Reidy *et al. International Journal for Equity in Health* (2025) 24:124
https://doi.org/10.1186/s12939-025-02463-w

International Journal for Equity in Health

RESEARCH **Open Access**

Equity, power and resources in primary health care reform: insights from Aotearoa New Zealand

Johanna Reidy[1*], Nina Bevin[2], Don Matheson[3], Ngaire Rae[4], Rawiri Keenan[5], Peter Crampton[6] and Max Harris[7]

Abstract

Background New Zealand's District Health Board reform (2000–2022) was underpinned by the goal of reducing inequities in health outcomes between population groups and improving health overall. A key policy vehicle for achieving the goal was a system-wide shift to population health with increased strategic focus on and investment in primary health care.

Methods This research explored shifts in power and resource to understand how equity as a policy goal for primary health care fared over the District Health Board era, and examined how the distribution of power and resources in the health sector changed for PHC over the period 2000–2020. The study used an exploratory case study methodology based on insights from key informant interviews.

Results The study found that despite policy intent, actors holding political power shaped health outcomes under the reforms, curtailing the mechanisms that could have made a significant impact on equitable health outcomes between population groups.

Conclusion It concludes that exploring power and resource shifts sheds light on power dynamics within a reform. Since power shapes how resources are deployed, attention to power and resource complements technical elements of health system reform, by helping to understand where and how to intervene so that reforms achieve their desired goals.

Keywords Equity, Primary health care, Reform, Indigenous, Power, Resources

Background

The World Health Organisation (WHO) recommends a primary health care (PHC) oriented health system to achieve [1, 2] better and more equitable health outcomes [2]. PHC-oriented systems enable efficient use of health resources [3] yielding good value for investment through early prevention, timely treatment and appropriate referral to secondary services [4].

Aotearoa New Zealand (NZ) has followed this WHO advice, maintaining its 88 year-old PHC-oriented system so at face value it functions well relative to similar countries [5–7]. However, good overall performance masks

*Correspondence:
Johanna Reidy
johanna.reidy@otago.ac.nz
[1]Department of Public Health, University of Otago, 43 Hanson St, PO Box 7343, Newtown, Wellington South 6242, New Zealand
[2]36 Cockburn St, Grey Lynn 1021 NZ, New Zealand
[3]Centre for Public Health Research, Massey University Centre for Public Health Research, Massey University - Wellington Campus, PO Box 756, Wellington 6140, New Zealand
[4]3 Whareora Rd, Whangārei 0112, New Zealand
[5]Division of Health, University of Waikato, Te Huataki Waiora, Private Bag 3105, 3240 Hamilton, Waikato, New Zealand
[6]Kōhatu Centre for Hauora Māori, University of Otago, PO Box 56, Dunedin, New Zealand
[7]Thorndon Chambers, PO Box 1530, 6140 Wellington, New Zealand

deficiencies. To date, health gains have not flowed to those most in need [6]. Similar to other high income countries with minority Indigenous populations (e.g. 8) ethnic inequity in health outcomes persist, with Indigenous Māori experiencing multiple barriers to PHC [9]. The stark 7 year life expectancy gap [10], alongside age-standardised rates of amenable mortality more than double that of New Zealand Europeans [11], reflect unmet need for PHC [12, 13]. This situation persists more than 20 years after PHC reforms with explicit policy goals and associated financial investment to reduce inequities (differences in health outcomes that are avoidable, unfair and unjust) [14, 16].

Since 2022 NZ's health system has been moving through the Pae Ora reforms [15], which aim to make the system more accessible, more sustainable and more equitable, the latter a goal of the previous reforms in 2000. This article explores the power and resource shifts around the PHC reform goal of equity in the 'District Health Board' (DHB) era (2001–2022), to help understand what needs to be different in order to achieve the equity goal in PHC [16] in the current (Pae Ora) reform.

The importance of power and resource to achieving the policy goal of equity in PHC reform

This article explores how the health system value of equity fared over the DHB era, using an interpretation of power and resource shifts within a wider political economy. Here Brett Christophers' articulation of the political economy frames the discussion [17–19] alongside recent work on law-and-political economy [20]. This framing describes 'the economy' in a particular way when analysing health system reforms, not as a field external to politics, but rather as a field that is deeply political. A 'political economy' lens accepts that 'the economy' is always interwoven with politics, and that political decisions structure the economy, including its boundaries. (For example, a ban on child labour is a political act that sets the limits of the labour market: this ban affects what is in 'the economy'.) Hence, in the political economy lens adopted here, 'the economy' is not independent from politics; rather, 'the political' and 'the economic' are co-constitutive. A 'political economy' analysis of political and/or policy decisions pays particular attention to the role of power and resources. Individuals or groups who hold power may shape policies or political developments. Conversely, their power can be entrenched or reconfigured by these same developments. A political economy approach also considers how the control and distribution of resources is reflected in, and affected by, political and policy decisions. 'Following the money' may be an important tool of analysis [19]. Because power operates through class, race, gender, and other forces, a political economy approach "requires attentiveness to the ways in which economic and political power are inextricably intertwined with racialized and gendered inequity and subordination" [20]. In NZ's context exploring shifts in power and resource also means paying particularly close attention to power and resources that continue to be influenced by colonisation [13, 21, 22]. Shifts in power and resource in the health system occur within a wider political economy. In the publicly funded health system context that is the focus of the analysis that follows, a political economy approach requires careful consideration of the way that health system developments are affected by– and themselves affect– broader political, economic, and social trends. Health system activity is not understood as a field of technocratic activity, immune from broader social forces; instead it is understood as an area of activity deeply marked by (and capable of shaping) class, race, and other inequalities [23]. It is also necessary as a means to understand changes in power and resource distribution over time to historicise health system developments: to understand how longstanding historical developments have shaped the present structure of PHC, and to emphasise that certain outcomes have not been timeless but have been the result of particular historical moments. Therefore we explore the shifts in equity with references to the wider context.

Some argue that health systems reforms generally [24] and PHC reforms in particular [25] cannot be sensibly undertaken without some analysis of the power and resource shifts within the political economy and management of risks and opportunities arising from the analysis. Health reforms are unavoidably political processes since they attempt to change the status quo via changes to public policy that materially affect the population, including the distribution of power and resource. Political economy analyses have been used to explore gaps between desired PHC policy outcomes and reality (e.g. 26, 27) and to understand variability in PHC's uptake and implementation in high income countries [28, 29]. However, there is a scarcity of publications in this area that bring a political economy lens to PHC, which is notable given the prevalence of various forms of PHC [26] and PHC's importance to health systems [29] in achieving health systems' stated strategic goals.

Fundamental societal values underpin PHC strategic goals, and are expressed in political and institutional arrangements and socioeconomic systems that shape PHC's form and functions [30]. There is a strong association between social democratic institutions, better health outcomes and equity [29]. Even in countries with comprehensive health and social protections (via tax or social insurance), mechanisms to factor in differences in power, resource, historical legacy and their impacts on health outcomes are far from settled [31]. Indeed, Kringos et al.'s [28] analysis of 33 European countries found that enduring public expectation of government involvement to ensure all citizens are provided for was one factor associated with stronger PHC. Similarly, Mou [32] found a government's political ideology influences the mix of public and private PHC provision and expenditure, noting that right-leaning governments favour market-led policies and models underpinned by values such as efficiency.

A government's underpinning policy values appear to influence PHC access. High income countries where political emphasis has been on austerity and savings [33] and on maximising market freedom and choice [34] have weaker access to PHC. Meanwhile, left-of-centre governments appear to have stronger PHC, providing more policy and financial support for PHC access [28]. Taking a different approach, Walker and Peterson [30, 35] hypothesize that PHC access depends on changing power relationships between the system and the community, especially the role of out-of-pocket payments. They note the negative impact of out-of-pocket payments for higher needs patients and on patients' equitable access to PHC services. However, despite evidence around out-of-pocket payments detracting from PHC access, globally reforms continue towards more neoliberal PHC arrangements [7]. The shifts continue even if shifts result in poorer health outcomes and inequities across populations [29, 36], because higher needs patients in the community cannot afford out-of-pocket payments and cost becomes a barrier to access (e.g. 37, 38).

