Primary Care Working Group on General Practice Sustainability

Report to the Minister of Health

November 2015

Contents

Executive Summary 3

1 Background 5

1.1 Primary Care Working Group 5

1.2 Sustainability of funding 6

1.3 Workforce 8

1.4 Shifting Services 11

2 Approach 12

2.1 Workshops 12

2.2 Quantitative Modelling 13

3 Findings 14

3.1 Theme One: Ensuring Affordable, Equitable Access to Sustainable General Practice 14

3.2 Theme Two: General Practice Workforce Sustainability 16

3.3 Theme Three: Shifting Services Closer to Home 18

3.4 Overall Views 19

4 Funding Mechanisms 20

4.1 Policy Goals for Primary Care Funding 20

4.2 Current State 20

4.3 Factors Related to Need 21

4.4 Factors Determining Co-payment Levels 22

5 Funding Options 30

5.1 Basic parameters 30

5.2 Community Services Card Characteristics 30

5.3 Option One: CSC alone 31

5.4 Option Two: CSC and Deprivation 33

5.5 Option Three: CSC, Deprivation and Ethnicity 35

6 Recommendations 38

Appendix 1: Population impact graphs 41

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 reinstated 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.

1 Background

1.1 Primary Care Working Group

The Primary Care Working Group (PCWG) arose from meetings of the PHO Services Agreement Amendment Protocol (PSAAP) group. PSAAP participants agreed that there were a number of broad issues facing primary care and that addressing them would require engagement with the primary care sector, particularly with general practice business owners. The Minister of Health asked the Ministry of Health to establish a small working group to provide him with guidance about primary care funding, sustainability and workforce arrangements. The mandate of the group was to:

- conduct consultation forums to engage primary care clinicians to canvas innovative ideas on how to best support the changes needed and enhance the breadth of services provided in the primary and community settings
- advise on implementing any changes to the Very Low Cost Access (VLCA) scheme
- be the conduit for sense-checking initial findings with the sector before reporting back to the Minister by 30 October 2015.

The three general areas the group were asked to explore were:

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

The Working Group was established in August 2015and met for the first time on 1 September 2015. The membership of the group is:

- Dr Peter Moodie (Chair), GP and practice owner
- Sharon Hansen, Nurse Practitioner and Chair, Rural General Practice Network
- Dr Nick Chamberlain, CEO, Northland DHB and former GP and practice owner
- Janice Kuka, CEO, Nga Mataapuna Oranga, Tauranga
- Dr Megan Bailey, GP and practice owner.

The activity of the Working Group has been sector-based and supported by General Practice New Zealand (GPNZ) with updates being provided to the Ministry of Health. This is the final report of the Working Group. This report summarises the themes which have emerged throughout the process, and specific modelling of funding options.

1.2 Sustainability of funding

1.2.1 A Brief History of General Practice Funding

The Social Security Act 1938 introduced the first comprehensive funding for general practice services in New Zealand, which was implemented in 1941. The New Zealand branch of the British Medical Association, as the New Zealand Medical Association (NZMA) was then known, opposed the Government's initial proposals for universal subsidy on the grounds that a universal service was unnecessary since many people were able to pay for services themselves. This resulted in a partial fee for service subsidy for General Medical Service (GMS) consultations undertaken by general practitioners which persisted in different forms for the following 60 years. The subsidy was universal, and when originally set constituted about 75% of a typical general practitioner's income. Subsidies for practice nurse employment emerged in the 1970s, initially for rural GPs, but extended to all GPs in 1977.

By 1986 the level of GMS income had fallen to 20-30% of a typical GP's income and was targeted, at $1.35 for an adult, $3.30 for beneficiaries, the chronically ill and the elderly, and $11.20 for children, with higher rates for after-hours consultations. Those standard rates in 2015 dollars equate to $2.35, $6.98 and $23.67.

The first experiment with capitation came with the Otumoetai Health Centre in Tauranga which started a pilot, approved and evaluated by the Department of Health, in 1979. In the 1980s Ropata and Karori Medical Centres adopted the model, in the Hutt Valley and Wellington respectively, and a small number of other practices then followed. The capitation formula for this pilot was a crude division of the historical GMS claimed by the practice over the enrolled population, with no adjustment for any demographic characteristics. In effect it was based on historical GMS, adjusted up and down proportionately as patients joined or left the practice, with patient co-payments making up a little under half of all practice income. Adjustment for Community Services Card (CSC) status was introduced to these capitation arrangements in 1993. While a small number of practices around New Zealand experimented with and adopted capitation during the 1980s, Midlands Regional Health Authority actively promoted capitation in its region from 1993. This activity was in tandem with the establishment of Independent Practitioner Associations (IPAs) from 1993, which provided organised general practice for groups of practices within a locality.

Widespread capitation began to be implemented from July 2002 with the establishment of the first Primary Health Organisation (PHO), Ta Pasifika Health Trust in Counties Manukau. Subsidies for capitation rates increased over the following years, along with the introduction of co-payment regulation, since the Government's policy objective was to reduce financial barriers to access general practice care, particularly for Maori, Pacific peoples and those on a low income. Co-payments still constitute half, or more than half, of revenue for many general practices.

Co-payment regulation is done on the basis of changes in price indices for health sector costs which are calculated annually. The estimated cost increase informs the Ministry of Health in making annual adjustments to capitation subsidies and to permitted co-payment increases. Co-payments are regulated at a practice level. This means that targeting of the benefits of government subsidy is, effectively, done at practice level rather than individual patient level.

Very Low Cost Access Funding was introduced in 2006, as a mechanism to fund low co-payments for whole practice populations. A top-up was offered over base capitation, with a requirement that all adult patients be charged the same low co-payment (with zero fees for children aged under six years). Any practice was able to opt in to the VLCA funding scheme. From 2009 access to VLCA funding for new practices was restricted to those that had more than 50% of enrolled patients who were in Deprivation Quintile Five, or had Maori or Pacific ethnicity. This changed the nature of VLCA from a universal low co-payment mechanism to an approach which is more oriented towards populations with unmet need.

1.2.2 Ensuring Affordable, Equitable Access to Sustainable General Practice

There is a perception that the current general practice funding formula and co-payment rules are failing to ensure the sustainability of, and equity of access to, general practice.

There is also a particular concern that the funding for VLCA practices is creating distortion and equity issues. These concerns were highlighted by both VLCA and non VLCA practices. 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. 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
- Practices with a high proportion of low need patients that took up VLCA before there was a requirement to have at least 50% high needs patients may be at a competitive advantage with surrounding practices, particularly in high needs areas
- Where a VLCA practice population changes and falls below the 50% high need threshold, VLCA status and funding is continued to ensure those already enrolled are not disadvantaged
- Where practices eligible for VLCA choose not to take it up, the effectiveness of the mechanism for targeting State resources to those in need of them is further diminished
- The financial viability of VLCA funding at practice level is also in question, particularly for practices with large percentages of very high need populations.

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

For example, capitation rates for general practice have not increased in line with cost inflation for the past decade. This means that the proportion of general practice funded by Government is decreasing and the proportion funded by patients via co-payments is increasing. This is at odds with the PHO Services Agreement which states: "it is the government's intention to regularly adjust the amounts payable for First Level Services [general practice consultations] to maintain the value of those payments"[1].

New Zealand Health Survey results in 2014 show that 14% of the New Zealand population (over 500,000 individuals) chose on some occasions to forgo attending a GP because of the cost barrier. This becomes even more worrying with 21% of Maori and Pacific peoples reporting the same cost issues. 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, shown in Table 1 below.

[1] Clause F.21(2)(a) of version 3 of the PHO Services Agreement effective from 1 July 2015 accessed from www.psaap.org.nz

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

Practice	Proportion of all high need patients	Number of high need patients
VLCA practices	56%	720,728
Non-VLCA practices	44%	563,145
Total	**100%**	**1,283,893**

(**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 to use the parameters:

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 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)

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

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

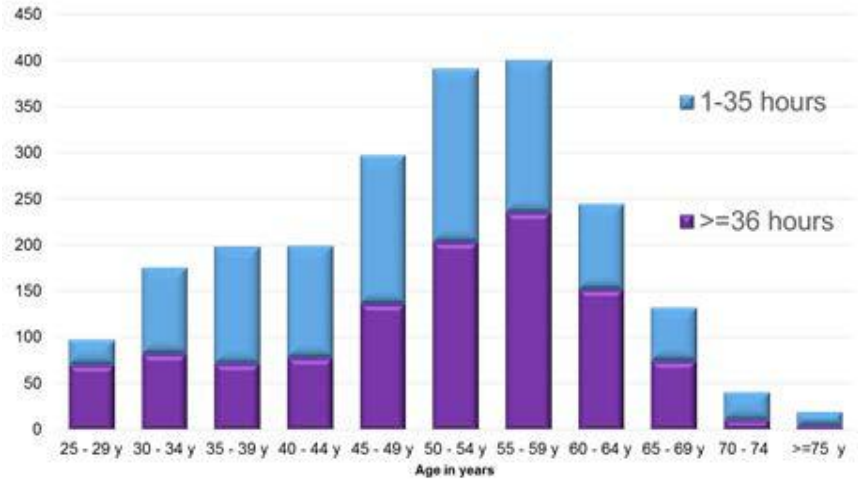
1.3 Workforce

An increasing proportion of the general practice medical workforce are choosing to become employees rather than being self-employed, with the consequences that expectations for conditions of employment are changing. At the same time gaps are increasing between the conditions for people working in general practice and those in 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 The Royal New Zealand College of General Practitioners (RNZCGP), which shows:

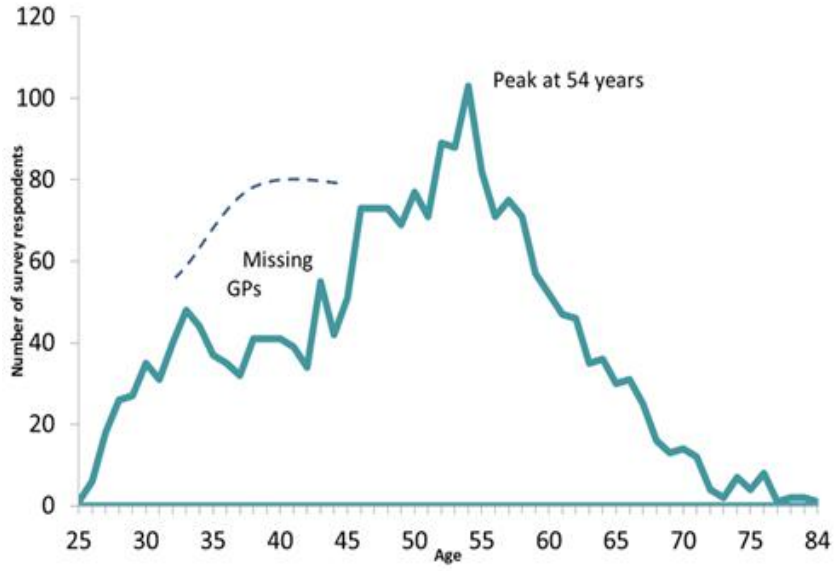
- a large proportion of GPs working part time
- a missing cohort of younger GPs aged under about 45 who chose not to enter general practice
- a large proportion of contracted or employed GPs, particularly those working part time.

