

Emergency COVID-19 funding to general practices in early 2020: lessons for future allocation to support equity

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ABSTRACT

AIM: To (1) describe the distribution of Ministry of Health (MOH) COVID-19 emergency funding to general practices in March and April 2020 and (2) consider whether further funding to general practices should be allocated differently to support equity for patients.

METHODS: Emergency funding allocation criteria and funding amounts by general practice were obtained from the MOH. Practices were stratified according to their proportion of high-needs enrolled patients (Māori, Pacific or living in an area with the highest quintile of socioeconomic deprivation). Funding per practice was calculated for separate and total payments according to practice stratum of high-needs enrolled patients.

RESULTS: The median combined March and April funding for general practices with 80% high-needs patients was 28% higher per practice (\$36,674 vs \$28,686) and 48% higher per patient (\$10.50 vs \$7.11) compared with the funding received by general practices with fewer than 20% high-needs patients. Although the March allocation did increase funding for high-needs patients, the April allocation did not.

CONCLUSIONS: Emergency support funding for general practices was organised by the MOH at short notice and in exceptional circumstances. In the future, the MOH should apply pro-equity resource allocation in all emergencies, as with other circumstances.

General practitioners (GPs) operate out of general practices, most of which are privately owned and funded by a combination of patient fees and government subsidies. The vision of the 2001 Primary Health Care Strategy included that “primary health care services will focus on better health for a population, and actively work to reduce health inequalities between different groups.”¹ A key mechanism for supporting health equity is reducing access barriers to primary healthcare services.¹ The Primary Health Care Strategy recognised that patient fees were a significant barrier to general practice services for low-income families. The strategy sought to reduce these by increasing government subsidies to general practice.²

Funding to general practices from the Ministry of Health (MOH) for the delivery of primary care services has mainly been in the form of capitation payments since the early 2000s.³ These payments are determined by the enrolled practice population and the capitation funding formula, which has evolved over time.³ Currently, practices are entitled to receive a standard capitation payment that varies according to the number and characteristics of their enrolled patients (age group, gender, whether or not the patient has a High Use Health Card [HUHC]) and whether or not the practice is an Access practice.⁴ Practices can opt to receive the following additional capitation payments according to the following funding schemes:

- Very low-cost access (VLCA): If at least 50% of patients enrolled in the practice are high-needs (ie, Māori, Pacific or living in an area with the highest quintile of socioeconomic deprivation) and the practice agrees to charge zero fees for their patients aged 0–13 years, and no more than a specified upper limit for older patients.
- Community services card (CSC) (for non-VLCA practices): If the practice agrees to charge no more than a specified upper limit for patients aged 14 years and older.
- Zero fees for under 14s or 6s (for non-VLCA practices): If the practice agrees to charge zero fees for their patients aged 0–13 or 0–5 years, respectively.⁴

Despite increasing government subsidies to general practice, cost continues to be a significant barrier to general practice services.² In 2018/2019, 13.4% of New Zealand adults reported that in the previous year they had a medical problem for which they hadn't visited a GP due to cost.² The proportion reporting GP cost access barriers is higher among Māori (21.9%, 95% CI 19.7–24.2%) and Pacific people (19.4%, 95% CI 16.4–22.7%) than among Europeans (12.7%, 95% CI 11.8–13.6%).² GP cost access barriers are also higher among people living in areas with the most socioeconomic deprivation (quintile 5: 19.2%, 95% CI 17.4–21.1%) than those living in areas with the least deprivation (quintile 1: 9.5%, 95% CI 7.9–11.3%).²