It is clear that dominant economic theories affect power and resource flows [39], with some groups retaining power and resource, despite policy intent [40] for more accessible care and more equitable health outcomes. Given the documented impact of history and societal values on health system reform and the political economy, it is worth unpacking four key elements that shape NZ's PHC reform environment, and the fortunes of the reform value of equity.

Key elements in NZ's history, institutions and power dynamics impacting on PHC

Four key elements throughout NZ's history shape population health status and PHC structures; identifying these elements helps to bring political economy and PHC into the conversation. The first element is NZ's founding document, Te Tiriti o Waitangi (Te Tiriti), a treaty signed in in 1840 between the British Crown and Māori. This outlined power and resource sharing arrangements and established the colonial state of New Zealand. However, the Crown has neither fully complied with its obligations under Te Tiriti, nor addressed the role of commerce inherent in the ongoing process of colonisation [41], which has severely undermined Māori health [42]. Deliberate anti-Māori legislation and policy removed access to the determinants of health, and explicit racism marginalised Māori from employment, civic life and government services [42]. This legacy of coloniality impacts on the health system today and is the root cause of Māori health and social inequity [11].

The second element is the ongoing policy compromise started at the founding of NZ's health system in 1938. Instead of the government's desired umbrella state health and social system, Government and general practitioners negotiated a policy compromise: GPs remained as owner-operators of private businesses and retained the right to charge a patient fee. GPs agreed to keep the patient fee low in exchange for a General Medical Subsidy from the government, claimed as fee for service. The result was vastly more affordable and accessible care for most New Zealanders, though less favourable for Māori. Since 1938, both ideologically left and right of centre governments have reformed the health sector. Throughout, PHC has remained largely at arm's length from government, operating as a for-profit (capitalist) paradigm that provides services within a predominately tax-funded public health system that is underpinned by social-democratic ideals. PHC services have remained in the private sector and funded via a government subsidised payment plus a patient co-payment [43], with little residual policy attention. Until 2001 there was no dedicated primary health care strategy. A particular political-economic compromise has been forged and maintained over time, which has prevented the full realisation of universal ideals in public healthcare and has preserved the strength of the private health market.

The third element is the theory of the state that has been operative in recent decades. New Zealand's state has expanded and contracted throughout its history, including during periods of zealous progressive reform (for some) in the 1890s and 1930s. In the 1980s and 1990s NZ embraced neoliberal economic theories, with the goal of improving efficiency and reorganising state macro-institutions to be more business-like. As well as progressive taxation being cut and regressive taxes being introduced, trade unions were weakened (including through the Employment Contracts Act 1991), benefits were slashed, public utilities were privatised, markets were deregulated, and the public sector was redesigned along corporate lines. Health policy shifted away from universal access to service provision, and introduced incentives for state services to be profitable [44]. In the late 1990s NZ was strongly influenced by third way politics [45], increasingly using the private sector to provide state funded services. The norms embedded by the changes in the 1980s and 1990s continue to shape debates about public health, and the existing shape of public health infrastructure.

The fourth element arose in 1996 when the electoral system changed from first past the post (FPP), where the majority party takes power, to a mixed member proportional system (MMP). MMP elections typically result in coalition governments where minority parties gain seats proportional to their share of the overall vote, not simply electorate wins. Since 1996 most NZ governments have involved minority parties, allowing more minority voice into parliament and policy while navigating the flipside of minority interest groups dominating the policy agenda, at times detracting from health-protecting public policy [46]. The electoral system has introduced a brake on transformative reform, and introduced more consensual elements into public debate, which has shaped the conditions of the reforms that are discussed further below.

These four elements influenced the period of study, from 2000 to 2022, beginning with the passage of the New Zealand Public Health and Disability Act 2000. The Act created geographically defined DHBs that were responsible for primary and secondary services in their area; hence the period was known as the 'DHB era'. The Act underpinned the New Zealand Health Strategy 2000 [47](NZHS) and the Primary Health Care Strategy 2001 (PHCS) [48] both of which identified reducing inequities as a key priority, with PHC identified as a key policy focus for the health system. The PHCS was an important element of the health reforms. It described how PHC was to become the gateway to the publicly funded health system, and outlined how comprehensive PHC could help tackle inequities and improve health outcomes by closing the gaps between Māori and other populations, guided by six key directions: community approach and focus; reducing health inequities; improving access to comprehensive PHC; co-ordinating healthcare across sectors, disciplines and levels; developing the workforce; and continuous quality improvement.

The PHCS heralded major changes in the way primary care was structured and funded, primarily with the establishment of meso-level organisations known as Primary Health Organisations (PHOs). These were umbrella organisations to enable health and social service providers to work together to provide services for their registered population (not simply GP management services). PHOs were to be not-for-profit bodies funded by DHBs on a capitation basis according to a formula that was to reflect the "relative need of their enrolled populations, taking account of factors such as age, sex, socioeconomic status and ethnicity" [48]. The Ministry of Health acknowledged that some population groups such as Māori, Pacific, rural and refugees may need additional funding as "the costs of reaching such populations are often not sufficiently taken into account in funding formulae" [49]. Practitioners (mainly GPs) could choose to join on a practice/clinic basis in order to access the new funding, with near universal uptake. To facilitate continuity of care, patients were encouraged to enrol with a provider as a proxy for its respective PHO. Communities were to be included in PHO governance and it was expected that PHOs would show how they were responding to community priorities. Furthermore, the PHCS stated that PHOs "demonstrate that all their providers and practitioners can influence the organisation's decision-making" avoiding dominance by a particular group [48].

In light of the contextual factors above that influence reform in New Zealand we wished to investigate shifts in power and resources towards the reform's stated goal of equity. We asked two key questions relevant to the NZ context related to power and resource shifts: First, what were the challenges and enablers to implementing equitable and Tiriti compliant PHC reforms in NZ? Second, how did the distribution of power and resources in the health sector– shaped by deeper historical forces– change for PHC over the DHB reform period 2000–2022?

Methods

This article focuses on PHC reform and arose from the broader work conducted as part of WHO's "Implementation solutions initiative: political economy analysis of primary health care-oriented reforms" [50]. The study used an exploratory case study methodology [51] chosen because of alignment with our questions. Specifically: (a) the research is a deep and extensive description of how and why PHC reform occurred in NZ; (b) the events under focus are historical; (c) the PHC system is of contemporary concern– what happened in the past has impact now. Data came from multiple sources, focussing on national and meso-level information about strategic levers and what helped or hindered PHC reform implementation, as well as a literature review which included government strategies and policies.

This article focuses on insights from the key informant interviews. Our interview sample focused on explanatory and information power, where adequate sample size is guided by the sample's specific knowledge [52]. We wanted to understand the how and why of the reforms, therefore we focussed on interviews with key policy stakeholders who might be able to yield high information power: those with both a national overview and unique insights into issues of policy development and implementation [53]. We then used a purposive sample of stakeholders who had been involved in the reform period to capture a unique insight from those who were there. To this end our sample had highly specific characteristics, particularly involvement with the reforms over time at the national and district level and familiarity with PHC in NZ from 2000 to 2022 and were 'privileged witnesses' [54] to policy formation and implementation. Additionally, some of the study team had been personally involved in the DHB reforms. Thus, using a form of auto-ethnography [55] aligned with the principles of kaupapa Māori research (research organised around Māori prinicples)

Table 1 Participant number, professional and PHC involvement over DHB era

Number	Professional background and involvement over DHB era
P1	Pacific health professional involved in early PHO establishment, policy work at regional and national level
P2	Māori GP, involved in PHO leadership; research and academic roles
P3	Pākehā * GP in community run PHC (union and Māori providers), National and regional policy work
P4	Pākehā GP in community run PHC (union and Māori providers), senior Ministry of Health roles; international experience
P5	Māori Public official,, senior leadership in Māori health, PHC governance roles, former nurse
P6	Pākehā public official, senior leadership roles in PHC within government and PHOs
P7	Pākehā academic, former GP, national health policy advisory roles

*Pākehā refers to a New Zealander of European descent

[56] we incorporated their knowledge in a workshop to develop a line of questioning regarding the DHB reforms, drawing on key themes from the literature review and participant insights. This resulted in two key questions above.

