of health that exist.

OUTLINE OF THE STUDY

The introduction chapter is followed by the first part of the study, the literature review that locates the research in an international and national context. Chapter 2 provides an overview of international health reform over the last ten years and then takes a closer look at the impact of reform in New Zealand. It continues by reviewing the different models of primary care in New Zealand including General Practice, Maori and Pacific primary care services and third sector primary care. It compares primary care and the role of GP with other countries. The chapter provides a brief overview of different payment mechanisms used in primary care, including fee-for-service, capitation, bulk funding, salary and co-payments.

Chapter 3 reviews the range of primary health care nursing providers who contribute to primary health care in NZ. It traces their history and provides an overview of their roles. The second section focuses on some of the issues confronting primary health care nursing and links some of the key issues that emerged in chapter 2.

Chapter 4 outlines the methodological and theoretical approaches applied to this study. It discusses the rationale applied to reach the decision to use qualitative document analysis applying the 'framework' approach. It notes that the researcher's employment changed once the study had commenced. This change meant that some of the constraints that had been identified at the start of the study no longer applied. The chapter will outline William's (2000) concern for identifying and managing the different professional identities in order to realise the potential

for primary care. Her concepts will be applied to inform the discussion in chapter 7, which focuses specifically on the implications of the strategy for providers. Chapter 4 will also include an overview of the model of community development that will be applied to inform the discussion in chapter 8, which is related to the implications of the strategy for consumers. This model reflects the characteristics of a population health focus and issues related to health inequities and represent a way of achieving the direction as outlined by King (2001) in her strategy.

Chapters 5 and 6 relate to the 3 key themes following the 'framework approach'. Chapter 5 discusses funding as an overarching and key feature of the strategy. The discussion will include the strengths and weaknesses of the population-based funding approach. This discussion will demonstrate that successful implementation of the strategy is dependant on providers accepting population-based funding. It highlights the implications of this method of funding for both providers and consumers.

Chapter 6 discusses the remaining 2 themes. The first section focuses on the services that are outlined in the strategy. The second section discusses the skills required of providers/practitioners in order to provide the services. The implications of both themes are discussed in relation to providers and consumers.

Chapter 7 and 8 demonstrate the deductive nature of the 'framework' approach, which allows for new categories to be derived partway through the analysis (Pope, Ziebland & Mays, 2000). During the analysis of the 3 key themes, it became apparent that there were specific implications emerging for both providers and consumers.

Chapter 7 discusses the specific implications of the strategy for providers. It considers the data from a much broader perspective than is taken when considering the implications in relation to the 3 themes. The discussion is informed by the work of Williams (2000), as noted above, because of her focus on nurses' and doctors' responses when confronted with policy change and/or health reform. These conditions, similar to the strategy, impact on professional identities and roles. The key is to understand and address them in order to move forward.

Chapter 8 discusses the implications of the strategy for consumers. The discussion is informed by taking a community development model, as noted above, and applying its characteristics to the population health focus of the strategy based on a community development model.

Chapter 9 discusses the findings that emerge out of each of the analysis chapters and relates these to the literature. Significant developments that impact this study, and that have occurred since the release of the strategy, are highlighted. The chapter highlights the constraints to successful implementation of the strategy and recommends an approach that takes into account the significance of the changes required of both providers and consumers. It will note the challenges faced by providers as they struggle to implement the strategy in the midst of restructuring the health sector for the fourth time in ten years, and where the primary health care strategy is only one of a number of strategies to be implemented.

Chapter 10 provides the conclusion to the study, reviewing the methodology and its strengths and limitations. It includes some recommendations for further research and actions related to practice.

CHAPTER TWO – PRIMARY CARE – THE INTERNATIONAL PERSPECTIVE OF THE PAST TEN YEARS

INTRODUCTION

Over the last ten years in particular, public sector health reform has been constant for many western countries. Longley (1996) suggests that in fact it is not just in health, but that government functions as a whole, are being redefined, not just at a central government level but equally at local government level. This has been particularly noticeable in the United Kingdom (UK) and New Zealand (NZ) and to a lesser extent in Canada, Australia and the United States of America (USA).

The main focus of change for health over the past ten years, has included the devolvement of decision making; the separation of policy making from service delivery; use of the private sector for public services; and a greater emphasis on quality of services while controlling costs (Longley, 1996). This focus on change in the health sector has largely been due to the enormous number and diversity of services, along with the development of technology that has changed the consumer's expectations regarding access to health care issues. Economic, political and ideological pressures have added to this (Ilaffe & Munroe, 2000).

Contracting has been instigated as a vehicle to purchase and subsequently deliver services, and decisions have largely been based on economic rationalisation (Brown, 1996). For primary care in particular, the focus on economics and rationalisation as the basis for change has been in direct opposition to the views of international organisations such as the World Health Organisation (WHO). Instead such organisations advocate for reform to be focused in primary care (Maynard & Bloor, 1995) due to the significant evidence of its effectiveness in improving health outcomes (Malcolm, 1999; Pincus et al, 1998.; Shi, 1997; Starfield, 1992).

Prior to 1996 a less ideological approach has been the driving force behind the reforms, resulting in providers competing for business, and a new generation of managers resulting in a devalued role for health professionals particularly in relation to decision making; and fragmentation of services. In the UK, under the Thatcher government, reform has been described as 'big bang' (Ham, 1997), where between 1989 and 1996 the National Health

Service (NHS) was transformed and central government planning gave way to networks. Ham describes the reforms in NZ and Israel as taking a similar 'big bang' approach. By contrast, reform in Holland and Germany has been incremental, while Sweden is described as approaching reform through a bottom up approach where county councils have set the pace and the role of national government is less important. In the USA, Ham (1997) notes, rapid change continues to occur but he describes it as reform without reform.

This chapter will discuss the reform process that occurred in countries such as NZ, the UK, USA, and Australia with specific reference to its impact on primary care. The first section provides an international perspective of reform. Section two outlines the impact for NZ and provides the reader with a broad overview of the way that primary care is funded. The NZ section includes a discussion on the range of models of primary care, specifically for Maori and Pacific people, and for disadvantaged groups which have emerged through the reform process. It provides an overview of the impact of reform on Public Health and the delivery of public health services. Chapter 3 will discuss the roles of the Public Health Nurses, the main providers of public health, in more detail.

INTERNATIONAL PERSPECTIVE

United Kingdom

Like most developed countries, the UK has consistently developed health policies to allocate (usually scarce) resources by determining access to care, either through willingness or ability to pay, or by need (Maynard & Bloor, 1995). This is compounded by the principle of cost containment, which has dominated health reform through the 1990s and which resulted in decision makers being pressurised to make rational choices based on knowledge.

In the UK, from 1948, the National Health Service (NHS) was run through regional authorities. Primary care however had its own equivalent of the District Health Authorities which paid GPs on the basis of the number of registered patients and gave them an administration fee which contributed to the cost of their premises and to pay staff. GP's continued to receive the fee-for-service subsidy[6] as well.

It was the *National Health System and Community Care Act* (1990) that introduced the purchaser/provider split, and the decision of the Thatcher government to develop a competitive model. This split was expected to enable a more independent assessment of population needs and priorities and would enable providers to compete with each other for contracts (Atkin & Lunt, 1997). While the role of the Regional Health Authorities (RHAs) was maintained as planners and distributors of funding, the number of them was reduced by 1996 (Atkin & Lunt, 1997).

A fundamental aspect of the NHS reforms was to shift the focus of health care from secondary to primary care, with a focus on providing care in the community. A population health focus was reinforced. The founding of the Family Health Service Authorities supported this shift along with delegating the responsibility of contracting GPs to deliver medical services for their population (Atkin & Lunt, 1997). To this end, in April 1991, the General Practitioner Fundholding Scheme was established, essentially enabling larger practices to opt to manage their own budgets and to purchase some hospital services as well as diagnostic tests and pharmaceuticals. Practitioner contracts introduced incentives for a range of preventative initiatives and primary care providers were encouraged to provide health education and promotion services.

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[6] Refer to NZ section below for definition of the different funding mechanism

Further change was signalled for primary care with the release of the White Paper (National Health Service, 1998). For primary care the paper focused on a delivery model that was to be developed over the next ten years. In particular it noted the important role of primary care and emphasised the key role of primary care professionals (doctors and nurses). They were considered the health care provider's best placed to understand the needs of individuals as s whole. By 1999 primary health groups had been established with responsibilities for defined populations (Bojke et al., 2001). The groups included NHS trusts, primary care groups and other primary care professionals working in partnership with local authorities and other local health interest groups accepting the devolvement of responsibility and decision-making at a local level (Bojke et al., 2001). This model was expected to encourage those organisations that had previously competed with each other, to work cooperatively and with a focus on treating people according to need. This approach was expected to increase flexibility and achieve improved integration - a contrast to the previous split which had resulted in fragmented services and poor strategic coordination (Bojke et al., 2001).

The contracting approach was changed with annual contracts being replaced with longer funding agreements. National service frameworks would require local teams of GPs and community nurses to work together in primary care groups to provide responsive, accessible and seamless care. A new system of clinical governance would ensure that clinical standards would be met and reinforced through continuous improvement activities. Primary care groups would have devolved responsibility for a budget that would cover most aspects of care (Department of Health, 1997).

Two key findings have emerged regarding this new service framework, from a study carried out by the Public Health Alliance (1998). The first finding highlighted that simply putting groups of people together required some effort being directed into finding new ways to genuinely involve all members of the group working effectively together. The second highlighted that management and organisational culture was shown to be unsupportive of population health initiatives. The study (Public Health Alliance, 1998), recommended that population health activities could not just be 'added on to' primary care and that it must be integral to the strategic development of primary health care.

There are risks associated with devolving responsibility for planning and providing health services to regional and local offices. While the intent is to focus on improved coordination and collaboration, there is the potential for it to result in a lack of coherence and duplication compounded by an increase in bureaucracy and management tiers. By contrast it is argued by

some that local decisions result in a reduction of geographic inequalities, improved integration of services and more coherently planned services (Higgins, 1999). This has yet to be evaluated.

Primary Care in the UK is similar to the NZ model, where individuals choose a GP for their first contact care, assessment, treatment and management of acute and chronic disease and referral to secondary services or specialist care, where appropriate. Like NZ, the GPs in the UK acts as gatekeeper to specialist and secondary services (Starfield, 1998). Some GPs will provide home visits and some provide care for people in nursing homes – known in NZ as Rest Homes and/or residential care. Their work is generally biomedical in nature. GPs in the UK are self-employed but have contracts (funding agreements) with the National Health System (NHS) for managing the health of all people registered with them. They are paid through a mix of fee for service and capitation payments (Koperski et al., 1999).

Australia

Primary health care in Australia, at both a federal and state level, focuses on the provision of services which promote, maintain and restore health. The Australian health care system, including primary care, has much in common with the NZ system. An individual will choose a GP for first point of contact care, management of common conditions, and ongoing maintenance of health problems. GPs themselves, argue that their role is wider than this and includes coordination of patient benefits as well as education regarding prevention and health promotion (Anderson, 1986). Reform in Australia, unlike the USA, UK and NZ, has been focused more on incremental reform as a way of strengthening primary care. The first wave of reform in the 1990s to impact primary care was the establishment of a *General Practice Strategy* (1991). Its purpose was to assist general practice reassert its role within the Australian health system and to ensure the provision of a high quality of care (Bolem, 1996). This strategy included two key programmes. The first programme involved providing financial support to develop infrastructure and projects for groups referred to as divisions of general practice. These divisions are not dissimilar to the NZ IPAs, in that they are self-managed entities formed on a geographical basis (Wilton & Smith, 1999). Funding is in the form of fee for service along with block grants. The second of the key programmes was in the form of a payment supplement for GPs who met the criteria demonstrating that they provided a more comprehensive range of services. This was an attempt to move away from the predominant fee for service funding mechanism and to encourage population health activities. A review of general practice (Commonwealth of Australia, 1998) recommended the need to further enhance the population health role of GPs in cooperation with public health networks. Similar to the UK and the USA, it was found that GPs needed specific training in population-based approaches.

More recently, policy changes have attempted to achieve cost containment and improve cost effectiveness within the primary care sector. One such reform has involved the introduction of coordinated care trials (Wilton & Smith, 1997). These trials have attempted to coordinate services for specific groups of patients using bulk funding rather than fee-for-service payments. A significant feature of the trials was the inclusion of other health services such as pharmaceutical, community, allied health as well as hospital impatient and outpatient services.

Unlike NZ and the UK, Australia has not implemented budget holding initiatives designed to manage the increase in pharmaceutical costs and to cap the level of overall public expenditure (Malcolm & Powell, 1996). Wilton and Smith (1996) suggest that the piecemeal reforms to date in Australia have not addressed the core problems facing primary care and budget holding needs to be considered. Alford (2000) reinforces this and notes that primary health services are uncoordinated and fragmented, resulting in duplication, wastage's and difficulties for people accessing services. Despite these more negative aspects, it has resulted in a change in the way General Practice has been organised, delivered and remunerated over the past decade (Commonwealth of Australia, 1998).

The reforms of 1999 have made an attempt to address these issues with a more political and economic focus, replacing the welfare model of service delivery with a more market oriented model (Alford, 2000). This has included splitting the roles of purchaser and provider and contracting for services. A population-based funding regime was also included in the proposals. These most recent proposed changes have aligned Australia more closely with the more radical reforms undertaken in NZ, UK and the USA.

United States of America

The USA model of primary care is generally very different from that of the UK and NZ, except for the fact that it is referred to as general practice. It has a stronger medical focus and consumers generally have their own secondary service providers instead of GPs, resulting in a much higher use of physicians. Primary care is comprised of teams including physicians, practice nurses and physician assistants which have emerged as a result of roller coaster change through the 1990s (Mullan, 1998). The teams are described by Koperski et al (1997), as poorly developed and dominated by physicians who utilise the other team members as handmaidens. Michel (1997) would suggest this practice of using nurses as handmaidens is not dissimilar to NZ where she describes the use of practice nurses by GPs in a similar way. Despite this, the establishment of the teams has demonstrated an endeavour to strengthen primary care.

By 1994 principles such as integration of health services, clinician accountability and a focus on addressing personal health needs in partnership with patients had been established, along with a concept of practicing in the context of the family and the community. As a result, over the past ten years primary care has gained prominence, particularly in terms of achieving outcomes in relation to health (Mullan, 1998). While there were reported successes of primary medical care practitioners embracing some health promotion and prevention activities, such as cervical screening and immunisation, other aspects have not been embraced to the same degree (US Preventive Services Taskforce, 1996). This issue is a particular challenge for those practitioners who have not received population health training. It is further constrained by the fee-for-service payments, which encourage limited consultation times in order to increase the volume of patients that can be seen in a day. Health education, a major component of population health, takes time and does not fit within a fee-for-service funding structure. The US Preventive Services Taskforce (1996) noted that population health and in particular, health education, is an activity that could be picked up by Nurse Practitioners. This will be discussed further in the following chapter.

Starfield (1998) argues the need for a strong primary health care infrastructure in order to integrate population health services with primary care. This includes addressing issues associated with effective use of resources, such as nurses; addressing roles and role boundaries; and reducing barriers such as co-payments.

Unlike NZ and the UK, the USA had undergone less constant policy change until the early 1990s when Clinton's health plan was introduced. The plan was introduced with overriding goals including the accomplishment of quality and cost control as well as improved access to services (Williamson, 1994). This required significant restructuring of the health industry. The plan however was dumped and replaced with the managed care system (Mullan, 1998). Managed care in the US has meant that managers have more say over physicians in determining care, and the health insurer controls and /or coordinates the use of health services in order to contain costs. It is within this managed care system that primary care and in particular, the physician, has attained the critical gatekeeping role, particularly controlling referrals to secondary care. While the main focus, as has been noted, is to contain costs, Starfield (1998) comments on some of the more positive aspects of managed care. She suggests that it encourages improved coordination of care due to the more formal links between the levels of care (primary and secondary), and better communication due to enhanced electronic communication. There are risks associated with managed care as it can segregate well populations from less healthy, lower socio-economic groups through the enrolment process,

thus reducing access to primary care services for these groups (Starfield, 1998). Koperski et al (1997) note that despite the potential for managed care to improve coordination, in reality the USA has no coherent policy for developing primary care whose system is currently "dispersed, uncoordinated and fragile" (p.319).

NEW ZEALAND - REFORM AND PRIMARY CARE

It was the National Government in 1991, in line with the 1989 Public Finance Act, who made the decision to split the purchaser/provider roles in health service provision and in 1993 enacted the *Health and Disability Services Act*. This resulted in the establishment of 4 regional health authorities which were each assigned the total health budget for their regions, along with a responsibility to purchase services to best meet the needs of the people. Details of how that should happen were reflected in the government's health policy statement (Upton, 1991) and which would become referred to as the Green and White paper.

The Green and White paper focused on the need for a more integrated approach to managing total health care. It described the health system as suffering from poor communication and coordination and costly duplication of services all compounded by fragmented funding. In particular the paper stated that the government planned to "encourage better coordination in the management of total health care across general practice, other community - based services and hospital services" (Upton, 1991, p.41). People's choices of different styles of health care would be improved by allowing, for example, more services to be delivered by nurse practitioners and other health professionals as well as doctors. This would make it easier for all those groups to deliver more health promotion and education.

Primary Care, in particular, was most affected by the reform processes, starting with the change to the funding body. Up until that time primary care services had been subsidised through the Department of Health with a subsidy level varying from between 0 – 100% and with the expectation that users of the services would pay part charges and thus contribute to the costs of some of those services. The subsidy, historically, has been paid to general practitioners (GPs) on a fee-for-service basis – a more detailed description of this will be outlined later – however the Green and White paper recommended that payment mechanisms, through contracts for services, should start to change. Upton (1991) described this mechanism for payment as a "procedure based medical care payment" (p.49), and stated that he wanted it changed to that of a capitated payment method. This, it was believed, would alter the perverse incentives that existed

in the fee for service payment mechanism and which were reflected in overservicing, a focus on less complex cases and inhibited or inappropriate use of other health providers (Crengle, 1999). Instead, it was expected that a capitation method of payment would encourage teamwork and enable more attention to be given to health promotion (Cumming, 1999).

However by 1996, despite the recommendations outlined in the Green and White paper, there had been little movement towards achieving a change in funding mechanisms and only 20% of GPs were being funded through capitation arrangements (Coster & Gribben, 1999). By 1998 further reform had taken place and the 4 regional health authorities had merged to form one national body, the Health Funding Authority. Again, the issue of funding mechanisms was raised with GPs, with the development of a proposal to implement capitation nationally in the form of population based funding (Health Funding Authority, 1998). This never progressed as GPs were concerned, as they had been all the way along, that they might be financially disadvantaged. Thus the proposal was rejected (Coster & Gribben, 1999).

Then in 1999, the general elections resulted in a change of government. The newly elected Labour led Coalition Government announced its decision to disband the Health Funding Authority and establish District Health Boards (DHBs), thus reversing the funder/provider split that had been recommended so strongly back in the early 1990s (Howden-Chapman & Ashton, 1994). These DHBs are similar to the old Area Health Boards that existed in 1989 under the Labour government. The most significant difference between the two structures is that the DHBs are responsible for both purchasing and providing services for people in their region, including primary care (French, Old & Healy, 2000).

General Practice has for some time been central to the delivery of publicly funded primary care in NZ with GPs remaining a core element in service provision (National Health Committee, 2000). It is also the largest recipient of funding for primary care services and furthermore it is argued by some that primary care is in fact dominated by primary medical providers (Tukuitonga, 1999). Over the last ten years the most significant development in relation to General Practice has been the development of Independent Practitioner Associations (IPAs). Simultaneously GPs moved away from working in sole practitioner situations to small group practices generally comprising a team of GPs, Practice Nurses, receptionist(s) and a Practice Manager. Today there are only approximately 27% of GPs working in sole practices with the remainder working in group practices (New Zealand Health Information Service, 2000). For IPAs, their development was largely in response to an *Auckland Uniservices Report* (1992) and occurred at about the same time that the 4 RHAs were established. They have emerged as

groupings of doctors who have formed to act as umbrella organisations to take contracts through the funding body for the provision of a range of primary care services (Coster & Gribben, 1999). What this served to do what to position them well for any future contracts and funding opportunities, establish them as lobbying bodies and subsequently disadvantage many other existing and potential service providers such as nurses. This was in spite of the recommendation in the Green and White paper (1991) which discussed the potential for the development of other service providers, in particular nurse practitioners. It must also be noted that the development of IPAs was largely achieved through significant financial support from the regional health authorities (Coster & Gribben, 1999). This has not gone unnoticed by other primary care providers and nurses argue strongly that GPs have been significantly advantaged through contracting efforts, which they have rarely been eligible for (Ministerial Taskforce on Nursing, 1998).

By 1996, there were forty-two IPAs but, as noted above, there was little movement towards any change in funding and payment mechanisms. Fee-for-service subsidies remained dominant. Over the following three years some consolidation in the number if IPAs occurred and as a result of amalgamation there was a resulting increase in the number of GPs per IPA. By 1999 IPAs were able to demonstrate that through some of the contracts that they had been awarded for services, such as budget holding for pharmaceuticals and laboratory tests, they had been able to achieve savings. This enabled them to develop additional services for patients as well as provide continuing medical education for their GPs and develop information systems (Coster & Gribben, 1999).

The role of the General Practitioner

Historically, primary care internationally has been characterised by the type of practitioner providing the service – the GP (Starfield, 1998). The GP is typically the first point of contact into the health system through self-referral for a specific health episode generally in reaction to an acute or chronic health need. The emphasis is mainly on the curative aspects of medical care (Carryer et al., 1999). In order to carry out the consultation the GP must be skilled in diagnosis and treatment modalities for both life threatening and chronic diseases. As well they need to be proficient in managing a wide range of minor problems for a cross section of patients of all ages. GPs also have a significant gate-keeping role, as noted above, and hold the responsibility for referring patients to specialist services where required (Jeffreys & Sach, 1983). Their role and responsibilities are not only general in nature but also quite diffuse. This role, generically described, would not differ significantly throughout the western world. .

Funding for General Practice

This section will describe the funding mechanisms for General Practice in NZ, however the descriptions of the mechanisms for fee for service and capitation are applicable to other countries that utilise those same payment mechanisms. GPs working in General Practice receive government subsidies for GP care, pharmaceuticals and laboratory tests along with variable levels of patient co-payments depending on the fees set by the GP. The funding arrangements vary from a fee-for-service model to capitation – a method of payment that had been proposed, as earlier mentioned, throughout the reform process and gradually introduced in some areas of NZ over the past few years. Both mechanisms of payment have been exposed to criticism and support with benefits and disadvantages identified for both.

Fee for Service

A fee-for-service subsidy involves the payment of a predetermined subsidy to the GP, from the health funder, in return for a consultation with a patient who is either the holder of a community services card or a child under the age of six years. A fee-for-service system tends to result in short visits and presents a risk of attracting additional visits in order to maximise the amount received. The more people the GPs see, the more they get paid. Because the fees are tagged specifically to a GP consult it tends to discourage the use of other and possibly more cost-effective providers (Cumming, 1999). Starfield (1992) notes that this is the most common method of payment for primary care in most western countries. In NZ this method of payment is received by approximately 85% of GPs (French et al., 2001).

Capitation

Capitation on the other hand involves providers being paid a "per head" amount for a given period for all the people enrolled or registered with them. The payments can be adjusted according to the type and range of services and for the type of population that is being served. The risk with this type of payment is that the GP may provide less care than is required may be delivered in order to improve or maintain health. By contrast it provides a strong incentive for providers to try and keep their population group healthy by providing preventive care, health education and health promotion. It predicts cash flow and also allows for more flexible use of resources such as nurses. (Cumming, 1999). French et al. 2001) reinforce the latter and suggests that this would free GPs to assume more complex work. French et al (2001) query whether GPs would retain the right to charge a fee-for-service, or co-payment, within a capitation-funding model. Approximately 15% of NZ GPs are remunerated in this way (French et al., 2001).

Budget Holding

Pharmaceuticals and laboratory services are funded through budget holding arrangements where a provider is paid a budget for a nominated period of service delivery. The risk with this sort of funding is that if more services are delivered than are funded for, the providers do not receive more funding. In other words the providers carry the risk of going over budget so have a strong incentive to stay within budget or reduce their ordering and make savings. These savings may then be used for additional services. Currently in NZ, this form of budget holding is nominal only and the risk is generally shared between the provider and the funder. However the common practice has been that the funders have usually covered additional costs above and beyond the budgets (Cumming, 1999).

Salary

In this method of payment, the GP receives a fixed sum from the health funder for their professional services (Starfield, 1992). The GP is usually not self employed. Health Care Aoteoroa (HCA), a large provider of primary health care services throughout NZ, is a good example of an organisation that employs GPs and other health professionals and reimburses them for the services they provide by means of a salary (Crampton, 1999).

