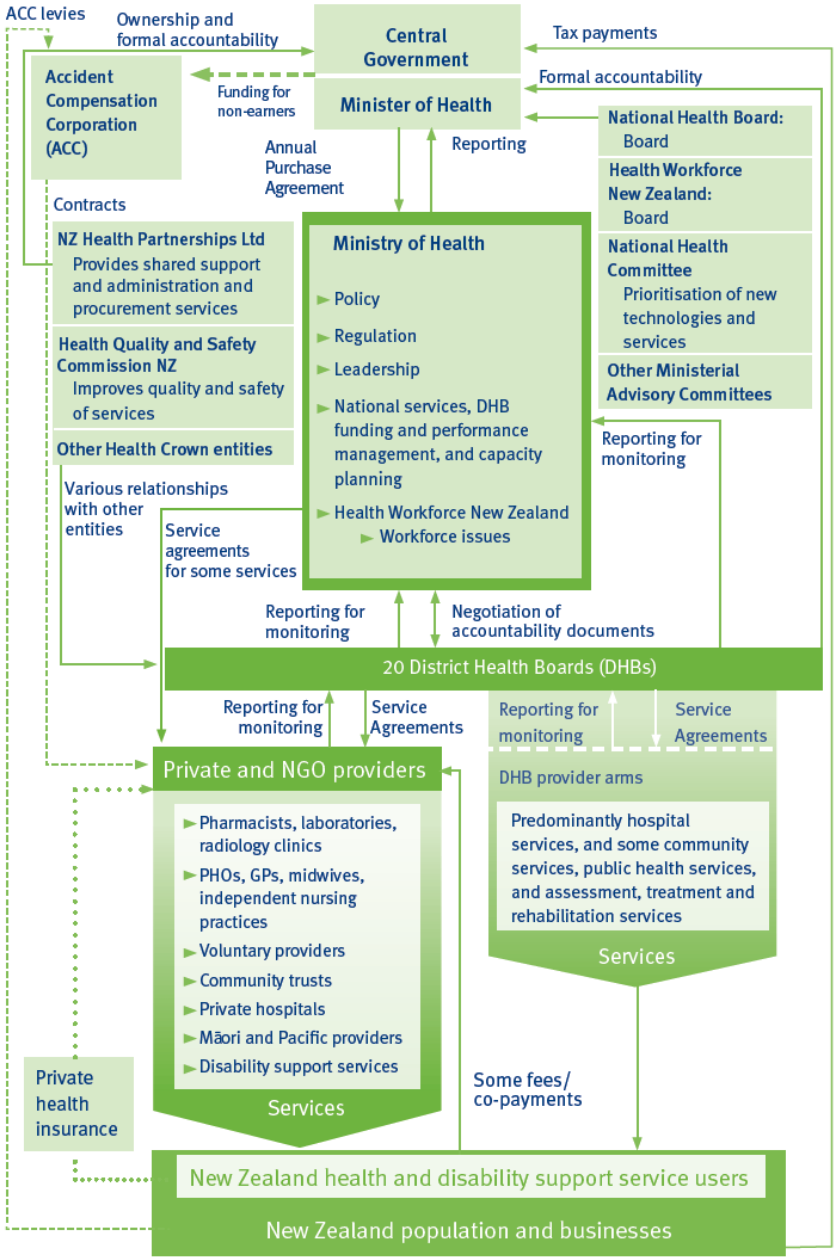
NZCPHCN 2017 Symposium

Kim Carter, RN, Director

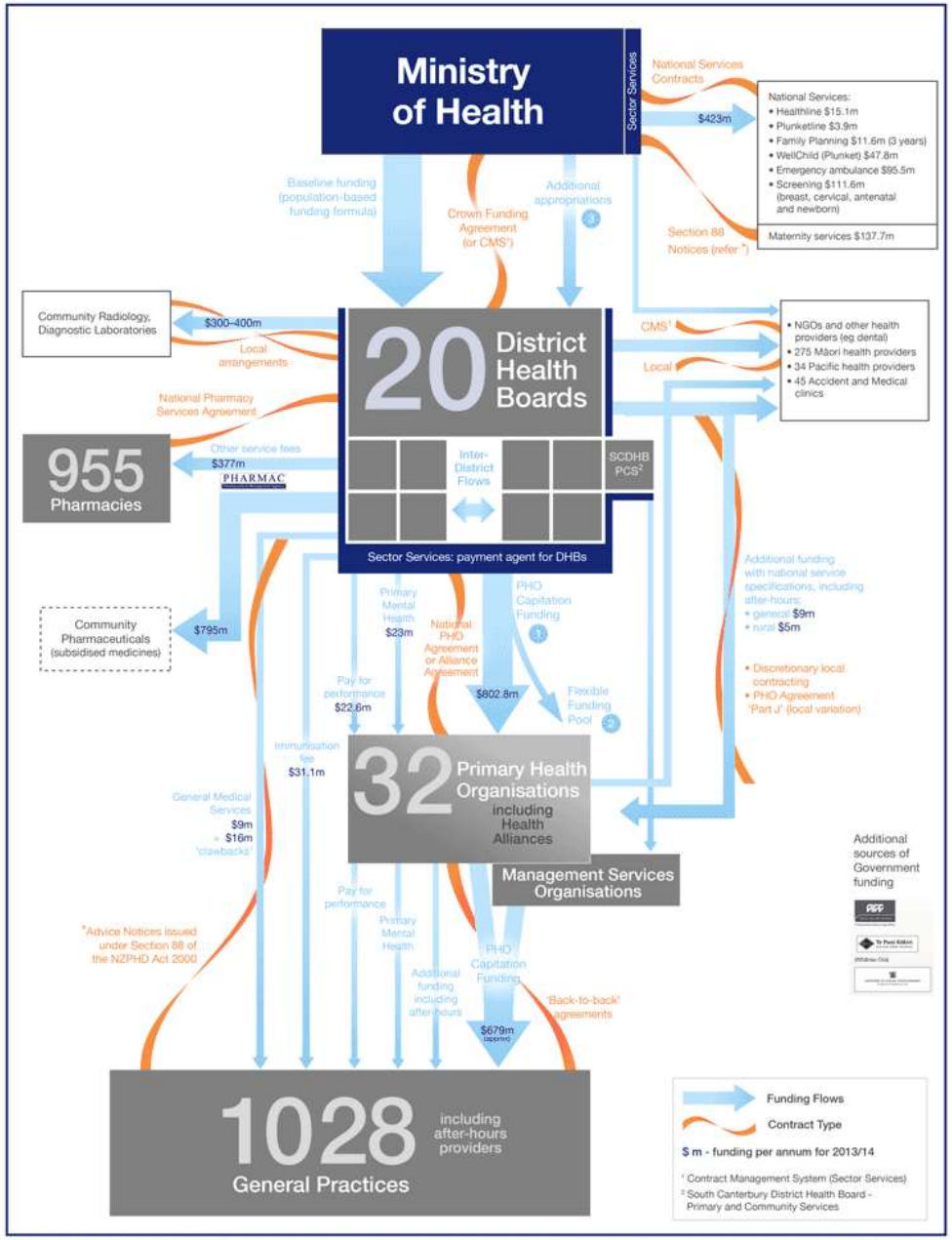
Wood Street Surgery Ltd

NZ Health System and General Practice Funding Explained!

The structure of the New Zealand health and disability sector



Primary Health Care Services Funding and Contracting



Vote Health

New Zealand's health and disability system is mainly funded from general taxation and is managed by the Ministry of Health

$16.773 billion in 2017/18

> ¾'s ($12.7 billion) of the public funds through Vote Health goes to 20 DHBs

The remaining public funding provided to the Ministry is used to fund important national services