The first case of COVID-19 was confirmed in New Zealand on 28 February 2020.⁵ There was considerable activity and anxiety among GPs and general practices as they struggled to keep up with frequent changes of advice from the MOH, to obtain adequate supplies of personal protective equipment (PPE) and influenza vaccines amid supply and distribution issues, and to contain the potential risks of COVID-19 to their staff and patients.⁵ General practice faced further considerable challenges when, on Saturday 21 March, the Royal New Zealand College of General Practitioners (RNZCGP) recommended that GPs switch from face-to-face to virtual consultations.⁵ Just as the switch to virtual consultations was being imple-

mented on Monday 23 March, New Zealand went into Alert Level 3 (Restrict) because community transmission of COVID-19 was suspected, and after a further 48 hours, on Wednesday 25 March, New Zealand was in Alert Level 4 (Lockdown).⁵ Virtually overnight there was a 50–80% reduction in GP consultations and, consequently, patient fees and cash flow too. This was likely due to fear and anxiety about catching COVID-19 and the (false) perception that general practices were overwhelmed by patients with COVID-19.⁵ The MOH agreed to provide emergency funding to support general practices in March and April 2020 due to serious concerns about their financial sustainability.

The aims of this study were to describe the distribution of MOH COVID-19 emergency funding to general practices in March and April 2020, and to consider whether future emergency funding to general practices should be allocated differently to better support equitable access for the patients experiencing the greatest financial access barriers to GP services.

Methods

The following information was obtained from the MOH regarding the emergency funding that had been distributed by the MOH during March and April 2020 to support general practices in their COVID-19 response:

- Total amount distributed
- Amount by general practice
- Criteria used to allocate the funding, in particular any patient and/or practice characteristics that were taken into consideration
- Practice primary health organisation (PHO) affiliation and funding scheme (VLCA, CSC, zero fees for under 14s or 6s)
- Number of patients enrolled within each practice by each of the following variables: ethnicity (prioritised, level 1), socioeconomic deprivation quintile, age group, CSC holder status, HUHC status, high needs

Practices were categorised according to the proportion of their patients who are high-needs enrolled patients: 0–19%, 20–39%, 40–59%, 60–79%, 80%+. Funding per

enrolled patient was calculated for separate and total payments according to practice stratum of high-needs enrolled patients. All funding figures were exclusive of goods and services tax (GST). Thirty-six practices were excluded from the analysis (see results).

The information was requested under the Official Information Act (Ref H202003461) on 18 May 2020 and was received on 16 June 2020.

Results

General practices received three sources of emergency COVID-19 funding, with a total value of \$45.22 million, from the MOH during March and April in 2020 (Table 1). Two payments were distributed by the MOH: \$15 million in March and \$22.42 million in April. The payment in March was to support capacity and capability in primary care. That payment was based on the characteristics of the enrolled practice population (\$4.50 per targeted patient [ie, Māori, Pacific, NZDep quintile 5 and/or >65 years of age], \$1.50 per non-tar-

geted patient), with a minimum payment of \$2,500 per practice and an additional payment of \$5,000 for practices with 50% or more targeted patients. The payment in April was to support general practices' business sustainability and was based on the rurality of the practice (\$4.69 per patient in non-rural practices and \$4.92 per patient in rural practices). The third payment, \$7.8 million in March, was distributed by district health boards (DHBs) to practices on a fee-for-service basis to fully fund general practice-based COVID-19 assessments. Details of the third payment were not able to be provided by the MOH and are therefore not included in this analysis.

Data were provided for a total of 951 practices, of which 915 (96%) were included in this analysis. Of the 36 excluded practices, eight (0.8%) were excluded because the practice received funding in March but did not have enrolment data in April, three (0.3%) because they did not receive both March and April MOH payments and 25 (2.6%) because they only received the

Table 1: General practice emergency funding, by package and allocation criteria.

Funding package	Amount	Allocation criteria
Allocated by the Ministry of Health		
March 2020: Primary Care Support – Capacity and Capability Funding	\$15 million	<i>Patient</i> <ul style="list-style-type: none"> • \$4.50 per targeted EP (Māori, Pacific, NZDep quintile 5 and/or >65 years) • \$1.50 for other EPs <i>Practice</i> <ul style="list-style-type: none"> • \$2,500 minimum payment per practice • \$5,000 additional payment for practices with 50% or more targeted EPs
April 2020: Additional immediate funding support for general practice business sustainability	\$22.42 million	<ul style="list-style-type: none"> • \$4.69 per EP (non-rural practice) • \$4.92 per EP (rural practice)
Allocated by DHBs		
March 2020: General Practice based COVID-19 Assessments	\$7.8 million	Provided to DHBs on a PBFF basis to fully fund general practice assessments and testing. DHBs set nationally consistent funding criteria and provided funding to PHOs and to general practices on a fee-for-service basis.

