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General Practitioner

Karori Medical Centre

Friday, August 12, 2016

(Plenary)

11:10 - 11:40 Sustainability of General Practice

SUSTAINABILITY OF GENERAL PRACTICE

Findings of the Primary Care Working Group

WHO WAS ON THE WORKING GROUP?

- Peter Moodie
- Megan Bailey
- Sharon Hansen Chair of the Rural GP Network
- Janice Kuka CEOof Nga Mataapuna Oranga PHO
- Nick Chamberlain CEO Northland DHB

PRIMARY CARE WORKING GROUP

- April 2015 conceived by General Practice leaders
- August 2015 appointed by MOH with technical and logistic support from GPNZ
- September 1st First meeting
- 10 face to face 3 hour workshops around the country

  We met 370 clinicians and 290 responded to an on line questionnaire

  October 1st consultation finished
- By mid November the Minister of Health received our report.
- What was the hurry?

THE TERMS OF REFERENCE

- To explore:
- affordable and equitable access to sustainable general practice with a particular focus on VLCA funding
- General practice workforce sustainability.
- Shifting services "closer to home"

CAPITATION AND HOW IT AFFECTS SUSTAINABILITY

IS THE CURRENT CAPITATION FUNDING ALLOCATED FAIRLY?

- The current allocation formula
- Takes three variables into account:
- Age
- Utilisation rates in each age group
- Gender
- The VLCA funding formula

CAPITATION
FAIRNESS AND EQUITY OF ACCESS

- Time for a review of the capitation formula including utilisation rates
- Time to change the age bands to 5 year from 10 year groupings
- Time to identify those in financial hardship using deprivation and CSC card status BUT simplifying the enrolment process
- Time to acknowledge that ethnicity is an important modifier of health and needs to be factored into the base rate
- Time to seek clarity from people like MSD as to what they fund and why

CO-PAYMENT TARGETING

- A combination of CSC eligibility and deprivation be used as to identify patients eligible for lower co-payments wherever they are enrolled.
- Ethnicity is not used as a co-payment modifier but it should be relfected in the base formula and perhaps performance targets.
- Fee regulation should only apply to those patients eligible for the lower co-payments.

THE FIRST ELEPHANT IN THE ROOM

If we simply redistribute the funding to high needs groups, what happens?

But there is the VLCA top up isn't there?

A LITTLE HISTORY

- 2006 VLCA funding was offered to any PRACTICE
- The offer was for Increased capitation BUT fixed maximum fees for EVERYONE in the practice
- 2009 1/3rd of practices had taken up the offer, MOSTLY those serving poorer areas of the country
- 2009 no new practices could join unless they could demonstrate that 50% of the patients were "HIGH NEEDS" as defined
- The extra funding was only age adjusted.
- Deprivation and ethnicity only appeared as ENTRY CRITERIA and only after 2009

WHAT DID THE WORKING GROUP FIND?

- Everyone hated the formula
- The fees were fixed
- The fees were not targeted
- The truly high needs practices were being swamped
- The 2009 changes meant that there were real tensions between practices.
- AND
- Over the whole country 45% of VLCA patients were not high needs and 45% of high needs patients were not in VLCA practices!

THE SECOND ELEPHANT

- Some VLCA practices would lose funding(but they could increase their fees)
- Some the VLCA funding would come to the non VLCA practices BUT they would have a fixed fee for some of their patients.
- The current fixed fee $16.50 is too low and so most non VLCA practices would want to increase their fees to non high needs patients to compensate for the financial loss

SUMMARY

- The PCWG recommendations are firmly focused on a fair redistribution of subsidy in a fair manner to those who need it.
- The system we have is however difficult to re-engineer without injecting some PATIENT subsidy into it
- If we don't, co-payments to non high needs patients are likely to rise
- There is a glass ceiling to the amount average New Zealanders can and will pay

THE CHANGING FACE OF GENERAL PRACTICE

- The traditional model of the "owner doctor" independent practitioner is changing but there is still room for concept.
- There is a "lost generation" of GPs
- The workforce has more women and part-time doctors
- There are real changes occurring to the traditional "doctor-dominated" model
- There is a move toward integrating primary and secondary care