Co-payments

The requirement for people to meet some or all of their primary care costs has been a part of government policy for some time. For low income people and children this requirement has been partially alleviated throughout the 1990s with targeted benefits aimed to improve access to primary care services and pharmaceuticals. This was achieved through benefits such as the introduction of community services and high user health cards to lower income people and the free services for children under 6 years of age. In turn, as highlighted above, this entitles the GP to the GMS subsidy. This targeted approach is different from other countries that have enforced statutory insurance (Hindle & Perkins,2000). This results in the insurance company either reimbursing the GP or the patient directly for services (Starfield, 1992). In NZ the targeted groups are still required to pay an additional fee-for-service to the GP. Cumming (1999), in her role as a health economist, puts patient co-payments into perspective. Her view is that co-payments have a tendency to impede attempts to improve access to health or to promote a population based approach to care particularly for lower socio-economic groups who already have poorer health status than their more well off counterparts. This is reinforced by the National Health Committee (2000) who note that evidence suggests that co-payments selectively reduce access to services for low income people and probably contribute to the

inequities in the distribution of public funding for primary care services. Because the co-payment is payable at the time of the visit, low income people tend to either not seek services or utilise the emergency department at public hospitals.

Other Models of Primary Care in New Zealand

General Practice, while being viewed as the mainstream provider for primary care services, is not the only model of care that is established in New Zealand and the National Health Committee in its report (2000) notes that alternative models, in particular, Maori and Pacific models should continue to be supported.

Models of Primary Care for Maori

Maori have been involved in the provision of primary care and public health since the early 1900s. Since the 1970s, Maori health initiatives have slowly increased, largely due to the political action directed to reaffirming the Treaty of Waitangi. Throughout the period between 1984 and 1994 there was increasing recognition of Maori rights, the establishment of Maori health committees and recognition of Maori health as a health gain priority area (Crengle, 1999).

In 1991 the government announced a programme of health reform which offered significant opportunities for Maori in health service provision (Upton, 1991). This included the development and management of Maori health programmes and services with particular emphasis on health promotion and education. More importantly it meant that Maori solutions would be developed to address Maori problems with the assistance of government funding. As a result of this, contracts were offered by funding authorities, throughout the period of the 1990s, to Maori providers for defined services. These usually encompassed general practice and health promotion and screening to specific services such as well child (Durie, 1998). As a result of this activity through the 1990s there are now over three hundred Maori health service providers, most of whom provide primary health care services (Crengle, 1999). These are commonly referred to as services 'for Maori, by Maori', are generally Iwi or tribal based, and many of them are funded on a capitation basis providing them with a degree of autonomy and some ability to risk share. This then enables them to provide services in a more flexible way with health centres and mobile clinics on marae and in other settings (Durie, 1998).

Despite this development, HFA data in the mid 1990s, show that disadvantaged groups such as Maori remained underserved contributing to their poorer health status and greater use of hospitals (Malcolm, 2000). This is described as 'inverse law' where those people who have the greatest need have less access to health care (French et al., 2001). This situation is also reflected in rural communities who are frequently comprised of lower socio-economic groups. This situation has led to the development of nurse-led services in Northland. Over the years these have grown to include medical practitioners (Carryer et al., 1999). Now there is a mix of services, some with general practitioners as an integral part of the services, and some where there is assurance that patients can access a doctor if required.

A further recent development has seen the growth of Maori Integrated Organisations (MICOs) who are beginning to act as purchaser/ contract managers. Crengle (1999) describes them as still being in their formative stage but that ultimately they should develop the capability to assume purchasing and monitoring responsibilities for all Maori health for their region.

Pacific primary health services

Pacific health services have also developed in response to health reform. For Pacific people financial, language and cultural barriers combined with a perception that mainstream services are inappropriately delivered to their people, has seen them over-represented in hospital discharge statistics for conditions which are frequently preventable (Tukuitonga, 2000). This situation is compounded by an over representation of their population in adverse socio-economic circumstances caused through unemployment, overcrowding and poor quality housing (Tukuitonga, 1998). Thus, in response to this and in line with opportunities presented through the health reforms of the 1990s, a number of 'by Pacific for Pacific' models of health care have emerged. By 1999 there were thirty Pacific owned health providers along with a lesser number of churches who due to the significant role they have in the community, were contracted to provide health education and promotion programmes (French et al., 2001).

The majority of these models are based in Auckland with services focused on prevention programmes and the provision of primary care. This is largely due to the high rates of hospitalisation for communicable disease, accidents and injury as well as for chronic disease (Ministry of Health, 1999). They are generally community focused, community owned and operated. They are funded through the existing funding arrangements that are available to all general practitioners throughout the country and include a mix of fee for service, bulk funding and some additional project funds (Tukuitonga, 1999). Their funding opportunities have not

included the specific workforce and provider development funding that Maori providers received.

Pacific health providers also differ somewhat from Maori in their approach to providing health services for Pacific people. While Maori strongly believe in services 'for Maori by Maori', Pacific providers acknowledge that their models of care cannot meet the entire needs of their population, largely due to a paucity of trained Pacific health professionals. In fact a considerable number of staff, particularly GPs who are employed within their service models, are not Pacific. This lack of appropriately trained Pacific health professionals places some pressure on mainstream providers to provide services in a way that make them acceptable to Pacific people in order to manage the demand on the 'by Pacific, for Pacific' models of care (Tukuitonga, 1999).

Third sector primary care

A third and different model again has been growing over the past ten years in NZ and is referred to as 'Third Sector' primary health care. It is a term applied internationally to describe organisations that are non-government and non-profit. In New Zealand, in particular, they have taken on a specific role to address the health care needs of vulnerable groups (Crampton, 1999). They started to have significant presence in the late 1980s with the establishment of the Union Health Centres, as a response to the trade union movement's commitment to respond to the demands of its members for affordable high quality care (Crampton, 1999). Throughout the 1990s they developed further as alternatives to traditional primary care arrangements (Shipley, 1995). They are frequently Iwi based, have a strong emphasis on providing primary care and population focused services for low-income people and on working bi-culturally. Funding is largely achieved through public health funding (Crampton, 1999).

Public Health

Public health services have been a part of mainstream health care since the *1983 Area Health Board Act* and generally refer to activities to prevent disease, prolong life and promote health (French et al., 2001). This changed in 1991, when it was determined through the Green and White paper (Upton, 1991) that personal and public health services would be purchased separately and that a Public Health Commission would be responsible for purchasing public health services. This according to Upton (address to the *Health Promotion Forum*, Auckland, 24 October, 1991), demonstrated the importance that the government placed on public health and health promotion activities. This separation of public health from personal health services is viewed as difficult as many personal health providers, and in particular primary care

providers, provide some elements of public health such as screening (Bandaranake, 1994). This concern is highlighted in the discussions related to the roles of nursing working in primary care settings[7]. It was also in contrast to the emphasis placed on integration of primary and secondary services in the Green and White paper (Upton, 1991).

In 1993 a report released by the Public Health Commission, in compliance with its requirement by the 1993 *Health and Disability Services Act*, described the health status of New Zealanders and attributed their low health status not just to people's lifestyles but also to the government's economic and social policies. The intent, therefore, of Upton (1991) to maintain a public health focus through the establishment of a separate structure and the subsequent disestablishment of the Public health Commission resulted in a loss of focus on the health status of New Zealanders and an emphasis on health expenditure (Finlayson, 1996).

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[7] See Chapter 3 re Practice Nurses and Public Health Nurses

CONCLUSION

The above discussion has highlighted the constancy of health reform over the past ten years, whether it has been incremental in nature such as in Australia and Europe or more radical as in the UK, USA and NZ. The driving forces have largely been economic and political, as governments have struggled to contain rising costs and increasing demand for services. The approaches taken have been diverse, ranging from introducing policy to address the barriers to care, to policy that changes the incentives to provide services. In particular this has included attempts internationally, with variable success, to encourage primary care to encompass population health activities. The need for GPs to receive additional training in population health activities is raised as an issue, as well as concern that population health can not just be 'added on' to primary care (Commonwealth of Australia, 1998). Starfield (1998) summarises the approaches by noting that whatever the approach, all countries face similar challenges " to provide services in an effective, efficient and equitable manner" (p.101).

Splitting the role of purchaser and provider was fundamental to most of the policies, providing a framework for establishing competition and the adoption of a market driven approach. Through this market driven approach, particularly in NZ, primary care and GPs have been encouraged to become more accountable through competition and contracting for services as well as being more responsive and flexible to consumers needs (Howden-Chapman & Ashton, 1994). Both providers and funders have appeared to have more of a concern for managing costs.

Considerable time (and funding) has also been directed to the establishment of the IPAs. While this has been a significant shift for GPs who were more used to functioning as autonomous practitioners, it has done little to shift funding mechanisms, which were proposed by Upton (1991). As a consequence, the benefits that Upton (1991) proposed would emerge from a more flexible payment mechanism, such as captitation, have not been realised. Fee-for-service payments remain the dominant mechanism, maintaining the status quo of the dominant primary care model, with the GP as the lead practitioner. GPs in NZ, like their international colleagues, are commonly self employed and although fee-for-service remains dominant there is a mix that includes capitation and private fees (Koperski et al., 1997).

The models of primary care or more appropriately, primary medical care, are similar in many western countries and have been briefly described. In general, individuals within a population

will choose a general practitioner for their first contact care; assessment, treatment and management of acute and chronic disease; referral to secondary services or specialist care where the GP acts as the gatekeeper (Starfield, 1998). The work of the GP to date has been biomedical in nature with a focus on technical and curative care rather than preventive or community oriented (Johnstone, 1995). This is despite attempts through reform, as noted above, to try and get GPs more involved in the provision of population health services.

Collaboration and teamwork between doctors and nurses has varied internationally with the UK and the USA leading the western countries in this area. Over the past few years it has increasingly become an issue in relation to effectiveness and efficiency of service delivery yet it has been slow to progress particularly in NZ. Evidence from the UK suggests that getting groups to work effectively together takes more than just forming them into a group (Public Health Alliance, 1998). Despite this, teamwork is seen as integral to successful integration of population health activities into existing primary health care services. The literature starts to highlight potential roles for nurses, particularly when barriers such as fee-for-service payments are replaced with capitation funding models (Cumming, 1999; French et al., 2001). Barriers such as the funding mechanism and the dominance of the GP continue to inhibit progress.

New models of primary care, as a result of Maori and Pacific provider development have emerged have emerged over the past few years in response to the reforms, highlighting a transition from the traditional, or mainstream, primary care model that dominates in NZ. Their models reflect more of a population focus where they provide services ranging from first contact through to health promotion and education. Services are frequently mobile and provided in settings that are more accessible to their consumer group.

Therefore, while for NZ in particular, the past ten years of reform have made significant attempts to change primary care both through service delivery and funding there has been little progress. The emphasis remains in a primary medical model with little evidence of a population health focus or any desire on the behalf of GPs to change.

The following chapter will address the role of nurses working in primary care and primary health care settings in NZ.

CHAPTER THREE – PROVIDERS OF PRIMARY HEALTH CARE NURSING SERVICES IN NEW ZEALAND

Chapter 2 focused on the impact of health reform on primary care. It located General Practice with its medical model as central to primary care. The movement that had been expected to occur in primary care in response to the Green and White paper (Upton, 1991), in particular in relation to funding, did not occur. This lack of movement and subsequent continuation of a fee-for-service payment mechanism is seen by nurses as one of the most significant barriers to effective and efficient utilisation of primary health care nursing services (Carryer et al., 1999; Ministry of Health, 1998).

This chapter will focus on primary health care nursing in NZ. The first section will include a discussion on the history and role of nurses located in primary health care settings. It will highlight the specialisation and the plethora of titles and roles that contribute to the current fragmented services. It will include discussions on the current role of Practice Nurses, situated in the domain of General Practice, Plunket, or well child, nurses, Public Health Nurses and the newly emerging roles of Nurse Practitioner. Following the section on each of the major providers of primary health care nursing, issues concerning primary health care nurses' and their impact on nurses ability to contribute effectively in primary health care, will be discussed. Some of the key issues that emerged in chapter 2 will be linked to this discussion.

HISTORY AND ROLE OF PRIMARY HEALTH CARE NURSES IN NZ

Practice Nursing

Practice nursing is the most dominant of the nursing groups in the community, with over three thousand nurses working alongside GPs (French et al., 2001). It has its origins in the development of GP services in rural areas in the 1970s. At that time it was seen as an incentive to rural GPs who received a 50% subsidy from the government for practice nurse services. This was expected to relieve the GP of some of the tasks that could carried out equally as well by the nurse. This investment into practice nurses has continued over the years and today GPs still receive the subsidy. This situation is viewed unfavourably by some nurses who consider that employing nurses in this setting results in GPs determining the scope of practice outside of a nursing framework (College of Nurses, 2001). The role is frequently referred to as that of handmaiden and will be discussed below.

The subsidy for practice nurses has been subject to several changes since its introduction in 1970. In 1974 it was increased to 100% and the role was extended to include urban as well as well as rural practice settings. Then again in 1991 the rate was changed again reducing it from the previous 100% subsidy to a rate of eleven dollars per hour for up to a maximum of thirty hours per week (Michel, 1997). This has had significant consequences for practice nurses and the services they offer as it has resulted in a trend to part time employment.

The role of Practice Nurse is seen as being quite different from that of other nurses working in primary health care settings. Atkin and Hunt (1997) distinguish the broader role of Practice Nurses from the more role-oriented definitions of district nurses, for example, and suggest the Practice Nurse has a more flexible role. Michel (1997) agrees with this in principle, but suggests that it might not be the situation in practice. She describes the role as predominantly task oriented and like others, such as Toop (1997), she describes a range of activities. Michel (1997) notes that most are GP delegated tasks resulting in them being more likened to a 'handmaiden'. (Docherty, 1996) describes two types of roles adopted by practice nurses. One she describes as that of a handmaiden, where the activities are delegated by the GP. A more autonomous role sees the nurse using a wide range of skills and making decisions within a scope of practice and running specialist nurses clinics. These are generally more focused on health education with topics such weight management or chronic disease management.

Practice nurses probably come under the most criticism within nursing due to the employer/employee nature of the role where, as indicated above, it is perceived that the GP sublimates the ability of the nurse to contribute as a full and independent member of a team[8]. his is well supported by reports such as the *Report of the Ministerial Taskforce on Nursing* (Ministry of Health, 1998) which noted that Practice Nurses were largely unable to contribute as full and equal team members due to their limited access to resources, physical work space and post graduate education. William's (2000) in her study relates this to the nurses and other's view of their role and their confidence in the understanding of the contribution they can make to health care.

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[8] Refer to Chapter 2 for discussion on teamwork

Public Health Nurses

Over the past twelve years, Public Health Nurses (PHNs) probably represent the group that have been most affected by health reform and subsequent acts that follow reform. Public Health Nursing emerged out of the *Public Health Act* (1900) which provided for the establishment of the Department of Health resulting in NZ being divided into 6 health districts, each administered by a medical health officer and supported by a Nurse Inspector. This act was particularly significant as it made some steps towards acknowledging health concerns relating to Maori and bringing about the Maori Health Nursing scheme (Mc Killop, 1998). This was later replaced with a Native Health Nursing Scheme in 1910, which by 1920 had employed twenty nurses. The role of these nurses, as described by McKillop (1998), was "to improve the sanitary conditions of the Maori settlements, to prevent the spread of infectious diseases and to avoid further epidemics" (p.52).

PHNs frequently worked in isolated areas, collaborating with the communities, in which they both lived and worked. Health promotion and disease prevention were major foci, contrasting significantly to the illness model that was central to hospital based nursing. McKillop (1998) notes that the Native Health nurses developed the role, achieving a degree of autonomy and independence beyond that of the nurses working in hospitals. This same degree of autonomy and independence remains a strength of the public health nurses today, despite the significant changes to their services as a result of fiscal constraints.

In 1920 a new health act was drafted and a division of nursing established with the accompanying reorganisation of the Department of Health. The nurses took on additional responsibilities in relation to child health in areas with high Maori populations, leaving Plunket to look after the Pakeha children (McKillop, 1998). It was through the 1920s, and in particular with the establishment of the Public Health Nursing service, that the focus changed from the more curative approach to health care delivery to one focused on health education and disease prevention. The name of the nurses was changed yet again in 1922 to the Maori Health nurse.

Between 1935 and 1985 health promotion, disease prevention and surveillance were provided through the population based public health nursing services delivered through family health services and school based health services – concurrently addressing the underlying issues concerning housing, financial hardship, employment and child behavioural problems (Carryer et al., 1999). The nurses worked with families with complex health needs frequently linking them with other health services. The nurses required effective and efficient utilisation of referral

processes for both medical and social services, thus requiring them to be knowledgeable of community resources and services (Jarvis, 1981). In addition they had a significant role, along with Plunket, in providing well child services to children up to the age of 5 years.

With the transfer of Public Health Nursing from the Department of Health to the Area Health Boards and later to the Crown Health Enterprises (CHE), Health and Hospitals Service (HHS), and then more latterly to the District Health Boards (DHBs), the function of the PHN has continuously changed.

The demise of the Public Health Commission in 1995 resulted in what was widely viewed in nursing circles as a retrograde step for public health nursing (Carryer et al., 1999). Since that time the number of nurses has significantly reduced and their activities have become more focused on communicable disease screening and management and health promotion, and less on family oriented health services. Their roles, however, vary within each DHB and continue to be reshaped and redefined as a consequence of reform. They are currently funded through ring fenced service agreements between the DHB and MOH as part of the larger contract for secondary and community services.

One of the barriers to recognition of PHNs, as significant contributors to primary health care nursing services is their own lack of realisation of their potential and thus an inability to successfully argue their roles and attract sufficient funding (Cernik, 1994). This is similar to most nursing groups. Never-the-less they, like Plunket nurses, have maintained their status as autonomous practitioners.

Plunket Nursing

In 1907, as a result of the efforts of Truby King, the Plunket Society was launched in Dunedin with a role described as "a professional infant welfare service to the parents and children of NZ" (Parry, 1982, p. 8). Under the auspices of the society Plunket Nursing was established with a focus at that time on feeding, particularly bottle feeding, along with support and advice to parents about hygiene and health.

Activities provided through the Plunket Society over the years have included health prevention programmes, household help, well child checks and crisis groups. Since its inception the Society

has demonstrated its concern for community health through programmes such as vaccinations, water safety, dehydration, safety guards for heaters, poisons, children's clothing, human relationships and education. Parent education and prevention has always formed the basis of Plunket Nursing services, although the range of activities and provision of services has changed over the years (Parry, 1982).

Their focus, however, has remained firmly in well childcare for children under the age of 5 and their mothers. As mentioned above, similar services were also provided by PHNs, through the Department of Health, up until the early 1990s leading to overlaps of service in some areas and no service in others (Dow, 1995). At that time all mothers were given a choice between Plunket and Public Health with PHNs assigned responsibility for children considered to be at risk and those living in rural areas (Ministry of Health, 1996b).

Through the 1950s, 1960s and 1970s Plunket underwent significant changes, not only to the structure of the Society but also to the services provided by the nurse. These impacted on routine contracts with the Department of Health, funder of health services, including home visiting and the closure of many of the Karitane units as a response to fiscal constraints (Dow, 1995).

In 1993 as a result of a Ministry of Health report, a national schedule for well child care was drawn up outlining an expectation of integrated and coordinated well child service provision which would include education and promotion, health protection and clinical assessment and family or whanau care and support (Ministry of Health, 1996a). It is this schedule that directs the work of Plunket nurses today. However while Plunket Nurses provide the majority of the well child care services for children under five years, fragmentation remains a concern. A number of different providers currently have contracts for different aspects of well child services. This has resulted in a confused picture for both health workers and families. Malcolm (1996) comments on the proliferation of providers of well child services, including GPs, nurses, social work services,, as well as voluntary and self help groups. He believes that this proliferation and resulting confusion could be a contributing factor to the under utilisation of well child care services particularly in groups such as Maori, Pacific people and the economically disadvantaged.

Never-the-less, Plunket nursing has influenced the culture of well child services and established itself within the community as a significant contributor to primary health care. It does need to be noted however that while it is the major provider of well child care services it is a private,

voluntary service that sits outside mainstream services. Tilah (1998), in her thesis, suggests that the contracting of well child services to providers other than Plunket may provide new opportunities for community based nursing. Carryer et al (1999), as noted above, argue the development of a primary health care nursing role to address some of the fragmentation that exists in the community. Not all nurses agree with this highlighting the conflict and differences in views that exist across nursing, creating tension in relation to progressing nursing (Ministerial Taskforce, 1998). However it through this tension that progress occurs. It is important to note that the suggestion for changes to primary health care nursing roles is not new and as far back as 1987, the NZ Board of Health recommended the need for skilled specialist nurses in primary health care. It is this role that Carryer et al (1999) and Tilah (1998) support.

Other primary health care nurses

It is important to note that while Practice Nurses, PHNs and Plunket nurses are the major contributors to primary health care nursing services, there are a number of other groups that need mentioning. They include groups such as Occupational Health nurses who are either self employed or employed by an organisation; Maori and Pacific health nurses, employed by Maori or Pacific providers; School nurses who are usually employed as PHNs in the Child and Youth team in DHBs or directly by the schools; Independent Nurse Practitioners who are self employed and Nurse educators employed in tertiary education settings. In addition, under the auspices of Home Health services in the DHB, are the group of nurses previously known as District Nursing services. These nurses, while generally not first point of contacts for consumers, do work in the community. Within the group are a number of specialist roles that support providers both in primary and secondary settings. Examples of these roles and titles include ear nurse, continence nurse, wound care nurse.

The above examples amplify the plethora of titles and roles associated with nurses working in primary health care settings, compounded by differing contractual and funding arrangements. Carryer et al (1999) emphasise that this situation has resulted in a fragmentation of services and a resulting failure to deliver comprehensive primary health care.

Nurse Practitioners

Nurses believe their ability to fully contribute to effective health care service delivery will be enhanced through the development of advanced practitioner roles. This issue was raised in the Taskforce report (1998) which recommended the need for a role of advanced and specialist

nurses working in collaboration with their medical counterparts. This should be not confused with the above discussion recommending the need for a primary health care nursing role but instead locates a role for nursing that starts to address the issues related to status, effective teamwork, professional identities and role boundaries. It is a role that is well recognised internationally for its effectiveness but with accompanying concerns that it is at risk of being located within a medical focus (Carryer et al., 1999).

NZ has made significant progress towards establishing the role with Nursing Council's (2001) completion of its framework for the regulation of the Nurse Practitioner, and tertiary institutes modifying their post graduate nursing programmes to meet the requirements outlined by Nursing Council. The development of the role is a reflection of several years of planning and consultation with the nursing sector in NZ and reviewing the evidence supporting its effectiveness both within NZ and overseas. As a result of the above work the role of Nurse Practitioner is described as that of a nurse working at an advanced level and who is expected in particular to target "specific populations or client groups, emphasising health promotion and maintenance, and disease prevention" (Ministry of Health, 2002a, p.1). Nurses who hold the title of Nurse Practitioner will have met Nursing Council's assessment criteria and will be experienced clinical nurses with post graduate qualifications. Some may be endorsed for prescribing rights (Nursing Council, 2001).

As highlighted above this is not a new role internationally and its benefits to consumers and contribution to the health sector and to improved health outcomes are well evidenced (Ministry of Health, 2002a). The role is most developed in the USA where it began more than thirty years ago in the area of primary care provision for children. Many of those nurses have prescribing rights and some receive direct reimbursement for their services. The role is seen as reducing the demand on family doctors and consequently enabling the practice to expand its practice base (Whitecross, 1999). Whitecross (1999) notes that the role is also well established in Australian primary care settings where, particularly in rural and remote areas, the nurses provide a considerable proportion of the acute and ongoing medical care. There is no legal recognition of their role across Australia. New South Wales was the first state to legislate the role and now following the *Nurses Amendment Bill* (1998) some nurses are authorised to practise as nurse practitioners and to prescribe. However there have been some barriers to effective utilisation of nurse practitioners in Australia due to the way nurses are funded in General Practice and the medico-legal situation. The United Kingdom also has a burgeoning nurse practitioner movement following a number of successful pilots in the early 1990s with GPs responding favourably to the development (Atkin & Lunt, 1997). The role is not recognised legislatively or

by the Nursing Council and most nurses are prepared to a bachelor level, unlike the criteria in NZ requiring masters preparation. Despite this, there is significant evidence supporting the effectiveness of nurse practitioners including patient satisfaction and the achievement of similar patient outcomes to their medical counterparts (Kinnersley et al., 2000).