DHB = district health board, EP = enrolled patient, NZDep = New Zealand socioeconomic deprivation index, PHO = Primary Health Organisation, PBFF = population-based funding formula.

minimum MOH payment (\$2,500) in March. Of the included practices, VLCA was the funding scheme for 271 (30%), CSC and free under 14 year olds for 587 (64%), free under 14 or 6 years olds for 38 (4%), CSC only for 12 (1%) and seven (1%) had elected not to receive any additional funding. Most practices (377, 41%) had under 20% high-needs patients, with 287 (31%) having 20–39% high-needs patients, 109 (12%) having 40–59%, 73 (8%) having 60–79% and 69 (8%) having 80% or more high-needs patients. The proportion of VLCA practices increased from 4% (n=16) among practices with under 20% high-needs patients, up to 97% (n=67) among practices with 80% or more high-needs patients.

In April 2020, a total of 4,721,710 patients were enrolled in practices included in this study (Table 2). Most patients (40%) were enrolled in practices with under 20% high-needs patients, with 33% enrolled in practices with 20–39% high-needs patients, 12% in practices with 40–59%, 8% in practices with 60–79% and 7% of patients enrolled in practices with 80% or more high-needs patients. The proportion of younger patients (aged 0–19 years) increased from 24% among patients enrolled with practices with under 20% high-needs patients, up to 34% among patients enrolled in practices with 80% or more high-needs patients. The proportion of Māori and Pacific patients enrolled with practices with under 20% high-needs patients was 6% and 2%, respectively, increasing to 40% and 36%, respectively, in practices with 80% or more high-needs patients. Similarly, the proportion of those living in an area in the highest socioeconomic deprivation quintile and those with a CSC increased from 5% and 15%, respectively, in practices with under 20% high-needs patients, up to 64% and 38%, respectively, in practices with 80% or more high-needs patients. The proportion of patients with a HUHC card was low across all strata of practices.

The total March amount (capacity and capability funding) paid to practices was \$14,849,697, and \$22,311,373 was paid in April (business sustainability funding) (Table 3). Practices with fewer than 20% high-needs patients (with 40% of all enrolled patients) received 30% of the March funding, 40% of the April funding and 36% of the combined

funding. Practices with 80% or more high-needs patients (with 7% of all enrolled patients) received 12% of the March, 7% of the April and 9% of the combined funding.

The median March funding was \$2.38 per patient (\$9,264 per practice) for practices with fewer than 20% high-needs patients. For practices with 80% or more high-needs patients, the median March funding was \$5.77 per patient (\$20,092 per practice). The median April funding was \$4.69 per patient irrespective of the proportion of high-needs patients. The median April funding per practice ranged from \$16,354 for practices with 80% or more high-needs patients and \$20,022 for practices with fewer than 20% high-needs patients.

The median combined March and April funding for practices with fewer than 20% high-needs patients was \$28,686 per practice and \$7.11 per patient; corresponding figures for practices with 80% or more high-needs patients were \$36,674 per practice and \$10.50 per patient, respectively. The median combined March and April funding for practices with 80% high needs patients was 28% higher per practice and 48% higher per patient than the practices with fewer than 20% high-needs patients.

Discussion

The median combined March and April MOH COVID-19 emergency funding for general practices with 80% high-needs patients was 28% higher per practice (\$36,674 vs \$28,686) and 48% higher per patient (\$10.50 vs \$7.11) compared with the funding received by general practices with fewer than 20% high-needs patients. Although the March allocation did increase funding for high-needs patients, the April allocation did not, thereby attenuating the pro-equity distribution of emergency funding to general practices in terms of the needs of Māori, Pacific patients and those living in areas of the highest socioeconomic deprivation.

