

THE ROLE OF THE THIRD SECTOR IN PROVIDING PRIMARY CARE SERVICES – THEORETICAL AND POLICY ISSUES

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Abstract

The purpose of this paper is to promote debate on the devolution of primary care services to the third sector. The paper first discusses definitions of the term “third sector”, then provides a précis of important political and economic theories related to the third sector. This is followed by a brief account of the development and role of third sector primary care in New Zealand. The final section discusses policy issues arising from third sector provision of primary care. The paper concludes that the emergence of third sector primary care in New Zealand has been consistent with international experience of third sector involvement – there were perceived “failures” in government policies for funding primary care, and private sector responses to these policies, resulting in lack of universal funding and provision of primary care and continuing patient co-payments. These failures created the type of “gap” that, based on international experience, third sector organisations tend to fill. If the existence in New Zealand of third sector primary care is accepted – either as explicit policy or de facto – policies may be required to limit the financial pressures placed on non-profits that may lead them to deviate from the social role they can and should play in New Zealand’s mixed

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economy, and to help move the economy to an agreed balance of institutional responsibilities among private enterprises, governments and non-profits.

INTRODUCTION

The third sector is the non-government, non-profit sector of a country's organisational system. The third sector occupies a significant part in the social, political and economic life of many countries – contributing, for example, to arts, culture, religion, recreation, and the provision of social services (Salamon and Anheier 1997b, Seibel and Anheier 1990). Research into the third sector has received growing attention over the past 30 years – there are now at least four English-language journals specialising in “non-profit studies”, and there has been a series of cross-national comparative studies examining the roles and extent of third sector activities (for example, James 1989, Anheier and Seibel 1990a, Salamon and Anheier 1997c).

There is a range of political and economic theories related to the third sector. Some of these theories suggest that a strong third sector is a necessary and healthy component of modern democratic societies, while others argue that the third sector is a mechanism for governments to eschew responsibility for what may be regarded as vital social services. The purpose of this paper is to promote debate and discussion of an aspect of primary care service and health policy development that has, to date, received very little attention in New Zealand – (planned or de facto) devolution of primary care services to the third sector. The paper examines, from theoretical and policy perspectives, the advantages and disadvantages of third sector provision of primary care services. It is hoped that elaboration of theoretical and policy issues related to third sector primary care services will inform, more generally, policy debates regarding the role of third sector provision of services in other social service sectors.

The paper first discusses definitions of the term “third sector”. The second section provides a précis of important political and economic theories related to the third sector. This is followed by a brief account of the development and role of third sector primary care in New Zealand. The fourth section discusses policy issues arising from third sector provision of primary care.

DEFINITIONS OF THE THIRD SECTOR

New Zealand society can be thought of as consisting of four sectors: public or state, private or commercial, a third or independent sector of non-profit community activity and voluntary association, and households (Cody 1993:2). The term “third sector” was first used by scholars in the United States in the early 1970s (Seibel and Anheier 1990:7). Other English language terms which are sometimes used to refer to the third sector

include non-profit (the term used most commonly in North American literature), non-statutory sector, voluntary sector (used commonly in the United Kingdom and New Zealand contexts), non-government organisations (NGOs), independent sector, the social economy, civil society, community organisations, charitable organisations, cooperatives and the commons (a term popularised by Lohmann (1992)).

Hall defined non-profit organisations as:

A body of individuals who associate for any of three purposes: (1) to perform public tasks that have been delegated to them by the state; (2) to perform public tasks for which there is a demand that neither the state nor for-profit organisations are willing to fulfil; or (3) to influence the direction of policy in the state, the for-profit sector, or other non-profit organisations. (1987:3)

A more recent, and more restrictive, definition of “voluntary” and “non-profit” organisations was developed by the Johns Hopkins Comparative Non-Profit Sector Project launched in 1990 (Kendall and Knap 1996:18). Their structural-operational definition had four criteria which had to be met. To be classed as a voluntary body an organisation must have a constitution or formal set of rules, be independent of government and be self-governing, be not-profit-distributing and primarily non-business, and have a meaningful degree of voluntarism in terms of money or time through philanthropy or voluntary citizen involvement. (However, the directors of the project later noted, based on their observations of the non-profit sector from an international perspective, that private giving played a relatively limited role in non-profit finance (Salamon and Anheier 1997b).)

