

Sustainability of General Practice

Consultation Forum Background Material

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1 Background

The sector is holding a series of ten consultation forums in September on the sustainability of general practice. Practice owners and clinicians are invited to attend one of the forums that will discuss:

- ensuring affordable, equitable access to sustainable general practice (including VLCA funding)
- general practice workforce sustainability
- shifting services closer to home.

A [Primary Care Working Group](#) comprising Dr Peter Moodie, Dr Nick Chamberlain, Sharon Hansen, Dr Megan Bailey and Janice Kuka has been established to provide advice to the Minister of Health by the end of October on options for change, and how to enhance the breadth of services provided in primary care settings.

Flyers with information on venues and RSVP details are attached in the following links:

- [Wellington](#), Monday 7 September
- [Dunedin](#), Tuesday 8 September
- [Christchurch](#), Wednesday 9 September
- [Palmerston North](#), Thursday 10 September
- [Rotorua](#), Monday 14 September
- [Auckland](#), Tuesday 15 September
- [Counties Manukau](#), Wednesday 16 September
- [Whangarei](#), Thursday 17 September
- [Nelson](#), Monday 21 September
- [Hamilton](#), Tuesday 22 September

A Survey Monkey questionnaire will be available for those who are unable to attend one of the forums. Details for this will be provided separately.

2 Ensuring Affordable, Equitable Access to Sustainable General Practice

There is a perception that current general practice funding formula and copayment rules fail to ensure the sustainability and equity of access to general practice. In particular, a number of issues with VLCA funding have been identified by general practice across the country:

- A large number of high need patients are enrolled in non VLCA practices, while many lower need patients are enrolled in VLCA practices, making it a very imprecise targeting mechanism;
- A practice may be at a competitive disadvantage with neighbouring practices, in some circumstances;
- As with standard capitation funding, there are pressures to erode the value of the capitation payment in real terms;
- Where a practice population changes to fall below the 50% high need threshold, VLCA is continued, so as not to disadvantage those already enrolled;

- Where practices eligible for VLCA choose not to take it up, this further diminishes the effectiveness of the mechanism for targeting state resources to those in need of them;
- The financial viability of VLCA funding at practice level is in question, particularly for practices with very high need populations.

If VLCA funding were to change, then that in turn raises wider issues about capitation for general practice funding across the board. A number of other issues with primary care funding have been raised across the health sector, and are part of the overall picture sustainable general practice service.

For example, capitation rates for general practice have not increased in line with cost inflation for the past decade. Figure 1 below shows that in the 2015/16 year, there is a gap of some \$47 million between the value that capitation should be to keep pace with cost inflation since 2006 (as measured by the Annual Statement of Reasonable Fee Increases report), and what it actually is. This means that the proportion of general practice funded by government is decreasing, and the proportion funded via copayments is increasing.

NZ Health survey results in 2014 show that 14% of the NZ population (over 500,000 individuals) chose to forgo attending a GP because of cost. Even more worryingly, 21% of Maori and Pacific People reported an unmet need for GP services because of cost. This situation exists in the context of a large number (nearly half) of high need patients who are enrolled with practices which are not VLCA, as shown in Table 1.

Table 1: Proportion of High-Need Patients in VLCA and Non-VLCA Practices

Practice	High-Needs Patients	Proportion (%)
VLCA practices	720,728	56
Non-VLCA practices	563,145	44
Total	1,283,893	100

Source: Ministry of Health in Cameron (2013) “High-level group tackles Very Low Cost Access”

A new funding approach should be supported by agreed design principles. One proposed set of principles is:

1. **Affordable:** Primary care should be affordable for everyone
2. **Sustainable:** General Practice should be financially sustainable
3. **Simple:** The system should be administratively simple
4. **Best value:** Funding is limited, and so should be prioritised to where it will provide the greatest benefit
5. **Needs based:** Funding should be based on the needs of the individual, not on the characteristics of the provider
6. **Universal enrolment:** funding should include everyone to promote universal enrolment in primary care.

Source: Martin Hefford, Oliver Hefford: Discussion paper 2015

Design issues and principles to consider are shown in Table 2 below.

