Primary Health Alliance

He huinga ratonga hauora

One team, many businesses:

Supporting delivery of the 2016 New Zealand Health Strategy

June 2017

Preface

The New Zealand Health Strategy, refreshed in April 2016, seemingly painted a compelling ten year vision for our health system underpinned by five themes which include that of a 'one-team' approach. The Strategy anticipates us all operating as a team in a high-trust system that works together with the person and their family and whānau at the centre of care.

This publication, the latest in the Primary Health Alliance's series of policy discussion papers, sets out our recommendations for the structured change management programme which is needed to support the thousands of private general practices, community businesses and charitable organisations, often relying on individual and family funds, to work as one team and deliver the expectations of the Health Strategy.

Under the current policy and financial framework, those same providers and private businesses are often forced into behaviours to protect their contracted revenue streams which can compromise what is best for their patients and their whānau. That has to change if we are to achieve the vision of the Health Strategy.

By any measure, what is expected to enable those many businesses to work as one team constitutes a major programme of change and yet, there appears very little by way of an agreed and funded change management plan to make it all a reality. We believe everything we are proposing here can be readily achieved within the current legislative framework.

We sought the support of a wide range of partners, stakeholders, multi-professional groups and agencies in the preparation of this publication to which we owe a debt of thanks for their willingness to give of their time, travel and valuable expertise.

A resounding message we heard over and over again is that the current financial framework and policy settings across the New Zealand health system do not support a one-team approach for integrated care which will ultimately result in the failure to deliver the vision of the New Zealand Health Strategy.

At the same time, the financial framework and policy settings are also failing, on a daily basis, to support those individual members of our communities and their whānau who are at their most vulnerable. Over half a million high-need New Zealanders cannot access affordable primary care because the funding that is intended to directly help them

is inappropriately subsidising care for more affluent and healthier individuals.

Likewise, the unacceptable gaps in health outcomes and life expectancy between Māori, Pacifica and our European communities across New Zealand remains a very significant and globally visible embarrassment to our health system and the leaders responsible for it.

During the development of this publication we were humbled by the willingness of sector colleagues to discuss challenging but potential solutions to those policy and financial framework settings. Many of the potential solutions discussed had already been set out in our previous publications, most notably *A time to act: 7 actions which will help sustain the New Zealand health service for future generations* in February 2015. We refer to many of them in passing again in this publication.

We also heard, and agreed with, many positives about our current system. A range of enablers and policy settings which must be protected to ensure we don't throw the baby out with the bathwater and undermine the continuity of the high level of care which New Zealand can already be proud of.

However, we need to move forwards for the future, and this publication together with the suggestions we make, is intended to be the starting point to foster further conversation about how we can better use public funding to drive the behaviour needed to deliver a truly integrated one-team service. We hope our suggestions prompt that discussion and help develop absolute solutions.

The changes we need will require a significantly different mind-set amongst our policy makers and politicians. They will also have a material impact upon many providers across the sector. There will be elements of shared risk but once again we believe that improved patient outcomes must stand above existing arrangements, policy settings and organisational barriers.

On behalf of our members, we stand ready to help support the changes required by the sector to give those same policy makers and politicians the confidence to take the steps required. In return, our collective goal where all New Zealanders live well, stay well and get well will become a reality rather than an unachievable set of fine words.

John Ayling
Chair, Primary Health Alliance

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1. Summary of Recommendations

In this publication we make the following key recommendations with regards the business operations of the various provider organisations across primary health care as well as the national policy and financial framework settings. Our overriding aim is to improve the health of the communities we serve and reduce New Zealand's unacceptable inequalities in access and outcomes.

We recommend:

1. The establishment of sector wide, inter-disciplinary provider organisations with a governance structure and consolidated budget covering general practice, community pharmacy (both services and cost of drugs), allied health, community midwifery, aged care, home support services, diagnostics and relevant NGOs (see Section 3).
2. The strengthening of true empowerment through community driven locality decision making (see Section 3).
3. A fundamental review of primary health care funding to include:
    a. The direct distribution and allocation of funding to primary and community health care (see Section 4).
    b. An update of the primary health care funding formulae to determine the consolidated budget set out in 1. above and thus ensuring the distribution of funds based on individual patient need and supporting equitable access (see Section 3).
    c. The introduction of longer term formal three-year funding allocations in place of the short-termism of the current annual cycle (see Section 4).
    d. Fully transparent year-on-year funding increases in respect of fair indexation, cost pressures and compliance costs (see Section 4).