OVERVIEW OF PRIMARY HEALTH CARE NURSING IN NZ

Nursing services between 1935 and 1985 were noted for their contribution to the delivery of population based primary health care where the focus was on the provision of health promotion, prevention and surveillance as well as home based care provision (Armstrong & Bandaranayakee, 1995). Any progression of public or population based health services appears to have been stymied by the attention given to the growth of primary medical care through the health reforms of the 1990s (Malcolm, 1993). Walsh and Gough (1999) argue that in the United Kingdom this is a result of the contract culture which has altered nursing to a commodity. Carryer et al (1999) note that this appears to be the case in NZ as well. Carryer et al, as noted above, strongly recommend the need for the development of a primary health care nursing role as well as the need for an integrated health care team. NZ at this point is a long way from achieving this, as highlighted by this chapter, due to the fragmentation of services; the wide range of contracts; and the plethora of titles and roles. This is compounded by the centrality of General Practice that is dominated by GPs and a primary medical model, and constrained by a fee-for-service funding model[9]. Collaboration is seen as one way to start to foster interprofessional relationships, particularly between doctors and nurses, and to address some of the issues confronting primary health care (Whitecross, 1999). Much of the evidence based on overseas experience recognises that it is the structure of primary care that has the greatest influence on successful collaboration. The most relevant factors impacting its effectiveness include the way primary care is funded, the primacy of primary care over primary health care, and whether the parties who are collaborating are in different organisations (Whitecross, 1999). This is an issue for NZ, with GPs working as owner/operators of their practice and nurses employed in a number of different arrangements.

The UK experience has shown a number of collaborative efforts with varying success. The biggest barrier, also noted in NZ, has been related to the dominance of the GP who has tended to take on overall responsibility for the team rather than enabling an interprofessional relationship with a shift in power relationships to be fostered (Iles & Aulick, 1990). One model that is viewed by some as successful is the model that has been established in the UK. This has

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[9] Refer to chapter 2, Section 2

resulted in all the professional groups including the GPs, practice nurses and nurse practitioners working from the same premises – the General Practice (Elwyn & Smail, 1999). The successful factor has been the fact that they all work under the same roof. However, other nursing groups such as health visitors and district nurses, have been more reluctant to give up their autonomous positions and move to a General Practice setting where they see their autonomy being subsumed by the GP (Elwyn & Smail, 1999). This reinforces Whitecross' (1999) concern relating to issues of structure. Williams (2001) supports this concern and suggests that in order for doctors and nurses to be able to work together, issues related to perceptions about their own and each other's roles need to be addressed. In the USA a mix of both collaboration and competition exists between nurse practitioners and family doctors. Australia by contrast sees opportunities for collaboration between the two groups particularly in geographically remote and socially inaccessible areas where GPs either do not or can not provide the services and therefore do not feel threatened by the nurses (Elwyn & Smail, 1999).

Carryer et al (1999) support the development of primary health care nursing in response to the evidence that supports the effectiveness of nurses both in first point of contact care as well as in population health service delivery.

CONCLUSION

This chapter highlights the significant presence of nursing in the provision of primary health care services. Unfortunately, the services they provide are generally poorly coordinated, resulting in duplication and gaps. This is largely due to the way services are contracted, as well as to the number of different roles assumed by nurses. It highlights the differences in particular between the more autonomous roles of Plunket nurses and PHNs and the more 'handmaiden' role of the Practice Nurse as described by Michel (1997).

Carryer et al (1999) promote the notion of a primary health care nurse as way to deliver services more effectively. The literature shows that while some nurses would view assimilation to a more comprehensive role as a positive move, other might be reluctant to support this (Carryer et al., 1999; Tilah, 1998). Existing structures, contracts, funding and employment arrangements for all the primary health care nursing groups create challenges for progress to move towards the primary health care nursing role proposed by Carryer et al (1999). As much as there is a drive to establish a primary health care nursing role, there is equally a drive to establish more collaborative interprofessional working relationships. This involves the establishment of the Nurse Practitioner role in primary health care, which is viewed as one way to develop equal collegial relationships with doctors. The Nurse Practitioner, not yet in place in primary health care in NZ, with their advanced knowledge and qualifications would strengthen nursing's professional identity (Nursing Council, 2001) and support other nurses who view the current dominance of GPs as barrier to effective collaboration.

Primary health care nurses, like the GPs, have been exposed to considerable change as a consequence of reform with Plunket Nurses and Public Health nurses experiencing the most change. For Practice Nurses, their change has been as a result of changes to subsidy provision, an issue that is debated strongly and concern expressed that it removes their scope of practice from a nursing framework (College of Nurses, 2001).

This chapter concludes the literature review that, over 2 chapters has outlined the impact of reform on primary health care over the past decade. The first chapter focused specifically on the impact of reform internationally and discussed primary care in NZ. This chapter has discussed the range of primary health care nursing providers in NZ and linked the discussion to some of the issues identified in Chapter 2. Chapter 3 discusses the methodological approach that will be used in this study.

CHAPTER FOUR – RESEARCH METHODS

This chapter describes the steps of the research process used in this study.

METHODOLOGY

Qualitative analysis, or more specifically, applied policy analysis, is used applying the 'framework' approach. This approach was initiated within a specialist qualitative research unit in the United Kingdom, which spans all areas of social and public policy research, on behalf of central or local government, universities and other bodies. It is described as an "analytical process which involves a number of distinct though highly interconnected stages" (Ritchie & Spencer, 1994, p.177). The approach is targeted towards providing answers by providing greater or better understanding of the issues. Details of the methodology are outlined below.

The choice of the topic for this study, and the methodology, has been based on a number of considerations. Firstly the rationale for the topic will be discussed. The researcher was employed with the Health Funding Authority (HFA) as a Project Manger for Primary Care. During this period, the work for the primary health care strategy was commenced, and a reference group was established to assist the Ministry of Health (MOH) in its task. The researcher was seconded from the HFA to participate on the reference group. The topic chosen for this study emerged as a result of this role.

The methodology has been chosen due to the researcher's close involvement with the development of the strategy, thus impacting on her ability to assume the impartial role, or freedom from bias, usually required of a researcher (Morse & Field, 1996). Because of this, it has been considered more appropriate to use a non-contact process. This involves using data from the strategy document as the main source of information, although publicly released documents, including media, directly related to the strategy and its development may be examined. Secondly, having the position of being an insider, that is, within the HFA, enabled the researcher easy access to background information, documents and to key personnel. However it is important to note that the researcher's employment situation has since changed. The 'framework' approach is is used mainly, as noted above, for its specific role in providing answers or a greater understanding of the issues (Pope, Ziebland & Mays, 2000).

Applied policy analysis

For the purpose of this study, it has been decided to use the 'framework' approach, which is commonly used in applied policy or policy relevant qualitative research. This requires objectives to be set in advance and shaped by the information requirements of the funding body (Pope et al., 2000). While for this study the funding body has not determined any requirements, the researcher has taken into consideration the political nature of the strategy, and the assumption that the findings are of benefit to providers and consumers of primary health care. Funders who are concerned with future planning in relation to the strategy may also find the study of some benefit (Ritchie & Spencer, 1994).

In addition to the features outlined above, applied research is noted for its potential for actionable outcomes (Ritchie & Spencer, 1994). This is particularly appealing to the researcher, who sees the potential for the primary health care strategy. Other features include a shorter rather than longer time scale, in order to provide groups such as those outlined above, with the findings. It is deductive, in that it starts from the preset aims and objectives; the data collection is more structured than other forms of qualitative research; and the analytical process is more explicit. The functions of applied policy research frequently include the defining of concepts, mapping, categorisation, finding associations, seeking explorations and developing new ideas, theories or strategies (Pope et al., 2000).

'Framework' analysis has been designed to determine meaning, relevance and connections related to the data, both creatively and conceptually. Its strength is that ideas can be reconsidered and reworked because the analytical process has not only been documented, but is accessible to other researchers (Ritchie & Spencer, 1994). This means that it is a well-defined procedure that enables the researcher to reconsider and rework ideas in a systematic way. This also assists in ensuring analytical rigor is applied (Patton, 1990).

Qualitative inquiry reflects both the science and art of research (Patton, 1990). The scientific inquiry in relation to this study is systematic, analytical, rigorous, descriptive and critical. By contrast, the artistic inquiry allows for creativity, exploration and insight. Creative analysis also includes openness and flexibility, exploration of a number of directions and possibilities. Sofaer (1999) supports the application of qualitative research methods in health services and policy research. Hurley (1999) supports this and suggests that qualitative inquiry tends to enable greater flexibility and a broader basis for understanding the issues. One of the most significant advantages of the 'framework' approach is the ability to derive categories deductively. This means that categories can be derived either at the beginning or part way through the analysis in

order to further explain some of the data (Pope et al., 2000). An example of this will be demonstrated below

Steps of the 'Framework Approach'

Ritchie & Spencer (1994) describe five steps to the process. While they are presented as following a particular order, the steps do not necessarily follow this order, although some steps will logically precede others. The approach involves a systematic process of sifting, charting and sorting material according to the key issues and theory.

The five steps of the 'framework approach' as defined by Ritchie & Spencer (1994) include:

- familiarisation

- thematic framework

- indexing

- charting

- mapping and interpretation

These steps are described along with the process applied for the purpose of this study. Prior to any of the steps being taken, the researcher had identified 2 themes – providers and consumers. Having established these 2 themes, she started with the first step of the 'framework' approach:

Step 1 - Familiarisation

This step involves the researcher becoming familiar with the document, the Primary Health Care Strategy (King, 2001), and gaining an overview of the body of the document's key ideas. This required several readings and an immersion in the data. The process was less time consuming than what normally might be expected, as the researcher had been a member of the reference group, as noted above, and therefore had significant familiarity with its content prior to the study. While this has some advantages, it also has disadvantages in that the researcher potentially had views and experiences that could affect her ability to be objective and unbiased. There was also the potential that she could assume that she was more familiar with data than she actually was. The researcher therefore had to take time to ensure this did not occur.

As a part of this first step the key issues that related to the a priori themes of providers and consumers were identified and listed. This process involved the researcher working through the

document, identifying all the requirements that the strategy outlined in relation to providers[10]. This process was repeated in order to identify all the requirements related to consumers[11]. This step started the process to identify the recurrent themes relevant to the research question, and in line with the key directions that King (2001) has determined for the future primary health care service for NZ.

Table 1 demonstrates these key directions.

Table 2 demonstrates the recurrent themes identified through the familiarisation process.

Table 1 Key Directions for the Strategy

Work with local communities and enrolled populations
Identify and remove health inequalities
Offer access to comprehensive services to improve, maintain and restore people's health
Co-ordinate care across service areas
Develop the primary healthcare workforce
Continuously improve quality using good information

King (2001, p.vii).

Table 2 Emerging, Recurrent Themes

Skills Required
Services to be provided
Collaboration/ Coordination
Population focus
Community involvement
Access
Ethnic specific
Funding

[10] See appendix 1
[11] See appendix 2

Step 2 - Thematic framework

While becoming familiar with the data, the researcher noted the recurrent themes as they related to the research question (see Table 2). These themes start the process to develop a thematic framework, so that the data related to each of the themes can be sifted and sorted into each of the themes. Only data contained within the strategy document is used.

As a result of this process a detailed index of the data in relation to each of the themes has been developed, enabling it to be sorted into manageable chunks and allowing for later retrieval and exploration if required. An example of this can be seen in Appendix 3. This ability for data to be retrieved and explored has two purposes. The first allows any future researcher to access the data and secondly it allows for an audit trail. This is one of the advantages of using the 'framework approach', as the process is quite transparent (Ritchie & Spencer, 1994).

The themes, or categories, are compiled using both logical and intuitive thinking. Initially, using logical thinking, the researcher considered using the six key directions as the basis for the themes, however intuitively this approach did not align with the research question. Therefore, while the key directions are a critical component of the strategy, it has been decided to develop a thematic framework that has a stronger application to the research question. As noted by Ritchie and Spencer (1994), this process involves making judgements about the meaning, relevance and the importance of the issues as well as the implicit connections between ideas.

Step 3 - Indexing,

This is the third phase of the framework approach and is the process where the thematic framework is systematically applied to the data and indexed. This requires annotating the data in textual form with numerical codes. This is not a straightforward exercise, as the researcher has to make numerous judgements as to the meaning and significance of the data. Many of the sentences and paragraphs containa number of different themes, each of which has to be indexed. A sample of this process can be seen in appendix 4, where the researcher has coded each sentence or paragraph in the strategy to the relevant theme. It is clear that several different codes appear even within one sentence. It must be noted that typically this process is subjective and open to differing interpretations. Because the 'framework' approach is so explicit, and all

documentation is kept, it means that the reader can refer to the data to help explain some of the interpretations that have been reached by the researcher (Ritchie & Spencer, 1994).

Table 3 below highlights the codes applied to each of the themes.

Table 3 Codes Applied To The Themes

Code	Theme
1	Skills required
2	Services to be provided
3	Collaboration / coordination
4	Population focus
5	Community involvement
6	Access
7	Ethnic specific
8	Funding

Step 4 - Charting

This stage involves linking all the indexed data to the themes and synthesising it. This encompasses the rearranging of data according to the appropriate part of the thematic framework. For the purpose of this study a slightly different process has been undertaken to achieve this. Most commonly charts are set up by devising headings and subheadings from the thematic framework, each of which contains a summary of the views. This approach is generally undertaken because of the number of different sources of data collectionThis was considered unnecessary for this study, as there has only been one source of data collection – the strategy document.

Instead, a table has been developed providing a brief description of each of the themes. The purpose is to illustrate that the data has been synthesised according to themes, thus completing a charting process.

Table 4 Description of Themes

Code	Theme	Description of the Text
1	Skills required	The type and range of skills that will be required within a primary health care organisation. Ranges from technological, administrative, professional, developing new skills. Focus on prevention, improving health
2	Services to be provided	Range of services based on the needs of the community, including first point of contact services and population health services. Focus on maximising health and addressing of social, cultural and economic issues related to health
3	Collaboration and Coordination	Coordination of services and providers, intersectoral activities, continuity, horizontal and vertical coordination, team work, linkages
4	Population focus	Community development, public health approach, services based on the demographics of a defined population
5	Community involvement	Community development and participation
6	Access	Choices for and of practitioners; removing of barriers; range of services
7	Ethnic specific	Culturally appropriate services for Maori and Pacific people; ethnic specific providers and services
8	Funding	Affordable, population based funding, cost effective service delivery

Step 5 - Mapping and Interpretation

This is the point where all the data has been organised into themes and key characteristics, and is drawn together to be mapped and interpreted as a whole (Ritchie & Spencer, 1994). At this point the original research question guides the process and determines which of the features of qualitative analysis will be applied. Generally these features include:

- Defining concepts
- Mapping range and nature of phenomena
- Creating typologies
- Finding associations
- Providing explanations
- Developing strategies

(Ritchie & Spencer, 1994, p.186)

Once this process started the researcher started to revisit the themes. A significant amount of the data was to be coded to more than one theme. One of the many benefits of the 'framework' approach is the ability to change themes throughout the process At this stage of the approach, due to the amount of cross-coded data, the researcher made the decision to modify the themes. This involves repeating the indexing and charting process[12].

Table 5 describes the revised themes.

Table 5 – Revised Coding and Themes

Code	Theme	Description
1	Funding	Funding is considered one of the most salient features of the document and has been discussed with the view that it overarches the direction of the strategy and focuses largely on the data that had been coded to 8 in Table 3
2 3	Services and skills	These themes merge most of the data described in Table 3, apart from funding

All of the data is interpreted taking the research question into account. At this point it has been realised that there are additional categories that need to be considered as part of the study. This

is in an integral component of the deductive nature of the 'framework' approach (Pope et al., 2000). While the research question has been addressed through analysis of the 3 themes, it has become clear that the implications of the strategy for both providers and consumers have not being addressed in full. Therefore, for both providers and consumers, there is a chapter that focuses specifically on the implications of the strategy for them. For providers, it has become apparent that the significance of the change in order to meet the direction and vision of the strategy has required more in-depth analysis. For consumers, it has become apparent that the population focus requires further analysis. It has been decided to use the work of Williams (2000) to inform the discussion to fully analyse the implications of the strategy.

Implications for providers

Williams (2000) notes that over the last few years in the United Kingdom, the spotlight has been on primary care, resulting in professional sensitivities and a culture of uncertainty. She suggests this occurs as a consequence of government reform and resulting policy changes that frequently influence professionals to look at their professional boundaries. Her work provides insight into the differences between medicine and nursing and the implications this has for a changing primary (health) care picture. Her anthropological study aimed to "explore the ideas, values and beliefs to which primary care professionals appeal in order to justify their work and distinguish it from the work of others" (p.11). The study included looking at the skill mix within the primary care sector and issues of professional identity associated with role change and expansion. These issues seemed particularly relevant to this study of the *Primary Health Care Strategy* whose vision and key directions involve broadening the boundary from primary care to primary health care, with a blurring of boundaries and roles.

Implications for consumers

The second part of the research question relates to the implications of the strategy for consumers. The direction of the strategy is grounded in a population-based approach to primary health care and an emphasis on finding ways to improve the health of disadvantaged groups. It notes that a community development approach where PHOs act as advocates and involve their communities will assist in achieving this (King, p.10). This reference to a community development approach when examined further reflects the principles that are contained in a community development model.

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[12] see appendix 4 for example of coding of themes to the data

A community development model involves a process where communities are empowered to improve their health and well being and where there is a partnership between provider and consumer based on collaboration and negotiation for information and services (McMurray, 1999). In this model the health professional adopts a role that is different from the traditional role of the health professional as carer and holder of knowledge. Instead the health professional adopts a more culturally sensitive role, advocating for the community and involving them in decision-making and change, both at a community level and as an individual (McMurray, 1999). This approach has particular relevance to the range of services outlined in the strategy which have both a population health as well as a personal (individual) health focus.

A community development model is based on principles that include integration of all the determinants of health including social economic and cultural determinants; community ownership of structures; partnerships and a vision to promote health and well being (McMurray, 1999). The approach encourages consumers to manage their own health. The community development model will be used to inform the discussion in relation to the implications of the strategy for consumers.

Application of the analysis
As noted earlier, the framework approach is a methodology frequently used for policy analysis with the aim to assists funders and others who may be affected by the policy. It is expected to provide answers or a greater understanding of the issues (Ritchie & Spencer, 1994). This can guide providers, consumers and funders through the implementation process.

RELIABILITY

Most importantly, the technical aspects of analytical rigor will be applied to this study. Strong supporting evidence will be provided to explain the data evidenced by the literature and references. The work of William's (2000) and a community development model, as described above, will be used to inform the discussion of the implications for providers and consumers.

The 'framework approach' assists to ensure reliability as all documentation is maintained to enable others to access the information. Samples can be seen in the appendices. The other most significant way to demonstrate reliability is to provide an audit trail. This can be evidenced in this study, by the researcher's use of direct references and quotes from the strategy.

Frequently when the 'framework' approach is used, other researchers are used to improve the consistency and reliability (Pope et al., 2000). This has not been practical for the purpose of this study, however the visibility of the process will enable other researchers to access the information and follow up with further study if required (Ritchie & Spencer, 1994). Key and expert informants could be approached to further review the accuracy of the data. The researcher herself also has a responsibility to ensure accuracy (Sarantakos, 1993), and to do this she has invited colleagues to review and interpret her work. In addition support and review has been provided through her supervisor.

ETHICAL APPROVAL

Ethics approval was sought and gained prior to commencing the study. This was achieved through the Massey University Human Ethics Committee. No further approval was required, due to the non-contact nature of the study.

CONCLUSION

This chapter has described the methodology applied to this study. It has outlined the 'framework' approach and provided a brief overview of the specific approaches used to inform the discussion related to the implications for providers and consumers.

The next section of the study will focus on interpreting the data. This will include the 3 key themes of funding, services and skills as well as the 2 further themes discussing the implications of the strategy for providers and consumers that were obtained deductively.

CHAPTERS FIVE THROUGH EIGHT - RESULTS

CHAPTER FIVE – POPULATION-BASED FUNDING

INTRODUCTION

Population-based funding is described as King (2001) as the way to achieve a population approach to primary health care. This, she claims, will require adequate funding that is fairly allocated "according to the needs of the population served" (p.14). Population-based funding is the key to achieving the shift in the way primary health care services are currently delivered. This shift, as outlined in the strategy, supports the government's overriding strategy to change the health system and its structure to improve the overall health and independence of New Zealanders (King, 2001). For primary health care the system will involve establishing structures, to be referred to as Primary Health Organisations (PHOs), which will be funded by District Health Boards (DHBs).

The establishment of PHOs signals a significant change for 'primary care' providers (GPs) who, as previously noted[13], have formed themselves into organisations known as IPAs. IPAs are largely comprised of shareholding GPs who operate in a private provider capacity, either in partnership or sole owners of the practice that they work in. As indicated in the literature, they generally work in a 'for profit' capacity.

The proposed funding mechanism compounds the significance of the change for providers, as the current funding mechanism, based on a fee-for-service payment for primary care (GP) services, dominates the primary care sector. This is despite unsuccessful attempts through previous health reforms to change the way they have been funded. These attempts have been viewed by GPs as mechanisms to control their income (Coster & Gribben, 1999). This strategy therefore, with its population-based funding approach, revisits the challenges faced by providers and funders over the past few years. This chapter will focus on the impact of population-based funding for both providers and consumers, highlighting its potential strengths and risks.

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[13] Refer to chapter 2

While the researcher has identified three themes as she applied the 'framework approach' to the document[14], she has identified funding as the most salient theme. The following discussion will demonstrate that population-based funding is the key to the strategy and for this reason needs to be situated separately from the other two themes. The discussion related to these themes will follow this chapter.

WHY POPULATION-BASED FUNDING?

The strategy claims that population-based funding is expected to achieve improvements in health outcomes and reduce inequalities in primary health care (p.14). It is an approach that is significantly different from the current fee-for-service payment for primary care, as highlighted above, or from the way that other primary health care providers are funded. The approach links funding to population needs, rather than to "particular numbers of services or types of practitioners" (p.14). According to the strategy, this approach will not only achieve the outcomes as described above, but will enable more flexibility in service delivery. This means that services may be provided without barriers "to using the most appropriate health practitioner in each situation" (p.14). This suggests that existing roles and practice boundaries may become more blurred. For example, nurses could take on some of the workload of GPs, such as health education, health promotion, that arguably they are better prepared to do. This frees the GPs to take on more complex work that may currently be provided in secondary care settings. This is supported by the substantial body of knowledge which shows nursing to be as cost effective as medical services in a number of settings, with no loss to safety or efffectiveness (Richardson & Maynard, 1995). Nurse-led services have also been shown to have positive effects on health outcomes (Knaus et al, Krakauer et al., 1996).

The government sees population-based funding as a way to have greater control over budgets and funds for primary care as well as enabling 'population based' health services, focusing on promotion and prevention, to be provided (French et al., 2001). Thus, the rationale for the move from current funding mechanisms is both about cost containment as well as health outcomes.

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[14] Refer to chapter 3 for explanation of the methodology

CURRENT FUNDING ARRANGEMENTS

The range of different funding mechanisms that are currently accessed by primary care providers (GPs), have been outlined in chapter two and include fee-for-service, capitation, salary and co-payments. This section will expand on this outline in order to contextualise the discussion of the proposed new funding approach.

Currently in the primary care setting, the majority of GPs are eligible to receive a range of different subsidies including, GMS and Practice Nurse subsidy, as well as subsidies for referred services such as laboratory and radiology. Most of these GPs 'budget-hold' for pharmaceuticals – an attempt to encourage more effective and efficient prescribing habits (Malcolm, 1999). Those GPs who are not receiving GMS are most likely to be capitated, This method of funding is determined by applying a formula that encapsulates both their GMS and Practice Nurse subsidies. By contrast, most community based services such as public health nursing services, or Plunket nursing, are funded through price-volume contracting.

The decision to move to a population-based funding is not new, as highlighted above and discussed in chapter two. Throughout the 1990s there were several unsuccessful attempts by the government and funding authorities, to move primary care providers to capitation, with the most recent attempt occurring unsuccessfully and following considerable debate in 1998 (Coster & Gribben, 1999, Cumming & Mays, 1999; Malcolm, 2000)). It appears anecdotally, that GPs are more open this time to considering the population based funding, although there are caveats to this - largely related to remuneration. These will be discussed below.

The lack of movement to capitated funding over the past years, has been viewed as a barrier to providing flexible service delivery and has impacted particularly on nursing's ability to provide effective and efficient primary health care services (Carryer et al.,1999; Ministry of Health, 1998). This is due in part, they suggest, to the way services have been contracted, based on the ability of a provider/practitioner to provide certain services, rather than around the needs of a population. Carryer et al (1999), suggest that finding a better way to fund services, would support the development of primary health care services and start to address the current fragmented system that is dominated by primary care (GPs). They support population-based funding as a way to address some of these issues.

