What’s going to happen in 2013?
Kate Baddock

First of all, I hope you all had a great Christmas and New Year. And that you managed to get some time with family and friends away from the constant demands of general practice, for 2013 may well be a year that brings challenges, threats and opportunities.

This is the second year of the second term of the incumbent Government. There is a window of opportunity to make changes that they may want, before their focus shifts to winning the next election.

The primary care contract is up for renewal this year, which offers a vehicle for the Government to accelerate change. So, we may well see changes in targets to support the service outputs and outcomes the Government would like primary care to deliver.

And, if there are to be any radical, undesirable, undesired or unpalatable changes to the healthcare system, this will be the year they happen.

Some of those changes have been signalled already. For instance, pharmacists taking on more vaccinations, including those funded by Government. For the past two years or more, qualified and certified pharmacists have been able to apply to provide a vaccination service. This coming year there are indications this is being expanded to funded vaccinations. This may be the beginning of travel vaccinations being offered by pharmacies, as is the case in other countries. And where might that lead?

Leaving vaccinations for a minute, what about point-of-care testing? Many practices, especially those in more rural or remote areas, have trialled point-of-care testing, particularly strep testing, INRs, troponins and blood sugars – to name but a few. But the Government and community laboratories have been reluctant to engage in contracting for that service with general practice and the cost-benefit has not been there.

Practices that have persisted with point-of-care testing have often done so at a financial loss. INR testing is a perfect case in point. Despite its obvious advantages in terms of patient satisfaction and timeliness it costs less to use the laboratory testing than to do point-of-care INRs. Unless, of course, you factor in doctor time, which most doctors don’t charge for, then point-of-care testing becomes a viable option, except that the Government will only contract with pharmacists.

The expansion of point-of-care testing will happen, I’m sure, and general practice needs to be lobbying for its inclusion in practices as well as allowing it in pharmacies. Another area where I believe we will see expansion is the drive for registration of patients with particular pharmacies. Already with the new community pharmacy contract there is a requirement for a patient allocated to the long-term conditions care programme to be registered with a particular pharmacy. It is only a small step to then link funding to that registration - which might then be used to manage other parts of patient care.

Another development is the evolving role of physician assistants - to use the American phrase - although here they are mainly in primary care roles.

The current trial involves four general practices and one emergency department. These PAs are being employed by their practices over the next two years, but their role is being evaluated by Health Workforce New Zealand. The evaluation design is being developed by an independent organisation with much more robust methodology.
than the initial demonstration. In parallel to this is the evolving role of nurse practitioners and their place in the healthcare system.

Last, no discussion on primary healthcare in 2013 would be complete without reference to the new and emerging business models of general practice. With the average age of GPs in their mid-50s, it is no wonder individual doctors are looking to succession planning. Many have been owner/operator models and an obvious way of planning retirement is to look at selling the practice but continue to be employed at it for a period of time.

There are various equity models from 20 to 100 per cent but the driver for some is to make a profit from general practice (or reduce loss elsewhere). And, where those buyers are corporate entities, there is always the possibility the profit motive has the potential to risk patient care. General practice needs to beware of this when making decisions about selling practices.

An emerging player in this, though, are the PHOs themselves - or arms' length subsidiaries - that may look to have an equity share in practices. This development may offer features that doctors considering selling their practice should bear in mind.

The Government is looking - through DHBs - to have a closer relationship directly with practices (particularly larger ones that offer the possibility of community-based services from the hospitals) and the PHO purchase of practices would allow this to be centralised, managed and coordinated by primary care.

All in all, 2013 looks to be an interesting year for primary healthcare and GPs.

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