Table 2: Design Principles

Design Issue	Considerations
How many tiers?	<p>Currently there are effectively four tiers of funding:</p> <ol style="list-style-type: none"> 1. casual patients - with 0% subsidy against the base cost of a GP consultation 2. enrolled patients not in VLCA practices – about 45% subsidy 3. enrolled patients in VLCA practices – about 70-80% subsidy 4. enrolled patient aged under 13 - with 100% subsidy <p>An individual funding schemes could replicate the four tiers by targeting current VLCA funding to a designated lower income group. Alternatively more tiers could be introduced, with graduated funding based on 2, 3, or more income tiers.</p> <p>More tiers is inherently fairer, in that funding can be tied more closely to ability to pay. However, having more tiers adds complexity, and, if there is not sufficient subsidy at the higher income levels, may erode the commitment to universal enrolment and publicly funded primary care services.</p>
How to assess ability to pay?	<p>Prior to capitation, general medical services benefit was targeted to those with a community services card. CSC status is recorded at enrolment and is administratively easy to use. Around 773,000 of the enrolled population had a CSC at June 2015. Unfortunately some eligible individuals do not apply for community services cards.</p> <p>One alternative is mesh block deprivation quintile. This is used to calculate SIA and HP funding and is readily available at the practice level and administratively simple to use. However, it is based on the average characteristics of the households in an area, hence some individuals who have high income may live in a deprived area, and vice versa.</p> <p>Future options may include direct matching with MSD/IRD records to identify individual and families with relatively high needs. This linkage is not yet established, and may provoke privacy concerns.</p> <p>In the interim a promising option is the use of combined CSC and deprivation to identify low income individuals. This has the advantage of being inclusive and is described in further detail below.</p>
Co-payment policies?	<p>Primary care funding policy needs to find the balance between the requirement to ensure subsidies are passed on to patients, and the risk of imposing undue restrictions on professional’s ability to set fees at a sustainable level. Currently there are no restrictions on fees to the unenrolled, and fees for the under 13’s and VLCA are prescribed by Government (with practices having an ability to opt in). The fees policy for general capitation provides for a general ‘reasonable’ increase annually, and the ability for practices to seek a review if their individual cost structure can justify it.</p>
How to deal with high users?	<p>High user cards are being phased out in favour of Care Plus Funding, which provides more proactive and flexible benefits.</p> <p>Some practitioners do not realise that the additional capitation that comes with HUHC is a zero sum game – with the amount paid out in HUHC deducted from PHO Care Plus funding. HUHC could be phased out by grand-parenting those on them currently, but not renewing them or issuing new cards.</p>

Design Issue	Considerations
	A design consideration is whether a global funding arrangement such as Care Plus, is better than an individual additional subsidy or not. If the individual entitlement was preferred then the HUHC subsidies would need to be passed on to the patient, and potentially to the practice also to reflect the higher utilisation and therefore cost to both the practice and the patient.
How many age bands?	Based on the available utilisation information, the current capitation rates over fund the 0-4 year olds and under fund the 75+ age groups. The capitation rates do not distinguish the 66 year old from the 86 year old, but their utilisation patterns are quite different – resulting in under funding of practices with more elderly (and resulting higher fee levels).
New models of care	Capitation and co-payment policies are based on the concept of a face to face visit with a GP. New models of care emphasis a wider practice team, and non-face to face patient contacts (e.g. using online patient portals. Formulae need to take these models into account.
Equity & ethnicity	Ethnicity has been used as a proxy for need in the VLCA formula, but about half the Maori and Pacific enrolees do not live in Deprivation 5 areas, and do not have a CSC. Ethnicity is used to calculate Care Plus, SIA and Health Promotion funding amounts. Ethnicity may be better for population level funding such as SIA or health promotion, rather than individual funding entitlements because of the extent of individual variability in ability to pay within ethnic groups – which will raise questions of equity.
Managing the Transition	Any new scheme will create winners and losers at both the practice and individual level. Change is likely to need to be implemented gradually over a 3 year period.

Source: Martin Hefford, Oliver Hefford: Discussion paper 2015

The funding challenges which general practice will have to grapple with in the future include:

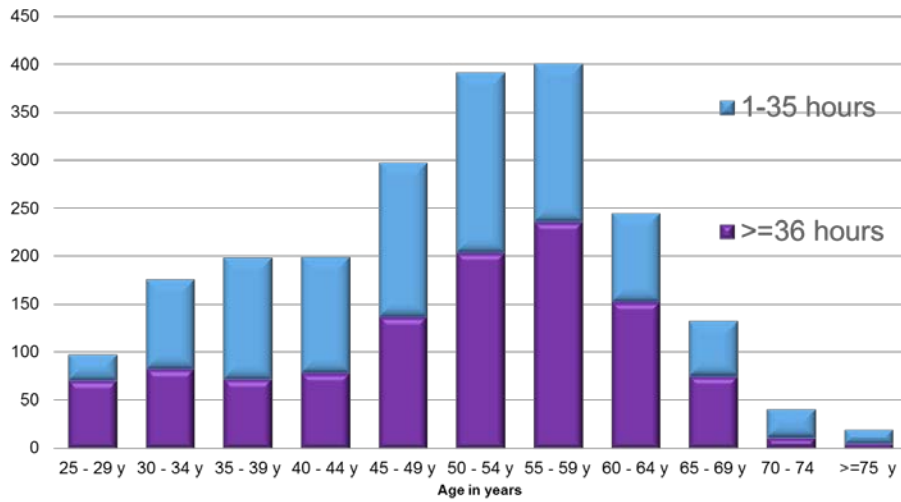
- What better ways are there for providing a fair funding distribution to high need patients?
- How should copayment be regulated in the future?
- How can we cater for practices with very high levels of high need patients?