In New Zealand, many third sector primary care organisations do not meet the last criterion. However, the term “voluntary” itself is open to varied interpretation. For example, Nowland-Foreman (1997) refers to “voluntary” as people voluntarily coming together “not because of commercial motives or under force of law but because of a common commitment to a cause”. Further, tax laws related to tax-deductible contributions vary from country to country – rendering the notion of “voluntary” partly dependent on local tax regimes (James 1987:398). For this reason a more inclusive definition of the third sector is preferred here – non-government and non-profit – as it is more appropriate in the context of third sector primary care in New Zealand.

This broader definition fits with the tendency to use interchangeably the terms “third sector”, “non-profit sector” and “voluntary sector” both internationally and in New Zealand (Ben-Ner 1987:434, Cody 1993, Copeman 1993, Hall 1987:4, James 1987:398, Nowland-Foreman 1997, Seibel and Anheier 1990:7). In any event, given the “terminological tangle” (Salamon and Anheier 1997a:12), a rigid unitary conception of the sector may be unhelpful (Dekker 1998). The various terms have overlapping but

different meanings depending upon the local tradition of philanthropy and social and political contexts (Anheier and Seibel 1990b:382) – “few societies have anything approaching a coherent notion of a distinct private nonprofit sector” (Salamon and Anheier 1997a:15).

The distinction between non-profit and for-profit rests largely on what may be termed the non-distribution constraint – a non-profit organisation may not lawfully pay its profits to owners or anyone associated with the organisation (Hansmann 1987, Weisbrod 1988:1). In non-profit organisations there is no formal connection between an individual’s financial interest in a venture and the power to select and control management. Various schema have been developed for describing different non-profit organisational forms (Hansmann 1987:28, Weisbrod 1988:59). One such scheme focuses on two organisational characteristics – the source of income and the form of management or control. The “donative non-profit” relies primarily on donation income; the “commercial non-profit” derives its income primarily from the sale of goods or services to paying consumers (or third party insurers); the “mutual non-profit” is run by a board selected by the donor or consumer members; and the “entrepreneurial non-profit” is managed by a self-selected board (Hansmann 1987:28). For example, in the hospital sector in the United States the dominant form of non-profit organisation is the entrepreneurial/commercial non-profit.

Issues related to ownership and control are, however, contested. It has been argued that the dichotomy of public/collective versus private/independent is unhelpful and limited (Mintzberg 1996, Ovretveit 1996, Schlesinger et al. 1987, Seibel and Anheier 1990:9). There are privately owned organisations, whether closely held by individuals or widely held in the form of market traded shares. There are also publicly owned organisations, more correctly known as state owned, because the state acts on behalf of the public. Citizens no more control state organisations than customers control private ones. Mintzberg identifies two other types of ownership, “cooperatively owned” organisations and “non-owned” organisations. Cooperatively owned organisations tend to be controlled by their suppliers (e.g. agricultural collectives), by their customers (e.g. mutual insurance companies), or by their employees (e.g. Avis). What Mintzberg refers to as “non-owned” organisations are controlled by self-selecting groups of people, an ownership pattern typical of the third sector.

From the point of view of ownership, private and state organisations may have more in common with each other than they do with third sector organisations. Both private and state organisations are tightly and directly controlled through hierarchies, one emanating from the owners, the other from state authorities. The transition from one to the other is not necessarily as great as the classical private-state dichotomy might suggest (as has been witnessed in New Zealand in the transformation of government departments into state-owned enterprises and private corporations).

In summary, the terms “third sector”, “non-profit sector” and “voluntary sector” are used here to refer to the non-government and non-profit sector. Definitional variations may apply depending on the specific context in which the terms are used.

POLITICAL THEORIES OF THIRD SECTOR ORGANISATIONS

There is a wide range of political theories that attempt to explain the existence of the third sector from various perspectives – e.g. historical, institutional, feminist and socialist. Three important themes, discussed below, concern the relationship between the third sector and the state, the political function of the third sector, and the various competing theories that challenge conventional theories grounded in liberal economics. This paper does not choose in favour of one political theory over any other. Rather, this discussion is used to demonstrate that the institutional location and functions of the third sector are closely linked to the political life of the state.

