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Five Primary Health Issues 2007 (with 8 suggestions)

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[A] Rural Health Subsidies - Inappropriate Application

- The 2006 RNZCGP Membership Survey revealed that 13.4% of respondents classified themselves as rural but only 11.6% achieved a Rural ranking of 35 or more meaning that about 14% of rural GPs are denied rural status under the current scoring system.
- The old Rural Ranking Scale is still being applied and some District Health Boards continue to allow their Portfolio Managers to make unilateral decisions about the scoring and whether "Discretionary Points" will be awarded with no apparent concern that many areas with a GP shortage continue to struggle with retention which would be assisted if they received rural ranking. The new Ranking Scale has the potential to identify GPs who should be supported in their rural communities only if DHBs and PHO keep their hands off.
- Some PHOs have not been passing on any or much of the rural workforce retention funding they receive for their GPs [*New Zealand Doctor* 11 April 2007 pg 4]. [See note 2]

Suggestion 1: DHBs should apply the new Rural Ranking Scale in the spirit it was intended to enable rural GPs to obtain appropriate rural subsidy support. They should advise a GP if they have made an error but not have the power to unilaterally change his or her claim. Payment should be to the GP or their employer, not the PHO as it is a support and retention subsidy, not a source of income for the PHO.

[B] Primary Health Organisations (PHOs) – Producing discrimination and inefficiency

- Labour introduced the PHO concept as its answer to Primary Health problems for New Zealand and when GPs showed little enthusiasm for being collectivised and controlled the Minister decided to provide new funding only to PHOs. All new Practice Nurse, patient and prescription subsidies have been made exclusively to PHO practices, financially forcing most (but not all) GPs to join a PHO.
- Currently only 73% of GPs in the 2006 RNZCGP Membership Survey were members of a PHO. If one looks only at self-employed GPs (excluding GPs who were locums, not doing GP work, salaried or overseas), then the figure rises to 85%, still leaving 15% electing to stay independent.
- There is no evidence that capitation and collectivisation make economic sense or improves health outcomes for individuals or populations. There is evidence that non-capitated (non-PHO) practices actually do better at Immunization, smear taking, managing diabetes and other preventative measures than capitated PHO practices, but they receive very little financial support for this.
- "Population based" policies often become reduced to "Race Based" policies with the blind application of funding to reduce access costs with no understanding of the causes of poor Maori health or any attempt to address those causes. Maori are in fact quite highly represented in non-PHO practices,

as many want “Good Health Care” not “Cheap Health care”, (and recognize that the two are often not synonymous).

- Recent policies by DHBs to force GP fees down (either by demanding under 6 year olds be free or by restricting fee increases) do not improve health outcomes as PHO GP practices are being forced to have shorter consultations in order to maintain practice income.
- GPs in PHOs are getting very annoyed with the interference in their practices. In the same *New Zealand Doctor* 11 April 2007 we read that there are 30 practices facing fees reviews, 76% are not prepared to suffer a loss in order to keep fee increases below the proscribed 4.5% and over 44% are going to put them up despite the threat of a fees review. We also read of GPs’ concern about unauthorized removal of patient data from General Practice computers.
- As mentioned in Note 1, rural PHO GPs are being deprived of rural retention funding by this extra (and quite unnecessary) layer of bureaucracy.
- Non-PHO practices continue to be ignored when important information is circulated, for Rural Retention and for any government support for patient consultation or prescription fees.
- Non-PHOs need their Practice Nurse to assist with the preventative measures necessary to improve health outcomes but their Practice Nurse Salary Subsidy remains very low (not even increased when GST went up), compared to the significant (almost full) income support provided to PHOs. We are now facing very large increases in Nurse salaries and an extra week’s holiday. The private GP will be increasing fees or moving away from poorer areas.
- However, the ostracizing of non-PHO General Practices is hurting patients and alienating experienced GPs, many of whom are NZ trained but sorely tempted to head off to Australia or Canada or into salaried posts. [See note 3]
- Surely there is a case for accepting that a **dual system** (PHO & private) exists in NZ and that private GPs are likely to be offering a very high standard of care (or they wouldn’t retain their patients).

Suggestion 2: Perhaps the Ministry of Health should be talking to CareNet with a view to being the Independent non-capitated GPs’ umbrella organization. Non-PHO GPs are likely to be happy to be associated with CareNet if it meant they could retain their independence while obtaining lower prescription fees, better GMS subsidies and higher Practice Nurse support to help their patients. Measures of quality of care are already in place for “true GPs” [See note 3]

- PHOs should justify their significant extra costs and GPs should be allowed to exit PHOs into a non-capitated system that didn’t increase fees for their patients.
- At present the free Diabetic check feedback is purely requesting the number of Maori and Pacific Island patients seen, with no interest in achieving improved outcomes!

