The silent revolution

Recent developments in the organisation of general medical practice in New Zealand

By Tom Marshall

A revolution has occurred in primary health care and general practice in New Zealand over the past decade. This revolution has been possible because of the direction various governments have taken as they have sought to improve the health of New Zealanders by making structural changes to the nation's health care system. At the same time, there has been an acceptance by health care policy-makers that general practice and primary health care delivery are pivotal in an effective health care system. The revolution has taken place because general practitioners have accepted and risen to the challenge presented by these circumstances.

The vast majority of New Zealanders, however, remain unaware of what has been happening. It has been a "silent revolution", with very few people outside of the health sector aware of the scope and scale of the changes. This article sets out to describe this revolution. It will outline the background to the revolution and focus, in particular, on one part of it: the emergence and development of ProCare Health Ltd.

As New Zealand's relative wealth has declined since the 1960s, the nation has been exposed to an almost continuous environment of health sector reform. The process, bristling with acronyms, commenced with a White Paper[1] produced, but not implemented, during the term of Norman Kirk's government in 1974. The development and formation of area health boards (AHBs), with the introduction of appointed as well as elected board members in the governance process took place during Helen Clark's tenure as Minister of Health in 1988. Those structures were superseded when the National government established regional health authorities (RHAs) in 1993. Subsequently, RHAs were supplanted by the Transitional Health Authority (THA) and then the Health Funding Authority (HFA) during the term of the first coalition government. Characteristic of that period was the funder/provider split and corporatisation of public hospital structures, as advocated in the

[1] 1974, "A Health Service for New Zealanders", a White Paper prepared by the Department of Health.

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so-called Gibbs Report[2] to the previous Labour government. The public hospitals were renamed successively crown health enterprises (CHEs), then hospitals and health services (HHSs) at the behest of the first coalition government. Pari passu came the emergence of primary care organisations (PCOs), of which the greatest numbers were established by general practitioners and became known as independent practitioners' associations (IPAs).

The most recent turn of the wheel has seen the abolition of the HFA and the corporate structures of the public hospitals and the creation of a further series of organisations, the district health boards (DHBs). These are hybrid structures, being both funders and providers, with a supposed "Chinese wall" separating, if not splitting, those functions. In addition, governance has both election and appointment processes.

Confusion and controversy have been continuous accompaniments of this saga as successive governments, with and without the assistance of supporting evidence, have sought to create some sort of nirvana: the perfect health care delivery system.

Medical practitioners in general, but GPs in particular have had an ongoing conflict with governments of various hues since the introduction of social security in 1943. But, by 1990, it had become apparent to some leading GPs that an alteration in the relationship between the leaders of organised medicine and the government might be beneficial to both parties. Senior GPs within the New Zealand Medical Association (NZMA) commenced discussions with Professor Alastair MacCormick, then Dean of The University of Auckland Business School, with the intention of obtaining advice as to appropriate business structures that could strengthen general practice.

The relationship established between the general practitioner section of the NZMA, the now defunct New Zealand General Practitioners' Association (NZGPA), and the School was well placed to take advantage of the opportunities presented with the publication of the "Green and White Paper" by Simon Upton, then Minister of Health. That document, officially entitled "Your Health & the Public Health, a Statement of Government Health Policy"[3], placed emphasis on the role of primary care in a rational health system.

The NZGPA established a working party comprising members of the association's executive, representatives of the New Zealand Nurses' Association, specialist doctors, plus commercial and legal experts. The working party met with Professor MacCormick to explore the possibilities offered in response to the original enquiry and, in addition, the potentialities within the changed political environment.

