

From the market to the Third Sector – what style for primary health organisations' accountability?

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Abstract

Primary health care delivered through General Practices (GPs) in New Zealand is funded through a unique mix of public and private sources (Kininmonth, 2005). It remains distinctly separate from the secondary health care system but, as in many countries, has recently been subject to reforms. New Zealand's *Primary Health Care Strategy* (Minister of Health, 2001) reflects a commitment to implementing the World Health Organisation's Alma Ata Declaration (1978) that primary health care should be the central focus of a nation's health system, be delivered equitably (by being universally available and accessible to all citizens) through multi-sectoral collaboration, as well as promoting health through community involvement.

From 1990-2000 New Zealand's health system followed market-based models popular in the United Kingdom and the Netherlands (Ashton, 1999). GP funding was almost evenly shared by patients/insurers and government, who part funded low-income patients' visits. During this period, GPs were also offered incentives to reduce diagnostic and pharmaceutical costs. A majority of GPs formed umbrella groups to manage and negotiate funding contracts.

In 2001, the government oriented away from market-based politics with the release of the *Primary Health Care Strategy*. Capitation based funding (an annual allowance based on the number of patients registered with a GP) and increased funding streams were made available to not-for-profit, or third sector, GP umbrella groups that formed as Primary Health Organisations (PHOs). It is widely believed that third sector organisations are flexible and innovative – attributes that government may have depended on in order to bring about a new focus in the primary health care system. In addition, government stated that by channelling funding through third sector organisations, they would ensure that public funds “would not be diverted into dividends” (Minister of Health, 2001; Nowland-Foreman, 1997).

The *Primary Health Care Strategy* requires PHOs to be responsive to their communities, have equal representation from health care providers and be fully and openly accountable for funding received as they improve communities' health outcomes. This suggests they need to move away from a purely contractual, hierarchical style of accountability between PHOs and their government funders alone, to a more holistic style of accountability that includes downwards accountability to communities and horizontal accountability to organisations working in the wider health sector (O'Dwyer & Unerman, 2006).

This paper provides an analysis of four case study PHOs established as third sector organisations. The providers in these case study PHOs had operated during the market-based period and subsequently formed as PHOs to take advantage of the new funding available from the reforms. These PHOs are now required to embrace new forms of accountability for primary health care concepts such as equity, health promotion and inter-sectoral collaboration.

This study found that three key attributes impacted the implementation and understanding of these accountability requirements. These were: the historical basis of the organisations, the stakeholders who were afforded priority by the organisation, and the funders' attitudes in respect of controlling and trust-enhancing contracts. These findings have wider application to third sector organisations in contracting relationships.