Suggestion 3: Studies of outcomes are needed, comparing PHO and non-PHO practices. These need to be non-identifiable for the patient and MUST be planned health professionals (not politicians or health managers) to be of any value.

Suggestion 4: PHO membership must be truly optional, with equivalent Practice Nurse, GMS and prescription subsidies being applied to non-PHO practices. I would predict a large number of GPs leaving PHOs once there was a “level playing field” with a huge cost saving to the country but no reduction in health outcomes (maybe a few health manager job losses). Remember, it is Labour who continue to promise reduced GP costs to “All New Zealanders” and that continuity of care was vital!!. **The reality is they mean “all NZs who join PHOs” and to hell with continuity of care.**

[C] Primary Health Workforce

- Health Workforce planning in New Zealand continues to ignore the fact that by trying to control GPs and restrict their incomes we continue to see a large number of New Zealand graduates and experienced vocationally trained GPs leaving New Zealand to work overseas for much higher income and in much better working conditions (currently 30% of graduates within 5 years).
- The only solutions tried to date have been to import overseas trained doctors, introduce schemes to have more medical students from rural areas and to introduce the concept of Nurse Practitioners.
- Overseas trained doctors have featured significantly in recent medical misadventures and complaints. The current *New Zealand Doctor* 11 April 2007 blames inadequate supervision but surely **retention of NZ graduates** (who hopefully have appropriate medical, social and cultural skills and understanding) **is the ideal**?
- The latest figures reveal that more than 80% of doctors newly registered in New Zealand are overseas trained.

- Improving remuneration and conditions is the key to retaining NZ GPs but this government is clearly unable to accept that someone who has spent 12 years to become a vocationally registered "specialist" GP [6 at Med School, 3 as a junior then senior House Surgeon then Family Medicine Registrar, then 3 doing Advanced Vocational Education to achieve a FRNZCGP] is of any more value than a Nurse with a little training in pharmacology and little if any in pathology and diagnosis.
- A GP is either someone vocationally registered (with FRNZCGP) or training to become that [according to the President of the RNZCGP Dr Jonathon Fox- *New Zealand Doctor* 11 April 2007 pg41]. Doctors with provisional or general registration working as GPs in PHOs are now giving qualified GPs a bad reputation, yet they get higher subsidies than Vocationally Registered GPs not in PHOs.
- A Vocationally registered GP can earn twice the taxable income working as a salaried GP for a DHB (and get 6 weeks holiday and CME leave) than most sole self-employed non-PHO GPs can earn yet health managers, who are earning more themselves, continue to attempt to restrict GPs' incomes! The really worrying thing is that an experienced NZ Vocationally trained & registered GP is able to between 4 and 6 times (in NZ dollar terms) by moving to Australia. **Nothing is being done to encourage them to stay in NZ**.
- The poor status given to qualified GPs is reflected in the value ACC places on identical work done by others, often with no more (or less) qualification. Examples are:
    - Minor suturing (<2m superficial) – GP [$35.58]; Specialist [$143.45]; Dentist [$159.40]
    - Incise/drain abscess (under LA) – GP [$30.21]; Specialist [$114.15]; Dentist [$215.20]
    - Consultation (& exam) - GP [$35.88]; ED [$110]; Specialist [$99.99]; Dentist [$62.53]

    This is not only insulting; it is one of the reasons why GP recruitment & retention is difficult.

Suggestion 5: The status of Vocationally Registered GPs must be enhanced. Already a few types of drugs are able to be applied for by "Appropriate Specialists and Vocationally Registered GPs". This should be vastly extended so that the specialty of General Practice regains the "mana" needed to attract our graduates into General Practice training and motivate all practising as GPs to do their Advanced Vocational training.

Suggestion 6: This status should be recognized across the board in remuneration – higher GMS (capitated or not), Retention funding, ACC subsidies, salaries etc and the government/Ministry of Health and DHBs should support fees that return an equivalent income for Vocationally Registered GPs as other specialists. This would encourage our graduates and experienced GPs to qualify and stay in NZ to the advantage of everyone.

[D] An unnecessary Tax – Prescription Fees are unfair and a barrier to good health care.

The political fighting over personal and company tax ignores those taxes we pay on goods and services we purchase. The place of GST is never raised but for the record, what about increasing this to 20% and abolishing personal and company tax altogether? It would do all sorts of interesting things to the economy. If nothing else, it would remove an army of tax collectors (as those registered for GST have to collect it for nix), but I suppose it would bring back the ancient sport of smuggling!

Seriously, there are three additional taxes on Goods and Services, over and above GST, which reflect on health. If a tax isn't achieving any social, economic or health goal, it should go.