The Relationship between the Third Sector and the State

Douglas (1997:47) argues that a healthy third sector is characteristic of democracies. Hall (1987) takes this argument a step further in proposing that the third sector is a product of democracy *and* capitalism insofar as the necessary ideological and political conditions for the development of a third sector can only exist in a social context in which individuals are socialised to responsible autonomy and the modes of authority are geared to compliance rather than coercion. Accompanying these sets of conditions is the capitalist economic system in which individuals’ financial resources and productive energies are subject to their discretionary disposal.

Hall states that both the United Kingdom and the United States, with their similar legal precedents and institutional experience, have depended very heavily on third sector organisations for performing public activities. Despite this dependence, government attitudes towards the third sector tend to vary over time. For example, O’Connell (1996) and Hall (1987) point out that neither the Reagan administration nor the defenders of the third sector managed to develop a coherent policy for the third sector during the 1980s. At best the Reagan administration was seen as ambivalent to the third sector, on the one hand pursuing its efforts to cut back federal social and cultural expenditure and supporting volunteerism, and on the other hand favouring tax reform that would reduce the giving incentives contained in the charitable deduction. Similarly, conservative economists, such as Milton Friedman, have questioned the diversion of capital from corporate sources to the third sector for philanthropic purposes, believing that firms serve society best by engaging in their business of making profits.

An important theoretical tradition conceptualises the third sector as filling a gap between the state and the private sector. The third sector, it is said, "...offers a buffer zone between state and society and mitigates social tensions and political conflicts". (Seibel and Anheier 1990:14). Further, third sector organisations "take on functions which the state, for various reasons, cannot fulfil or delegate to for-profit firms" (ibid.). This formulation is consistent with the classical demand-side economic "gap-filling" theory of the third sector discussed below, in the section on economic theories.

Not only is the third sector able to fill the gap, Douglas (1997:47) suggests it is also able to cater for diversity in a way that would otherwise not be achievable. In stating this argument Douglas draws on the view that the third sector is a private version of government, and achieves this diversity through representing various interest groups – secular, religious, rightist and leftist. A less positive variant of this theoretical approach characterises the third sector as a convenient solution for government, allowing government to create the impression that "unsolvable" societal and political problems are being addressed (Seibel 1990:114).

Third sector organisations compete for resources with three other forms of social organisations: the family, commercial for-profit organisations, and government-run services. Thus, one of the important questions underlying this paper is whether society needs to supplement government and private commercial services with private non-profit services. One might suppose that the state possesses a clear advantage in its coercive power – its ability to commandeer goods, services and money (via taxation). However, it has been argued that non-government status per se is important for welfare organisations from the point of view of institutional stability (Copeman 1993).

In western democracies governments tend to alternate between conservative, free market policies which favour privatisation and market approaches, and social democratic policies which traditionally favour a strong public sector. The oscillation between these two approaches may be damaging for social services. Copeman (ibid.) argues that they may therefore be better off located in the third sector, which is likely to be acceptable to both political ideologies. Indeed, he states the view that it is desirable to progressively reorient both government and non-profit organisations towards a model that allows organisations to function semi-independently of government with community-elected boards of management. Such a model would recognise pluralism of interests of providers and consumers, yet would require a continuing role of government in funding, coordinating and monitoring the wide range of services.

The Political Function of Third Sector Organisations

Douglas (1997:51-52) describes three classes of non-profit organisation. The first class consists of non-profits set up to provide a public benefit from private funds. This class

is an alternative to government, permitting a greater diversity of social provision than the state itself can achieve. The second class is the mutual benefit organisation, which is established to provide collective benefits for its members. The third class is the political action organisation, which aims not to provide benefits, but to persuade government to do so. This latter class of non-profit organisation is crucially important to the workings of democratic government – political parties themselves are a member of this class. In general, political action organisations form part of the system by which conflicting interests are represented, expressed and reconciled – they allow for the non-violent resolution of conflict.