While the burden of COVID-19 in New Zealand has remained modest to date, likely largely due to the national elimination strategy,⁶ commentators have noted that “the health impact of COVID-19 will be greater for Māori” and “the strong focus on numerical age as a risk factor is to the

Table 2: Patient characteristics by practice stratum of high-needs enrolled patients.

Characteristics of patients enrolled in the practice in April 2020	% high-needs patients enrolled in the practice in March 2020					Total
	0-19%	20-39%	40-59%	60-79%	80-100%	
Number of people*	1,894,575 (40%)	1,561,350 (33%)	555,321 (12%)	366,046 (8%)	344,418 (7%)	4,721,710
Age group (years)						
0-19	463,519 (38%)	392,945 (32%)	150,193 (12%)	110,268 (9%)	118,092 (10%)	1,235,017 (26%)
20-39	467,718 (38%)	409,412 (33%)	154,727 (13%)	100,047 (8%)	100,119 (8%)	1,232,023 (26%)
40-59	515,327 (43%)	396,429 (33%)	135,362 (11%)	88,432 (7%)	76,943 (6%)	1,212,493 (26%)
60-79	366,847 (43%)	298,197 (35%)	95,709 (11%)	58,407 (7%)	43,285 (5%)	862,445 (18%)
80+	81,164 (45%)	64,367 (36%)	19,330 (11%)	8,892 (5%)	5,979 (3%)	179,732 (4%)
Ethnicity (prioritised)						
Māori	118,172 (6%)	201,147 (13%)	128,180 (23%)	136,945 (37%)	136,194 (40%)	720,638 (15%)
Pacific	39,367 (2%)	65,695 (4%)	50,737 (9%)	63,447 (17%)	125,169 (36%)	344,415 (7%)
Asian	278,840 (15%)	224,232 (14%)	82,796 (15%)	43,744 (12%)	32,049 (9%)	661,661 (14%)
European	1,414,910 (75%)	1,036,471 (66%)	276,384 (50%)	115,801 (32%)	46,872 (14%)	2,890,438 (61%)
Other / not stated	43,286 (2%)	33,805 (2%)	17,224 (3%)	6,109 (2%)	4,134 (2%)	104,558 (2%)
Socioeconomic deprivation quintile						
5 (most deprived)	90,863 (5%)	243,172 (16%)	174,131 (31%)	171,890 (47%)	221,088 (64%)	901,144 (19%)
4	231,393 (12%)	363,270 (23%)	134,516 (24%)	87,018 (24%)	58,081 (17%)	874,278 (19%)
3	366,343 (19%)	347,434 (22%)	97,435 (18%)	45,493 (12%)	27,878 (8%)	884,583 (19%)
2	501,693 (26%)	299,919 (19%)	74,360 (13%)	30,107 (8%)	17,061 (5%)	923,140 (20%)
1 (least deprived)	649,353 (34%)	263,202 (17%)	59,634 (11%)	20,049 (5%)	10,309 (3%)	1,002,547 (21%)
Missing	54,930 (3%)	44,353 (3%)	15,245 (3%)	11,489 (3%)	10,001 (3%)	136,018 (3%)
High needs	231,098 (12%)	434,833 (28%)	273,230 (49%)	253,894 (69%)	298,615 (87%)	1,491,670 (32%)
CSC holders	281,640 (15%)	336,088 (22%)	155,082 (28%)	122,442 (33%)	129,854 (38%)	1,025,106 (22%)
HUHC holders	2,452 (0%)	4,722 (0%)	1,243 (0%)	693 (0%)	359 (0%)	9,469 (0%)
Practice funding scheme						
VLCA	87,923 (5%)	320,118 (21%)	341,997 (62%)	361,069 (99%)	334,360 (97%)	1,445,467 (31%)
CSC and free <14y	1,662,325 (88%)	1,181,961 (76%)	210,923 (38%)	4,675 (1%)	10,058 (3%)	3,069,942 (65%)
Free <6y or <14y	115,652 (6%)	56,411 (4%)	2,401 (0%)	-	-	174,464 (4%)
CSC only	6,303 (0%)	1,421 (0%)	-	195 (0%)	-	7,919 (0%)
None	22,372 (1%)	1,439 (0%)	-	107 (0%)	-	23,918 (1%)

Number of patients (%), % within columns (ie, within practice stratum of high-needs enrolled patients, or across total patients) unless otherwise specified.

