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The Stewardship Deficit in New Zealand Health Policymaking

This article reports on the findings of comparative research conducted in England and New Zealand to explore relative levels of autonomy and capacity for primary health care policymaking in the two countries between 2001 and 2007. England and New Zealand both introduced pay-for-performance schemes in their primary health care systems, with incentives for general practitioners to achieve improved population-based health outcomes. The purpose in both countries was to increase state influence over the quality and allocation of publicly funded primary health care delivered by the medical profession. Policy change was needed to increase preventive and population-based practice among general practitioners, and resolve increasingly visible problems of variation in the quality of, and access to, primary health care which were leading to substantial disparities in health outcomes for some citizens. The highly individualised and treatment-centred practice norms of the general practice profession meant that general practitioners, especially in New Zealand, 'had their strongest focus on

Introduction

The autonomy and capacity of a state to make and implement public policy (or to exercise its 'stewardship' functions) (WHO, 2000, p.122) is a fundamental characteristic of statehood. 'Autonomy' for a state is defined as 'the ability of government institutions to resist being captured by interest groups and to act fairly as an arbiter of social conflicts' (ibid.). 'Capacity' refers to the ability of government systems to make and implement policy and 'springs from the expertise, resources and coherence of the machinery of government' (Buse, Mays and Walt, 2007, p.81). Understanding the nature of autonomy and capacity in a particular state and how well that state is able to maintain or extend its autonomy or capacity to develop effective public policies is important because this enables states to strengthen these characteristics over time.

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patients who walked in the door ... [and] did not understand "disparity" in access to health services very well, feeling little responsibility for a population-based approach to health' (O'Malley, 2003). The pay-for-performance scheme in New Zealand was aimed at changing this model of practice.

Subsequent research (Smith, 2015) investigated how the 'stewardship' functions of each state were exercised in these pay-for-performance policymaking episodes, and the results are reported here. The research also identified how the different contexts within the health system in each country affected the state's policymaking autonomy and capacity, and which of the two countries was most successful in achieving the outcomes sought. This article also updates progress on the outcomes sought by policymakers, reporting research published in 2014 which rated the New Zealand health system poorly on variables of safe care, access and equity in comparison with England (Davis et al., 2014). This indicates that the steps taken between 2001 and 2007, although laying important foundations for achieving better outcomes, and for subsequent policymaking in New Zealand, have been considerably less successful than those taken in England. In 2016 the New Zealand Ministry of Health published a new health strategy which acknowledged that New Zealand's health system continues to face significant challenges in terms of access, equity and affordability (Minister of Health, 2016).

It is hoped that the findings reported here will assist New Zealand policymakers to monitor and develop their health policymaking autonomy or capacity, based on evidence about their current performance, and will enable policymakers to consider whether and how to change elements of this context to facilitate more effective policymaking in future. Recommendations for a process of stewardship-building within New Zealand's primary health care system are made.

Contextual structural and historical considerations for the two case studies

Both countries are Western majoritarian unitary democracies with strongly adversarial political systems and high levels of autonomy and authority for central government (Richards and Smith, 2002; Shaw and Eichbaum, 2008; Pollitt et al., 2010). They followed similar patterns of national health system establishment in the 1930s and 40s (Lovell-Smith, 1966; Hanson, 1980; Bolitho, 1984; Hay, 1989; Ham, 1992; Fougere, 1993; Tuohy, 1999; Klein, 2006). However, in New Zealand politicians failed to secure a single-payer arrangement for general practice services. The dispute over payment arrangements left a legacy of division and mistrust between general practice organisations and politicians. Later attempts at reform were vehemently resisted by the profession (Hay, 1989). However, both England and New Zealand undertook similar New Public Management-inspired reforms to introduce competitive and market-oriented approaches into their health systems in the 1990s, driven by concerns about escalating medical costs (Davis and Ashton, 2000; Pollitt and Bouckaert, 2011). In the literature on health system typologies, they are both assessed as being national health systems with comprehensive, universally available health services, largely publicly financed through taxation (Scott, 2001; Burau and Blank, 2006). Despite significant differences of ownership and financing within the general practice subsystem of each country, these shared features of their overarching health systems make them suitable for a most similar systems comparative case study method (Yin, 2009).

