COVER STORY

Boiled frogs, tight nooses: The making of a PHO contract

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The boiling frog that is the annual capitation review process continues to endure [Image: Adobe Photoshop AI generated image]

Another year, another annual increase offer rejected for failing to recognise the ever-growing crisis in general practice. How did we get to this “boiling frog” moment? **Fiona Cassie** looks at the past and future of general practice contract negotiations

In 2003, a GP leader wrote a grim, some might say prophetic, warning about the risks of primary care's new contract in the making.

Unless the new funding contract was "truly negotiated" with the Government, said specialist GP Doug Baird, "it will be a noose that will rapidly tighten around the necks of all of us in general practice".

More than two decades later, some might argue the noose is now well and truly tightened. General practice is at a crisis point – long warned about – as underfunding and understaffing put primary care under intense pressure and vulnerable practices at the risk of failure.

There are many factors to this crisis, but some point to funding contracts and mechanisms negotiated in the early days of the millennium, which evolved into the current PHO Services Agreement process, as a significant contributor to too many patients today struggling to join a practice or get a timely appointment (see timeline below).

As early as 2008, the primary care sector talked about a breach of contract as capitation increases first fell short of cost pressures. Over the years, those murmurs grew to a loud rumble about PHO Services Agreement funding failing to keep up with the growing costs, diversity and complexity of primary care or to address patient need.

Roll on to this month when the Government's annual funding increase was, once again, unanimously rejected as "absolutely inadequate" by the PHOs, who are the 30 direct signatories to the agreement, and by the PHOs' "contracted providers", that is, the country's 1000 or so general practices.Once again, the Government forced through the annual increase under the "compulsory variation" clause of PSAAP.

PSAAP is the snappy acronym (not) for the flawed PHO Services Agreement Amendment Protocol negotiation process, through which PHOs and contracted providers have called for funding reform for more than a decade (see panel: Snappy acronym no.1).

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So, how did we get to this "boiling frog" moment for primary care funding?

In the early 2000s, general practice sustainability was also under threat, with *New Zealand Doctor Rata Aotearoa* reporting in 2001 of a Christchurch GP advertising to give his practice away and an Auckland GP walking away from his group practice. Eroded government funding and rising patient fees were also impacting patient access.

Then, also in 2001, came the Primary Health Care Strategy, the biggest shake-up in primary care funding for 60 years. The General Medical Services (GMS) subsidy, introduced in 1941 as a now much-depleted fee for service subsidy, was to be replaced by capitation or annual perpatient funding.

The Labour-led Coalition Government aimed to win over general practice to the strategy's broader reform ambitions through a $500 million boost in annual funding. In return for rolling out the capitation-based funding boost by 2007, the health system wanted practices to lower their patient fees initially and then only increase fees annually by an inflation-based figure.

The strategy also created primary health organisations (PHOs) to progress the reforms and be the "middleman" between the Government and contracted general practices.

The reform's aims of improving access, reducing inequalities and encouraging multidisciplinary approaches are greeted with high hopes by Māori, Pacific and high-needs provider groups, some of whom quickly formed PHOs, as well as by nursing and allied health. Many of these early PHOs with high-needs populations promptly signed up to PHO agreements offering higher "access" capitation funding in return for lower fees than their "non-access" counterparts. This capitation funding distinction continues today. Later, in 2006, individual high-needs practices could also sign up for the Very Low Cost Access scheme, which offered a funding top-up in return for capping adult fees at then $15 (now $19.50), with VLCA practices today some of the most vulnerable and squeezed in the country.

More wary in its reforms response was the Independent Practitioner Association Council, representing the 84 per cent, mostly “non-access”, general practices belonging to IPAs.

Dr Baird’s “noose” comment came in a 2003 column he wrote as IPAC deputy chair advising GPs and IPAs not to sign a draft national PHO contract as it gave the Government too much license to “interfere” with practices’ “clinical and business autonomy”.

GPs battled for 60 years to retain the right to set and charge patient fees, so there was strong resistance to the latest reforms regarding fees control (see timeline).

More money and flexibility won over many mainstream practices to capitation funding. Eventually, IPAs, by either becoming PHOs or creating a PHO arm, went on to sign PHO funding contracts one by one.

A Christchurch accountancy firm at the time told *New Zealand Doctor* that some of its GP clients were earning 30 per cent more in 2006 than they did in 2004. GenPro chief executive Mark Liddle was the inaugural practice manager for a big, new Tauranga practice at the time and recalls that “initial capitation was enough money to innovate and do things slightly differently”.