Figure 1: Number of Respondents Working Part Time and Full Time in General Practice by Age



(**Source**: RNZCGP Workforce survey 2015)

Figure 2: Age Distribution of Practising Doctors Working in General Practice or Rural Hospital Medicine



(**Source**: RNZCGP Workforce survey 2015)

As might be expected, the full and part time nature of the general practice role varies according to ownership and partnership status of general practitioners.

Table 2: General Practitioner Hours per Week

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 role of the general practitioner as owner and operator of the practice as a small business is also changing. In 2015 a minority of GPs responding to the RNZCGP workforce survey were practice owners or partners, while the largest single category or role was long term employee or contractor. While there are differences in gender between the types of practice role, a substantial proportion of men are working in employee/contractor roles, as well as the majority of women.

Table 3: General Practitioner Ownership/Employment Role

Employment status	Female		Male		Total	
Practice owner	187	16%	338	32%	525	24%
Practice partner	142	12%	197	19%	339	15%
Long-term employee/contractor	616	53%	359	34%	975	44%
Short-term employee/contractor	177	15%	113	11%	290	13%
Other	40	3%	39	4%	79	4%
Total	**1162**	**100%**	**1046**	**100%**	**2208**	**100%**

(**Source**: RNZCGP2015 Workforce Survey)

While many GPs do not participate in practice ownership and partnership roles, the clear majority of GPs still work in practices which are owned by their GP colleagues.

Table 4: Numbers and Proportions of Respondents Working in Practices with Various Ownership Structures

Ownership structure of the practice in which you are working	#	%
Owned by one or more GPs who work in the practice	1609	73%
Fully or partially corporate owned	162	7%
Other	135	6%
Fully or partially owned by a PHO or a GP organisation	87	4%
Community owned	74	3%
Fully or partially owned by an iwi organisation	54	2%
Owned by a university (student health)	45	2%
Fully or partially owned by a DHB	39	2%
Total	**2,205**	**100%**

(**Source**: RNZCGP2015 Workforce Survey)

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

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

1.4 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. 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.

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.

This whole area is one that is being addressed by concepts that are developing around the country, for example the Health Care Home initiatives, and the relevant documents should be read in conjunction with this report.

2 Approach

2.1 Workshops

The PCWG undertook a consultation process which involved 10 forums around the country, one teleconference and an online survey accessible to those who could not attend.

In the interests of efficiency the PCWG developed a set of questions to stimulate discussion on each theme. These were used, in all the forums across New Zealand, to explore the key themes the PCWG had been charged with advising on, and elicit the views of front line primary care clinicians. At least two members of the PCWG attended each forum and often three or four. Each forum was interactive and lasted two to three hours. The 10 face-to-face forums were delivered in a two and half week time frame. The majority of participants were general practitioners who were joined by a small number of primary care nurses, practice managers and staff from PHOs and DHBs.

Ten of the eleven consultation forums were face to face, with one event held by teleconference with members of Te Akoranga a Maui, the Maori Faculty of the RNZCGP. In total there was direct engagement with 370 people. To supplement the direct engagement, the PCWG used a web survey tool to provide an opportunity for feedback to those who could not attend the consultation forums. There were 291 responses to the survey. Of these, 235 survey respondents had not attended a face to face consultation forum. This process has had the direct participation of over 600 general practice team members from across New Zealand.

Table 5: Consultation Forum Locations and Number of Attendees

Date	Location	Attendees
7 September	Wellington	47
8 September	Dunedin	28
9 September	Christchurch	22
10 September	Palmerston North	44
14 September	Rotorua	31
15 September	Auckland	51
16 September	Counties Manukau	24
17 September	Whangarei	40
21 September	Nelson	45
22 September	Hamilton	31
24 September	Te Akoranga a Maui	7
Total		370

2.2 Quantitative Modelling

Quantitative modelling was undertaken for the purpose of informing the discussions of the PCWG. This work was based upon national register and consultation data provided by the Ministry of Health. Register data was provided at practice level allowing for detailed investigation of the impact of potential funding changes across the full distribution of general practices. No patient level data was used in the modelling process.

The models developed for this stage of the project used the following assumptions:

- Patients under 15 years old were excluded from the analysis. Under 13 year olds largely receive free care. There is no suggestion of change to this recent policy. The age bands available were in groups of five years so, as an approximation for excluding those receiving free care, those under 15 were not included. A more detailed analysis following this early stage of option development will be required for more precise results at practice level.
- Patients with a High User Health Card (HUHC) were treated as if they did not have one, and allocated to the respective age and sex funding categories. This assumption was made because it simplified the number of different calculations required.HUHC is a cost neutral factor from an overall perspective, since HUHC funding is subtracted from Care Plus funding allocations.
- Where co-payment levels affect the analysis, a typical adult co-payment level of $40 per medical consultation has been used. This reflects co-payment data collected from PHO websites by General Practice New Zealand in 2014, and included in a report for GPNZ.
- The Ministry of Health supplied consultation data for both nurse and medical consultations. Only medical consultation data has been used for the analysis since it is understood that practice recording of nurse consultations varies widely, as does practice charging for nurse consultations.

In any future implementation of this report, the Ministry of Health is likely to need to conduct a more complete modelling exercise. Such an exercise would also require providing tools and advice to individual practices to enable them to make decisions about their various funding and co-payment settings.

The PCWG met face-to-face on two occasions in order to formulate approaches and discuss findings discussed in the next section.

3 Findings

3.1 Theme One: Ensuring Affordable, Equitable Access to Sustainable General Practice

This theme was the subject of the most comment in all meetings. A widely held view amongst participants reflected a lack of targeted support for people with high health need and low income in the existing funding formula was a major problem both for patients and for general practices.

The existing VLCA funding formula was felt by most participants to be problematic because:

1. The lower co-payment associated with VLCA is not well targeted to those patients with limited ability to pay for the care that they need. Many participants felt that this represented a poor use of government resources
2. VLCA practices that serve populations with very high levels of need (eg populations with uniformly high deprivation, or refugee communities) find the VLCA formula unsustainable. The inability to charge a higher co-payment to those patients who may be able to afford it means that these practices are deprived of an important source of revenue to help make them sustainable and manage business risks
3. Neighbouring practices with similar populations can find themselves with different levels of funding and co-payment, resulting in inequitable access for patients and inequitable funding for general practices. These differences are often more visible in rural and provincial areas, are not always transparent to patients, and are difficult to explain.

Some participants noted that the VLCA formula works appropriately in some specific cases and suggested that they would be reluctant to move away from it. In particular, it was felt that practices serving Maori populations could be well served by some form of VLCA funding combined with a top up for unmet need.

The general conclusion was that there was widespread support for a funding mechanism which is targeted at an enrolled patient level, rather than based upon allocation at a practice level. This was matched with an acknowledgement that a small number of practices with populations of very high unmet need (for example refugee populations) were different in kind from most other general practices and might need a different, and significantly higher, funding regime. There was a view from some that more individually based funding approaches might undermine community owned practices which provide a wider range of services than usual general practice. There was a very general acknowledgement that practices, particularly those with substantial Maori, Pacific and populations with high health need and/or low income, required more government funding than they receive today.

Participants noted the importance of financially sustainable general practice when there is an expectation that general practices will make the investments, in both workforce and facilities, which will be needed for new models of care. Financial sustainability and workforce sustainability were widely considered to be intimately linked. Financial sustainability has an impact upon the ability to pay clinicians and the ability of practices to compete in the recruitment of clinical staff. Practices struggling to maintain viability of service provision to populations with unmet need also struggle to offer terms and conditions which attract and retain clinical staff.

All forums discussed possible approaches for targeting funding to individual patients. The administrative burden of individual targeting mechanisms, for both practices and for patients, was a concern for many

participants. There was a widespread view that modern information systems should be able to make available relevant information on funding eligibility for both a patient and a practice. If such automated systems could be developed, this would mitigate issues of individual targeting not being taken up by eligible people as a consequence of administrative barriers.

The Community Services Card (CSC) was the subject of specific discussion. Issues noted with the card included:

- Administrative difficulties in application, resulting in poor uptake for some who are eligible and need support
- A low maximum income threshold for eligibility, resulting in a significant group of people with a need for funding who would not be eligible if the current CSC thresholds remained and were the only mechanism for targeting.

Against this, the simplicity of the card system in determining co-payment treatment appealed to many participants. This reflected a range of views among participants, some of whom felt that very devolved funding which gave practices discretion to decide who to provide support to would be appropriate (as is often the case with Care Plus funding at present). But, by contrast, an equally commonly held view was that general practices were run by clinicians, and that requiring clinicians to make decisions about who should be eligible for funding support was not fair and reasonable, and would result in too much variability and lack of transparency for patients.

The use of eligibility for Working for Families (WFF) tax credits was raised on a number of occasions as a potential mechanism for targeting funding. This was seen as being potentially administratively simple for general practice (since eligibility is already determined elsewhere) and a mechanism that would allow a higher threshold for targeted funding than is the case with CSC thresholds. One limitation of this approach is that WFF is applies only to families with dependent children aged under 18 years old so people on low incomes above the CSC threshold without dependent children would not qualify for targeted subsidies.

Most, but not all, participants felt that universal co-payment regulation was not reasonable or sustainable. Many noted anomalies where practices which had higher co-payments when regulation was introduced had seen larger absolute increases in co-payment, magnifying differences between practices and regions. The onerous nature and variable application of the fees review process was also widely noted. Some expressed the view that co-payment levels should be regulated for some patient groups with a particular need for low cost care, but not regulated for others.

The majority of participants felt that ethnicity was an important factor for targeting funding, but also that co-payment differentiation could never defensibly be determined on the basis of ethnicity. It was noted by some participants that Maori and Pacific peoples experience long-term conditions at an earlier age, and that the additional capitation funding which goes with patients aged over 64 should start earlier for Maori and Pacific people.

Participants noted a number of funding streams which were relevant to the overall picture of funding and equity for patients. These included Care Plus (and other flexible funding), which is used highly variably across PHOs but, in many cases is an important part of the package of subsidised care for people with long term conditions. Participants also noted the use of acute demand programmes, such as Primary Options for Acute Care (POAC), which have the impact of targeting additional funding to those with acute needs.

The impact of the difference in ACC funding for A&M clinics compared to general practice, which can cause issues between neighbouring services at a local level, was also noted.

A further part of the funding picture lies with the Ministry of Social Development, which provides a Disability Allowance to a number of patients. This is sometimes used to cover the cost of co-payments for people with long term conditions who cannot otherwise afford them. For some practices and patients the Disability Allowance appears to be an important component of the overall funding picture. However, it imposes a significant administrative burden upon both patient and practice, and the resulting funding may or may not actually be used to cover co-payment costs.

The view from participants was frequently that a number of patients can afford to pay more for general practice care, and that many such patients would accept increases in co-payment, if the change was supported by a Government-led national communications plan. A number of anecdotes were provided about patients who were surprised that they were sometimes charged so little for a general practice visit.

Many participants felt that any change to funding arrangements should be implemented as quickly as feasible rather than via a prolonged transition process. Little benefit was seen from drawing out implementation if the practice level impact was not fundamentally different at the end of the process.

Some participants considered small size to be a challenge for practice sustainability, while noting that in many rural areas small sizes and dispersed populations are inevitably part of the challenge of maintaining services. As an indication of concern about size, a number of participants indicated that they would not want to purchase or take on a solo general practice. It was felt in some quarters that it was harder to maintain financial viability in a small practice, and also harder to make the capital and workforce investment required to support new models of care.