4. The establishment and enforcement of a code of conduct across all members of the collective team to embed the principles of trust and respect whilst empowering all health professionals to independently act on behalf of their patient within their professional scope of practice (see Section 3).
5. A greater national focus on the development and implementation of integrated IT solutions (see Section 3).
6. All healthcare contracts should include an obligation on the provider to support patients in an integrated system and recognise where other practitioners may be better placed to meet an individual patient's needs (see Section 3).
7. Prioritisation of outcome focused contracting with top-down health targets based on evidenced practice in support of the same outcomes (see Section 3).
8. The establishment of an agreed change management framework (see Section 4) to underpin model-of-care changes which ensures:
    a. The required capacity, capability and infrastructure across primary health care is fully funded
    b. All providers can reasonably expect 'no new work without new funding'
    c. All changes prioritise the highest needs patients with the worst outcomes.
    d. New Zealand's vital secondary care sector is not destabilised.
9. The full alignment of health funding streams with national policy intent, in particular to remove inherent perverse incentives across the system (see Section 4).

2. Introduction

We believed that the 2016 refresh of the New Zealand Health Strategy presented a compelling and laudable ten year vision for supporting even better health for all New Zealanders. But it appears to have become yesterday's news and has been left to gather dust. It seems destined to be a spectacular failure unless the current policy and financial framework settings are updated to enable the one team, integrated and patient centred approach required.

A health system to be proud of

New Zealanders should rightly be proud of our health system. Overall life expectancy and health outcomes in New Zealand compare well against virtually every other country in the world. Greater still is the pride we should have when we compare the value for money our health system delivers for the percentage of our country's Gross Domestic Product (GDP) invested in it.

Fundamental to our health system is a primary health care sector that is the envy of many elsewhere. Enrolled patient lists, capitation funding, a multiplicity of professional services, myriad neighbourhood access points and a highly trained dedicated workforce provide primary health that is innovative, flexible and predominantly patient focused.

Vitally underpinning such a national asset is a network of thousands of privately owned providers and charitable organisations (NGOs) all balancing the precarious demands required to keep businesses running and solvent against the altruistic calling of any health professional providing help and support to members of the local community at a time when they are at their most vulnerable or in need of support.

A common public misconception is that such businesses are fully funded by the taxpayer through the public purse. The reality in fact tells a story of billions of dollars of borrowing, investment and personal liability made by thousands of individual health professionals and non-government organisations to fund the buildings, infrastructure, assets

and working capital of those businesses in every community and neighbourhood – businesses on which the wider health sector and public are completely dependent to deliver essential health care.

With that private ownership however comes entrepreneurship, motivation and incentivisation. This is a sector populated by professionals prepared to go the extra mile, prepared to put their hand in their own pocket for the benefit of their patients, prepared to be contactable and accessible at unsocial hours or beyond their normal working day and, prepared to make personal sacrifices and risks for the benefit of all New Zealanders.

A compelling ten year vision

The 2016 New Zealand Health Strategy seemingly paints a compelling ten year vision which builds on the strength of our current health system and continues the patient focused, closer to home and integration of care themes of the preceding health strategy published in 2000.

There is a dawning reality however that we have reached a cliff face. We, and many sector stakeholders we talk to, believe there is a complete disconnect between the expectations of the Health Strategy and the underpinning policy settings determining how the system works, how it is funded and how it prioritises its services.

An integrated system operating as one-team with a focus on preventative out-of-hospital care and equity of outcomes is incongruous with a health system that:

- is funded through a multitude of unaligned and competing silos;
- fails to appropriately acknowledge the unacceptable gaps in access and outcomes for our most vulnerable communities;
- underwrites DHB provider services at the expenses of non-DHB services, especially those in the primary and community sectors which are so essential for the delivery of the Strategy; and,
- fails to appropriately invest in maintaining a fit-for-purpose infrastructure and workforce across the primary and community sector.

Some say the primary care business model has to change. Of course, we agree that all businesses have to continually adapt. We would also say that, as innovative private business owners, most primary health care providers are better than many at changing and responding to patients'

needs. Whilst that change is rightly expected, it is also essential to change the national policy and funding framework to enable the change management required to deliver the expectations of the Strategy.