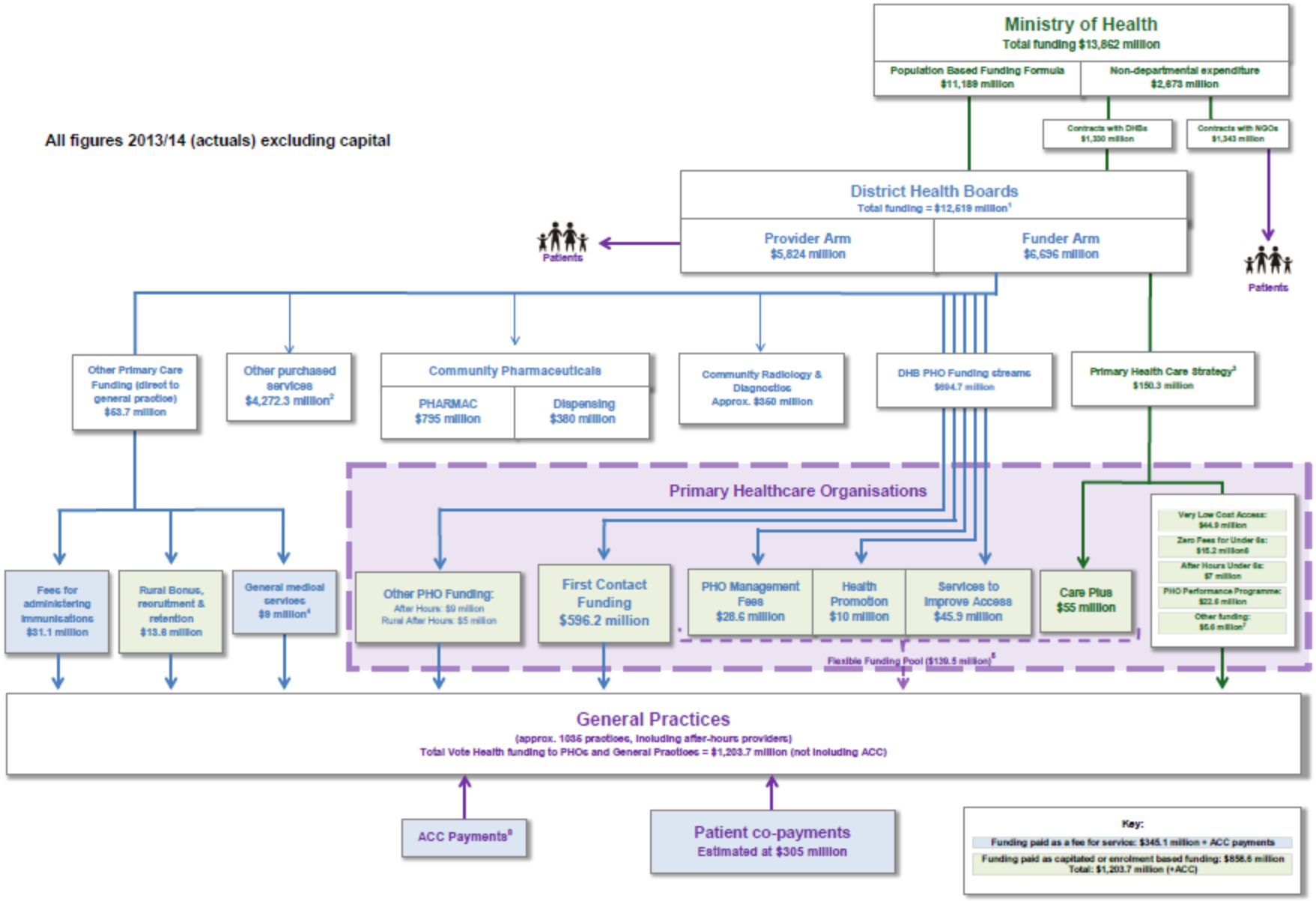
WORKFORCE SUSTAINABILITY

- Broaden the scope of general practice
- Improve undergraduate and post graduate training
- Look at new ownership models but don't throw out the good parts of the existing models
- Reward practices for improved standards and accreditation
- As practice standards improve reward those practices with greater autonomy
- Look very seriously at the concept of the Health Care Home

SHIFTING SERVICES CLOSER TO HOME

- Devolve services to primary care BUT
- Make the funding follow the service
- "Stop DHBs transferring services to primary care and then withdrawing the funding"
- Look at some of the innovative ideas in various DHBs and coordinate them. Mental health. Imaging services, District nursing services
- Allow flexible funding to be used creatively by Health Care Home (HCH) practices.

IS IT ALL ABOUT THE MONEY?



BACKGROUND INFORMATION: CSC

Card Type	Issued CSC June 2015	Percentage
Families	10604	1%
Low Income	16888	2%
Working for Family	113686	13%
Beneficiaries	384082	43%
NZ Superannuation	267601	30%
Residential Subsidies	24006	3%
Student Allowance	60244	7%
Veteran's Pension	8649	1%
Total	**885760**	**100%**

Household	1/04/2007	1/04/2015
Single (Sharing)	$ 21,676	$ 26,042
Single (Alone)	$ 22,981	$ 27,637
Couple	$ 34,328	$ 41,327
2 person family	$ 41,196	$ 48,797
3 Person family	$ 49,364	$ 59,093
4 person family	$ 56,096	$ 67,282
5 person family	$ 62,684	$ 75,302
6 person family	$ 70,073	$ 84,265
Each additional child thereafter	$ 6,482	$ 7,898

BACKGROUND INFORMATION: WORKING FOR FAMILIES

	Annual Income (before tax)		
Number of children*	**Family tax credit**	**In-Work tax credit**	**Parental tax credit**
1	$59,041	$73,724	$110,530
2	$74,811	$89,493	$126,300
3	$90,580	$105,262	$142,069
4	$106,350	$124,702	$161,509
5	$122,119	$144,142	$180,949
6	$137,888	$163,582	$200,389
*Eldest child under 15, others under 12			