GENPRO

General Practice Owners Association
of Aotearoa New Zealand

Sustainable and viable General Practice healthcare for our next generation of New Zealanders

A virtual panel discussion & member consultation

31st July 2020

Preface

General Practice is facing significant sustainability and viability challenges. They have been building for some time. Unless we act now they will impact the health of all New Zealanders, their whānau and their communities. They will impact the ability of the wider New Zealand health system to manage the tidal wave of demand which will reach the doors of every District Health Board, hospital and emergency department throughout the country. The health of our nation would suffer.

The current financial framework settings for General Practice and Urgent Care Centres are unsustainable. Never has that been more starkly brought into focus than during the worldwide COVID-19 pandemic. The Government's Review of the Health and Disability System acknowledges that there are problems and points to the current underfunding of the health system as well as the recommendation for the increased weighting of population-based funding towards need.

This paper is part of a process through which the General Practice Owners Association of Aotearoa New Zealand (GenPro) has been privileged to secure the input and views of a knowledgeable panel of sector stakeholders. We now invite you to join us in this virtual panel discussion and member consultation which will help inform GenPro's future advocacy and national representation activity on behalf of our members and the communities they serve.

We are providing an opportunity for our members and sector partners to inform this future funding debate through which GenPro will work alongside the government and health leaders to ensure we deliver our Vision of sustainable, viable and high quality General Practice for all New Zealanders.

We thank you for, and look forward to reading your feedback and contributions.

Dr Tim Malloy
Interim Chair

Dr Angus Chambers
Interim Deputy Chair

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1. Introduction

This virtual panel discussion and Member consultation paper has been developed by GenPro to inform debate around the future funding model for sustainable and viable General Practice and Urgent Care services for the people of New Zealand.

This virtual panel discussion forms part of a process which aims to collate feedback and input from GenPro members to establish a position paper to underpin the Association's national advocacy and representation activity on behalf of member General Practice and Urgent Care Centre owners.

The subject of Primary Care funding and the sustainability of General Practice and Urgent Care Centres is critical to the sustainability of our wider health and disability system. Whilst the findings of the Government's Review of the Health and Disability System and its associated recommendations acknowledge the underfunding of the health system and the need for greater targeting of resources, they do not explicitly acknowledge the sustainability crisis for essential General Practice business owners.

In this virtual panel discussion we review the challenges of the current funding arrangements as well as encourage 'blue sky' thinking on what the future may look like.

Our intention is not to replicate or add to the myriad reviews and their associated recommendations relating to the current funding methodology, but we do note that too many of those reviews remain on the shelf with un-actioned recommendations.

Our virtual panel is brought together to share their personal views to help thinking and discussion on the consultation questions raised. Those panel views, whilst not necessarily reflecting the views of the GenPro board, are offered in good faith to help inform debate and we express our sincere thanks to the panel members for their participation.

We now seek member input and feedback on those same questions to help us establish a position on behalf of GenPro and the General Practice and Urgent Care business owners we represent.

2. Introducing the Panel

GenPro is pleased to present the following virtual panel members to help inform this discussion paper and to aid the thinking of GenPro members.

Whilst a range of views have been sought, it is emphasised that the views and opinions provided are not the opinion or GenPro and nor do they represent a pre-determination of the outcome of this consultation process. In accordance with GenPro's Constitution and operating model, the Association's position will be mandated directly by members.

When considering the panel views, the following should be noted:

- The views expressed are the views of individual panel members and should not be assumed to be the views of GenPro, its members, Board or Chair, nor the organisations employing or otherwise normally represented by the panel members
- The views and opinions have been offered in good faith at the point in time of this report. They have been received with the grateful appreciation of GenPro on behalf of members
- The panel, whilst constituted to offer a range of views is not intended to be representative of the sector nor the membership of GenPro
- The panel members have been approached due to their interest and/or stake-holding in the sector. They are not intended to be presented as specific experts or to provide a definitive answer to the questions raised.

Prof. Tony Dowell

Tony Dowell is Professor of Primary Health Care and General Practice at the University of Otago in Wellington and a GP in Wellington.

He has worked in primary care in New Zealand the UK and Central Africa.

His current research interests include primary mental health care, communication between patients and health providers and the application of complexity and implementation science in health care settings.

Dr Geoff Cunningham

Geoff is a GP and partner at Bush Road Medical Centre in Kamo, Whangarei - an access practice of over 11,000 enrolled patients serving a high number of elderly, low income and high needs patients.

Geoff's GP expertise, spanning more than 20 years, includes Paediatrics, Sports Medicine, Dive Medicine and Minor Surgery. He is a long standing member of the College Faculty, POADMS and Clinical Governance Committees.

The owners of Bush Road Medical Centre are members of GenPro.

Dr Angus Chambers

Dr Angus Chambers is a GP and business owner at Riccarton Clinic in Christchurch – a practice service approximately 17,000 enrolled patients and also providing urgent care services.