Policies to increase funder influence over general practice activities represented a challenge to the set of institutions which permit professional self-regulation and professional autonomy within medicine. They encroached upon doctors' highly valued professional independence (Immergut, 1990; Freidson, 2001; Burau and Vranbaek, 2008). Medical institutions 'organize and advance the discipline by controlling training, certification and practice on the one hand and by supporting and organising the creation and refinements of knowledge and skill on the other' (Freidson, 2001). Pay-for-performance is part of a set of 'managerial notions that efficiency is gained from minimizing discretion' (ibid., p.3) and was seen by some general practitioners as the standardisation and commodification of care based on targets set not by the profession but by the funder, and therefore inimical to these norms. However, others were more open to pay-for-performance approaches, and it was not a new idea in 2001. A small, voluntary pay-for-performance scheme within general practice was introduced in 1990 in England as part of an imposed contract with general practitioners (Klein, 2006). In New Zealand, a variety of pay-for-performance initiatives had been adopted by doctors' organisations themselves to assist them to fulfil contracts for improved use of pharmaceutical prescribing and referrals to other services. With the election of a new Labour government in New Zealand in 1999 and the re-election of the Labour government in 2001 in England, in both countries politicians decided, in a 'logic of escalation' (Pollitt et al., 2008), that those small pay-for-performance measures which had taken root in the 1990s would be scaled up for national implementation, and substantial sums of additional money provided for meeting clinical and organisational quality targets within general practice.

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Methods

A comparative case study methodology in a most similar systems design (Yin, 2009) was used, based on purposeful selection of the two case studies. The drivers of non-incremental policy change, including institutions, networks, ideas and socio-economic circumstances (John, 1998), were identified in each policymaking episode and comparatively. The two case studies showed outputs which differed in size, scope and speed of implementation and achieved differing levels of impact upon health outcomes.

The two case studies

England: the design of the Quality and Outcomes Framework

In England in 2000, the pay-for-performance programme was part of a new National Health Service plan (Secretary of State for Health, 2000) 'to introduce systems where the money spent was linked to performance and where the service user was in the driver's seat' (Blair, 2010). There was also a strong commitment to use the reforms to reduce health inequalities (Comptroller and Auditor General, 2010) by increasing the quality of care and introducing more preventive practices into primary care services. Both goals were in Labour Party manifestos and ministerial speeches during the election campaign in 2001. During that campaign, general practitioners, who were entirely dependent on state funding for their income, threatened to strike unless a new, improved contract was offered to them.

A large scheme, which included 146 targets and determined the level of over 30% of the new income of GPs, was jointly designed and negotiated by the government and BMA teams.

The primary research question considered is: in what respects and why did two similar episodes of policy formulation and implementation in two similar jurisdictions follow different processes and have different outcomes? A qualitative methodology, including documentary analysis and semi-structured interviews with 26 decision makers, leaders of and participants in the policymaking process, was used. The data was thematically analysed (Braun and Clarke, 2006), using an inductive approach, and written up as two case study narratives. These cases were then compared, including contextual, structural and historical considerations, to develop a set of similarities and differences. The process sought to 'locate some particular feature in which otherwise very similar nations differ [so that] we are entitled to suggest that it is attributable to one of the few other factors distinguishing them' (Castles, 1991). For this process, the dependent variable was the policy outcome and all other variables, including institutional and structural features, network and group structure, rational choice explanations, ideas and socio-economic factors, were explored as independent variables.

Once the Labour Party was elected the manifesto promises were immediately implemented. The health policy adviser to the prime minister described the reform process as 'constructive discomfort'. It would put some pressure on professional autonomy within the medical profession through a top-down imposition of standards and targets and by subjecting the profession to competition from other suppliers of medical services. In this reform programme, more money for general practitioners was conditional upon better performance: 'GPs' new contracts will allow them to earn around a third more, linked to markers of quality' (Stevens, 2004). The British Medical Association (BMA) represented all English GPs and was the sole bargaining agent on their behalf. BMA negotiators readily agreed that a pay-for-performance mechanism could form a major part of a new contract. However, they had little choice; it was hard for them to resist the strong expectations of the secretary of state for health that new money for general practitioners would be subject to pay-for-performance. A participant in the negotiations saw the secretary of state for health as insistent that 'there would be no pay rise for work already being done'. He had a 'bloody-minded determination for performance pay'.

