The ownership elephant is becoming a mammoth: a policy focus on ownership is needed to transform Aotearoa New Zealand's health system

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ABSTRACT

Explicit government policy about ownership of health services is an important yet missing element in Aotearoa New Zealand's health system. Policy has not systematically addressed ownership as a health system policy tool since the late 1930s. It is timely to revisit ownership amid health system reform and increasing reliance on private provision (for-profit companies), notably for primary and community care, and also as an integral part of digitalisation. Simultaneously, policy should recognise the importance and potential of both the third sector (NGOs, Pasifika, community-owned services), Māori ownership and direct government provision of services to address health equity. Iwi-led developments over recent decades, along with the establishment of the Te Aka Whai Ora (Māori Health Authority), and Iwi Māori Partnership Boards provide opportunities for emerging Indigenous models of health service ownership, more consistent with Te Tiriti o Waitangi and mātauranga Māori. Four ownership types relevant to health service provision and equity are briefly explored: private for-profit, NGOs and community, government and Māori. These ownership domains operate differently in practice and over time, influencing service design, utilisation and health outcomes. Overall, the New Zealand state should take a deliberate strategic view of ownership as a policy instrument, in particular because of its relevance to health equity.

Ownership is an important policy tool within health systems.[1] It significantly influences structural arrangements and the political economy of the health sector,[2] its culture and health outcomes. Ownership interests can drive the behaviour of system actors: healthcare workers, government, business and the community.[3] Until recently, ownership has been something of an "elephant in the room"—that is, highly significant as an issue but not much discussed—in New Zealand health policy.[4,5] However, global institutions such as the OECD,[6] World Health Organization[7] and academics[6–9] have been critically examining the importance of ownership in health systems, especially in light of how ownership impacted the COVID-19 response.

Ownership exists at a nexus between how society values a healthy population, private enterprise and core public services. Prevailing economic theory holds that market disciplines place private sector organisations in a better position than governments to provide products and services.[10] However, market effectiveness is influenced by, among other things, the balance between supply and demand plus the degree of information symmetry between buyer and seller. The very nature of health and health services means there is frequently limited supply, and also information asymmetry between health professionals and patients. Consequently, many elements of the health system can only effectively operate in a market that is highly regulated.[10] Furthermore, sometimes the market fails to provide any service where market conditions are not favourable, or to effectively address negative or positive consequences of market activities (externalities) as is the case with potentially harmful products, for instance alcohol, or beneficial interventions such as community-wide immunisation.

Health inequities result, in part, from market conditions, and profoundly damage both health and the economy,[11] hence the importance of social and economic policies to reduce inequity in outcomes between and within population groups. A key policy option for government concerns the deliberate decision to use markets and private for-profit provision only when this is considered the most effective way to deliver health services, and to use other non-market approaches when markets and private provision are not geared

to meeting the overarching societal objective of reducing inequity. Governments can intervene strongly in healthcare markets in order to ensure that ownership arrangements are consistent with wider health system and social goals.

Ownership arrangements intersect with society's attitudes towards health service access: is access to comprehensive essential health services a right of citizenship? Should access to health services be determined by ability to pay? Is access to health services an individual concern or a community concern?[12] At the individual level, ownership shapes how service users are conceptualised:[13] as consumers of services provided by the market, as patients in a professional encounter or as citizens exercising their right to healthcare. Ownership influences the scope of the health system encounter, whether it focusses on the individual, or an individual in a whānau and/or an individual in a population context with either an episodic or a continuity focus.[14] Flexibility for professional discretion, time per consultation and service responsiveness are informed significantly by profit imperatives and commercial responsibilities to shareholders.[15] While ownership arrangements do not wholly determine the model of care, they influence how services are run and how professional and business conflicts are managed, as evidenced in recent vigorous discussions over the provision of radiology services.[e.g.,16] Notwithstanding the strong influence that ownership arrangements exert on health system performance,[17,18] for example through service accessibility,[4,19,20] current New Zealand health policies pay insufficient attention to this important health system design parameter. This is an important policy omission, since New Zealand's health services are currently provided by a range of service providers with a mixture of state, private for-profit, and NGO owners. Most services are owned and provided by various private sector actors, especially community-based services, each service attracting varying degrees of government funding.

