The 'elephants in the room' for New Zealand's health system in its 80th anniversary year: general practice charges and ownership models

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ABSTRACT

The 2018 year signalled the 80th anniversary of the Social Security Act 1938. In order to implement this legislation, a historic compromise between the government and the medical profession created institutional arrangements for the New Zealand health system that endure to this day. The 2018 year also marked the commencement of a Ministerial review of the New Zealand health system. This article considers two intertwined arrangements which stem from the post-1938 compromise that the Ministerial review will need to address if goals of equity and, indeed, the original intent of the 1938 legislation are to be delivered upon: general practice patient charges; and ownership models. It describes the problems patient charges create, and options for ownership that the Ministerial review might contemplate.

In the UK, 2018 marked the celebration of the 70th anniversary of the founding of the National Health Service (NHS), including the principles on which it was founded and how it functions with its focus on universal access to a full spectrum of services. Yet this was not the world's first effort to create a national health service. Indeed, some 10 years prior, the New Zealand Government passed its Social Security Act 1938.[1] This included goals of creating a national health service, along with other universally accessible state services such as education and social support. As with the NHS, the New Zealand legislation was underpinned by a series of values and principles. For health, and very importantly, these included that healthcare access should be universal and a right, with no barriers for patients to receive needed care; and that all New Zealanders should have equal access to the same standards of treatment.[2]

As noted elsewhere, these goals were not achieved.[2] Instead, a historic compromise following passage of the 1938 legislation between the government of the day and the New Zealand branch of the British Medical Association (NZBMA) led to a very different health system canvas that endures to this day. The compromise followed considerable negotiation between the government and NZBMA.[3] For its part, the government sought to place all health professionals on the government payroll, as is the case for teachers and police in New Zealand. It wanted to expand investment in public hospitals and health services, such as primary care and general practice (at the time, very underdeveloped and only in certain parts of the country), and ensure that barriers—geographical and financial—to accessing care were removed.

Most doctors worked in community settings at the time, with their own practices (and general practitioners (GPs) continue to do so today), and the government proposed a form of national insurance to cover patient costs. This would likely have

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resulted in a form of capitation payment, based on the number of enrolled patients with a practice and no direct patient charges to patients at point of service. The NZBMA's view, strongly held, was that this would erode the doctor-patient relationship. Its argument was that direct patient charges brought a strong focus on accountability to the patient. If a third party, the government, became involved, the 'personal arrangements' between doctor and patient would be affected through shifting a doctor's focus away from the patient and towards the demands of government.[4] While this was in counterposition to the views of the UK BMA's vice-president at the time, who visited New Zealand, and argued that fee-for-service medicine was equivalent to selling goods over the counter, and that doctors should not have to be concerned with presenting an invoice to patients, the NZBMA view prevailed.

The rest is history, and the price of that compromise is still resonating down the years. It is timely, in the 80th anniversary year of the 1938 legislation, to debate the adequacy of the institutional arrangements that resulted from the compromise. It is also timely for such debate as a New Zealand Government health system review, expected to deliver interim recommendations in mid-2019 and a final report early 2020, gets underway. Announced in May 2018, this review, expected to be "wide-ranging and firmly focused on a fairer future", is in response to a series of issues emphasised by the Minister of Health. These include a need to deliver equally well for all, to improve services for increasing numbers of older people and those with chronic diseases, and to focus more strongly on primary and community care in order to reduce pressure on hospital and specialist services. Undoubtedly, and in order to achieve these aims, the review will need to confront how New Zealand primary care and general practice are funded, including whether a break with the past and a completely new model is needed. It will also need to consider interrelated issues of ownership that stem from the historic compromise. The rest of this article outlines some of the issues and debates. It suggests options for the review to consider in terms of patient charges and ownership models, for primary care, general practice providers, and the public—the funders and clients of our health services—to debate.

The problem with patient charges

New Zealand is in a peculiar position when it comes to general practice access and access to other health services. It is considered routine by New Zealanders to pay a fee to see a GP or practice nurse, and broadly accepted as 'how things work' in the health system. Yet all public hospital services, including outpatient and emergency services, are free of charge. One short-lived government attempt to install hospital charges in the early-1990s was a costly failure. In an attempt to balance hospital costs with general practice costs, it was administratively complex and politically damaging.[5] The public and health professionals all know that hospital treatment is accessible, with no payment barrier. It is simply tradition and discouragement that stop the public from using public hospitals more than they currently do for healthcare needs that could be at least as adequately provided by general practice. In general, district health boards (DHBs) as funders of public hospitals have never explicitly sought to move into the general practice market. That said, recognising the financial difficulties for patients who seek hospital consultations, some DHBs, all of which provide public hospital services and fund primary care, have implemented initiatives to encourage seeing a GP as an alternative. These range from providing payment vouchers to be used to access a private GP through to developing free general practice services adjacent to the emergency department.