Both parties then sought a large scheme. On the government side, it was believed that the success of early pay-for-performance schemes (Spooner, Chapple and Roland, 2000, 2001) had demonstrated the effectiveness of rewarding doctors for preventive practice, justifying a scheme with as many indicators as possible. For the BMA, the larger the scheme, the more money was available to its members. In addition, the pre-eminent role of the BMA in its relationship with government was at stake. The BMA feared, it was said, that if it could not broker a popular and lucrative national deal for its members, other forms of localised contracting would erode its sole bargaining rights for all GPs.

Medical professionals dominated the membership of the team which designed the pay-for-performance component of the new contract, the Quality and Outcomes Framework (QOF), constituting seven of 11 members. An academic team was recruited as interlocutors to consider evidence for suitable clinical targets for the scheme. Members of the different teams involved had known one another for a number of years in some cases. Almost all were practising GPs for at least a small part of their working week, even when the rest of the week was spent as a medico-politician or academic. A large scheme, which included 146 targets and determined the level of over 30% of the new income of GPs, was jointly designed and negotiated by the government and BMA teams.

The QOF could not be implemented without the design of a major new software application. A participant describes how, having designed an indicator, 'then we had to go on and work out how you would verify it' by extracting performance data from every general

practice. This presented significant practical problems. There were many different suppliers of computer systems for general practice; some practices were not yet computerised; and there were concerns about confidentiality of patient information. Yet this project was achieved in 26 weeks. A 'high trust' system for monitoring and reporting achievements against targets was introduced, along with a provision for independent audit, enabling general practices to monitor their progress and be funded for their achievements against the QOF. The scheme was implemented remarkably quickly by 99% of general practitioners. Within a year of its launch, performance against the targets was higher than expected and payments to general practices under the QOF exceeded budget allocations.

Evaluations of the success of this large pay-for-performance scheme have been mixed and widely reported (Comptroller and Auditor General, 2008; Doran and Roland, 2010). Several studies reported positive results, including a surge in morale and recruitment within the general practice profession, an initial acceleration in quality of treatment for a small number of chronic conditions, and reductions in variation in quality of care related to deprivation (Doran and Roland, 2010; McDonald et al., 2010; Roland and Campbell, 2014). A key study found that there were statistically significant associations between higher levels of achievement on QOF clinical indicators for coronary heart disease, hypertension, congestive heart failure, diabetes and chronic obstructive pulmonary disease and reductions in rates of ambulatory-sensitive hospital admissions for those conditions (Dixon et al., 2010).

New Zealand: the design of the Performance Programme

The New Zealand Labour Party manifesto of 1999 also promised a new focus on improving the quality of primary health care and increasing population-based and preventive health care, seeing general practice services as 'too focused on treatment services at the expense of improving the health of the community' (New Zealand Labour Party, 1999). The focus on population-based and preventive health care grew out of concerns about disparities in health outcomes within New Zealand. Research had shown that there were 'significant and enduring health disparities relating to both ethnicity and deprivation'. These included a nine-year gap in life expectancy between Māori and non-Māori New Zealanders, and between males living in the most deprived and least deprived geographical areas (Crampton, 2000). Once elected, Labour replaced state funding on a fee-for-service basis with capitation-based funding of primary care services (King, 2001). A new network of primary health organisations (PHOs) was formed to manage primary health care services, including general practice services, and people were required to enrol on a PHO register for health care. Targets were set for PHO delivery of preventive as well as curative services.

Unlike England's single-payer and single-ownership model for general practice, New Zealand had many types of general practice service delivery approaches and ownership forms. There were multiple payers for general practice services, creating a wide variety of interest groupings within the heterogeneous primary health care sector. No single organisation existed to represent all general practitioners in their dealings with state funders. Most GPs were members of for-profit independent practitioners' associations (IPAs) (Malcolm and Mays, 1999). 'Almost all' of the IPAs held contracts with the state to manage and improve the quality of prescribing and referral services. For IPAs the reforms meant the end of these lucrative contracts, which had funded quality improvement activities among their members for many years (Crampton et al., 2004). Three per cent of GPs worked in not-for-profit community-governed health centres, which had been established to improve access and equity of outcomes for poorer communities. The changes to primary health care governance were implemented by the Labour government despite misgivings in large parts of the primary health care sector. As part of this process, officials recommended the implementation of a national pay-for-performance scheme to improve the quality and equity of pharmaceutical prescribing and referrals to services within a population-based funding framework, now that budget management contracts with IPAs for this purpose had been cancelled. As in England, the idea drew upon successful local initiatives to incentivise performance which had been developed in the primary health care sector in previous years.