After ethics committee approval (Otago University, Category B, approved 2/6/23), we longlisted and invited 33 potential participants, undertaking 7 semi-structured interviews with 7 participants via zoom between May and July 2023 (Note the study duration was longer running from March-October 2023).

Table 1 summarises participants.

Data Analysis

We used rapid qualitative analysis based on the Consolidated Framework for Implementation Research (CFIR) [57] where the interviewer records a summary of each interview based on the notes taken during and immediately after the interview. Each interview was also transcribed using an electronic transcribing service, with each interviewer reviewing the transcription checking for accuracy and ambiguity in the transcripts. We noted how each participant discussed the key themes previously identified from the literature and researcher discussions. If other themes were identified themes were noted and quotes attributed. Once data collection was complete, team members met in person to review summary responses. Through this discussion the themes and subthemes and their relationships with each other were identified and refined, then applied to our research questions.

Results

How did the distribution of power and resources in the health sector change for PHC over the DHB reform period 2000–2022?

There was an initial shift of financial resources into PHC

Participants noted that initial investment via capitation facilitated improved access and changes in models of care, and a more reliable population denominator (P3, P4, P5, P6, P7). Most primary care providers and practices opted to join PHOs due to increased government funding for practices nationwide, where most practices doubled their income without giving up too much power. "Initially, it really did reduce the cost barrier for patients and most people could enrol…there was an impact on acute demand, pretty much straightaway…the hospitals were freed up to do the work that hospitals should do" (P3).

Continuity of care was improved (P6), the primary health care team expanded beyond GPs (P1, P3, P4), and different models of care evolved (P1, P3) because of increased funding. The new requirement for patient enrolment enabled the establishment of a population register, for the first time providing a denominator to measure system performance and accountability for funding (P3, P4, P6). A critically important development was the ability to observe primary care utilisation by population sub-groups (P3, P4). Participants observed that enrolment improved the National Health Index (NHI) number dataset's quality across the health system eliminating duplicate numbers, and enabling better integration between primary and secondary care data systems (P6) [58]. Importantly NHIs facilitated the creation of a place-based register of health outcomes to aid intersectoral work on the determinants of health, such as housing (P3).

Expedience of implementation overshadowed embedding policy aims

Despite policy goals of empowering the community to participate in PHC, medical profession dominance was sustained. Rather than developing from scratch as implied in the PHCS, early PHOs largely arose from pre-existing Independent Practitioner Associations (IPAs) which had been formed by GPs in the 1990s. IPAs were for-profit organisations formed by networks of doctors, providing management services for members enabling them to collectively conduct health-service contract negotiations with government agencies under the pre-2000 health system structure [59]. From 2000, IPAs "rapidly became the largest corporate entities in the primary care system" (P7). This created a critical mass focused on health provider interests possibly at the expense of broader policy goals of responsibility for a population, Māori representation and responding to unmet need (P3, P5).

Participants reported that senior politicians articulated a clear vision for PHC but the implementation pathway was less developed. Ultimately, the Ministry of Health prioritised expedience of implementation over policy detail, ultimately sustaining GP dominance. The role of pre-existing power structures within the landscape is notable here. When implementation became the responsibility of the Ministry of Health, it sustained the status quo, resulting in continued GP dominance. "The big IPAs…became…the big PHOs. And they got around the [requirements for] local community and not-for-profit by creating these management services organisations" (P6). "The government…didn't really have much of an interest in primary care once they set up PHOs and capitation" (P2). "The problem over time politically was that there was no ongoing…consideration of what were the aims of the policy. So the policy intent was good, the document of the strategy was good…But [we'd] just entered a period of kind of neglect and flatlining" (P3). "You know, it's like, we don't do the hard work that follows on from these amazing, wonderful aspirational goals. Actually, operationalizing things is really hard" (P1).

Power of the medical profession further consolidated in four large PHOs

Contrary to the policy goal of elevating community voice in primary care, participants stated that the governance of PHOs became increasingly dominated by GPs' interests, and later by commercial ones that were well placed to maintain their power in future reforms:

> *You can argue well- good, sustainable primary care providers are good for population health, and there's good evidence for that. But there are times when… their needs conflict…lower fees are better for populations that can access…GPs. Well that's fine, but not if I can't pay my nurse or myself (P6).*

Another participant observed that there was a "reduction…[in] the value of the community voice and the rise of the clinical voice" (P5).

While the PHCS envisaged PHOs as being local structures of 'various shapes and sizes' (PHCS 2001, p5) over time, many smaller PHOs amalgamated to form four large PHOs, a shift encouraged by the incoming right-of-centre National government in 2008. Participant P6 believed this resulted in large PHOs having significant influence over policy. They gave an example of successfully advocating for increased subsidies for Community Services Card holders (issued to low-income earners).

> *[We did] a lot of work with politicians around election time… explaining why it was a problem…we had media people talking about the cost going to the GP… both parties, Labour and National, put out policies [to] bring in additional subsidies for Community Services Cards…you can influence public policy by kind of mixture of analysis and PR (P6).*

From 2008, the large PHOs evolved into increasingly commercially-driven rather than medical profession-driven entities, structurally splitting not-for-profit and commercial elements and becoming self-interested institutions in their own right.

> *Policy settings allowed the ability to syphon off… funding into those commercial arms. There was a deal done…I think it was still with a Labour government where they could keep the funding that they had, which was basically from under-servicing [patients]…as long as the purpose was to improve health services…they've bought practices, [a large PHO]…developed [a patient management system] software…selling it as a commercial product. This is privatisation of public funding…funding that should have been going into service delivery or to supporting their very general practices…their members (P3).*

Implementation failures undermined shifts in power and resources

Participants identified aspects of implementation over subsequent years which constrained the achievement of PHCS policy goals. GP dominance was observed to be coupled with a lack of willingness or understanding to pursue the policy goals of the PHCS by Ministry of Health officials. An initial example was the failure to set a cap on patient co-payments at the time increased funding was introduced. "[Practices] were getting a lot of extra funding… there were no controls on [co-payments] so people put their prices up…that was an opportunity missed. But because of the political pressure, the Ministry basically didn't push hard and the Minister compromised" (P3). Further, capitation seemed to be viewed as simply a funding mechanism rather than a driver of a model of care to improve population-level health outcomes.

> *The misunderstanding…about what a capitation model is supposed to achieve…moving from episodic care to planned care…we never got to that point of really understanding and implementing…the capitation model, because we kept…a sort of fee-for-service mindset…it was always seen as just a, a contract or funding…instead of fully understanding the power of the capitation model (P5).*

This meant that public health elements of PHC were undervalued. Consequently, initiatives such as Care Plus (targeted funding by exception for individuals with long term conditions) undermined the capitation model, which was intended to bulk-fund services for populations rather than individuals.

Another explained how carving out different funding streams drove transactional care and shifted away from the holism capitation aimed to create. "We ended up with multiple funding streams, [it] became…about who was the most efficient at claiming [which]…really supported practices with the infrastructure to support claiming" (P3).

Over time, the reductionist view of capitation as a contract for first-contact services undermined the PHCS's vision of a multidisciplinary primary care team, focussing on capitation as a mechanism for paying GP first contact services rather than other models of care such as nurse-led practice [60, 61], especially when GPs were business owners as opposed to salaried staff [61].

The policy intent of the PHCS to fund PHOs to provide population-based initiatives such as health promotion was also undermined through contract rules. "[GPs] were reassured that the money wouldn't be taken away and used for other things. The downside of that is that the money couldn't be taken away and used for other things, I think it's quite sensible sometimes to do that" (P6).