But since its publication in April 2016, some fourteen months prior to this publication, the Strategy appears to be forgotten and has been left to gather dust. We see no signs of an implementation plan, nor any supporting guidance. We see no prioritisation process or re-targeting of the resources required to deliver the change in focus or model-of-care changes anticipated.

We acknowledge that to enhance the national policy and funding framework such that it directly supports and enables the vision within the Strategy is not an easy ask, however over the next few pages of this publication we set out a number of proposals and themes which we believe will help do just that.

3. Working as one-team

We believe that the current operating and financial framework creates dysfunctional competition across the sector and prevents, rather than supports, a 'one-team' approach. The time is right to change both the national policy settings and how the various provider business models work together to truly underpin and incentivise a patient-centred, one-team environment.

Consolidated provider interests

It is time to remove the barriers inherent in the silo funding of providers for their specific service functions and give them a collective incentive to 'do the right thing' for their patients and the local community.

We believe there is a need for a 'collective vehicle' through which relevant providers in a specific locality can work together with patients' outcomes and longer term well-being as the focus of their attention thus ensuring collective benefit through the right care being provided regardless of who in the collective team provides that care or service.

We specifically note that 'one size will not fit all' when it comes to defining the 'collective vehicle' which will best serve the needs of the community in each locality. However, we believe there are a number of criteria which should underpin each vehicle to enable it to be a credible organisation through which a number of the further recommendations of this report can be implemented. The organisation should:

1. include services covering general practice, community pharmacy, allied health, community midwifery, aged care and relevant NGOs (explicitly including vital Māori and Whānau ora providers where relevant)
2. be owned and governed in such a way as to prioritise patient and collective interests over the silo business interests of its participating professionals and thus to incentivise integrated practice
3. be financially structured to encourage reinvestment of surpluses into direct patient care and service developments (whilst

recognising the need for fair reward and incentivisation for its constituent professionals and businesses)

4. be responsible for contracting with and determining the appropriate apportionment of funding to each service/business based on prioritisation to address the health status of the local population (whilst not necessarily cutting across the independent business status of each provider's private business)
5. support all health professionals to work at the top of their scope in a sustainable, safe and best-for-patient approach
6. have a governance and decision making framework which includes consumers and has no single professional group in the majority
7. be funded independently from local statutory arrangements which are held to account for the financial balance of secondary care provider services
8. be driven by a bottom-up community defined approach and enabled by a national policy and funding framework

Some localities may already have organisations which are ready to step-up to the level of this proposed collective provider model. We do not stipulate what that collective organisation should look like other than to say there are likely to be a variety of structures which could best incentivise integrated practice based on the specific needs of the local population and their communities. For example, some Primary Health Organisations and some emerging Neighbourhood Healthcare Homes may fit many of the proposed criteria, but we note that the predominance of general practitioners in the governance of many such organisations has the potential to create a conflict of interest which could mitigate, in their current form, fulfilment of the vision we have.

Some localities may decide that a new 'Primary and Community Health Trust' may be the best local solution to achieve the stated aims and meet the criteria. We suggest it may be sensible, but not essential, for such Trusts to be an evolution of existing Primary Health Organisations bringing with them many of the strengths of the current models.

Consolidated budget

To enable the 'one-team' to adopt a best for patient, best for system approach, we believe funding should be based on an annual capitated list-based model. Integrated care needs to be enabled by integrated funding which for primary health care should include:

- General practice funding including first contact care, CarePlus, VLCA, Services to Improve Access and associated funding streams
- Community Pharmacy (both services and the cost of drugs)
- District nursing
- Community Midwifery
- Aged care services
- Home support services
- Allied Health
- Diagnostic services

To enable the establishment of integrated funding and associated budgets, we recognise that further work is required to ensure we do not undermine processes already in place, or being put in place, through relevant professional associations (e.g. New Zealand College of Midwives) which seek to ensure the secure and equitable use of funds.

In determining the formula for the allocation of such a consolidated budget, we have previously made recommendations with regards strengthening the primary care funding formula in our December 2015 policy discussion paper '*Targeting Resources: strengthening New Zealand's primary care capitation funding formula*' in which we set out proposed factors for inclusion in a formula for achieving an equitable distribution of resources based on need (see Appendix A to this report). We believe the same approach and principles should determine the targeting of a wider consolidated budget.