The current mix of public and private provision of health services in New Zealand dates back to the health system's founding in the 1930s, where the government's aim was to ensure the provision of universally accessible healthcare services. While the Social Security Act 1938[21] envisaged free-at-the-point-of-care health services, the government of the day was unable to reach agreement with the medical profession on eliminating patient fees. The policy compromise that resulted was a free government-provided hospital system alongside privately provided primary healthcare (PHC), funded by government subsidies and patient co-payments, and insurance to a lesser extent.[22] This compromise cast a long shadow, which is still evident now, in terms of (in)equity of access to PHC services and service integration.

In the decades following the 1940s, New Zealand's health service ownership arrangements remained reasonably stable. The health system has historically been made up of a range of different service provider types, characterised by three main ownership types: private for-profit, third sector/not-for-profit (also referred to as NGOs, community trusts), and state-owned. A fourth ownership form has emerged over the past three decades: Māori ownership. These four ownership forms are described briefly below.

State ownership of health services

In New Zealand, the state has responsibility for health system stewardship, legislation and regulation, and as the main funder of health services.[23] It also owns most of the hospitals. This dual funder/provider role has led to system distortions when the purchasing was decentralised to a hospital-dominated district organisation during the time of district health boards (DHBs). For instance, DHBs' ownership of hospitals meant that, for example, investment for the PHC sector was diverted towards hospital care,[24] and there was a lack of pay parity for nurses across the secondary and PHC sectors.[25]

To ensure policy goals are met the state has intervened to address the failure of markets to meet the needs of vulnerable populations, frequently through fees subsidies (including CSC subsidies and free care for under four-year-olds[26]) and in direct provision centred on, but not limited to, hospital services. Direct state ownership of PHC services occurred from the late 1930s when the state introduced "special medical areas" providing essential PHC services in certain high-needs, high socio-economically deprived rural settings, because of failure of the market to provide adequate PHC services.[27] More recently DHBs (now Te Whatu Ora) have undertaken direct provision of PHC services, such as in Taranaki,[e.g.,28] operating government-owned, fee-charging rural PHC services in areas of under-provision.[29]

Private for-profit ownership of health services

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has consistently featured in New Zealand's health system since its inception, particularly for primary and community care. For instance, general practice and community pharmacy services have traditionally operated with a sole owner-operator style, "guild-like" professional ownership. Now a transition is underway where doctor/pharmacist/professional ownership of this part of the health sector is shifting to private corporate ownership where business models ultimately drive professional behaviour. Additionally, the steady aggregation of health services into fewer corporate hands,[30,31] with some owners being off-shore investors, has positive and negative consequences for the health system. Corporatisation may bring advantages, for example economies of scale, standardisation of services and quality management, and the ability to pool resources and redirect them towards other parts of a business. However, there are downsides to corporatisation, especially related to market failure, unresolved tensions between professional ethics and profit imperatives and the corporate models' impact on continuity of care for vulnerable people who live with complex health needs.[e.g.,32] Further, clinicians report curtailed clinical freedom to practice in corporate environments, and unless there is government regulatory policy intervention, the focus can be on high-volume episodic throughput rather than health outcomes,[8,9,15] at the expense of high-needs populations.[33] Recent discussions about outsourcing radiology procedures highlight the clash of doctors' ethical and professional duties to patients with commercial responsibilities to shareholders.[16]

In the context of market failure, the shift from smaller professionally controlled organisations to larger corporately owned organisations means the health system will need to rely on assertive government regulation if equity objectives are to be achieved. There are likely to be tensions between companies' aims and those of government, and it may well prove harder for citizens and governments to influence larger, offshore-owned companies; once liberalised, it is virtually impossible to de-liberalise health service provision, even if it transpires that the shift to liberalisation is not effectively contributing to health system goals.[34,35] Close monitoring by government of the behaviour of private for-profit health organisations is important.[8,9,36] Commercial incentives risk both over- and under-servicing.[36] Additionally, the practice of cost-shifting from private to public services, for example when surgical complications arise in private facilities, requires active management by government.[19]