Professor MacCormick, during a visit to the United States, serendipitously came upon a structure within the Health Maintenance Organisation (HMO) model known as independent practice associations (IPAs). The American structures were groups of doctors who had united to contract with insurers and other funders of health care. On his return to New Zealand, it quickly became apparent to Professor MacCormick that within the US model there was a nidus that could be developed to suit the requirements of general practitioners and the evolving structures of the latest version of health sector structural reforms. What had now become clear was a need for a mechanism that could provide a link between the commercial imperatives of providing health care within a finite expenditure limit and the professional aspirations and objectives of GPs operating within their own private businesses or, in the case of a small minority, within private businesses owned by others.

Work that would determine the initial structures of IPAs in New Zealand then accelerated. The NZGPA, working in association with Professor MacCormick and his team at the Business School, produced a proposal for the body established within the Prime Minister's Department, the Health Reform Directorate (HRD), that would enable the

[2] 1988, Gibbs, A., Fraser, D., Scott, P.J. "Unshackling the Hospitals – Report of the Hospital & Related Services Taskforce".

[3] 1991, Upton S. "Your Health & the Public Health, a Statement of Government Health Policy", by Health Minister Simon Upton.

development of a New Zealand model of IPAs[4].

IPAs (following the US nomenclature, referred to at that time as independent practice associations, a description that later underwent mutation to independent practitioner associations) had been mentioned in 1986 as a possible vehicle for general practice reform in "Choices for Health Care"[5]. This publication was the report of the Health Benefits Review that had been commissioned by then Health Minister Michael Bassett and carried out by a committee chaired by Claudia Scott. The committee did not regard the structures mentioned with great favour and the NZMA was no more enthusiastic in its discussion paper, "Primary Health Care Alternatives"[6], published in 1987. The NZMA paper was written in response to the government's review and because the association "has viewed with increasing consternation for many years the decline in funding for primary medical care".

A model was formulated and was presented as a report to the HRD and the NZGPA. Included in the model was an assumption that principles established by the NZGPA that should be prerequisites to contractual arrangements between GPs and the state would be adhered to. These principles were and are:

1. that general practitioner services should be accessible to all New Zealanders;
2. that the right of patients to choose their own doctor should be maintained;
3. that the quality of general practice should be preserved;
4. that the independence of general practice should be preserved;
5. that the competitive fee for service should remain as a choice in GP remuneration.[7]

Armed with these principles, many groups of GPs acted quickly on the report. Embryonic IPAs were established by early in 1993 and many had commenced negotiations with the RHAs to prepare contracts for the provision of the primary health care services the RHAs wished to purchase from GPs.

STRUCTURE OF PROCARE HEALTH LTD

In Auckland, along with others, a group that would become known as ProCare Health Ltd (ProCare) was formed with 350 GPs as shareholders. The actual ownership structure was complex because the Northern Regional Health Authority (NRHA), fearful, one assumes, of the strength of such a large body of GPs, stipulated during negotiations that it would not execute a contract with any group of GPs numbering more than 200. The GPs finally accepted this as an irrevocable decision of the NRHA and established three IPAs as separate companies, each with less than 200 shareholders. In April 1995, each executed identical contracts, or purchase agreements, with the NRHA. The three companies then immediately founded and became shareholders in ProCare and contracted with it, so that ProCare would perform all of the functions required under the shareholders' purchase agreements. The NRHA, surprisingly, expressed no opposition to this arrangement and its obvious subterfuge.

From such uncertain beginnings, ProCare has grown to be a forceful and significant factor in healthcare delivery in the Auckland region, along with four other smaller regional IPAs with similar agreements with the NRHA. One of those four, South-Med Ltd, merged with the ProCare group at the end of 2001. ProCare Health Ltd now has four shareholders – ProCare North & West Ltd, ProCare

[4] 1992, MacCormick A., Hansen S., Ansley, C.J., Diaz, J., Powell, M., Sharp, B. "Independent Practice Associations in New Zealand: Policy Issues", report to the HRD and NZGPA by Auckland UniServices Ltd, June.

[5] 1986, Scott, C., Fougere, G., Marwick, J. "Choices for Health Care", report of the Health Benefits Review (page 95).

[6] 1987, "Primary Health Care Alternatives", an NZMA discussion paper.