Trust and respect

We believe the principles of trust and respect should be embedded and expected across all members of the collective team. A code of conduct should help establish appropriate behaviours for working alongside fellow health professionals and practitioners particularly where such behaviour is not already the norm.

We have a vision where all partners strive for self-determined wellness, equity, transparency, collaboration and empowered patient-focussed leadership.

Such principles need to be more than just 'fine words' and we would expect best-practice day-to-day operating arrangements to be underpinned by those principles. For example, each and every health professional should be trusted to act in the patient's best interests. If a community midwife identifies the symptoms of depression during a routine visit with a prospective or new mother, they should be

empowered to make a direct referral to the community mental health service (and, with informed consent, advise the client's GP) rather than having to direct the patient back to their own GP for the very same referral.

Enabled through IT

The debate regarding the need for integrated IT solutions is well rehearsed and is currently a significant barrier as well as prospectively an essential enabler to many of the proposals within this publication.

We do not repeat any parts of that debate here. Instead we would point the reader to our February 2015 publication '*A time to act: 7 actions which will help sustain the New Zealand health service for future generations*' (A time to act).

Integration expectations

Integrated working as part of 'one-team' requires a different approach for many practitioners and businesses. Transitionally, it may require additional time and resources as well as a way of working which might adversely impact on the business's traditional income generating fee-for-service and contract approach.

We believe that all healthcare contracts, covering both primary and secondary care, should include an obligation on the provider, and their practitioners, to support patients in an integrated system and recognise where other health providers, professionals and practitioners may be better placed to offer the required care or support the patient needs.

Outcome focussed contracting

A recurrent message we heard in the gestation of this publication is that current top-down health targets prevent providers, across both primary and secondary care, working as one-team with patients at the centre of everything they do.

This is another theme which we previously covered in *A time to act*. Rather than repeat those messages here we simply restate the absolute need to refocus contracts towards outcomes, and health targets towards those areas that have an evidenced link to the very same outcomes.

4. Sustainability of the sector

We believe that primary health care cannot continue to be at the front-end of service delivery whilst remaining at the back-end of service funding. Primary health care is the solution to the delivery of the New Zealand Health Strategy and must be resourced accordingly.

Longer-term financial planning

We believe it is time to put aside the short-termism in the funding of one of our country's vital services and ensure a framework which provides longer-term certainty to all stakeholders and partners across the full health system.

The myriad private businesses, facilities and enterprises across primary health care rarely have absolute certainty of income for more than twelve months ahead. We acknowledge the similar constraints which District Health Boards and Primary Health Organisations also have to contend with.

We believe there is no legislative barrier to providing all those key stakeholders and providers increased certainty through formal three year funding allocations.

Fair indexation

No business or organisation can continue to provide the proactive and innovative service which the New Zealand Health Strategy expects of our primary health care sector whilst its year-on-year funding is being constantly eroded.

There are many calculations seeking to demonstrate the extent to which this has happened to our primary health care sector over the previous ten years. We do not offer any absolute figure here other than to say the evidence indicates that it runs into hundreds of millions of dollars.

Such an environment pits front-line providers into greater competition with each other as they respectively join the lolly-scramble to fight for their own financial sustainability. We believe competition of this nature is a massive barrier to the required one-team approach.

Providers have consistently told us that fair indexation, year-on-year funding and support for additional compliance costs would help change the focus from their own on-going sustainability to one where the needs of the patient are truly central to day-to-day decision making.

Planning for model-of-care changes

We require a significant and well acknowledged change to our model of care in New Zealand to deliver the expectations of the Health Strategy. Commonly used terms such as closer to home, secondary to primary care shift and, patient-focused cannot be turned into reality without the appropriate level of change planning and management required of the multi-billion dollar industry we are all leaders of.

The changes required are dependent upon funded capacity, capability and infrastructure across primary health care at the same time as ensuring the country's vital secondary care sector is not destabilised. We have consistently heard of example after example of where such service changes are attempted without appropriate consideration of the funding and implications for both sides of that equation. Such approaches will invariably fail as any change management requires careful planning, inclusive engagement and buy-in, and crucially, relevant change funding.