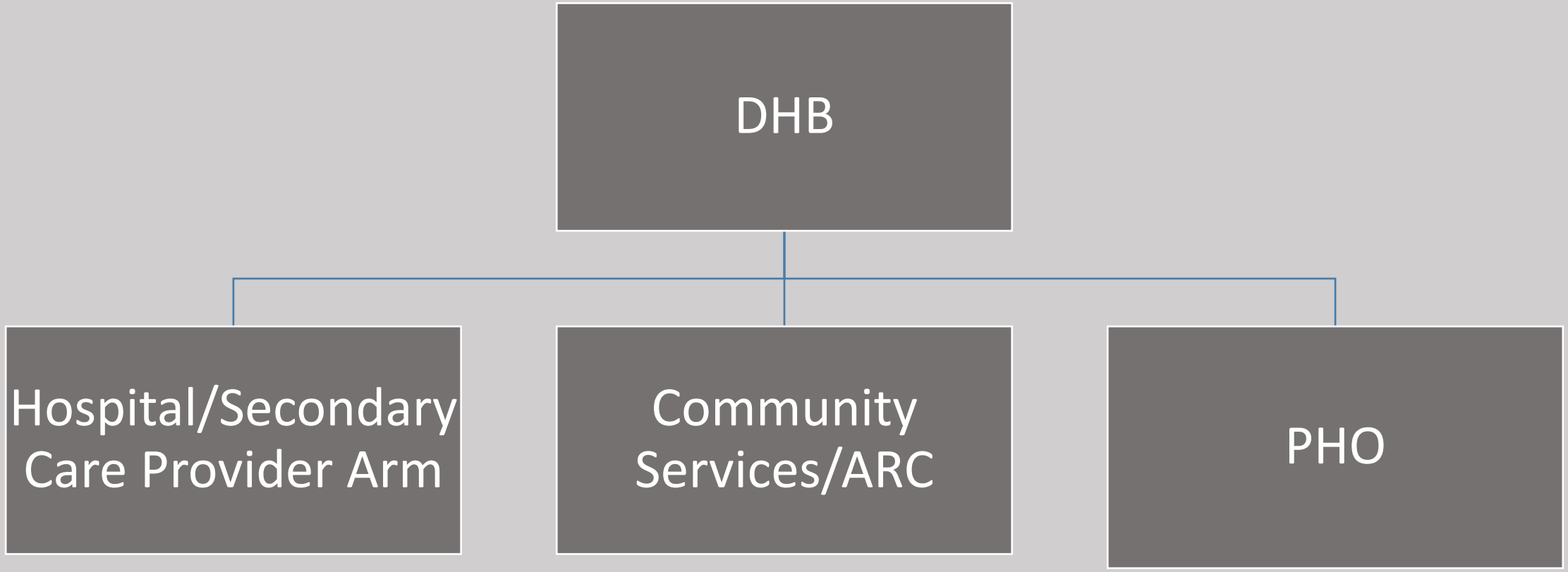
? Enough $$

- Estimated to be $215 million behind just what's needed to cover
  - announced new services
  - pay equity
  - Inflation
  - population growth
  - aging population
- Services receiving more funding will get it from reducing funding to other services
- Health system $2.3 billion behind the value of the 2009/10 funding

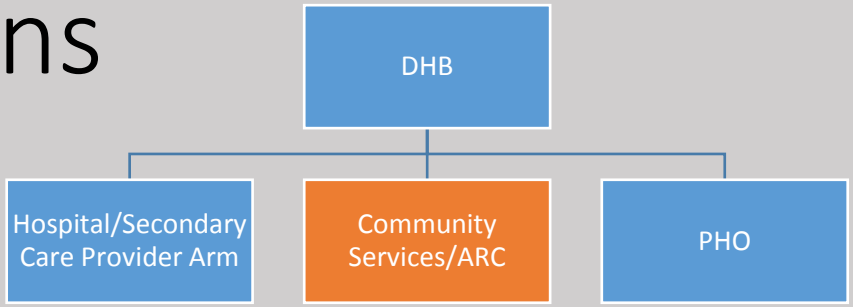
MoH

Has a range of roles in the system and a $198 million budget

- The principal advisor and support to the Minister
- It directly funds a range of national services (including disability support and public health services)
- Regulatory functions


DHB
Hospital/Secondary Care Provider Arm
Community Services/ARC
PHO

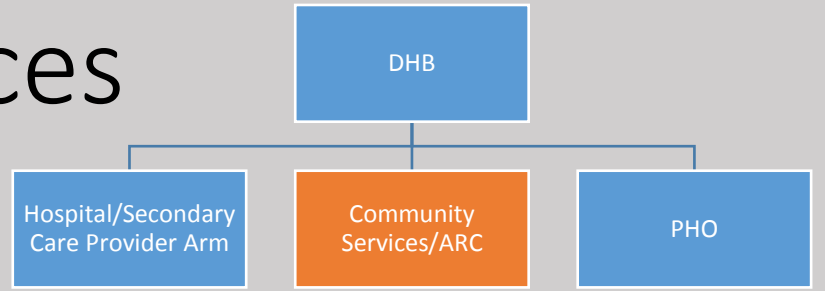
Non-governmental organisations



- Non-governmental organisations (NGOs) receive significant funding ($2–4 billion per year)

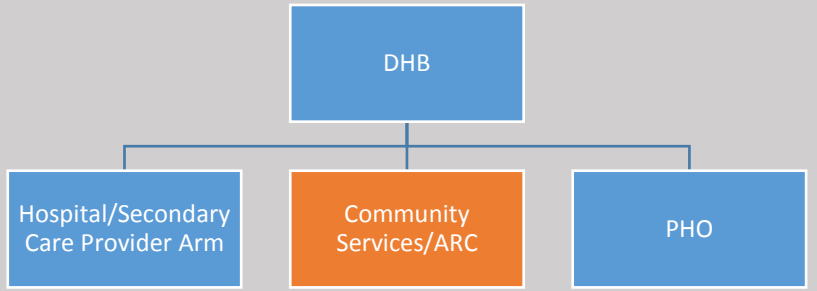
- Diverse services are offered in primary care
  - mental health
  - personal health
  - disability support services
  - includes Māori and Pacific providers DHB