3.2 Theme Two: General Practice Workforce Sustainability

Forum participants expressed a wide variety of views on the challenges of workforce sustainability in general practice. Many participants viewed general practice as moving towards a wider team model which, in some cases, ultimately reflected a Whanau Ora or Health Care Home approach in which health and social services work as a team around a family/whanau. The emerging role of Nurse Practitioners was frequently viewed as very important, although the lack of support for developing these roles, and a wider nursing career pathway was also widely noted.

Most participants saw the clinical ownership model of general practice businesses as an important part of the overall mixture of general practice workforce models, while recognising that an increasing number of General Practitioners appear to be interested in other models of clinical work in general practice. There was frequent concern about the impact on productivity if the majority of General Practitioners ceased to have productivity incentives related to activity in the practice.

Terms and conditions for both medical and nursing staff in general practice were often compared unfavourably to terms and conditions for DHB employed clinicians, in particular the non-financial rewards of protected non clinical time and heavily supported professional development. These non-financial conditions were often seen as potentially important for the avoidance of workforce burnout, which is widely perceived as a high risk for primary care clinicians.

A common theme in many of the forums was recruitment into general practice and the challenge of enthusing medical and nursing students for a primary care career at an early stage. It was often felt that hospital-based training could actively discourage younger clinicians from considering general practice, and that the view that general practice is a lower status career was commonly promulgated, particularly in the early postgraduate years of medical training. A number of factors were seen to compound this effect, including the drop in income commonly faced by general practice registrars coupled with the lack of training budget and funded examinations compared with other specialties and poor experience sometimes faced by junior doctors when training in general practice. In some cases participants commented that General Practitioners themselves could give an unduly negative view of their profession to graduates, and could talk down the attractiveness of primary care as a career.

There was a widespread view that postgraduate medical training in general practice requires more resource and support if general practice is to be an attractive career in the future. This would require not only more time spent in community settings for trainees, as is current policy, but concerted effort and resource to ensure that such time is productive and results in stimulating and attractive general practice experiences for trainees. Unsupported time spent training in general practice was seen by some as at risk of being counterproductive.

A number of participants felt that the lack of recognition of seniority and qualification in general practice was an issue, whether shown in financial or in status terms. It was felt that this could discourage some from pursuing postgraduate qualifications, and that it generally made the primary care sector less attractive to younger graduates than other parts of the health system. The lack of a career pathway for primary care nursing was seen as a related and important issue..

The importance of training Maori, in particular, was noted by some participants as part of ensuring that the future primary care workforce reflects those communities which primary care serves more closely than is the case today. This direction was seen as one element of a move towards Whanau Ora models, involving a wider workforce spanning clinical and community roles. In this context navigation and coordination for whanau are a key area for workforce development.

Some participants set out the strengths of general practice as a career and the elements of the profession which they saw as most rewarding, which they felt were:

- Autonomy, including determining your own hours and conditions
- Lifestyle advantages, and the flexibility to work and live in a variety of ways and settings
- The challenge of managing complex patients, including the intellectual challenge of mastering a greater breadth of knowledge than in some specialties
- A relationship of continuity with the patient and family from birth to death
- The ability to subspecialise to some degree, for example with minor surgery or emergency work
- Teamwork within the practice.

Many participants noted that GPs with Special Interest (GPSI) roles, Nurse Practitioner and Nurse Specialists had the potential to be stimulating and attractive for clinicians as well as facilitating new models of care. It was seen as important to embed such special interest roles firmly within a generalist primary care culture of professional practice.

Participants noted that at a practice level there were no financial incentive improvement standards, with particular reference to Cornerstone accreditation and Vocational Registration of General Practitioners. It was particularly noted that achieving Cornerstone accreditation was expensive and resource intensive, however there was no real recognition of this. Similarly, it was felt that for general practices to be sustainable, there needed to be access to capital for improvements, or at least financial recognition that improvements had been made and were valued.

3.3 Theme Three: Shifting Services Closer to Home

The current state of service configuration, and the degree to which hospital and community services are strongly integrated with general practice, is highly variable. The forum discussions made it clear that some parts of New Zealand are well down the track of orienting services towards primary care, using agreed pathways, and funded services such as Acute Demand or Primary Options for Acute Care (POAC). Access to community-based radiology and diagnostics, with appropriate clinical governance mechanisms for managing the resources involved, is good in some areas but remains poor in other parts of New Zealand. There was a general view that primary care-level work undertaken by hospitals should be moved into (and provided within) the community. In some quarters there was considerable frustration that existing, effective models for facilitating access to these services were not more widely implemented.

The development of Health Care Home models was seen by some as an important mechanism for providing a wider range of services, in an interdisciplinary team environment, in a primary care setting. The potential for linking more widely with community based coordinators or navigators, based in general practice, was seen as a mechanism which had the potential to coordinate a range of more complex services around patients in a community setting, and as an approach which was consistent with and complementary to Whanau Ora services. Many participants strongly felt that shifting services could only be accomplished with a more diverse interdisciplinary team in primary care.

Among the services which participants saw as a high priority for coordinating better with general practice, and improving access from primary care services, were:

- Community-based radiology and other diagnostic services
- District and community nursing
- Dietetics and nutrition advice
- Social workers and other allied health practitioners.

A number of participants noted the importance of information technology in shifting services, and in improving the continuity and coordination of care with general practice. Again, this is something which is more advanced in some parts of New Zealand than in others.

As noted in the workforce discussion, GPSI roles were seen as having some place in providing services closer to home, as well as having workforce sustainability benefits, so long as such roles are properly resourced and supported and represent an extension to core primary care activity rather than becoming a distinct role which is apart from core general practice.

Discussion on the issue of resourcing and supporting services closer to home produced a number of consistent views. It was clearly felt in many areas that moving services into a primary care setting without sufficient resource resulted in greater pressure on primary care rather than greater empowerment. It was

also acknowledged that in many cases hospital services can be left with stranded costs if services are moved out in an unplanned way.

Resourcing service change requires DHBs to fund services appropriately when they change setting, rather than seeing the shifting of services as a short term cost cutting exercise, but it also requires investment from general practice in workforce and facilities in order to provide services in a new way. The issue of changing service configuration is therefore intimately linked with achieving progress in the sustainability of general practice in both financial and workforce terms. The ability of primary care to make appropriate capital investment is an important strategic prerequisite for moving to new models.

3.4 Overall Views

Overall, participants in the 11 forums expressed a strong sense of satisfaction at being engaged in conversation on some of the pressing issues facing general practice and wider primary care. There was a view that there has not been enough connection of this kind with general practice on a national scale. Some forums had very high percentages of local GPs attend, and some people travelled long distances to attend. There is, however, an atmosphere of disenfranchisement in general practice and a strong perception that there is a need to listen more to the concerns and views of frontline primary care clinicians and business owners. Many of the participants were concerned at the risks facing the future of primary care services and the health professionals who work in the sector, and seek reassurance that these issues have been heard.

The perception that the existing funding arrangements for primary care are not fit for purpose is very widespread. Participants saw some urgency in addressing this issue, on the grounds of both equity of access for patients and sustainability of general practice business models. While understanding some of the complexity of changing the model, and the trade-offs which inevitably arise when funding models alter, there is a general appetite for change. There was a very wide, but not quite universal, view that funding for primary care services should follow patients rather than be tied to general practices, and that funding and co-payment rules in general should be based more strongly upon the individual, particularly in an environment in which government funding subsidises approximately half the cost of general practice care with the remainder coming from patients.

The sustainability of the general practice workforce is also a source of general concern to many frontline clinicians. In particular, the recruitment of younger clinicians into an attractive primary care career pathway is seen as problematic. Participants could see a number of factors which could be changed to improve the attractiveness of primary care careers, particularly for medical graduates (reflecting the professional background of the majority of participants), but also for primary care nursing. Addressing these issues is seen as key both to ensuring the longer term viability of existing services and to developing the capacity to provide more, and more comprehensive, services in a primary care setting close to patients' homes.

The current state of integrated services provided close to the patient is a highly geographically localised issue, but participants consistently expressed priorities for better access to particular services where they are not already managed in such a way. The ability to shift services is widely seen as dependent upon both the realistic investment of resources in such services shifts and the workforce development required to provide an increasingly complex and interdisciplinary range of services in a general practice setting. Moving to a more comprehensive, coordinated, set of services provided in the community is a key element in progressing to a Whanau Ora approach to services for local communities.

4 Funding Mechanisms

4.1 Policy Goals for Primary Care Funding

Apart from broader issues of effective government investment (eg, spending on primary care may reduce costs elsewhere), the specific policy goals of a primary care funding formula are:

1. To make the service more affordable to those with need who cannot afford it
2. To compensate primary care service providers for the workload and resources involved in providing the service
3. To incentivise providers to undertake certain activities and procedures.

The relative importance of these goals depends upon the funding context of the system. If the majority of general practice resource is funded by the state, then patient affordability is less of an issue: nobody is paying very much for their care so the main problem to address with a funding formula is a fair recognition of the service workload needed to meet demand (the 'input' side). Where there is a fully funded service, such as general practice in the UK, affordability is not an issue at all, so the key elements of capitation are about fairly reflecting need and workload/resource. Where this is the main issue, then the kinds of factors which are important in a funding formula are age, sex, ethnicity, and deprivation, because they reflect, largely, the level of need for services in a registered population.

By contrast, if the state covers a relatively small total proportion of the overall cost of general practice, then the majority of general practice revenue will effectively take the form of fee for service co-payments. In this case, workload/resource is less of an issue for a funding formula, because the fee for service nature of most of the revenue will inherently reflect the level of work provided by a given general practice. However the issue of affordability is much greater – the policy issue is, "who should the state subsidise in order to ensure that they can afford care?" This is the case that prevailed in New Zealand in the 1990s, when the Community Services Card was introduced. Where affordability is the main issue, then the kind of factors which are important in a funding formula reflect burden of ill health at the individual level, and income (ie. ability to pay). Such modifying factors could be Community Services Card status, Working For Families status, and direct household income. Co-payment regulation becomes very important in this scenario.

In 2015 Government funds approximately half of general practice activity in New Zealand, leaving a difficult trade off between the two kinds of factors which might be wanted in a funding formula.

4.2 Current State

The main characteristics of primary care funding in 2015 are:

- Most practices (about 70%) are funded using a first contact funding formula which has varying capitation rates for age and sex of patients. This typically accounts for something like 50% of a general practice's revenue, though this can vary markedly. For historical reasons, some of these practices are funded using a formula called the "Access" formula. This has slight differences from the main First Contact formula, largely for children. It makes a difference of around 3% to a practice's income
- About 30% of practices are VLCA. On top of the base First Contact Formula, these practices receive a top up using a VLCA formula, which is also based upon age and sex of enrolled patients

- First Contact formula practices receive total funding of about $430M per annum
- VLCA practices receive about $190M per annum from the basic First Contact formula and a top up of about $53M from the VLCA formula
- Between them, First Contact funding and the VLCA top up expenditure total about $670M per annum.

In addition to first contact funding, other primary care funding streams such as Health Promotion, Services to Improve Access and Care Plus are weighted with ethnicity and deprivation factors. These funds, together with Management Funding, are currently administered as part of a flexible funding pool which is the responsibility of an alliance between the PHO and its District Health Board. There is considerable variation in the way this funding is used, and in the autonomy which is given to individual general practices to make decisions about the use of these funds for their patients.