Any underfunding of the secondary care sector, together with any increase in 'stranded fixed costs' in secondary care as services are devolved, cannot be allowed to get in the way of an appropriately funded primary health care sector enabling the one-team transformation.

For example, the recent simple extension of the Community Pharmacist role to include the ability to administer flu vaccinations for over 65 year olds and pregnant women has not been welcomed by many in the general practice community due to the potential impact upon vital general practice income and therefore sustainability. A different approach which considered those factors is likely to have enabled widespread support for what is intended to be a significant improvement in patient access to services.

Similarly, model of care changes which result in more components of traditional hospital based care being undertaken in primary health care settings (e.g. management of Hep C or post-op follow-ups) should be underpinned by full funding for that transferred activity rather than assuming such activity is already funded by existing primary care capitation payments.

We believe a change management framework agreed by all sectors of our health system and which includes the issues highlighted above would go a long way towards increasing the momentum of service change required as well as increasing the overall success rate.

Aligning funding streams with policy intent

There are many examples of perverse incentives within New Zealand health policy and its financial framework which present a barrier to the desired actions and outcomes of the Strategy. We have referenced many of them in our previous publications and we do not therefore repeat them all again here.

However, we do feel the need to mention specific examples of where the current funding framework appears totally at odds with the policy intent of the Health Strategy and, through no fault of their own, results in key stakeholders and decision makers failing to invest appropriately to deliver the desired model of care.

Firstly, the funding streams and incentives which require District Health Boards to underwrite their own provider arms at the expense of investing in the solution which is primary and community care, will continue to prevent achievement of the Health Strategy until it is addressed. Even those more proactive DHBs across the country who seek to invest in their primary health care sector, recognising it as part of the solution to the strategic challenge, appear frustrated by the financial framework settings that determine their accountability for financial imperatives which seem at odds with an integrated one-team system.

Secondly, our strategic and policy intent to address inequalities in access to primary health care and shift care closer to home will perpetually fail as long as we have a funding framework which encourages attendance at a free-to-use ED service rather than a fee-for-service general practice or primary health care service.

Finally, and we make no apology for repeating this message yet again, the funding formula needs a major update underpinned by the fundamental principle of equity thus prioritising and targeting funds at individual patient level based on need.

Direct targeting and distribution of funding

We believe that the methodology for the distribution of funding to invest in primary health care services and associated developments is failing and has been doing so for many years. We hear repeated examples of where primary and community services are consistently pillaged to address deficits elsewhere across the health system, most notably those in DHB's secondary care provider arms.

We stop short of recommending the ring-fencing of primary health care funding as this would serve to perpetuate the silo funding mentality which prevents the integrated one-team approach we seek. However, we call for the direct distribution of funding to the primary and community sector to avoid the consequences of such action which is preventing the appropriate funding of the intentions of the New Zealand Health Strategy as well as preventing compliance with successive years instructions to the sector through the annual 'Letter of Expectations' from the Minister of Health.

Extract from:

Targeting Resources: Strengthening New Zealand's primary care capitation funding formula (PHO Alliance, December 2015)

3. Proposed factors of the formula

We believe the primary care funding formula should be updated to incorporate specific new or updated factors.

We believe the formula should be updated to incorporate specific factors which primarily combine to determine the likely future need of individual members of the population. We also propose including factors which indicate how well a provider is addressing and managing the needs of those individual patients.

In making these proposals we have also drawn on the learnings from the review of the [UK] General Medical Services global sum formula[3] which, in 2007, made strong comment regarding data availability to be able to make accurate, forward looking predictions of the likely health need of individual registered patients.

We propose an approach for funding primary care for registered patients only. We believe such an approach best incentivises registration as well as the proactive list-based management of a community's health needs. We also recognise that casual, fee-for-service health care will remain available to patients outside of capitated services. We do not comment on those casual services in this publication other than to note that the funding regime should always incentivise registration.

Age and sex

These are both clearly still significant factors affecting the health need of individual members of the population and should form a key component of the future formula. However, the current age and sex 'cost-curves' utilised in the first contact capitation formula should be updated and based on a full national dataset of current utilisation rates (rather than an out-of-date and non-representative sub-set).