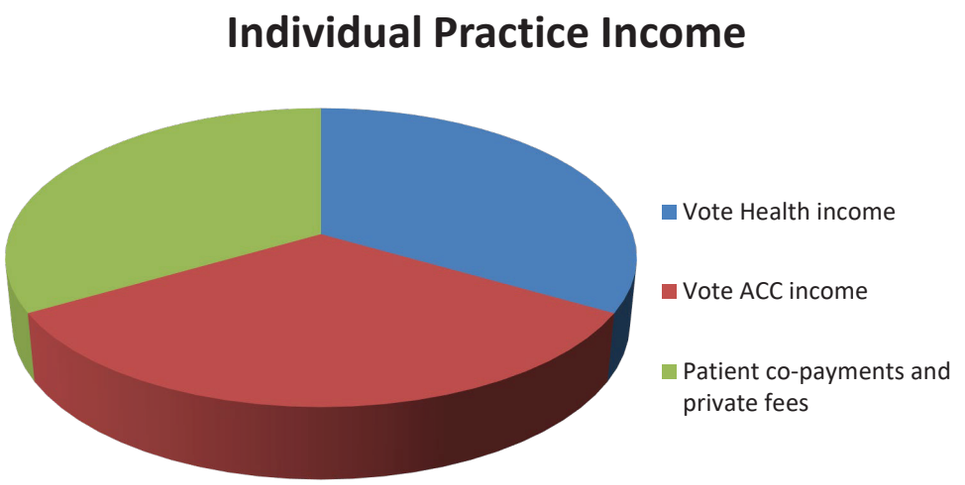
Angus studied medicine at Otago University and has been a GP in Christchurch since 1990. He also has a degree in Law from Canterbury.

He has been a keen supporter of the establishment of GenPro to try to support sustainable and viable General Practice. He is currently interim Deputy Chair of GenPro.

3. Overview of Primary Care Funding

Individual General Practice and Urgent Care Centre funding is broadly derived from three main sources:

1. Vote Health: Government funded services via the Ministry of Health
2. Vote ACC: Government funded services through the Accident Compensation Corporation
3. Patient co-payments and private fees



The percentage composition of each Practice's income will vary between these three funding streams and be dependent upon a number of factors.

An Urgent Care Centre with a low number of enrolled General Practice patients will, for example, have a higher percentage of its income derived from Vote ACC rather than Vote Health.

A VLCA Practice will, by comparison, have a higher percentage of its income through Vote Health on account of the increased capitation funding for its enrolled list, but the level of its patient co-payment income is, by definition, capped and will therefore be a comparatively lower percentage of its total income.

Vote Health:

There are two separate, but inter-related factors which determine an individual practice's income from Ministry of Health funding:

- The "slice of the pie" which is appropriated to primary care from the overall Health budget/vote
- The distribution of that "slice" across and between individual General Practices

Vote Health funding is predominantly paid to Practices in accordance with the nationally negotiated terms and conditions of the PHO Services Agreement and the associated Back-to-Back agreement between each General Practice and their relevant PHO.

Both the PHO Services Agreement and the Back-to-Back agreement are negotiated through the PHO Services Agreement Amendment Protocol (PSAAP) forum*.

Vote Health funding is typically appropriated through a number of parallel silos including capitation funding, services to improve access (SIA) funding, Health Promotion funding, CarePlus funding. Further detail on each funding stream is provided on the Ministry of Health website here: https://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services.

Vote ACC:

ACC operates under legislation set out in the Accident Compensation Act. Under the Act, ACC is liable to pay or contribute to approved providers the amount stated in a contract or agreement.

Rural General Practice and Urgent Care Clinics have separate contracts with ACC, but other General Practice providers are paid under regulations.
The regulations provide specific fee-for-service rates for visits, treatments and imaging by provider type, e.g. GP or nurse.

Current ACC funding arrangements and fees are typically non-negotiable. The Cost of Treatment regulations are overseen by the Ministry of Business, Innovation and Employment (MBIE).

Concern has been expressed by many in the sector that the lack of alignment between ACC funding arrangements/fees and those of the Ministry of Health can result in unhelpful tensions between neighbouring providers as well as some perverse incentives.

Patient co-payments and private fees:

The combination of Vote Health funding and patient co-payments is intended to cover the full costs of providing services. Patient co-payments chargeable by General Practice are controlled. In many cases this means the General Practice has no flexibility at all to vary the co-payment.

Since the extension of the very low cost access scheme for CSC card holders, Practices have received a higher capitation payment for such patients to compensate for the application of a maximum consultation fee (recently increased from $19.00 to $19.50) for those patients.

Similarly, additional capitation payments to Practices were agreed at the time of the extension of free access for under 14 year olds. The higher capitation payment compensates for the fact that Practices cannot charge any co-payment for consultations for such patients.

For all remaining patients, Practices may only vary their fees by an agreed amount annually (Annual Reasonable Fees Increase) – this amount being determined by the government. Variations from this agreed amount risk legal challenge through the Fees Review Process.

Outside of Crown funded or subsidised services, practices can secure income through private fees for services such as private/insurance consultations or immigration medicals, although the latter may have been impacted through recent changes to the procurement arrangements with individual practices.

4. Short-term Sustainability Challenge

The immediate funding challenges for General Practice are well documented and, for the purpose of this discussion, we specifically consider three main aspects of that challenge:

- The “slice of the pie” which is appropriated to primary care from the overall Health budget/vote
- The distribution of that “slice” across and between individual General Practices
- The fee-for-service approach during times of crises such as with the COVID pandemic.

