

Development of primary health organizations in new zealand



Body

The delivery of healthcare services to the people in every nation had always been a problem for the government considering there are a lot of factors affecting its delivery. New Zealand is an example of a government which delivers healthcare to its citizens and permanent residents through public subsidies and private insurance. Even with the help of private insurance, there still exist a number of problems faced by the government.

These problems revolve in the availability and accessibility of healthcare services. New Zealand has its concerns and these barriers to healthcare can be categorized into four: economic barriers, utilisation and socio-economic status, interplay of material, cultural and geographic factors, and the implications for the wider health system (Barnett R. and Barnett P. 2003). All of these factors have had an implication in the shaping of the national healthcare policy.

The social and economic inequality within New Zealand has widen substantially, thus new initiatives have been made to address such problems. The government has learned its lessons from the previous health system and is now undergoing constant changes and improvements. The policy formulated is now more focused on cooperative over competitive models of service provision and giving emphasis on the delivery of primary care as the key in achieving its goal of health for all and as a sign of overall improvement in the health system (Barnett R. and Barnett P. 2003).

Ref: Barnett, R., Barnett, P. (April 3, 2003) . *Primary Health Care in New Zealand: Problems and Policy Approaches* . Retrieved from <https://www.msdsd.com/development-of-primary-health-organizations-in-new-zealand/>

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Evidence of New Zealand's attempts to develop better equitable policies was the implementation of New Zealand Health Strategy and Primary Health Care Strategy (Minister of Health, 2001). The former had anticipated new arrangements and have chosen district health boards (DHBs) to implement these new policies. Within the charter of DHBs is the Primary Health Care Strategy (more recent) that suggests new organisational structures. This newly proposed structure is known as primary health organisations (PHOs), to solve problems relating to accessibility and availability in the provision of healthcare services. Moreover, primary health organisations address the lack of co-ordination between health providers. Although the district health boards (DHBs) are well established and setting up of Primary health organisations is going well, there still lies uncertainty about achieving equity in the provision of health (Barnett R. and Barnett P. 2003).

Economic Barriers to Primary Health Care in New Zealand

Just like in many other developed countries, the economic restructuring in New Zealand and the abolishment welfare state had led to the increase incidence of poverty (Waldegrave et al. 1995, Jamieson 1998) and socio-economic disparities in health (Ministry of Health, 2000).

In the beginning with the legislation of Social Security in 1938, medical services have been provided as free of service to the people through

government subsidies. However, it is also true that the subsidies did not <https://assignbuster.com/development-of-primary-health-organizations-in-new-zealand/>

cover 100% of the total cost of patient care. At first the effect to the masses was minor during 1970s where there is “ long boom” of prosperity in New Zealand. Then again, in 1980 the utilisation of the GP and other health services from the ethnic groups, including the positive class are diminishing due to the economic restructuring and growing cost of doctor fees (Gribben 1992, Barnett and Kearns 1996).

Utilisation and Socio-Economic Status

The utilisation of health services according to socio-economic status is mixed in New Zealand. A recent survey from the National Health Survey 1996/97 (Ministry of Health 1999) reports that people with low-income status are more likely to have a higher frequency of visits to General Practitioner than families from a more affluent areas or people with a higher income.

However, the results from the survey shows that people living in a less well-off area have a late seeking behaviour and less visits to GPs because of cost.

Key results from the survey are as follows:

1. People had continued to express their dissatisfaction towards the cost of GP fees. The percentage of patients who considered the GPs fee expensive as “ too high” or “ far too high” rose from 32. 3% to 68. 3% from people paying \$10 - \$14 and \$15 - \$19 and some rose to 90% from people paying \$25 or more (Fergusson et al. 1989).
2. Patients with financial difficulties in obtaining health services opt to have a number of strategies, both active and passive, such as; late seeking behaviour of care, delay in obtaining medication and seeking financial help from GPs (Barnett R. and Barnett P. 2003).

3. Patients frequently change their doctors even when they don't want to.
4. The introduction of Community Service Card (CSC) in 1992 is relatively ineffective in accessing the health provision of care. There is a high level of unmet need among CSC population. The reason for a rising unmet needs among the population group was partly due to low usage by those entitled and the stigma attached to it (Barnett R. and Barnett P. 2003).

Interplay of Material, Cultural and Geographic Factors

Low utilisation of health services in relation to health needs cannot be attached to cost alone. According to Barnett et al. (2003) it is also because of the interplay of factors; material, cultural and geographic factors. It was proved in a survey that Māori and low-income New Zealanders have a low rate of GP utilisation given that the centres were set up to provide service in a low-income population. The health centres were there to improve access to care to Māori and low-income populace. The cost for the provision of service was reduced as compared to the average cost. It was clear in the survey that financial barrier was not the reason but rather cultural values and expectations as well as the benefits from the services rendered (Barnett R. and Barnett P. 2003).