Prevalence	The health status of individual registered patients has to be the most significant individual predictor of likely future health need. Unlike technicians working on the development of past allocation formulae, we now have a comprehensive electronic database of disease prevalence to enable us to incorporate this into our funding formula. New Zealand's biggest killers and those conditions generating the biggest demand on primary care should feature here including Cancer, Diabetes, CVD, COPD and Mental Health.
Prevalence Management	As stated previously, we believe the formula should incentivise outcomes. It is not enough to simply fund the recording of a patient's disease prevalence. We propose that the formula includes an additional factor to recognise the extent to which a patient's recorded disease prevalence is being appropriately, and proactively, managed by the provider.
Ethnicity	We know that health outcomes for Maori and Pacific peoples are unacceptably worse than for the white European population of New Zealand. The same is also true, to varying levels, for several other ethnicities which now form a growing percentage of the New Zealand population. We propose that such key ethnic variations in health status should be recognised within the formula.
Deprivation	There is a well evidenced correlation between deprivation and poor health and therefore deprivation data should rightly be included within the formula. Our caveat here is to what extent incorporating deprivation as a factor would duplicate the effect of including prevalence data. We say more about this potential duplication later.
Refugees	We know that refugees place significant pressures upon the health system for a range of reasons. We believe this additional pressure should be recognised within the formula for 1 year only. Following this period we do not believe that having

	refugee status on its own is any indicator of need that wouldn't otherwise be recognised through that patient's ethnicity and prevalence status for example.
Newly registered patients	We believe newly registered patients are likely to place a greater pressure upon their registered provider for the period immediately following their registration. As with refugees, we believe this effect should be recognised within the formula for a maximum period of 1 year and only to a level which does not encourage or incentivise 'practice/provider hopping'.
Rurality	There is considerable literature regarding the additional pressure and cost of providing primary care to registered patients in rural and remote communities. We believe this is for many reasons and includes the cost barriers to travel longer distances to access services, lack of local access to secondary/specialist care, wider determinants of health such as social and economic isolation, and, the greater cost of recruiting and retaining health professionals in such isolated communities. We disagree that the impact of rurality upon primary care providers is best left to the vagaries of a case-by-case process through non-statutory local Alliances and therefore, we propose there should be a rurality factor within the formula ensuring the consistent recognition of rurality regardless of which DHB or PHO's locality the provider is based within.

As mentioned previously, we acknowledge the existence of potential double counting between the factors listed above. For example, to what extent are the health need implications of deprivation accounted for in the recording of prevalence? There will of course be other health implications of deprivation, but once you have taken out the effect of prevalence, are the remaining deprivation implications material enough to warrant inclusion within the formula?

We do not seek to resolve such potential double counting here other than to say that the commissioning of standard regression analysis by

statistical experts should provide appropriate recommendations for the extent to which such factors should be included. Similarly, such processes would also assist with modelling the appropriate compounding effect of utilising all of the above factors within a single formulaic approach.

We acknowledge that construction of such a formula is not an absolute science, we are seeking to predict likely future need based on a manageable process which balances simplicity, timeliness and accuracy. In doing so, we believe the factors listed above are those which would have most consistent and material impact to warrant inclusion.

We acknowledge however that there are many other factors in addition to those we propose above, which will determine health need at an individual patient level and there will always be exceptions to the rules. In this regard, we support the inclusion of a provider level discretionary budget such as the ARI (At Risk Individuals) scheme implemented by Counties Manukau DHB which allows providers flexibility to fund additional consultations or referrals for services such as psychology or dietetics where the funding and services framework does not cover their exceptional need. We note that the scheme is well received by patients and practitioners alike.

About the Primary Health Alliance

The Primary Health Alliance (previously the PHO Alliance) is a sector-wide consortia of member primary health care organisations and representative associations working together to share learning, share best practice and support better outcomes for patients.

Our member organisations encompass a wide range of health practitioners, including pharmacists, midwives, allied health professionals and doctors, providing services in each and every community across New Zealand.

Our member Primary Health Organisations encompass over 1 million enrolled New Zealanders living in some of the most deprived communities from Cape Reinga to Bluff.

Our reason for being is to improve health outcomes and reduce inequalities for the communities we serve.

Primary Health Alliance
He huinga ratonga hauora

PO Box 5262
Wellington 6140
New Zealand
Tel 022 131 8393

www.primaryhealth.org.nz