Not-for-profit ownership of health services (community, NGOs, the third sector)

New Zealand has a long history (137 years)[37] of non-government non-profit provision of health services, largely in response to unmet need, encompassing a range of populations and issues from ambulance and stroke care to primary care. From the 1980s, community-initiated and led "third sector" providers of comprehensive PHC emerged as a response to the failure of markets to provide services in areas of high socio-economic deprivation, for those who were in low-paid employment, Māori, Pasifika or youth. Both theory and practice[38] suggest that third sector providers are likely to fill service gaps for high-needs populations in circumstances that are difficult or impossible for for-profit services and where government services may be inadequate or not exist.[39,40] During the COVID-19 pandemic, third sector organisations and community-based services were best placed to respond to high-needs populations such as Pasifika communities, because their existing relationships enhanced community mobilisation and outreach.[41–43]

Māori ownership of health services – an emergent Indigenous fourth sector

The three ownership forms described above reflect colonial institutional arrangements. Until now Iwi and other Māori health organisations have largely conformed to the third sector/NGO or private for-profit ownership types in order to receive funding and provide services.[39] The current health reforms present an opportunity to shape the health system's ownership arrangements for Māori beyond the constraints of existing ownership paradigms.[44] Alternative models of sector leadership, such as by Te Aka Whai Ora and Iwi Māori Partnership Boards, offer opportunities for different future paths for ownership arrangements within the framework of Te Tiriti o Waitangi. It is possible that new kaupapa Māori ownership models will emerge that challenge both the narrow scope of health services in relation to health, and existing ownership paradigms.

Hybrids

New Zealand has experimented with a range of hybrid ownership arrangements mixing features of private for-profit, third sector and government provision, and private-public partnerships, the latter being outside the scope of this paper. For example, the 1990s saw a largely failed attempt to introduce private sector corporate culture into public health sector provision.[45,46] Then the 2000s saw an attempt to establish primary health organisations as third sector organisations to support the meso-structure for PHC. These have now evolved to be significant owners of frontline services, including pivotal national health infrastructure such as Whakarongorau/Healthline, which operates as a separate company and returns dividends to its third sector owners.[47]

Breaking the policy silence: let's discuss the mammoth

The mix of ownership types in the system requires deliberate policy attention if equity goals are to be met. However, ownership remains the elephant in the room (particularly the growth of corporate ownership), possibly because of anxiety about whether discussing ownership would precipitate a crisis akin to the professional threats to withdraw service at the advent of the health system in the 1930s.

Successive governments have neglected strategic policy to address practical implications of different ownership arrangements for health services, systems and population health. Instead, state responses to ownership conundrums have been *ad hoc*, pragmatic responses to immediate concerns, largely lacking a longer-term strategic view. Meanwhile, ownership arrangements have become more complex. The private sector has become larger, with a trend towards corporate ownership aggregated into fewer hands. Private provision is an integral part of the provider landscape, and is growing to mammoth proportions. The Health and Disability System Review Interim Report highlighted how the business and professional interests of a few had a disproportionate impact on models of care, and access for everyone, particularly Māori.[48] The issue has become too large to ignore.

Since the Pae Ora reforms are underway, it makes sense for the state to develop a deliberate policy approach so ownership arrangements better support policy and health system goals and outcomes. Thus, instead of defaulting to any one model of provision (private for-profit, third sector/not-for-profit, state-owned, iwi, hybrid), government should dispassionately assess the mix and nature of service providers against their ability to serve populations to meet health system goals in a manner that leads to health improvement across a range of populations. This is particularly important in areas of high need. Ownership policy should be overseen by clear values and supported by a strategic framework and intervention logic that outlines how ownership can be optimised to improve health equity, support health system goals and benefit everyone. This approach would allow governments to be deliberate in addressing market failure in the provision of health services, providing a framework to actively manage ownership as a tool of health service provision. Additionally, specific policy mechanisms (for example subsidies, incentive payments, regulation, capacity building, workforce initiatives, growing different models of care that achieve similar impact across populations) could be deployed to expand on successes (particularly in areas of high socio-economic deprivation) and to explore different ways of improving health delivery in service of health system goals.

