



## Australian Primary Health Care Research Institute

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### **A System-Eye View from an Australian Perspective: Reflections on the IPA Council (IPAC) of New Zealand Conference, Rotorua, 14-15 May 2004.**

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Held in gloriously sulphurous Rotorua in chilly May, the 2004 IPAC conference was entitled, most significantly, “Advancing the Primary Care Strategy”. Under this banner, there were six sessions, organised around these themes:

- Health outcomes
- Resource management
- Change management
- Teamwork
- Infrastructure
- Quality

There were two keynote addresses, one by David Colin-Thome<sup>1</sup> who reviewed the current health reforms in the NHS and one by Bonnie Sibbald<sup>2</sup> who looked at the international evidence on ‘non-physician clinicians’ and to the future of the skill mix in primary health care. In preparing this brief report, I have taken a systems-eye view from an Australian perspective of the main take-home messages that emerged over the two days.

#### **What a Difference a Strategy Makes**

Instructive from an Australian perspective is the existence in New Zealand of a Primary Health Care Strategy, which is underpinned by the New Zealand Health Strategy. The Primary Health Care Strategy is the blueprint for quite sweeping reforms to the primary health care system which are being implemented incrementally. Key elements of the Strategy are:

- devolution of health funds and expenditure to District Health Boards;
- the establishment of Primary Health Organisations (PHOs) which are regional coalitions of primary health care providers that are governed by boards that

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- include providers and community representatives and have quite prescriptive requirements with respect to community involvement; and
- voluntary registration or enrolment of consumers with PHO member organisations, primarily general practices, and Maori, Pacific and Union ('third sector') providers.

Conference activity highlighted how having a Strategy provides clarity of purpose, not only for policy and practice but also for research in primary health care. It also highlighted how, within a broad 'aspirational' framework, there is lots of room for local innovation and the development of local solutions to address local needs.

### **Cooperation between Government and General Practice**

So what was so significant about the conference title? It was a clear signal that IPAC<sup>3</sup> was supporting the government's *Primary Health Care Strategy*. In her opening remarks, Associate Health Minister Ruth Dyson acknowledged IPAC's willingness to engage with PHOs. General practitioners, IPAs and IPAC have been resistant to elements of the *Strategy's* implementation, so the level of support was quite remarkable. One got the sense that underneath there had been a huge amount of churning and debate to get to this point. Without ignoring this history, or pretending that there won't be future issues about which general practice and the government disagree, there was an energising sense of common purpose between the two that infected the meeting.

### **Health Disparities**

As with any contemporary health conference in New Zealand, it was interesting to see how much New Zealand's increasing bi-culturalism was reflected in the way the meeting was organised and conducted. More than that however, the issue of health disparities was clearly in the government's eye, as well as in the eyes of most others at the conference. The need to address the serious and apparently worsening health disparities between Maori and Pacific Islanders and other New Zealanders was not challenged. There were a couple of presentations however, that indicated that at the coalface in 'mainstream' general practice there is still some way to go before responsiveness to different sets of needs and approaches to service delivery are embedded in practice. It will be interesting to see what impact PHOs – through which general practices are joining forces with Maori and Pacific providers, and with Maori and Pacific community leaders in governance - will have on this over the next few years. That this was principally a general practice meeting no doubt explained the limited space given to 'third sector' providers to talk about what they are doing to address health disparities.

### **OGP**

Described in the conference welcome as 'yet another three letter abbreviation to the already crowded health lexicon', OGP stands for Organised General Practice. OGP was presented as being conceptually very important in the UK reforms and was promoted at the IPAC conference as the way of the future for primary health care in New Zealand. It was something of a unifying concept that energised the meeting and drew together important threads from all of the sessions.

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<sup>3</sup> The national representative body for Independent Practitioner Associations, known as IPAs.

Key elements of OGP are:

- responsibility for an enrolled population;
- a team-based approach to care;
- funding for outcomes; and
- appropriate management and IT support systems.

Based on what was presented and discussed at the conference, New Zealand OGP is up and running and has its sights set squarely on the future. There was evidence that general practice, as a key player in the primary health care sector, is taking a very business-like approach to regional resource management and alternative funding models; to data collection, collation and analysis and the IT systems needed to support this; to determining optimal configurations for primary health care teams; and to quality improvement and performance monitoring activities. In the theme entitled 'infrastructure', there was talk of the importance of aligning 'major assets' with 'strategic goals', and what constitutes good governance. There was clear acknowledgement that this all constitutes quite profound change for New Zealand general practice and that as a consequence, change management is an important consideration (exemplified by its inclusion as a theme in the conference program). It seems that BHAGs – Big Hairy Audacious Goals - are good for change management! There was also acknowledgement of the importance of inspirational leaders in bringing about change. And there was seemingly widespread support for 'bigger is better' when it came to practice size and what was possible with economies of scale.