The lack of a requirement for PHOs to share data they held on the health of their enrolled populations, and their reluctance to do so voluntarily was seen as a failure by several participants:

> *We've got some very large PHOs…they are very clear that they've…invested in the infrastructure to enable them to…collect and interrogate data, that they're not prepared to hand it over to the system, despite the fact that the system pays for them to collect it (P5).*

The ability to control health data further embeds the power of large PHOs within the broader health system.

External influences impacted the distribution of power and resources in PHC

Participants supported the aims of the PHCS but expressed dismay that they were not realised. This was attributed to a lack of political will to intervene in PHC (P1, P2, P3). A critical reason for this is politicians' perceived lack of currency for PHC among voters because of a hospital and elective services focus. "We're hospital focused, I think [given] three-year election cycles, it's much easier to do something around waitlists for…hip operations…[and] hospital waitlists…and measure…before and after" (P2). "Their bravery…evaporates as the elections become closer" (P6).

The machinery of government and its focus on particular fiscal outcomes (such as "prudent" public debt, a goal legislatively enshrined in the Public Finance Act 1989) was another factor identified by participants that inhibited the achievement of policy goals:

> *The…public management system [is focused] on financial fidelity…I used to have to sign a [declaration] as a senior public servant to say…I had…complied with the Public Finance Act, I never had to sign anything that said, I'm making the health of the population better (P1).*

What were the enablers and challenges to implementing equitable and Tiriti-compliant PHC reforms in New Zealand?

Māori, Pacific and pro-equity leadership were key policy enablers

Participants identified Māori, Pacific and pro-equity leadership throughout the system as critical enablers of achieving equity in primary health care (P2, P3, P5). Ministers of Health released the first Māori Health Strategy (He Korowai Oranga) in 2002 [62]. This document set a strategic direction for improving health outcomes for Māori, and introduced the concept of whānau (extended family) as the fundamental unit for Māori health policy. The Whānau Ora (Whanau/Extended -Family Wellbeing) policy was seen as a "significant policy shift" because it recognized "whānau as an institution" (P4) and provided a middle ground between individuals and populations. This policy was:

> *about understanding and supporting whānau [extended family] and their aspirations, and then designing your health and other social responses in support of [these]. It's a radical idea…I don't think it's ever been fully implemented the way it should have (P4).*

Afterwards, the first Māori PHOs were established, eventually merging to a national Māori PHO coalition focussed on health and wellbeing (National Hauora Coalition (NHC)) in 2011 creating the critical mass to provide a strong Māori voice within the primary health care sector.

Leadership within the Ministry of Health was also identified as important. With respect to the establishment of PHOs, one participant observed:

> *The inequities work that the Ministry was leading… had quite a lot of influence… we need governments and ministers who really understand primary care*

> *and its role in the system. And its ability to address inequality. I don't feel we've had any ministers... since...who have really understood primary health care (P3).*

Furthermore, the importance of having Māori and Pacific policy expertise was highlighted, noting the strong role a focal point for advocacy provided in the Ministry (P2, P3, P5).

A primary care workforce that reflected Māori, Pacific and other groups experiencing inequities was identified as a key enabler for equity (P2, P3), as well as Māori and Pacific health academics (P3).

Overall, this period of primary health care reform was seen as a step towards achieving equity for Māori, in particular "the development of Māori, and particularly iwi-based [tribe-based] providers [is]...hugely significant" (P7).

Establishing a denominator enabled greater accountability

For the first time, the establishment of PHO enrolment registers provided a denominator and enabled monitoring of performance, including by demographic factors such as ethnicity in service utilisation. *A* robust denominator provided evidence for where inequities existed; this data was also used to argue for pro-equity interventions with successive governments. "We...show[ed Minister of Health] the data...to convince him...to get 95% of the total population immunised...you could not ignore the Māori and the Pacific population...because they are a significant part of [the child] age group" (P5).

Policy challenges for achieving equity

Participants identified the homogeneity of PHC policy makers in the Ministry (P2), particularly a lack of Māori or Pacific input into the PHCS' development at a policy level, including from the Ministry's Te Kete Hauora/The Māori Health Directorate (P5). The capitation model provided a funding injection and improved access, at least initially. However, Māori health providers were disadvantaged in the policy design because ethnicity was not included in the capitation funding formula despite Māori and Pacific peoples having a much higher burden of disease, which participants viewed as a major barrier to achieving health equity (P7). The Associate Minister of Health's advice was overridden:

> *by a [view that] Māori have been under utilising the services, and once the cost barriers reduce, and because there's a utilisation factor in the formula, and because they're a younger population, deprivation's in there [it] will benefit Māori without putting ethnicity in the formula (P3).*

Subsequent attempts to address inadequate capitation funding for patients with higher health needs did not address fundamental problems with the funding formula.

> *It was easier to tinker, that was just pragmatic policymaking [and] politics. 'Look, we've just increased the allowance for under 14-year-olds or increase this, there's been a lot of that.' Meanwhile, the fundamentals of the formula weren't right. And the formula is such a powerful tool potentially...It's not being used properly (P7).*

Participants observed that larger PHOs were advantaged by being able to negotiate contracts for additional funding based on their large enrolled population and perceived efficiencies:

> *[A large PHO] argued that...they wanted to develop...healthcare homes [model of care]...they got something like $9 million...they get [funding] opportunity[ies] to develop... something which suits mainstream...it's not the same deal for Māori providers or rural providers" (P3).*

This systemic bias towards large PHOs was felt to reflect the ongoing process of colonisation within the health system. "The assumption of marginality or inferiority of Māori culture, language, ways of being...is paramount. In the way the Pākehā [Western] institutions conduct themselves, there are notable exceptions...in the health system. But it's still the dominant ideology" (P7). Another observed that a small section of PHC providers with a particular model of care has become the default group for commissioning (P3).

Furthermore, despite policy commitments to Te Tiriti o Waitangi and achieving health equity, there were no consequences for PHOs or practices for ineffective implementation. "That's certainly what the [Wai 2575 Waitangi] Tribunal report came out with...if you didn't implement partnership, participation or protection in the system, there was no consequence (P5)."

Power shifts in the socio-political context

Examining the deeper reasons behind the failure to incorporate ethnicity into capitation funding formula as envisaged in the PHCS, participants uniformly identified the changing socio-political context as a key factor. A notable change was sparked by the widespread media and public discussion of the Orewa speech 2004, where a right-wing politician, Don Brash, argued that Māori received special privileges. As one participant noted, this had a chilling effect on proposals to include ethnicity in the funding formula:

> *The Ministry did propose [ethnicity as a factor in the capitation model in] a briefing paper…and Ministers didn't sign off…It was around the time of the…[broader] review of ethnic based programmes and policies…the Brash incident [had] occurred, and that's at the point where…the Labour government was seeking another term…so they were prepared to become pretty unprincipled around it (P5).*

One participant who was working at the Ministry of Health at the time observed "I think we always underestimate what the level of backlash will be to equity" (P1). Initially a key proponent of primary health care reform, the Minister of Health was observed to be less willing to advocate for equity as the election drew nearer. One participant described the Minister of Health as having "lost political nerve during implementation" (P7).

Later, in 2016 the right-of-centre National Government disestablished Te Kete Hauora/the Māori Health Directorate in the Ministry of Health. This further undermined Māori influence on health policy since there was no longer a Māori health policy focal point, relying instead on expertise being distributed throughout the Ministry of Health, and no way of measuring accountability of policy responsiveness to Māori (P5).

Pervasiveness of the inverse care law

When commenting on the current state of primary care, participants noted the unequal distribution of access to primary care resulting from policy settings over previous years. "Overall…primary care still works. For most of us with high income…it is a good quality service…But it has failed for highest needs communities, low socioeconomic groups…it does not work" (P1).

Participants noted the mismatch between the geographical distribution of the PHC workforce, and areas with a high concentration of health need. Workforce distribution is currently visible in PHC in two different forms. First, inability to enrol with a practice was identified as an ongoing problem, with many closing their books. This "created a whole new marginalised group of unenrolled, who…[were] predominantly Māori. We've got 20% unenrolled here in the Waikato community at present" (P3). The second manifestation of the maldistribution of the primary care workforce is practices enrolling patients at a high patient: provider ratio, such that appointments are in short supply and wait times are long. "If you go to Otara [a neighbourhood with high socioeconomic need], there [are] practices all over the place…the model is to keep the people waiting for long periods of time while they take huge amounts of capitation" (P1). A potential reason for this mismatch was identified as a lack of growing "a provider sector where the needs are greatest" (P4).