ADVANTAGES OF A POPULATION-BASED FUNDING APPROACH

The strategy claims that a population-based approach to funding is well supported by evidence, particularly in relation to helping "to reduce inequalities by directing resources to communities with greatest health needs" (p.14). Cumming and Mays (1999), argue that not only will this approach distribute resources more fairly, but also it will reduce variability in practice, as well as increase the mix of skills and contribute to improved health outcomes. French et al (2001), argue that it enables greater flexibility in service delivery, as well as a more predictable cash flow for GPs – despite the concerns expressed by GPs that it may contain their income. It is also viewed as an opportunity to put more emphasis on health promotion and disease prevention and increase choices beyond GP care (Cumming & May, 1999). This supports the direction outlined in the strategy (p.13). Cumming (1999) cautions that improved health outcomes will not be achieved by changing the way providers are funded, without other measures to support the change. She suggests a range of measures such as peer review, evidence-based practice and quality assurance programmes, combined with contractual arrangements that monitor and record such activities in combination with population based funding, are more likely to achieve the desired outcome. Coster and Gribben (1999) would argue that most of these measures have been established by IPAs over the past few years.

Despite the advantages, some organisations suffer under capitation. Jennings et al (1996) note in order for organisations to thrive, they need to have robust structures and be organisationally prepared. This usually means they need to increase their number of providers to be able to deliver the services differently and more responsively to consumer and market demand. They also need to have robust information systems.

Broader Approach
As already noted, population-based funding will take a broader approach than the traditional fee-for-service subsidy. According to the strategy, it will account for "components for things like improving access for high need populations, health promotion and management support" (p.11). This approach signals a significant change in direction, and a potential for a much wider range of services to be provided. The new approach to funding is likely to be most significant for GPs, who are more familiar with the fee-for-service approach where they are remunerated

for each patient visit. This means that their revenue is directly proportional to the number of people they provide services for and who are eligible for a subsidy.

Fee-for-service funding is criticised as encouraging overservicing, and discouraging of programmes to support self-care and wellness. By contrast, a population-based funding approach is viewed as encouraging practitioners to keep their population well through proactive prevention and health promotion activities, and discouraging of unnecessary visits to health practitioners. A more negative aspect, and a risk, is that it can encourage practitioners to under service their population and avoid enrolling those people who are more likely to be high users of health services (Cumming, 1999). The latter is commonly referred to as 'cherry picking'.

The strategy is also concerned with the perverse effects of fee-for-service funding and notes that it has "led to an uneven and inequitable distribution of resources, often more related to the number of practitioners rather than to people's needs" (p.14). This is further supported with anecdotal evidence in line with Cumming's argument, that fee-for-service encourages repeat consultations. This is observable in some GP waiting rooms, where notices inform people that they can only discuss one problem per consultation. These behaviours all contribute to the way resources get distributed in a fee-for-service funding environment (Malcolm & Powell, 1997).

For consumers with high needs and who are more deprived, fee-for-service payments are less likely to support their health needs. They are a group that is typically less likely to visit the doctor, or if they do, they tend to wait until they have a number of problems and get them addressed at the one consultation. These same people are less likely to pick up their prescriptions or to return for a repeat consultation (Crengle, 1999). Some of this is explained anecdotally through examples where consumers claim they have not understood the reason for the prescription. This is compounded by the cost of the visit - co-payment – as well as the cost of the prescription. Malcolm (1999) also notes that pharmaceutical expenditure for these groups is lower despite the fact that they have higher health needs. Again anecdotally, GPs report that they generally prescribe less for this group as they frequently find that they have not picked up the medication or have picked it up but not taken it. The GPs consequently feel it is a waste of time to prescribe.

Funding Formula

The document briefly outlines the way the way population-based funding will be calculated, and states it will be developed "according to a formula that reflects the relative need of their enrolled populations, taking account of factors such as age, sex, deprivation level and ethnicity" (p.14). This will require data to be collected by providers as people enrol for services. The data will not only assist in determining the funding for their population, but will also inform future planning and funding decisions (p.25). The inclusion of ethnicity data, which will be taken into account in any funding formula, is expected to increase the amount of funding for providers with significant numbers of Maori and Pacific people. In turn this is expected to encourage those providers to consider different ways to deliver services to reach disadvantaged groups in order to start address some of the health inequalities (p.10).

There is a risk associated with this approach. In that it can encourage adverse selection of enrolled people, sometimes, as noted above, described as 'cherry picking'. This can work in two ways. The first way encourages providers to select those disadvantaged groups in order to attract the additional dollars that they will get both through the formula and through new funding (p.14) The second way is to avoid the more high cost service users. Adverse selection therefore might mean that some providers will build their enrolled populations around Maori and Pacific people to attract the additional funding. Or, they might try to avoid those people with complex health needs or with chronic health problems, who consume health care resources disproportionate to their numbers (Browne et al., 1995). Browne et al found in their study, that a more holistic approach to managing people with chronic illness achieved higher levels of wellness and cost less. This meant using a range of practitioners and services rather than the more traditional bio-medical, or primary care model. This finding further reinforces the move outlined in the strategy to a more collaborative, multidisciplinary approach to service delivery (p.18).

Risks associated with population-based funding (or capitation[15]) have been discussed above and in some depth in the literature review in chapter two. As part of a process to mitigate these risks, the strategy notes that the Ministry of Health will be developing some business rules in conjunction with the development of the funding formula (p.16).

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[15] Refer to Chapter two for discussion on funding methodologies

Not for profit

Critical to the intent of the strategy's direction, and in order to receive any of the funding, is the requirement for the new structures, PHOs, to be formed as not for profit organisations and for providers to join a PHO. "This will guard against public funds being diverted from health gain and health services to shareholder dividends" (p.14). This creates tensions for GPs who operate as 'for profit' business owners and operators', but it will have more of an impact on the organisations (IPAs) that the majority of them belong to. This is due to the fact that IPAs are largely constructed as limited liability companies, with GPs and in some (minority) cases Practice Nurses as shareholders. It will also impact any other 'for profit' private providers, however for those non-profit providers such as Plunket or the DHB, this will be less of an issue.

Therefore, unless an organisation has been accorded PHO status, it will not be eligible for the funding and will not be a part of the new primary health care system, as propsed in the strategy. This also means that those who choose not to join a PHO, will be in the same situation. This is a risk for the government, particularly if there are significant numbers of providers not involved.

Health inequalities

The strategy claims that the removal of inequalities will be a crucial role to be undertaken by primary health care (p.10) with the support of population based funding. Despite the inclusion of ethnicity data in the funding formula which will provide some additional funding, the strategy recognises the need for further additional funding over and above the basic population based funding, in order to fully address the health inequalities. This is particularly relevant for Maori and Pacific populations, refugees and those in remote areas (p.14) who the strategy claims will get first priority for any additional funding (p.16). The strategy expects that providers will identify those groups whose " health lags behind that of others" (p.10).

This expectation applies to both Maori and Pacific provider organisations, as well as 'mainstream' providers. The process of identifying those groups will also raise the issues associated with barriers that currently impact access to services which are expected to be addressed within the allocated funding (p.15). Some barriers, as discussed below, will be more difficult to address within that funding.

BARRIERS

Affordability and Access

The strategy highlights a number of the barriers that currently exist, such as cost and affordability, physical access, and the appropriateness and availability of services. It specifically notes the government's commitment to reducing cost barriers to accessing services, but also requires that PHOs and providers will need to consider the affordability of services. This, it claims, can be achieved both through the population based funding, as well as through more flexible use of resources and flexible approaches to service delivery (p.16). The strategy also notes that supporting people to look after themselves will "reduce their need to visit (and pay for) health services" (p.16).

While costs to accessing services poses barriers for some groups, the costs associated with providing services for those same groups can also be an issue. Crengle (1999) notes that this is the case for Maori services that use tikanga Maori, or traditional philosophies. Traditional Maori healing encompasses several activities including spiritual, physical, and mental with the extended family having a central role in each with health viewed as an interaction involving each of the activities (Durie, 1998).

Providing care to rural communities is also considered to be more costly than care delivered to urban areas, compounded by the fact that significant numbers of Maori live in rural areas. However any move to redistribute resources, including addressing cost barriers to support Maori and others such as those in poorer or rural communities, in the absence of specific activities to address the health inequalities, is unlikely to bring about any change (Cumming & Mays, 1999).

In order to address the issue of costs as a barrier for some groups, and in particular for lower socio economic groups, providers will need to consider a range of different strategies. Crengle (1999) outlines some solutions that have been implemented by Maori providers including activities such as reducing co-payments and delivering outreach or mobile services as well as delivering services in ways that are more culturally appropriate. However services that reflect the specific cultural needs of Maori as identified above, frequently require longer consultations. This is due in part to the need to address other determinants of health, such as housing and money, as part of the consultation. Frequently these issues need to be addressed before the health problem can be tackled. This approach takes more time and resources and reinforces the need for additional funding (Crengle, 1999).

Tukuitonga (1999) also describes similar issues that emerge through 'Pacific for Pacific' models, where the Pacific owned models of health care deliver services based on their philosophy and in a style that meets the cultural needs of that group. This generally requires additional resources. Cost and affordability are not the only barriers to accessing services. For Pacific people there is the issue of language barriers where older Pacific-born people speak very little English (Tukuitonga, 1999), compounded by the number of different Pacific groups who each speak a different language. Tukuitonga (1999) suggests that language barriers are compounded by a lack of communication about services.

The strategy also notes this and suggests this creates barriers and leads to inappropriate use of Accident and Emergency clinics for primary care services, for example (p.16). The strategy expects that people will be provided with adequate information and notes that "information about what primary health care services are available and how people can get to them must be provided in ways that people in the communities can understand" (p.16). This expectation implies that this should be achieved within the funding allocation. For both Maori and Pacific people the traditional printed material is frequently ineffective and for both groups oral communication is preferred (Crengle, 1999; Tukuitonga, 1999).

For the majority of providers who commonly use leaflets and posters to support or to impart health promotion and disease prevention information, it will mean different approaches will need to be considered with more focus on oral media. This might include health education sessions on marae or in church based settings, as suggested by Crengle (1999) and Tukuitonga (1999), and seeking more individual and group health promotion opportunities. Other media will need to be considered for visual and hearing-impaired people (p.16). In order to ensure affordable services, providers will need to consider innovative approaches (p.17).

CULTURAL COMPETENCE AND EFFECTIVENESS

The strategy expects that providers will provide services in a culturally competent and effective way (p.11). Frequently, as noted by the strategy, disadvantaged groups such as Maori and Pacific represent the hard-to-reach, and PHOs are going to need to look at different approaches within their funding allocation to meet their needs. This will mean establishing services at particular locations such as marae, or providing specific services, or clinics (p.10). In line with this, Tukuitonga (1999) suggests that for Pacific people "the philosophy of the service and delivery staff could either enhance or discourage attendance" (p.12).

CONCLUSION

The above discussion has highlighted the potential for population-based funding and supports the researcher's argument that it is the key to the new primary health care system, as outlined in the strategy. Based on the above discussion, it can be confirmed that the advantages outweigh the disadvantages. This method of funding enables more flexible service provision by a range of practitioners and in a variety of settings and supports the population health approach promoted in the strategy. This is in contrast to the more limiting fee-for-service funding that currently dominates service provision; has limited provider eligibility (that is, only GPs are eligible to receive it); and constrains service delivery.

Maori and Pacific providers view population-based funding as an opportunity to provide services in a more culturally appropriate and flexible way. The flexibility enables longer consultations, in settings more appropriate to the consumers, and an ability to provide health education and disease prevention activities. This is important if the population focus promoted by the strategy, particularly for disadvantaged groups, is to be implemented.

Nurses also view the new funding approach positively, recognising the opportunity for them to be more effectively involved in service delivery. They describe the range of positive features associated with population-based funding, which are expected to enable providers to focus more on health promotion and disease prevention activities through more flexible use of resources and service delivery (Carryer et al., 1999). For the majority of providers, it will require them to make significant changes to the way they currently provide services. This is unlikely to occur just with a change in funding, but will require a range of other measures to be implemented as well (Cumming, 1999). For nurses, the change means that GPs will no longer have exclusive access to primary care funding, and presents them with the opportunity to position themselves to attract funding.

The literature[16] also suggests that while GPs may be more ready to accept a change in the way they are funded, they have in the past rejected any moves away from their fee-for-service funding mechanism. Population-based funding is more likely to be welcomed by those GPs for whom it will mean an increase in predictable income. It is also most likely to be attractive to

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[16] See chapter 2, funding section

those GPs whose population is predominantly made up of disadvantaged groups as they are more likely to attract any additional funding as it becomes available (p.14).

There are however, some elements of risk for consumers, associated with population-based funding, particularly for those populations who might consume more health care resources than is expected and therefore cost more in service delivery. This has been identified in relation to tikanga Maori services for example (Crengle, 1999). There is also the risk that the population may be underserviced, or that costs may be shifted between providers.

The proposed change to funding presents challenges and opportunities for providers. Both are dependent on providers changing the way they deliver services and to expand their range of services to encompass the population focus outlined in the strategy. As a method of funding, it receives significant support from health economists who view it as a more equitable and fair way to redistribute resources as well as a way to improve health outcomes (Cumming & Mays, 1999).

For consumers, according to the strategy, population-based funding is expected to improve health outcomes. This direction is supported by Tukuitonga (1999) and Crengle (1999) for disadvantaged groups such as Maori and Pacific. Recognition of ethnicity in the funding formula will increase the amount of funding for providers with significant numbers of Maori and Pacific people in their enrolled populations. This will enable providers to consider more appropriate ways to deliver services to those disadvantaged groups whose health status is affected by the barriers that currently exist. Providers may reduce co-payments for disadvantaged groups, whose health status, according to the strategy requires specific attention. These groups should also benefit from improved access to health services. For many consumers, any change to funding is likely to go unnoticed.

Therefore, while the advantages of population-based funding outweigh the disadvantages from a population health perspective, the service and practice changes required of providers can not be ignored.

CHAPTER SIX – SERVICES AND SKILLS

This chapter will focus on the two themes that underpin the previous chapter, which situated population-based funding as the most salient feature in relation to the research question. The two themes in this chapter relate to service and skills requirements. The data emerged during the initial familiarisation process

Section one of the chapter will focus on the first theme, related to the services that King (2001) asserts will be provided in order to achieve her vision for primary health care. Section two will discuss the skills that will be required of providers/practitioners, in order to provide the services within the new primary health care environment. Both themes are integral to the primary health care strategy, as is the move to population-based funding.

The two sections are set out in slightly different ways. In the first section the services are divided into two categories which will be discussed separately. The first category focuses on services that are referred to as 'first-level' services, while the second category focuses on 'population health' services.

The first part of the second section summarises the key requirements of providers related to skills. This will be followed by a discussion on the implications of those requirements for providers and consumers. The conclusion will draw the discussions of both sections together.

SECTION ONE - SERVICES TO BE PROVIDED

The vision and the new directions outlined in the strategy involve a system "where services are organised around the needs of a defined set of people" (p.5) and "will include services that improve, maintain and restore people's health" (p.13). PHOs will be the structures through which these services, defined by King (2001) as " a defined set of services" (p.13), will be provided. At a minimum this will "include approaches directed towards improving and maintaining the health of the population, as well as first-line services to restore people's health when they are unwell" (p.5).

For the purpose of this discussion 'the approaches' will be separated into two distinct categories. The first category encompasses 'first-level' services that appear to be comparable to

the types of services that GPs and Practice Nurses provide. The second category encompasses the services that will be required in order to improve and maintain the health of the population. The discussion will demonstrate the strategy's focus on primary health care services that King claims will achieve "better health for a population" (p. vii).

King (2001) signals this as a new direction for primary health care where there is a much greater emphasis on population health (p. vii). Based on the literature this will be a challenge for existing primary health care providers, who are more familiar with working in a system where services, particularly nursing services, are fragmented and dominated by GPs. The current system emphasises the work of GPs, and to a lesser extent practice nurses. This commonly involves GPs responding to individuals or families who present at their clinics (or general practice settings) with a wide array of problems or health issues (Starfield, 1998). The current approach, Carryer et al (1999) argue, is primary medical care and does not take into account the wider concept of primary health care as determined by the strategy, and based on the definition drawn up by the International Conference on Primary Health Care, Alma Ata 1978.

Overview of services

In general the strategy's requirements relating to service delivery suggest a much wider range of services but they broaden to encompass a more wide reaching population focus. The strategy strongly attempts to integrate primary care with primary health care services. This means integrating services such as those provided in general practice settings with providers such as PHNs. While King argues for an integrated approach to the provision of primary health care, she states that some services will be continued to be provided through separate arrangements through the current arrangements (p, 14). She refers to family planning, sexual health and maternity, and cites the two former services as more sensitive and confidential (p.13). King also refers to well child services, which according to the literature, is one of the more fragmented of the primary health care services, with a range of providers and contractual arrangements contributing to the poor outcomes, evidenced through the childhood immunisation statistics.

King's rationale for a different approach for 'specialist' services is based on "the continued importance of continuing to provide such alternative choices for people" (p.14). She considers these services as "sensitive and confidential" (p.14). It remains unclear as to why they should not be integrated into the new system that attempts to integrate services for the population. This approach appears to promulgate the fragmentation in a way that contradicts the strategy's

general direction. It will challenge provider's skills to effectively coordinate services and care as required in the strategy (p.18). This will be discussed further below. There is also the risk that unless effective systems are established to coordinate care, the current gaps and duplications in care for consumers will remain. The strategy emphasises that the "best possible package of care" should be provided but exclusion of some services from the PHO may preclude this from occurring in a seamless way.

The strategy appears to contain a number of contradictions in relation to the benefits that consumers may realise from the new direction for primary health care. On one hand, it emphasises the importance of continuity and relationships with a usual source of care, albeit not necessarily one provider (p.8). On the other hand, it supports alternative choices and arrangements that may sit outside a PHO. This approach may impact on the benefits of coordination for consumers, that the strategy claims will occur in the new primary health care system.

The direction for services, as outlined by the strategy, implies that for some providers, such as family planning, sexual health, or maternity there will be little change. For others who choose to be involved in providing primary health care services as defined in the strategy, including health improvement, screening and prevention (p.13), there are likely to be significant changes.

First-level services

These services are currently provided in a General Practice, or primary (medical) care setting, where people present to the GP or Practice Nurse when they are unwell or concerned about their health. While the strategy refers to the need for first-level services, the types of activities it describes take a different approach to the current first-level service provision. The first significant difference is related to the need for services to be provided "in a range of different settings" (p.16), such as in people's homes, or in schools or on marae, so that people who usually do not or cannot access these services can be reached. This is in acknowledgment of the inequities that exist in different groups throughout NZ (p.10) and shifts current primary care provision from the more typical general practice setting. It reflects a more population oriented service delivery rather than a provider-focused service.

This shift in focus infers changes for primary care, where typically services are provided in a general practice setting where individuals are treated and managed, usually by the GP in

accordance with their presenting problem (Starfield, 1992). The strategy shifts this current approach to an expectation that providers will be more responsive to the needs and priorities of their community (p.5) as opposed to individuals. This frames first-level services more within a population focus. Starfield (1998) supports this approach and agrees that by increasing the orientation of primary care towards meeting the needs of the community rather than individuals, it will draw primary care closer to the concepts of primary health care. Carryer et al (1999) would argue that the changes to first-level services as outlined in the strategy will not occur if a primary medical care model exists. This suggests that if GPs continue to provide first-level services they will need to change their approach to align service delivery to the strategy. For GPs this means a shift from a treatment focus to a more preventive focus and for all providers it involves a shift from a primary care philosophy to one of primary health care.

The direction outlined in the strategy is probably better aligned with services provided by Maori and Pacific providers, who generally provide services in a range of different ways and settings. Their approach is focused on endeavours to better meet the needs of the people they serve. While the strategy affirms that Maori and Pacific provider development will continue, it acknowledges that these providers do not have the capacity to address all the health problems of their populations. Mainstream providers, therefore, will need to consider ways to deliver services to their ethnic populations that are "culturally competent and effective"(p.11). This will be discussed further below and in Chapter 8 – Implications for Consumers.

Multidisciplinary Approach

The strategy emphasises the need for a range of practitioners with the skills to meet the "broad vision of primary health care" (p.18). This will challenge GPs who are currently the dominant providers and for other providers where service provision is fragmented. The strategy acknowledges a variety of practitioners who could contribute to service provision and notes that while it will more commonly involve doctors and nurses, it notes that in some instances, for some populations, there will be a need for a "range of community workers" (p.18). This is most likely to be appropriate in areas where there is a shortage of health professionals, such as rural settings, or to reach people who are not currently accessing the services. It also presents an opportunity for more effective utilisation of nursing services. It reinforces the absence of models of primary health care service delivery in NZ to support providers to work collaboratively.

Access

First-level services have been described in the strategy as the type of services that people need "when they are unwell or concerned about their health" (p.13). For both consumers and providers this will mean provision of "24- hours-a-day, seven-days-a-week urgent services" (p.8). Primary care providers would argue that they already make provision for these services. For some they rotate on an 'on call' system while others have arrangements with private accident and medical centres. This frequently raises issues of access and affordability as disadvantaged groups, or those whose health is affected by socio-economic as well as health factors, frequently avoid such centres and either do not access after hours health services or go straight to public hospital accident and emergency departments (Tukuitonga, 1999).

Continuity of Care

The strategy argues that the current after-hours arrangements are episodic in nature and do not adequately meet the needs of some groups and do not meet its requirements for continuity of care (p.8). While choice of provider is considered important for consumers, the strategy is concerned that the benefits associated with continuity of care are realised (p.8). This is expected to be achieved despite the fact that the strategy supports the continuance of the provision of some services outside a PHO structure. GPs support this concern and argue that continuity of care will be challenged if there are too many providers to choose from or that consumers may move from one provider to another depending on need. Starfield (1998) summarises evidence supporting continued associations and establishing long term relationships with a particular provider or place. This, she suggests, results in both providers and consumers developing better knowledge and understanding of their health problems. She acknowledges that free choice is important but limits the choice to doctors rather than a wide range of different practitioners. The strategy is clear that it will not limit choice and consumers must be free to "use a number of services provided by different providers in various settings" (p.19). This broader approach, encompassing a wider ranger of practitioners presents some practical problems related to coordination, collaboration and teamwork that will need to be addressed. These will be discussed in more detail in chapter 7.

Barriers to effective implementation of first-level services

Currently there are a number of barriers that inhibit effective and efficient utilisation of the range of practitioners as suggested by the strategy. For example up until recently it has only been practitioners such as midwives and doctors who have been eligible to prescribe and access government funded laboratory and radiology services. This scenario is changing with the

advent of the Nurse Practitioner and particularly the Nurse Practitioner with prescribing rights (Nursing Council of New Zealand, 2002). This newly emerging role increases choices for people and opportunities for increasing the range of primary health care services available. While there is some opposition to this role, its inception will support the strategy's direction for primary health care to improve and maintain health. The strategy places considerable responsibility in the hands of primary health care providers. It asserts that the majority of health problems can be "successfully dealt with at the primary level" (p.13). This assertion is supported with evidence demonstrating that ninety per cent of new problems can be managed at this level, supported by pharmaceuticals and diagnostic testing such as laboratory and radiology services, often called referred services.

The emergence of other practitioners such as primary health care nurses and nurse practitioners are considered by Carryer et al (1999) as a solution to enhancing the effectiveness and efficiency of service provision. Nurse Practitioners in particular could contribute significantly to improving health outcomes (Nursing Council of New Zealand, 2002). This is central to the strategy's focus to develop a strong primary health care system (p.1) and will be discussed below in relation to skill requirements.

First-level Advice

While one component of first-level services includes treatment and management, the strategy introduces a second component that relates to the importance of "ready access to first-level advice" (p.13). To achieve this it emphasises that practitioners will need to consider different ways to source advice such as "telephone helplines and the Internet" (p.13). The issue of a place for nursing services is raised with the requirement for "increasing nursing involvement" (p.13).

Wider Range of Services

The strategy reinforces a much wider range of services than currently exists which will be advantageous to consumers. Their right to choose is viewed as important by the strategy and in particular for situations where consumers might have "sensitive and confidential problems" (p.14). This might mean that at times they choose to seek advice and treatment for such problems from a provider who is not their usual source of care and where they might not want to go to their usual practitioner. The risk is that if the strategy continues to support the location of some services outside of PHOs, as noted above, the benefits associated with continuity may not

be achieved, as dispersed services and providers will compromise effective service coordination (Gulbrandson et al., 1997). This supports the argument for including these services under the umbrella of a PHO.

Despite this aberration the strategy notes that primary care services need to be comprised of the right mix of services, with a wide range of practitioners (p.13) as well as different and innovative approaches ((p.17). To manage this, the strategy focuses on the importance of coordination firstly to avoid duplication; secondly to ensure people do not miss out on services; and thirdly to ensure continuity of care. This becomes even more important as primary health care services are extended beyond first-level care "towards a more comprehensive disease prevention and management approach" (p.18), and a population health approach. It reinforces the absence of an appropriate model in NZ for primary health care service delivery.

Population Health Services

The direction outlined in the strategy expands the current focus of primary care and first-level service provision to a focus on services that are expected to have a significant role in reducing health inequalities and improving the health of communities (p.1). This is particularly important for Maori and Pacific people, according to the strategy, whose "health lags behind that of others in the population" (p.10). Consequently the strategy places significant emphasis on activities to address these health inequalities (p.10). It describes a community development approach as a means to improve the health for these groups who are considered the most disadvantaged. This approach will be explored in some depth in chapter 8.