The third sector has the ability to experiment with policy options relatively unconstrained by government. In contrast, the state is constrained by political processes, and may find it easier to follow models that have been tested in the voluntary sector. Douglas (1997:50) claims that third sector organisations, being less politically accountable than public agencies, need to devote a smaller proportion of their resources to justifying their actions.

While this is undoubtedly true in some respects in New Zealand, changes in both the health and non-health parts of the third sector have led to largely state-funded third sector organisations facing increasing transaction costs as a result of contracting (Cheyne et al. 1997:212-213, Nowland-Foreman 1997). The level of accountability of third sector organisations to government has also increased, as the dominant funder (the state) demands a greater say in deciding what activities it wishes to “purchase” (Nowland-Foreman 1997). In any event, there seems to be a basic tension between the level of bureaucracy in third sector organisations, and their having sufficient organisational machinery to remain accountable to their constituencies and their funders.

Challenges to Liberal Economic Thought

A variety of competing theories challenge those third sector theories that have their basis in liberal economic thought. Examples include feminist critiques (Nyland 1995) and Marxist critiques (Kendall and Knap 1996:15).

From a socialist point of view, the third sector may not only obscure the absolute role and responsibility of government (O’Connell 1996), it may also be regarded as a “protective layer” for capitalism to dissipate the energy to devise, promote and initiate radical alternatives to the present system (Roelofs 1995). Indeed, Marx and Engels observed in *The Communist Manifesto* (cited in Roelofs 1995):

A part of the bourgeoisie is desirous of redressing social grievances, in order to secure the continued existence of bourgeois society...To this section

belong the economists, philanthropists, humanitarians, improvers of the condition of the working class, organisers of charity, members of societies for the prevention of cruelty to animals, temperance fanatics, hole-and-corner reformers of every imaginable kind.

Importantly, researchers have argued that rather than occupying a “gap filling” role in response to state and market failures, the state and third sectors can be conceptualised, historically and currently, as existing in mutual dependence and cooperation – frequently with the state as the dominant funder and regulator of the third sector (Salamon 1987:111, Smith and Lipsky 1993:5). Starting with the conceptual basis that the third sector is the preferred mechanism to provide a range of services (rather than a residual mechanism), Salamon (1987:11) formulated the “voluntary failure” theory. He identified four “voluntary failures” (failures of the third sector) that justify government involvement and support for the voluntary sector.

The first of the four failures is philanthropic insufficiency – inability to generate sufficient resources to provide collective goods – that justifies government support. For example, New Zealand’s colonial voluntary hospitals eventually failed for this reason:

The absence of a sizeable class of wealthy philanthropists in the first years of colonisation led to the general failure of early endeavours to establish voluntary type hospitals in New Zealand. (Minister of Health 1974:12)

This situation undoubtedly persisted into the 20th century. The second failure is philanthropic particularism and favouritism, resulting in relative neglect of certain population sub-groups. For example, there is a tradition of voluntary organisations serving the needs of the “deserving” poor. This failure highlights the responsibility of representative democratic government for the general welfare of populations (O’Connell 1996).

The third failure is philanthropic paternalism – the corrosive attitude of noblesse oblige that may be adopted by charity organisations – or, from a socialist perspective, “social control through philanthropy” (Roelofs 1995). The central tenet of this failure is that community resources are channelled into the hands of elites of the capitalist system, who then disburse them according to their perception of worthiness. The fourth failure is philanthropic amateurism – ineffective approaches to dealing with human problems. This failure focuses on the provision, on occasions, of non-professional services to vulnerable groups.

ECONOMIC THEORIES RELATING TO THE BEHAVIOUR OF THIRD SECTOR ORGANISATIONS

There is a large literature covering economic theories relating to the role of non-profit organisations. Some comment regarding demand-side and supply-side theories is warranted, as these theories have considerably influenced mainstream understandings of the third sector.

Weisbrod (1975, 1988:5) developed the classical demand-side theory that the third sector responds to demands for public goods or quasi-public goods and services supplied by neither the market nor the state (termed “the excess-demand theory” by James (1987:401)). He argued that goods that are non-excludable and non-rival will not be provided optimally by the market. In the face of this market failure the state will step in and provide some services, leaving a residual demand to which the third sector is seen as an efficient response. (However, notwithstanding excess demand, non-profits tend to respond much more slowly to increases in demand than do for-profit firms, due to constraints in their access to capital (Hansmann 1987:38).)