One participant recalled that equitable funding of PHC was poorly understood even among leaders of the health system:

> *"I remember arguing with a DHB CEO. They wanted fairness between providers. And I would argue…you shouldn't be fair to providers, you've got to be fair to communities…high need communities need more resources than low need communities, you don't distribute it according to your providers, it was sad that something as basic as that was having to be argued" (P4).*

Discussion

The DHB era provides insights into how policy aims of improved health equity fared through attempts to shift power and resource. Expert informant interviews demonstrate that an initial shift in power and resource appears not to have been sustained because underlying mechanisms were not factored into the reform's implementation. The interviews reveal that long-running historical forces– such as colonisation and approaches to the role of the state– still shape the operation of New Zealand's PHC system and constrain the way reforms can be conducted. This occurs alongside existing structures, such as the influence of medical professionals as business owners on PHC policy that also conditioned the DHB era. Understanding the shift in power and resources can help to illuminate a set of barriers to PHC reform, and points to the need for reformers themselves to be explicit about the historical and existing distribution of power and resources when setting out to enact desired policy change. Specifically, this means giving attention to power and resource flows encapsulated in funding arrangements as these are important to achieving reform goals [31].

However, NZ policymakers and health reformers rarely discuss the fundamental structures, arrangements and ideas [40] that embed ways of organising the PHC system. NZ's 2000–2022 reform failed to fully meet its promise for PHC, especially for Māori. This research explores what drove gaps between policy aspirations and eventualities by exploring how power manifested itself through dominant groups [25] over the DHB-era, despite power and resource shifts being in the interest of most citizens [63].

The fortunes of equity as a policy objective in NZ's PHC reforms highlight fundamental challenges in reform implementation. Despite a pro-equity PHC policy intent, a lack of attention to the prevailing political economy and corresponding influences on power and resource flows resulted in failure to mitigate against existing known forces that detract from equity in the PHC system, especially funding barriers and professional dominance.

Issues with the PHCS' funding and governance that could frustrate reform goals were noted early, yet not remedied. First, the PHCS itself provided little detail [64] on implementation to achieve the reform goal of equity, apart from stating this would occur via existing DHB funding and accountability measures. In 2005, Howell [40] noted that old distortions persisted in the DHB reform, specifically the providers' continuing right to charge patient co-payments alongside requirements for GP governance, frustrating the PHCS policy goal of broadening PHC governance membership [40]. Others also noted an unresolved problem in policy implementation– the tension between targeting and universalism inherent in the capitation rollout alongside targeted funds for sub-populations [65–68]. NZ is not alone with this experience. Similar implementation gaps have been noted in other countries with reform in PHC oriented health systems: For instance, in Australia Dadich and Hosseinzadeh [69] found that funding arrangements and governance strongly influenced knowledge translation in PHC reform. Similarly, in Canada Levesque et al. [70] found professional resistance and lack of financial arrangements frustrated PHC reform policy implementation in different provinces. In terms of capitation funding, in NZ's case, ethnicity remains missing from the first-contact payment calculations, the largest tranche of PHC funding which was calculated based on information available in the late 1990s/early 2000s [71]. Since then clear evidence has emerged that ethnicity is a material factor in health outcomes in NZ, yet the first-contact formula remains unchanged. This reflects the experience that even if health need is clearly documented [71] resourcing involves balancing technical concerns against contextual ones such as political appeal of such an adjustment [23].

The way in which overt and covert power was exercised within PHC was not critically examined and addressed by reform policy, resulting in a lack of a strategic approach to counter the forces that deliberately or not, impede progress toward health equity. Further, this study highlights a focus on the technical parts of reform missed opportunities to address the importance of the political elements in PHC in four main ways.

First is the fundamental and unaddressed tension between NZ's capitalist/market-driven for-profit PHC system (characterised by government subsidy via capitation payments plus out-of-pocket patient copayments) and a socialised secondary care system (government owned, provided and free for the patient) [40]. This tension has been noted elsewhere (e.g. 5, 72), and affects equity of access [73] to PHC services [74, 75]. This tension has existed since the founding of both NZ in 1840 and its organised health system in 1938, and was exacerbated by state-sector reforms in the 1980s and 1990s that prioritised financial accountability as the ultimate goal, for example through the Public Finance Act 1989. Unless there is clarity that market mechanisms are used primarily in service of population health improvement in health systems, rather than in service of the market or interests of provider groups, countries will find it hard to shift resources, share power, or achieve fairer health outcomes [76]. The 2000–2022 health reforms were influenced by third way politics, making use of private resource for public services. However, history has demonstrated that where there has been a tension between for-profit or social/community outcomes, the for-profit ones were prioritised [40] as only a subset of PHC which largely constitutes not-for-profit services has capped copayments [37].

Second, the DHB era reforms underestimated the path dependency of the system [77]. Likewise the reforms' stated goals were not hardwired into the system's fundamentals [78] and therefore not observed in the health system's behaviour. Resource that was already invested in the health system was not redeployed to create change, a common health system reform problem [79]. Successful reform requires a more determined effort to change course, inviting a different way in which actors conceptualise the nature of health systems to elicit different reform outcomes.

Third, and related to the second point, is that NZ also failed to outline and measure how resource and power should shift or extra resource be invested in underserved populations. Thus in this study, general practice, IPAs, and PHOs represent a certain segment of PHC. Over time this segment has become the default setting. Services from the third sector or Indigenous providers are different from the default, therefore more difficult for the system to deal with. Similarly, financial models for capitation, workforce development, or extra PHC services should explicitly factor in features of the populations that are left behind. Thus, the underserved would be calculated in to population level resource allocation processes from the outset, as an attempt to ensure that they are not at the mercy of the health system's internal politics or short term political means.

Fourth, for the health system to be Te Tiriti-compliant, it cannot treat Māori health as peripheral. It must be a central focus and included in every element of reform, especially funding.

What can be done to address these shortcomings? First, it is important to focus on both the technical and the political in reforms. Somehow the machinery of government has let the country down in realising reform intent, likely because of the party-political pressures of maintaining MMP coalitions to stay in power, added to the focus on finances above all else.

More fundamental is the question as to whether NZ's democratic systems are robust enough to counter capitalist pressures and support fairness for minorities when pursuing policy goals such as equity. PHC is competing for a government's political capital. Successive governments (both left and right of centre) have been aware of how palatable policies are to the majority and how policies are likely to be seen as a success, within a three year electoral cycle. This finding chimes with Rajan et al. [27] who noted wavering political commitment and investment as key problems in PHC implementation and reform. If health policy had broad political support for universal access (as exists with superannuation in NZ) then perhaps equity driven policy would have more chance of success.

Further, how power (historical and current) is exercised is neglected in policy discussions and resources do not appear to match the rhetoric in subsequent implementation mechanisms, including PHC capitation. The DHB era shows that greater attention should be paid in policy design to the risks of disruption to PHC reform caused by racist rhetoric (both political and societal), institutional and professional capture, and macro-economic ideals that directly impact on the system's ability to deliver health equity. The present research work echoes overseas experience where despite clear policy aims, countries have failed to reduce inequity (geographic, ethnic, gender or class [80]) for lack of shifting power and resources within the health sector.

The study on which this article is based is limited in that it was undertaken in a short timeframe (6 months), limiting the number of participants. It coincided with the implementation of further health reforms so many potential participants did not have time to participate, or were aware of possibly compromising their professional positions; NZ is a small country and this study's participants were senior enough to feel that they could speak freely. Nonetheless, the researchers invited many different participants of differing political hues, and the study sample represents the people with the time and inclination to participate. Although Māori and Pacific voices are included in this study further contribution would have benefitted the study by including additional diverse perspectives to reflect the heterogeneity of Māori and Pacific realities within NZ. The other limitation within the participants is the dominance of medical perspectives with a significant underrepresentation of nursing, allied health or community perspectives. This limitation reflects the dominance of medical professionals on the study team. Of the six involved four are primary health care trained physicians, one was a health promoter, and two were lawyers by training, one of whom has expertise in political economy. However, despite the limitations the results hold: the information power from our sample provides a rich data set that allows us to draw indicative conclusions about New Zealand's situation and explore core elements of our research questions.