3 Workforce

An increasing proportion of the general practice medical workforce is employed, with the consequences that expectations for conditions of employment are changing from the traditional self-employed model, while at the same time gaps are increasing between the conditions for people working in general practice and hospital based medical positions. Workforce is an important part of the overall sustainability of general practice, and attracting practitioners continues to be key to the future of the profession.

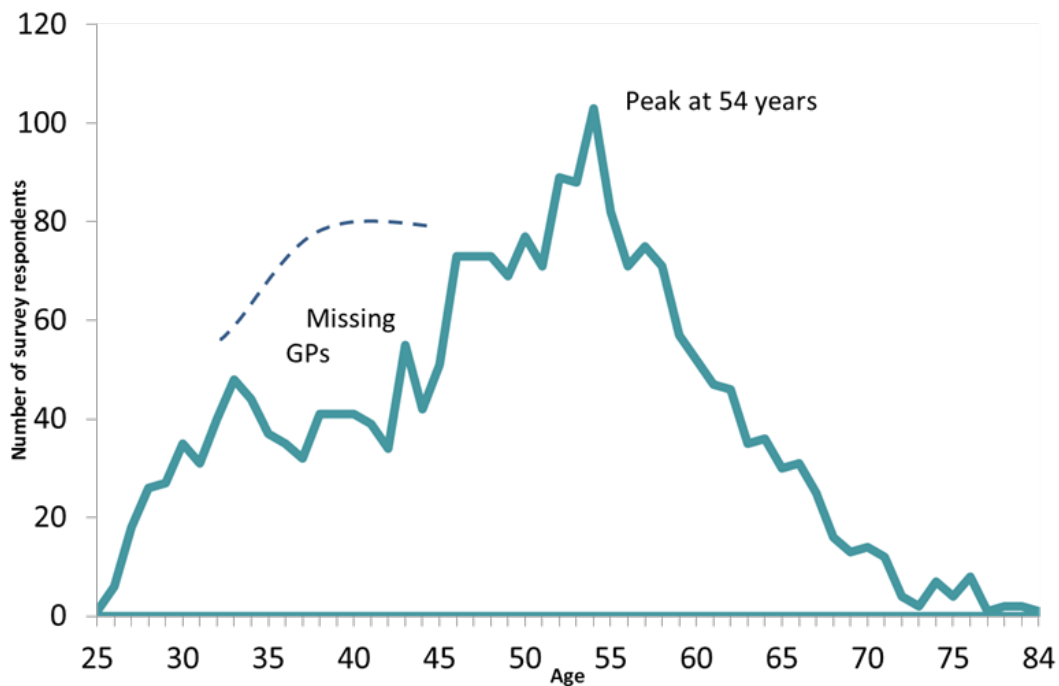
These effects are clearly demonstrated in the workforce research conducted by RNZCGP, which shows a large proportion of GPs working part time, a missing cohort of younger GPs aged under about 45, and a large proportion of contracted or employed GPs, particularly those working part time.

Diagram 1: *Number of Respondents Working Part-Time and Full-Time in General Practice by Age (RNZCGP 2015)*



Source: RNZCGP Workforce survey 2015

Diagram 2: *Age Distribution of Practising Doctors Working in General Practice or Rural Hospital Medicine (RNZCGP survey 2014)*



Source: RNZCGP Workforce survey 2015

Table 3: Hours Worked By Employment Type

Hours worked per week	Practice Owner		Practice Partner		Long-term Employee/ Contractor		Short-term Employee/ Contractor e.g. Locum		Other	
	#	%	#	%	#	%	#	%	#	%
Over 55	75	16	35	10	33	3	2	1	6	4
36-55	289	61	225	61	367	36	64	32	85	60
21-35	98	21	99	27	382	38	65	32	36	25
20 or less	14	3	8	2	230	23	71	35	15	11
Total	476	100	367	100	1,012	100	202	100	142	100

Source: RNZCGP Workforce Survey 2014 Report

The workforce challenges which general practice will have to grapple with include:

- How should general practice optimize and support its workforce performance?
- How do you incentivize a more diverse, multidisciplinary workforce?
- How do we make sure the workforce is distributed to areas of need?

