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Funding Primary Care for Better Outcomes

Abstract

This article reviews a recent report advocating transformational change in the funding and recruitment of staff for Aotearoa New Zealand's primary care services, including taking a social investment approach to the funding of primary care. The article develops these arguments and discusses new accountability frameworks for primary care delivery, including financial incentives for improving treatment of chronic conditions and collaborative approaches to community-led initiatives to promote preventive healthcare, drawing on a wide range of literature, including mātauranga Māori.

Keywords social investment, financial incentives, preventive primary care

A recent report from the New Zealand Initiative (Gorman and Horn, 2023) makes some wide-ranging comments about how to improve the performance of primary care with respect to managing and reducing the burden of chronic disease on both patients and their carers and our general practitioners. It rightly advocates a once-in-a-generation paradigm shift in how we recruit and support general practitioners, who are on the front line of diagnosis, treatment and referral of patients in our national health system. This is indeed part of the story of how we might develop responsive healthcare services to achieve better health outcomes for New Zealanders, but there are many factors which need to be considered as we evaluate this situation.

The report identifies funding frameworks for primary care as key to improved performance by primary care practitioners and makes many claims about the efficacy of our current primary care funding system. In particular, it critiques capitation as non-accountable, while acknowledging that a component of capitation is necessary in the funding framework for general practice. The dilemma of how to best fund general practice is as old as our health system, and nearly derailed the introduction of that system in 1938 when general practitioners throughout New Zealand successfully rebelled against the Labour government's goal of making their services free at point of care to all New Zealanders. The New Zealand Initiative report proposes some alternatives to the current mix of fee for service, subsidies and capitation payments, which are well founded. The report also recommends taking a social investment approach to funding of healthcare and this holds much promise.

Aotearoa New Zealand is a world leader in the application of a form of social investment in a wide range of social and public policy areas. The New Zealand Initiative rightly identifies the Accident Compensation Corporation (ACC) as the progenitor of this approach in the management of the treatment and rehabilitation of accidentally injured New Zealanders, which has a framework for calculation and management of forward liability for every claim as its funding

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model. Expanded for use in a number of government departments, including child welfare and welfare benefit management, the social investment approach is now supported by a dedicated Social Wellbeing Agency, which manages the integrated data infrastructure necessary for the analysis of statistics and the targeting of investments which underpin such an approach. Boston and Gill (2017) chart the evolution of the social investment approach in Aotearoa New Zealand as it successfully navigated a change of government and resolved some disquiet about its approaches and use of data to solve public policy problems.

Goijaerts, van der Zwan and Bussemaker (2023) consider the impact of social investment approaches in preventive healthcare and are unequivocal in their championing of the utilisation of social epidemiology in support of the goals of the welfare state to maintain a healthy and productive workforce, advocating that we study health not as an outcome of the healthcare sector but of the welfare state as a whole. They argue that the social investment framework facilitates these endeavours and see health not just as an outcome of specific policies, but rather as input for a sustainable welfare state:

> By integrating health into the social investment framework, we have shown how the stock, flow and buffer functions could be understood, when including health. The stock function could be extended to include health prevention programmes, especially for children. The flow function could be strengthened with the understanding that health is an essential life-course transition, determining when people potentially exit and re-enter the labour market. The buffer function is crucial in a health perspective on the social investment framework, since social protection in itself is an investment in a healthy population and should thus no longer be understood exclusively as 'old' social spending. (Goijaerts, van der Zwan and Bussemaker, 2023, p.841)

If we look at this issue through the lens of a particular condition, diabetes, which presents a great burden of disease in Aotearoa New Zealand not only to the patient and their whānau, but to the healthcare sector and our economy, then we can see that in other similar jurisdictions, the funding of general practitioners affects the way that these chronic conditions are managed. Key to this is the development of 'a more constructive relationship with general practitioners [which seeks] to resolve the problem of access' (Smith, 2021).

Unfortunately, Aotearoa New Zealand lacks a collaborative relationship between health policymakers and the general practice profession. This reflects a history of mutual disengagement and suspicion dating back to the genesis of our national health system and the struggle over how to pay doctors. In the process of implementing the current health reforms, the general practice profession has claimed to be under-consulted, despite the centrality of community- and home-based services to the new business model for health delivery. It is vital for this key group of stakeholders to be actively engaged in the development of new initiatives to support general practice and to encourage greater confidence in the general practice community about a well-funded future for their profession.