There is no question that OGP will be a key player in New Zealand's primary health care sector, as it is in the UK. A risk though, is that OGP will be a way of pulling the PHO-based reform back into general practice rather than general practice better integrating itself with the broader aspects of primary health care including public health, community development and intersectoral collaboration.

Divisions of General Practice provide an infrastructure not dissimilar to IPAs through which OGP could develop in Australia. As in New Zealand though, there would need to be a blueprint so that the inevitable churning and debate that would have to take place had a clear purpose.

### **Global budgets**

Properly organised OGP extends old opportunities and creates new opportunities in New Zealand for global budgets. There was an air of optimism at the conference about the possibilities that flow from global budgets, characterised by one of the most prominent IPAs as allowing innovative, comprehensive and locally responsive primary health care. There was a paper that reported on the effectiveness of opportunities presented by global budgets to shift demand at the primary care-hospital interface. Opportunities within primary health care were also examined. Hokianga Health in the remote north has had a global budget for some years. It is a PHO that integrates general practice, community nursing, maternity services, the community hospital, dental services, mental health

services, home help, disability support and community development activities (eg its water quality project). However, how global budgets reflect 'need' and unmet need and how funding based on need gets to the individuals in need remain important issues. Notwithstanding this, the opportunities presented by global budgets certainly reinforce the need for different ways of thinking about how state and commonwealth expenditure could be regionally deployed in better ways in Australia.

### **Primary Health Care Teams**

Not surprisingly, the conference was oriented towards general practice, and the roles of nurses and other health providers were really only 'visible' through this lens. It was apparent that the longer history in New Zealand of nurse involvement in general practice has resulted in a greater level of taken-for-grantedness of future roles for them in OGP. Notwithstanding a paper which highlighted the involvement of nurses not only in clinical work, but also in IPA governance and management, it was unclear however, how much nursing roles are expected to expand nationally, and the extent to which nurses and nursing organisations are playing a role in shaping this future. It was argued that the notion of 'working together' rather than 'working alongside' has resulted in 'new and effective ways of providing care'. We heard from one general practice group in which there are equal numbers of GPs and nurses (60 of each). It was also argued that the expansion of the health promotion component of primary health (more possible with global budgets) would probably expand the roles for nurses in primary health care. Practices being funded to provide particular services also opens the way for local flexibility in the make-up of the teams to provide those services. The keynote address on skills mix set the imperatives for change in international context but highlighted both the mixed evidence and some of the costs and difficulties of changing professional roles.

### **Performance Assessment**

Against a backdrop of the first keynote address, which outlined the sweeping changes to performance monitoring being implemented in the UK through the Quality and Outcomes Framework, there were some interesting presentations on performance assessment activities in New Zealand. The presentations related to both organisational quality and clinical outcomes. These were set in context by one of the presenters as part of an international trend towards greater accountability in health services and an increasing emphasis on evidence-based approaches to care. Interestingly, HealthCare Aotearoa, the umbrella organisation for 'third sector' providers, has been pro-active in the area of organisational quality and now has a fully operational accreditation system for its members, that includes clinical, organisational and community participation indicators. We heard from an IPA that has embarked on an ambitious outcomes quality program, agreeing a slowly expanding list of targets and monitoring achievement against those targets in a consistent and coherent way across member practices. Such presentations were impressive in terms of their ability to demonstrate impact on health outcomes, much of this relying on good computerisation in general practices with relevant data extracted by the IPA. There seemed to be a fair degree of comfort with sharing data for various purposes, including comparison of outcomes at the practice level.

There was a very strong sense at the meeting that it was right and proper that performance should be monitored. Such a mood is clearly heavily reliant on provider perceptions that what is being monitored is rational and reasonable and that there are financial incentives for good performance (a key factor in the UK).

### **Summing Up**

Outwardly, the conference was characterised by an air of cooperation between government and general practice, high energy and optimism about the possibilities opened up by the current reforms and confidence within organised general practice of the opportunities these present and the role it will play in the future.

The cautionary tales that I heard were mostly about variation in local commitment to the reforms; continuing major health disparities that may or may not be adequately addressed; concerns that affordability and thus access to primary health care had still not been adequately addressed, despite significant rises in the levels of funding; the governance, management and IT hurdles still to be got over; whether PHOs will create a mechanism through which 'third sector' providers are dominated by general practices; and the extent to which general practice is prepared to be a true partner rather than a principal in New Zealand's primary health care future.

In thinking about the direction organisation, financing, delivery and performance assessment in primary health care might take in Australia there is clearly much to be learned from our neighbours across the Tasman.

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