A response to: The ‘elephants in the room’ for New Zealand’s health system in its 80th anniversary year: general practice charges and ownership model

Kate Baddock, Jan White, Lesley Clarke

Professor Gauld et al’s editorial calls for debate on GP fees and ownership models without acknowledging the good-quality care GPs provide; we see this as an inherent failure in the paper.

In New Zealand GPs work hard, providing the public with an excellent standard and quality of care. They have shown themselves to be adaptable and have evolved smoothly from the solo practitioner often working from the family home to many different iterations. They have also shown themselves to be willing early adopters of new technology and ideas. Any debate on the health of New Zealanders involving changes to the GP ownership model must not disregard the value currently provided by GPs under the current models.

The authors of the editorial state that further research is needed but imply that GP fees and current ownership models need to be discarded. This would be a mistake as, although we acknowledge there are issues that need fixing such as equitable access for all our patients and a funding model that works to address this (and other) inequities, general practice does work.

We note that the editorial stemmed from a panel discussion that the authors participated in hosted by the Centre for Health Systems and Technology at the University of Otago on 30 July 2018. This may go some way to explain how the authors have failed to back up some of their subjective comments including their view that private general practice providers are less likely to cater to diversity. As well as being wrong, this is insulting to all doctors and especially GPs working in public and/or private practice, as GPs cater to a wide range of ethnicity, geography, sexual orientation, age, religious beliefs, different experiences and backgrounds and want better health for all their patients.

The two published papers referenced in Table 1 were an editorial by Les Toop and a viewpoint paper by Peter Crampton in 2005 based on 2001 information that was pre-PHO data. Almost 20 years later the primary care environment is very different to that prior to the development of PHOs. Since 2005 we have seen the rollout of capitation, the advent of Very Low Access practices, the evolution of Independent Practitioner Associations (IPAs), Primary Health Organisations (PHOs) and Primary Care Networks. Very different to fee for service, General Medical Services (GMS) payments, and no subsidies for a substantial part of the population.

Other points of concern include the statement that DHBs are funders of public hospitals, ignoring the fact that they are expected to fund the health of populations. There is certainly not equity in the public health system at the moment, so one wonders why would GPs believe they would get adequate funding if the DHB was responsible for it?
Furthermore, the statements: “patient fees have arguably played a part in this ranking” and “there is growing, anecdotal agreement within the GP community that cost has become an unacceptable barrier for many people accessing general practice service in New Zealand” are unsupported assumptions with no place in any meaningful debate as the implication is that patient fees are the barrier to general practice healthcare. We need only look at the data presented in the editorial that suggests that in the NHS some 7% of patients do not access healthcare, citing cost as a barrier—and this is in a system which has no patient fees.

In terms of business ownership models there are changes afoot internationally, most recently in the UK where a new GP contract deal is being developed that may be a game changer for primary care. There is also new research in the US that receipt of primary care was associated with significantly more high-value care, slightly more low-value care, and better healthcare experience. Policymakers and health system leaders seeking to improve value should consider increasing investments in primary care. While we may agree that “most GPs have benefitted from increased capitation payments but remain(ing) reliant on patient charges for a significant portion of their income”; the questions remain, should general practice be completely funded by third parties so that it is free to patients at the point of care? What would this mean for patients in the future? What would it mean to new GPs? And what would it mean to GPs who own their own general practices? Should funding belong to the patient?

Other unanswered questions include: would GPs retain autonomy over how a practice is run; would the government buy practices from owners who have invested hundreds of thousands of dollars in establishing them; would the pro-rata basis guideline of 1,250 patients per GP continue?

To fully answer these and other questions we welcome evidence-based dialogue taking account of all that general practice currently does.

However, any new model must provide confidence to current and future GPs that it will enable the best primary healthcare available, and that it will be both funded satisfactorily, maintained over time and indexed to the Health Inflation Index.

NZMA wants to ensure that its GP members’ voice is heard in this debate and to that end will be asking its members for both their thoughts and comments, which will inform future conversations with policy makers.

Further change must be clearly thought through and it is vital that GPs and GP leaders are involved from the start in both the discussion and the decision making, otherwise a profession that is already facing workforce challenges may be left in a perilous state.

It is with some concern that we note that Peter Crampton is both a co-author of the original editorial and a member of the Health and Disability Sector Review panel and this interest was not declared. We would hope that his thoughts as expressed in the editorial do not predicate his stance on the panel.
LETTER

Competing interests:
Nil.

Author information:
Kate Baddock, Chair, New Zealand Medical Association, Wellington;
Jan White, General Practitioner, Mt Eden Medical Centre, Auckland;
Lesley Clarke, Chief Executive, New Zealand Medical Association, Wellington.

Corresponding author:
Kate Baddock, Chair, New Zealand Medical Association, Wellington.
kateb@kawaubayhealth.co.nz

URL:

REFERENCES:
2. http://www.bmj.com/content/364/bmj.l531
3. http://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2721037?guestAccessKey=0983f57a-7a4e-480a-b0b4-7bcc2c6649b