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Primary care teams: New Zealand's experience with community-governed non-profit primary care

Peter Crampton[a,*], Peter Davis[b], Roy Lay-Yee[c]

[a] *Department of Public Health, Wellington School of Medicine and Health Sciences, Faculty of Medicine, University of Otago, New Zealand, PO Box 7343, Wellington, New Zealand*
[b] *Department of Public Health, Christchurch School of Medicine, PO Box 4345, Christchurch, New Zealand*
[c] *Centre for Health Services Research and Policy (CHSRP), School of Population Health, Tamaki Campus, University of Auckland, Private Bag 92019, Auckland, New Zealand*

Abstract

Community-governed non-profit primary care organisations started developing in New Zealand in the late 1980s with the aim to reduce financial, cultural and geographical barriers to access. New Zealand's new primary health care strategy aims to co-ordinate primary care and public health strategies with the overall objective of improving population health and reducing health inequalities. The purpose of this study is to carry out a detailed examination of the composition and characteristics of primary care teams in community-governed non-profit practices and compare them with more traditional primary care organisations, with the aim of drawing conclusions about the capacity of the different structures to carry out population-based primary care. The study used data from a representative national cross-sectional survey of general practitioners in New Zealand (2001/2002). Primary care teams were largest and most heterogeneous in community-governed non-profit practices, which employed about 3% of the county's general practitioners. Next most heterogeneous in terms of their primary care teams were practices that belonged to an Independent Practitioner Association, which employed the majority of the country's general practitioners (71.7%). Even though in absolute and relative terms the community-governed non-profit primary care sector is small, by providing a much needed element of professional and organisational pluralism and by experimenting with more diverse staffing arrangements, it is likely to continue to have an influence on primary care policy development in New Zealand.

Keywords: Primary care; Non-profit; Population-based; Workforce; Team

1. Introduction

New Zealand has a largely tax-funded health system which, in its general form, looks similar to the United Kingdom's National Health Service, including its foundation of general practitioner-based primary

* Corresponding author. Tel.: +64 4 385 5999; fax: +64 4 389 5319.
E-mail address: cramptonp@wnmeds.ac.nz (P. Crampton).

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care. Yet New Zealand is unusual among welfare states of the liberal democratic model because primary care is only approximately 60% funded by government [1]. Because of patient co-payments, the paucity of indigenous (Maori) and Pacific Islanders in the primary care workforce [2], and the uneven distribution of general practitioners (GPs), significant financial, cultural and geographical barriers to access exist for primary care [3–5]. These barriers have a long standing historical basis (discussed below) and, in response, community-governed non-profit primary care organisations started developing in the late 1980s [6]. The first non-profit trade union health centres were set up in 1987, and a diverse range of non-profit primary care organisations emerged during the early and mid 1990s, most notably Maori initiatives. In 2004 there were 51 member organisations in the country's principal network of non-profit primary care centres, 32 of which provided comprehensive primary health care services (personal communication: Petra van den Munckhof, National Co-ordinator, Health Care Aotearoa). In many instances these organisations aimed to provide population-based primary care, which included the targeting of high needs populations, locating in geographical areas lacking in primary care services, adopting population-based funding, and enrolment-based management of the patient population [7,8].

New Zealand's *Primary Health Care Strategy* [9], released in 2001, charts a course for primary care that draws on the experience of on the community-governed non-profit sector. Increasingly, primary care and public health strategies are expected to be coordinated and inter-meshed, with the overall objective of improving population health and reducing health inequalities. The *strategy* therefore foreshadows important changes in primary care, including the formation of new non-profit umbrella organisations, called Primary Health Organisations (PHOs). PHOs are responsible for ensuring that their constituent general practices and community organisations provide comprehensive, continuing and coordinated care to their enrolled populations, including health promotion and prevention programmes. Increasingly, PHOs will be held accountable to their funders for a range of population health outcomes. The development of PHOs mirrors, to an extent, the development over the past 5 years of primary care groups and trusts in the UK [10].

Staff are the most important resource in PHOs. New Zealand has approximately 23,000 health practitioners plus around 30,000 support workers delivering services in the community [2]. Around 40% of its medical practitioners and 23% of its nurses work in primary care settings. Research has addressed a range of issues related to primary care staffing. For example, evidence from the UK suggests that workload in primary care varies according to socioeconomic deprivation [11], that nurse practitioners can successfully take on an expanded role [12], and that well-performing primary care teams provide better health care [13]. However, very little is known about the preparedness of traditional primary care teams in New Zealand to take on the new population-based focus expected of them. The Health Workforce Advisory Committee raised the following questions [2]:

1. How can the existing primary care workforce be supported, retained and appropriately rewarded throughout the implementation of the *Primary Health Care Strategy* and introduction of Primary Health Organisations?
2. How can the primary care workforce be supported to adapt to the new models of care required by Primary Health Organisations?
3. Should all District Health Boards [purchasing agencies] and Primary Health Organisations be required to have a workforce development strategy, specific to their own context?
4. What role is there for allied health professionals in Primary Health Organisations?

1.1. Aims of the study

There are very few up-to-date data concerning primary care staffing arrangements. The purpose of this study is to carry out a detailed examination of the composition and characteristics of primary care teams in community-governed non-profit practices and compare them with more traditional primary care organisations, with the aim of drawing conclusions about the capacity of the different structures to carry out population-based primary care. The study used data from a representative national cross-sectional survey of primary care practitioners in New Zealand.

The discussion section examines the policy implications of the findings as they apply to the