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A working group of primary health care stakeholders was convened to design the new Performance Programme (PP) for primary health care. Although one of the joint chairs of the group was a general practitioner, GPs were invited to be members of the working group as individuals with no representative mandate for their profession. These GP members also held differing views about the role of general practice, reflective of the professional divisions in the country at large: some were for and some were against a state-led pay-for-performance scheme. The group utilised a variety of consultative methods and the assistance of academics to select a small set of 13 indicators for the PP. The choice of indicators was based pragmatically on data elements already available from central sources, even though they did not relate to many of the major health

outcomes the Ministry of Health was most interested in improving. This was because, unlike in England, efforts to gain access to data within practice management systems were opposed by most New Zealand GPs.

The set of indicators and the funding framework were approved in July 2005. Twenty-nine PHOs participated in the first phase of the roll-out (a number higher than expected), rising to 42 the following year. Payments for performance were made to PHOs, which distributed all or some of these to practices. The number of participants rose to 81 of the then 82 PHOs in 2007. Achievement levels against the indicators averaged 81% in 2009 and the budgeted funding for the PP was never fully utilised.

Evaluations found that GPs had mixed views about the effectiveness of the Performance Programme, that it had low visibility among clinicians and that it had a low-profile effect on clinical quality (MartinJenkins, 2008). GPs appointed to the governance group for the PP later regretted the missed opportunity. When informed that

> there was a line item for $35 million but [officials] didn't expect to spend it because people wouldn't achieve the targets ... [i]n the room GPs suddenly had a quick discussion and said so if we lowered the targets we could get all the money and the ministry people nearly fell off their chairs. It was a good example of the thinking of different groups.

A later evaluation did, however, find that there was a statistically significant relationship between achievements under the PP for one of the 13 indicators – immunisation of under-two-years-olds – and vaccine-preventable ambulatory sensitive hospital admissions (Cranleigh Health, 2012).

Findings

To recap, the comparative analysis of the case study evidence set as the dependent variable the policy output and outcomes: namely, the size, scope and speed of uptake of the policy and the health impact achieved by the policy in each country. Independent variables investigated were institutional factors, group/network factors, ideas, socio-economic drivers and rational actor drivers of policy change. The findings showed that politicians in both these Westminster systems successfully planned and implemented non-incremental change in their primary health care systems. However, there were certain institutional features which differed between the two countries. In particular, the use of bargaining and negotiation processes supported the large size, scale and speed of design and implementation of the QOF in England, and therefore the level of health outcomes attributable to the scheme. In contrast, New Zealand policymakers did not negotiate the PP directly with representatives of the general practice profession as part of a contract of service. This differentiates the two episodes of policy formulation and implementation in two similar jurisdictions most strikingly, and it is also because of this feature that the outcomes of each scheme differ.

There was no mechanism within the profession in New Zealand for a process of coordinated debate or negotiation with state funders to occur in a similar way.

Differences in the institutional framework within the general practice subsystem in each country were found to be the primary driver of policy variation, facilitating change in England but frustrating it in New Zealand. In each country, institutional structures had arisen from highly path-dependent patterns of policymaking over successive decades. These structures had given rise over time to effective mechanisms for collective action and a well-developed working relationship with the state for English GPs. There were ineffective mechanisms for this and a poor and conflict-dominated relationship with the state in New Zealand. Chief among these weaker mechanisms is New Zealand's lack of a mechanism for the general practice profession as a whole to be represented by a bargaining agent and therefore to negotiate new policy proposals directly with state funders. The mandate held by the BMA in England to be sole bargaining agent for general practitioners holding general medical services contracts meant that GPs had trusted delegates representing them in their dealings with the state. Their own well-organised professional forums enabled them to have a voice in discussions about the design of the pay-for-performance scheme. Within the negotiating teams, debates were conducted along familiar collegial, peer-to-peer lines. A GP negotiator for the government side described it thus:

> When I was involved in the negotiation it felt like a practice meeting ... we thought the patients were going to benefit ... we were negotiating this in order to achieve patient benefit. Of all the team that was what we were genuinely trying to do.

Another described the process as 'discussions rather than negotiations. The government people were very well informed. It was between peers ... with very much a shared purpose.'