The slice of the pie

There is strong belief amongst many across the sector that the slice of the pie has not kept pace with the increased costs and expectations of the service provided by General Practice over many years.

At a fundamental level, many believe that annual funding uplifts (including for capitation rates) have not been sufficient to cover annual inflation levels and associated cost pressures. The PHO Services Agreement states “it is the government’s intention to regularly adjust the amounts payable for First Level Services to maintain the value of those payments”. In reality however, whilst PSAAP members are ‘consulted’ on the level of annual uplift, they have no ability (unless through other negotiation leverage) to agree or directly determine the approach and it is therefore neither negotiated nor free from political pressure (having increasingly been ‘imposed’ by the Minister of Health in recent years in the absence of a proactive agreement by PSAAP members).

Such underfunding of annual inflation and cost pressures through Vote Health results in a higher percentage of Practice costs needing to be met through patient co-payments. However, where increasing policy settings also cap the amount of patient co-payments (e.g. very low cost access for CSC cardholders, free consultations for under 14 year olds), Practices have to directly cover any shortfall themselves having been left with neither the ability to negotiate the Vote Health funding increase nor to alter patient co-payments.

Many also believe the formulaic approach (incorporating the Annual statement of reasonable GP fee increases*) to advising the government on the impact of annual inflation and cost increases to be flawed and that it doesn't take into account many of the true cost pressures for General Practice. Concern has also been expressed about the retrospective nature of including many cost pressures including, specifically, staffing pay awards such as the impact of the DHB nursing MECA which was agreed in advance of negotiations with primary care nursing representatives and created a significant pay differential and unhelpful competition with DHB nursing positions and therefore additional primary care cost pressures and staff shortages.

Some of those sector representatives who are closer to the development of the formulaic approach, have also noted that it does not appear to take into account the rising percentage of Practice income which is now capped by policy settings. Typically the annual increase in subsidy funding may assume that 50% of Practice income might come from patient fees – but that percentage figure has materially reduced over recent years.

Other areas of increased costs and expectations over recent years which many believe General Practice have not been appropriately resourced to cover, include:

- Additional compliance and administrative requirements
- The shift of services/demand from secondary to primary care without appropriate corresponding resources (Explicitly through locally determined schemes such as POAC* as well as through secondary care demand management practices such as increases in pre-referral work-up e.g. diagnostics, or higher referral thresholds resulting in patient referrals being declined and returned to primary care for on-going management). Such an increase in shift of workload to primary care can also have the consequences of increasing costs to patients
- Service re-design (with or without primary care consultation – such as earlier post-op discharge)
- Additional workload and/or services being funded at cost with no margin for overheads or risk
- COVID19 pandemic response
- Higher than anticipated demand increases due to policy changes such as free consultations for under 14 year olds.

The collective risk under the above scenarios is that other parts of the service equation have to compensate for the increased costs and potential loss of income which could increasingly lead to service quality reducing through shorter opening hours, reduced staffing or longer waiting times for example.

The distribution of the slice

There have been many reviews and recommendations over recent years with regards the siloed funding framework and distribution of funding across General Practice. GenPro notes that despite many stakeholders agreeing that the current apportionment methodology is flawed or out of date, only a limited number of those review recommendations have been implemented or have led to any beneficial impact upon the sector. A notable exception is the extension of the Community Services Card scheme to offer low cost access to General Practice consultations which was implemented in 2018 following its recommendation by a number of organisations and reviews.

Despite the extension of low cost access to cover high needs patients who were not previously able to enrol with a VLCA Practice, GenPro notes that significant inequity remains embedded within the VLCA framework which continues to unfairly disadvantage individual patients as well as neighbouring contracted providers.

Of the reviews undertaken over recent years, GenPro specifically notes that of the Primary Care Working Group (PCWG) which was established, at the request of the Minister of Health, in August 2015 following agreement between PSAAP participants (Ministry of Health, DHBs, PHOs and General Practice Provider representatives) that action was needed to explore:

- ensuring affordable, equitable access to sustainable general practice
- general practice workforce sustainability
- shifting services closer to home.

We specifically refer to that review here due to it being formally established through the PSAAP forum in direct recognition of the above inherent sector challenges. Similarly, it is included due to the wide ranging input which the review secured from across the sector.

The PCWG was chaired by Dr Peter Moodie (GP and Practice owner) and included membership from across the sector as well as the lead DHB CEO for Primary Care (Dr Nick Chamberlain).

PCWG's report* and associated recommendations received widespread support and appear to remain as relevant and appropriate today as they were at the time of the report in 2015. Appendix B of this report provides an extract of the Executive Summary and recommendations of the PCWG report.

With specific reference to the VLCA funding framework, the PCWG report noted it was "creating distortion and equity issues... for example: A non VLCA practice, even with a high need population, may be at a competitive disadvantage with neighbouring practices who have VLCA status and a different funding regime."

Much has been written and commented about the formula which determines the weighted distribution of capitation funding. The formula is currently weighted for the gender and age of enrolled patients in order to allow for the different anticipated levels of patient need.