* % across rows.

CSC=Community Services Card, High needs = Māori, Pacific or living in an area with the highest quintile of socioeconomic deprivation, HUHC=High Use Health Card, VLCA=Very low-cost access.

Table 3: Funding by practice stratum of high-needs enrolled patients.

		% high-needs patients enrolled in the practice in March 2020					Total
		0–19%	20–39%	40–59%	60–79%	80–100%	
Total funding, \$ (% across rows)							
March		\$4,516,647 (30%)	\$4,513,993 (30%)	\$2,305,574 (16%)	\$1,742,475 (12%)	\$1,770,938 (12%)	\$14,849,627
April		\$8,942,201 (40%)	\$7,380,727 (33%)	\$2,625,340 (12%)	\$1,737,385 (8%)	\$1,625,720 (7%)	\$22,311,373
Total		\$13,458,848 (36%)	\$11,894,720 (32%)	\$4,930,914 (13%)	\$3,479,859 (9%)	\$3,396,658 (9%)	\$37,160,999
Funding by practice (not adjusted by practice size)							
March	Median (Q1,Q3)	\$9,264 (\$5,726, \$15,626)	\$11,738 (\$7,216, \$19,306)	\$18,078 (\$11,983, \$25,033)	\$17,674 (\$12,178, \$27,980)	\$20,092 (\$13,781, \$31,954)	\$12,616 (\$7,500, \$20,612)
	Mean (SD)	\$11,980 (\$8,314)	\$15,728 (\$13,041)	\$24,265 (\$17,374)	\$23,870 (\$17,804)	\$25,666 (\$18,634)	\$16,229 (\$13,352)
April	Median (Q1,Q3)	\$19,271 (\$11,022, \$31,493,)	\$18,268 (\$10,963, \$32,891)	\$20,022 (\$10,778, \$28,651)	\$16,471 (\$9,186, \$28,464)	\$16,354 (\$10,004, \$31,831)	\$18,676 (\$10,780, \$31,371)
	Mean (SD)	\$23,719 (\$16,961)	\$25,717 (\$21,830)	\$25,277 (\$22,322)	\$23,800 (\$22,353)	\$23,561 (\$21,547)	\$24,386 (\$19,874)
Total	Median (Q1,Q3)	\$28,686 (\$16,434, \$47,307)	\$29,662 (\$18,369, \$51,720)	\$38,947 (\$23,015, \$53,363)	\$33,971 (\$20,940, \$56,223)	\$36,674 (\$24,022, \$64,983)	\$31,062 (\$18,725, \$51,598)
	Mean (SD)	\$35,700 (\$25,120)	\$41,445 (\$34,661)	\$53,425 (\$43,451)	\$47,669 (\$40,143)	\$49,227 (\$40,097)	\$40,613 (\$32,424)
Funding by patient enrolled in April							
March	Median (Q1,Q3)	\$2.38 (\$2.21, \$2.54)	\$2.75 (\$2.61, \$2.90)	\$4.40 (\$4.00, \$5.33)	\$5.18 (\$4.54, \$6.28)	\$5.77 (\$4.97, \$6.69)	\$2.70 (\$2.41, \$4.31)
	Mean (SD)	\$3.56 (\$15.61)	\$3.45 (\$5.30)	\$5.51 (\$4.23)	\$6.85 (\$8.53)	\$10.07 (\$30.63)	\$4.51 (\$13.80)
April	Median (Q1,Q3)	\$4.69 (\$4.69, \$4.69)	\$4.69 (\$4.69, \$4.69)	\$4.69 (\$4.69, \$4.69)	\$4.69 (\$4.69, \$4.69)	\$4.69 (\$4.69, \$4.69)	\$4.69 (\$4.69, \$4.69)
	Mean (SD)	\$4.73 (\$0.09)	\$4.73 (\$0.09)	\$4.73 (\$0.08)	\$4.75 (\$0.10)	\$4.73 (\$0.09)	\$4.73 (\$0.09)
Total	Median (Q1,Q3)	\$7.11 (\$6.91, \$7.30)	\$7.47 (\$7.31, \$7.66)	\$9.14 (\$8.71, \$10.02)	\$9.98 (\$9.34, \$11.11)	\$10.50 (\$9.71, \$11.39)	\$7.42 (\$7.13, \$9.05)
	Mean (SD)	\$8.29 (\$15.61)	\$8.18 (\$5.30)	\$10.24 (\$4.23)	\$11.59 (\$8.52)	\$14.80 (\$30.62)	\$9.24 (\$13.79)

