

# How general practice is funded in New Zealand

Laurence A Malcolm

How general practice is funded in New Zealand depends upon an answer to the question “This week or next?”! General practice, and primary healthcare generally, is currently undergoing a revolution greater than anything since the early 1940s, when government funding of general practitioners was introduced. GPs then successfully argued for the “sacred” right to charge a fee commensurate with their services, making them unique compared with similar countries, including Australia. Substantial patient copayments resulted, rising at times to more than 80% of practice income.

In the early 1990s, the government introduced a “community services card” (CSC) for people on below-average incomes. Currently, the threshold for this is NZ\$21 913 for a single person and NZ\$31 225 for a married couple, and rises with number of children. The CSC entitles holders to higher subsidies, including for prescriptions, but the quid pro quo was the removal of all government subsidies for adults on above-average incomes, including the elderly. However, the government proportion of GP funding remained low, averaging about 30% of practice income.<sup>1</sup>

With this underfunding, many GPs became Robin Hoods, charging minimal or no fees to patients who could not afford to pay, with some compensation from their well-off patients. Many (understandably) located themselves in more affluent areas.<sup>1</sup> Hence, central Aucklanders have 800–900 population per GP, whereas more disadvantaged populations have almost twice as many people per GP.<sup>2</sup> Of course, the Robin Hood system did not work for practices serving predominantly poorer and disadvantaged (including rural, Māori and Pacific Islander) populations.

Radical organisational reforms in 1993<sup>3,4</sup> encouraged GP leaders to voluntarily form independent practitioner associations. Similar to Australian Divisions of General Practice, these primary care organisations (PCOs) rapidly expanded to include 85% of GPs by the end of the 1990s.

PCOs took on the financial management of pharmaceutical and pathology services to improve quality use.<sup>1,3-5</sup> Savings from this were used to promote other services, such as vaccination, smoking-cessation programs, chronic disease management and terminal-care services. They were also used to remunerate GPs and associated services (eg, free nursing and radiology services for community-based alternatives to hospital admission). This was never called fundholding, the term for a scheme implemented, then abandoned, in the United Kingdom.

The real revolution began in 2000, with the New Zealand Public Health and Disability Act. This established 21 decentralised and population-based district health boards (DHBs) providing public

## 1 General practice funding in New Zealand, by type of organisation to which GPs belong

	Non-PHO organisation and individual GPs	Access PHOs serving high-need patients	Interim PHOs serving other populations
Current and expected GP membership	20%–25%, diminishing rapidly	20%–25%, increasing	50%–55%, increasing
Current government subsidy for GP (includes practice nurse at \$1.70 per consultation)	Fee-for-service claims \$0–\$35 Average \$13 per consultation	Capitation payments for enrolled population Average \$24 per consultation	Average \$15 per consultation
ACC subsidy per consultation*	\$2.00	\$2.00	\$2.00
Patient copayment†	\$0–\$45	\$0–\$20	\$0–\$45, and reducing
Special funding groups	Extra funding for low-income and high-need patients	Aged under 6 years, \$35 per consultation; aged 6–17 years and high users, and (from 1 July) aged over 65 years, \$26 per consultation	
Expected subsidy trends over next few years	Expected to diminish to insignificance over next year	All to be based on Access formula	To become equivalent to Access PHOs over time

ACC = Accident Compensation Corporation. PHO = primary health organisation. \* ACC funding for treatment of injuries is paid as fee for service, averaging \$2 per consultation, or \$30 for all consultations. † Patient copayment is paid as fee for service.

hospital services and managing government funding of all health and disability services, including primary healthcare.

In 2001, a new government primary healthcare strategy launched the evolution of PCOs into broader primary health organisations (PHOs).<sup>6</sup> These are needs funded and serve defined populations enrolled in member GP practices. They provide population healthcare as well as treatment services, involve communities in their governance, and are multidisciplinary. GP membership is voluntary. This strategy is supported by the New Zealand Medical Association and the Royal New Zealand College of General Practitioners, but there is ongoing criticism over the implementation process.

Two forms of PHOs have been established, the first (Access PHOs) serving disadvantaged populations. The remainder are called Interim PHOs, in the expectation that Access funding will eventually apply to all PHOs. An alternative strategy, Care Plus, is being launched to fund the needs of individual high users. The different levels of funding are shown in Box 1.

## Disadvantages of the current system

The additional funding still covers less than half of the cost of running a general practice. More has been promised after 2005 by

### Aotearoa Health, New Zealand.

Laurence A Malcolm, MD, FRCPE, FFFPHM, Professor Emeritus and Consultant.

Laurence A Malcolm is Professor Emeritus and former Professor of Community Health at the University of Otago. He has extensive New Zealand and international experience in health services development, especially in primary care.