The strategy reinforces a coordinated approach not only between population health services, but also inclusive of first-level and other primary health care services (p.1), such as public health. This cannot be achieved by simply 'adding on' population health programmes to primary care services. Based on the UK experience, issues related to skills, organisational capability and teamwork need to be addressed (Public Health Alliance, 1998). This reinforces the significant change in service provision that will be required to address the current fragmentation of services and dominance of GPs. This will be discussed further below.

Range of Population Health Services

The strategy notes that the health promotion approach will include a range of prevention and health promotion services. This extends current primary care service provision of treatment and support services "towards a more comprehensive disease prevention and management

approach" (p.18) – an approach which is expected to address some of the current health inequalities and contribute to improving health outcomes (King, 2001).

While first-level services are based in treatment and support for people when they are unwell, population health services encompass those services aimed at improving and maintaining health. The strategy describes health improvement services as those that involve "health promotion, education and counselling and helping people to adopt health lifestyles" (p.13). It describes maintaining health as involving services such as screening, education and interventions to prevent damaging behaviours (p.13). These services will be discussed in more depth in chapter 8 in relation to a community development approach.

Population health, commonly described as public health, has until now largely been the domain of public health service providers, with a ring fenced budget established to protect public health service provision. However some prevention and health promotion services have been provided by primary care (French et al., 2001). Overall the approach has been quite fragmented as highlighted above, with a number of different providers and resulting in significant duplication and gaps. Some of the services, as noted by French et al (2001), are provided by GPs and Practice Nurses who currently offer a limited range of health promotion services, including childhood immunisation, cervical screening, and education around chronic disease management. Family planning and women's health services also provide a significant proportion of population health services. Added to this list are the public health services provided through the DHB. These include programmes for communicable disease screening and management, well child services, health promotion activities and health education (French et al., 2001).

Maori and Pacific Providers

Maori and Pacific service providers focus significantly on population based approaches to primary health care. This way of working is supported by the strategy that claims ongoing support for provider development for these groups (p.12). Maori providers, for example, provide health promotion and education services on marae and in ways that are understood by Maori. This reflects the traditional philosophies of holistic healing including the use of traditional healing remedies as well as traditional beliefs and values (Durie, 1994). It has included using a range of practitioners, including Maori health workers, to support the work of the health professionals and mobile nursing services (Crengle, 1999). This approach reflects the overview in the strategy on culturally competent health services (p.11).

Pacific primary health care providers have also developed services that are specifically designed for the needs of Pacific people. Tukuitonga (1999), suggests that population-based approaches provide the best strategy for achieving health improvements for the Pacific people in New Zealand. They have achieved this already by developing a number of different models, mainly in Auckland, but each have the same basic philosophy of 'by Pacific for Pacific'.

Improved Coordination

The strategy claims that population health services, as part of its new direction, will be better coordinated. This will mean that the majority of population services will be provided by PHOs and within the population-based funding. In recognition of wider health needs the strategy requires links to be established both across the health sector such as public health, mental health and disability support services (p.19, 20) as well as with groups including "local bodies, education, welfare, housing" (p.19). This is in recognition of the socio-economic determinants of health.

PHOs will be expected to provide a much wider range of services and initiatives, learning to work in a more collaborative and coordinated way, both within primary health care as well as with other providers. The strategy expects that a coordinated, comprehensive approach will contribute to changes that will achieve improved health for people. As noted in the above discussion related to first-level service this new direction for primary health care is significantly different from current service provision.

Population Focus

The need for a focus on population health services is timely if the existing health inequalities are to be addressed and if the broader vision of the strategy is to be realised. Despite the number of providers involved in population health activities, there has generally been less emphasis placed on its importance. This has in part been due to the demise of the Public Health Commission in 1995 as well as the ringfencing of public health funding, as noted above. This resulted in separating the funding, contracting and provision of public health from personal health services. The situation currently remains the same which increases the complexity of delivering upon the strategy's direction of "population health and the role of the community, health promotion and preventive care" (p.vii).

The success of this is going to be dependent on providers and practitioners learning to work together, and to work alongside their communities, sharing information and contributing to health initiatives to improve health outcomes.

Summary of Services to be Provided

The strategy expects that the services for the new primary health care system focus will be comprehensive and focused on improving, maintaining and restoring peoples health. This section has discussed the range of services that King requires PHOs to provide through a population-based funding mechanism. The services have been separated into two categories named 'first-level' services and 'population health' services.

First-level services have been described as similar to those services traditionally provided through primary care, or General Practice. The discussion has demonstrated the deficits of the primary care model. It notes its focus on treatment and affirms that those providers will need to change to a focus on a more population approach where they get to know and understand their communities and thus provide services according to their needs and priorities. It broadens primary care to reflect the concepts of primary health care by including requirements for services that include health promotion, health education and disease prevention activities. This is reflected through the second category of population health.

The discussion has highlighted the need for change. It notes the current fragmentation of service provision and reinforces the need for a coordinated multidisciplinary approach both within primary health care as well as with other health sector and non-health sector providers. Effective coordination combined with a wider range of services and providers is seen as the way to address the existing health inequalities. This will be significant for mainstream providers who are advised by King to meet the needs of their ethnic populations by taking note of the way Maori and Pacific provide services. This means different approaches in different settings.

Services provided through the new system will be different. Settings will change as services move out into the community. Consumers will be encouraged to choose the practitioner who can best meet their health needs. Their needs will be better managed through the diversity.

The new approach requires a more integrated approach involving service coordination and collaboration between providers. It is more than just modifications to the way primary care

services are provide. For consumers, it presents opportunities for increased choice and access to both the ranges of services and settings in which they are provided and to a wider range of providers. It is expected that primary health care services will contribute to improved health outcomes.

SECTION TWO - SKILLS REQUIRED

This section of the chapter discusses the range of skills that providers will need in order to provide the services described above. This will require PHOs ensuring that they have access to range of practitioners/providers with the appropriate skills (p.13). The strategy argues that this will involve a more coordinated approach to service delivery (p.18).

As discussed above, population-based funding will be the key to shift the direction to enable PHOs to take responsibility for both service delivery, and achieve the capacity to meet the technological, administrative and professional requirements outlined in the strategy (p.13). The first section of the discussion will provide an overview of the data related to the skills that will be required of providers to implement the strategy. The data has been collated under headings including population health and first-level service provision, communication, relationship building, information management and issues of accountability. The second section will discuss the meaning of those skill requirements and their implications for providers.

OVERVIEW OF KEY REQUIREMENTS RELATED TO SKILLS

Population Health Skills

The new system that is outlined in the strategy expands service provision to one where providers are " expected to respond to the needs and priorities of their communities" (p9) through the provision of comprehensive services (p.13). It supports the population approach, which is viewed by King as a means to achieve improvements in health outcomes. As discussed earlier, emphasis is placed on the importance of reducing health inequalities with providers being required to "identify disadvantaged groups within their populations" (p10) and to find ways to "provide for their different needs and priorities" (p10). This involves providers taking accountability for the health of their population; actively involving the community; identifying and measuring risks; implementing effective interventions; promoting health and preventing disease; working intersectorally (National Health Committee, 2000). They reflect the features

of a community development model that will be discussed further in chapter 8. This will mean that providers will need to develop a better understanding of their communities and apply skills such as epidemiology to gather demographic and health status information. This information will be critical to determining the funding for their enrolled population which takes "age, sex, deprivation level and ethnicity" into account (p.14). It is a skill more commonly used by public health specialists and is not typically a skill required by providers in primary care settings. This reinforces the need for links between public health services and primary health care as suggested by the strategy (p.20), where ways to share information about the enrolled population can be established.

Other skills that will be new for primary care health providers in relation to population health services are health promotion and education, which according to the strategy, will help people "to adopt healthy lifestyles" (p13). This will involve the application of a variety of techniques and approaches that are frequently seen in the delivery of programmes in schools, well child settings, 'safe sex' and family planning (French et al., 2001). They are skills commonly used by public health nurses who provide health promotion and education services in schools. They are less commonly applied by GPs who generally do not participate in health promotion activities, due to both a lack if skills and a preference for curative care (National Health Committee, 2000). This reinforces more effective utilisation of primary health care nursing skills whose practice and education is based in health promotion and disease prevention (Carryer et al., 199).

McMurray (1999) suggests that health professionals are not always the most appropriate people to be carrying out health education. The role of the community is integral and, as noted by Caraher (1994), any focus on developing practitioner skills should take second place to the development of relationships between health professionals and consumers. She describes the importance of targeting education appropriately ensuring that the audience is both ready and willing to receive the information and that learning occurs best through peer teaching. This implies greater involvement for the community. She does however suggest that in settings where health professionals are involved in providing one-on-one health education, it is advisable for them to draw on the knowledge and expertise of practitioners who have experience in providing population health education and promotion programmes.

This approach is recognised in the strategy (p.20). It is relevant to both planned and opportunistic education activities which help people to "change behaviour that threatens their

health" (p20) and is applicable to individuals and groups. These activities will include teaching people to look after themselves with the premise that "many health concerns and problems can and should be managed by individuals themselves" (p13). This will not only potentially result in improved knowledge for consumers about health but will "also reduce the need to visit [and pay for] health services" (p16). The strategy suggests that this responsibility will not only lie with health practitioners and providers, but will also extend to include providers in other sectors as well as consumers. This is recognition of the importance of community involvement as well as recognition of other determinants of health such as housing, education and socio-economic factors. The strategy notes the contribution these other factors make in relation to health inequalities in the different groups and states "such health gaps are shown in higher mortality rates ---- and in higher rates of avoidable hospitalisation" (p10).

First Level Skills

While a population health focus is one component of the strategy, first-level services as described above, are another key component. This involves providers including "ready access to first-level advice and treatment for people when they are unwell and concerned about their health" (p13). This requirement relates to those skills commonly found in primary care services and dominated by GPs.

First level skills require practitioners to be clinically competent and to have generalist knowledge and experience to provide the defined set of services as outlined in the strategy (p.13). The strategy refers to these practitioners as "first-contact practitioners" (p22) and generally is represented by GPs and nurses. While the types of skills required for these services have traditionally been the domain of GPs, the strategy promotes the role for primary health care nurses who "share a common set of generalist knowledge and skill as well as developing advanced skills" (p23). There is significant international evidence of nurse's effectiveness in the provision of first-level services and that they are able to provide them more cost effectively than GPs (Dunham-Taylor, 1995).

In addition, first-contact providers will need to be able to "support people with chronic health problems" (p13), as well as being able to assess, treat people for ill health.

Collecting, maintaining and exchanging information

As people enrol with a provider they will be given information about such things as accessing services at any time of the night or day, or choice of practitioner, that the results of any tests or consultations will be passed on to their nominated provider. This will be achieved through the establishment of "national minimum requirements or protocols" (p8) that will ensure consistent messages are given to people throughout the country. The strategy notes that information will be provided "to clearly explain enrolment [and] will be widely communicated to all New Zealanders" (p.9). While this suggests a national communication process may be undertaken, it implicitly suggests that individual providers, including PHOs, will also have a responsibility to impart or reinforce the information.

The strategy also envisages that optimal care will be achieved through the development of "joint 'plan of care' arrangements" (p21). This will mean where more than one provider is caring for an individual they will need to ensure that the individual is involved in contributing to plans for managing their care and to understand that this plan will be accessed by and shared with all the involved providers. It will again mean that providers will need to talk to each other in order to coordinate care for people with specific health needs such as mental health or disability or where people transition from primary to secondary services (pp. 19-21). While most providers are used to keeping notes about individual consultations, they may be less used to sharing the information.

The concept of care plans as outlined in the strategy is not new for nurses who use this as a way of planning, implementing and evaluating care. However the concept of joint care plans may require a new or different way of working for both nurses and doctors alike and issues of privacy and confidentiality of information will need to be taken into account. This has implications in particular for consumers who will need to give consent for any information sharing to occur between providers although the strategy suggests the approach will ensure "optimal care ...... and clarity about their care regime" (p.21).

This concept, along with activities involving service planning, delivery and monitoring is expected to be supported by "an effective infrastructure for information collecting and sharing" (p.25). The strategy provides examples of projects that have focused on information management and recommends that providers build on these initiatives (p.25). It does however assume that providers have the capacity and capability to manage information in the ways described.

Accountability

The strategy states that "quality and safety are critical aspects of any health services" (p.24) and requires PHOs to demonstrate the quality and safety of the services that they provide. It notes that some primary care providers are now more used to being accountable for their practice and they are "more prepared to take responsibility for the quality of their clinical care" (p. 24). This has in part been achieved with the move towards evidence-based practice and initiatives that GPs have participated in through their IPAs (Coster & Gribben, 1999). They describe some of the continuous quality improvement and quality assurance processes, as well as professional development activities, that have been developed over the past few years. Activities such as these provide a platform for the future where compliance and accountability to both funders and the community will be measured through reports (p.24).

SUMMARY AND DISCUSSION OF THE IMPLICATIONS OF SKILLS REQUIREMENTS FOR PROVIDERS

Overall the strategy adopts a generalist approach to the skills requirements of providers. In this approach it focuses less specifically on the providers and tends instead to blur boundaries. This situates the direction of the strategy away from the current primary health care scene where primary care and GPs dominate and nursing services are fragmented and ineffectively and inefficiently utilised. Instead it describes a more integrated model where PHOs provide services and ensure they have the right mix of practitioners to support service delivery and appropriately manage the wide range of services (p.20). The emphasis is changed from a focus on primary medical care and the skills associated with that of diagnosis, treatment and management to one of primary health that goes beyond the 'medical' approach to include services and skills that incorporate health promotion, education and disease prevention activities.

Nursing in particular views the new direction as an opportunity for more effective and appropriate utilisation of nursing skills. To date this has been impeded by a number of structural, contractual and legislative barriers (Ministerial Taskforce, 1998). The more generalist directions outlined in the strategy explicitly notes that the new direction has implications for the health care workforce (p.22). It promotes the need for "well-trained primary health care nurses" (p.23) although it acknowledges the concept needs further development. William's (2000) discusses the implications of policy change on health professionals noting that it frequently results in changes to roles and role boundaries. Her work will inform the wider discussion in Chapter 7, which focuses on the implications of the strategy for providers.

While the strategy clearly presents opportunities for nursing, it is important in the first instance to recognise the combined contribution that both medicine and nursing can equally make. Nursing offers its skills based on the concept of family health where both health and illness are taken into account within the context of the family (Anderson & Tomlinson, 1992). Nursing is well prepared through its education programmes to deliver care in a number of different settings and with an outcome focused goal (College of Nurses, 2001). This positions them well for the requirements outlined in the strategy.

By contrast, doctors link disease and pathology with family events and processes, taking into account an understanding of disease and its connection to an understanding of relationships (Richardson & Maynard, 1995). Their preference, as highlighted above, is directed more to curative work rather than health promotion. What both groups have in common is their concern with relationships and taking a holistic approach to the provision of care (Williams, 2000). Both, as noted above, have an equal but different contribution to make – " doctors apply ideas about disease and pathology to ideas about holism, relationships and caring, whereas nurses apply ideas about knowing the person and mutual sharing of experiences" (Williams, 2000 p.55). It is these differences that provide room for both occupational groups to work alongside each other, recognising their differences as well as similarities. For nursing in particular, it poses additional problems due to the fragmented nature of nursing services and specialist nursing roles (Carryer et al., 1999).

Williams (2000) in her work describes the opportunities that emerge for both groups in times of change and refers to it as role expansion. She suggests for GPs too, it is an opportunity to expand their skills base to incorporate some of the activities that have traditionally been carried out by practitioners in secondary settings, such as minor surgery.

For nursing it creates an opportunity to better utilise their skills base. The substantial body of international research reinforces nursing's positive effect on health care delivery and on health outcomes (Knaus et al.; Krakauer et al., 1996; Prescott, 1993).

The role of nurse practitioner becomes critical in relation to the directions outlined in the strategy. While the role is well developed in the USA and less well developed in the UK, it is a newly emerging role in NZ. The role is internationally recognised as an effective and efficient role where the skills of these nurses are well utilised in primary health care settings particularly

as first point of contact. The evidence suggests that the role sits well alongside that of the GP where in combination their combined skills provide a more comprehensive and flexible service (Venning et al., 2000). This supports the strategy's claim that people may need a small team of providers/practitioners to provide their care so that their wide range of needs can be met (p.7). The UK experience of primary health care teams including, GPs, nurses, other health professionals, managers and representatives of other providers provides an example for NZ to consider as it moves towards the new system

Alcolado (2000) cautions that while nurse practitioners have a valid role in primary health care, and in fact may be a better alternative particularly for minor illnesses, triage and telephone consultation, in the longer term they may undermine the role of the GP. This reinforces the issues related to role identities and blurring of roles that will be discussed in chapter six but should not distract either group from making the transition from current practice to encompass the direction outlined in the strategy.

CONCLUSION

The strategy presents a challenge to current providers of primary health care. It broadens the focus of service provision and delivery to encompass a population focus involving the concepts of health promotion, health education and disease prevention. Current provider organisations, such as IPAs, are to be replaced with new systems, known as PHOs. These will be the vehicles through which primary health care services will be funded and provided. This is in contrast to the current situation where primary health care is comprised of the dominant GP owned and operated primary 'medical' care and fragmented primary health care nursing services. The direction outlined in the strategy indicates that the range of services will be broadened and providers will need to need to develop new skills, or look to different practitioners who have the skills to provide the required services.

Services have been divided into two distinct categories – population health services and first-level services. First-level service provision, currently the domain of General Practice, is considered a part but not central to the new direction. The strategy modifies the current treatment mode of practice to one where consumer responsibility and self-care practices are as important as effective treatment and management. First-level service provision is expected to be responsive, rather than reactive, to community need. This will be addressed in part, by changing the range of services and the settings in which they are delivered.

The direction outlined for service provision appears to lessen the dominance of the GP role and instead encourages utilisation of a range of practitioners, linking services to skills, rather than linking services to providers, which is the current approach. Through this approach, roles become blurred and opportunities for greater nursing involvement emerge. The role for Nurse Practitioners becomes evident, with international evidence demonstrating their effectiveness in primary health care service delivery and improved health outcomes. The blurring of roles and the potential for shifting boundaries of practice signals the significance of change and the implications that will emerge for providers.

Knowledge of the community is seen as a basis for planning, signalling a shift from the more individualised approach currently taken by primary care to the population focus and increased consumer and community involvement. A better understanding of the community will help providers identify the needs of their communities and to plan and deliver services accordingly. In particular it will assist them to deliver services to those disadvantaged groups. Service delivery approaches such as those used by Maori and Pacific providers are recommended as effective ways for mainstream providers to adopt to reach those groups.

CHAPTER SEVEN: IMPLICATIONS FOR PROVIDERS

This chapter reflects the deductive nature of the 'framework' approach. As the data related to the themes in the previous chapters was described and explained, it became clear that another approach needed to be taken in order to fully explain the implications of the strategy for providers. This chapter therefore approaches the data from a different perspective and instead analyses it specifically in relation to the research question. A similar approach is taken in the following chapter, which discusses the implications of the strategy from a consumer's perspective.

As a consequence of some of the findings that emerged in chapter 6 in particular, this chapter will focus its discussion on the affect of the impact of the strategy in relation to professional roles and potential changes to practice. The discussion is informed by the work of Williams (2000). Her study claims that health professionals respond in quite typical ways when faced with policy change and/ or health reform.

The first section of this chapter will provide a sample of the data that relates to the potential changes that will implicate the roles for both medicine and nursing in light of the direction taken by the strategy. The second section interprets the data in relation to the implications of the strategy for providers. The discussion is expected to provide some insight and direction for providers in particular in relation to the changes required for the new primary health care system. This approach reflects the practical application of applied policy analysis, where findings are useful and frequently used either by policy makers or those affected by the policy (Ritchie & Spencer, 1994).

SAMPLE OF THE DATA RELATED TO THE IMPLICATIONS OF THE STRATEGY FOR PROVIDERS

Blurring of Roles

Throughout the document, King takes a more generalist approach when discussing who will be responsible for service provision. In most cases she refers to either 'providers' or 'practitioners', implying that the provider with the competencies most applicable to the needs of the consumer, or population, will provide the service. This approach is in contrast to current service provision that is bound by contractual arrangements, largely based on inputs and outputs rather than health

outcomes[17]. Instead, the strategy takes a different approach and acknowledges the need for "the right mix of services and practitioners" (p.13) to provide the defined set of services. This, as discussed in chapter 6, will involve practitioners in the provision of activities such as screening, education, treatment and management, and disease prevention (p.13), which in the past have been contracted through a range of different providers. As highlighted in chapters 2, 3 and 6, this has resulted in fragmentation, duplication and gaps in services, largely due to current contractual arrangements and structures.

The strategy starts to address these types of constraints, and notes that while first-level services will usually involve doctors and nurses, they may also involve a range of other providers including community workers, pharmacists and midwives (p.18). It emphasises the need to recognise the importance of each role and to work collaboratively (p.18). This is in contrast to the current situation where roles are more clearly defined either through contracts or by employment arrangements. This has been clearly identified in chapter 3. The strategy not only blurs roles and boundaries of practice but also presents opportunities for nursing as well as new and different ways of working. This is apparent in its note for "increasing nursing involvement" (p.13)

This type of change will be assisted in part by the proposed change to population-based funding. The strategy explains this, noting "that when funds are not tied to particular numbers of services or types of practitioners, there are no barriers to using the most appropriate health practitioner in each situation" (p.14).

Changing Role Boundaries (expanding practice)

The direction of the new primary health care system encourages providers to consider different technologies and strategies and the strategy states they should "make good use of new sources of health advice increasing nursing involvement, improved technology" (p.13). As noted above, the reference in particular to increased nursing involvement not only suggests the potential for roles to become more blurred, but also implies that roles and practices may change.

The strategy, acknowledges that "no single practitioner or type of practitioner can meet people's needs completely" (p.18) and that the new system envisages the "best total package of care is provided to the patient without unnecessary duplication" (p.18). This signals a change for

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[17] Refer to the discussion on funding in chapter 2

practitioners who are more used to providing care within the constraints of their contract and which, as highlighted in chapter 3, has resulted in fragmented service delivery resulting in duplications and gaps.

The strategy reinforces the need for a range and choice of practitioners, capable of meeting the needs of their communities, particularly those who are disadvantaged or have special health needs (pp 18–23). This approach particularly impacts GPs, who currently dominate primary care, and as employers generally assume the lead role in the assignation and oversight of work. This inhibits autonomous practice for the nurses they employ and, as noted above and in the literature, sublimates the potential of nursing. This is in contrast to the more autonomous role experienced by Plunket Nurse and Public Health Nurses as well as the specialist nurses working in the community[18].

The future system outlined in the strategy supports role and practice development. This is reinforced, for example, with its requirements for providers to develop and implement "specific initiatives that will help improve coordination between primary and secondary care" (p.19), thus supporting a more integrated approach to achieve concatenation both of providers and of care. The approach will involve other groups within the health sector including, disability support, mental health, public health and specific population groups (pp 20-21).

According to the strategy, service provision is more aligned to consumer need, requiring providers to be responsive both in where and in the way they provide. This requires providers to deliver services in a range of setting (p.23) and specifically requires services to reach those groups who do not normally access primary health care services (p.10). This might include going to marae, schools or work places (p.16). This, as noted in chapter 6, will require providers to review the way they practice. The types of changes outlined in the strategy and noted above are not unfamiliar way to Maori or Pacific providers. Some examples of these are outlined in chapter 4. In addition a recent initiative through Auckland University, involving education for Maori nurses working in the community, has prepared nurses specifically to provide the services, particularly for disadvantaged groups, as outlined in the strategy. Undoubtedly traditional roles and practices in the new primary health care system are likely to be quite different.

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[18] Refer to chapter 3

Collaboration and Multidisciplinary Teams

The strategy, with its concern for continuity, and recognition that one single practitioner may not be able to meet all the needs of a consumer all the time, recommends that a small team of practitioners may share the care (p.7). This presents a new way of working for primary health care providers, who are currently disconnected from each other due to employment and contractual arrangements. While the strategy promotes continuity, it balances this by allowing consumers to choose their provider and to change their provider "without difficulty or explanation" (p.9). This challenges providers to address their disconnected relationships and to establish effective ways to share or exchange information. This is referred to as collaboration (p.18). Collaboration is extended to include health professionals, as well as "professional, managerial and support staff" (p.18). The strategy notes that by increasing the number of practitioners combined with a change to roles, there is a risk that fragmentation of care will be exacerbated (p.18). This should not be seen as a barrier, but rather an opportunity to change "old isolated ways of working" (p.18) and replace them with "new collaborative models" (p.18).