Details of the various funding formulas are available from the Ministry of Health website: http://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/capitation-rates

4.3 Factors Related to Need

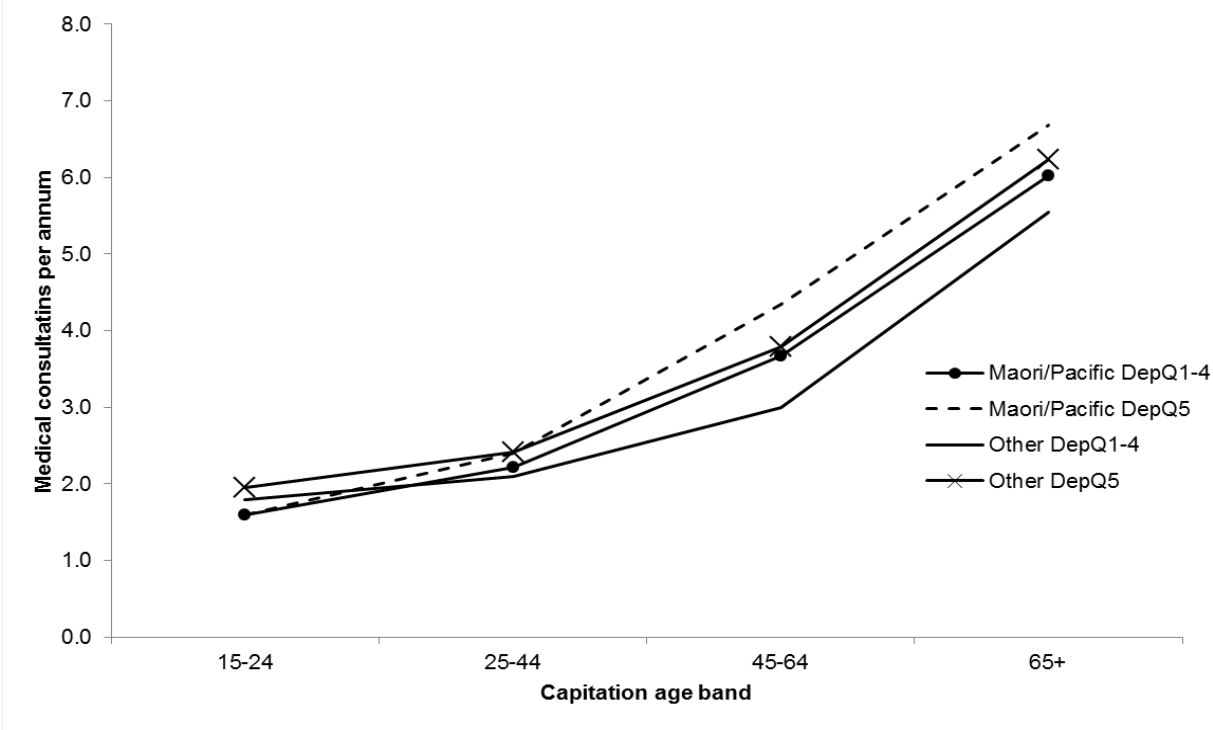
The first element of funding is that which subsidises a given level of workload for a general practice.

The existing formula uses age and sex categories to adjust for expected and differing levels of patient need for care. The rates used to set the existing formula were calculated at the first national implementation of capitation in 2003. Capitation levels have since been adjusted annually on a cost basis, although any variation in utilisation rates has not been changed. In 2006, the underlying pattern of utilisation upon which capitation was modelled was reviewed by a joint Ministry and DHB team, supported by an Expert Advisory Group. That review concluded that there was a strong argument for including ethnicity and deprivation variables in the capitation formula, to adjust for differing levels of need for primary care.

The fundamental observation of the 2006 review, that there are substantially higher rates of consultation for Maori and Pacific people and for people with high socioeconomic deprivation, remains the case in current consultation data.

It is worth noting that for the youngest age group in Figure 3 below – those aged 15 to 24 – Maori/Pacific and Deprivation Quintile Five populations have a slightly lower consultation rate than other ethnicities in less deprived quintiles. This is likely to reflect unmet need in these populations.

Figure 3: Medical Consultations by Ethnicity and Deprivation



It should be noted that age remains the dominant single factor associated with consultation rates, with variation by age much greater than variation by ethnicity and deprivation characteristics.

4.4 Factors Determining Co-payment Levels

If different people pay different levels of co-payment, then there is a need for a robust and objective way of determining who is eligible for the various levels of co-payment. Age is the existing mechanism for differentiating co-payment among patients within a single practice. General practice charges low or no co-payments to the very young, and usually varies co-payment in the broad age categories of the existing capitation formula, though variation across age bands is not usually large. VLCA practices are required to apply the same co-payment level to all of their patients (with children at a lower level or free).

In order to bring equity to this issue a number of options were considered by the PCWG. These included:

- The Community Services Card (CSC)
- Working For Families tax credit status
- Deprivation quintile.

Ethnicity, while considered as part of the funding formula, was at no stage considered as a factor suitable for co-payment differentiation.

4.4.1 Community Services Card

The CSC was introduced as part of health reforms in 1993. It is regulated by the Health and Disability Act 2000, but it is administered on behalf of the Ministry of Health by the Ministry of Social Development.

Before capitation was introduced into general practice nationally, the CSC attracted a $15 subsidy for a medical consultation, which was paid on a fee for service basis to each practice. This arrangement still occurs for casual consultations where a patient visits a practice they are not enrolled with, but the CSC currently has no other role in primary care funding. It has continuing use as an eligibility criterion for some services, including travel and accommodation supplements and childhood optometry. It is not formally used for services outside the health sector although other agencies, often including local councils, may use it is a convenient criterion for access to lower cost services. Such use is entirely informal, and at the discretion of those agencies.

Community Services Card eligibility largely depends upon both income and family size[2]. The current thresholds for access are shown in Table 6 below.

Table 6: CSC Eligibility Thresholds

Family size	Gross annual income cut-out point
Single sharing accommodation	$26,042
Single living alone	$27,637
Married, civil union or de facto couple	$41,327
2-person family - 1 adult, 1 child	$48,797
3-person family	$59,093
4-person family	$67,282
5-person family	$75,302
6-person family	$84,265
Family of 7 or more add $7,898.00 for each extra family member	

The Ministry of Social Development (MSD) assigns CSCs automatically to beneficiary recipients and to those in aged residential care. CSC application is not automatic for people who do not receive benefits, and involves an onerous application process declaring income and family size. More generally, while state agencies such as IRD have knowledge about the income of individuals, the state does not appear to hold information about household structure unless individuals volunteer that information, via a process such as applying for a CSC or Working For Families tax credits.

The number of people currently holding a CSC under various criteria is recorded by MSD. There are a total of 863,127 card holders. It is estimated that approximately 240,000 of these are households with children.

A breakdown of CSC holders by eligibility is shown in Table 7 below.

[2] Children who receive a Disability Allowance automatically receive a CSC regardless of parental income levels.

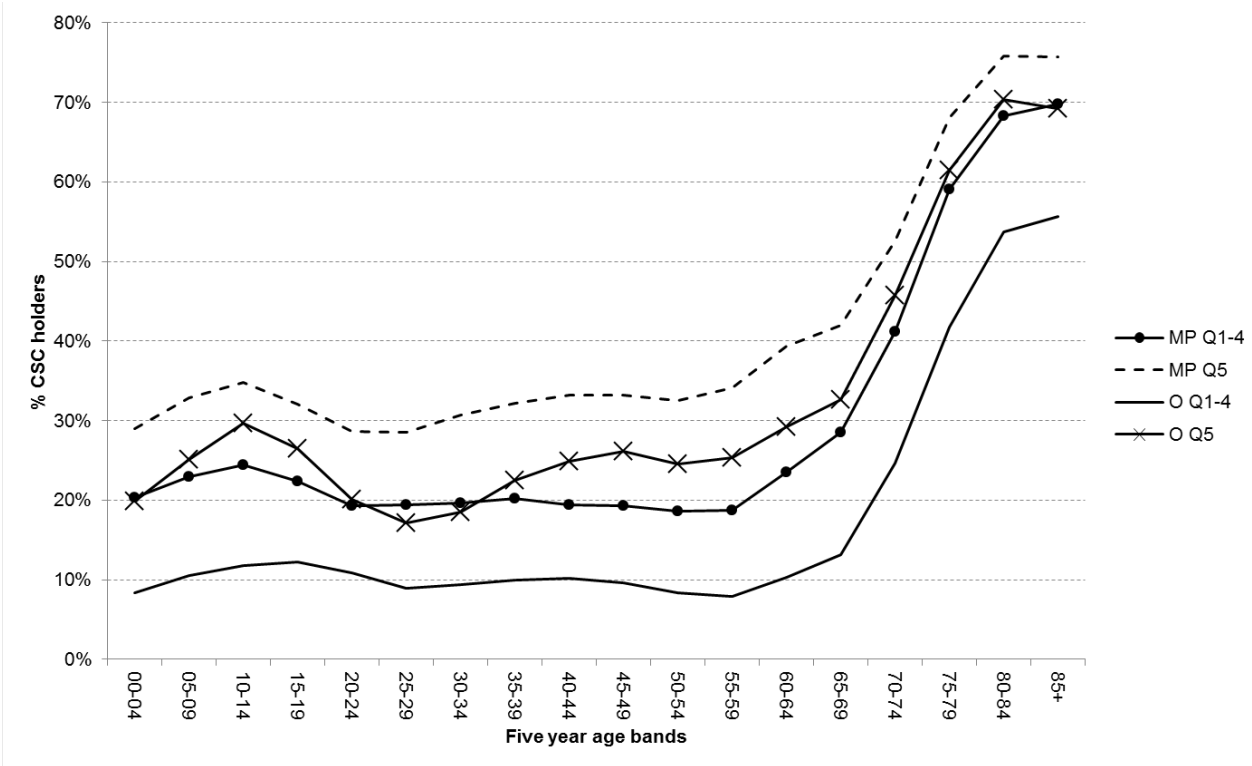
Table 7: CSC Holders September 2015

Eligibility Criteria	Total	Health Entitlement Cards Regulations 1993
Income Tested Benefit *	381,541	8(1)(a) and (b) *excluding (vii)*
NZ Superannuation	267,346	8(1)(d)
Working for Families Tax Credits**	88,895	8(1)(c)
Student Allowance	65,387	8(1)(f)
Residential Subsidy	23,561	8(1)(g)
Low income no dependents	16,879	8(1)(e)
Families with dependents**	10,936	8(1) (c)
Veteran's Pension	8,582	8(1)(a)(vii) and (ab)
Total	**863,127**	

General practices can still record CSC status in their registers. Currently, practice registers record 572,025 adults (aged 20 or more, which is likely to be the most comparable figure to the number of adult CSC holders recorded by MSD), suggesting that general practice recording of CSC is presently at a level of about 66%. Since CSC has little direct value for general practice, it is unsurprising that recording levels are low.

Of those patients on general practice registers where CSC is recorded, there is a strong differentiation between deprivation and ethnicity groups at younger ages, but the dominant effect is the high level of CSC in the population aged over 75 as shown in Figure 4 below.

Figure 4: CSC Holders by Age, Deprivation and Ethnicity



The CSC thresholds are currently at a very low income level, particularly for households without children. An individual working full time on the minimum wage ($590 for a 40 hour week) would, over 52 weeks have an income of $30,680, which is above the eligibility threshold for a CSC for an individual person.

Concerns about the CSC therefore focus upon two aspects: the mechanism of application, which is not automatic (and which may exclude some patients who are eligible), and the very tight level of income targeting at current CSC thresholds. The CSC has the merit of being already a component of general practice information systems, and of being a clear and unambiguous marker for an individual patient of co-payment status.