James (1987:402) adds a complementary demand-side explanation for the third sector – the theory of differentiated demand – where differentiated demand is not accommodated by government production. Arguing that the above demand-side theories may be necessary but not sufficient, she also posited that particular types of entrepreneurship are necessary for the development of third sector organisations (p.404). She isolated religion, the pursuit of status, prestige and political power, and the goal of disguised profit distribution as critical motivating factors. In the context of Third World countries, demand-side theories may need some modification, as much of the third sector is financed from abroad. Preferences of and cultural diversity amongst foreign donors and policies of foreign governments may be more important than domestic factors (p.412).

Hansmann (1987:29) developed a supply-side theory – the contract failure theory. This theory suggests that third sector organisations arise where ordinary contractual mechanisms do not provide consumers with adequate means to police producers, that is, they feel unable to evaluate accurately the quantity or quality of the service a firm produces for them. In these circumstances, the non-distribution constraint under which third sector organisations operate acts as a powerful signal to consumers about the motives and behaviour of those who operate them. Following the neo-classical tradition, most models of the behaviour of non-profits have been optimising models. As it is unlikely that profit maximisation is a key goal for non-profit firms, it is often assumed that non-profits seek to maximise the quality or quantity of the services they produce.

Hansmann (p.39) goes on to point out that a consequence of non-profits providing services of a quantity or quality that cannot be supported by market demand is that some form of subsidy must be found. One source of such a subsidy is cross-subsidisation, where one service is sold by the non-profit at a profit, which is then used to finance provision of another service that is more highly valued by the firm. In the context of non-profit hospitals in the United States, quality/quantity maximisation theories are qualified by the observation that hospitals may serve indirectly the financial interests of doctors (p.38).

Optimising models assume that firms minimise cost. An alternative theory applied to the behaviour of non-profits suggests that they are inherently subject to product inefficiency (failure to minimise costs) due to the absence of ownership claims to residual earnings (Hansmann 1987:38). Hansmann argues that it is almost certain that non-profit firms are productively inefficient because, in the absence of subsidies or a substantial degree of market failure, they will generally produce a given good or service at higher cost than would a for-profit firm. This argument is justified with the observation that, if it were otherwise, non-profits would operate in a much broader range of industries than is actually the case. The point to note is that non-profits are able to operate, due to subsidies or the presence of substantial market failure, in contexts where for-profit firms tend not to operate. Hansmann states it thus:

Non-profit firms seem to have survivorship properties that are superior to for-profit firms only where particular forms of market failure give them an efficiency advantage sufficient to compensate for their failure to minimize costs. (p.38)

A further theory, the stakeholder theory, attempts to synthesise other theories concerning the role of the third sector by theorising third sector organisations as coalitions of stakeholders providing “trust goods” and “collective goods”, both for their own benefit (as simultaneously demanders and suppliers) and for the benefit of non-controlling stakeholders (Ben-Ner and Van Hoomissen 1993:29-30). It is argued that non-controlling stakeholders use third sector services because they identify with the coalition of demanders-suppliers, and recognise that because the coalition are themselves demanders it is unlikely that quality standards will be compromised.

In the context of health care services, the stakeholder theory particularly concerns public perception of health care professionals. In the United States (as perhaps in New Zealand) (Marmor et al. 1987), trust in the fiduciary responsibility of health providers may be somewhat eroded as the service ethic in health care has become demythologised and a more commercial ethic has emerged. Third sector health care may lead to increased trust in health care providers. As James (1987:413) points out, however, even though medical care is often cited as a service whose quality consumers

are unable to evaluate, and hence should prefer “trustworthy” non-profit providers, the relatively small scale of third sector health care providers in many countries suggests that these stakeholder theories of non-profit organisations may have only minor explanatory value.

In summary, economic theories have been important in shaping understandings of the third sector. Weisbrod’s classical demand-side theory, in particular, provides a simple economic “justification” for the third sector, and is largely consistent with other demand-side and supply-side theories that provide complementary explanations.