The underpinning data to support the weightings was developed based on actual utilisation rates in 2003 and there have been no material changes to the formula since that date. Subsequent reviews have recommended various updates and extensions to the formula to reflect factors such as ethnicity, deprivation and rurality as well as a greater consideration of unmet need and, refinement of the age bands and associated weightings.

In addition to the PCWG report, we also refer here to the December 2015 PHO Alliance publication, Targeting Resources: Strengthening New Zealand's primary care capitation funding formula*, which provides a more detailed discussion with regards strengthening the formula underpinning the 'distribution of the slice'.

The fee for service approach

A significant percentage of practice income remains on a fee for service approach. That is, income is only secured on the basis of specific service delivery - traditionally a face-to-face GP consultation – which despite being subsidised through the annual Vote Health capitation funding, also typically generates a patient co-payment fee.

The fee for service approach is even greater for services covered by the ACC regulations – including, most notably Urgent Care Centres, who do not receive a capitation payment for such activity. Instead the full cost of the service is intended to be covered by the ACC fee for service payment (plus any potential patient co-payment).

The significant risk that this poses to continuity of service has been brought starkly to the fore during the 2020 COVID19 pandemic which resulted in an almost overnight contraction in the number of patient attendances of up to 80% - 90% at all General Practices and Urgent Care Centres.

The impact upon each and every provider was enormous with an instant reduction in income and cash-flow and, the associated knock-on impact upon continuity of services. Widespread reporting pointed towards reduced staffing and reduced opening hours across an essential public service and the country's front-line of attack at times of such a pandemic.

Consultation Question 1.

a. Are the recommendations of the 2015 Primary Care Working Group on General Practice Sustainability still valid?
b. Are any of the recommendations no longer appropriate?
c. Should anything new be added in respect of action that can be immediately implemented to strengthen the current General Practice and Urgent Care funding framework and the sustainability of services provided for all New Zealanders?

Panel Responses.

Dr Geoff Cunningham:

a) Yes the "Moodie Report" is still valid in that it recommends a boost to funding and the abolition of VLCA. I strongly feel whichever funding model is adopted it must be singular, targeted and fair. VLCA wastes precious Vote Health and is grossly unfair to surrounding non-VLCA practices.

b) In five years since the Moodie report nothing substantial has been done for General Practice funding, the need for positive change has merely increased. The advent of Neighbourhood Healthcare Homes has indicated that out funding model is no longer fit for purpose if innovations like these are to be adopted.

c) For General Practice I strongly feely VLCA must be abolished, the money previously spent subsidising visits for over 500,000 "wealthy" patients can then be targeted to our most high needs, truly benefiting our most needy patients in all practices. Capitation is now grossly undervalued as it has not been corrected for health inflation, this must be addressed. Huge variability in co-payments is resulting in "GP Ghetto Regions" which is hugely problematic for workforce recruitment and retention. The unfair mechanism of "claw-back" must cease.

Dr Angus Chambers:

Even though low cost access has now been extended to all Community Service Card (CSC) holders, there are still significant and unacceptable inequities within the funding framework – for patients as well as contracted providers. Addressing these inequities should be a priority for the collective negotiators (Ministry of Health, District Health Boards, PHOs and, Contracted Providers) for the next contract changes and update to the funding framework.

There appeared widespread agreement to the Primary Care Working Group recommendations and it is difficult to see why these have not been progressed because they would have addressed many of the current challenges.

In the interests of equity we should be updating the capitation formula, targeting funding based on patient need and, addressing unfair funding differences between contracted providers. None of these issues require further analysis or procrastination – let's get the respective funders, providers and policy makers in the same room to agree an implementation plan and change management framework.

Professor Tony Dowell:

Many of the Primary Care Working Group (PCWG), recommendations remain valid, and have continuing relevance in the light of the current extraordinary COVID-19 environment. The need for frequent updating and review of capitation and co-payment mechanisms remains important, as does the need to reduce the considerable disparities to access that currently exist. The PCWG was clear about the challenges caused by differing routes to access care and the need to review the VLCA arrangements. Those challenges still exist.

The PCWG recommendations were and are relevant in terms of the changing workforce landscape in General Practice and Primary Care and their support of special interest roles and new workforce models has become even more important in the last few years with the demands posed by increasingly complex care scenarios and multi-morbidity. Their call to prioritise shifts in services so that General Practice can make full use of inter-professional work with allied health practitioners and increase the consistent use of information technology is even more vital given the enhanced opportunities for virtual and remote working observed during initial and existing phases of COVID-19 activity.

In this area of virtual care in general practice future sustainability models need to facilitate access for populations and infrastructure and training for General Practice.

5. Sustainability for our Next Generation

Looking to the future, it is important that there is continuing evolution of the General Practice and Urgent Care business model to align with advances in clinical practice and technology, respond to patient expectations and, adapt as an integral part of a wider primary care and health and disability system.

As predominantly independent owner-operator businesses with significant personal investment risk and whose livelihoods depend on protecting their own business interests, such business owners have, for the most part, exhibited high levels of agility, innovation and entrepreneurship. This was no more evident than in response to the COVID19 pandemic whereby over the course of a single weekend the entire New Zealand model of General Practice and Urgent Care provision changed almost unrecognisably.

