Health reforms: a New Zealand perspective

The Health Reforms in New Zealand are underway, but not all are happy with the direction that they are taking. In this editorial, we focus on comparisons between the New Zealand and the UK reforms. There are some general lessons that have relevance for health reforms internationally.

In early 1991, the New Zealand Government, with a conservative party in power, decided to reform the way health care was delivered. Cabinet formed a Health Service Taskforce which produced a Green and White Paper entitled *Your Health and the Public Health* in July 1991.[1] The Government objectives for the health reforms were to obtain fairer distribution of health care, greater responsiveness to patients' needs, more efficiency, a cap on open-ended financing of primary care, and greater integration of primary and secondary care. These objectives would be achieved by creating a funder–provider split and by setting up four regional health authorities (RHAs), each responsible for purchasing all health and social care for a population of approximately 800 000. The scope for the purchaser is much greater than in the UK, with the RHAs able to purchase all social care for the elderly, physically disabled and those with learning disabilities, providing an opportunity to switch resources between health and social care according to local need.

Contracts would be legally binding to ensure open accountability for purchasers and providers. Health expenditure would be capped and financial risk transferred to the providers, including general practitioners, who would become budget holders. Public health services would be purchased and monitored by a new Public Health Commission. Hospital care would become more efficient and be better managed through the new Crown Health Enterprises, which would operate on a competitive commercial basis, with a projected return to their shareholder, the Crown. A National Advisory Committee on Core Health Services (now known as the National Health Committee) would be established to advise the Minister on the core personal health services that should be available to all New Zealanders. Targeted assistance to those in low income groups and to high users of health services would be provided.

The reforms were implemented in 1993 in the absence of the necessary information systems to facilitate contract mechanisms. Specifications are still not as sophisticated as in the UK: price does not equal cost.[2] In order to facilitate more effective contracting and risk sharing, general practitioners have formed Independent Practitioner Associations (IPAs) which contain 30–40 doctors on average, but range from 10 to 300 members in size. These IPAs contract on behalf of the group with the RHAs for the delivery of primary care services, including general medical services, maternity services and immunizations. A fee-for-service system still operates for that part of the payment not covered by the RHA contract. The RHAs plan to shift to capitation payments within the next 2 years.

Independent Practitioner Associations have taken non-riskholding budget holding contracts for prescribing, and in some instances, for laboratory services. One significant difference from the UK is that savings made in prescribing are split between the RHAs and the IPAs, both of which are required to spend those savings on patient services for patients in that area. Ethical agreement has been reached that no personal benefit to the general practitioner or practice shall result from non-riskholding contracts. The debate has not yet taken place on the use of savings where risk is taken: many believe that profits should rest with those who have borne the risk of loss.

Government is currently considering the concept of managed care, defined by the Ministry of Health as, 'giving an organisation responsibility for ensuring that a given population receives a defined set of services in a co-ordinated fashion.'[3] If this form of managed care proceeds, then it is likely that IPAs will not only budget-hold for general medical services, prescribing and laboratory services, but also for district nursing, and like UK fundholders, some secondary care services. It is anticipated that this should lead to an improvement in coordination of care across the primary–secondary interface.

Historical funding issues mean that equitable distribution of funding between the RHAs on a population basis has yet to be achieved, leaving some RHAs currently underfunded. Soon after the commencement of the reforms, it became apparent that the hospitals had been chronically underfunded and that necessary maintenance had been deferred. Despite a significant injection of funds (NZ$1.2 billion since 1993), there is still a shortfall. As in the UK, waiting lists for hospital care have become a major political issue. Poor management or underfunding has led to a number of hospitals exhausting their budgets before the end of their financial year. This has created further delays in elective procedures, and currently, waiting lists for surgical procedures in come areas of the country have increased by more than 50%.

In common with the UK, guideline development and implementation is becoming more widely accepted. In 1992, the predecessor of the National Health Committee, the National Advisory Committee on Core Health Services, embarked on an ambitious project to define the core services that should be available to all New Zealanders as a right. The task proved too great a challenge and has now been redefined along the lines of promoting evidence based clinical practice: 'The Committee advocates the use of evidence based guidelines as the means of describing the circumstances in which services will be publicly funded.... There is growing acceptance of the importance of the evidence based approach to health and disability services.... We will continue to press for the systematic evaluation of services expressed in guidelines or statements of best practice.'[4]

In contrast to the UK, where there has been funding for the reforms, there has been little contribution by the New Zealand Government to the costs of reforms, particularly in primary care. General practitioners have personally borne the costs of administrative restructuring to meet the requirements of the reforms. Not surprisingly, there is inadequate investment in the management of IPAs, and to date, 50% of general practitioners have still not agreed contracts with their RHAs.