It is also important to consider the geographic factors in understanding the levels of GP utilisation. There is a strong relationship between distance and patterns of use in both hospital and GP services; it is also not surprising that there is a sub pattern to it. People with poorer population have a 30% less expenditure or budget in health as compared to the well-off population with

40% over funding as computed by the Health Funding Authority (Malcolm 1998b). It shows that the basing on the budget in each region, the number of GP available is also dependent on the budget, thus with low budget comes less number of available GP and health centres while areas with higher budget comes a larger number of GPs available (Barnett R. and Barnett P. 2003).

Implications for the wider health system

New Zealand research had been focused on the different patterns in GP and hospitalisation utilisation. However, there is also another reason that can be attributed to the low health status among low-income population in the access of health care services. There is a relationship between patient admission and average length of hospital stay. Reducing the average length of stay contributes in the increased rate of readmissions within the poor (Barnett R. and Barnett P. 2003).

One factor that might have an effect in the rate of readmissions among the poor is that the access to primary care is prevented by circumstances such as distance, cost and availability of the service itself. It is said that the importance of primary care is great in reducing or limiting hospitalisation (Barnett R. and Barnett P. 2003).

Primary Health Organisation Model

To address the problems New Zealand has in the delivery of health care and to provide equity to all, new initiatives were created. The development of primary care organisations (PHOs) created new frameworks for health

service delivery and an avenue for change. Not only it involves the general practitioner and the community but it includes a wide variety of health providers to achieve the goal of giving equity in the access of health care provision. PHOs are a broad based organisation comprised of many primary care providers. These providers include midwives, iwi groups, and non-government organisations aside from General Practitioners. The new system is locally based, funds were computed through the affected population and PHOs are given an important role in formulating new public health initiatives. Partnership with Māori and with Pacific communities is expected and where if needed, Ethnic group representation in the governance is allowed (Barnett R. and Barnett P. 2003).

Potential Benefits of PHOs

Upon the development of Primary Health Organisations, there are three potentials benefits that can be gained. One would be the likelihood of improving the population health is higher as compared to before, the rate of hospital admission will decrease and an empowerment to both the health providers and the consumer. Although after the introduction of capitation, in itself, is not an assurance of an improved population health and access to health. However, there are evidence claiming that a country with strong primary health care and a fewer barriers to healthcare accessibility have a better health outcomes (Barnett R. and Barnett P. 2003).

A better primary health care have another advantage of potentially reducing the rate of admissions in hospitals. It is an important factor in determining health outcomes in New Zealand, given the case that it has a high rate of

hospital admissions. With higher rate of admissions means higher hospital expenditure for the government. Although, there is no clear relationship between access to primary care and hospital admissions, there exist evidence that shows a reduction in healthcare cost reduces Ambulatory care sensitive (ACS) admissions just like in the United States. Some studies in New Zealand back it up with data showing after the removal of patient charges for consultation; a significant decline in hospitalisation was seen (Barnett R. and Barnett P. 2003).

Lastly, with the development of primary health organisations with a greater emphasis in community will have the potential in increasing social empowerment in the poorer and disadvantage populations. This is important because cultural and economic barriers influence health seeking behaviour of an individual. Moreover, with the goal of fostering a broader links between health organisations, the potential of having a more holistic and social model of health is made. It has the possibility of not only improving the access to care but also other social conditions that foster inequalities in health (Barnett R. and Barnett P. 2003).

Conclusion

The development of the Primary Health Care Strategy and the recent move toward the development of PHOs in New Zealand has the potential to improve equity of access to care, reduce unnecessary hospitalisation and improve overall population health. It represents a fundamental shift in national primary health care policy away from an individual to a population focus (although this has been emerging among primary care organisations

for some time), and from fee-for-service to a funding approach stressing capitation with reduced co-payments, with inter-regional distribution of funds based on population need. The potential is for a fairer system of primary health care where services will be more freely available to those in need (Barnett R. and Barnett P. 2003).

However, improved equity of access may be difficult to achieve, given the problems and risks in developing PHOs. In New Zealand these include fragmentation of providers, inadequate attention to the regional sensitivity of allocation formulas, concern over the extent to which funding should be based on individuals or areas, and the extent to which full participation of both providers and the public is secured. Given the significant additional investment by the government, PHOs will need to demonstrate not only fairer access to primary care reductions in health inequalities, but also improvements in population health overall (Barnett R. and Barnett P. 2003).

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