[7] 1990, NZGPA.

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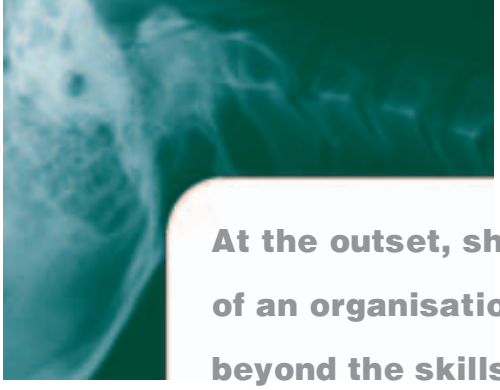


At the outset, shareholders realised that governance of an organisation with these undertakings was beyond the skills of even the best-motivated GPs

Central Ltd, ProCare South Ltd and ProCare South-Med Ltd – with 385 GP members.

The initial contractual obligations included information collection that demanded computerisation of a sceptical workforce, management of GPs' pharmaceutical prescribing and diagnostic laboratory testing budgets in the order of $100,000,000 a year, and management of certain quality targets. At the outset, shareholders realised that governance of an organisation with these undertakings was beyond the skills of even the best-motivated GPs and that outside directors with recognised business experience and acumen were required.

A board of eight was formed, five of whom were doctors and elected by the shareholders. Three directors with recognised business experience and acumen were appointed by the elected directors.

The board's first task was to determine how a diverse group of GPs could be persuaded to make dramatic changes in the way in which they conducted their businesses. This was against a background of a requirement to develop an accountability to the government (via the NRHA) for the services they provided for their patients that were partially funded by the government, while also providing services to those patients who received no state funding.

It was decided that the GPs would be divided into cell groups. Accordingly, the GPs, who by now were referred to as members, were asked to form groups with their associates and neighbours that would number 15-20 members. These cell groups would meet regularly and have the opportunity to influence ProCare policy and implement activities that would develop. Monthly meetings were agreed to.

The title of cell group was chosen for its biological connotations, as the groups were seen as the fundamental structures that would permit achievement of the obligations determined by the purchase agreements. The totalitarian connotations of the term were ignored by the board, but did not escape the attention of members!

Subsequently, expert advisory committees of the board were established that report directly to the board with policy recommendations and provide an avenue for stakeholder participation in the company. These committees each have a charter that determines their appointments, role and scope of activities.

The first committees formed were the Pharmaceutical and Quality Committees, because the purchase agreements envisaged that ProCare's (and other IPAs') principal source of income would be derived from pharmaceutical and diagnostic laboratory test ordering budget management. The plan was that budgets based on the historical prescribing and test ordering patterns of ProCare members would be set. If ProCare members' activities then resulted in expenditure that was under budget, ProCare and the NRHA would share the savings generated, in the proportion of 50:50.

To achieve these targets and to provide assurances to the principal stakeholders, i.e. customers (patients) and suppliers (GPs), the committees were charged with ensuring that shortcuts in prescribing did not occur and high-quality medical standards were maintained.

The Pharmaceutical Committee's membership has comprised an academic pharmacologist, community pharmacists and GPs as representatives of the shareholders. The Quality Committee's membership has comprised representatives from Maori, The University of Auckland Medical School, the Royal New Zealand College of General Practitioners, the community and GPs as representatives of the shareholders.

Following the establishment of these two committees, advisory committees with similar external stakeholder and ProCare membership have been formed as Privacy, Practice Nurse, Maori Advisory and Pacific Advisory Committees. There are also more traditional board committees, viz. Audit Committee and Contracts Committee.

The relationship of the GP members, shareholding IPAs and the advisory committees to ProCare and details of the company's current

activities can be found in the latest annual report[8].