There was no mechanism within the profession in New Zealand for a process of coordinated debate or negotiation with state funders to occur in a similar way. In the pay-for-performance policy design forums, GPs' voices were to some extent crowded out by those of officials and of other primary health care professionals, such as pharmacists and pathologists. GP participants in the policy design process described it thus:

> This was a state-directed programme. I have often reflected that I don't think a single thing [some partici-

> pants] said ... was reflected in the programme that was rolled out ... [such as] peer-led, based on feedback and performance data to individuals, the data referenced to colleagues and the group as a whole and using clinical meetings based on the evidence and outlier management visit ... a non-judgemental peer accountability process.

The process was perceived as a threat to professional organisational rules and standards and reduced the willingness, collectively and individually, among New Zealand general practitioners to engage in the policymaking process.

There was also a reduced level of incentive for rational choice drivers to influence New Zealand GPs. They did not depend on the state for their income to the same extent as in England, and could simply raise their fees to patients if they needed to. Unlike the English GPs, who readily agreed to permit the sharing of their practice data with the state in order to increase the size of the scheme and the speed of assessment and payment of performance incentives, the New Zealand GPs declined to do so. A key difference between the two schemes, this affected the size of the scheme, the type of targets that could be set and therefore the level of take-up of the new pay-for-performance policy.

In both countries the offer of a national pay-for-performance scheme was a lucrative inducement to general practitioners to increase preventive and population-based health actions in their medical practice. But in New Zealand the benefits and opportunities of the proposed policy did not outweigh the perceived challenges it presented to general practitioners' professional dominance and associated autonomy, monopoly and right of self-regulation (Freidson, 2001). In 2001, pay-for-performance health policymaking in national health systems was relatively untried. With the passage of time, both schemes have evolved and much new research about pay-for-performance has been completed, and has drawn upon the experience of the QOF development in England. There can also be an assessment of whether improved population-based health outcomes have been achieved by the initiatives in both countries. Researchers have commented that the research question today is not whether to use pay-for-performance, but how best to incorporate it into financing arrangements for general practice services (Roland and Campbell, 2014).

Discussion

New Zealand has a growing problem with the quality and allocation of its publicly funded health care. There are increasingly visible problems of variation in the quality of and access to primary health care, which are expected to lead to unsustainable costs in the long term (Health Quality and Safety Commission, 2015; Minister of Health, 2016). The steps taken in 2001–07 to initiate an effective framework for population-based approaches within primary health care were partly successful. Ninety-five per cent of New Zealanders are now enrolled in a PHO; they hold a unique patient identifier, and their health status can be proactively monitored and supported to identify and prevent the development of chronic and costly health conditions. Positive progress can be seen. For instance, the gap between Māori and non-Māori life expectancy has narrowed from 8.2 years in 2000–01 to 7.3 years for males and from 8.8 to 6.8 years for females. The success of initiatives such as the immunisation programme for under-two-year-olds, as mentioned above, part of the Performance Programme of incentivised health actions from 2007, has demonstrated the potential of this and a range of other population-based and proactive approaches (Ministry of Health, 2013) to achieve important health gains as well as reduced costs over time.

However, research conducted in 2010 confirmed a stewardship deficit in primary health care policymaking in New Zealand and Australia, where 'a powerful profession appears to have succeeded in securing significant autonomy and self-determination while receiving public funding in return for relatively little specification or monitoring as to how that funding is used', by comparison with England (Smith et al, 2010, p.101). Many building blocks of effective population-based health care are once again at risk, including cost of access, quality and availability of best practice preventive care, and adequate numbers of general practitioners to meet population health needs. The challenge of equalising problems of access remains, with 14% of New Zealanders reporting that they are unable to visit a GP because of cost; this figure is worse for Māori (22%) and Pacific peoples (21%) (Minister of Health, 2016, p.20). The projected cost of providing health services through the current model is reported by the minister of health to be unsustainable (ibid., p.11). For instance, preventive treatment approaches to diabetes, which accounted for 14% of hospital bed days in 2013 (Health Quality and Safety Commission, 2015, p.48), are poorly delivered, with only about half of people over 25 years of age with diabetes recorded as being treated for good glycaemic control, including through the prescription of metformin or insulin. The rate of undiagnosed diabetes in England is reported as approximately 27%.[1] Unexplained levels of variation in treatment patterns in this country show, according to the Health Quality and Safety Commission New Zealand, that improvements remain possible. General practice services, which are an essential foundation of population-based health care, are themselves under significant pressure. The Royal New Zealand College

> ... New Zealand policymakers continue to exhibit weak stewardship over the primary health care system, ... between the general practice profession, ... and the state, ...

of General Practitioners reports a low and falling ratio of GPs to population in a predicted environment of increasing need (Royal New Zealand College of General Practitioners, 2015, pp.4-5).