Currently in NZ there is no working model for providers to emulate, although there are aspects of the more community focused Maori, Pacific and Health Care Aoteoroa (HCA) models of service delivery that could be adopted. NZ needs to take note of the lessons learned from the pilots of primary health care models in the UK, which suggest that consideration needs to be given to genuine collaboration (Marks & Huner, 1998). This will be a challenge for providers who are likely to be concerned for the impact any change will have for them.

Initiatives and Relationships

The strategy emphasises the need for "specific initiatives that will help improve co-ordination between primary and secondary care' (p.19) and between primary and public health, mental health and disability support (pp 19,20). In addition it recognises the socio-economic determinants of health and stresses that initiatives will involve sectors outside of health. It envisages that through joint initiatives, the health and independence of groups and individuals will be maximised (p.21).

The concept of developing new initiatives and building on existing work is seen as having the "potential to improve patient care" (p.26). The approach suggests a breaking down of the more competitive health market established through the 1990s, as highlighted in chapter 2, to one which will require the building of relationships and trust to achieve King's vision. It will require providers learning to work together.

SUMMARY OF DATA

This section has extracted some examples of data that predicts change and implications for providers, as the new system for primary health care is implemented. Much of the data has been mapped to the themes in the previous chapters. In order not to repeat some of the discussion in these earlier chapters, the data extraction has been minimised, but is sufficient to provide the audit trail demonstrating reliability.

The data highlights the broader approach taken by the strategy, which involves a wider range of providers, in order to achieve the directions which are key to achieving King's vision. Roles appear to be more blurred, as are practice boundaries. The need for a more collaborative, multidisciplinary team approach is reinforced. This implies that current ways of working are likely to change. This, based on the work of William's (2000), will threaten some providers, in particular GPs, as they see their current dominant position being eroded. Some nurses will view the implications as an opportunity to expand and change their roles, while others, such as Practice Nurses, may prefer to maintain the status quo. These issues will be examined in more detail in the following section.

INTERPRETATION OF DATA RELATED TO IMPLICATIONS FOR PROVIDERS

The discussion in this section interprets the data in the strategy specifically in relation to the implications of the strategy for providers in the face of change.

The strategy, as noted earlier, broadens the current provision of primary health care, increasing the range of practitioners and blurring roles so that more effective delivery of care can be achieved. The strategy notes that while increased nursing involvement, in particular is likely (p.13), it "needs further development with clarification of the appropriate capabilities, responsibilities, areas of practice, educational and career frameworks and suitable employment arrangements" (p.23). This approach is supported by Williams (2000) who claims that in order for nurses to be more effective in primary health care, they need to develop their confidence. This, she claims, is best achieved through education.

While the strategy clearly promotes the nursing role, there is a need for both medicine and nursing to accept change, and to grow and develop in a way that avoids conflict and tension.

This means that systems need to be created where both professionals work collaboratively and co-operatively to achieve the vision. This involves both groups having equal status (Williams, 2000). This is not the case currently, particularly for Practice Nurses, whose roles are sublimated due to their employment situation (Carryer et al., 1999). Other primary health care nurses, such as Plunket and PHNs have more autonomous roles[19]

Change

Any change, such as that outlined in the strategy, that impacts services and roles frequently results in work being transferred from one professional group to another, or with groups working more closely together. On one hand, this can create tension and conflict between the groups, while on the other hand it presents opportunities to expand roles and practices. The tensions or opportunities are not restricted to any one professional group but can exist between doctors and nurses, as well between nursing groups. This is largely due to the way each values their own role and contribution (Williams, 2000). For nursing it is compounded by specialisation[20], contractual constraints and subdividing and splitting of roles (Ministerial Taskforce, 1998).

Changing roles in response to policy changes such as the strategy is not uncommon with either medicine or nursing. It is usually undertaken in line with their own limitations in relation to competence and knowledge (Jefferys & Sach, 1983). They note that sometimes the limitations are a consequence of structural arrangements. Practice Nursing provides a good example of this, where their role is sublimated due to the employer/employee relationship, compounded by the subsidy received by GPs, which has resulted in a largely part-time workforce[21]. As a consequence their professional development opportunities have been compromised, due to lack of employer support and lack of a career pathway (Michel, 1997). All of these issues have resulted in medical control over nurses, resulting in the 'handmaiden ' description applied above. According to Williams (2000), policy change similar to the strategy provides opportunities for groups such as Practice Nurses to change their situation, although it is dependent on significant change to their structure.

The strategy provides a framework that encourages role expansion, multidisciplinary teamwork and collaboration. The risk is that this will not occur and instead the existing medical dominance will continue and nurses roles change, but only to assume delegated medical tasks.

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[19] Refer to chapter 3
[20] Refer to chapter 3

For GPs, the potential for role expansion will be viewed from two aspects. With the first, they view the potential for expanding and blurring of roles as more interesting than their current role, while for the other, they may see it as increasing their already heavy workload, or concern for who would pick up the work they may drop (Jefferys & Sach, 1983). The changes to roles and practice experienced by GPs throughout the 1990s have provided a platform for them to readily expand their roles. The majority, as noted in chapter 2, have moved from their solo practices into small group practices, joined IPAs and have become involved in peer review and quality assurance programmes. Through these changes they now have improved access to diagnostic facilities and medical specialists, both of which support them to advance their practice.

For nursing, opportunities for role expansion generally emerge as a consequence of education, changing technology or changes to health policy (Williams, 2000). Their concerns related to role expansion vary, ranging from the view that is economically based and situates them as cheap alternatives to doctors, or assuming delegated medical tasks, through to assuming advanced nursing roles where knowledge and practice is embedded in a nursing framework. The concern in particular around delegated medical tasks, is probably most relevant to the Practice Nurse role, due to their subordinated status (Williams, 2000). Others claim that the assuming of delegated medical tasks occurs as a consequence of a lack of understanding or clarity about roles (Iles & Aulick, 1990). The issue, suggest Jefferys and Sach (1983), is avoided where nurses have undertaken relevant education, which in turns develops their confidence.

Evolving Role for Nurses

The strategy signals a range of opportunities for nursing to become more effectively involved in primary health care, and in a way that does not threaten GPs. If NZ nurses follow the example of their UK colleagues, they will identify the gaps that exist in service delivery and establish services accordingly. In the UK primary health care pilots, this resulted in nurses working, either with hard to reach groups, or in isolated rural communities, both of which had little impact on GP services (Lewis 2001). This, Lewis (2001) suggests, occurs because they are working in areas where GPs do not or can not provide services, and so did not concern doctors, but in fact enhanced relationships between the two groups.

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[21] Refer to section on Practice Nursing in chapter 3

For NZ, the gap in service provision lies in the area of health promotion. Chapter 6, notes that health promotion and disease prevention activities are poorly provided particularly by GPs and, which according to Carryer et al (1999), could be assigned to nurses who are well prepared for those activities. Bowling (1996) reinforces this suggestion, noting that for some years Practice Nurse roles have been evolving to a more preventive focus. For NZ, it remains fragmented due to the number of different contracts.

For NZ the most significant role that is emerging and one that is likely to have some impact on the direction outlined in the strategy, is that of the Nurse Practitioner. This is a role held by nurses who have completed a clinical masters degree and have significant experience at an advanced level in a specific scope of practice (Nursing Council, 2002). While there are currently no Nurse Practitioners within primary health care, it is a role that will strengthen nursing's position. Their value-added contribution is well outlined in the previous chapter. As noted above, their advanced knowledge combined with the confidence this knowledge and experience brings, situates them equally alongside their medical colleagues. It is this type of relationship that fosters collaboration.

Collaboration

Positive collaboration is built on trust, mutual respect and a willingness for groups to work together and help each other (Gott, 2001). It is something that is not easily built where professional groups are antagonistic towards each other or if one group dominates, such as GPs. McEniery (1992), suggests that the solution is to address structural barriers. This is a significant challenge for primary health care due to the number of structures including IPAs, General Practice, DHBs and Plunket to name a few. While these structures remain, and service delivery remains fragmented, it will be very difficult to progress collaboration and the teamwork required to achieve the co-ordination promoted by the strategy. This is reinforced by Elwyn and Smail (1999), who caution that teams are not suitable models where there are large dispersed organisations. Long (1996) reinforces this view, noting that teams are more successful where people share the same premises and the same management structure, but it is isolating for those members who don't share the same premises. Consideration needs to be given to this as, and if, PHOs and models for service delivery are developed. It may mean that as this occurs primary health care models may be constructed of small teams, however in the absence of a model within NZ, there remains a lack of clarity as to how this may develop. It may be that General Practice settings with their structures more aligned to that described by Elwyn and Smail (1999), might be better placed to start to establish teams. However, based on the UK experience (Atkin & Lunt, 1997) where they attempted to merge district nurses and health visitors into

general practice, nurses in NZ (except for Practice Nurses) may strongly resist being controlled by GPs. Carryer et al (1999) recommend that one way to establish teams for nursing is to develop a comprehensive nursing role. While they support multidisciplinary teams, they note that issues related to structure as well as roles need to be addressed.

Despite these concerns, the strategy promotes teams as a means to achieve co-ordination and continuity of care. This is supported by McEniery (1992), who reinforces teams as effective and efficient ways to provide population focused primary health care services. Williams (2000) recommends that shared learning and interprofessional education and training resolve some of the barriers impacting effective teamwork. Her view is supported by Wicks (1998), who suggests that when groups learn together, over time they will learn to work together. This reinforces that the changes required to meet the strategy's direction will not be achieved quickly. Poulton (1993) notes that as groups learn to work together, they develop a better understanding and appreciation of each other. They learn to recognise the contributions and value that each individual can add. This view is also supported by Longley (1999) who supports integrated team work but cautions that the work of nurses should not evolve to tone that resembles delegated medical tasks.

SUMMARY OF INTERPRETATION O DATA RELATED TO IMPLICATIONS FOR PROVIDERS

The strategy presents an element of uncertainty for both doctors and nurses, where past traditional roles are challenged. This creates both opportunities and threats for both groups.

If the vision for the future primary health care system is to be realised, there must be an emphasis on co-operation, collaboration and recognition of each other. The more subsumed nursing workforce must develop confidence in its ability to contribute to primary health care and GPs will need to release their control. For nursing, it involves them proactively seeking professional development opportunities and taking some responsibility for their current situation. It also requires government and DHBs to work on the contractual and structural barriers that constrain effective contribution.

Changes have occurred over the past few years within nursing, with new roles emerging, and in particular, the specialist roles such as wound care nurse, continence nurse, palliative care nurse, Plunket, Practice Nurse and PHN. To a certain extent this has been to the detriment of seamless health service delivery. Nursing leaders are now suggesting that it is time to rationalise some of

those roles and develop a more generalist primary health care nursing role supported by the Nurse Practitioner (Carryer et al., 1999). GPs, over the past years have also changed and expanded their roles, taking on some of the work, such as minor surgery, that was previously the domain of secondary care.

The strategy calls for co-operation in order to achieve improved health and address the health inequalities. This requires equal contribution of practitioners who function in a culture of teamwork and collaboration. This discussion has demonstrated that current primary health care providers have some way to go to achieve this. The risk is that GPs will resist any endeavours to address their dominant position and nurses, particularly Practice Nurses will continue to be subordinated.

Nursing is a large group and as Williams (2000) notes "it must embrace the will to work collaboratively" (p.101). This is dependent on the will and strength of nursing to develop a strong professional identity and enable the broader collaborative vision for primary health care.

CONCLUSION

The above discussion highlights the implications of the strategy for providers, whose boundaries of practice will change as the new primary health care system is implemented. This change commonly results in professionals' roles either expanding or evolving. The risk, according to Williams (2000), is that this can result in the health professionals experiencing a sense of loss and erosion, not only to their professional role, but also for the relationship they might have with the people they provide services to. Jeffries & Sach (1983) note that while GPs in particular agree that no one individual can possess the skills, abilities or techniques to provide all services across the board, they have in the past seen themselves as the key provider or case manager. They, in particular, are most likely to be affected by the change.

The discussion demonstrates that both doctors and nurses have roles in common, but their contribution, while equal, is different. This suggests that concerns for loss or erosion to roles are unnecessary. The differences between the two should allow room for both to work alongside each (Williams, 2000). This will achieve the collaboration promoted in the strategy, rather than result in the conflict or tension which frequently occurs in times of change (Williams, 2000). This will be avoided if some of the factors identified in the discussion are considered including addressing some of the structural barriers, and encouraging teamwork. This will be a challenge in the current environment where GPs dominate primary care, and nurses are constrained by a range of employment and contractual barriers, as well as a lack of confidence in their professional identity. This is particularly relevant for Practice Nurses, but also a concern for other primary health care nurses who will be concerned that their current autonomous roles will be eroded if they work alongside GPs (Atkin & Lunt, 1997).

The strategy creates uncertainty for providers, who will need to put aside their competing interests and concerns. This is most significant for GPs, who historically have maintained control over both services and practice within primary care. This has resulted in a subsumed role for the Practice Nurses whom they employ. One way to overcome this is for primary health care nurses, as a group, to develop and promote their professional expertise (Williams, 2000). This involves professional development through ongoing education. The role of the Nurse Practitioners becomes important, not only because of their expertise in relation to practice, but also because their advanced knowledge enables them to work confidently and equally alongside doctors (Nursing Council, 2002). GPs need to accept their traditional professional autonomy is no longer viable (Williams, 2000).

The discussion highlights the gap between current practice and role boundaries and the requirements for the new primary health care system. It highlights the urgency for nurses to develop a strong sense of professional identity in order to work alongside their medical colleagues in ways that reflects true collaboration. This will not occur while their roles are valued as less than that of the GP. While this situation remains, role expansion merely becomes role substitution where nurses assume delegated medical tasks (Carryer et al., 1999).

The role for a generalist primary health care nurse emerges as an option to address the current fragmentation, and to strengthen nursing's position within primary health care. However there is a risk with this approach it could further alienate nurses from GPs, and increase the concern of GPs related to role erosion. It could detract from the multidisciplinary collaborative model promoted in the strategy, and inhibit the benefit of teamwork that is seen as an effective and efficient way to provide population health services (Williams, 2000).

The strategy presents opportunities for both nurses and doctors to review their roles and contributions in light of the directions outlined in the strategy. Their concerns for themselves need to be put aside and replaced by involving all providers, as well as the community, in planning and providing services that will improve health outcomes for all New Zealanders.

CHAPTER EIGHT: IMPLICATIONS FOR CONSUMERS

This chapter, similar to the previous chapter, focuses specifically on the implications of the strategy for consumers. Similar to chapter 7, it was decided part way through the analytical process that the implications for consumers were far wider than what was being discussed in relation to the 3 key themes. The 2001 Primary Health Care Strategy, with its focus on a population approach to improve health and address health inequalities, has significant implications for consumers both in terms of requirements as well as opportunities. This is evidenced by the range of references in the strategy, which will be summarised in the first part of this chapter.

King (2001) clearly sees consumers involved in primary health care and states "a strong primary health care system means community involvement so local people can have their voice heard in the planning and delivery of services" (p.iii). In particular King (2001) is concerned for the health of Maori and Pacific people whose "health lags behind that of others in the population" (p.10).

The strategy expects that there will be involvement of people in the community at governance and decision-making and planning levels (p.7) right through to involving people in managing their own health care needs (p.13). This is expected to have a positive impact on health outcomes although it could be viewed as way to contain costs.

The vision outlined by King (2001) has particular focus on consumers and the community will provide the focus for this discussion. It expects that people will be part of local health 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 a population, and actively work to reduce health inequalities between different groups (p. viii).

As noted above, the first part of this chapter will summarise the data related to the implications for consumers, dividing it into requirements and opportunities.

The second part of the chapter will discuss these implications and will be informed by applying the concepts of a community development model[22]. This model was chosen because of the population focus of the strategy and the specific references to community involvement (p.iii) and a community development approach (p.10). A community development model focuses on community involvement in population health activities and has specific application for disadvantaged groups (McMurray, 1999).

SUMMARY OF THE STRATEGY'S REQUIREMENTS AND OPPORTUNITIES FOR CONSUMERS REQUIREMENTS:

Governance

The strategy is clear in its expectation that communities are to be involved in determining the needs, priorities and services that will be required to achieve improved health status of the population (p.7). This, according to the strategy, will require PHOs, the structures that will be responsible for improving and maintaining the health of the population, to " involve communities in the governing approaches" (p.3) as well as involving them in decision-making and planning. Usually representation in this situation involves one or two people from the community at the most. This will require either PHOs to determine who in their community should be represented, or for the community to determine their own representation. The strategy does not outline a process. Whether the community will want to be involved is another question. Frequently this situation results in the same few community members becoming involved in all community groups.

Enrolment

Consumers will be required to enrol with a PHO to receive subsidised services. The process will be voluntary and ii is expected will occur over a period of time (p.7). As part of the enrolment process, consumers will be provided with information about the services, providers and options that are available to them. In response they will be expected to nominate a provider who they can develop a long-term relationship with as well access them for their usual source of first-level care. Those people who chose not to enrol for health care services will not receive the same benefits as others and in particular are likely to miss out on the preventive services (p.9).

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[22] Refer to methodology chapter for outline of a community development model

According to the strategy "national protocols will spell out information to people" (p.9) to protect their confidentiality and to outline requirements that must be met by PHOs.

Improving, maintaining and restoring people's heath

As part of the new direction for primary health care consumers will be expected to adopt healthy life styles (p.13). This implies that consumers will be more actively involved in taking responsibility for their own health. The strategy notes that this will occur through activities such as screening programmes. This may mean that consumers will be offered or confronted with invitations to participate in such programmes provided at an individual level through their practitioner or in wider population programmes offered through the community.

OPPORTUNITIES FOR CONSUMERS

Hard to reach populations and Maori and Pacific people

Maori and Pacific people and other disadvantaged groups should expect to see services developed specifically to meet their needs and in particular to reach those groups who are currently missing out on services (p.10). Services will continue to be provided through ethnic specific providers (p.11) but in addition Maori and Pacific people can expect their mainstream providers to develop services that are specific to their particular needs (p.11). This is expected to encourage Maori and Pacific people to be more proactive and seek out services with the goal to improve their health.

Improving and maintaining health

Consumers can expect services to be more accessible to them. The strategy requires providers to provide services in settings that are closer to the population they serve. This means that for consumers services will be provided in different settings, such as marae, that may be more appropriate and accessible for them (p.16). It may also mean that more mobile services are provided thus addressing some of the barriers, such as transport, that currently inhibits them from going to their health practitioner.

Community development approach

This approach has been recommended as a way to find solutions for disadvantaged groups (p.10). These groups should expect to see a range of different approaches to best meet their

needs, involving greater involvement of the community. This is likely to take a 'bottom up' approach rather than the more traditional 'top down' professional approach where communities are frequently imposed upon (McMurray, 1999). It presents an opportunity for communities to share the responsibilities for health with the health professionals. This approach reflects the principles of community development – an approach that is considered to have benefits for disadvantaged groups (King, 2001, p.10). It is a model whose principles also involve a process where communities are empowered to improve their health and wellbeing and thus take responsibility for their own health (McMurray, 1999). This will be discussed in more detail below, applying the concepts of a community development model.

Range of services

Consumers with specific health conditions should expect to have their conditions detected as early as possible and then to be supported by careful management p.13). They and others should expect "ready access to first-level advice and treatment when they are unwell or concerned about their health" (p.13) combined with appropriate pharmaceuticals, diagnostic testing and other referred services that may be required. This is not significantly differently to the services most people currently receive through their GP and Practice Nurse. The most significant difference is the focus on self-care, which is to be supported by different sources of health advice that providers will be required to use (p.13). Encouraging people to look after themselves should result in making fewer visits (and therefore less payment) to their health practitioner (p.16). This may be viewed as positive from a cost perspective but may be less welcome for consumers who do not choose or are not able to take responsibility for their own health.

Cost of services

The strategy gives special attention to the barriers to accessing health care that are associated with the costs of services. The way services will be funded in the future through population-based funding[23] is seen as one mechanism to address some of the barriers that currently exist. Population-based funding is seen as a vehicle to reduce co-payments and the strategy explicitly notes that in the first instance costs will be reduced for those people with the greatest health needs. It adds that as more funds become available support will be able to be given to a wider group of people (p.16). This suggests that it is most likely that Maori and Pacific people will be given priority access to lower cost services in the first instance.

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[23] Refer to funding chapter for detailed description of population based funding

The strategy, as outlined above, also encourages practices that support people to take more responsibility for their own health and as a result have less need to access health services.

Improved coordination

The strategy claims that continuity of care has a number of benefits for consumers "particularly where there is a relationship with a particular practitioner" (p.8). As identified above, this requires consumers to nominate a practitioner for their usual source of care (p.7). It also acknowledges that people have diverse health needs and that it is not always possible for one practitioner to meet all their health needs. It suggests that some people may require a team of people as well as a number of different services in a number of different settings (p.18). The strategy puts more emphasis on providers needing to manage this through collaboration and communication (p.18) but consumers will need to be made aware that their health information is being shared between practitioners and from time to time with providers outside of the PHO that they belong to. This is due to the need for wider sector and community involvement in order to address the socio-economic determinants that impact health (p.21).

Range of Practitioners

The strategy presents new opportunities for consumers through its requirement for PHOs to ensure they have a range of practitioners to provide the services to meet the needs of their defined population. For most consumers they will be more familiar with the concepts of general practice where they visit their GP or Practice Nurse although the strategy notes that an increasing number of people have been accessing after hours or 'walk-in' arrangements (p.8). However in most instances the GP has been the first point of contact for most people largely as a result of the way primary care services are funded[24].

The new direction outlined in the strategy places less emphasis on which practitioner should provide the services and instead refers to a range of different practitioners and freedom for consumers to choose (p.8). In particular it notes that with the emphasis on a population focus and a wider range of services there is an increased "need for well-trained primary health care nurses" (p.23) and suggests they will have a crucial role as the strategy is implemented. This suggests that consumers could expect that nurses would have a larger role to play in meeting

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[24] Refer to lit review

their health needs than they have done in the past. This will be discussed in more detail particularly in relation to the provision of services and strategies to meet the needs for those hard- to- reach and disadvantaged groups identified in the strategy (p. 10).

Access

As the strategy is implemented consumers should expect to see more services being available closer to where they live and work. This may include new health clinics being established, mobile services, services on marae or in churches. The strategy describes this shift in service provision and delivery as occurring through a "wide range of formats and tools" as well as a range of settings (p.16). For consumers it is a significant shift from the current situation where they generally access mainstream primary care services by going to their GP's practice. This has been considered a barrier for some groups in the past.

IMPLICATIONS FOR CONSUMERS

This second part of this chapter discusses the implications of the strategy for consumers. As noted above the discussion will be informed by applying the concepts of a community development model.

In order for consumers to be involved in the new direction for primary health care and "gain the benefits associated with this population approach" (p.7), they must join a PHO. As noted above in the summary, this requires them to enrol "with a provider of first-contact services" (p.7) in order to be entitled to receive all of the benefits. For those who do not enrol, they "will still be entitled to seek care – but they may miss out on some preventive services" (p.9). For many people, in the first instance, this will not be an issue as by default, if they are currently going to a GP, they will be on a list. The strategy notes that initially this listing will be accepted as a starting point to enrolment "but, over the first couple of years, individuals will be asked to make an active choice to join the Primary Health Organsiation" (p.7). This time frame should enable people to have a better understanding of the enrolment process and its implications. The implication that has the most impact for consumers is that the enrolment process will enable information to be collected about their health and any health events that they experience. The risk is that the people most likely to not enrol with a PHO are those who most need the health promotion and prevention services.

It is these services that the strategy claims are most likely to achieve improved health outcomes, particularly for those groups whose "health lags behind that of others" (p.10). The strategy intends that these groups, who are frequently 'hard-to-reach' will be offered a range a different strategies and it recommends a community development approach will help to find solutions (p.10). While the strategy is clearly concerned that health inequalities are identified and removed (p.10) its overarching direction involves a population focus where both providers and consumers participate actively in primary health care (p.viii). This requirement and /or opportunity for active involvement has implications for consumers. For this reason, the researcher has chosen to inform the discussion based on the concepts of a community development model.

A community development model is one that requires both communities and health professionals to work together. The health professional assumes a role more aligned with advocacy and both the consumer and health professional share the responsibility for health (Downie et al., 1996, McMurray, 1999). The approach is different from the traditional top down professional approach and is only effective if communities are included rather imposed upon. This approach and therefore the strategy has implications for consumers who are more familiar with a primary care model (better understood as primary medical care), with its focus on reaction to a health episode rather than a population focus which involves health promotion and prevention activities (College of Nurses, 2001).

Health Promotion

Health promotion is a key component of a community development model and is defined as a combination of health education and prevention (McMurray 1999). Both of these activities are emphasised throughout the strategy as a way of maintaining health and independence (p.13). The approach also supports the framework outlined by the World Health Organisation (1996) which notes that health promotion activities must include creating supportive environments; developing personal skills; and strengthening community action.