BUDGET MANAGEMENT

Budget management has been a successful activity and during the period 1995 to financial year end 2002, ProCare has delivered in excess $30,000,000 of savings against the pharmaceutical budgets of the funding authority in its various transmogrifications. ProCare has received contractually determined portions of this money and those sums may only be applied to developing, delivering and ensuring the quality of additional health care services to ProCare's patients. This requirement has been established by the ethical needs of members and is defined in the various iterations of the purchase agreements between ProCare and the funders.

The process has not been without controversy and ProCare was involved, in 1998, in a lengthy, acrimonious and expensive arbitration with the HFA. The arbitrator was Sir David Tompkins, then a recently retired High Court judge, but the matter was finally settled by negotiation.

The underlying difficulty that led to that dispute was a difficulty in setting budgets and was compounded by, among other factors, inadequacies in the funder's information systems and data. These difficulties are not completely eradicated to date.

ProCare's success in budget management is due to the successful participation of its members in a collaborative programme that has evolved during the life of the company. Guidelines for prescribing have been developed that are evidence-based and reflect the prescribing preferences of the members. The process of guideline development is:

1. evidence-based draft guideline produced by the Pharmaceutical Committee;
2. reviewed by cell groups and possibly modified;
3. proposed modifications considered by the Pharmaceutical Committee;
4. revised guideline considered by selected cell groups and possibly modified;
5. final draft of guideline referred back to Pharmaceutical Committee for consideration and ratification;
6. guideline published and adopted, on a voluntary basis linked to patients' requirements and clinical situations, by members;
7. guideline reviewed annually or as required by changes in best practice.

[8] 2002, ProCare Health Ltd, annual report, 2001-2002.

SAVINGS FUNDS PROJECTS

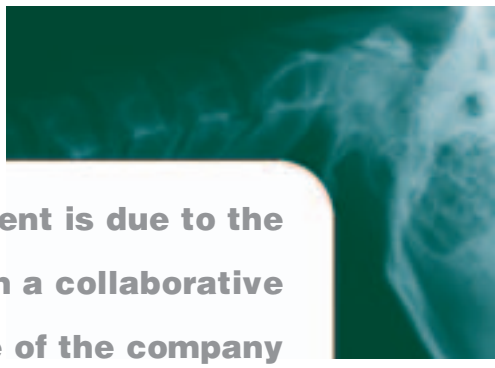
The funds accumulated from budget management activities have been utilised to deliver health services to patients who consult ProCare members and their practice teams. These savings funds projects include:

U22 Sexual and Reproductive Health

This programme enables ProCare members to provide sexual and reproductive health services, including contraception, to patients under the age of 22 years at no cost to the patients. This age group was chosen as a cohort especially at risk and less likely than others to consult GPs. The programme has been most successful and a particularly pleasing feature of it has been that the proportion (22 per cent) of Maori patients using the service exceeds the proportion of Maori in the general population.

Ultrasound Examinations

This project enabled ProCare members to purchase private-practice ultrasound examinations, in the Waitemata health district, for patients who were unable to obtain public hospital services within a realistic timeframe and would not usually



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have been able to afford a private examination.

Pacific Island Consultation Skills

ProCare members have been introduced to, or made more familiar with, Pacific languages and culture in this programme that has the objective of improving the acceptability of mainstream GP services, as provided by ProCare, to Pacific peoples. It has been modelled on earlier courses conducted by ProCare to improve Maori consultation skills. The impetus to conduct these activities was derived from a market survey conducted among a random selection of ProCare registered patients that indicated preferences of Maori in GP consultations.

Prompt Cardiovascular Risk Assessment (CVRA)

Prompt is an innovative web-based programme that, by collection of clinical data, enables CVRA, makes management recommendations and generates epidemiological information. The programme has been developed by Professor Rod Jackson, of the Department of Community Health at The University of Auckland's Medical School, and his colleagues (including cardiologists and ProCare GPs), with the support of the National Heart Foundation and Enigma Publishing Ltd (architects of online knowledge management mechanisms)[9]. ProCare practices that have high-speed internet connectivity, with appropriate security and available under an attractive bulk-purchasing arrangement, are the first practices in the country to implement the programme, as a result of the availability of savings funds.