Reprints will not be available from the author. Correspondence: Professor LA Malcolm, Aotearoa Health, RD 1 Lyttelton, New Zealand. [lm@cyberxpress.co.nz](mailto:lm@cyberxpress.co.nz)

**2 Features of New Zealand primary health organisations contrasted with Australian Divisions of General Practice**

Feature	Australia	New Zealand
Organisation	Divisions of General Practice	Variable, but primary care organisations forming into PHOs
Roles	Largely GP focused	Broad primary health/ population focus, multidisciplinary, strong community participation
Membership of organisation	Based on geographic location	Chosen by practice from local options
Health services funding	Fragmented between federal and state levels	Fully integrated through district health boards
Government payment/subsidy for services	Open-ended fee for service. AMA strongly opposes capitation	Rapid progress towards universal capitation
Patient copayment	Small but increasing	Large but decreasing
Organisational accountability for primary-care-related expenditure (eg pharmaceuticals)	No direct financial accountability and resisted by AMA	Well accepted. Expenditure to be in PHO budgets
Ability to shift resources (including savings) from low- to high-priority services	Nil. No referred-services budgets and hence no incentives or ability to make savings	Substantial. Expected to increase with global budgets for PHOs
Models of service integration, including primary/secondary	Limited to selected high-risk diseases and local initiatives	Wide-ranging developments (eg, community alternatives to acute hospital admission)
Relative power balance between primary and secondary care	Hospitals in a much stronger position than primary care	Improving balance through government policy and DHB and PHO collaboration
Quality improvements in primary care	Largely "top down" and through local initiatives	Major improvements driven by clinical leadership

AMA = Australian Medical Association. DHB = District health board. PHO = Primary health organisation.

populations to those below equity, but the funding distribution may be vital to improving the health of the disadvantaged.

**Relevance to Australia**

Is this relevant to the future of Australian general practice? Almost certainly, given the recommendations of the 2003 Review of Divisions.<sup>8</sup> A comparison of primary care in both countries (Box 2) suggests that New Zealand is some 10 years ahead,<sup>9</sup> with a more integrated and influential primary healthcare service. Although the organisational upheavals and additional paperwork have been traumatic for many GPs, the prospects of improved care and better outcomes for patients and communities, while yet to be proven, appear to be good.

**Acknowledgements**

I am grateful for comments on an earlier draft of this article from the Chairman of the NZMA, the CEO of the RNZCGP, staff of the Ministry of Health and two reviewers.

**References**

- 1 Malcolm L, Wright L, Barnett P. The development of primary care organisations in New Zealand: a review undertaken for Treasury and the Ministry of Health. Wellington: Ministry of Health, 1999. Available at: [www.moh.govt.nz/moh.nsf/wpg\\_Index/Publications-Index](http://www.moh.govt.nz/moh.nsf/wpg_Index/Publications-Index) (accessed Jun 2004).
- 2 Malcolm L. Major inequities between DHBs in referred services expenditure: a critical challenge facing the primary health care strategy. *N Z Med J* 2002; 115: 1157.
- 3 Malcolm L, Mays N. New Zealand's independent practitioner associations: a working model of clinical governance? *BMJ* 1999; 319: 1340-1342.
- 4 Coster G, Gribben B. Primary care models for delivering population-based health outcomes. Wellington: National Advisory Committee on Health and Disability, 1999.
- 5 Malcolm L, Wright L, Barnett P, Hendry C. Clinical leadership and quality improvements in primary care organisations in New Zealand. Auckland: Clinical Leaders Association of New Zealand, 2002. Available at: [www2.clanz.org.nz/downloads/](http://www2.clanz.org.nz/downloads/) (accessed Jun 2004).
- 6 The primary health care strategy. Wellington: Ministry of Health, 2001.
- 7 Referred services management: building towards equity, quality and better health outcomes. Report of the Referred Services Group to the Ministry of Health. Wellington: Ministry of Health, 2002. Available at: [www.moh.govt.nz/moh.nsf/wpg\\_Index/Publications-Index](http://www.moh.govt.nz/moh.nsf/wpg_Index/Publications-Index) (accessed Jun 2004).
- 8 The future role of the divisions network. Report of the Review of the Role of the Divisions of General Practice. Canberra: Commonwealth of Australia, 2003.
- 9 Malcolm L. Australian GPs are beginning battle faced by other countries. *BMJ* 2002; 325: 167.

(Received 16 Mar 2004, accepted 25 May 2004)

□

the Health Minister, "subject to the availability of funding". A particular issue is the inequity between the two forms of PHOs, with funding being based upon the level of disadvantage of the enrolled population rather than individual need. Hence, poorer patients in Interim PHOs remain disadvantaged. The Care Plus strategy is an attempt to rectify this.

From late 2004, PHOs will be required to manage equitably funded budgets for pharmaceutical and pathology services, commonly called "referred services",<sup>7</sup> in a more formal process than PCOs used. There is clear evidence of serious inequities in current referred-services expenditure.<sup>2</sup> This will mean significant shifts of expenditure from practices, PHOs and DHBs serving well-off