The strategy clearly considered this approach in its requirements around flexible and innovative service provision in particular for hard-to-reach groups. A community development model takes a similar approach and recommends that health promotional activities such as education and prevention do not necessarily have to take place in health care settings. McMurray (1999) suggests that they can occur in a variety of non-health settings such as schools, work places as

well as in the home and they do not necessarily need health professional involvement. She also suggests that it does require "planned, consistent, integrated learning opportunities" (McMurray, 1999, p.276) aimed at empowering consumers with the skills and knowledge to bring about change. She notes that mass media campaigns have in fact proven to be useful in contributing to positive health outcomes, particularly where they have obtained community participation. Examples of anecdotally successful media campaigns in NZ include the breast and cervical screening programmes and to a lesser extent the Hepatitis B screening programme which commenced in the year 2000, targeting the at risk group of Maori, Pacific and Asian people.

Pender (1987) has a similar view to that of McMurray (1999) and suggests that any focus on health promotion that includes education, involves people taking responsibility for their own and others' health in combination with professional care. This concern for self care is emphasised in the strategy which suggests that consumers should be able to manage many of their health concerns themselves, providing they have adequate information and access to help when appropriate (p.13). McMurray (1999) reinforces that consumers must feel a sense of ownership in relation to the health promotion activities described above. Positive outcomes from these activities will only be achieved if consumers are supported rather than coerced to change their lifestyles (McMurray, 1999).

The focus on self care and self responsibility that will be an integral part of health education involves consumers accepting responsibility for their health and making decisions without the direction of health professionals and other authorities. This is a significant shift for many people, particularly for disadvantaged groups. Oakley and Kahssay (1999) describe people in this situation as being active in their communities and participating in community initiatives. Many consumers will require considerable support to achieve this status.

Maori providers in particular have developed a range of initiatives including community worker roles, health clinics on marae and mobile nursing services in endeavours to start to empower people to take more responsibility for their own health (Crengle, 1999). There is balance of shifting the approach from a 'top down' to a 'bottom up' with the risk that consumers are reluctant to assume responsibility and providers reluctant to hand it over. McMurray (1999) reinforces this notion and notes that the impact of shifting control for health to the consumer and away from the health provider cannot be underestimated and requires a significant change process. There is also an associated risk that the shift could be perceived by consumers as a cost cutting or service reduction exercise. This does not appear to be the intent of the strategy. In

contrast the content of the strategy implies that there will a broadening of primary health care services as well as a change in the way they will be delivered.

Participation

Involving consumers in planning and decision-making as required in the strategy (p.7) will involve significant effort on the part of both consumers and providers. Based on the concepts of a community development model it can be achieved in a number of different ways, ranging from community representation at governance level to much wider involvement where the community is actively involved in community based health initiatives (Oakley & Kahssay, 1999). The involvement of the community in decision-making and health policy development is not new. It has been in place since the 1996 publication of the *Code of Health and Disability Services Consumers' Rights*, observable through consumer representation and participation on advisory committees, focus groups and public consultation processes. However the majority of people lack the knowledge or ability to access the different vehicles in order to express their views. The risk is that the community will only be represented in a nominal way at governance level as it takes time and effort to engage them fully. It is a process that is not straightforward and does not commonly follow a linear or prescriptive path (Clarke, 2002). This is particularly relevant for Maori. It has the potential to fail if effective processes to involve the community are not established. This involves a significant shift for both consumers, who are generally not used to being actively involved, and for providers who are more familiar with a 'top down' approach.

Oakley and Kahssay (1999) outline key principles to promote effective participation. These include ensuring the needs of the community are taken into consideration; that local knowledge is seen as useful and that capacity and capability is further developed; that local resources are utilised in order to sustain development; that the community is encouraged to make decisions and that they are actively involved in any initiatives. It means that frequently projects or initiatives take much longer, but in general will have more positive outcomes.

The reality is that participation is based on relationship development between consumers, or the community, and providers. It relies on consumers 'allowing' providers into their community in order that they can get to know each other and develop trust (Oakley & Kahssay, 1999). Consumers therefore should see much more flexibility emerging from health providers and more contribution being sought from them as consumers in relation to decision-making and planning. Consumers will see providers considering different approaches and different ways of

delivering health services to ensure their active participation. Maori and Pacific people should see more emphasis placed on culturally sensitive approaches. Crampton (1999) sees that this will then help to address some of the language and cultural barriers and empower disadvantaged groups, in particular, to participate in a meaningful way.

The development of the union health centres in 1993, which have subsequently evolved to a national network of non profit health care providers called Health Care Aotearoa (HCA), provides a good example of an organisation where the community is actively involved and participating. As part of its structure, HCA has significant community participation at the level of governance as well as representation from its enrolled population on committees where they have responsibility for ensuring that the health services meet the needs of the community. Some of the critical success factors of this network include their role in providing services to vulnerable populations; their location in low income areas; different funding arrangements and in particular moving away from a fee-for-service funding (Crampton, 1999).

Clarke (2002) in her address to the *Primary Focus Conference* in Wellington highlighted the difference in the approach HCA takes in comparison to mainstream organisations. She attributes HCA's success to their adoption of the principles of 'doing with and not for' the community; taking the composition of the community into account and understanding its culture and values as well as its geographic factors; listening to the voices of the marginalised and finally recognising the leaders and the leadership structures that exist in the community. She concluded her address by reinforcing that community participation is more than just having one or two community people participating in decision-making and planning alongside health professionals and managers and suggested that consumers need to be supported in a way that enables them to participate and contribute with confidence. The approach taken by HCA reflects the model adopted by third sector organisations[25].

However for some consumers the goal for self-care and the community development approach may be at odds with their beliefs. It needs to be acknowledged that some people will prefer to leave health matters to the professionals while others will believe that health status is predetermined and unable to be changed (McMurray, 1999).

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[25] Refer to Chapter tow for outline of a Third Sector model

Addressing health inequalities

The strategy expresses concern for the health of Maori and Pacific people noting that it "lags behind that of others in the population" (p.10). This, it claims, is to be addressed through ongoing support for both Maori and Pacific provider development as well as by improved mainstream health service delivery. The needs of these and other disadvantaged groups are to be addressed through specific health strategies which will include addressing the barriers, including cost, which inhibit access to health care services (p.15).

As discussed above, one of the ways to address health inequalities is to actively involve communities in decision-making, planning and service delivery. (p.10). As a first step consumers will need to become involved at governance level. The different approaches to achieve this have been discussed above and, as highlighted by Clarke (2002), this involves recognising the diversity that exist within groups. For Maori this occurs at whanau – hapu – iwi levels while for Pacific people it will require acknowledgement and representation of the different Pacific groups including Tongan, Nuiean, Samoan.

For Maori it will be important to ensure that their philosophical approaches to health and well-being are reflected and, as noted in the strategy, that services 'for Maori by Maori' continue and that mainstream providers "address their needs in ways that are culturally competent and effective" (p.11). Crengle (1999) suggests that with appropriate information and support, Maori are able to participate in decision-making and to determine needs and priorities and she agrees that a community development approach is consistent with positive development for Maori.

Pacific-owned models of care, suggests Tukuitonga (1999), not only provide health promotion activities but also reflect the community development model of active community participation. The models outlined by both Crengle (1999) and Tukuitonga (1999) are consistent with the direction outlined in the strategy in relation to addressing the health disparities that exist among Maori and Pacific people. They are dependant on ensuring effective representation of both Maori and Pacific people at decision-making levels in order to plan for services that reflect the specific needs and priorities of these disadvantaged groups.

As much as representation at governance level is critical, issues of cost of services create barriers to accessing services. This concern is reinforced by Crengle (1999) and Tukuitonga (1999) in relation to health services for Maori and Pacific people. They suggest that current

funding arrangements do not take into account the poorer health status and higher health requirements of those groups and the associated costs that are incurred to deliver culturally appropriate and effective services[26].

Issues of cost have been raised in the strategy with claims that cost related barriers will be reduced over time and that those groups with the highest needs will be given first priority (p.16). For communities with significant numbers of Maori and Pacific, they are likely to be advantaged by population-based funding. For areas where the pockets of disadvantaged groups are too small to be reflected in the funding formula they are at risk of not attracting adequate funding to reduce co-payments and compounded by not being represented enough to attract the additional or new funding.

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[26] Refer to funding chapter for further discussion related to funding for Maori and Pacific services

CONCLUSION

The strategy has significant implications for consumers in terms of requirements and opportunities. Both involve active consumer participation either in planning and decision-making at governance level or in aspects of service delivery. The strategy signals a change for consumers, who to date are more familiar with going to their health practitioner, usually their GP, when they are unwell or want advice for a specific health problem. By contrast the direction outlined for primary health care services for the future, involves a focus on population health based in health promotion, education, prevention and increased self-management of health problems.

The discussion has been informed by applying the concepts of a community development model that situates the consumer in partnership with the health professional. In this model the consumer is active in their contribution to and participation in health promotional activities.

While provider groups such as HCA, cite the benefits of a community development model, it likely that some consumers will perceive the need for their active involvement as more negative than positive. These consumers will represent the beliefs of those people described by McMurray (1999) above, who either prefer to leave their health in the hands of professionals or who believe that health is predetermined and little can be done to change the situation.

The argument for embracing a community development model is strong, if the direction outlined for primary health care in relation to community (consumer) involvement is to be achieved. While the challenge exists for consumers to embrace the model, successful involvement of consumers will ultimately be dependent on providers. As highlighted above, much of the success will be dependent on provider's skills to support and influence consumers to participate. Equally consumers will need to be responsive as providers work with them to bring about the change. As with other aspects of the strategy, this implementation of this model requires cognisance of the need for a change management process.

While the model is likely to be more advantageous for disadvantaged groups, the evidence suggests that at the least some of the concepts are already in place with Maori and Pacific providers as well as third sector provider groups such as HCA [27]. Therefore, while at one level

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[27] Refer to Chapter two for outline of these models

the implications for consumers appear to be significant, those who will gain the most benefit, are most likely more familiar with the concepts of community development approaches than those consumers who visit mainstream practitioners.

For many consumers the strategy presents opportunities for greater choice of provider and service delivery as well as opportunities to gain improvements in their health status.

CHAPTER NINE: DISCUSSION

This chapter discusses the overall findings in light of the literature and the research question: 'What are the implications of the 2001 Primary Health Care Strategy for providers and consumers?'

In the first part of this chapter, the findings from each of the themes will be discussed including: Population based funding; services and skills; implications for providers; and implications for consumers. The findings from each theme are examined in relation to the literature reviewed in chapters 2 and 3.

The second section discusses developments that have been made subsequent to the release of the strategy. Following this, the researcher concludes by concatenating the findings from the themes and the post strategy developments, and examines them as a whole in relation to the research question. The discussion will demonstrate that the strategy's direction and vision could be achieved, but requires a different process than is indicated in the strategy. It highlights the significant implications for providers and indicates that for consumers the implications are less significant. The vision and directions outlined in the strategy, while directed at consumer involvement, are more dependent on providers to achieve this. The findings suggest the most effective way to achieve the direction and vision of the strategy include providers making significant changes to the way they work. The findings suggest the new primary health care services are targeted at disadvantaged groups and that providers who are most willing and ready to work with these groups should be supported to meet the requirements to attract funding to provide the services. This, the findings suggest, will be more successful than trying to reach all New Zealanders and attract all providers to the new system. The findings suggest that the professional identity of nurses should be strengthened through the development of primary health care nursing models with Nurse Practitioners taking a lead role. Nurses should be assigned the responsibility for delivering against the population health activities. Finally, the issues in General Practice relating to funding mechanisms and structure have some way to go to meet the requirements of the new primary health care system.

FINDINGS FROM EACH OF THE THEMES

Population- based Funding

Population based funding is the key enabling King's vision for primary health care in NZ to be implemented. It is one of the most pragmatic ways to reduce barriers that currently inhibit effective service delivery. These barriers include Delivering services more in line with the needs of the community; utilising other resources, such as nurses, more effectively; and reducing the costs of services, particularly for disadvantaged groups, these include Maori and Pacific people. Population-based funding represents a significant transformation from the way most primary health care services are currently funded. For GPs, it will change their current exclusive rights to subsidies including GMS, the Practice Nurse subsidy, and diagnostic services. For other providers, it transforms their funding from price volume contracts that focus on inputs rather than outcomes. This method of funding, like the fee-for-service funding for GPs, has inhibited flexible service delivery.

Despite the positive features associated with population based funding, there is some concern that wide spread implementation will be resisted by GPs in particular. The literature highlights the resistance of NZ GPs over the past decade, to move from the fee-for-service payments to capitation – a similar method of funding to population-based funding. While Coster and Gribben (1999) indicate that GPs might be more ready now to accept a change, there has been little evidence of their readiness in the past. This resistance appears to be persisting according to media releases over the past year. Issues that have concerned GPs in the past, including potential loss of income and constraints around co-payments, continue. Responses from those GPs who work with more disadvantaged groups appear to be more positive, seeing it as an opportunity to not only predict their income but also as a means to deliver services more effectively to the more disadvantaged populations they serve. These groups of GPs will also be eligible for any additional funding that may be directed to those groups with more disadvantaged populations. The findings indicate that for most providers there is little incentive to make the transformation to population-based funding

One of the most significant concerns that emerge from the discussion related to funding, is the overriding concern that GPs, in particular, have for their incomes. This is in conflict to the direction of the strategy that is more altruistic in its concern for the health of New Zealanders and specifically for disadvantaged groups. Because the concern for health improvement is targeted at disadvantaged groups, the researcher argues that the improvements expected as a

result of implementing the strategy will only be realised through those providers noted above, who seem most likely to be prepared to make the transformation. This specifically relates to Maori and Pacific providers, as well as nurses, if they are able to attract funding.

Nursing, which due to funding arrangements, has never had the opportunity to attract funding in a similar way to GPs or other providers, considers the change to population-based funding as an opportunity, both for them to attract funding, as well as an opportunity to be involved in more effective service provision. However existing funding arrangements will need to be adapted or changed. These issues will be further discussed below.

Benefits to consumers focus on improved access to services from a number of different perspectives, as well as a reduction in patient co-payments. As noted above, GPs are likely to resist any move to control their income. Other benefits will include services that are more closely aligned to the needs of the community, and delivered in ways and settings that access groups in particular who generally do not access health services. It is likely, as discussed that benefits to consumers will only be realised by those who are involved with a PHO. While this might appear to create disadvantages for those consumers whose provider is not involved with a PHO, there will be nothing to prevent them from transferring to a provider who has met the requirements to attract population based funding. The risk with this provision is that less disadvantaged members of the PHO may consume the services that should be provided to disadvantaged groups.

Services and Skills

PHOs are the new organisations through which primary health care services will be funded and provided. The strategy rejects most of the current provider arrangements, in particular IPAs. This is evidenced by key requirements for PHOs to be 'not-for-profit' and for governance to include representation of all providers, and members of the community. This is in contrast to the GP owned and dominated 'for profit' IPAs, that were established through the mid 1990s (Coster & Gribben, 1999). The new PHO structures will be responsible for planning, prioritising and delivering services. They will be quite different from most of the systems that currently operate in the primary health care system, although Maori and Pacific provider structures, and others such as HCA, are most closely aligned.

The new system describes a more coordinated approach to primary health care than currently exists. Exploration of this highlights the current fragmentation of primary health care nursing services, and the dominance of primary care and GPs, as noted in the literature in chapters 2 and 3. This has resulted in primary care dominating primary health care services, working within a 'medical' model focused on treatment and management and responding to individuals when they are unwell (Carryer et al., 1999; Starfield, 1992). The strategy, by contrast, proposes to broaden the existing primary care service to a population focused primary health care model, inclusive of a range of providers and services. Its direction provides a framework for both providers and consumers to work in a more collaborative, participative way. Its most significant change is reflected in its requirements for health promotion, health education and disease prevention. This approach impacts on the way providers will need to work in the future, requiring them to be flexible in the way and where they practise, as well as them learning to work in a more coordinated way. This approach blurs professional and service boundaries, which to date have been more clearly defined through contractual and structural arrangements.

Traditional first-level services, currently the domain of GPs, are reframed to better reflect a primary health care focus. This requires practitioners (not just GPs) to be more concerned with, and responsive to, the needs of their communities. Maori and Pacific models of service delivery are shown, through both the literature and the discussion in chapter 6, to reflect features that could be adopted by providers to better meet the requirements of the strategy in particular in relation to disadvantaged groups.

As well as caring for people when they are unwell, the strategy emphasises the role of population health services that includes activities such as health promotion and education and disease prevention. While the literature showed that some of these services are currently provided in primary health care, it highlights the fragmentation and duplication. GPs provide some of these services, albeit inadequately, with the majority being provided by PHNs. It notes that over the years their early involvement in population health and personal health activities have been eroded as a consequence of reform (Carryer et al., 1999).

Chapter 6 highlights the contribution nurses working in primary health care can make, to both population health and first level service provision but are constrained by a number of barriers. This is due in part to their lack of a strong professional identity and an inability to attract funding (Cernik, 1994). Williams (2000) recommends that nurses need to develop this confidence and take advantage of professional development opportunities. In the absence of nurses taking the initiative, there is no clear pathway to address these issues.

The system, as noted above, is expected to have a more coordinated approach to primary health care. This represents a transformation from current service provision, with examples of effective teamwork in primary health care in the UK, but little evidence of the same or similar ways of working in NZ. The lack of a model representing effective coordination and teamwork within primary health care presents a challenge for primary health care providers.

IPAs represent one model through which services can be provided, although nurses are unlikely to willingly accept this option, due to the dominant role of GPs (Public Health Alliance, 1998). Despite this, the literature demonstrates the IPAs' positive contribution to health service improvements throughout the 1990s, through new service initiatives and quality assurance programmes (Coster & Gribben, 1999). They have also developed significant infrastructure and experience that could well support PHO development. The problem with this approach is that it may merely result in some modification to GP provided primary care services. This has been demonstrated in the UK as not being the most effective way to introduce population health services, as it has resulted in the addition of a few additional services, rather than the population focus that was intended (Public Health Alliance, 1998). Neither nursing nor medicine would disagree that primary health care services could and should be delivered more effectively and efficiently, although nurses will strongly oppose any reinforcement of GP dominance (Williams, 2000). The findings in this chapter and the literature highlight a lack of an appropriate model through which primary health care services could be delivered.

Both nursing and medical leaders have attempted to address the issues of appropriate models for primary health care as evidenced in the *National Health Committee Report* (2000). Both groups have points of similarity as well as differences. They both agree on a funding model based on a per capita basis, although GPs argue against any constraints to their earning capacity, as highlighted above. Both nursing and medicine in their reports, support a team based community oriented approach (Carryer et al., 1999; Coster & Gribben, 1999).;However both have a different perspective on what it might look like.

Primary Health Care Models

The UK, as shown in chapter 2, most probably provides the closest resemblance to a primary health care model comprising multidisciplinary, integrated teams (Bojke et al., 2001). Issues related to structure and medical dominance, and nursing's struggle to maintain autonomy have

challenged the different professional groups within the teams. As it progresses down a more integrated pathway, NZ could learn lessons from the UK experience.

For NZ, on behalf of medicine, Coster and Gribben (1999), describe a concept of Primary Care Organisations, where primary care maintains its centrality, but has a community orientation. This is more in line with MOH (2002b) paper regarding PHO development. Their concept reflects many of the requirements of a PHO including a population approach, enrolment and recognition of socio-economic determinants. The paper recognises the need for a full range of health professionals to be included in clinical governance but is less informative about overall governance. Their focus remains on primary care and fails to encompass the broader approach outlined in the strategy. Carryer et al (1999) in their paper, emphasise the role of nursing, in particular in community settings. They argue strongly for greater recognition of nursing in primary health care and suggest that rather than retraining doctors to accommodate primary health care, as suggested by Coster and Gribben (1999), that nurses are already well prepared for the role. Their model for primary health care is strongly located in nursing, in combination with a community development model similar to that discussed in Chapter 8. It represents nursing's concern about establishing itself more strongly and autonomously. The fragmentation of roles that is currently experienced, in particular the Practice Nurse role, remains a barrier to developing a model as outlined above.

Maori, Pacific and third sector organisations, such as HCA, are possibly the most closely aligned to models that reflect the principles of primary health care. For nursing, HCA reflects a structure that mitigates most of their concerns, where both doctors and nurses are employees, salaried and the management structure is not dominated by any one profession. These models, similar to those outlined above also have gaps. A combination of the strengths of each of the models would achieve a compromise that would be acceptable to both groups

Nursing

The strategy clearly supports a role for nursing within a primary health care setting, with a section dedicated to primary health care nursing (p.23) and references throughout the document, such as " the need for increased nursing involvement" (p.13). Both the literature and the findings support this approach. The barriers to the effective utilisation of nurses have been well articulated in a number of forums, including the 1998 Ministerial Taskforce and through papers presented by nursing groups, including the College of Nurses (2001). The findings from this study have shown that unless the structural, contractual and funding issues are addressed then it

is unlikely that there will be progress in the development of nursing roles. Since the release of the strategy, there has been some high level support for nursing, evidenced through the recent article in *Nursing Review* (November 2002) of the government's commitment to fund fifteen pilots for innovative primary health care nursing. Hughes, in the article, reinforces that the funding is for proposals that address the current fragmentation of primary health care nursing. The researcher argues that is a risk to this approach, in that it potentially alienates nurses from their medical colleagues rather than encourages the collaboration that is reinforced in the strategy. It does present an opportunity for nurses to develop an infrastructure that could facilitate a transition to a more integrated model over time. This will be discussed further below.

Implications for Providers

The findings from the discussion of this theme have indicated that the implications of the strategy are far reaching for providers. Existing structures, services, providers and roles will need to make changes to the way they practise to realise King's broad vision for primary health care in NZ. The direction outlined blurs practice boundaries, roles and responsibilities. The findings suggest that roles will change, with nurses picking up much of the work that has previously been the domain of doctors, and doctors picking up work that has traditionally been provided in a secondary care setting. Unless the transitions are handled sensitively, it is likely to create tension rather than promote effective collaborative working relationships. The strategy presents opportunities as well as challenges and explicitly states that a new primary health care system will be achieved over the next 5 to ten years (p.6). The key directions imply change. The findings highlight the amount of change that will be required of providers to achieve the vision

The findings have demonstrated that both nursing and medicine have an equal but different contribution to make to primary health care. Chapter 7, informed by the work of William's (2000), highlights the importance of acknowledging the issues that will confront both nurses and GPs as they change the ways they practice to better meet the needs of their communities, in line with the direction of the strategy.

In a changing environment such as is indicated in the strategy, education for nurses is important. It not only increases knowledge and skills but also develops confidence (Williams, 2000). This is important particularly for Practice Nurses, who, as this study has demonstrated, currently work in a more subservient role, constrained by funding and employment arrangements. For primary health care nurses in general, their role becomes more critical as they need to move

beyond the current specialisation and the range of different roles, as these have the potential to impede progress. The findings reinforce the role for a more generalist primary health care nurse, as well as the importance of the Nurse Practitioner role. The value added to service delivery and health outcomes through this role is well evidenced (Ministry of Health, 2002c).

Education for medicine is also important, particularly as a vehicle to establish a positive professional identity in a time of change. Most importantly, the findings highlighted the value of shared learning for doctors, nurses and other health related professions (Williams, 2000). This can be achieved both through tertiary education and through less formal channels such as inservice education. Williams (2000) promotes it as an effective way to reduce professional rivalry, and notes that it frequently facilitates professionals rearranging themselves into groups, thus moving some way to achieving the collaboration promoted by the strategy.

While the strategy recommends the value of teams to provide the full range of care that any one person might need, the study has highlighted the tensions and conflict that emerge when health professionals are confronted with change (Williams, 2000). This needs to be accounted for, if effective teamwork is to be established in an environment where providers are more familiar with working in 'silos'. Teams are seen as not only being effective in ensuring continuity of care, as noted in the strategy, but also for effective and efficient ways to provide population focused primary health care (Williams, 2000). They are most effective where teams are not dispersed.

The role of Nurse Practitioner emerges as a key role to position nurses more confidently alongside GPs The findings demonstrate that their advanced knowledge and experience enable them to work more collaboratively alongside other nurses and with GPs with whom they have a more equitable relationship (Nursing Council, 2002).

The findings suggest that unless issues of professional identity are addressed for both groups, in this time of change, there will be little progress made towards achieving the vision for primary health care. Based on the literature, GPs are likely to resist change particularly if their current dominant role is challenged. Practice Nurses, over and above other primary health care nurses, will be confronted with the biggest challenge to change. This supported by the discussion in chapter 2, which highlights their more subservient role in comparison to other primary health care nursing roles. Nurses as a whole in this changing environment, as noted by Williams (2000), have the opportunity to expand and change their role in order to be more effective in

primary health care service delivery. The risk, as highlighted by Williams (2000), is that as both nurses' and doctors' face the change, they retract and no or little progress will be made. This will only serve to promulgate the current model of primary 'medical' care rather than achieve the population focus, as proposed by the strategy.