The combination of fees to see a GP alongside free public hospitals is unusual globally.[6–8] Most health systems feature payments across the spectrum of care, or none at all. The UK NHS provides free general practice and hospital services as was the intent of the New Zealand Social Security Act 1938. The result in New Zealand is a significant percentage of the population routinely reporting service access barriers and avoiding medical and associated services through inability to pay.[9] For example, the 2016/17 New Zealand Health Survey revealed 28% of respondents reporting unmet need for GP services,

with 14.3% citing unmet need due to cost barriers and 20% of those living in the most socioeconomically deprived areas indicating cost as a reason.[10] A 2016 Commonwealth Fund survey showed 18% of New Zealand respondents reporting cost-related barriers to care, behind only Switzerland (22%) and the US (33%). Only seven percent of UK and German respondents reported such barriers, with the Netherlands and Sweden on eight percent.[11]

Clearly, general practice and other payments pose a challenge for many New Zealanders and place them in an unenviable position. Barriers to GP services are inequitably distributed with highest rates among Māori, Pacific and those living in socioeconomically deprived areas.[10] These barriers and their impacts are reflected in The Commonwealth Fund's 2017 data, which show New Zealand ranked eighth out of 11 countries for health equity.[12] Patient fees have arguably played a part in this ranking.

The cost barriers persist despite considerable government investment via the Primary Health Care Strategy of the 2000s, and associated development of Primary Health Organisations (PHOs), with goals of reducing charges for enrolled patients.[13] Funding to reduce charges was provided on a population basis, meaning some PHOs and associated general practices continue to have lower charges than others.[14] Those on lower-incomes in higher socioeconomic status areas have smaller capitation subsidies unless they have a Community Services Card, while wealthier patients enrolled in poorer areas benefit from reduced charges through higher capitation payments. Most GPs, for their part, benefitted through introduction of PHOs from increased capitation payments but remain reliant on patient charges for a significant portion of their income. Indeed, implementation of the Primary Health Care Strategy and PHOs was premised on this model.[15] Any PHO or general practice wishing to eradicate patient charges has had to factor this into their business model and overall income. As such, it is very unusual for a general practice to deliver free services though small numbers of 'third sector' (non-government, non-profit) practices do exist in New Zealand serving vulnerable populations.[16,17] The usual approach, often associated with a general practice being funded via the Very Low Cost Access (VLCA) scheme, which does not cover total costs, has been to make consultations 'low cost'—perhaps $10–20. This continues to pose a barrier for those on low incomes, although to be fair, successive governments have incrementally removed patient charges for children up to age 13, with further reductions in patient charges for people on lower incomes and children under 14 being introduced by the beginning of 2019.

Do patient charges support a healthcare model fit for the future?

This is a fundamental question. New Zealand's GPs are ageing with increasing pressure to manage and treat a wider range of patients. This pressure is in parallel with implementation of alliance organisational models which are required across the health system with a focus on strengthening system integration.[18,19] The implication is that services are shifted from hospitals to primary care settings, with the government review likely to provide further impetus for this. In practice, if patient charges for traditional general practice services continue, this means developing mechanisms for ensuring that GPs and associated providers are paid for specific services such as management of particular patient groups and conditions to avoid cost shifting on to patients. GPs, after all, are largely private business people albeit in receipt of government subsidies. No conversation around shifting services to primary care can occur without discussion around payment. Similarly, development of newer models of delivering primary care such as 'healthcare homes'[20] will still have to work within current funding arrangements and patient charges if these are not reformed. This may mean it is not possible to realise the full benefits of these models, especially with respect to equity, as there is still a financial barrier to access.

The GP private ownership model, in existence since before the 1938 legislation, is also increasingly in question. On the one hand, there are opportunities with stronger community care emphasis, for GPs to grow new services and income streams. GPs with special interests (GPSIs), offering convenient low-level specialty consultations, are a case in point. On the other hand, GPs in many

areas have long highlighted difficulties in attracting younger GPs into business ownership, meaning practices are often hard to sell. As a result, other ownership models, such as corporate ownership and community trusts, with GPs being remunerated in various different ways from salary through to profit-sharing and co-payments, have grown around New Zealand.[21,22] The landscape is complex and not ideal for a small country. Further research is needed into the business ownership model, including whether this is fit for purpose for the future in meeting the increasingly complex health needs of diverse communities, whether GP owners are comfortable with the model, whether younger GPs find ownership an attractive proposition and what the alternatives are.