4 Shifting Services

Shifting services is an organising principle for the design and delivery of health services. It is an umbrella term used to describe a range of processes aimed at delivering the right care, in the right place, at the right time, by the right person or people. It involves working together to ensure the right mix of activities for patients are delivered in the right mix of places, so that patients can access personalised, high-quality care, conveniently and safely, as close to home as possible. Patients must remain at the centre of any service reconfiguration.

District Alliances are the appropriate forum for this service development as they are based on a partnership approach which aims to provide what is best for the system, not individual providers. Using the Alliance ensures all service reconfiguration is co-designed. The principles that underpin shifting services are:

- Collaborative working between clinicians and managers, hospital and community based services and different health professionals.
- A systematic approach must be taken to service reconfiguration.
- Agreeing that only those services that need to be delivered from a hospital setting will be unless the costs (to all parties) are prohibitive.
- Quality and safety of care.
- Having the right infrastructure and pathways in place – including appropriate capacity/capability in primary care.

The approach to shifting services can be broken into four broad categories as shown in Table 4.

Table 4: Four Approaches to Shifting Services

Approach to shifting services	What this Means	Examples
Substituting skills	Shifting services so that care is provided by the right person	Discharge follow-up by primary care, supported self-management, clinical nurse specialists, primary care provision of services, nurses as lead clinicians for certain patients, greater use of allied health, navigators
Integration	Bringing organisations and professionals together with the aim of improving outcomes for patients through delivery of integrated care	Disease management programmes, care pathways, case management, care co-ordination, integrated IT solutions, bridging across specialist community services
Simplifying access	Providing better access to services closer to home, by bringing care to the patient and/or simplifying referral pathways from community based care	Specialist out-reach clinics, community based diagnostics, hospital-at-home, GP direct access to hospital-based tests
Professional support	Providing support for primary care to manage a wider range of patients and to reduce avoidable referrals	Specialist nurses or physicians providing support, advice, peer review for primary care practitioners, medication reviews, structured referral sheets

Part of the challenge for providing services closer to patients will be to identify:

- What works well, and what models can be adapted more widely;
- Where better access will make the most difference for patients and health professionals.

Appendix: Additional Material

1. Discussion paper on general practice funding principles and issues commissioned by GPNZ from Sapere Research Group in 2014: http://www.srgexpert.com/wp-content/uploads/2015/08/GPNZ_funding_paper-20_November.pdf
2. RNZCGP 2014 Workforce Survey: https://www.rnzcgp.org.nz/assets/documents/Publications/Workforce-Survey-RELEASED2_2.pdf
3. The Ministry of Health has supplied a diagram of the funding streams for General Practices. This is shown on the last page of this paper, but comes with the following notes that reference to the relevant numbers in the diagram:
 1. District Health Boards also receive funding from ACC for purchased services and a small amount (approx. 3%) from interest, donations and non-eligible patient contributions. This funding is not displayed on this diagram.
 2. Includes all other funder arm services (examples include aged care, mental health, inter district flows)
 3. Primary Health Care strategy funding is paid to PHOs by DHBs. But, DHBs are funded directly for this by one of the Ministry's NDE contracts with DHBs. As a result, this funding line is displayed in green unlike the blue DHB funding lines to denote that it is effectively Ministry funded.
 4. Fee for service funding for general practices when they provide services to non-enrolled patients.
 5. These funding lines constitute the Flexible Funding Pool for PHOs. PHOs do not have to pass it directly on to general practices. Instead, they have flexibility to use it for new models of service delivery to meet the needs of their enrolled population. As a result, the amount of this funding that does flow to general practices varies. The dashed line to general practice is to remind the reader that this is not a direct funding transfer (unlike the other funding lines displayed).
 6. From July 2015 the Ministry will also make doctors' visits and prescriptions free for children aged under thirteen, costing an additional \$30 million per year.
 7. This includes additional funding to sustain VLCA in particularly high need areas, and additional funding for selected rural practices.
 8. ACC purchases health services for covered individuals. The figure varies each year (\$1,325 million in 2012/13), as does the recipient of the funding (ie it's split across private providers, DHB provided services, pharmaceuticals and general practice). We are unable to quote the exact figure that goes to general practices.

Diagram 3: Simplified Funding for General Practices in the Public Health System

All figures 2013/14 (actuals) excluding capital