The success of the strategy is dependent on providers making the changes to encompass the broader population focus for the new primary health care system. The implications for providers are far reaching. Nurses and GPs not only have to change the ways they practice, but they have to make a paradigm shift in the way they perceive their own and others' contribution to primary health care. GPs will need to relinquish their dominant role in primary care and embrace other providers as equal contributors. Nurses will need to address the barriers such as lack of confidence, education, and the fragmented nature of primary health care nursing. This has implications for all primary health care nurses, but most particularly for Practice Nurses, as noted above, due to their employment constraints

.

Implications for Consumers

As for providers, the strategy has significant implications for consumers. These are represented as both *requirements*, for example the requirement to enrol in order to receive subsidised services, and *opportunities*, for example increased choice of both services and providers. The strategy places some emphasis on the importance of consumers both at a planning and decision-making level, and in becoming more actively involved in self-care practices. As highlighted in the discussion, consumers need to be supported to do this rather than coerced (McMurray, 1999).

The discussion in chapter 8 focused on the strategy's emphasis on population health, community involvement and approaches to achieve improved health outcomes particularly for disadvantaged groups. For this reason it was decided to use a community development model to inform the discussion. The model based on the work of McMurray (1999), highlights the benefits of such an approach from a consumer perspective. It is an approach that is dependent on relationships being developed between providers and consumers in order to achieve active consumer participation (Oakely & Kahassay 1999). They note that participation of consumers as indicated in the strategy, at governance level and in health promotion activities, involves their active participation. This means providers need to lead a process that takes time and results in gaining consumer support and community knowledge (Oakely et Kahassey, 1999). There is the potential that providers could ignore the community development approach and achieve the

requirements particularly related to governance through nominal community involvement, but the successes purported to emerge from a community development model would not be realised (McMurray, 1999).

The population, or health promotion, focus promoted throughout the strategy is one of the key activities within a community development model. In this model health education, a component of health promotion, takes a central role. This is shown to be a role that is well delivered by consumers. While not noted in the discussion in this chapter, Carryer et al (1999) in earlier chapters, recommend that nurses work well within a community development approach and are well prepared educationally to support consumers to deliver health education in ways that will result in improved health outcomes. The non health settings recommended for delivering health education, involving schools, work places, homes reflect the direction outlined in the strategy.

Consumer participation in primary health care is not common in NZ, as traditionally they are more used to the first-level service provision from their GP. This more reactive, treatment oriented approach is in contrast to the more proactive promotion, disease prevention focus of both a community development model and the strategy.

The implications of the strategy for consumers are varied. Whether they notice any change in the way primary health care services are delivered will be dependent on a number of factors. Primarily, any noticeable change will be dependant on providers firstly embracing a community development model and supporting consumers to be more actively involved in primary health care service planning and delivery. Secondly the broad range of primary health care services will only be available through a provider who has joined a PHO.

The findings show that the implications are more significant for providers, who will need to take a lead role and support the community to embrace a community development approach.

DEVELOPMENTS SUBSEQUENT TO THE RELEASE OF THE STRATEGY

The NZ health sector and in particular primary care, as highlighted in Chapter 2, has undergone major structural change over the past decade. The release of the 2001 Primary Health Care Strategy indicated a new direction for primary health care in NZ. Its release was one of a number of strategies under the overall framework of the *NZ Health Strategy* (2000), put into effect through the *NZ Public Health and Disability Act 2000*. The act established twenty-one District Health Boards tasked with the responsibility for funding as well as providing primary, secondary and public health services for New Zealanders.

The release of King's (2001) *Pprimary Health Care Strategy* signalled a significant change in the way primary health care services would be delivered in the future, with implications for both providers and consumers. Historically, as noted in the literature review, primary health care had been fragmented both in the way it has been contracted and ways in which it has been provided. Primary (medical) care that dominates, is focused on treatment oriented services. Preventive services are fragmented and provided by a range of providers, resulting in gaps and duplication. By contrast, the strategy broadens the focus and outlines 6 key directions, which encompass a population health focus including first-level services, better known as primary care type services, and population-based services. This is to be achieved by changing the way services are currently funded, as well as changing the way services are provided. This will occur through PHOs.

It is now nearly 2 years since the strategy has been released. In that time the MOH has completed some of the work they were assigned to complete (King, 2001). This has included 2 major documents. The first outlines the enrolment requirements for PHOs (Ministry of Health, 2002a), and the second provides a guide for establishing PHOs (Ministry of Health, 2002b). Work on the funding formula is still under development, with the 6 newly established PHOs being funded through an interim funding formula (media release in the Nursing Review, November 2002). The media release notes that all of the PHOs established to date are targeted at high need groups. Of the provider groups that have formed PHOs, there are only 2 IPAs. The rest are comprised of Maori and Pacific providers. This early involvement of Maori and Pacific providers in PHOs reinforces the findings above, which note that they are more closely aligned to the strategy's direction than the majority of providers.

Nurses have been active in looking at how they could best address the direction outlined in the strategy. To this end, the College of Nurses (2001) released their strategy document outlining their concern for the current fragmentation of primary health care nursing services and presented a structure to establish what they refer to as a primary health care nursing directorate in the health sector. This model aligns with some of the findings from chapter 7, which indicate that nurses need to confidently establish their professional identity in order to work effectively and collaboratively alongside GPs. As noted above, the MOH has actively demonstrated its support for nursing development with its release of funding for primary health care nursing initiatives. This demonstrates King's support for strategy where she offered funding through the MOH for initiatives as highlighted above. Further support has been noted with the release of $850,000 scholarship money, by the MOH, to encourage nurses to undertake post graduate education for primary health care nursing.

Anecdotally, it is reported that GPs continue to resist any move to population -based funding.

CONCLUSION

The above discussion has highlighted that the new primary health care system proposed by King (2001) is significantly different from today's system, which includes the more narrowly focused primary care service dominated by GPs` and a range of fragmented primary health care nursing services. The directions outlined in the strategy for the new system involve a broader range of services, focused on the needs of an enrolled population that will be funded and provided through new structures, known as PHOs. The strategy promotes the new system for all New Zealanders, although highlights the need for providers to provide for and meet the needs of disadvantaged groups, in order to address the existing inequalities of health. This, it claims, will be achieved by changing the way primary health care services are currently funded, to a population-based method of funding. This is expected to enable the broader range of population focused services to be provided more effectively both in the way and by whom they are provided.

The findings have shown that GPs are the group least likely to embrace the new system. Firstly, it has been demonstrated that any attempts in the past to change the way they are funded have been rejected. There is little evidence to suggest that this stance has changed. Secondly, both the literature and the findings suggest that GPs and primary care are not the most effective routes through which to provide health promotion and disease prevention activities. Instead, the literature and the findings suggest that nurses are better prepared for a health promotion, disease prevention role through their nursing education (Carryer et al., 1999). Their ability to provide these effectively is currently constrained by funding, contractual and structural arrangements as well as lack of confidence in their professional capability (Williams, 2000).

Health promotion is critical to achieving a population focus, as well as addressing the existing health inequalities. The strategy supports a community development approach as a way of involving communities in finding ways to address this (p.10). This is examined in more detail by applying a community development model to the discussion related to consumers in chapter 8. The findings suggests that responsibility lies with providers, and not consumers, to ensure consumers are actively involved in primary health care in the planning and health care activities required in the strategy. This involves a new way of working for providers. The findings reinforce nurses as the most effective group to work with consumers, as they are familiar with a community development approach (Carryer et al., 1999).

The potential role for nurses in the new primary health care system is emerging strongly. However, as noted by Williams (2000), when faced with policy change, both opportunities and threats emerge for nurses and doctors. The finding suggest that unless these are actively acknowledged and addressed, conflict will occur and the requirements for collaboration and teamwork, as outlined in the strategy, will be more difficult to achieve. For nurses, the most effective route to address this, is through the establishment of primary health care nursing models. This, the findings suggest, will provide them with the opportunity to develop their confidence and skills without being overpowered by doctors. Nurse Practitioners will facilitate this through role modelling confident behaviour largely due to their advanced knowledge and experience (Nursing Council, 2002).

Changes for providers (doctors and nurses) include a blurring of roles and a focus more on services being provided by the most appropriately skilled provider, and in some cases teams of providers. The literature highlights the 'silos' that currently exist, exacerbated by contracts focused on inputs rather than outcomes. In addition, the strategy requires the provision of a comprehensive range of services to be provided in ways that meet the needs of the consumer. In the face of change, according to the findings, health professionals generally react in a range of different ways. Nurses are more likely to embrace the changes positively, viewing them as an opportunity to expand their roles. Doctors may, or may not, choose to expand their roles (Williams, 2000). The strategy clearly presents an opportunity for nurses, not only to expand their roles but also, through funding changes, to be actively involved in more effective service delivery. GPs as noted by Williams (2000) are likely to feel threatened.

PHO development has been slow, although the 6 PHOs that have emerged over the past year signal a trend towards a different direction than that outlined in the strategy. Instead of a new primary heath care system for all New Zealanders, the early developments are suggesting a more targeted approach. This approach is emerging as a result of findings as the most likely way for the vision and direction of the strategy to succeed. The findings suggest that the majority of providers (GPs) are unlikely to make the transition to the new system easily. Instead, the findings show that Maori, Pacific and third sector providers such as HCA are more closely aligned both philosophically and in service provision, than most other providers. They traditionally work with disadvantaged groups and provide services in ways and settings to meet the needs of their enrolled population (Crengle, 1999; Tukuitonga, 1999). They tend to utilise nurses more effectively than GPs who belong to IPAs. The early PHOs, as noted above, are

mainly comprised of Maori and Pacific providers. Thus, it appears that the wider population focus inclusive of all New Zealanders will not be achieved according to the direction outlined in the strategy. The concern for disadvantaged groups will be realised through the more targeted approach that is emerging, with the potential for the health outcomes, expected as a result of population-based funding and a population health focus to be maximised due to the way the providers will provide the services.

A targeted approach with groups such as those described above, is also more likely to contribute to successful implementation of the strategy in the absence of an existing appropriate primary health care model, and with the majority of GPs continuing to resist a change to population-based funding. As noted in the findings, there is no single model in NZ that best represents the requirements of the strategy, although the providers noted above most probably bear the closest resemblance. Another potential model is emerging – primary health care nursing. The strategy, as already noted, clearly presents opportunities for more effective utilisation of nurses. In addition, the subsequent funding support for primary health care nursing initiatives, from the MOH, reinforces the potential for nursing. While the findings suggest that a separate primary health care nursing model may detract from achieving the multidisciplinary approach outlined in the strategy, there is significant evidence to suggest that the approach may support nurses to develop their confidence, as noted above, in order to stand strongly and equally alongside doctors. The findings also suggest that significant work needs to be undertaken in order to achieve the strategy's multidisciplinary, co-ordinated approach. This includes: Addressing the contractual, structural and employment barriers; establishing shared learning and education opportunities for doctors and nurses; establishing teams who preferably share the same premises; and finally addressing the dominant role of GPs.

These findings suggest that that the most pragmatic approach to achieve the direction outlined in the strategy include: Support the development of PHOs who will work with disadvantaged groups – a targeted approach; continue the development of primary health care nursing models in order to more effectively support nurses in the provision of primary health care services and in particular health promotion and disease prevention; support the development of the Nurse Practitioner role so that they can support primary health care nurses to develop their professional identity. Further more their role will support the development of collaborative relationships based on equal contributions by both doctors and nurses and recognition of each other's values. While GPs remain reluctant to embrace the change to funding, and therefore the new primary health care system, they should be left with the responsibility for providing the

majority of the treatment focused services to those New Zealanders who experience higher rates of health status. Funders however should not ignore GPs' resistance to move to the new primary health care system, which over the past ten years has constrained the population health focus that is considered the key to achieving improved health outcomes.

The approach described above takes into account the findings from each of the themes and provides, at the least, an interim step that progresses the strategy, although in a different way than was anticipated. This approach outlines a number of strategies for providers (and funders) and allows for some of the changes to occur in order for the vision of the strategy to be realised. The developments since the release of the strategy support the findings, and are indicative of a transition process that is acknowledging the issues related to the way providers respond when faced with changes to policy involving blurring of roles and practices (Williams, 2000).

CHAPTER TEN: CONCLUSION

This chapter examines the strengths and limitations and makes recommendations for further research and actions to strengthen the potential of the *Primary Health Care Strategy* (King, 2001) are identified.

STRENGTHS AND LIMITATIONS OF THE METHODOLOGY

Applied Policy Analysis

Applied policy analysis has been used in this study because of its specific application in policy research. It typically is used to meet specific information needs requested by the policy maker (Ritchie & Spencer, 1994). This has not been the case for this study, although the findings provide explanations and insights to assist funders and providers with a better understanding of the implications of the strategy in relation to providers and consumers. The methodology has enabled the researcher to address the issues from a number of different perspectives, including contextual, diagnostic and strategic. Commonly in applied policy research, qualitative methods are used to achieve this (Ritchie & Spencer, 1994). From a contextual perspective the researcher has related the strategy to health reform over the past ten years, current practice, and developments that have occurred since the release of the strategy. The diagnostic perspective has been achieved by examining and interpreting the data according to the original research question. Strategically, the study has enabled the researcher to identify the implications and the actions required by providers and consumers to meet the direction and the vision of King's (2001) strategy. The study has achieved the key goal of applied policy research, which is to provide answers or to highlight and provide a better understanding of the issues (Ritchie & Spencer, 1994).

This type of research usually has a specified deadline, which aligned with the constraints of writing a thesis with a deadline. The most significant difference between typical applied policy research, and this study, is that only one researcher was involved. Usually a team of researchers is involved in this type of research to promote discussion and exchange views, as well as manage the time scales. The researcher does not consider this affected the results, as the study was confined to document analysis rather than the wider use of data that is generated through interviews, observation or group work (Ritche & Spencer, 1994).

Typically applied policy analysis includes both quantative and qualitative analysis. This has not occurred in this study. As Ritchie and Spencer (1994) note, qualitative methods are now well recognised for their strengths in providing insights and explanations to those most affected by the policy.

Framework Approach

The 'framework' approach is designed to enable systematic analysis within the constraints of applied policy analysis, as identified above. Its key attribute for this study, is its systematic but flexible process. This enabled the researcher to work and rework ideas and themes within the 'framework' as well as discard them as necessary (Pope et al., 2000). This process was outlined in chapter 4, where the original 8 themes were reduced to 3, and 2 additional themes were established part way through the process and highlights its flexibility. The ability to deduct information part way through the process has strengthened the discussion related to the research question and contributed to the findings.

One of the benefits of the 'framework' approach is the ability to revisit the study at a later date for further analysis. This requires all information to be easily retrievable. It also provides an audit trail to demonstrate reliability (Pope et al., 1994). This has been achieved through the course of this study in two ways. Firstly, the researcher has used direct quotes from, and made references to, the strategy, enabling the reader to easily retrieve the data and check for consistency and trustworthiness. Secondly, samples of all the steps taken as the methodology was applied, have been included either in the body of the study, or in appendices.

To the researcher's knowledge there has been no nursing study undertaken using the 'framework' approach and limited published studies from other disciplines. It is hoped that this study gives nurses the confidence to try new and different methods and take risks.

Application of the Methodology to the Research Question

The research question related to implications of the strategy for providers and consumers.

For the purpose of the study, the researcher made the decision to limit discussions relating to providers to nurses and doctors. The focus is biased towards nursing, due to the researcher's background. She acknowledges that the strategy has implications for a wider range of

providers. Both these issues put some limitations around the findings, although the majority of providers in the new primary health care system will be nurses and doctors.

Use of Theory

Using Williams' (2000) study to inform the discussion related to the implications of the strategy for providers, enabled salient points to be discussed in more depth than by only analysing the data within the 3 key themes. Williams' (2000) concern for the way health professionals respond when faced with policy change had particular relevance for this study.

The community development model provided a useful tool for analysing the strategy in relation to its implications for consumers and in particular its relevance to the strategy's focus on population health and the inequalities of health experienced by disadvantaged groups.

Finally, the researcher has developed a different understanding of the significance of the strategy. She started the study with an understanding and knowledge gained from her involvement in the reference group. Her views and understanding have changed as a result of applying a research frame to the strategy.

RECOMMENDATIONS

* That process evaluation is undertaken at 3, 5 and ten years

* That the *Primary Health Care Strategy* becomes a component of the undergraduate medical and nursing programmes

* That the *Primary Health Care Strategy* becomes a component of postgraduate nursing programmes

* That the MOH and/or DHBs address the employment situation for Practice Nurses

* That nursing leadership is established within primary health care, in line with the College of Nurses (2001) proposed model

* That DHBs seek to actively support and employ Nurse Practitioners in primary health care

* That a community development model becomes a requirement of PHOs

This chapter has highlighted the strengths and limitations of this study. It has concluded with recommendations for further research and actions to strengthen the potential of the primary health care strategy

APPENDICES

Appendix 1 – Provider data

Page	Provider type	Requirement
6	PHC services	Focus on better health Actively work to reduce health inequalities Improve health, keep people well Easy to get to coordinate on going care
7	PHOs	Will include some members of the community Demonstrate processes for identifying need Allow community members and service users to influence the organisations decisions Will seek to directly enrol people in their communities
	PHC	Involve participation by people in the community Organise services around defined populations
8	PHC system	Will enable people to have continuity of care Will not reduce freedom to choose b/t different practitioners Minimal requirements will be explained to people when they make their choice of providers – 24 hrs, 7 days week urgent services; allow people to ask to see a particular practitioner; nominated provider will receive info about consultation/tests with other practitioners
9	PHC	Enrolment system allows people to see any PH carer; allows people to change their nominated provider without difficulty, or without permission
	PHO	Will respond to the needs & priorities of their communities and involve them in governing processes
10	PHOs	Will identify and address groups with poor health or missing out on services Will take a community development approach Will involve communities in finding ways to improve health for the most disadvantaged Improvement for Maori and Pacific through Maori and pacific development
	PHOs and providers	Required to understand the nature of their populations Identify disadvantaged groups in order to address their needs
	PHOs	Required to work with their communities Find appropriate solutions for disadvantaged groups
	Providers	Identify different ethnic communities Provide for different needs and priorities especially those not being reached through existing services Expected to organise and deliver services that are culturally competent and effective Establish specific services where there is significant maori & Pacific people enrolled

11	Pacific Providers	Will form PHO in their own communities All will show they know the ethnic mix of their populations and address needs in a way that is culturally competent and effective
12	Mainstream PHOs	Will establish specific services where there are significant numbers of Maori and Pacific people
	Maori & Pacific	May form PHOs in their own communities
13	General	Services will include ways to improve, maintain and restore health
	Practitioners & providers	Will work closely with Public Health service providers Required to be skilled at various techniques for identifying and helping people change behaviours that threaten their health Will focus on screening, opportunistic education, interventions to help change damaging behaviours, early detection and management and support for people with ongoing conditions
	PHC	Include access to first level advice & treatment for people when unwell or concerned Include appropriate use of pharmaceuticals, diagnostic testing, referred services Make good use of new sources of health advice eg Helplines, Internet, increasing nursing involvement, improved technology to manage patients safely in the community
	PHO	Will provide a defined set of services plus some may offer an expanded range
14	PHO	Funded according to a formula
15	PHO	Will coordinate best use of therapeutic and support services through population based funding
16	PHOs and providers	Will be encouraged by their communities to consider affordability of services To support people to care for themselves and reduce their need to visit and pay for services Will actively need to go out to people who can't or don't come to them Need to be open to providing services in a range of different settings
17	PHO	Will be not for profit but can contract services from private not for profit providers Will be encouraged to develop innovative ways of providing services people can afford

18	PHOs	Will work through DHBs to highlight and help address intersectoral issues affecting the health of the community Along with DHBs will increasingly work with local bodies etc to facilitate/lead change to improve the health of the community Need a range of practitioners with skills to communicate & collaborate in patients interests
	Providers	Will involve nurses & doctors as well as range of community workers
	PHOs	Need various professional, managerial and support staff Role recognition, importance of others & working collaboratively important Will help to minimise costs through networking & sharing some admin services Wide expertise necessary and new ways of workin
19	PHOs	Will coordinate care for enrolled patients Will be the central point of contact for the community and secondary care providers Will be responsible for keeping key information and linking patients with appropriate service providers where appropriate Not responsible for providing all services Will work with other providers and agencies to maximise opportunities for prevention and early intervention Will work in partnership with Maori and Pacific providers to reduce health inequalities Will share local health initiatives with other provider groups
20	PHOs	Will build linkages and networks with public health services and consider - how PHC can contribute to intersectoral and population health initiatives; useful and effective ways to share information; how best to draw on public health knowledge & expertise when delivering 1:1 health improvement services Will need to consider how best to ensure barriers to access are minimised for people with disabilities; build linkages with disability organisations and input into their initiatives; maximise intersectoral activities to enable people with disablties to participate in the community
21	PHOs	Need to consider activities to reduce incidence & impact of mental health problems; skill mix of practitoners; building effective linkages with other mental health providers. Need to consider maintaining continuity of care for people who spend time in the care of other providers Developing joint care plans to ensure optimal care
22	PHOs	Consider activities to maximise health & independence by working intersectorally Will participate in intersectoral activities to address social, cultural & economic causes of ill health Take responsibility for coordination of care Coordinate & manage resources to ensure best use of workforce, diagnostic & therapeutic services Support initiatives to improve coordination between primary & secondary care Consider how to coordinate & link with providers from other service areas
23	PHOs	Will deliver services in a range of settings

24	PHOs	Will document compliance to DHB requirements for quality & safety. This will be available to the public and DHBs
25	PHOs	Will support development of further initiatives such as Kidznet
26	PHOs & providers	Will ensure patients are informed about information collected & its intended uses
	PHOs	Will be openly accountable to the public for the quality standards they plan to achieve Will build on promising information initiatives that have the potential to improve care Will cooperate with the effectiveness & accuracy of NHI
	Providers	Will ensure patients are informed about information collection
	PHOs & providers	Will build evaluation research & development into new PHC programmes
viii	PHOs	Will be funded by DHBs for an essential set of services for enrolled people Will involve communities in their governing process Will involve providers & practitioners in decision making Will be not for profit Will be fully accountable for public funds Will have voluntary practitioner membership

Appendix 2 Requirements for Consumers

Page	Requirement
vii	People will be part of local primary health care services Emphasis on the role of the community
viii	Involve communities in governing processes
1	Involves community participation
5	Involve communities in governing processes
7	Reflect needs and priorities that are set by the people Some members of the community on their governing bodies Allow community members … to influence the organisation's decisions People will be encouraged to join a PHO to gain the benefits Will enrol with a provider of first-contact services Individuals asked to make an active choice to join the PHO People will have a usual source of care …and for advice and help Form relationships with their provider
8	Will have continuity of care Will be free to choose between different practitioners Will be asked to nominate a practitioner, practice or provider for continuity of care Will have minimum requirements explained at the time they make their choice Will have access to 24-hours-a-day, 7-days-a-week urgent services Free to seek care wherever they wish
9	Will be able to change their nominated provider Will make informed choice based on information received Able to choose practitioner at any time and change without difficulty
10	Many Maori and Pacific people will be cared for outside of Maori and Pacific providers Will have specific services established
11	Maori communites will have control over their health and community Active involvement of pacific communities in service delivery
12	Individuals should be able to manage many health concerns and problems themselves
17	Will be informed and educated about primary health care services
26	Will give consent for information to be shared

Appendix 3 - Sample of indexed data related to the theme of services to be provided

- will include services that improve, maintain and restore people's health
- a defined set of services
- include approaches directed towards improving and maintaining the health of the population, as well as first-line services to restore people's health when they are unwell
- better health for a population
- some services will be continued to be provided through separate arrangements through the current arrangements
- provide alternative choices for people
- effectively coordinate services and care
- best possible package of care
- importance of continuity and relationships with a usual source of care
- health improvement, screening and prevention
- provided in a range of different settings
- inequities that exist in different groups throughout NZ
- Maori and Pacific provider development
- culturally competent and effective
- services for when they are unwell or concerned about their health
- 24- hours -a –day, seven-days-a-week urgent services
- benefits associated with continuity of care are realised
- services provided by different providers in various settings
- problems successfully dealt with at the primary level
- ready access to first-level advice
- to consider different ways to source advice such as telephone helplines and the Internet
- increasing nursing involvement
- services for sensitive and confidential problems
- services need to be comprised of the right mix of services, with a wide range of practitioners as well as different and innovative approaches
- importance of coordination
- comprehensive disease prevention and management approach
- population health
- services to reduce health inequalities and improve the health of communities
- Maori and Pacific health lags behind that of others in the population
- community development approach
- activities to address health inequalities
- a coordinated approach
- a range of prevention and health promotion services
- more comprehensive disease prevention and management approach
- health promotion, education and counselling and helping people to adopt health lifestyles
- population health services will be better coordinated
- working with local bodies, education, welfare, housing
- population health and the role of the community, health promotion and preventive care

Appendix 4 – Sample of Coding

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