Since CSC is not used formally for purposes outside the health sector, it is technically open to the Ministry of Health to change thresholds as a mechanism for broadening the targeting for the CSC. This is a matter of health policy for the Ministry to consider.

4.4.2 Working For Families Tax Credits

Working for Families (WFF) tax credits are not a single mechanism, but constitute a suite of tax credits for people in different circumstances. The tax credits are:

- Family tax credit: provides ongoing support for beneficiary and working families with dependent children
- In-work tax credit: available to working families only, who meet the minimum number of hours worked per week
- Minimum family tax credit: paid to working families to ensure they earn a minimum annual income after tax
- Parental tax credit: paid for the first eight weeks after birth to assist with the costs of a new baby.

The quantum of the tax credits varies for individual families in a complex fashion, but the eligibility thresholds for receiving the credits is based upon income and family size, in a similar fashion to CSC thresholds. Working For Families tax credits do not apply to households where there are no dependent children aged under 18 years old.

Income thresholds for the main elements of WFF are shown in Table 8 below. It is thought that the majority of households with children and an income under $100,000 are likely to receive some level of WFF tax credit.

Table 8: Working For Families Eligibility Thresholds

Number of children	Annual Income (before tax)	
	Family tax credit	**In-Work tax credit**
1	$59,041	$73,724
2	$74,811	$89,493
3	$90,580	$105,262
4	$106,350	$124,702
5	$122,119	$144,142
6	$137,888	$163,582

Households at the lower end of the income range of WFF are also eligible for CSC, and data matching is presently used to facilitate the automatic assignment of CSC for these households.

Table 9 below shows the number of households with children at different levels of income, based upon the 2013 census.

Table 9: Household Income Distribution

Family income for households with children	Number of households	Cumulative
$20,000 or less	54,216	54,216
$20,001 - $30,000	44,979	99,195
$30,001 - $50,000	86,898	186,093
$50,001 - $70,000	88,170	274,263
$70,001 - $100,000	117,156	391,419
$100,001 or more	189,606	581,025

Given this income distribution and the numbers of CSC holders in households with children, it appears likely that CSC will cover the majority of households with children up to an income level of approximately $50,000 to $60,000 per annum, with WFF adding in the region of an additional 100,000 to 150,000 families with higher levels of income. It would be a matter of government policy whether this group would be a priority for lower general practice co-payment.

As a co-payment indicator, WFF credit status has merit, in that it can be clear and unambiguous for individuals, with a direct link to income and ability to pay. However, as a mechanism, it has a number of downsides, including:

- There is no current data sharing arrangement which would facilitate the automatic determination of co-payment in a general practice (although such a mechanism could be developed if this became a priority)
- It does not cover individuals with low income who do not have children in the household
- It requires active application on the part of recipients
- It adds a relatively small number of households to the existing CSC targeting mechanism.

These downsides could be mitigated if WFF were to be used in combination with other co-payment targeting mechanisms.

4.4.3 Deprivation Index

The New Zealand Index of socioeconomic deprivation was developed as part of a social indicators research programme at the University of Otago. A small area-based index of deprivation is calculated after each census, allocating a principal component for deprivation based upon a number of census variables. The most commonly used form of the index groups the principal component into deciles or quintiles for simplicity. Decile five of deprivation is currently used as a factor for some primary funding streams, such as Services to Improve Access funding.

The census variables currently used to derive the index are shown in Table 10 below. While income is an important factor, it captures a wider dimension of socioeconomic deprivation than income alone, reflecting a broader picture of living circumstances in a small geographic area (typically 50 to 100 households).

Table 10: NZDep Index 2013 Variables

Dimension of deprivation	Description of variable (in order of decreasing weight in the index)
Communication	People aged <65 with no access to the Internet at home
Income	People aged 18-64 receiving a means tested benefit
Income	People living in equivalised households with income below an income threshold
Employment	People aged 18-64 unemployed
Qualifications	People aged 18-64 without any qualifications
Owned home	People not living in own home
Support	People aged <65 living in a single parent family
Living space	People living in equivalised households below a bedroom occupancy threshold
Transport	People with no access to a car

Deprivation is an area based measure. Association with income is important in a co-payment mechanism, since ability to pay is the dominant indicator of need. Table 11 below shows the distribution of people with individual income over $50,000 by deprivation decile.

Table 11: Personal Income by Deprivation Decile

Decile	% earning $50k or more
1	41%
2	36%
3	33%
4	31%
5	28%
6	25%
7	22%
8	19%
9	15%
10	10%

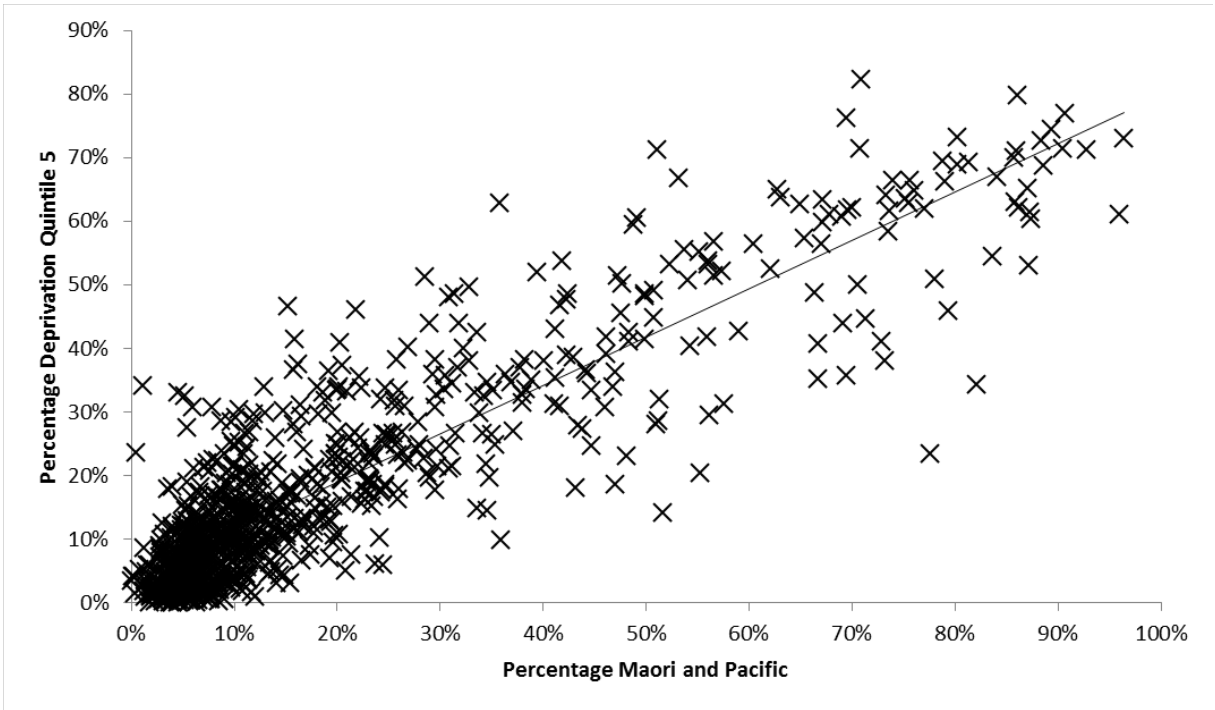
This suggests that targeting by deprivation is reasonably specific for low income. In quintile five (deciles 9 and 10 combined) only 12% of people earn above $50,000 per annum. Conversely, deprivation is not very sensitive for low income. Low income people live across all deprivation deciles, as shown in Table 12 below which indicates, of all people under less than $30,000 per annum (approximately the individual person income threshold for a CSC), what proportion of those people live in each decile of deprivation.

Table 12: Deprivation Distribution for People Earning Under $30,000

Decile	% of all people earning under $30k
1	8.3%
2	9.2%
3	9.4%
4	9.3%
5	9.7%
6	10.1%
7	10.6%
8	11.0%
9	11.4%
10	11.0%

Deprivation does, however, have a strong correlation with Maori and Pacific ethnicity at practice level and can therefore serve, to some extent, as a proxy for ethnicity in targeting mechanisms. Figure 5 below shows the scatterplot of proportion Maori/Pacific and proportion DepQ5 patients for each general practice in New Zealand. The overall correlation is very high, at 0.76.

Figure 5: Deprivation and Ethnicity Correlation at Practice Level



Deprivation is not widely used as a co-payment targeting mechanism, although anecdotally there are some instances where it has been used to differentiate co-payment levels for services, including co-payments for publicly funded but privately provided radiology. While it is a strong mechanism as an indicator of health need, and to some extent as an indicator of ability to pay, and is already a piece of information which is

well integrated into general practice information systems, as a co-payment targeting mechanism it has a number of disadvantages:

- It is an area based measure, so there is some level of variability for individuals within a deprivation quintile, and targeting will therefore be imprecise
- Since it is based upon address, the equity of targeting on deprivation index may not be transparent to individuals, and people may perceive anomalies when near neighbours are targeted differently
- It could attract adverse publicity if a high income individual is given access to increased subsidy.

4.4.4 Co-payment Targeting

While not under the direct control of health services, MSD has an important mechanism which reduces co-payments for a significant number of individuals. People who face costs arising from a disability are eligible for the means tested disability allowance. MSD advise that approximately $50M per annum is disbursed under the disability allowance for medical fees, the bulk of which is believed to be for general practice co-payments (this figure excludes pharmacy co-payments, which are treated separately). There is room for greater understanding about how this allowance is allocated, and the services which it supports.

Disability allowance is presently administered via an application process, with payment to the individual. There may be scope to streamline the eligibility and application process for the benefit, and the payment process for the service, in order to reduce co-payment pressure upon individuals more directly. There appears to be a number of existing pilots in which the allowance is paid directly to a health provider, with lower co-payment for the patient, streamlining the whole process. There may be scope for developing and broadening such processes, working across health and social welfare sectors.

Overall, there is no single co-payment targeting mechanism which currently has all the properties which could make co-payment fair, transparent, and administratively simple. If there is a move towards co-payment differentiation for individuals attending a practice, the options are most likely to be, in the short term, to use a combination of mechanisms which mitigate each other's weaknesses and, in the longer term, to develop a better mechanism, either by adapting the thresholds and eligibility for existing mechanisms, or by improving information sharing and administrative processes to facilitate straightforward and robust assignment of co-payment relief to those who need it.

5 Funding Options

5.1 Basic parameters

The preferred direction of the PCWG is, in the short term, to redistribute VLCA top up funding to patients with higher levels of need regardless of where they are enrolled, and to require lower co-payment levels for such patients, such as the $17.50 currently charged to adult patients in VLCA practices. It is noted that the dollar value of any lower co-payments would be negotiated but for modelling purposes the current VLCA adult co-payment amount of $17.50 is used as a proxy.

The modelling presented here is not definitive. It will require validation and supplementation during the implementation phase of any change to health funding, and, in particular, will require more detailed modelling which can provide specific advice to practices about their options.