THIRD SECTOR PRIMARY CARE

The term “primary care” is used here as a generic term for community-based health services that specifically include doctor services and may include a wide variety of other services – for example, the term is used to refer to general practice in New Zealand, Australia and the United Kingdom and family medicine in the United States.

In general, third sector primary care has tended to develop in two broad sets of circumstances: in the context of countries with inadequately developed health care systems where social mobilisation and access to basic services are key motivating factors; and in the context of industrialised countries in which the public provision of primary medical care is lacking (particularly for vulnerable populations) or where there is no universal financial cover for primary medical care (i.e. where significant barriers to access exist). As a result, third sector primary care has developed largely in the context of political and social inequality.

It is noteworthy that these circumstances have applied to a varying extent in the United States, Canada, Australia and New Zealand, but to a far lesser extent in the United Kingdom. In the cases of Canada (Geekie 1972a, 1972b) and Australia (Scrimgeour 1996), despite universal coverage, there were perceived weaknesses in the dominant private sector, fee-for-service mode of delivery. In Australia Aboriginal community-controlled health organisations provide a clear example of the third sector compensating for government and private sector failure in the provision of primary care services for a specific population group.

Third sector organisations provided a range of social services throughout New Zealand’s colonial history. There is evidence to support the view that during the post-war decades political and institutional conditions were permissive with respect to the development of third sector primary care. Although the private sector model for provision of primary care services dominated during most of the 20th century, governments and policy makers acknowledged and, in respect of certain primary care services such as wellchild care, valued the role taken by the third sector in social and

health service provision (Committee to Review Primary Medical Services 1982:5, Minister of Health 1974:12 and 88, Royal Commission on Social Policy 1988a:719, Royal Commission on Social Policy 1988b:751).

The policy environment was more openly conducive to the development of new third sector primary care organisations during the late 1980s and 1990s, when governments expressed the desire to alter existing patterns of service provision and explicitly envisioned an increased role for the third sector in the ownership and provision of both primary and secondary care services (McIntosh 1998a, McIntosh 1998b, Ministry of Health 1993, Ministry of Health 1996, Muir 1997, Schouten 1998, Shipley 1995:29, Upton 1991:35). During the 1980s third sector organisations providing comprehensive primary medical and related services started having a significant presence in New Zealand. During the late 1980s and 1990s a range of union health centres, tribally based Māori health providers, and community-based primary care providers were established (Crampton et al. in press).

The 1990s also saw the rapid development of independent practitioner associations (IPAs) – groupings of general practitioners formed for the purposes of contracting and collective infrastructure development (Malcolm and Mays 1999). Since the publication of the primary care strategy (King 2001) some IPAs have made efforts to increase their degree of consumer representation at a governance level. Those IPAs that are non-profit may be classed as third sector organisations, however a more useful term is “peak body”. The term peak body is used to denote an organisation that has other organisations as members, formed to represent the collective views of its members to government, the community and other bodies (Melville 1999). While peak bodies are considered an important component of the third sector, it should be remembered that in the case of IPAs their membership generally consists of private for-profit organisations that are not part of the third sector.

New Zealand evidence demonstrates that third sector organisations provide primary care services to vulnerable populations (Crampton et al. 2000b). This is important because of the sustained failure of the state and private sectors to provide freely accessible primary care services for low-income populations, rural communities and Māori populations (Brown and Crampton 1997, Crampton 2000). Similar conclusions can be drawn from the United States, Canadian and Australian experiences of third sector primary care. Third sector primary care organisations in New Zealand are generally located in low-income areas that have high need for primary care services, and have comparatively low user charges (Crampton et al. 2000a, Crampton et al. 2000b). Geographic and financial barriers to access are thereby minimised. American experience indicates that third sector community health centres result in improvements in access to services (Abramson 1988, Blumenthal et al. 1995, Geiger 1984:28).

It is perhaps relevant to recall that evidence related to secondary care suggests that for-profit hospital providers in the United States are more likely to be located away from poor areas, to exclude patients with limited ability to pay, and to discourage admission to hospital of those unable to pay for care (Marmor et al. 1987). It may be reasonable to expect parallel circumstances to arise in primary care. Indeed, with market-based approaches there has been an abiding problem in New Zealand with inequitable distribution of general practitioners (see below).