Terminal Care

The costs of visits by ProCare members to terminally ill patients are subsidised. Inhibitions to home visits are reduced in this manner.

Smoking Cessation

An evidence-based smoking cessation programme that subsidises support, including counselling and pharmacotherapy. It is provided by ProCare GPs who have completed appropriate training and is showing promising abstinence rates by international standards.

Minor Surgery

Almost 50 per cent of ProCare GPs have completed additional training in minor surgery and are providing heavily subsidised or free minor surgical procedures.

Primary Options for Acute Care (POAC)

This is a programme based on a successful intervention developed by the Pegasus Medical Group, another leading IPA located in Christchurch, to manage acute demand for hospital admission management. The Pegasus group has supported and assisted the implementation of this programme in association with other Auckland IPAs and all three of the Auckland region DHBs. The first DHB involved was the Counties-Manukau DHB (CMDHB) and in that district over a two-year period the growth in demand for acute admissions, which was running at nine per cent a year, is now between zero and two per cent, according to the ProCare manager who is responsible for the programme[10]. In the CMDHB, POAC is complemented by a chronic disease management programme that enhances the effect of POAC activities and contributes significantly to the excellent results obtained. The beneficial effect on hospital costs is such that CMDHB is now funding both programmes entirely and ProCare savings funds, which initiated the activity, no longer contribute.

Engage – Mental Health

Mental health consultations are subsidised, from savings funds, and there is access to private community-based mental health services in a preferred-provider arrangement. The objective of this programme is to improve access to and increase utilisation of primary health care services by the mentally ill.

ProExcellence

High-quality health care service provision has been an aspiration of IPAs from the outset and the

[9] 2002, Jackson, R. (personal communication).

[10] 2003, Roseman, P. (personal communication).

concept is embodied in NZGPA principles[11]. ProExcellence is a programme being implemented throughout ProCare practices and is a systematic approach to continuous quality improvement. ProCare has ISO9001 accreditation and ProExcellence facilitates attainment of quality accreditation by ProCare practices.

INTEGRATED CARE PROJECTS

In addition to these services that complement traditional general practice and have been funded by savings, a number of projects that integrate primary and secondary services have been provided under contractual arrangements with, successively, CHEs, HHSs and now DHBs. These Integrated Care Projects include:

Integration Task Force (ITF)

The ITF was established in 1995 as a joint venture funded equally by ProCare and the Auckland CHE to identify areas of service provision that would lend themselves to integration of primary and secondary services. The ITF's role is to ensure that projects are adequately constructed and funded, but not to participate in the administration of the projects.

Paediatric Asthma Clinical Pathway

This programme, initiated by ProCare, was developed as an HFA integration pilot and involved a team of ProCare GPs and Starship Hospital paediatricians led by Professor Ed Mitchell. Community consultation through focus groups contributed to a robust tool being produced. Its adoption by ProCare GPs and Starship clinicians was accompanied by a 40 per cent fall in the admission rate of children with asthma at Starship.

Older Persons Care

This ITF project aims to maintain the independence of older people in their own homes and avoid institutional care by attention to medication compliance and integrating medical records.

Congestive Heart Failure (CHF)

This is a project that aims to improve the ambulatory care of patients with congestive heart failure. It enables members to review the diagnosis and management of this group of patients, provides access to hospital specialist advice and subsidises the costs to patients. The project was initially developed in the Auckland district where funding is shared by the ProCare savings fund and Auckland DHB (ADHB). It has also been implemented in Counties-Manukau and is fully funded by CMDHB in that district.