Part of the problem relates to the structural arrangements for relationships between the state and the general practice community. To present an alternative scenario, the relationship between the state and the general practice community in England is very close: there are annual negotiations on behalf of all general practitioners, conducted by their union, the British Medical Association, with the government setting wide-ranging funding parameters covering pay and incentives for particular quality outcomes, staffing type and remuneration, equipment and premises provision, and pensions. In Aotearoa New Zealand there is no single union for general practitioners, and thus no framework for the development of a unified and trust-based relationship such as exists in England. The current contract for general practice services in England is based on multi-year funding at a generous level, and includes an imaginative set of strategies to offset general practitioner staffing shortages through the recruitment of pharmacists, physiotherapists, practitioners to support take-up of social and lifestyle programmes, and paramedics to offer services in place of general practitioners wherever possible.

Taking a social investment approach to management of chronic conditions within primary care services immediately animates the business case for unlocking the extra spending necessary to fulfil some of the conditions said to be necessary for a rejuvenated general practice sector in Aotearoa New Zealand – expenditure to train more doctors, improved working conditions to retain existing doctors, nurses, and other allied health professionals who are engaged in the delivery of preventive healthcare and other services, reduction or elimination of co-payments paid by most patients to attend

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general practice consultations, and investment in new forms of data-based and digital aids to healthcare delivery.

Critical to the implementation of such an approach would be the development of a shared vision and long-term strategic plan to address the current workforce, access and funding challenges. In England this was resolved with the decision to implement a five-year funding framework, supplanting annual funding allocations. This resulted in the development, jointly between the general practice profession and NHS England, of a Five Year Forward View (NHS England, 2014). The mix of funding certainty and clear negotiated targets for general practice performance appealed to politicians and the profession alike, and has provided a well-defined road map for annual contract negotiations for the last eight years.

If such a process were to be followed in Aotearoa New Zealand, some of this new funding could be subject to meeting new accountability targets. As a result of the close working relationship between the state and general practitioners in England, the two parties have been able to negotiate targets for best practice treatment of chronic conditions such as diabetes, and reward general practitioner compliance with these standards through payment of financial incentives to the practice. The English Quality and Outcomes Framework for incentivising best practice care has been in place since 2004, and was recently subject to a comprehensive review which engaged general practitioners in deciding its future. Its value was upheld and it continues to reward preventive care and quality management of chronic conditions (NHS England, 2018). New Zealand introduced a smaller scheme in 2007, with less constructive discussions with general practitioners about its design, but abandoned it in 2017 (Smith, 2018). There is an opportunity to reconsider whether such initiatives could focus attention and effort on the management of the debilitating conditions which consume so much of general practitioners' time.

A key element in meeting the challenge of chronic health conditions is their disproportionate incidence in communities of poorer citizens with reduced access to and confidence in mainstream healthcare services. Bridging this delivery gap is crucial to improved preventive healthcare. A major task for Te Aka Whai Ora (the Māori Health Authority), for instance, is to explore the commissioning of culturally appropriate and accessible services for such Māori communities. In this regard, Durie sets out a framework for the delivery of public health services which is grounded in mātauranga Māori (Durie, 1999) and which enlists Māori community leaders in the design and promotion of preventive healthcare strategies in their own local areas. Collaboration with initiatives such as Whānau Ora would be a key element of such an approach. This service, implemented in 2010, is designed by Māori to assist Māori to navigate through complex mainstream services, achieving goals set by the whole whānau together with their ill member rather than health professionals (Smith et al., 2019). In this regard, it would be an appropriate role for the localities within the new health system to facilitate such service development. By building relationships between communities with particular needs and their leaders, the primary care providers delivering services in those regions, and national funders of these services, new programmes which reflect local needs, resources and the aspirations of each community can be implemented.

In short, Aotearoa New Zealand has many elements of a nuanced response to the funding and delivery of general practitioner services already in place and which can be leveraged to target chronic conditions and the communities they ravage through the use of established public policy approaches. Such a response requires a mix of funding mechanisms, including capitation, fee for service, and, it can be argued, incentives for best practice which, if funded on a social investment model and negotiated carefully between the general practice profession and Te Whatu Ora (Health New Zealand), might transform the lives of both patients and providers within primary care.

The New Zealand Initiative is to be commended on its timely, wide-ranging and critical analysis of a pressing health policy issue and has set the scene for a credible debate between the general practice profession and its funders. Much depends upon the forging of a new and collaborative relationship between the profession and its funders. Only then will it be possible to design and implement new modes of funding and delivery which can secure the widespread buy-in of general practitioners, other health professionals, patients and their whānau.

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