There is a clear need to develop general practice with increased practice support together with training in practice management skills, but how will this be funded? There is no equivalent in New Zealand of the FHSA/DHA function of facilitating practice development; for example, through the MAAGs, support for team building, skill-mix reviews and management training. The concept of quality in the delivery of primary health care is poorly understood by health managers whose focus remains on the Crown Health Enterprises (hospitals). Primary care could be forgiven for thinking that the notion of primary-care-led reforms has long been forgotten. Regional health authorities could usefully consider their role as one of developing a long-term secure relationship with providers, facilitating an environment to develop and improve health services overall.

Dixon and Glennerster[5] recently drew attention to the need for

more research into the National Health Service reforms, including the effect of fundholding on transaction costs, equity and quality of care (particularly for patients of non-fundholding general practitioners). To some extent, fundholding has curbed the upward trend in prescribing costs and has given general practitioners leverage in improving access to hospital services for their patients. So far, there appears to be no evidence that fundholding has improved the quality of secondary care.

In New Zealand, there are concerns about the dominance of the hospitals and the lack of any real credence being given to the notion of primary-care-led reforms. In both countries, underfunding of both primary and secondary care means that the achievement of many of the goals of the reforms will be slow. Perverse incentives driven by the purchaser–provider split exist in both systems and need to be fully understood and their impact quantified.[6] Cost containment is a key theme and little attention has been given to the quality of care delivered so far.

There is a clear need to evaluate the effects of the reforms in both countries. It is imperative that governments commit substantial funding to research the changes being brought about by the health reforms. Potentially, there could be much to learn from research comparing the performance of the two similar but different systems.

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Some dilemmas in managing gynaecological infections

Asking patients for their views on what their symptoms mean, and on what they would like done about them, can resolve as many difficulties in the individual consultations[1] as it can be useful as a research question. In this month's *Journal,* O'Dowd and colleagues provide an example of this usefulness in their report on women's experiences of the management of vaginal symptoms.[2] Nearly 90% of the women either believed their symptoms to be sexually transmitted or suspected that they might be. Partners developed symptoms in a quarter of the cases. One-third of the women had bought over-the-counter (OTC) medicines. Whether or not a vaginal examination was performed was not influenced by the gender of the doctor, a finding similar to that reported by Coulter *et al* in their study of menorrhagia, when men and women general practitioners managed the condition similarly.[3]

O'Dowd *et al* report a high level of recurrence of symptoms, with 85% of women having previous episodes of vaginitis, and one-third reporting three or more attacks in the past year. Out of the patients with previous episodes, two-thirds said they consulted the doctor with every recurrence. As the authors comment, the study methodology may have led to the selection of a sub-group of patients: those who have both recurrent symptoms and a belief in the benefit of a medical approach. This is relevant when analysing the study's suggestion that an appropriate clinical standard would be for every patient with vaginal symptoms to receive the offer of a vaginal examination in a practice equipped with the knowledge and skills to diagnose and manage vaginal infections, since this suggestion may then be best applied to those patients who have recurrent symptoms.

This recommendation from O'Dowd *et al's* study also raises a number of issues common to many other clinical conditions managed in general practice. These issues include the need for improved predictive information on symptoms and signs to enable general practitioners to identify more quickly those patients with serious disease from those with minor self-limiting conditions, net-working with secondary care services on medical advances and developing a strategy for managing the workload and time implications as the clinical direction of primary care evolves.

Approximately 5% of women present to their general practitioner every year with a new problem associated with a gynaecological infection or related symptoms.[4] A small number of these women will have a potentially serious infection, such as *Chlamydia trachomatis,* which requires investigation and treatment. Others will have minor, self-limiting conditions best managed by advice and OTC preparations. As always, the general practitioner's dilemma is in deciding which patient falls into which category. A recent review of chlamydial infection in general practice recommended that chlamydia testing should be offered to women requesting a termination of pregnancy and to those who have the following risk factors: less than 25 years of age; absence of barrier contraceptions; a recent change of sexual partner; vaginal discharge; or sterile pyuria.[5] But how accurate are these risk factors in primary care? If we restrict investigation to these patients, how many with serious disease will we miss? And are we going to over-investigate those women presenting with vaginal symptoms who have a fungal infection, especially if thrush is the gynaecological equivalent of the viral URTI? The best way to answer these questions is with a coordinated programme of research in a number of practice populations, giving general practitioners regular, updated information on the changing prevalences of gynaecological infections, and the predictive value of symptoms and signs.

Communication between primary care and genito-urinary medicine clinics is limited. Because of the position taken by genito-urinary medicine clinics on patient confidentiality, general practitioners rarely receive out-patient letters detailing the investigation and management of their patients. This removes a useful source