But, as the millennium's first decade progressed, frustration was already emerging over two aspects of PHO contract funding that continue today. First, there were concerns that the value of capitation was already starting to be eroded (but our metaphorical "frog" is still reasonably relaxed bathing in a lukewarm pot at this stage). Second, the funding boost and capitation mechanism introduced via the contract were not delivering the flexible models of care or equity improvements hoped for.

By 2006, a group of Māori providers and PHOs, initially optimistic that the reforms would improve Māori health outcomes, file a Treaty of Waitangi claim, saying they are disadvantaged by the rollout of the 2001 Primary Health Care Strategy.

That claim is a forerunner of what becomes the long-running Wai 2575 claim, with the Waitangi Tribunal stage one report in 2019 finding that the Crown breached the Treaty. It included the Crown failing to “properly fund the primary health sector to pursue equitable health outcomes for Māori” by not targeting funding or ensuring money earmarked for Māori health issues was used for that purpose.

The 2022 Sapere report, *A Future Capitation Funding Approach*, was commissioned as part of the health reforms process by the Transition Unit to examine addressing “fundamental problems” with the capitation formula, including that the Wai 2575 claim “clearly” established that the “current funding mechanism for primary health care is inequitable”.

That report raised sector hopes by finding that the country's practices were theoretically running at a loss and suggesting most practices needed capitation rises of at least 10 per cent, with very high-needs practices needing increases of at least 34 per cent. It also found that the current funding approach, weighting capitation funding on age and gender only, embedded historic inequity for Māori and recommended that capitation funding also be based on ethnicity, deprivation and morbidity

To date, nothing has changed. Instead, Te Whatu Ora has commissioned another review from Sapere of capitation and primary care funding, due to report shortly, to inform the agency of capitation "adjustments" that may be required.

> GenPro chair and specialist GP Angus Chambers [Image: Supplied]

By now the “frog” is starting to boil – but did it need to be this way? Right from the start, all PHO funding agreements have included a clause stating the Government’s intention to “regularly adjust” capitation funding to maintain its value. A PSAAP process involving the ASRFI, or Annual Statement of Reasonable Fee Increase, (see panel: Snappy acronym No.2) has also existed from the start to negotiate and raise issues with funders over the PHO Services Agreement in all its variations.

“I think it’s a cynical clause myself,” says GenPro chair and specialist GP Angus Chambers. “It is highly likely that the state knew that the clause was unenforceable and toothless.” While PSAAP has had “good people” on all sides over the years, says Dr Chambers, who has sat at the table for over a decade, “it’s never been a true negotiation”, able to make significant changes to the fundamentals of the funding contract.

Justine Thorpe, chief executive of Tū Ora Compass PHO and another PSAAP veteran, agrees that PSAAP is “posed” as a negotiation, but “the core of that agreement is really not negotiable”. So, funding issues raised at PSAAP for over a decade – leading to the 2015 Peter Moodie report on general practice sustainability and the 2022 Sapere report – remain unresolved because the Government cannot commit to resolving them, says Ms Thorpe, chair of General Practice NZ’s CEO forum.

“We’ve got these reports that highlight these engrained, chronic underfunding issues, and nothing ever happens.”

Dr Chambers says GenPro has received legal advice that the PHO Services Agreement is “undoubtedly unfair” but not illegal under contractual law.

“We need to change the fact that contracted providers are not [a signature] party to the actual contract that dictates all the terms and conditions that they have to comply with.”

It is a natural justice issue, he believes, that general practice has no right to take the contract to court to challenge it.

Specialist GP Rawiri McKree Jansen, chief medical officer for the now disestablished Te Aka Whai Ora and former clinical director of the National Hauora Coalition PHO, believes PSAAP lost its way when contracted providers first “threw a grenade” into the works by rejecting a capitation offer and forcing the Government to impose it by a compulsory variation.

Dr Jansen believes that rejection, as a protest against underfunding, predictably lost impact, with funders quickly seeing compulsory variation as an easy option. Or the Government opting, as happened with COVID-19 and nurse pay-disparity funding, to use different mechanisms than PSAAP and the PHO Services Agreement to introduce them.

It would have been “awesome”, he says, if PSAAP had been the platform that supported the funding and model of care changes the Waitangi Tribunal 2575 report says are needed.

“But it’s probably had its day. We probably have to reimagine another forum or vehicle to build that relational space to get the work done.”

