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Radical funding overhaul key to equity in GP care, says Tauranga GP

Geoff Esterman

Friday 4 October 2024, 03:51 PM

3 minutes to Read

Without restructuring the funding model to prioritise vulnerable populations, the disparities in healthcare access and quality will persist, says Geoff Esterman [Image: Franck V on Unplash]

What's happened to equity and patient-focused general practice care, asks **Geoff Esterman**. He argues for a radical change to health funding

The funding model for general practice in New Zealand is in urgent need of a comprehensive overhaul, not just a tweak of capitation. The current system, based primarily on capitation, patient copayments and limited target funding has been in place for over 20 years. While the transition from fee-for-service to capitation was intended to encourage more preventative and proactive healthcare, it has only been partially successful. Today, it is clear that the existing funding structure is incentivising behaviours that are counterproductive to the goal of delivering high-quality, equitable healthcare.

The capitation model has led to some (not most) practices enrolling as many patients as possible while underserving them, prioritising patients who pay the higher copayments. This means the vulnerable populations, particularly those from high-needs groups such as Māori, Pacific Islanders and Community Services Card holders, are often left without timely access to primary care services, resulting in increased rates and disparity in ambulatory sensitive hospitalisations across the country. These practices are more likely to prioritise patients who can afford higher copayments, leaving those most in need without adequate care.

Practice teams that are focused on doing the “right thing” for patients are becoming worn out, carrying the load for some practices that prioritise profitability over patient outcomes.

Particularly problematic are some larger, profit-driven practices, generally in urban areas. These practices are often not owned by general practitioners and tend to have long waiting times for in-person appointments, forcing patients to rely on virtual consultations or after-hours services for both acute and chronic care. Despite their lack of patient connectivity, these practices continue to enrol more patients.

The issue is further compounded by the fact that increases in capitation funding in these practices is less likely to flow into better patient services and, rather, is retained as profit.

Possibly Te Whatu Ora is aware of this, and presumably, this is one of the reasons why capitation payments have not kept up with inflation.

This situation is exacerbated by the significant influence these practices hold at various levels of the healthcare system, including Te Whatu Ora, primary health organisations and GP representative bodies as they advocate for the status quo rather than change to the system.

When resources are limited, you need to focus the resources on the most at need – ie, the high-needs groups. To do this, you need a funding system that encourages it.

A shift in the funding model is essential to modify the behaviour of the profit-driven practices. If practices are financially incentivised to improve access for high-needs groups and deliver quality care, their focus will change because that will enhance profitability.

Without restructuring the funding model to prioritise vulnerable populations, the disparities in healthcare access and quality will persist.

A new hybrid funding model is needed – one that combines ongoing capitation with patient copayments, a new GMS (fee-for-service) for high-needs groups and more intelligently designed incentivised target funding. The fee-for-service component would ensure that practices are rewarded for seeing high-needs patients, with payments adjusted based on the level of interaction with practice team members. This approach would encourage practices to prioritise the care of vulnerable populations, leading to better health outcomes overall.

The Government, through Te Whatu Ora, must take action to ensure that funding is directed towards those most in need. This requires a shift in focus away from hospitals and towards primary care, where investment has been shown to have the most significant impact on health outcomes. Unfortunately, Te Whatu Ora appears to be repeating the mistakes of the former district health boards, remaining “hospital-centric” and attempting to squeeze efficiencies out of an underfunded primary care system.

For any meaningful change to occur, funding formulas must be restructured to incentivise the provision of care to high-needs groups.

If this is done, all practice teams will become focused on doing the “right thing” for their patients, quality of care will improve, and workforce issues will immediately improve as staff move away from working in the non-connected third-party virtual services space to the more productive and satisfying “in person” roles. As connectivity and whanaungatanga improves, and especially if outcome-driven incentives are implemented for such things as immunisation and cervical screening, these rates will improve along with other health outcomes.

The current funding model for general practice in New Zealand is unsustainable and inequitable. It rewards practices that prioritise profit over patient care and leaves high-needs populations with reduced access to essential services. A hybrid funding model that combines capitation, copayments, fee for service and intelligently designed incentive target funding is a solution. By directing resources towards those most at need, we can improve health outcomes and workforce issues while reducing the overall cost of healthcare in New Zealand.

It’s time for a radical funding change, one that ensures general practice is both a sustainable profession and a cornerstone of a more equitable healthcare system.

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