Ownership is not the only determinant of organisational behaviour, with some public providers and NGOs adopting corporate-like behaviours, and some corporates giving greater emphasis to social impact, over and above their profit margins. Policy makers should seek to understand an organisation's core drivers and values, irrespective of the particular organisational form; otherwise, some health service providers will exhibit isomorphic mimicry, that is operating for their own commercial benefit while mimicking an ownership profile that is theoretically more responsive to the health needs of communities. Government ownership policy could help identify and manage conflicts between business interests, commercial responsibilities, professional mores, ethical duties and health system goals. By framing ownership as a tool to support health system goals, the strengths and weaknesses of different ownership arrangements to achieve goals would be apparent. In addition, ownership policy could enhance the ability of the health charter to ensure that commissioning facilitates the link between provider and system values, policy aspirations and health system outcomes (outlined sections 56–58 in the Pae Ora (Healthy Futures) Act 2022) and remedy the worst effects of contractualism with narrow

service specifications that reflect government priorities at the expense of responding to local needs.[49]

Since ownership and provision of health services are inextricably linked to sovereignty, mana motuhake and mātaraunga Māori, deliberate ownership policy could help advance the Crown's Tiriti o Waitangi obligations, helping to address overlaps and conflicts between Western and Māori ownership paradigms.[50,51]

In commissioning and localities, all four ownership types should be considered based on their potential contribution to the policy goal, avoiding the assumption that private provision is the default setting. Rather, it would allow assessment of whether market-led supply works, whether there is the need for a community-led third sector, and where the fourth sector—Māori and iwi providers—should predominate.

It would also guide the use of government provision especially in PHC, where the failure of markets to provide adequate services is most extreme and health inequities most apparent. For instance, instead of a last resort crisis response, government-provided properly resourced and sustainable PHC should be normal in underserved areas that will never be serviced equitably within a market paradigm.

Conclusion

Since the beginning of our national health system, the ownership elephant in the room has quietly become a mammoth, literally, as corporate ownership slowly aggregates control into increasingly fewer hands. Eighty-five years of rich health system experience and research evidence has shown the circumstances in which markets are most effective, those where the state should step in and those where the third sector and Māori owners are best suited to meet needs. Global organisations are calling for this policy focus.[52] Yet here in Aotearoa, we have an ownership policy void.

Without filling this policy void we risk missing the promise of the Pae Ora reforms. Without deliberate ownership policy we risk establishing entrenched ownership arrangements that fail to protect and enhance people's health. There is not one "correct" ownership model, especially for PHC, but there is overseas and local evidence that certain arrangements are better suited in some contexts, especially for vulnerable populations[e.g.,1,53] Policy should intentionally address ownership arrangements so the upsides of market-led approaches are harnessed, but not at the expense of comprehensive and pro-equity service delivery, professionalism or Indigenous sovereignty.

In exercising its stewardship function, the state should not be timid in policy intervention or service provision to ensure all citizens have access to core services as a right. This action is especially vital for Māori and the evolution of the fourth sector—Māori and Iwi ownership. The first step is to talk about the ownership elephant, or mammoth, in the room.

COMPETING INTERESTS
Nil.