POLICY PERSPECTIVES

Broad policy options for primary care and other social services cover a spectrum of views, from the standpoint that all social services should be publicly financed and provided, through a “mixed economy” position that allows diversity in funding and provision, to a neo-liberal economic view that direct public provision is permissible only as an exceptional last resort where market failure is intractable (Sheaff 1998).

For policy makers an array of questions arises with regard to third sector provision of social services. First, policy makers have the task of assessing the desirability of third sector approaches. For example, is the third sector model worth actively promoting as a mechanism for providing accessible primary care services for low-income (and general) populations? How large a role should the third sector play within the mixed economy of primary care? What are the pitfalls of third sector approaches? How successful are different models in providing services to vulnerable populations? How do health outcomes differ between different models? What are the costs of different approaches?

Third sector primary care arrangements for vulnerable populations have been adopted in countries such as the United States, Canada, Australia and New Zealand either to augment existing arrangements, or as a partial alternative to universal funding and provision of primary care. New Zealand has experienced rapid development of third sector primary care over the past 15 years. Three policy implications arising in respect of third sector primary care are discussed here – the possible future role of third sector primary care, the relationship between the state and the third sector, and evaluation.

A Future Role for the Third Sector

The first, and principal, policy implication concerns the role of the third sector in providing primary care services, particularly to vulnerable populations. Policies related to third sector primary care are particularly pertinent in circumstances where there is a diminution of publicly provided care, and lack of universal financial cover for primary medical care (as has been the case in the United States and New Zealand) (Whiteis 1998).

A potential problem concerning the breadth of third sector activities arises if the third sector increasingly diverts its attention to cover services previously provided by the government or private sectors (O'Connell 1996). For example, if the third sector is mandated to deliver basic services, competition amongst third sector organisations for financial and other resources (see, for example, Nowland-Foreman 1997) may lead to diminishment of the pool of resources (including voluntary input) available for other third sector activities – e.g. arts, culture and recreation.

Balancing the various potential strengths and weaknesses of third sector primary care discussed above, evidence points strongly to a positive role played by third sector primary care organisations during the late 1980s and 1990s (Crampton 1999a, Crampton et al. 2000a, Crampton et al. in press). They built strong working models of primary care for vulnerable populations at a time when the government and the private sector were making only limited progress with respect to improving access to primary care services in highly deprived areas.

The combination of strong leadership and social entrepreneurialism allowed third sector organisations to capitalise on the strengths afforded by their third sector status – they “filled the gap” created by state and private sector failure; they catered for the diverse needs of poor communities, iwi and Pacific Islands populations; they experimented with new organisational forms; and they built strong relationships with successive governments during a time of marked political changes (Crampton 1999b, Crampton et al. in press).

Potential weaknesses of the third sector – such as philanthropic paternalism, philanthropic amateurism, disguised profit distribution, and providing governments with a “convenient solution” thereby allowing them to eschew their fundamental social responsibilities – are either little in evidence or seem relatively unimportant compared with the considerable achievements of third sector primary care organisations.

The Relationship between the State and the Third Sector

The second policy implication concerns government's relationship with third sector primary care providers. In New Zealand, government is a key stakeholder in third sector primary care in two important ways. First, third sector primary care organisations have been largely successful in achieving their main aim of providing care to vulnerable populations, and in so doing have helped to achieve key government health objectives (Crampton 1999b). Second, government is the principal, and in many cases only, funder of third sector primary care organisations. Although government has no direct ownership of third sector organisations, reliance on government funding potentially blurs the boundary between the government and the third sector from the point of view of governance and control (James 1987:409, Nowland-Foreman 1997).

Hence, it may be of benefit both for government and third sector providers if there were greater clarity in the relationship between the two.