For the purposes of this analysis, the following assumptions are used to simplify the model and to produce a result which can inform decisions on the preferred option:

- Patients under 15 are excluded from the model, since the majority of these receive free general practice care under the free under 13 policy. Under 15 is the chosen cut-off for the pragmatic reason that register data is available in five year age bands
- A typical co-payment level of $40 for an adult has been assumed for non VLCA practices, based upon data held by GPNZ which indicates that this is the national average co-payment level
- Patients with High User Health Cards are treated as non HUHC patients for the purpose of the modelling, to simplify interpretation. HUHC is cost neutral to Care Plus funding, so will not affect the overall results
- Co-payment calculations are based upon national consultation rates, varying by age (in capitation age bands), sex, ethnicity and deprivation. More detailed modelling with local and practice level consultation rates will be required for implementation
- Consultation and co-payment analysis is purely for medical consultations since data on nursing consultations is believed to be incomplete.

Comparing MSD and GP register records, it appears that current register data records approximately 66% of CSC holders. Detailed modelling can be conducted on the existing register data, but an extrapolation is needed in order to estimate the true impact of funding changes involving CSC.

5.2 Community Services Card Characteristics

Community Services Card holding is modelled on the basis of currently recorded CSC in practice registers. The overlap between CSC and other targeting mechanisms must be known in order to allow some extrapolation for the known population of CSC holders who are not recorded. Table 13 below shows the overlap of CSC holders with high need ethnicity and deprivation groups on the basis of existing practice registers. Thirty percent of CSC holders are in Deprivation Quintile Five, and 28% have Maori of Pacific ethnicity. In total, 57% of currently recorded CSC holders do not fall into either of these high need categories.

Table 13: CSC overlap with Maori/Pacific Ethnicity and DepQ5

	DepQ1-4	DepQ5	Total
Maori/Pacific	13%	15%	28%
Other	57%	15%	72%
Total	70%	30%	100%

5.3 Option One: CSC alone

5.3.1 Scenario

Fund all practices on the same formula. Use the weights from the current standard first contact formula but, where patients have a CSC, add the VLCA top up weighting appropriate for that age and sex category.

Regulate co-payments for CSC holders to $17.50 in all practices. Allow increases in co-payment for patients who do not hold a CSC.

As a broad assumption, extrapolation for non-recorded CSC holders is based upon there being 50% more CSC holders than actually included in the model practice register data.

5.3.2 Population Impacts

Changing primary care funding arrangements will change the distribution of state funding across population groups. Since CSC holders are dominated by the elderly, applying this scenario will generally shift state primary care funding:

- Towards the elderly, and particularly those aged over 75
- Away from Maori and Pacific people.

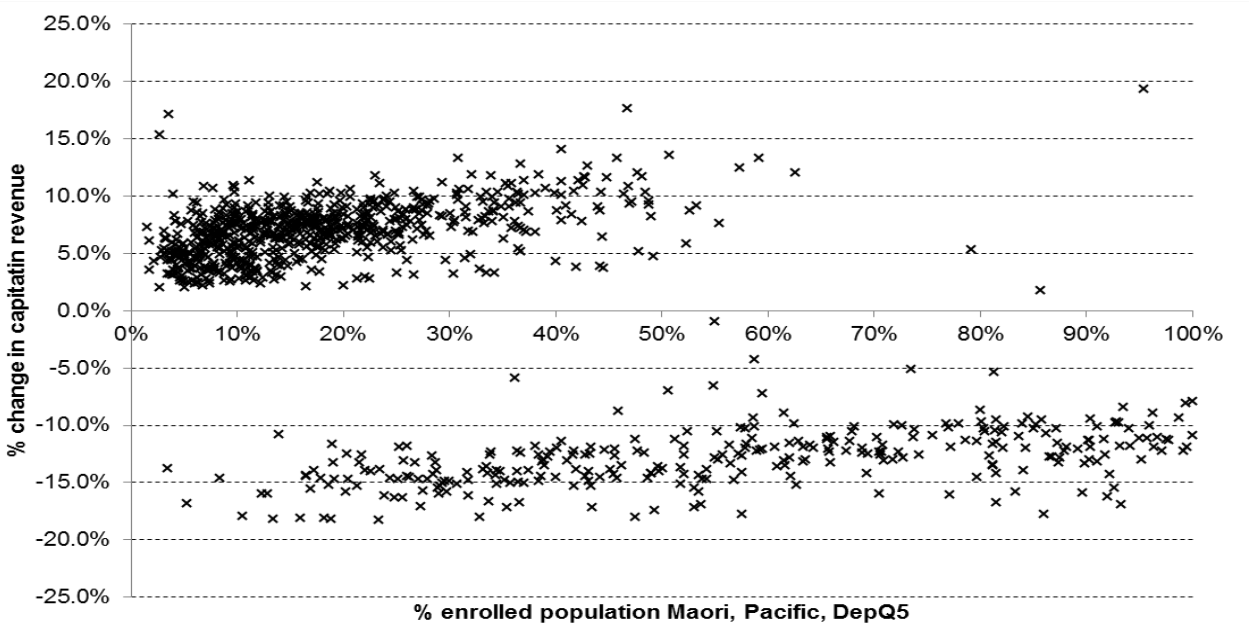
5.3.3 Impacts on Capitation Revenue

On the basis of the currently recorded level of CSC holders in practice registers, the following changes in capitation revenue would be expected for practices with differing levels of high need patients.

- Non VLCA practices all see an increase in funding, typically in the range of 5% to 10%, although the relationship with high need patient populations is not strong
- VLCA practices all see a decrease in capitation funding in the range of 10 to 15%.

These effects reflect the high level of elderly in the CSC holding population. The impact on Figure 6 below, of the additional CSC holders who are not currently recorded in practice registers, will be to shift all practices up by a small amount.

Figure 6: Change in Practice Capitation Revenue Compared to Unmet Need Population



5.3.4 Impacts on Co-payment

VLCA practices, on average, would need to increase co-payments for their non CSC holding patients by $10.01 in order to maintain existing levels of funding. This estimate is an upper limit since the number of recorded CSC holders is known to be less than the true number of people who have a CSC. The true increase required is likely to be of the order of $7 co-payment increase, to a level of about $24 per consultation for non CSC holders. This increase could be less if there are increased charges for services other than medical consultation (such as nursing consultation).

Non VLCA practices would be likely to have to increase their co-payment for non CSC patients in order to offer a $17.50 co-payment to CSC holders, even with the newly redistributed VLCA funding. On the basis of existing recorded CSC patients and an average co-payment of $40, this increase would be an average of $3.32 for a medical consultation. Given the true number of CSC holders, the increase is likely to be approximately $4.50 per consultation, although this could be higher or lower depending upon the existing co-payment level in each practice.

5.3.5 Funding Implications

At face value, this model results in a reduction in overall funding because the VLCA top up applied to the VLCA population is now being used for a small CSC holding population. The reduction in capitation would nominally be $7.6M. In reality, because the true number of CSC holders is higher than observed, this approach would be likely to see a smaller decrease of the order of $2-3M.

To fund an increase in the base capitation formula which made co-payment increases unnecessary for non CSC holders in an average practice charging $40 per consult, would require an additional $18M in base capitation compared to current funding.

5.3.6 Discussion

Community Services Card alone has the merit of being an independent and simple mechanism for determining co-payment in general practice. Historically, there have been issues with the narrowness of targeting of the CSC, and with uptake among the eligible population. These issues could to some extent be addressed if the eligibility criteria and issuing mechanism were improved, and it is likely that with emerging information technology and data linkage such streamlining would be possible. Since the CSC is not used outside the health sector, there remains some possibility of changing the eligibility thresholds for CSC, which government may wish to explore.

It is noted that the current income threshold for CSC eligibility is below the minimum wage.

CSC eligibility is based upon income and family size. Because income varies more over the life cycle of an individual than it does between other demographic factors, a targeting mechanism which is predominantly based upon income will always have a strong tendency to favour the elderly, while being less effective in identifying up younger populations who may have more income than the elderly, but particularly high need for care.

Table 14: Strengths and Weaknesses of Option One

Strengths	Weaknesses
▪ Simplicity of using an existing targeting mechanism without further change; ▪ Same mechanism on both the funding allocation side and the co-payment regulation side is simple and transparent for practices.	▪ Narrowness of existing CSC targeting; ▪ Shift of primary care funding away from some high need groups; ▪ Historically issues of uptake among the eligible population.

5.4 Option Two: CSC and Deprivation

5.4.1 Scenario

Fund all practices on the same formula. Use the weights from the current standard first contact formula but, where patients have a CSC or are in deprivation quintile 5, add the VLCA top up weighting appropriate for that age and sex category.

Regulate co-payments for CSC holders and people in Deprivation Quintile 5 meshblocks to $17.50 in all practices. Allow increases in co-payment for patients who do not hold a CSC.

As a broad assumption, extrapolation for non-recorded CSC holders is based upon there being an additional 35% of CSC holders over and above the modelled CSC and DepQ5 population.

5.4.2 Population impacts

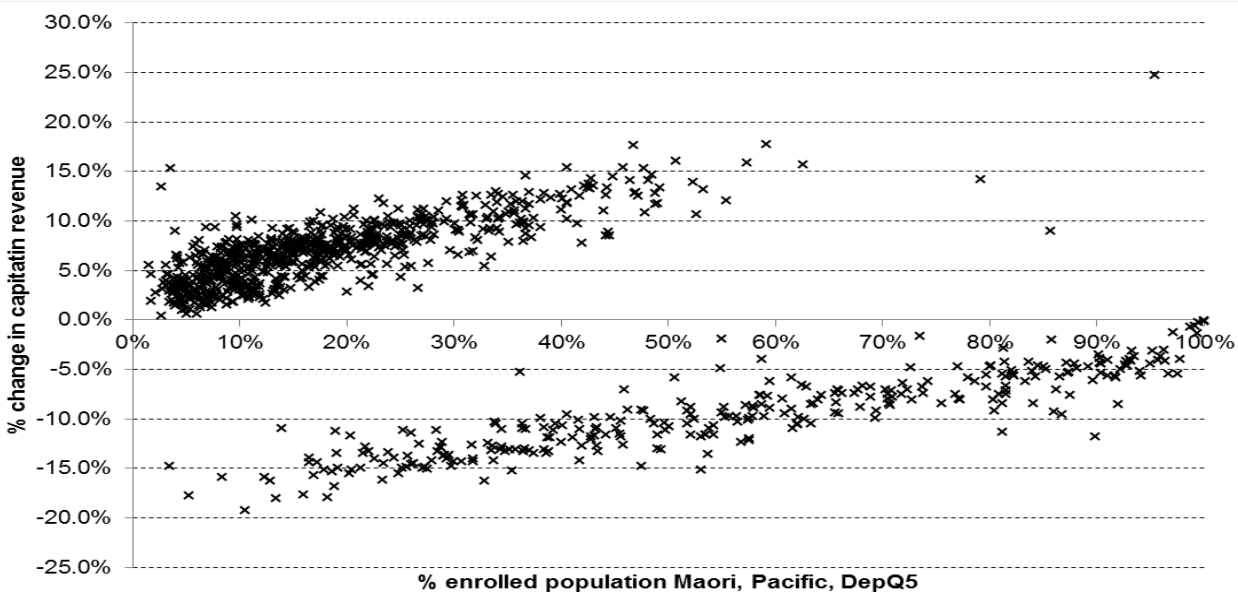
On the basis of currently recorded CSC holders in registers, this model would still shift primary care subsidy to the elderly, but the explicit use of deprivation in the model moderates the raw CSC impact, improving the deployment of primary care subsidy for those who are most deprived, including Maori and Pacific people who live in deprivation quintile five meshblocks. There remains a net shift of subsidy away from Maori and Pacific people who do not live in DepQ5 areas.