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REFERENCES
1. Herrera CA, Rada G, Kuhn-Barrientos L, Barrios X. Does ownership matter? An overview of systematic reviews of the performance of private for-profit, private not-for-profit and public healthcare providers. PLoS One. 2014 Dec 1;9(12):e93456. doi: 10.1371/journal.pone.0093456.
2. Harvey M. The Political Economy of Health: Revisiting Its Marxian Origins to Address 21st-Century Health Inequalities. Am J Public Health. 2021 Feb;111(2):293-300. doi: 10.2105/AJPH.2020.305996.
3. Tenbensel T. Multiple Modes of Governance: Disentangling the Alternatives to Hierarchies and Markets. Public Manag Rev. 2005 Apr 29;7:267-88.
4. Crampton P. The ownership elephant: Ownership and community-governance in primary care. N Z Med J. 2005 Sep;118(1222):U1663.
5. Gauld R, Atmore C, Baxter J, Crampton P, Stokes T. The 'elephants in the room' for New Zealand's health system in its 80th anniversary year: general practice charges and ownership models. N Z Med J. 2019;132(1489):8-14.
6. OECD. Results in development cooperation: Measuring the results of private sector engagement through development co-operation Discussion paper for the OECD/DAC Results Community Workshop [Internet]. 2018 Apr 10–11 [cited 2023 Feb 8]. Paris; 2018. Available from: https://www.oecd.org/dac/results-development/docs/results-pse-results-workshop-apr-18.pdf.
7. World Health Organization. Engaging the private health service delivery sector through governance in mixed health systems: strategy report of the WHO Advisory Group on the Governance of the Private Sector for Universal Health Coverage [Internet]. Geneva; 2020 [cited 2023 Feb 8]. Available from: https://www.who.int/publications/i/item/9789240018327.
8. Goodair B, Reeves A. Outsourcing health-care services to the private sector and treatable mortality rates in England, 2013-20: an observational study of NHS privatisation. Lancet Public Heal. 2022 Jul 1;7(7):e638-46. doi: 10.1016/S2468-2667(22)00133-5.
9. Quercioli C, Messina G, Basu S, et al. The effect of healthcare delivery privatisation on avoidable mortality: longitudinal cross-regional results from Italy, 1993-2003. J Epidemiol Community Health. 2013 Feb 1;67(2):132-138. doi: 10.1136/jech-2011-200640.
10. Laugesen M. Why Some Market Reforms Lack Legitimacy in Health Care. J Health Polit Policy Law. 2005 Dec 1;30(6):1065-100. https://doi.org/10.1215/03616878-30-6-1065.
11. Stiglitz J. Making Globalization Work. London: Penguin; 2006.
12. McGinnis MD. Caring for the Health Commons: What it is and Who's Responsible for it. SSRN. 2013. http://dx.doi.org/10.2139/ssrn.2221413.
13. Neuwelt PM. Community participation in primary care: what does it mean 'in practice'? J Prim Health Care. 2012 Mar;4(1):30-8.
14. Sandvik H, Hetlevik Ø, Blinkenberg J, Hunskaar S. Continuity in general practice as predictor of mortality, acute hospitalisation, and use of out-of-hours care: a registry-based observational study in Norway. Br J Gen Pract. 2022 Jan 27;72(715):e84-e90. doi: 10.3399/BJGP.2021.0340.
15. Rudden MG. "A weird culture of coercion": The impact of health care corporatization on clinicians. Int J Appl Psychoanal Stud. 2022;19(3):270-90. https://doi.org/10.1002/aps.1765.
16. Pennington P. Pressures, profits and patients: Debate rages around ethics of private medical scanning [Internet]. Radio New Zealand; 2022 Aug 28 [cited 2023 Feb 8]. Available from: https://www.rnz.co.nz/news/national/473245/pressures-profits-and-patients-debate-rages-around-ethics-of-private-medical-scanning.
17. World Health Organization. The World Health Report: Health systems financing: the path to universal coverage. [Internet]. Geneva; 2010 [cited 2023 Jan 17]. Available from: https://apps.who.int/iris/handle/10665/44371.