As independent businesses, it would be reasonable to expect that those business owners accept and take responsibility for management of certain business risks and, in return, receive appropriate compensation for that level of risk, which is otherwise invariably underwritten through personal and family liability.

Time will tell what the lasting impact of the COVID19 pandemic will be upon the General Practice and Urgent Care business models, but what was already clear was that changes to the policy and financial framework are needed to sustainably underpin the transition of the service for our next generation.

Balance of capitation and fee-for-service funding

There are a mixture of advantages, disadvantages and potential perverse incentives within the funding framework which delicately balances business income across Vote Health, Vote ACC and patient co-payments.

As seen during the COVID19 pandemic, the loss of business income ordinarily received through fee-for-service arrangements (e.g. current ACC funding and patient co-payments) places significant risk on the continuity of service at a time of crisis. Unlike many, but not all, other front-line services, General Practice was required to continue operating during the pandemic and whilst also subject to increased costs to ensure the safety of its staff and patients.

Conversely, a higher percentage of business income received through government funded capitation (or other bulk funding arrangement) risks the autonomy of independent business owners and their ability to respond agilely at time of challenge with their traditional innovation and entrepreneurship.

Consultation Question 2.

a. Is the current General Practice funding model incorporating part capitation, part fee-for-service and, part patient co-payment, fit-for-purpose for another 25 years?
b. Is there a better way that the fixed costs of General Practice and Urgent Care services should be covered to ensure service continuity of what are essential front-line public services?

Panel Responses.

Professor Tony Dowell:

In all OECD countries there is ongoing debate about the most effective way to fund and access General Practice and Primary Care services with no evidence of an ideal Goldilocks 'just right' model. From that perspective and with significant increases in demand and complexity of care it seems very unlikely that the current General Practice funding model is sustainable and fit for purpose for another 25 years.

At the heart of the debate is the balance between different funding streams and in particular the degree to which capitation and government subsidy can be made effective in differing practice contexts (rural / urban / differing socio-economic settings etc), and the role of co-payments in the equation. Co-payment is a feature of New Zealand General Practice and in many other health systems (eg Norway), and has been regarded as a way of managing General Practice demand and the self-management of minor illness [1].

The evidence is also clear that in many settings co-payment has a negative impact on those with low income in terms of access to care [2]. There are also problems with existing models of capitation fee for service and insurance schemes [3].

It seems appropriate to use the current challenges to the sustainability of General Practice, and the relative lack of detail about funding sustainability in the Health and Disability Review to debate the core principles of General Practice funding. The possibilities are broad, from a much greater investment by Government, either directly or through potential insurance schemes, or more sophisticated

workings of capitation and co-payment. It is important the voice of General Practice owners is heard in the debate.

1. Toop, Les, and Claire Jackson. "Patient co-payment for general practice services: slippery slope or a survival imperative for the NHS?." BJGP (2015): 276-277.

2. Kiil A, Houlberg K. How does co-payment for health care services affect demand, health and redistribution? A systematic review of the empirical evidence from 1990 to 2011. The European Journal of Health Economics. 2014 Nov 1;15(8):813-28.

3. Robinson JC. Theory and practice in the design of physician payment incentives. The Milbank Quarterly. 2001 Jun;79(2):149-77.

Dr Geoff Cunningham:

a) *The term "co-payment" should be replaced with "gap payment/ gap health tax" to more accurately describe its nature. Changing models of care are making the current model no longer fit for purpose. The income generated as a result of years of underfunding and cost pressures no longer makes General Practice an attractive specialty, especially in comparison to our SMO colleagues' remuneration and the conditions they enjoy.*

b) *Given the importance of a high quality and adequately staffed General Practice and Urgent Care network, it is vital the Government invests in this resource to reduce the financial and workload burden on secondary care services. The sector desperately needs investment. One option is for central funding of the costs of these entities with pay equity for the Primary Care workforce with their secondary care colleagues (doctors and nurses).*

   Primary Care can no longer continue under the "sinking lid" funding that has been occurring which devalues core General Practice. These effects are worse in high needs regions which are having increasing workforce issues as a result.

Dr Angus Chambers:

The COVID pandemic has clearly highlighted weaknesses in the funding framework when it comes to maintaining continuity of service during times of crisis. Maintaining an essential front-line public health service is different to maintaining non-essential businesses and yet during the COVID pandemic, and specifically level 4 lockdown, the same criteria for Government support appears to have been applied. In the future that may mean we lose many General Practices and Urgent Care Centres at a time when they are essential to the safety of our nation.

We should otherwise be careful not to throw the baby out with the bathwater. I believe there have been some naïve mistakes made by primary care negotiators over recent years which have damaged the sustainability of contracted providers – including increasingly giving up the ability to increase patient co-payments to cover rising costs, failing to secure the right to negotiate annual inflationary increases to capitation funding and, failing to negotiate appropriate funding for additional activity and compliance costs - if these issues were addressed, the funding framework and the longer-term viability of providers would be significantly strengthened.

Alignment of funding silos

Many in the sector are challenged daily with determining whether a presenting patient falls within ACC regulations or not. The requirement for a determination to this effect can be influenced by factors such as the fees payable under each determination as well as the administrative burden in completing claim forms and associated paperwork. Such unintended consequences of the system are unhelpful and give rise to perverse incentives around decision making.