This study's implications point to actions that could help the PHC tranche of the ongoing Pae Ora reform to meet its stated goals of access, sustainability and fairness based on this analysis. Others from countries with Indigenous populations may find this study of interest.

Further, a contingency theory lens could be complementary to tracking shifts in power and resources. Contingency theory examines an organisation's function and performance, holding that there is no best way to act. Rather, performance is linked to the nature of an entity and what is happening in the wider environment [81]. Instead of being wedded to a particular set of managerial or economic theories, a contingency lens would allow decision-makers to scan the environment and draw on the best approaches and investments in a given context to achieve a particular goal [82]. It follows that in trying to create a more equitable health system, the Pae Ora reform could explore how policy options might work in relation to contingent factors in the wider environment (e.g. health need, models of care, workforce) and implement policy accordingly [83]. Applying a contingency theory perspective to PHC reforms [84]), would help identify key barriers and enablers to implementing the proposed health policy. In NZ's case this would highlight broader issues around capitation and workforce changes and align implementation strategies to address those issues [81].

This research demonstrates the profound influence of wider political and economic factors on NZ's reform. It follows that for reforms to be successful, attention should be paid to describing and measuring resource and power shifts to affect changes to models of care and improved access to PHC.

The research shows that in the NZ context, strong allyship with Māori social and organisational structures that endeavour to do things differently is essential, and realising Tiriti o Waitangi obligations must be paramount. Existing Māori models of care and third-sector models demonstrate alternative ways of organising PHC [12] These should become part of the core, not the periphery.

Effective policy instruments for redistribution of resources, especially funding and accountability mechanisms, are vital to change. This means redesigning how resource is invested and progress measured around a different set of values, with health outcomes at the centre and financial prudence and efficiency in service of those outcomes.

An associated point is the importance of the core values underpinning a health system reform and naming them directly and explicitly at each part of the reform, and measuring progress towards them. Such an approach links the political to the technical, ensuring that the values of the reform are reflected in the way the reform is implemented and progress monitored. This also means being honest about quick fixes and highlighting that while there can be short term gains, meaningful reform takes time and sustained effort.

Conclusion

The DHB era highlights a persistent disconnect between the stated reform goal of equity and the system's observed behaviour, where equity is at the mercy of changes in the political climate that constrain power and resource shifts. In NZ, PHC reforms have been shaped by historical and current political and economic factors, including colonisation, racism and neoliberalism. These broader socio-political and economic elements have rarely been directly addressed: they remain unremarked, unaddressed and normalised. For the value of equity to be realised through power and resource shifts anticipated by reforms, and for Te Tiriti to be complied with successfully in PHC, future reform requires attention to shifts in power and resource, informed by robust population health data. History tells us that implementation of any pro-equity, pro-Tiriti aims in PHC reform requires strong political leadership, effective policy instruments to direct resource and maintain its direction, and allyship with Māori social and organisational structures so that reforms address equity and honour Te Tiriti.

Abbreviations

CFIR	Consolidated Framework for Implementation Research
DHB	District Health Board
GP	General practitioner
IPA	Independent Practitioner Association
NHI	National Health Index number is a unique identifier assigned to each person who receives healthcare in New Zealand
NZ	Aotearoa New Zealand
NZHS	New Zealand Health Strategy 2000
PHC	Primary health care
PHCS	Primary Health Care Strategy 2001
Te Tiriti	Te Tiriti o Waitangi/The Treaty of Waitangi 1840, New Zealand's founding document outlining governance arrangements between the British Crown and Indigenous Māori
PHO	Primary Healthcare Organisation
WHO	World Health Organisation

Acknowledgements

Thank you to the participants, and to the anonymous reviewers for their helpful feedback on this article.

Author contributions

J.R was involved in conceptualisation, methodology, formal analysis, project management, writing– original draft, review and editingN.B was involved in conceptualisation, investigation, formal analysis; writing– original draft, review and editingD.M was involved in conceptualisation; investigation, formal analysis; writing -review and editing. DM led the original project on which this article is based. N. R was involved in conceptualisation, methodology, investigation, data curation, formal analysis; writing- review and editing R. K was involved in conceptualisaton, methodology, investigation, review and editing P. C was involved in conceptualisation, writing- review and editingM. H was involved in conceptualisation, review and editing.

Funding

This article arose from the broader work conducted by the authors as part of WHO's "Implementation solutions initiative: political economy analysis of primary health care-oriented reforms", funded by the WHO. The funder did not have any role in the data collection, analysis or interpretation of the data, nor input into the report or decision to submit the article for publication.

Data availability

No datasets were generated or analysed during the current study.

Declarations

Ethics approval and consent to participate

This article was approved by the Otago University Ethics Committee (Category B) in June 2023 and all participants consented to participate.

Consent for publication

Not applicable– no individuals are identifiable and study participants consented to their words being used in research outputs such as academic articles.

Competing interests

The authors declare no competing interests.

Received: 14 September 2024 / Accepted: 28 March 2025

References

1. Henry TL, Britz JB, Louis JS, Bruno R, Oronce CIA, Georgeson A et al. Health Equity: The Only Path Forward for Primary Care. Ann Fam Med. 2022;20(2):175–8. Available from: http://ovidsp.ovid.com/ovidweb.cgi?T=JS%26;PAGE=reference%26;D=med21%26;NEWS=N%26;AN=35165088
2. Starfield B, Shi L. Macinko J. Contribution of Primary Care to Health Systems and Health. Milbank Q. 2005;83(3):457–502. Available from: https://doi.org/10.1111/j.1468-0009.2005.00409.x
3. World Health Organisation. Declaration of Astana: Global Conference on PHC, Astana K. 2018. Available from: https://www.who.int/publications/i/item/WHO-HIS-SDS-2018.61
4. Davy C, Harfield S, McArthur A, Munn Z, Brown A. Access to primary health care services for Indigenous peoples: A framework synthesis. Int J Equity Health. 2016;15(1):163. Available from: https://doi.org/10.1186/s12939-016-0450-5
5. Goodyear-Smith F, Ashton T. New Zealand health system: universalism struggles with persisting inequities. Lancet. 2019;394(10196):432–42. Available from: http://www.sciencedirect.com/science/article/pii/S0140673619312383
6. Schneider E, Mirror M et al. 2021: Reflecting Poorly Health Care in the U.S. Compared to Other High-Income Countries. 2021. Available from: https://www.commonwealthfund.org/publications/fund-reports/2021/aug/mirror-mirror-2021-reflecting-poorly
7. Polin K, Hjortland M, Maresso A, van Ginneken E, Busse R, Quentin W. Top-Three health reforms in 31 high-income countries in 2018 and 2019: an expert informed overview. Health Policy (New York). 2021;125(7):815–32. Available from: https://www.sciencedirect.com/science/article/pii/S0168851021001032
8. Bramley D, Hebert P, Tuzzio L, Chassin M. Disparities in Indigenous health: a cross-country comparison between new Zealand and the united States. Am J Public Health. 2005;95(5):844–50.
9. Reid J, Cormack D, Crowe M. The significance of socially-assigned ethnicity for self-identified Māori accessing and engaging with primary healthcare in New Zealand. Health (Irvine Calif). 2015;20(2):143–60. Available from: https://doi.org/10.1177/1363459315568918
10. Stats New Zealand. Growth in Life Expectancy Slows. 2021 [cited 2024 Jan 25]. Available from: https://www.stats.govt.nz/news/growth-in-life-expectancy-slows/
11. Health New Zealand.| Te Whatu Ora. Health Status Report 2023. 2024.
12. Sheridan N, Jansen RM, Harwood M, Love T, Kenealy T, Aguirre-Duarte N et al. Hauora Māori– Māori health: a right to equal outcomes in primary care. Int J