For example, third sector primary care organisations have tended to be planned on the basis of needs assessments, and provided in areas of greatest need. Government may want to be more active in supporting the development of further third sector primary care services in areas that traditionally have been under-serviced, such as rural areas and deprived urban areas. There is an ongoing problem with inequitable distribution of general practitioners in New Zealand (Barnett 1991a, 1991b, 1991c, 1993, Malcolm 1993). Overseas evidence suggests that providing financial incentives to doctors is not an effective way of inducing them to settle in rural areas, and local evidence suggests that market-based approaches have limited effects in smoothing the distribution of general practitioners. Third sector primary care organisations have partially addressed this problem for government.

A further example concerns population approaches to primary care provision. If government considers population approaches to be desirable (see, for example, King 2001 and National Health Committee 2000), third sector organisations provide a New Zealand model with over a decade of experience. Government may want to take further advantage of this experience.

It is important to emphasise that third sector status does not, per se, provide any guarantee that an organisation is chiefly concerned with non-profit public-good service. There is diversity in the third sector, just as there is in the private sector. Experience from the United States, New Zealand and elsewhere suggests that third sector status can provide an effective vehicle for the pursuit of business objectives (disguised profit distribution (James 1987:404, Weisbrod 1988:11)), as may be the case with self-employed doctors working for non-profit health organisations or where profits are dispensed in the form of increased wages (Schlesinger et al. 1987, Weisbrod 1988:11). As Bradford (1993) succinctly states, “patients, payers, and communities can suffer if health care providers are oriented more to reimbursement maximisation than to providing appropriate services”.

While the evidence points to third sector primary care organisations in New Zealand pursuing non-profit public-good service, in circumstances where third sector organisations pursue disguised profit distribution, “undesirable” practices may become more difficult to regulate because they are camouflaged in a non-profit setting. Support by successive governments of third sector primary care, on the basis of its objectives being congruent with those of government, should not lead to complacency in judging the merit of third sector primary care organisations – government should support third sector organisations only when their structure and objectives are consistent with government’s health objectives. Indeed, Weisbrod (1988:163) argued

that third sector organisations should be encouraged to focus on the provision of collective goods, and not otherwise; and they should be restricted from engaging in “unrelated business activities” that lie outside their tax-exempt activities.

Evaluation

The third policy implication concerns evaluation. As there has been very little comparative research carried out in New Zealand, considerable effort is now required to measure cost, quality and effectiveness (including health outcomes) of services provided by different types of primary care organisations serving comparable populations.

It seems likely that New Zealand will continue to develop a diverse range of primary care organisational arrangements. There is a need to deliver culturally appropriate services for Māori, Pacific and other ethnic groups. Recent developments such as the emergence of large primary care organisations and urgent medical centres have encouraged plurality in primary care organisation.

Health outcomes data, though scant at present, are becoming increasingly available as primary care organisations take advantage of new computer-based clinical and morbidity data collection systems. Evaluation would provide government with the opportunity to build future primary care policy on models that have been demonstrably successful in achieving health policy objectives.

CONCLUSIONS

The emergence of third sector primary care in New Zealand has been consistent with international experience of third sector involvement – there were perceived “failures” in government policies for funding primary care, and private sector responses to these policies, resulting in lack of universal funding and provision of primary care and continuing patient co-payments. These failures created the type of “gap” that, based on international experience, third sector organisations tend to fill.

The principal policy implication of the growth of third sector primary care concerns the extent to which the third sector should be regarded as a partial alternative to universal funding and provision of primary care services. Such an alternative may be convenient for proponents of reduced state involvement in funding and provision of health care, but may not be desirable from the point of view of equity and social cohesion insofar as the role of the welfare state is diminished.

As described above, there is a range of both practical and theoretical strengths and weaknesses associated with third sector provision of primary care services. While there

may be a case for third sector primary care in New Zealand – government and private sector failure – current health policy does not make clear the desired role and extent of third sector primary care. Future policy decisions should ideally reflect careful weighing of the full range of advantages and disadvantages of third sector approaches, and also take into account the unique policy and historical contexts in New Zealand, and alternative policy options.

If the existence, in New Zealand, of third sector primary care is accepted – either as explicit policy or de facto – policies may be required to limit the financial pressures placed on non-profits that may lead them to deviate from the social role they can and should play in New Zealand’s mixed economy, and to help move the economy to an agreed balance of institutional responsibilities among private enterprises, governments and non-profits.

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