Chronic Obstructive Pulmonary Disease (COPD)

This project was initiated as a randomised controlled trial with the active arm of the trial receiving intensive case management of COPD patients and the control arm receiving standard general practice care. The trial was co-ordinated by Professor Harry Rea and Dr Peter Didsbury. The intervention being assessed was intensive case management of patients who had previously been admitted to Middlemore Hospital with exacerbations of COPD, by GPs and their teams with readily available secondary care support and consultation. The costs of such intensive care were funded by the project. The intervention was compared with standard subsidised or non-subsidised GP care funded by patients, who had similarly previously been admitted to Middlemore Hospital with exacerbations of COPD and were the control arm of the trial. The GP participants were members of IPAs, viz. ProCare, South-Med (which in 2002 merged with ProCare) and First Health, as well as the non-IPA PCOs Mangere Health Resources Trust and Raukura Hauora O te Tainui. The PCOs all contributed to the cost of the trial and, as well, major financial support was given by CMDHB. The trial demonstrated a 60 per cent reduction[12] in annual hospital days for COPD admissions in the active arm, but also a 40 per cent reduction in co-morbidity-related hospital days. The trial was regarded as being so successful that the intervention has been made available as a continuing service funded by CMDHB.

Dyspepsia Management

This programme initiated in the CMDHB involved the development of a guideline for the investigation and management of dyspepsia by ProCare GPs and gastroenterologists at Middlemore Hospital. Adoption and implementation of the guideline by ProCare GPs resulted in the reduction of the waiting list time for gastroscopy at Middlemore Hospital from six months to two weeks. The programme has since been adopted by ADHB and the initial benefits have been sustained in both districts.

[11] 1990, NZGPA.

[12] 2002, Rea, H.H., & Didsbury, P.B. Proceedings of CMDHB Integrated Care Conference.

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These examples of integration projects and projects funded from savings are part of and indicative of the changes in health care delivery that may very well be referred to as a revolution. The vast majority of New Zealanders remain unaware of them.

Primary health care and general practice have come a long way, especially in the past decade, and now further changes are imminent as the present government's reforms begin to take affect. Minister of Health Annette King has made reform of the primary health care sector an important component of her efforts to establish a milestone, or perhaps even a beacon, along the pathway to nirvana.

The government has determined that new units for delivery of primary health care should be established. These new structures, known as Primary Health Organisations (PHOs) have been described in the Primary Health Care Strategy[13]. This strategy lays out the government's vision and its wish to change "the health system and its structure to focus better on getting health results through understanding the factors that determine health and by influencing them positively". The Minister has given a timeframe of five to 10 years for the achievement of her vision.

[13] 2001, King, A., "The Primary Health Care Strategy", a statement of government health policy by Health Minister Annette King.

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PHOs will be the vehicles that will facilitate the changes she envisages. They will:

- be funded by DHBs for the provision of a set of essential primary care services to an enrolled population;
- include services that will be directed toward improving and maintaining the health of the population, as well as personal services to sick individuals;
- be expected to involve communities in governance and be responsive to communities' priorities and needs;
- be able to have all the providers and practitioners who are part of the organisations able to influence decision making, rather than one group being dominant;
- be not-for-profit.

The question that hangs over IPAs such as ProCare is whether the successful changes that have been implemented and the gains made as a consequence of the opportunities presented by the "Green and White Paper" and which are, to a large extent, the same aspirations and ideals as espoused by the Minister of Health's primary health care strategy, will be sustainable in the changed regulatory model. Will the gains achieved by IPAs in primary health care, mutatis mutandis, survive in the PHO environment?

Government's funding contribution to primary health care will be directed through PHOs and, as a consequence, IPAs will have to work with and within the new organisations. Their survival depends on successful achievement of this. Whether the transition delivers the hoped-for outcomes, only time will tell.

Mrs King's tilt at the quest for nirvana depends on the delivery of those outcomes. But nothing is assured and, as we are reminded in television advertising, the search for perfection is never straightforward[14].

[14] 1992, Perfect Girl, Lion Breweries-Speights Ale (Saatchi & Saatchi), television advertisement.