Some alternative ownership arrangements

There are two broad alternatives to the present situation, if universal access to New Zealand's health system and delivering on the original 1938 goals are aims. Indeed, the 2018 '80th anniversary' Ministerial review may choose to focus on establishing the values that underpin the New Zealand health system in order to contextualise its deliberations. These values could well be those envisioned in 1938, as outlined above. At the heart of this is the question of how GPs are viewed and how they view themselves within the health system. The status quo has been that they either see themselves as private practitioners with a government contribution to costs or as public servants with a private patient co-payment.[23–25] But is this fit for purpose into the future?

If the Ministerial review reconfirms the 1938 goals and values, one alternative would be full funding for general practice services. In practice, this could involve raising capitation rates and continuing to ensure that these provide a viable income for private GPs and business owners. Patient charges would need to be abolished. A more radical alternative would be for government to salary all GPs and gradually purchase clinics, evolving these to align with present policy directions that support development of larger facilities capable of providing a broad range of general practice and community-based specialist services. Of course, there are advantages and disadvantages for any ownership model, funding arrangement and method of organisation. For example, Table 1, drawn from previously published work,[26,27] summarises some of the pros and cons of different ownership arrangements.

Table 1: Summary of strengths and weaknesses of different ownership arrangements in New Zealand primary care.*

	Ownership		
Characteristic	**Private non-profit**	**Private for-profit****	**Government**
Direct accountability to government	+	+	+++
Willingness to cater to diversity	+++	+	++ / +++
Likelihood of producing public goods and quasi-public goods	+++	+	+++
Able to experiment with new policy options	+++	++	++
Likelihood of exploiting information asymmetries between patients and providers	+	+++	+
Likelihood of disguised profit distribution (disguised profit)	+++	+	+
Responsiveness to increases in demand	+	+++	++
Likelihood of blunting more extensive policy development	+++	+++	+

* + small ++ intermediate +++ large.
** Private for-profit ownership can be further divided into proprietary-style general practice to entrepreneurial investor-owned organisations (see below).

While few would challenge the assertion that primary healthcare is an essential service that should be available for the entire population, and that government has a fundamental responsibility to ensure its effective and equitable provision, the ability of government to deliver on this responsibility is determined to some extent by ownership. Ownership typologies, such as that illustrated in Table 1, have blurry boundaries and, in health as elsewhere, ownership type can be a poor predictor of organisational behaviour.[28,29] Nevertheless, ownership is an important consideration because it confers governance responsibility (ultimate control) for an organisation, and accountability for its actions. Further to this schema, there is a spectrum of for-profit behavior in health, from proprietary-style general practice to entrepreneurial investor-owned organisations. Proprietary health services are independent, owner-operated organisations (typical of general practices in New Zealand, Australia and the UK), and investor-owned are often part of multi-facility systems the owners of which may have little if any direct contact with the institution or the populations being served.

There is growing, anecdotal agreement within the GP community that cost has become an unacceptable barrier for many people accessing general practice services in New Zealand. Whether the trajectory for healthcare services continues on the current path where people who cannot afford to access primary care services have to wait until they are sick enough to get it for free, or shifts to one where funding truly follows the patient into freely accessible community-based services focused on personal and whānau wellbeing will be a key question for the government review. Of course, whether private-for-profit ownership models, reliant on profit generation, will ever be able to deliver on a goal of free patient services needs to be analysed and debated; in particular, whether free access and private ownership are compatible. History suggests that government, regardless of political persuasion, would need to provide confidence to the practice ownership community that incomes would be adequate—for example, GP salaries could be based on the hospital senior medical officer pay scale; GPs would need to give away demands, made strongly when negotiating the historic post-1938 compromise and since,[4] to be able to generate income independently from the state. Given the challenges facing our society of an ageing population living longer with multiple health conditions[30,31] and increasing inequity, how such questions are answered is of critical importance to us all.

The ideas expressed in this article are those of the authors in their individual capacities and do not necessarily represent those of the organisations they work for or on behalf of.