5.4.3 Impacts on Capitation Revenue

Explicitly including deprivation in the model means that there is a greater association between high need population enrolled in a practice and the impact of funding changes than there is in the base scenario of CSC alone. In this case in Figure 7 below:

- Non VLCA practices all see an increase in funding, and those with a greater than 30% high need (Maori/Pacific/Dep5) population see increases in capitation revenue of 10% or more
- VLCA practices all see a decrease in capitation funding, but the adverse effect for those practices with very high levels of need is much smaller than in the CSC scenario.

Figure 7: Change in practice capitation revenue compared to unmet need population



5.4.4 Impacts on Co-payment

Under this scenario VLCA practices would, on average, need to increase their co-payment for non CSC and DepQ5 patients by $5.40. This is lower than the increase for non CSC patients under Model One, because there is a wider base of patients who continue to attract the level of VLCA top up currently being received. Again, this is an upper limit, given the trend which will result from more complete CSC recording. The true actual level could be expected to be of the order of $4.50

Non VLCA practices would be likely to have to increase their co-payment for non CSC and non DepQ5 patients in order to offer a $17.50 co-payment to CSC holders and DepQ5 patients, even with the newly redistributed VLCA funding. On the basis of existing recorded CSC patients and an average co-payment of $40, this increase would be an average of $6.02 for a medical consultation. Given the true number of CSC holders, the increase is likely to be approximately $8 per consultation, although this could be higher or lower depending upon the existing co-payment level in each practice.

5.4.5 Funding Implications

At face value, this model results in an slight increase in overall funding because the VLCA top up currently applied to the VLCA population would be used for a larger population of people with both NZDepQ5 and CSC. On the basis of current CSC numbers, the increase to top-up funding required for this model would be approximately $4M, although this would increase once the true CSC holding population is included. As an estimate, the level of increase needed is likely to be approximately $10-12M.

To fund an increase in the base capitation formula which made co-payment increases unnecessary for non CSC holders in an average practice charging $40 per consult would require an additional $26M in base capitation compared to current funding.

5.4.6 Discussion

This scenario has a wider targeting effect than CSC alone, with a stronger shift of state primary care subsidy to high need populations. It has less impact on practices with high need populations, while maintaining a distributive effect. It is, however, likely to require additional funding in order to achieve these results. The co-payment impact on lower need patients in practices which are currently not VLCA is greater than in Model One, though still moderate. This could be mitigated if co-payment regulation were to a higher level than the $17.50 assumed in this model.

Table 15: Strengths and Weaknesses of Option Two

Strengths	Weaknesses
▪ Broader targeting than CSC alone, and better impact on targeting state subsidy to high need populations; ▪ More manageable impact on co-payment for current high need VLCA practices.	▪ Would require using deprivation status as a new co-payment differentiator; ▪ Would require additional funding; ▪ Does not show benefits for Maori and Pacific not in DepQ5. ▪ Increased requirement for co-payment increases in current non VLCA practices.

5.5 Option Three: CSC, Deprivation and Ethnicity

5.5.1 Scenario

Fund all practices on the same formula. Use the weights from the current standard first contact formula, but where patients have a CSC, are in a DepQ5 meshblock of have Maori/Pacific ethnicity, add the VLCA top up weighting appropriate for that age and sex category.

Regulate co-payments for CSC holders and people in DepQ5 to $17.50 in all practices. Allow increases in co-payment for patients who do not hold a CSC.

As a broad assumption, extrapolation for non-recorded CSC holders is based upon there being 28% more CSC holders over and above the CSC, DepQ5 and Maori/Pacific populations combined.

5.5.2 Population Impacts

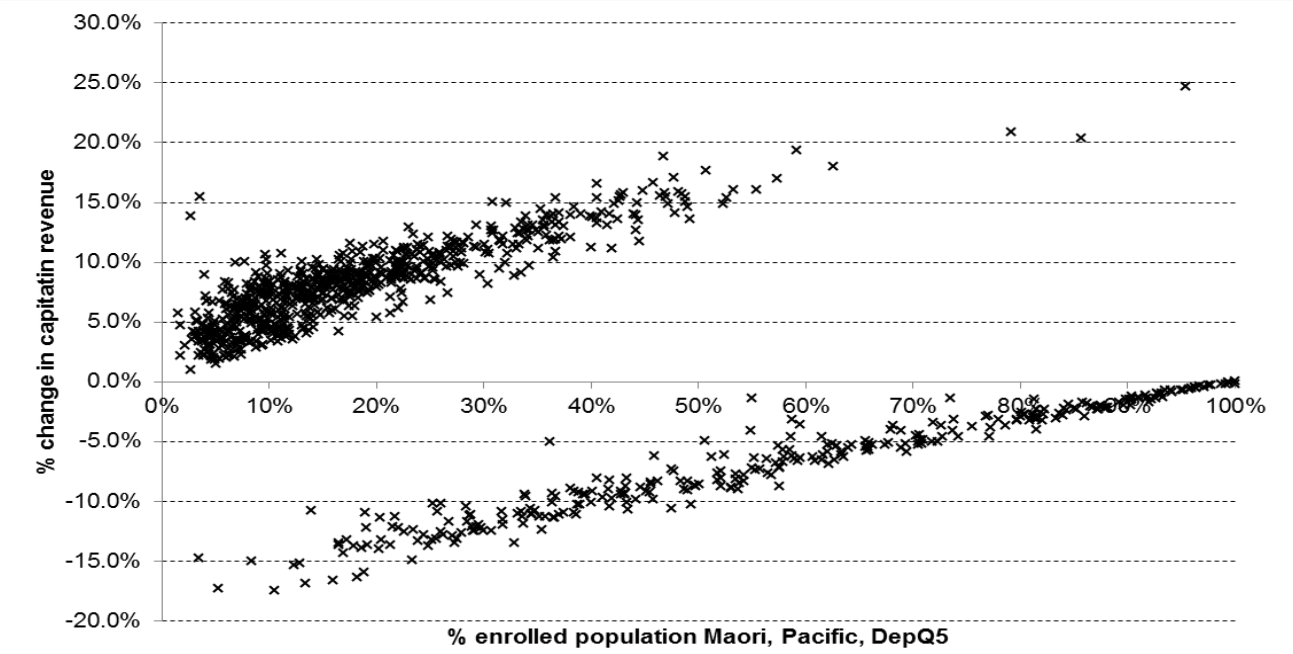
Explicitly including ethnicity as well as deprivation and CSC in the formula means that while this model requires additional funding to provide a top up to a wider population (estimated below under Funding Implications), such additional funding is well directed to those with low income, Maori or Pacific ethnicity, and those in DepQ5 areas. The impact, shown in Appendix One, is to increase, at a population level, the primary care subsidy allocated to these high need populations, with effectively no change in other populations with less unmet need.

5.5.3 Impacts on Capitation Revenue

Explicitly including both ethnicity and deprivation in the model means that there is a greater association between the high need population enrolled in a practice and the impact of funding changes than there is in either the base scenario of CSC alone, or in Model Two with DepQ5 added. In this case in figure 8 below:

- The increase in capitation for current non VLCA practices is a little more than is the case under Model Two, particularly for those with more than 40% high need populations
- VLCA practices all see a decrease in capitation funding, but the adverse effect for those practices with very high levels of need is much smaller than in other models, especially for those with 80% or more high need patients enrolled.

Figure 8: Change in Practice Capitation Revenue Compared to Unmet Need Population



5.5.4 Impacts on Co-payment

Under this scenario VLCA practices would, on average, need to increase their co-payment for non CSC and DepQ5 patients by $3.97. This is lower than the increase for non CSC and DepQ5 patients under Model Two because there is a wider base of patients who continue to attract the level of top up currently being received. Again, this is an upper limit, given the trend which will result from more complete CSC recording. The true actual level could be expected to be of the order of $3.

Non VLCA practices would be likely to have to increase their co-payment for non CSC and non DepQ5 patients in order to offer a $17.50 co-payment to CSC holders, even with the newly redistributed VLCA funding. On the basis of existing recorded CSC patients and an average co-payment of $40, this increase would be an average of $5.27 for a medical consultation. Given the true number of CSC holders, the increase is likely to be approximately $7 per consultation, although this could be higher or lower depending upon the existing co-payment level in each practice.

More broadly, this model is the only scenario in which the input side (factors for allocating funding) differs from the output side (factors for regulating co-payment). Adding ethnicity to the weighting does not directly reduce co-payments for individual people with Maori and Pacific ethnicity, although it will reduce pressure on co-payments for practices which have a greater proportion of Maori and Pacific people in their enrolled populations.

5.5.5 Funding Implications

Implementing this model will result in a requirement for additional funding because the VLCA top up currently applied to the VLCA population would be used for a larger population of people with NZDepQ5, Maori/Pacific ethnicity and CSC. On the basis of current CSC numbers, the increase to top-up funding required for this model would be approximately $12M, although this would increase once the true CSC holding population is included. As an estimate, the level of increase needed is likely to be approximately $20M by the time the additional CSC holders are taken into account.

To fund an increase in the base capitation formula which made co-payment increases unnecessary for non CSC holders in an average practice charging $40 per consult, would require an additional $22M in base capitation compared to current funding.

5.5.6 Discussion

This option has the most effective distributional impact, in terms of allocating state subsidy for primary care to populations with unmet need. But, to achieve this impact, it requires significant additional funding from current levels. It has a positive impact upon primary care funding for Maori overall, without requiring crude co-payment differentiation for individuals by ethnicity.

Table 16: Strengths and Weaknesses of Option Three

Strengths	Weaknesses
▪ Broad targeting, with a positive net effect upon distributing state subsidy to populations with unmet need ▪ Moderate impact upon co-payment changes required for current VLCA practices, with maximum potential for VLCA practices to increase current revenue from new co-payments ▪ Reduced co-payment impacts across the board compared to Models One and Two.	▪ Would require using deprivation status as a new co-payment differentiator ▪ Would require the most additional funding of the models considered here.

6 Recommendations

The primary care working group recommends to the Minister of Health that:

6.1 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.**

   The PCWG noted that new models of care may result in transfer of resources from traditional modalities of care that contribute to service utilisation figures. It is vital any new funding formulae support new and developing models of care.

   The PCWG also noted that while patient co-payments contribute approximately 50% of the total mixed funding model service utilisation will remain a key factor.

2. **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 VLCA top up payment to individual high need patients wherever they are enrolled.**

   The PCWG noted that a small group of practices who can demonstrate extremely high and complex levels of need, should be entitled to extra funding, possibly to the point of providing a fully funded service. The decision as to which practices would qualify should be a matter for individual DHBs but under Ministry of Health guidelines.

4. **In the medium term, CSC status, ethnicity and deprivation be considered as factors in the base capitation formula.**

5. **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.**

   MSD currently spends over $50 million per year for medical fees (as well as $25 million on pharmaceuticals). This funding need to be analysed to ensure that the truly needy are receiving them and that they are used to improve access to health care.

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.**

   There appeared to be wide variation in how this type of funding was applied. In some areas it was managed by PHOs and in other areas it was distributed to practices. The PCWG view is that DHBs and PHOs should be encouraged to provide flexibility to practices that can demonstrate enhanced capability and preparedness to be held accountability for agreed outcomes.

6.2 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.**

   The PCWG noted fee moderation may be required if a practice has a monopoly position in a community.

10. **The current fee restriction based on historical fees be reviewed as there are significant inequities in different regions.**

    The PCWG noted the low average co-payment levels of those practices within districts that were early adopters of the original Low Cost Access funding formula. The current Fees Policy has locked them into this low fee environment which has compromised their financial viability.