Equity Health. 2024;23(1):42. Available from: https://doi.org/10.1186/s12939-023-02071-6

13. Talamaivao N, Harris R, Cormack D, Paine S-J, King P. Racism and health in Aotearoa new Zealand: a systematic review of quantitative studies. New Zeal Med J. 2020;133(1521):55.
14. Reid P, Paine SJ, Te Ao B, Willing EJ, Wyeth E, Vaithianathan R, et al. Estimating the economic costs of Indigenous health inequities in new Zealand: a retrospective cohort analysis. BMJ Open. 2022;12(10):e065430.
15. NZ Government. Pae Ora (Healthy Futures) Act. New Zealand. 2022. Available from: https://www.legislation.govt.nz/act/public/2022/0030/latest/versions.aspx
16. Tenbensel T, Cumming J, Willing E. The 2022 restructure of Aotearoa new Zealand's health system: will it succeed in advancing equity where others have failed? Health Policy. 2023;134:104828.
17. Braun B, Christophers B. Asset manager capitalism: An introduction to its political economy and economic geography. Environ Plan A Econ Sp. 2024;56(2):546–57. Available from: https://doi.org/10.1177/0308518X241227743
18. Christophers B. Rentier Capitalism: Who Owns the Economy, and Who Pays for It? Verso; 2020.
19. Christophers B. Our lives in their portfolios: why asset managers own the world. Verso; 2023.
20. Britton-Purdy J, Grewal DS, Kapczynski AMY, Rahman KS. Building a law-and-political-economy framework: beyond the twentieth-century synthesis. Yale Law J. 2020;129(6):1784–835.
21. Reid P, Cormack D, Paine S-J. Colonial histories, racism and health—The experience of Māori and Indigenous peoples. Public Health. 2019;172:119–24. Available from: https://www.sciencedirect.com/science/article/pii/S003335061930126X
22. Simon-Kumar R, Lewycka S, Clark TC, Fleming T, Peiris-John R. Flexible resources and experiences of racism among a multi-ethnic adolescent population in Aotearoa, New Zealand: an intersectional analysis of health and socioeconomic inequities using survey data. Lancet. 2022;400(10358):1130–43. Available from: https://doi.org/10.1016/S0140-6736(22)01537-9
23. Reich MR. Political Economy of Non-Communicable Diseases: From Unconventional to Essential. Heal Syst Reform. 2019;5(3):250–6. Available from: https://doi.org/10.1080/23288604.2019.1609872
24. Reich MR. Political economy analysis for health. Bull World Health Organ. 2019;97(8):514.
25. Sparkes SP, Bump JB, Özçelik EA, Kutzin J, Reich MR. Political economy analysis for health financing reform. Heal Syst Reform. 2019;5(3):183–94.
26. Félix-Bortolotti M. Part 1– unravelling primary health care conceptual predicaments through the lenses of complexity and political economy: a position paper for progressive transformation. J Eval Clin Pract. 2009;15(5):861–7. Available from: https://doi.org/10.1111/j.1365-2753.2009.01274.x
27. Rajan D, Jakab M, Schmets G, Azzopardi-Muscat N, Winkelmann J, Peiris D et al. Political economy dichotomy in primary health care: bridging the gap between reality and necessity. Lancet Reg Heal– Eur. 2024;42. Available from: https://doi.org/10.1016/j.lanepe.2024.100945
28. Kringos DS, Boerma WGW, van der Zee J, Groenewegen PP. Political, cultural and economic foundations of primary care in Europe. Soc Sci Med. 2013;99:9–17. Available from: https://www.sciencedirect.com/science/article/pii/S0277953613005236
29. McCartney G, Hearty W, Arnot J, Popham F, Cumbers A, McMaster R. Impact of political economy on population health: A systematic review of reviews. Am J Public Health. 2019;109(6):e1–12.
30. Peterson CL, Walker C. Universal health care and political economy, neoliberalism and effects of COVID-19: A view of systems and complexity. J Eval Clin Pract. 2022;28(2):338–40.
31. Harvey M. The Political Economy of Health: Revisiting Its Marxian Origins to Address 21st-Century Health Inequalities. Am J Public Health. 2020;111(2):293–300. Available from: https://doi.org/10.2105/AJPH.2020.305996
32. Mou H. The political economy of the public-private mix in Heath expenditure: an empirical review of thirteen OECD countries. Health Policy. 2013;113(3):270–83.
33. Borges FT, Fernández LAL, de Campos GW. S. Austerity measures on fiscal policy: an attempt to dismantle the Spanish National Health System and citizen resistance TT - Políticas de austeridade fiscal: tentativa de desmantelamento do Sistema Nacional de Salud da Espanha e resistência cidadã. Saude e Soc. 2018;27(3). Available from: https://www.proquest.com/scholarly-journals/austerity-measures-on-fiscal-policy-attempt/docview/2791773986/se-2?accountid=14700
34. Sandy LG, Bodenheimer T, Pawlson LG, Starfield B. The political economy of U.S. Primary care. Health Aff (Millwood). 2009;28(4):1136–45.
35. Walker C, Peterson CL. Universal health coverage and primary health care: their place in People's health. J Eval Clin Pract. 2021;27(5):1027–32.
36. Ekman B, Wilkens J. A literature review of the regional implementation of the central Swedish government's health care reforms on choice and privatization. Health Econ Rev. 2015;5(1):39. Available from: https://doi.org/10.1186/s13561-015-0076-0
37. Jeffreys M, Ellison-Loschmann L, Irurzun-Lopez M, Cumming J, McKenzie F, Team on behalf of the PHCPG. Financial barriers to primary health care in Aotearoa New Zealand. Fam Pract. 2024;41(6):995–1001. Available from: https://doi.org/10.1093/fampra/cmad096
38. Maynou L, Coll-de-Tuero G, Saez M. The effects of copayment in primary health care: evidence from a natural experiment. Eur J Heal Econ. 2019;20(8):1237–48. Available from: https://doi.org/10.1007/s10198-019-01089-4
39. Raphael D, Bryant T. Maintaining population health in a period of welfare state decline: political economy as the missing dimension in health promotion theory and practice. Promot Educ. 2006;13(4):236–42.
40. Howell B. Restructuring primary health care markets in new Zealand: from welfare benefits to insurance markets. Aust New Z Health Policy. 2005;2:20.
41. Fletcher N. The english text of the treaty of Waitangi. Wellington, NZ: Bridget Williams Books; 2022. p. 736.
42. King M. The Penguin history of new Zealand. Auckland: Penguin; 2003. p. 592.
43. Reidy J, Matheson D, Keenan R, Crampton P. The ownership elephant is becoming a mammoth: a policy focus on ownership is needed to transform Aotearoa new Zealand's health system. N Z Med J. 2023;136(1576):74–81.
44. Kelsey J. The new Zealand experiment: A world model for structural adjustment? Auckland: Auckland University; 1997. p. 407.
45. Manwaring R, Duncan G, Lees C. 'Thin labourism': Ideological and policy comparisons between the Australian, British, and New Zealand labour parties. Br J Polit Int Relations. 2023;26(1):39–61. Available from: https://doi.org/10.1177/13691481221148326
46. Hoek J, Edwards R, Waa A. Tobacco industry interference: is the new government meeting its international obligations? Public health expert briefing (The briefing - Te Mahere). Public Health Communication Centre Aotearoa; 2024.
47. King A. The new Zealand Heath strategy. Ministry of Health; 2000. p. 54.
48. Ministry of Health. The New Zealand Primary Health Care Strategy. 2001;6736. 2008:6–8
49. Kirchner JE, Woodward EN, Smith JL, Curran GM, Kilbourne AM, Owen RR et al. Implementation Science Supports Core Clinical Competencies: An Overview and Clinical Example. Prim care companion CNS Disord. 2016;18(6). Available from: http://ovidsp.ovid.com/ovidweb.cgi?T=JS%26;PAGE=reference%26;D=med13%26;NEWS=N%26;AN=27959478
50. WHO. International conference celebrating the 45th anniversary of Alma-Ata. and 5th anniversary of Astana declarations. 2023 [cited 2024 Jul 16]. Available from: https://www.who.int/europe/news-room/events/item/2023/10/23/default-calendar/international-conference-commemorating-alma-ata-45-and-astana-5---on-primary-health-care-policy-and-practice--implementing-for-better-results
51. Yin R. Case study research and applications: design and methods. 6th ed. Thousand Oaks CA: SAGE; 2018.
52. Malterud K, Siersma VD, Guassora AD. Sample size in qualitative interview studies: guided by information power. Qual Health Res. 2016;26(13):1753–60.
53. Signal LN, Bowers SG, Edwards R, Gifford H, Hudson S, Jenkin GLS et al. Process, pitfalls and profits: lessons from interviewing New Zealand policymakers. Health Promot Int. 2018;33(2):187–94. Available from: https://doi.org/10.1093/heapro/daw065
54. Silva EA, Healey P, Harris E, Van den Broeck P. The Routledge Book of Research Methods. Routledge; 2014.
55. Ellis C, Adams T, Bochner A, Autoethnography. An Overview. Forum Qual Sozialforsch. 2011;12(1). Available from: https://www.qualitative-research.net/index.php/fqs/article/view/1589/3095
56. Walker S, Eketone A, Gibbs A. An exploration of Kaupapa Maori research, its principles, processes and applications. Int J Soc Res Methodol. 2006;9(4):331–44.
57. Nevedal AL, Reardon CM, Opra Widerquist MA, Jackson GL, Cutrona SL, White BS, et al. Rapid versus traditional qualitative analysis using the consolidated framework for implementation research (CFIR). Implement Sci. 2021;16(1):67.