> Specialist GP Rawiri McKree Jansen was chief medical officer for the now disestablished Te Aka Whai Ora and is a former clinical director of the National Hauora Coalition PHO [Image: Supplied]

In 2020, there was a thought that PSAAP may have “had its day” with Heather Simpson’s *Health and Disability System Review* report recommending the Government “deliberately move away” from the national PHO Services Agreement within five years.

It’s now two years since Te Whatu Ora replaced the DHBs, and there is no replacement in sight – although there was early talk of a universal base contract for all primary and community healthcare with attached modules for the different services that piqued interest before fading out of the picture.

Work is under way, though, between the sector and Te Whatu Ora living well director Martin Hefford (whose many past hats include being a DHB negotiator for the first PHO contract back in 2003) on the future role of “PHO/meso-level organisations” in the health system.

But nobody expects any change to the PHO Services Agreement or PSAAP soon, certainly not by 1 July next year.

“I’m not sure how much spotlight primary care will get in the next wee while [from Te Whatu Ora] with the commissioner now being put in place with a real focus on turning the hospital challenges around,” Ms Thorpe says. “I think we may have to roll over for a while.”

So, to mix our metaphors, as the noose tightens and the frog boils, the vast bulk of primary care funding continues to be delivered via the PHO Services Agreement and “negotiated” via PSAAP.

It has failed to be a “true negotiation” to resolve chronic underfunding, but, for now, says Dr Chambers, “it’s better to have something than nothing, that’s for certain”.

For (to add another metaphor to the mix): “You’ve got an old car, and it’s beaten up and running poorly, but you wait until you’ve bought your next car before you get rid of your old one. Because, otherwise, you are stuck without transport.”

> Justine Thorpe, chief executive of Tū Ora Compass PHO and PSAAP veteran [Image: Supplied]

TIMELINE

Primary care funding agreement

1941 GMS[1] primary care subsidy introduced after battle by general practices to retain right to set and charge patient fees. GMS remains main government funding source for the next 60 years.

1979 First pilot of capitation[2] funding at Tauranga practice, followed by some Wellington practices in the 1980s and a push in the Midlands region in the 1990s.

1990s General practices start forming independent practitioner associations (IPAs) to manage contract funding. By the late 1990s, about 84 per cent of GPs are with an IPA or similar group.

1993 Introduction of Community Services Cards and High Use Health Cards along with subsidised primary care visits for cardholders.

2001 Primary Health Care Strategy launched, which includes the proposal to increase access and equity by boosting primary care funding and rolling out capitation funding nationwide by 2007. It also creates primary health organisations (PHOs) to implement reform aims and distribute funding to practices rather than IPAs.

2002 First PHOs start forming – “access” funding is offered to PHOs with majority Māori, Pacific or other high-needs populations in return for reducing patient fees. Formal contract talks begin in December on refining a national PHO contract document, known as Version 16, drafted by the DHBs and Ministry of Health (see panel: PSAAP: What’s that again?).

2003 IPAC (the IPA Council) advises all GPs and IPAs not to sign draft national PHO contract as it gives the ministry too much license to “interfere” with practice “clinical and business autonomy”.

2004 DHBs start setting up the first fees review committees to look at practices’ patient fee increases.

2006 The country has 81 PHOs, varying from small Māori provider groups to large former IPAs. The group representing Māori providers and health organisations files Treaty of Waitangi claim over disadvantages in the Primary Health Care Strategy rollout.

The forerunner of the Sapere Research Group report develops the cost-pressure methodology used to set the Annual Statement of Reasonable Fee Increase (ASRFI) and guide capitation increases.

2007 Rollout of capitation complete with funding streams added for ages 25 to 44. Very Low Cost Access scheme introduced under compulsory variation, providing extra funding for signed-up eligible practices in return for capped adult fees of $15. Extra under-6s funding also pushed through under compulsory variation for all practices that agree to charge zero fees to this age group.

2008 PHOs and general practices first raise concerns about the value of capitation funding falling.

2013 A newly negotiated Version 1 PHO Services Agreement, embedding in alliancing, rolled out.

2015 Zero fee doctors' visits for children under 13 introduced.

2018 Zero fee visits extended to under-14s plus capped cheap fees for CSC holders, leading to negotiation of Version 6 of the PHO Services Agreement.

2020 All PSAAP parties (funders, PHOs and practices) “acknowledge that the current primary care funding formula is not fit for purpose”.