18. Clarke D, Doerr S, Hunter M, et al. The private sector and universal health coverage. Bull World Health Organ. 2019;97(6):434-5.
19. Penno E, Sullivan T, Barson D, Gauld R. Private choices, public costs: Evaluating cost-shifting between private and public health sectors in New Zealand. Health Policy (New York). 2021;125(3):406-14.
20. Health and Disability System Review. Health and Disability System Review - Final report/Pūrongo whakamutunga [Internet]. 2020 Jun [cited 2022 Apr 8]. Available from: https://systemreview.health.govt.nz/final-report/.
21. Hyslop J, Dowland J, Hickling J. Health facts New Zealand [Internet]. Wellington: Department of Health; 1983 [cited 2022 Apr 8]. Available from: https://www.moh.govt.nz/notebook/nbbooks.nsf/0/
22. Gauld R. Revolving doors: New Zealand's health reforms. Wellington; 2001.
23. Goodyear-Smith F, Ashton T. New Zealand health system: universalism struggles with persisting inequities. Lancet. 2019;394(10196):432-42. doi: 10.1016/S0140-6736(19)31238-3.
24. New Zealand Treasury. District Health Board Financial Performance to 2016 and 2017 Plans [Internet]. Wellington; 2017 [cited 2022 Aug 2]. Available from: https://treasury.govt.nz/sites/default/files/2017-05/dhb-performance-feb17.pdf.
25. Cassie F. Looming $20,000 practice nurse pay gap: Minister says no quick solution [Internet]. NZ Doctor; 2022 [cited 2022 Nov 2]. Available from: https://www.nzdoctor.co.nz/article/news/np-nurse/looming-20000-practice-nurse-pay-gap-minister-says-no-quick-solution.
26. Crampton P. The ongoing evolution of capitation funding for primary care: the December 2018 PHO capitation funding changes for Community Services Card holders. N Z Med J. 2019 Jul;132(1498):69-78.
27. Kearns RA. The place of health in the health of place: The case of the Hokianga special medical area. Soc Sci Med. 1991;33(4):519-30. doi: 10.1016/0277-9536(91)90334-9.
28. Manatū Hauora – Ministry of Health. H202106851 [Internet]. Official Information Request. 2021. Available from: https://www.nzdoctor.co.nz/sites/default/files/2021-09/South Taranaki Rural General Practice OIA response.pdf.
29. West Coast DHB. Official Information Act request WCDHB 9664 23 February 2022 [Internet]. 2022 [cited 2023 Feb 8]. Available from: Official Information Act request WCDHB 9664.
30. Cassie F. Changing practice ownership 2022 MAPPED: Trends - Green Cross buy-ups, GP joint ventures [Internet]. NZ Doctor; 2022 [cited 2023 Feb 12]. Available from: https://www.nzdoctor.co.nz/article/news/changing-practice-ownership-2022-mapped-trends-green-cross-buy-ups-gp-joint-ventures.
31. IBIS World. Dental Services in New Zealand - Market Research Report [Internet]. 2023 [cited 2023 Feb 12]. Available from: https://www.ibisworld.com/nz/industry/dental-services/613/.
32. Scahill S, Harrison J, Carswell P, Shaw J. Health care policy and community pharmacy: implications for the New Zealand primary health care sector. N Z Med J. 2010 Jun 25;123(1317):41-51.
33. Reid P, Paine SJ, Te Ao B, et al. Estimating the economic costs of Indigenous health inequities in New Zealand: a retrospective cohort analysis. BMJ Open. 2022;12(10):e065430. doi: 10.1136/bmjopen-2022-065430.
34. Jarman H, Greer S. Crossborder trade in health services: Lessons from the European laboratory. Health Policy. 2010;94(2):158-63. doi: 10.1016/j.healthpol.2009.09.007.
35. Powell I. How to fix the NZ laboratory fiasco [Internet]. Business Desk; 2023 [cited 2023 Apr 11]. Available from: https://businessdesk.co.nz/article/how-to-fix-the-nz-laboratory-fiasco.
36. Nind J, Smith A, Devananda M, Auvray B. A whole of population retrospective observational study on the rates of polypharmacy in New Zealand 2014 to 2018 Polypharmacy in New Zealand: What is the current status? Heal Sci Reports. 2021;4(2):e263. doi: 10.1002/hsr2.263.
37. Tennant M, O'Brien M, Sanders J. The History of the Non-profit Sector in New Zealand [Internet]. Office for the Community and Voluntary Sector; 2008. Available from: http://www.communityresearch.org.nz/wp-content/uploads/formidable/sanders4.pdf.
38. Tan L, Carr J, Reidy J. New Zealand evidence for the impact of primary healthcare investment in capital and coast district health board. N Z Med J. 2012;125(1352):7-27.
39. Crampton P, Dowell A, Woodward A. Third sector primary care for vulnerable populations. Soc Sci Med. 2001 Dec;53(11):1491-502. doi: 10.1016/s0277-9536(00)00438-x.
40. Crampton P, Starfield B. A case for government ownership of primary care services in New Zealand: weighing the arguments. Int J Health Serv. 2004;34(4):709-27. doi: 10.2190/FMJW-R4R9-C4R1-W8RJ.
41. Matheson D, Reidy J, Keenan R. Guest Editorial: Bringing primary health and community care in from the cold in the New Zealand health reforms?

