Where has all the money gone? Not to GPs’ business growth

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Cheaper access to the doctor costs the Government more, but does not mean more money in total

Since 2003, large amounts of money have been poured into general practice with very little improvement in healthcare to show for it.

That's a view Ministry of Health and Treasury officials often propound. They cite, for example, capitation funding having increased from $405 million in 2004/05 to $737 million in 2010/11.

Prior to 2003 and progressive introduction of capitated funding under the Primary Health Care Strategy, it was clear that government funding was attached to the patient.

When you saw someone, there was a government subsidy for that visit, and a fee to the patient.

Since the advent of capitated funding, this has become blurred.

Part of the reason lies in the fact the capitated funding is only partial, so there is still an element of fee-for-service in healthcare delivery by GPs.

So capitated funding is seen rather more as a subsidy for the patient, paid on a quarterly basis, and rather less as a fund to cover the responsibility for the total care of that same patient.

'Dummy' GMS

Many general practices still operate a "dummy" General Medical Subsidy (GMS) system to calculate their distribution of overheads and payments to doctors, and do not think in terms of populations but in terms of individual patients.

As capitation has been increased, the copayment (or fee) to the patient has been reduced. This has resulted in cheaper access to the doctor and to primary healthcare, but it has not meant that more money in total is moving into primary care.

It has simply meant that third-party payment (the Government) has increased at the expense of patient payment.

On that basis, why would the Government assume that this would result in better healthcare?

Meeting health targets

Many targeted programmes have been run, aimed at meeting certain health targets set by the Government, and these have been separately funded through PHOs.
They include Care Plus, CVD risk assessments, Diabetes Get Checked and asthma clinics. But it would be naive to suggest that these change the basic work of general practice.

New Zealand cannot afford fully government-funded general practice; we have a mixed model of private and public funding with variable patient payment.

While it is true that the balance has shifted with more public funding, for most general practices the split is 50:50.

This means GPs continue to rely on seeing patients, and receiving their copayments, to keep their practices viable.

The Government, meanwhile, would like general practices to take a population health approach to their patient populations and keep them well.

Keeping patients well and healthy is an admirable goal but it costs; and to meet those costs, GPs need to see patients.

This leaves less time than is desirable to keep people well and away from general practices and hospitals. You begin to see the problem.

**Time and education**

One of the main issues regarding wellness is around empowering patients - which takes time and education and, arguably the most important and least addressed, improvement in health literacy.

How are people meant to look after their own health issues when they may not know:
- how to negotiate a general practice visit (signage, access, directions, different people in different roles)
- how to understand what is being said to them
- how to ask questions
- how to understand their health issues
- how to manage their health issues, and
- how to use any medicines they may have been prescribed.

That's just the start of a long list of "hows". I tackled this subject in these pages nearly two years ago (*New Zealand Doctor*, 6 June 2012).

So the money has not gone anywhere, except to make it easier for patients to access primary care.

To do more needs a different mindset and a different approach.

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