2022 Capitation review by Sapere Research Group finds general practice running a theoretical loss of $137 million a year and suggests most practices need a capitation increase of at least 10 per cent.

2024 The Government proposes to waive fees review for patient fee increases up to $65 to make up for 4 per cent capitation increase falling short of cost pressures.

[1] GMS is the General Medical Services subsidy, paid per patient visit, which was first introduced in the wake of the Social Security Act 1938, which aimed to make both hospital and primary care services free.

[2] Capitation funding delivers bulk funding to general practices per enrolled patient (capita). The current formula is based on historic GMS utilisation rates (visits a year) by different age groups in the 1990s.

Sources include:

Gauld R and Mays N. Are New Zealand's new primary health organisations fit for purpose? BMJ 2006; 333:1216–8

Moodie P. Primary Care Working Group on General Practice Sustainability report 2015

Howard M. Government support for primary care: Past and future.

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SNAPPY ACRONYM NO.1

PSAAP: What's that again?

So, what does PSAAP stand for again? The PHO Services Agreement Amendment Protocol.

When did it start and why? The first mention of PSAAP is in 2003. It was a negotiating group set up to nut out the first base contract between the Government and the newly created PHOs.

Who first sat around the PSAAP's table? The first members of the PSAAP included IPAC (the Independent Practitioners' Association Council representing general practice networks), some of the early PHOs, Māori and Pacific groups, the DHBs and the Ministry of Health.

When did grassroots general practice get a seat? Contracted providers got two official seats at the PSAAP table in late 2013, filled by specialist GPs Tim Malloy (for RNZCGP) and Mark Peterson (for the former NZMA). But, unlike individual PHOs, which could each appoint an agent, general practice was limited to two agents selected by the General Practice Leaders Forum.

What does PSAAP actually do? It is the official forum to negotiate amendments to primary care's main contract, the PHO Services Agreement, between the funders (Te Whatu Ora), the contract holders (PHOs) and the PHOs' contracted providers (mostly general practices). The PSAAP has become primarily associated with the sector's annual funding increase, but it can also be used for discussing and working through other policy and operational issues either at formal forum meetings or PSAAP working groups.

Why did PSAAP go into temporary limbo in 2022/23? Formal PSAAP meetings came to a halt in the second half of 2022, largely due to an impasse over who represents general practices under an updated protocol recognising Te Whatu Ora as the sector's new funding agency.

When did general practices get to directly appoint their own PSAAP agents? The impasse was broken at the start of this year after an agreement saw general practices for the first time directly nominate 18 contracted provider agents to PSAAP, including the General Practice Owners Association (GenPro), Hauora Taiwhenua Rural Health Network, RNZCGP and 10 PHOs or PHO collectives.

Does PSAAP have any teeth as a negotiation forum? There's the rub…In 2008, PHOs and general practices started claiming the Government was breaching their contract by not maintaining the value of primary care funding. Only one out of the past six annual funding increases, during the pandemic in 2021, was introduced by a "voluntary variation" to the PHO Services Agreement after getting consensus support from PSAAP members. The sector rejected the other five offers as inadequate before being imposed by "compulsory variation". Many in the sector regard funding offers as a fait accompli, with PSAAP talks leading to only minor tweaks.

So, is PSAAP worth it? Yes, is the consensus. PSAAP is imperfect but it gets all parties around the table with the potential to make positive change for primary care and patients.

SNAPPY ACRONYM NO.2

ASRFI and the cost-pressure formula

From 2002, the new funding contracts with primary care had a clause stating the Government's intention to "regularly adjust" capitation funding to maintain its value.

It is controversial whether the Government has honoured that intention. But a cost-pressure formula guiding that annual funding adjustment for most of the past two decades was developed in 2006 by what is now known as the Sapere Research Group.

With the new contracts introducing fees control on general practices, the now annual Sapere calculation report was first commissioned to provide a methodology for deciding how much practices could increase their patient fees each year. Hence, it is known as the Annual Statement of Reasonable Fee Increase or ASRFI.

The Sapere formula, using a weighted mix of labour, building, material and other cost indexes, retrospectively calculates a percentage figure for what extra costs general practice faced the previous year.

If the Government decides to increase capitation by that cost-pressure percentage then, based on a hypothetical practice getting half of its income from capitation and half from patient fees, a practice can only raise its fees by the same percentage. If, like this year, the Government increases capitation by less than the cost-pressure figure, practices can raise their fees by more to compensate for the underfunding.

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