11. **Ethnicity is excluded as a factor in co-payment differentiation.**

6.3 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.**

6.4 Shifting Services

17. **Make it a priority to enhance coordination with general practice and include the following services under primary (or joint) governance:**
    e. **Community-based radiology and other diagnostic services**
    f. **District and community nursing**
    g. **Dietetics and nutrition advice**
    h. **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.**

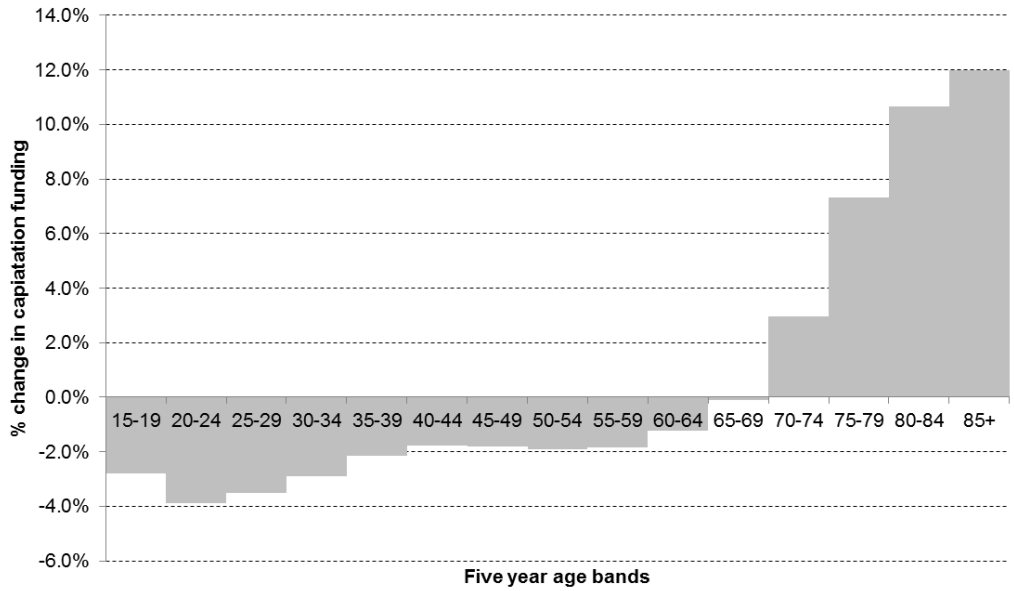
19. **In particular support the consistent use of information technology across New Zealand, as a tool for shifting services closer to home and facilitating the key role of a health care home model.**

Appendix 1: Population Impact Graphs

Option One: Community Services Cards

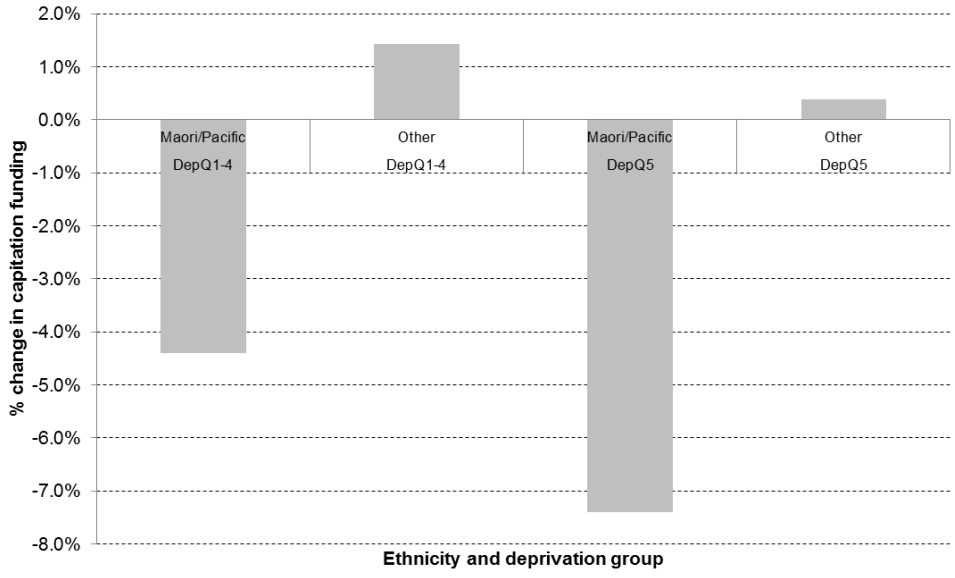
Because CSC has a high take-up in the elderly, the impact of using CSC as a criterion is generally to shift capitation funding from the population under 65 and to increase capitation funding for the elderly, particularly those aged 70 and over.

Figure 9: Impact by Age



Compared to the current state, the impact of CSC is generally to shift funding away from Maori and Pacific people, and towards those of other ethnicities. By comparison with the current distribution of capitation, this model also tends to shift funding away from people in NZDep Quintile five.

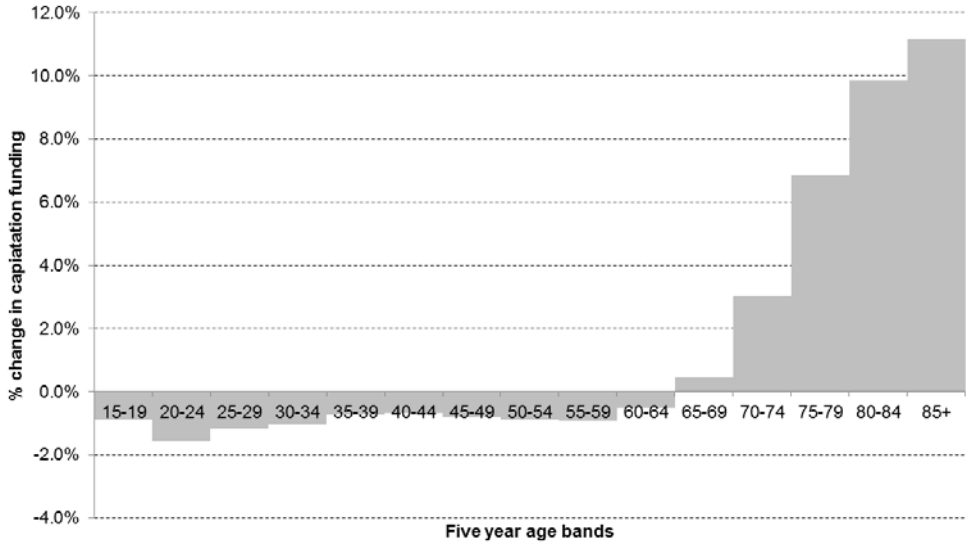
Figure 10: Impact by Ethnicity and Deprivation



Option Two: CSC and Deprivation Quintile 5

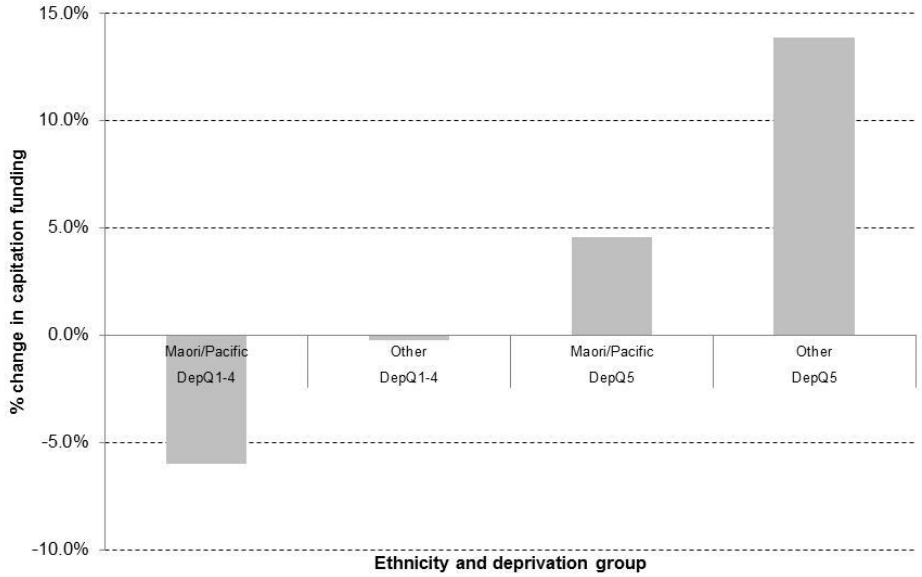
Because CSC has a high take up in the elderly, the impact of using CSC as a criterion is generally to shift capitation funding from the population under 65, and to increase capitation funding for the elderly, particularly those aged 70 and over. This is somewhat moderated by the use of deprivation compared to the model which is purely based upon CSC.

Figure 11: Impact by Age



Compared to the current state, this model (unsurprisingly) increases the proportion of funding for people in the highest quintile of deprivation. By comparison with the current distribution of capitation funding , this model tends to shift funding away from Maori and Pacific people in NZDep Quintile five.

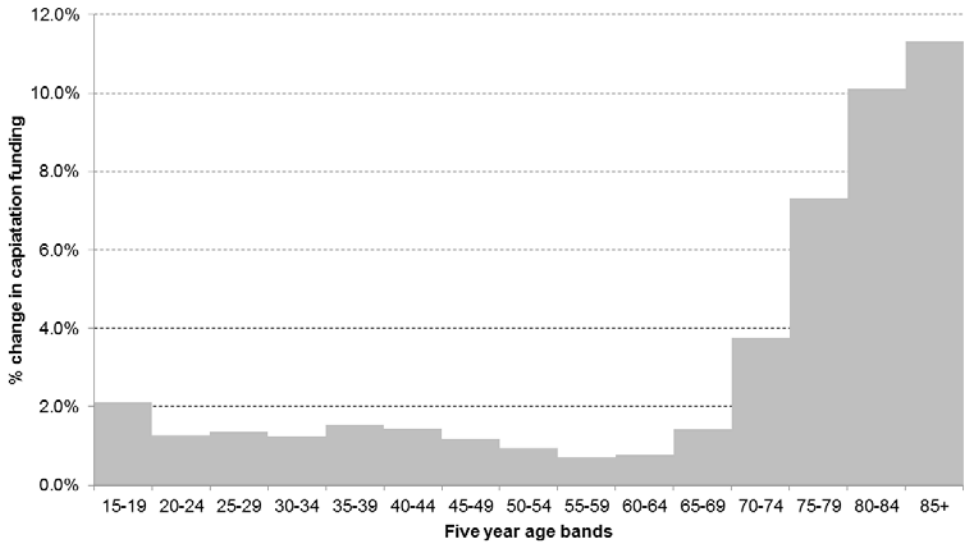
Figure 12: Impact by Ethnicity and Deprivation



Option Three: CSC, Deprivation and Ethnicity

Because CSC has a high take-up in the elderly, the impact of using CSC as a criterion is generally to increase capitation funding for the elderly, particularly those aged 70 and over. Because this formula implies a net increase in funding, there are increases for all age groups, rather than a re-distribution from young to old.

Figure 13: Impact by Age



Compared to the current state, this model increases the proportion of capitation funding assigned to people in the highest quintile of deprivation and for Maori and Pacific people across all deprivation categories. By comparison with the current distribution of capitation funding, this model tends to shift funding away from Maori and Pacific people in NZDep Quintile Five.

Figure 14: Impact by Ethnicity and Deprivation