It is argued here that New Zealand policymakers continue to exhibit weak stewardship over the primary health care system, and in particular have been unable to develop the necessary quality of partnership between the general practice profession, which holds responsibility for training, certification and practice, and the state, which provides the overwhelming majority of funding for general practice professional development and service delivery. Where existing institutional arrangements fail to resolve abiding challenges of access and quality within a publicly funded primary health care system, there is a strong case for reform of general practice/state institutional relationships, and for enhancement of institutional forms within the general practice profession itself, to achieve the necessary progress.

A strong case exists for New Zealand policymakers to seek to emulate the ownership and financing arrangements which exist in England in order to achieve similar levels of influence over the primary health care system.

Looking forward

As a final contribution from this research, some next steps are proposed for consideration by policymakers in New Zealand which might improve their ability to achieve population-based health outcomes through primary health care services.

First, there is opportunity for a stronger collaboration between New Zealand and England. Despite the different results and the differences between the general practice subsystems in the two countries (which have grown in recent years, with the decision to implement general practice-based commissioning in England), there remain many similarities in the institutional, structural and cultural features of the two overarching health systems. There are well-developed linkages between England and New Zealand for policymaking dialogue in both the political and the policy streams. The United Kingdom's health system is currently ranked as much more effective than New Zealand's in a regular health systems monitoring report issued by the Commonwealth Fund, ranking first of eleven health systems for safe and patient-centred care which is accessible on cost grounds (Davis et al., 2014).

However, the two primary health care systems exhibit significant differences relating to the ownership and management arrangements for general practice, the relationships between the general practice profession and the state, and the structure of the general practice profession. In the period since 2000–01 England has improved its health system performance overall. For instance, in developments since 2004, English policymakers have made step-by-step improvements to their pay-for-performance scheme, including removing the design of the QOF from the collective bargaining environment. It has recently been decided to reduce the component of income which is dependent upon it within the general medical services contract. GPs have undertaken more extensive roles in the commissioning and management of a continuum of medical services in their locality. New Zealand, by contrast, has stalled its development of pay-for-performance frameworks, despite their early signs of promising achievements and international evidence that these form a desirable component of physician remuneration schemes. A strong case exists for New Zealand policymakers to seek to emulate the ownership and financing arrangements which exist in England in order to achieve similar levels of influence over the primary health care system. While this would undoubtedly be a radical and costly reform, examination of the evidence base and the cost–benefit case, based on projected levels of forward liability for health care costs, could be undertaken as part of a process of active consideration of a more assertive model of state stewardship of primary health care services.

A key variable to consider in approaching such a radical policy reform is the appropriate scale and pace of change to resolve New Zealand's primary health care stewardship deficit. New Zealand policymakers could support the evolution of both the current general practice institutional forms and interest group structures towards different types of political exchange over time, with incentives for the development of greater trust and collaboration within this subsystem. This would entail, for instance, developing a more consensual and receptive institutional context for the introduction of improved accountability frameworks. Steps to take to provide for the development of such a framework might include:

- Mandating a single national representative body for general practice, perhaps consisting of a forum of representatives from the various segments of the general practice professional community. Such a body would have unrestricted access to government decision-makers regarding policymaking which affected general practice, utilising principle-based bargaining and negotiation processes. This could be expected to lead to the slow building of greater mutual trust, between general practitioners and the representative body and between that body and the state, through repeated examples of consensus-based policymaking that was seen to balance the interests of both parties.
- Supporting the development of a stronger policy community within

primary health care (including general practice) to inform policy ideas and develop information and knowledge infrastructure based on evidence. This could include investment of adequate resources to build a comprehensive shared database for primary care service delivery on the model of the QMAS (Quality Management Analysis System, developed by the NHS), and rapid development of an evidence base, shared national service frameworks and quality standards and targets on the model of the domains developed within the QOF.