Similarly, the different payment arrangements and funding levels for the same, or very similar, care (such as whether it is undertaken through an Urgent Care Centres, a General Practice, a rural clinic or a secondary care provider e.g. orthopaedic specialist) undoubtedly causes issues between neighbouring services at a local level and is, again, potentially perverse and unhelpful.

Consultation Question 3.

a. How important is it for ACC and Health services to be funded on a like-for-like basis?
b. How important is it for neighbouring providers to be funded on a like-for-like basis where the service provided is the same?

Panel Responses.

Dr Angus Chambers:

It is concerning that the ACC appears to operate within its own silo with little consideration of the bigger picture or its relationship with sector partners. Treatment costs are a good example of this – they appear to be set without consultation or alignment with key health sector partners (such as the Ministry of Health) – which results in perverse price inequities.

Similarly, a bit more thought and better co-design could secure significant cost and outcome benefits for the taxpayer, for example a funding framework to support proactive case management in primary care could result in a large reduction in ACCs liability for earnings related compensation cost. It would be good to be able to work jointly with ACC to optimise the balance between budget lines covering treatment costs and earnings related compensation.

There will always be situations where the service provided incurs additional costs such as when the patient's need is more complex (e.g. severity of injury) or when

the delivery of the service is subject premiums (e.g. rurality factors or out-of-hours payments). These variations can be understood, agreed and justified.

Otherwise, there is no justification whatsoever for variations in funding for the same service and we might be risking breaching legislation such as the Commerce Act or the Fair Trading Act by maintaining a funding framework which has such clear inequities.

Dr Geoff Cunningham:

a) It is moderately important that ACC and Health services be funded on a like for like basis however I feel that many providers have adapted to the disparities in the systems. It would be a massive undertaking to change.

b) It is vital neighbouring providers are treated equally. The current ACC payment structure that sees an urban GP paid a quarter of a rural colleague or a consultation or procedure is appalling. The current payment anomalies create the impression among patients they are being unfairly charged by their GP when the "free visit" at the Urgent Care service is in fact far more lucrative, for procedures the GP is often left out of pocket. In addition to this GPs can only claim for one injury seen in a day despite often seeing more in a single visit and there is no recognition by ACC for the GP specialist qualification of Fellowship. Sadly ACC continues to pay lip service to these issues.

Professor Tony Dowell:

Equity is an appropriate core theme of discussions about the current and future state of New Zealand health care. It is important that equity considerations extend to health providers in terms of funding for equivalent amounts of service effort.

ACC is an important component of the New Zealand health landscape, and ACC claims a significant component of General Practice workload. It is appropriate there should be consistent and equivalent funding to General Practice from different funding sources for the same level of service.

Equity should also extend to equivalent funding for neighbouring providers where the level of service is the same. There is a need to explore current definitions of 'like for like' in terms of workload models and case mix and complexity.

Alternative funding and sustainability arrangements

The sector has an opportunity to consider alternative or new funding arrangements to support future service sustainability. Through this consultation we welcome views on potential options which may include consideration of:

- Evolution or replacement of the capitation model

- Cost-plus options which may directly fund certain fixed cost components of service provision (e.g. a premises rental payment)

As part of the consideration of alternative arrangements, the impact upon well-established clinical governance principles would potentially need to be considered. For example, there appears to be widespread support for enrolled list-based primary care as well as for continuity of care through the lead clinician/patient relationship. We would welcome views on the importance of maintaining these arrangements.

Consultation Question 4.

a. How important is it to maintain continuity of care and the enrolled list-based approach to primary care?
b. Is there a better way of funding General Practice and Urgent Care services in the future?

Panel Responses.

Professor Dr Tony Dowell:

It is vital that patients can secure access to primary care services that meet their need, and that they can continue to do that in an ongoing way. The enrolled list system has provided many advantages to primary care, particularly in terms of health promotion and preventive care programmes. Current advances in information technology offer opportunities for different and innovative ways that enrolment can be linked across different health and social services.

The current funding matrix of General Practice and Urgent care offers overall a high quality of primary care services and outcomes in comparison with many OECD countries. It is also a source of tension and concern to both patients and many health practitioners, in terms of access, supply, demand and sustainability. It is appropriate to debate and consider variations and alternatives to current funding models, with options ranging from greater direct Government funding through more sophisticated versions of capitation, to greater insurance involvement. It is important the voice of General Practice owners is heard in the debate.

Dr Geoff Cunningham:

a) *Primary Care researcher Andrew Bazemore has written extensively on the benefits of continuity of care with patients. It is a fact that patient care is improved when managed long term by a single Primary Care physician. Continuity of care improves outcomes for patients!*

b) *A model of funding must primarily cover the costs of providing effective care in both General Practice and Urgent Care. The COVID crisis proved undeniably how inadequate our funding is and how vulnerable we now are to financial events. If any Government wants to improve health outcomes and reduce money spent in secondary care it must invest in Primary Care where a $1 spend saves $6 in secondary care according to Barbara Starfield, leading Primary Care researcher.*

Dr Angus Chambers:

There is much evidence to underpin the benefits of continuity of care, particularly for example for more vulnerable patients and those with multiple co-morbidities. Similarly a list-based approach provides possibly the single most important ingredient for effective public health and population health services – such as we see with the childhood vaccination programme or, as will be needed when a COVID vaccine is developed.