58. Te Whatu Ora Health New Zealand. National Health Index questions and answers. 2023. Available from: https://www.tewhatuora.govt.nz/our-health-system/digital-health/health-identity/national-health-index/national-health-index-questions-and-answers/
59. Kriechbaum A, Crampton P, Dowell A. Independent practice associations in new Zealand: a study of governance structures and process. N Z Med J. 2002;115(1147):50–2.
60. Downs A. From theory to practice: the promise of primary care in new Zealand. Fulbright New Zealand; 2017.
61. Pullon S, McKinlay E, Dew K. Primary health care in New Zealand: the impact of organisational factors on teamwork. Br J Gen Pract. 2009;59(560):191 LP–197. Available from: http://bjgp.org/content/59/560/191.abstract
62. Ministry of Health. He Korowai Oranga. Māori Health. 2002. Available from: https://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga
63. Khemani S. The Political Economy of Reform: 2017.
64. Gauld R. The unintended consequences of new Zealand's primary health care reforms. J Health Polit Policy Law. 2008;33(1):93–115.
65. Hefford M, Crampton P, Foley J. Reducing health disparities through primary care reform: the New Zealand experiment. Health Policy (New York). 2005;72(1):9–23. Available from: https://www.sciencedirect.com/science/article/pii/S0168851004001344
66. Cumming J, Mays N. New Zealand's Primary Health Care Strategy: early effects of the new financing and payment system for general practice and future challenges. Heal Econ Policy Law. 2009/10/30. 2011;6(1):1–21. Available from: https://www.cambridge.org/core/product/93DA2B34CCB4B44ED6A4F24D83969772
67. McGlashan J, Johnstone M, Creighton D, de la Haye K, Allender S. Quantifying a Systems Map: Network Analysis of a Childhood Obesity Causal Loop Diagram. PLoS One. 2016;11(10):e0165459. Available from: http://ovidsp.ovid.com/ovidweb.cgi?T=JS%26;PAGE=reference%26;D=med13%26;NEWS=N%26;AN=27788224
68. Thomson M. Who had access to doctors before and after new universal capitated subsidies in New Zealand? Health Policy (New York). 2019;123(8):756–64. Available from: https://www.sciencedirect.com/science/article/pii/S0168851018305517
69. Dadich A, Hosseinzadeh H. Healthcare reform: implications for knowledge translation in primary care. BMC Health Serv Res. 2013;13(1):490. Available from: https://doi.org/10.1186/1472-6963-13-490
70. Levesque J-F, Haggerty JL, Hogg W, Burge F, Wong ST, Katz A, et al. Barriers and facilitators for primary care reform in Canada: results from a deliberative synthesis across five provinces. Healthc Policy. 2015;11(2):44–57.
71. Penno E, Gauld R, Audas R. How are population-based funding formulae for healthcare composed? A comparative analysis of seven models. BMC Health Serv Res. 2013;13(1):470. Available from: https://doi.org/10.1186/1472-6963-13-470
72. Jatrana S, Crampton P. Do financial barriers to access to primary health care increase the risk of poor health? Longitudinal evidence from New Zealand. Soc Sci Med. 2020;(June):113255. Available from: https://doi.org/10.1016/j.socscimed.2020.113255
73. New Zealand Ministry of Health. Annual Update of Key Results 2023/24: New Zealand Health Survey. New Zealand Health Survey. 2024 [cited 2025 Mar 25]. Available from: https://www.health.govt.nz/publications/annual-update-of-key-results-202324-new-zealand-health-survey
74. Norris P, Cousins K, Horsburgh S, Keown S, Churchward M, Samaranayaka A et al. Impact of removing prescription co-payments on the use of costly health services: a pragmatic randomised controlled trial. BMC Health Serv Res. 2023;23(1):31. Available from: https://doi.org/10.1186/s12913-022-09011-0
75. Jeffreys M, Irurzun Lopez M, Russell L, Smiler K, Ellison-Loschmann L, Thomson M et al. Equity in access to zero-fees and low-cost Primary Health Care in Aotearoa New Zealand: Results from repeated waves of the New Zealand Health Survey, 1996–2016. Health Policy (New York). 2020;124(11):1272–9. Available from: https://www.sciencedirect.com/science/article/pii/S0168851020302190
76. Reidy J, Crampton P, Matheson D, Keenan R. Ownership matters: using ownership as a policy tool for reaching health system goals. WHO Country Connector Series. 2023. Available from: www.ccph.org
77. Barnes W, Gartland M, Stack M. Old habits die hard:path dependency and behavioral Lock-in. J Econ Issues. 2016;38(2):371–7.
78. Trenholm S, Ferlie E. Using complexity theory to analyse the organisational response to resurgent tuberculosis across London. Soc Sci Med. 2013;93:229–37.
79. Braithwaite J, Mannion R, Matsuyama Y, Shekelle P, Whittaker S, Al-Adawi S et al. Accomplishing reform: successful case studies drawn from the health systems of 60 countries. Int J Qual Heal Care. 2017;29(6):880–6. Available from: https://doi.org/10.1093/intqhc/mzx122
80. Fai FM, Tomlinson PR. Levelling up or down? Addressing regional inequalities in the UK. Contemp Soc Sci. 2023;18(3–4):285–97. Available from: https://doi.org/10.1080/21582041.2023.2282161
81. Leeman J, Baquero B, Bender M, Choy-Brown M, Ko LK, Nilsen P et al. Advancing the use of organization theory in implementation science. Prev Med (Baltim). 2019;129:105832. Available from: https://www.sciencedirect.com/science/article/pii/S0091743519303081
82. Engelseth P, Kritchanchai D. Innovation in healthcare services– creating a Combined Contingency Theory and Ecosystems Approach. IOP Conf Ser Mater Sci Eng. 2018;337(1):12022. Available from: https://doi.org/10.1088/1757-899X/337/1/012022
83. Gabutti Irene FM, Pia R, Chiara. Testing contingency theory to drive organizational change in community care: A case study in the Emilia Romagna Region. Heal Serv Manag Res. 2024;09514848241265749. Available from: https://doi.org/10.1177/09514848241265749
84. Contandriopoulos D, Perroux M, Duhoux A. Formalisation and subordination: a contingency theory approach to optimising primary care teams. BMJ Open. 2018;8(11):e025007.

Publisher's note