- Negotiating greater alignment between both interest groups and policy specialists and the two major political parties on key aspects of population-based health policy. A bipartisan agreement to support the key elements of agreed infrastructure-building over a ten-year period, avoiding the regular cycle of policy windows at election time, which can bring policy reversals, could be a first step towards achieving longer periods of time for policy changes to embed.

Predicted changes within the general practice workforce over the next ten years provide an opportunity to negotiate new terms and conditions of work, new financing and ownership arrangements for state-funded general practice services, and new working relationships between the profession and the state. Forty-one per cent of current general practitioners plan to retire by 2025. Younger GPs are predominantly female, and these younger, female GPs are more likely to work part-time and as employees; it is unclear whether they will continue working part-time in future years or look to increase their hours either as employees or practice owners (Royal New Zealand College of General Practitioners, 2015). While revolutionary, top-down, non-consensual policymaking, such as has characterised previous episodes of health system reform in New Zealand, is in theory also an option, this would reinforce rather than remedy the fractious relationships which currently exist between the general practice profession and the state. These relationships can only be repaired and better government within the health system advanced by building an environment in which courageous decision-making, skilful relationship-building and collaborative, evidence-based policymaking can be undertaken by both the profession and the state.

1 https://www.nice.org.uk/guidance/ph38/chapter/2-Public-health-need-and-practice.

References

Blair, T. (2010) *A Journey*, London: Hutchinson

Bolitho, D.G. (1984) 'Some financial and medico-political aspects of the New Zealand medical profession's reaction to the introduction of social security', *New Zealand Journal of Health*, 18 (1), pp.34-49

Braun, V. and V. Clarke (2006) 'Using thematic analysis in psychology', *Qualitative Research in Psychology*, 3, pp.77-101

Burau, V. and R. Blank (2006) 'Comparing health policy: an assessment of typologies of health systems', *Journal of Comparative Policy Analysis*, 8 (1), pp.63-76

Burau, V. and K. Vranbaek (2008) 'Institutions and non-linear change in governance', *Journal of Health Organization and Management*, 22 (4), pp.350-67

Buse, K., N. Mays and G. Walt (2007) *Making Health Policy*, Maidenhead: Open University Press

Castles, F.G. (1991) *Australia Compared,* Sydney: Allen and Unwin

Comptroller and Auditor General (2008) *NHS Pay Modernisation: new contracts for general practice services in England,* London: National Audit office

Comptroller and Auditor General (2010) *Tackling Inequalities in Life Expectancy in Areas with the Worst Health and Deprivation,* London: National Audit Office

Crampton, P. (2000) 'Policies for general practice', in P. Davis and T. Ashton (eds), *Health and Public Policy in New Zealand*, Auckland: Oxford University Press

Crampton, P., P. Davis, R. Lay-Yee, A. Raymont, C. Forrest and B. Starfield (2004) 'Comparison of private for-profit with private community-governed not-for-profit primary care services in New Zealand', *Journal of Health Services Research and Policy,* 9 (supplement 2), pp.17-22

Cranleigh Health (2012) PHO *Performance Programme Evaluation,* Auckland: Cranleigh Health

Davis, K., K. Stremikis, D. Squires and C. Schoen (2014) *Mirror, Mirror on the Wall: 2014 update,* New York: Commonwealth Fund

Davis, P. and T. Ashton (2000) *Health and Public Policy in New Zealand,* Auckland: Oxford University Press

Dixon, A., A. Khachatryan, A. Wallace, S. Peckham, T. Boyce and S. Gillam (2010) *The Quality and Outcomes Framework (QOF): does it reduce health inequalities? Final report,* London: National Institute for Health Research

Doran, T. and M. Roland (2010) 'Lessons from major inititiaves to improve primary care in the United Kingdom', *Health Affairs,* 29 (5), pp.1023-9

Fougere, G. (1993) 'Struggling for control: the state and the medical profession in New Zealand', in F.W. Hafferty and J.B. McKinlay (eds), *The Changing Medical Profession,* Oxford: Oxford University Press

Freidson, E. (2001) *Professionalism,* Chicago: Univerity of Chicago Press

Ham, C. (1992) *Health Policy in Britain,* London: Macmillan

Hanson, E. (1980) *The Politics of Social Security,* Wellington: Auckland University Press