However, modern lifestyles, patient expectations and evolving models of care all present a challenge to the traditional notion of continuity of care. I believe we need to adapt our health systems and infrastructure (e.g. patient information systems) to support stronger clinical governance arrangements which underpin new ways of working. A further benefit of such an approach would be the protection of our valuable workforce – we can no longer expect individual GPs to be available for their patients on a 24/7 basis.

For the future we need a financial framework which ensures that we can rely on the continuity of General Practice and Urgent Care services when they are most needed, as well as which fairly rewards the providers of those services for the inherent day-to-day business risks. I don't think we currently have that balance right but that doesn't mean that the whole framework needs throwing out.

Demand, need and outcomes-based funding

The distinction between funding based on demand, need and outcomes is important, yet often overlooked.

An example of demand-based funding might be the current age and gender weightings of General Practice capitation funding. The weightings, and therefore funding levels, were based on historical usage determined in 2003. That process looked at the historical demand placed upon General Practice by each gender and according to different age bands. Such an approach however, fails to consider a number of important factors:

- Whether each visit to General Practice was actually necessary
- Whether the health needs of those patients visiting General Practice were actually addressed (e.g. successful outcomes delivered)

- Whether there are other members of the population with health needs remaining unaddressed because they do not access General Practice (for whatever reason).

An example of need-based funding might be the additional capitation subsidy applied in respect of CSC card holders (which, not unreasonably, assumes that such CSC card holders have poorer health outcomes). In this example, such an approach fails to consider whether the needs of that vulnerable population group are proactively being addressed by the provider receiving those additional funds.

An example of an outcomes-based funding approach might be the System Level Measures (SLM) or previous PHO Performance programme funding which awards funding to providers based on their successful achievement of performance targets such as immunisation rates or screening levels. In this example, such an approach might be considered as loading risk on the provider who foots the bill in advance for tracing and providing services to the relevant patients and risks being left out of pocket if the specific performance targets are not achieved.

Whilst there are advantages and disadvantages of each funding methodology, we would suggest that a key purpose of New Zealand's health system is to improve health outcomes for the population of the country. We would therefore welcome your views on whether there is a better way to sustainably fund General Practice and Urgent Care providers based on health outcomes.

Consultation Question 5.

Is there a better way that we could ensure funding for General Practice and Urgent Care specifically delivers better health outcomes at the same time as sustainability of service?

Panel Responses.

Dr Geoff Cunningham:

In my region I am increasingly aware that we are struggling to provide care for our rapidly growing high needs population due to a workforce shortage. We simply cannot compete with the remuneration and therefore conditions being

offered elsewhere. I am therefore weary of a funding model that punishes a service for being unable to service a population due to factors they cannot control, as has also occurred in the past where SLMs have been chosen that have been virtually impossible to achieve. Out of the models I feel a demand based formula is fairest but this also ignores the massive inequities that occur secondary to widely disparate co-payments across different regions.

Dr Angus Chambers:

I think much of what has already been discussed could improve outcomes as well as sustainability of services. I also think that a lot of progress could be made very quickly without the need for further reviews and debate. If policy makers and funders worked directly with contracted providers we could agree:

- *Better targeting of funding based on need*
- *The removal of a number of inherent perverse incentives*
- *The removal of unfair and potentially illegal variations in funding between different contracted providers*
- *Greater recognition and reward for risk management and ensuring continuity of essential services*

Professor Dr Tony Dowell:

Primary care and General Practice are responsible for over 90% of all organised health sector activity, yet consistently Primary Care struggles to gain sufficient political leverage in terms of funding and prioritisation compared with secondary care services. Delivering better health outcomes sustainably is dependent in the first place on Government declaring a clear commitment to Primary Care, linked with increased General Practice and primary care representation at Ministry of Health and DHB levels. It is clear that given the increasing complexity of primary care and General Practice workload, additional funding will be required, particularly to enhance IT infrastructure and capability and also to change the current 'short consultation ' throughput model.

6. Consultation Submissions and Timescales

Through this consultation paper GenPro is seeking feedback to help support the future sustainability and viability of General Practice.

Member views will be consolidated into a follow-up paper which will be circulated to members for final comment and agreement before being adopted by the GenPro Board as the mandated position for GenPro's national advocacy and associated representation activities on behalf of members.

The material and views contained within this consultation document are intended to help inform member views and considerations of the challenges faced by the sector. It is emphasised that this paper does not present an agreed GenPro position and nor does it pre-empt the outcome of the consultation. The final mandated position will be determined through GenPro member feedback and any associated further discussions.

The GenPro Board would like to record their thanks to the panel members who have contributed to this consultation paper as well as to thank, in advance, GenPro members and associated partners for their consultation responses to help further this debate and support the agreement of GenPro's mandated position. Your feedback and contributions are strongly encouraged and most welcome.

Submitting feedback

You can submit your feedback using the online template https://www.surveymonkey.com/r/GenProConsultation which replicates the questions set out in this consultation paper. Submitters should feel free to provide any additional information they feel is relevant using the 'free text' fields. Alternatively, you can email your feedback directly to enquiries@genpro.org.nz.