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REFERENCES:

1. Fraser G. An Examination of Factors in the Development of New Zealand's Health System. In: Wilkes C, Shirley I, eds. In the Public Interest: Health, Work and Housing in New Zealand. Auckland: Benton Ross; 1984:53–74.
2. Gauld R. Questions about New Zealand's health system in 2013, its 75th anniversary year. New Zealand Medical Journal 2013; 126:1–7.
3. Wright-St Clair R. The attitude of The Medical Association to medical services and the Social Security Act, 1938. New Zealand Medical Journal 2001; 114:75–6.
4. Hay I. The Caring Commodity: The Provision of Health Care in New Zealand. Auckland: Oxford University Press; 1989.
5. Gauld R. Revolving Doors: New Zealand's Health Reforms - The Saga Continues. Wellington: Institute of Policy Studies and Health Services Research Centre; 2009.
6. Kuhlmann E, Blank RH, Bourgeault I, Wendt C, eds. The Palgrave International Handbook of Healthcare Policy and Governance. Basingstoke: Palgrave; 2015.
7. Gauld R, Blank RH, Burgers J, et al. The World Health Report 2008 - Primary Healthcare: How wide is the gap between its agenda and implementation in 12 high-income health systems? Healthcare Policy 2012; 7:38–58.
8. Wendt C. Changing healthcare system types. Social policy & administration 2014; 48:864–82.
9. Jatrana S, Crampton P. Primary health care in New Zealand: who has access? Health Policy 2009; 93:1–10.
10. Ministry of Health. Annual Data Explorer 2016/17: New Zealand Health Survey. Wellington: Ministry of Health; 2017.
11. Osborn R, Squires D, Doty MM, Sarnak DO, Schneider EC. In new survey of eleven countries, US adults still struggle with access to and affordability of health care. Health Affairs 2016; 35:2327–36.
12. Schneider EC, Sarnak D, Squires D, Shah A, Doty M. Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better US Health Care. New York: The Commonwealth Fund; 2017.
13. King A. The Primary Health Care Strategy. Wellington: Ministry of Health; 2001.
14. Gauld R, Mays N. Reforming Primary Care: Are New Zealand's New Primary Health Organisations Fit for Purpose? British Medical Journal 2006; 333:1216–8.
15. IPA Council of New Zealand. Options for Introducing New Primary Health Care Funding. Wellington: IPA Council of New Zealand; 2002.
16. Loh L, Trevallyan S, Main S, Revell L, Patton V, Ojo A. The case for a systematic policy approach to free primary health care for vulnerable groups in New Zealand. The New Zealand Medical Journal 2015; 128:2010–9.
17. Crampton P, Dowell A, Bowers S. Third sector primary healthcare in New Zealand. New Zealand Medical Journal 2000; 113:92–6.
18. Timmins N, Ham C. The Quest for Integrated Health and Social Care: A Case Study in Canterbury, New Zealand. London: The King's Fund; 2013.
19. Lovelock K, Martin G, Gauld R, MacRae J. Better, Sooner, More Convenient? The reality of pursuing greater integration between primary and secondary healthcare providers in New Zealand. SAGE open medicine 2017; 5:2050312117701052.
20. Grant R, Greene D. The health care home model: primary health care meeting public health goals. American Journal of Public Health 2012; 102:1096–103.
21. Thomas F. Keeping up with the corporates: a who's who of general practice ownership. New Zealand Doctor 2018; August:12–3.
22. Greatbanks R, Doolan-Noble F, McKenna A. Cheques and challenges: business performance in New Zealand general practice. Journal of primary health care 2017; 9:185–90.
23. Marshall T. Back to Back: Co-payments must go!: No. Journal of primary health care 2011; 3:230–1.
24. Main S. Back to Back: Co-payments must go!: Yes. Journal of primary health care 2011; 3:228–30.
25. Toop L, Jackson C. Patient co-payment for general practice services: slippery slope or a survival imperative for the NHS? : British Journal of General Practice; 2015.
26. Crampton P. The ownership elephant: ownership and community-governance in primary care. The New Zealand Medical Journal (Online) 2005; 118.
27. Crampton P, Starfield B. A case for government ownership of primary care services in New Zealand: weighing the arguments. International Journal of Health Services 2004; 34:709–27.

28. Perrow C. Complex Organizations: A Critical Essay. New York: Random House; 1986.

29. Goold M, Campbell A. Strategies and Styles: The Role of the Centre in Managing Diversified Corporations. Cambridge: Basil Blackwell; 1987.

30. Stanley J, Semper K, Millar E, Sarfati D. Epidemiology of multimorbidity in New Zealand: a cross-sectional study using national-level hospital and pharmaceutical data. BMJ open 2018; 8:e021689.

31. Stokes T, Tumilty E, Doolan-Noble F, Gauld R. Multimorbidity, clinical decision making and health care delivery in New Zealand Primary care: a qualitative study. BMC Family Practice 2017; 18:51.

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