Tracing reform recommendations to budgets and structures. J Prim Health Care. 2022;(3):194-196. doi: 10.1071/HC22077.
42. Huston P, Campbell J, Russell G, et al. COVID-19 and primary care in six countries. BJGP Open. 2020 Oct;4(4):bjgpopen20X101128. doi: 10.3399/bjgpopen20X101128.
43. Mcmeeking S, Savage C. Maori Responses to Covid-19. Policy Quaterly. 2020;16(3).
44. Boulton A, Gifford H, Allport T, Research W, White H. Delivering on diversity: The challenges of commissioning for Whānau Ora. J Indig Wellbeing. 2018;3(1):45-56. Available from: https://journalindigenouswellbeing.co.nz/media/2022/01/111.121.Delivering-on-diversity-The-challenges-of-commissioning-for-Whanau-Ora.pdf.
45. Vaithianathan R. The Failure of Corporatisation: Public Hospitals in New Zealand. Agenda A J Policy Anal Reform. 1999 Nov 12;6(4):325-38. http://www.jstor.org/stable/43199049.
46. Howell B. Ownership-Based Analysis of Public Hospital Corporatisation in New Zealand. Agenda A J Policy Anal Reform. 2000 Nov 12;7(3):237-50. http://www.jstor.org/stable/43199081.
47. New Zealand Companies Register. Whakarongorau aotearoa new zealand telehealth services (GP) limited (4961479) [Internet]. NZ Companies Office; 2023 [cited 2023 Feb 12]. Available from: https://app.companiesoffice.govt.nz/companies/app/ui/pages/companies/4961479.
48. Health and Disability System Review - Interim Report, Executive Overview. Hauora Manaaki ki Aotearoa Whānui – Pūrongo mō Tēnei Wā. Wellington; 2019.
49. Aimers J, Walker P. Is community accountability being overlooked as a result of government-third sector partnering in New Zealand? Aotearoa New Zeal Soc Work. 2017;20(3):14-24. https://doi.org/10.11157/anzswj-vol20iss3id337.
50. Crengle S. The development of Māori primary care services. Pac Health Dialog. 2000 Mar;7(1):48-53.
51. Waitangi Tribunal. Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry [Internet]. Wellington; 2019 [cited 2022 April 8]. Available from: https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_195476216/Hauora%202023%20W.pdf.
52. World Health Organization. The private sector, universal health coverage and primary health care. Tech Ser Prim Heal Care. 2018;1-9. https://apps.who.int/iris/rest/bitstreams/1216992/retrieve.
53. Vanyoro KP, Hawkins K, Greenall M, Parry H, Keeru L. Local ownership of health policy and systems research in low-income and middle-income countries: a missing element in the uptake debate. BMJ Glob Heal. 2019 Aug;4(4):e001523. doi: 10.1136/bmjgh-2019-001523.