We encourage submissions from partner organisations and sector colleagues to help inform our thinking but we would emphasise that the final GenPro mandated position will be determined solely by GenPro members. For this reason we ask that all submissions include your name(s) and contact details to enable us to establish your membership status as well as to be able to follow-up any areas of clarification.

Please note we kindly request that submission responses are received by 31 August 2020.

Appendix A: Supporting Publications, Material and References*

1. **Annual statement of reasonable GP fee increases**. This is an annual report prepared for the DHBs Central TAS agency, typically by Sapere Research Group which provides advice on the weighted increase in input costs for General Practice over the preceding twelve months. An example from the TAS website is available here https://tas.health.nz/assets/Uploads/GP-Fee-Increase-Statement-2018-19-Final.pdf

2. **PCWG Report.** This is the 2015 report to the Minister of Health from the Primary Care Working Group on General Practice Sustainability chaired by Dr Peter Moodie. A copy is available on the GenPro website here http://genpro.org.nz/docs/pcwg-report-2015.pdf

3. **POAC.** This is the Primary Options for Acute Care scheme (may be titled differently in different regions) through which Primary Care practitioners are contracted/funded to undertake services which may have typically been provided through secondary care settings (e.g. vasectomy, removal of skin lesion) with the intention of better managing demand upon secondary care and securing earlier interventions for patients and thus better outcomes

4. **PSAAP.** This is the Primary Health Organisation Service Agreement Amendment Protocol. A national forum encompassing representatives from the Ministry of Health, DHBs, Primary Health Organisations (PHOs) and, Contracted Providers (General Practice) and through which the PHO Services Agreement is "negotiated". The forum also determines the Back-to-Back Agreement which then exists between each Contracted Provider and their respective PHO. PSAAP is administered by the DHBs TAS agency who host the PSAAP website and relevant documentation here https://tas.health.nz/dhb-programmes-and-contracts/primary-care-integration-programme/primary-health-organisation-service-agreement-amendment-protocol/

5. **Targeting Resources: Strengthening New Zealand's primary care capitation funding formula**. A 2015 discussion document published by the Primary Health Alliance and available here http://primaryhealth.org.nz/targetingresources.pdf

Appendix B: Extract of 2015 Primary Care Working Group Report on Sustainability of General Practice

Executive Summary

The Primary Care Working Group recommends to the Minister of Health that:

Capitation Subsidy and Targeting of High Needs

1. The service utilisation rates in the current base capitation formula are reworked to reflect current service usage. Utilisation should be calculated in 5 year bands to reflect the impact of the ageing population.
2. Community Services Card (CSC) be re-instated as a funding variable and eligibility thresholds be reviewed, access be simplified, issuance of the card be automated and CSC data be available within the National Enrolment Service.
3. CSC, ethnicity and deprivation be used as factors to reallocate the existing Very Low Cost Access (VLCA) top up payment to individual high need patients wherever they are enrolled.
4. In the medium term, CSC status, ethnicity and deprivation should be considered as factors in the base capitation formula.
5. Ministry of Social Development (MSD) funding (eg. Disability Allowance) currently subsidising patient fees be made more transparent to ensure that it is being allocated in an equitable manner and pilot schemes where MSD payments are made directly to practices be expanded.
6. Care Plus funding be reviewed and increased with a view to apportioning this funding directly to qualifying practices to address the needs of high risk patients not otherwise recognised in the capitation formula.

Co-payment Targeting

7. A combination of CSC and deprivation be used as factors to determine patient eligibility for low co-payment wherever they are enrolled.
8. Fee regulation be applied only to those patients eligible for low co-payments.
9. All practices, including those that are currently VLCA practices, have the flexibility to charge non-high needs patients a fee commensurate with service.
10. The current fee restriction based on historical fees be reviewed as there are significant inequities in different regions.
11. Ethnicity is excluded as a factor in co-payment differentiation.

Workforce Sustainability

12. Support the development of special interest roles, to broaden scope of practice in primary care and to improve access to services which are currently largely provided in specialist settings.
13. Investigate improved support for undergraduate and postgraduate training in general practice.
14. Investigate mechanisms for recognising and rewarding practice accreditation and Vocational Registration including the development of career pathways for medical, nursing and other professionals within the inter-disciplinary general practice team.
15. Investigate mechanisms for increasing funding for practices where standards such as Cornerstone and Vocational Registration are reached.
16. Endorse the basic principles related to the work on Health Care Home that encourage new workforce models, new models of care and an emphasis on the comprehensiveness and coordination of care provided by the wider team.

Shifting Services

17. Make it a priority to enhance coordination with general practice and include the following services under primary (or joint) governance:
    a. Community-based radiology and other diagnostic services
    b. District and community nursing
    c. Dietetics and nutrition advice
    d. Social workers and other allied health practitioners (eg. physiotherapy).
18. Support the development of Health Care Home initiatives that encourage new workforce models, new models of care and an emphasis on the comprehensiveness and coordination of care provided by the wider team.
19. In particular support the consistent use of information technology across New Zealand, as a tool for shifting services closer to home and facilitating the key role of a health care home model.

GENPRO

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