Sustainability of General Practice

Themes from Sector Consultation Forums

Primary Care Working Group

28 September 2015

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1 Executive Summary

The Primary Care Working Group (PCWG) was set up in August 2015 at the request of the Minister of Health to advise him on various aspects of general practice funding and sustainability. The PCWG will report to the Minister by the end of October 2015.

This is an interim report of the PCWG. This report summarises the themes which have emerged so far in the process. Further discussion and analysis will inform the final report, and any recommendations the PCWG will make in the report to the Minister of Health which is due end of October 2015.

The three general areas the PCWG were asked to explore in a series of 11 consultation forums and an electronic survey were:

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

370 participants, largely from general practice, took part in the 11 forums. A further 291 submissions were received to an electronic survey.

Main points from the consultation forums were:

- That the current Very Low Cost Access (VLCA) funding formula was not fit for purpose as an effective targeting mechanism;
- That there was universal support for better targeting of general practice funding through capitation and other means to patients with unmet need;
- A number of mechanisms for targeting were identified, including ethnicity, deprivation, Community Services Card, Working For Families status, Disability Allowance, income and increased Care Plus eligibility;
- Although there was general distaste for co-payment regulation, many participants agreed that co-payments could create inequities for people with low incomes or complex needs;
- Some populations with very high levels of unmet need are likely to require exceptional funding in order to address access and complexity issues;
- There was a widespread view that the existing clinical business ownership model of general practice will continue to have an important place within primary care services;
- There was a concern that general practice as a career are not attractive enough to maintain strong recruitment of younger health professionals, and that general practice should be recognised as a financially and professionally rewarding specialty;
- There was wide agreement to shifting services closer to home, if supported with adequate funding and capital investment;
- Priorities for shifting services to primary care included: community based radiology; district and community nursing; dietetics and nutrition advice; and social work.

2 Background

The PCWG arose from meetings of the PHO Services Amendment Agreement 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, and 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 included:

- conducting 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
- advising on implementing any changes to the Very Low Cost Access (VLCA) scheme
- being 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 PCWG was established in August 2015, and met for the first time on 1 September 2015. The membership of the group is:

- Dr Peter Moodie, 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.

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3 Approach

The PCWG developed a set of questions to stimulate discussion on each theme. These were used, in a series of 11 consultation forums across New Zealand, to explore the key themes the PCWG had been charged with advising on, eliciting the views of front line primary care clinicians.

Ten of the 11 consultation forums were face to face, with one event held by teleconference with members of Te Akoranga a Maui, the Maori Faculty of The Royal New Zealand College of General Practitioners. In total there was direct engagement with 370 stakeholders.

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. At the time of preparing this report 291 responses had been provided to the survey, of which 184 had not attended a face to face consultation forum. Survey results have yet to be analysed. This process has had the direct participation of a large number of general practice team members in New Zealand.

Table 1: 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**

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.

4 Themes

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

This theme was the subject of the most comment in all meetings. There was a very widespread view among participants that the 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, and 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 to manage their business risks.

3. Neighbouring practices with similar populations can find themselves with lower levels of funding and co-payment, resulting in inequitable access for patients and inequitable funding for general practices. These differences are not always transparent to patients and are difficult to explain.

Some participants noted that the VLCA formula does work 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 high unmet need (including 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 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 practice 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). However 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 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 pointed out that anomalies had emerged across the country between practices which happened to have higher co-payments when regulation was introduced and have seen larger absolute increases in co-payment and those practices that were early adopters with low co-payments 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 could 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, 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. ACC funding was also noted, and 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.

A further part of the funding picture lies with the Ministry of Social Development, which provides Disability Allowance to a number of patients, which in turn 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, although 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 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 is 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.

4.2 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 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 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 by DHB employed clinicians, noting 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 revolved around recruitment into general practice, and the challenge of enthusing medical and nursing students at an early stage for a primary care career. 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 both more time spent in community settings for trainees, as is currently policy, but a 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. This related to both professional qualifications such as Fellowship of The Royal New Zealand College of General Practitioners, and to practice-based accreditation like Cornerstone. 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 an important, related 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.

4.3 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. 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. There was considerable frustration in some quarters that the existing effective models for facilitating access to these services were not more widely implemented.

The development of Health Care Home models was seen by those who were familiar with the model 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

A number of participants noted the importance of information technology in shifting services, and in improving the 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, as long as such roles were properly resourced and supported and represented an extension to core primary care activity, rather than becoming a distinct role which s 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 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 could be left with stranded costs if services were moved out in an unplanned way.

Resourcing service change requires DHBs to fund services appropriately when they change setting, rather than seeing shifting 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 fund appropriate capital investment is an important strategic prerequisite for moving to new models.

5 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. There is 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 sought reassurance that these issues had been heard.

The perception that the existing funding arrangements for primary care are not fit for purpose is very widespread, and participants saw some urgency in addressing this issue, on the grounds both of equity of access for patients and of 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 both upon the realistic investment of resources in such services shifts, and upon 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.