- Taxes on cigarettes and alcohol have been an incentive to reduce or give up smoking and excessive drinking and the income generated should be available for smoking cessation programs and alcohol addiction programs as well as contribute to the high cost of managing the health consequences of smoking and alcohol abuse.
- Petrol & diesel taxes discourage the use of fossil fuels and hopefully reduce pollution (which affects our health) and the income can be directed to producing and maintaining a safe and efficient roading system that reduces our road carnage.
- However the tax on prescriptions (the "Prescription Fee") is a tax on those with health problems and should be abolished. Non-essential drugs should be restricted by having little or no government subsidy, not by taxing the user.

The advantages of removing this unfair and illogical prescription tax include:

- Removing a major cost barrier to necessary pharmaceuticals for all people with poor health, so those with poorest health, such as Maori, Pacific Islanders and "high deprivation" would benefit the most [See note 5]
- Removing a major inequality in the NZ health scene, namely low prescription cost ($3) for those (of whatever income and ethnicity) attending a GP who has joined a Primary Health organisation (PHO) and those attending a GP who has sensibly declined to be collectivised, who currently face a $15 per

item tax. Many people attending non-PHO GPs are in categories identified as having high health needs but do not qualify for a Community Service Card so they pay the $15

- Patients attending a Midwife or public or private specialist would benefit from not having a $15 cost added to each prescription item.
- Reducing the prescription fee from $15 to $3 for those in PHOs or with a Community Service Card was stupid, as the $3 doesn't even cover the cost of administering the fee.
- Pharmacists currently have to collect this silly tax from patients, many of whom believe it is a pharmacy co-payment, and so the pharmacists get labelled as greedy and profiting from others' ill-health, when it is in fact the government which is greedy and profiting from others' ill-health.
- Even just four necessary items on a prescription to a casual patient or one attending a non-PHO doctor will cost an additional $60 making patients reluctant to take preventative medicines that don't have any immediate overt effect, resulting in poorer long term health and more attendances to hospitals and Emergency Services.
- The massive undue and uncompensated administrative burden to GPs (and their Practice Management software) and pharmacists would be eliminated, along with a large number of unnecessary health administration jobs. I very much doubt the funding collected actually covers the cost of administering it.
- If Pharmac spent less time and money administrating this silly tax, it might be able to pay for some of the drugs currently withdrawn from New Zealand because of lack of funding or only available with part charges. The reality is we are becoming very "third World' in access to modern effective pharmaceuticals with either no access or limited by ridiculous bureaucratic restrictions on medicines freely available in Australia.

Suggestion 7: Prescription Fees should be abolished outright.

[E] Improving Maori Health – without racial discrimination.

Racial Discrimination is a major feature of current health policies yet most New Zealanders are not comfortable with policies based on the colour of one's skin, even when disguised with words like "ethnicity". However there is no denying the poor health statistics for Maori and Pacific Islanders.

Not all Pacific Islanders or Maoris need extra help in the area of health and conversely many non-Polynesians have significant health needs (in fact more do, because there are more non-Polynesians). It is simple maths, if there is twice the number of Maori with a poorer health outcome (e.g. hospitalisation with asthma) than non-Maori, but they make up 16% of the population (1/6th), then the actual number of non-Maori (who make up 5/6th of the population) hospitalised with asthma will be 2.5 times bigger (1/2 of 5 times).

Current policies on improving Maori health are often no more than collecting "ethnicity data" to demonstrate a known difference rather than defining what problems exist and the causes of those problems. This leads to incorrect assumptions and wasted programs such as ACC assuming that it is through ignorance that Maori make fewer ACC claims than predicted (hence the costly TV advertising campaign) rather than the more likely possibility that they may injure themselves less often.

So the answer?

Suggestion 8: Aim health policies at the problem, not the race.

Maori Health policy should be "more about funding a particular type of service that can be accessed rather than funding exclusively for Maori" [a reluctant admission from TDHB management].

This concept means we should be looking at the causes of poor Maori Health (eg smoking, obesity, poor management of chronic disease) and improving the delivery of prevention and health maintenance programs in those areas for all races and ethnicities, so by default, a greater proportion of Maori will benefit than non-Maori BUT a greater number of non-Maori with be helped as there are more non-Maori with these problems.

General policies to prevent commencing smoking or support quitting are non-racially discriminating yet will have a large impact on Maori Health as a greater proportion of Maori are smokers than non-Maori. Non-Maori also benefit, in greater numbers, but in a lower proportion. However, what actual programs are used should be decided by public health experts based on evidence and local conditions, not politicians or managers, just like a Board of Trustees shouldn't tell teachers how to teach.

Care must be made to avoid exclusion of people who would benefit from programs to improve health

because of the perception or actual policy that a program is for Maori exclusively. This involves using culturally neutral venues and not having programs only available to Access PHOs (that do receive ethnicity based funding). Care must also be made not to exclude people who, for whatever reason, are not part of the PHO system (ie just under 10% of the population), as many of these people have high health needs (and many are Maori).

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