CSC=Community Services Card, High needs = Māori, Pacific or living in an area with the highest quintile of socioeconomic deprivation, HUHC=High Use Health Card, Q1=first quartile, Q3=third quartile, SD=standard deviation, VLCA=Very Low Cost Access

detriment of Indigenous populations”.⁷ A modelling study that sought to disentangle the effects of age structure and comorbidity has estimated that, if there were widespread community transmission in New Zealand, the infection fatality rate of COVID-19 for Māori is likely to be at least 50% higher than for non-Māori.⁸ The authors of that study consider that inequities in the burden of COVID-19 for Māori and Pacific compared with Europeans could be even greater because 2009 influenza H1N1 pandemic hospitalisation and fatality rates were higher for Māori and Pacific people than for Europeans, and Māori and Pacific people are more likely to experience multi-morbidity, avoidable hospitalisations and racism than Europeans. Further, inequities in the infection fatality rate of COVID-19 could be even greater if differences by ethnicity in age-specific health outcomes or unmet healthcare needs are underestimated in available data.⁸

These predictions of the likely inequitable burden of COVID-19 according to ethnicity have already become manifest in other countries. Black, Latinx and Indigenous populations in the United States, as well as black, Asian and minority ethnic (BAME) groups in England are experiencing an increased burden of COVID-19 compared with whites.^{9,10} An international study across 13 countries also found inequities in the burden of COVID-19 according to ethnicity and income.¹¹

We acknowledge that the emergency support funding for general practice was organised by the MOH at short notice and in exceptional circumstances. However, although the March tranche was allocated in a way that was pro-equity, the April tranche was not. In the future, the MOH should apply pro-equity resource allocation in all

emergency circumstances. Understanding the reasons for the differences in allocation between the March and April tranche would be useful and may help to support better implementation of equity policy imperatives. Ideally reasons for these differences in allocation would be pro-actively shared by the MOH in the first instance. Alternatively, or in order to obtain more in-depth understanding, the reasons for these differences could be ascertained through case study research.

The limitations of our study are that we were not able to include the DHB funding for practice-based COVID-19 assessments. We were also unable to take into account baseline practice financial vulnerability. Further, as noted by Hauora, the Waitangi Tribunal Health Services and Outcomes Inquiry report on primary healthcare claims, “In relation to the capitated funding formulas, we have found that the formulas disadvantage primary health organisations and providers that predominantly service high-needs populations and particularly impact on Māori-led primary health organisations and providers that predominantly serve these populations.”¹² Māori providers, some of which have general practices, “have been underfunded from the outset,”¹³ and the Crown (represented by the MOH) has now committed to “engagement on a methodology for assessing the extent of underfunding of Māori primary health organisations and providers”.¹⁴ Finally, while we assume that additional funding is needed with higher proportions of patients with high health needs, we have not considered how much additional funding is required according to additional need. Further research exploring how much additional funding is required according to additional need is required to ensure funding is truly pro-equity.

Competing interests:

There was no external funding source for preparing this article. The views, opinions, findings and conclusions or recommendations expressed in this paper are strictly those of the authors. They do not necessarily reflect the views of the institution where the authors currently work. The paper is presented not as policy, but with a view to inform and stimulate wider debate. Dr Murton is President of the RNZCGP and she also has an academic appointment at the University of Otago; the views expressed here are her own and not those of the College. Prof Crengle reports other from New Zealand Ministry of Health, personal fees from RNZCGP and other from WellSouth PHN, outside the submitted work.

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