Hay, I. (1989) *The Caring Commodity,* Wellington, Oxford Univerity Press

Health Quality and Safety Commission (2015) *A Window on the Quality of New Zealand's Health Care,* Wellington: Health Quality and Safety Commission New Zealand

Immergut, E.M. (1990) 'Institutions, veto points, and policy results: a comparative analysis of health care', *Journal of Public Policy,* 10 (4), pp.391-416

John, P. (1998) *Analysing Public Policy,* London: Cassell

King, A. (2001) *The Primary Health Care Strategy,* Wellington: Ministry of Health

Klein, R. (2006) *The New Politics of the NHS,* Abingdon: Radcliffe Publishing

Lovell-Smith, J.B. (1966) *The New Zealand Doctor and the Welfare State,* Auckland: Blackwood and Janet Paul

Malcolm, L. and N. Mays (1999) 'New Zealand's independent practitioner associations: a working model of clinical governance in primary care?', *British Medical Journal,* 319, pp.1340-2

MartinJenkins (2008) *Evaluation of the PHO Performance Programme,* Wellington: MartinJenkins

McDonald, R., S. Cheraghi-Sohi, M. Tickle, M. Roland, T. Doran, S. Campbell, D. Ashcroft, C. Sanders, S. Harrison, R. Mannion and K. Milsom (2010) *The Impact of Incentives on the Behaviour and Performance of Primary Care Professionals: report for the National Institute for Health Research Service Delivery and Organisation programme,* Manchester: National Institute for Health Research Service Delivery and Organisation programme

Minister of Health (2016) *New Zealand Health Strategy: future direction,* Wellington: Ministry of Health

Ministry of Health (2013) *Targeting Prevention,* Wellington: Ministry of Health

New Zealand Labour Party (1999) *Labour on Health,* Wellington, New Zealand Labour Party

O'Malley, C. (2003) *A Reality Check: the early sector response to the primary health care strategy,* Wellington: Wellington Independent Practitioners' Association and Compass Health

Pollitt, C. and G. Bouckaert (2011) *Public Management Reform,* Oxford: Oxford University Press

Pollitt, C., S. Harrison, G. Dowswell, S. Jerak-Zuiderent and R. Bal (2010) 'Performance regimes in health care: institutions, critical junctures and the logic of escalation in England and the Netherlands', *Evaluation*, 16 (1), pp.13-29

Pollitt, C., S. Harrison, G. Dowswell, R. Bal and S. Jerak-Zuiderent (2008) 'Performance indicators: a logic of escalation?', paper given at the European Group for Public Administration conference, Erasmus University, Rotterdam

Richards, D. and M.J. Smith (2002) *Governance and Public Policy in the UK,* Oxford: Oxford University Press

Roland, M. and S. Campbell (2014) 'Successes and failures of pay for performance in the United Kingdom', *New England Journal of Medicine,* 370 (20), pp.1944-9

Royal New Zealand College of General Practitioners (2015) *2015 Workforce Survey,* Wellington: Royal New Zealand College of General Practitioners

Scott, C. (2001) *Public and Private Roles in Health Care Systems,* Buckingham: Open University Press

Secretary of State for Health (2000) *The NHS Plan,* London: The Stationery Office

Shaw, R. and C. Eichbaum (2008) *Public Policy in New Zealand:* Auckland, Pearson Education

Smith, J., N. Mays, C. Ovenden, J. Cumming, J. McDonald and J. Boston (2010) *Managing Mixed Financing of Privately Owned Providers in the Public Interest,* Wellington: Institute of Policy Studies

Smith, V. (2015) 'Pay-for-performance in primary health care: a comparative study of health policymaking in England and New Zealand', PhD thesis, Victoria University of Wellington

Spooner, A., A. Chapple and M. Roland (2000) *The PRICCE Project,* Manchester: National Primary Care Research and Development Centre, University of Manchester

Spooner, A., A. Chapple and M. Roland (2001) 'What makes British general practitioners take part in a quality improvement scheme?', *Journal of Health Services Research and Policy,* 6 (3), pp.145-50

Stevens, S. (2004) 'Reform strategies for the English NHS', *Health Affairs,* 23 (3), pp.37-44

Tuohy, C.H. (1999) *Accidental Logics,* Oxford: Oxford University Press

WHO (2000) *The World Health Report 2000,* Geneva: World Health Organisation

Yin, R.K. (2009) *Case Study Research,* Thousand Oaks: Sage