NASC/ARC/Home Support Services



- Every person who is > 65 years is entitled to a needs assessment
- <65 people with disabilities are also assessed via a NASC process
- DHBs also fund home support services “Aging in Place”

Public Health



- 12 Regional public health services/units
- DHB-based services and NGO's each deliver about half of these services
- PH Unit's focus on environmental health, communicable disease control, tobacco control and health promotion programmes
- Many of these services include a regulatory component (i.e. Medical Officers of Health)

PHC System

The New Zealand approach to primary health care was criticised for many years on the grounds that it contributed to:

- Poor access to care for some groups in the population, arising from financial, cultural and other barriers to care
- Little incentive for practices to promote health or prevent disease
- A poorly distributed workforce in relation to population needs
- A bias towards GP care
- An inability for the government to fund according to population health needs.

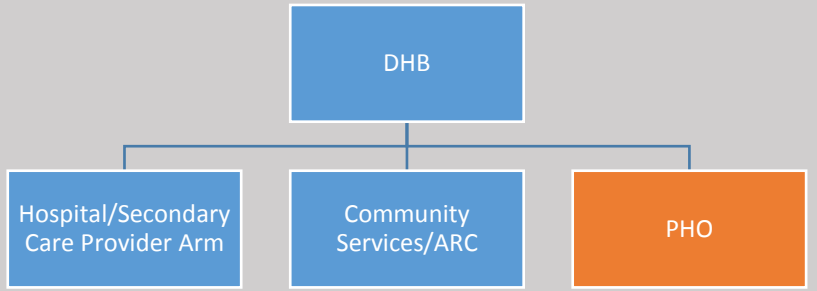
PHC Strategy 2001 (King 2001)

The Strategy envisaged a greater emphasis on

- population health and the role of the community
- health promotion and preventive care
- the need to involve a range of professionals in service delivery
- the advantages of funding based on population needs rather than fees for service

3 Main Policy Changes

- Funding for primary health care increased
- The development of Primary Health Organisations (PHOs)
- Public funding of primary care changed from fee-for-service subsidies at the practitioner level to capitation funding of PHOs.



Primary Health Organisations

PHO Services Agreement

- PHO's funded via this national agreement
- PHO's contract with providers via a similar agreement
- Outlines scope, quality and criteria for provision of services
- Includes multiple funding streams and clinical programmes

PHO Services Agreement

- Key principles
  - Future proof
  - General use of “Health Practitioner” meaning registered health professional rather than GP or RN
  - Funding is available and flows to all health practitioner types
  - Barriers to nurses attracting GMS, Capitation and other funding removed
  - www.gpnz.org.nz

General Practice Provider Agreement

Providers

Two types of general practice providers

- Access
- Very Low Cost Access

PHO Services Agreement- Funding

- Capitation - First Level Health Services
- Services to Improve Access for High Needs groups
- Rural Funding
- Very Low Cost Access Payment
- High Use Health Card

PHO Services Agreement- Funding

- Zero Fees for Under 13 year olds
- Clinical Programmes
- Immunisations
- General Medical Subsidy
- Flexible Funding Pool
- PHO Management Service
- Quality framework – PPP – iPIF - System Level Measures

Capitation

Capitation is a payment arrangement for general practice providers.

It funds each practice a set amount for each enrolled person per year,

Paid each month,

Whether or not that person seeks care.

First Level Services (Capitated Services)

Defined in the contract and includes

- Health promotion
- Health education
- Evidence based screening and assessment
- Early detection and diagnosis of illness
- Urgent medical and nursing services
- Coordination of care

Access Practices

- In addition an annual payment made for each enrolled child < 13 yrs if $0 fee charged

($45-81 depending on age and gender)

- GMS subsidies are paid for casual patients but clawed back from the enrolled practice

		Annual rate
Enrolled Person		
Age Group	Gender	
00-04	F	$395.9588
	M	$416.8892
05-14	F	$125.3340
	M	$117.3144
15-24	F	$115.6512
	M	$63.6512
25-44	F	$101.6272
	M	$65.6932
45-64	F	$139.1972
	M	$103.9652
65+	F	$239.8772
	M	$206.8680

VLCA Top Up Payment

Fee limits

- $0 for <13 yrs
- $12 for 13-17 yrs
- $17.50 for > 18 yrs

Enrolled Person		
Age Group	Gender	Annual Rate
00-04	F	$103.4676
	M	$108.9356
05-14	F	$52.2740
	M	$51.6556
15-24	F	$29.6752
	M	$16.3328
25-44	F	$26.0764
	M	$16.8564
45-64	F	$35.7164
	M	$26.6764
Over 65	F	$61.5504
	M	$53.0804

Rural Ranking Score

- Reasonable rosters funding
- Workforce Retention funding
- The level of funding paid is based on the rural ranking scale.

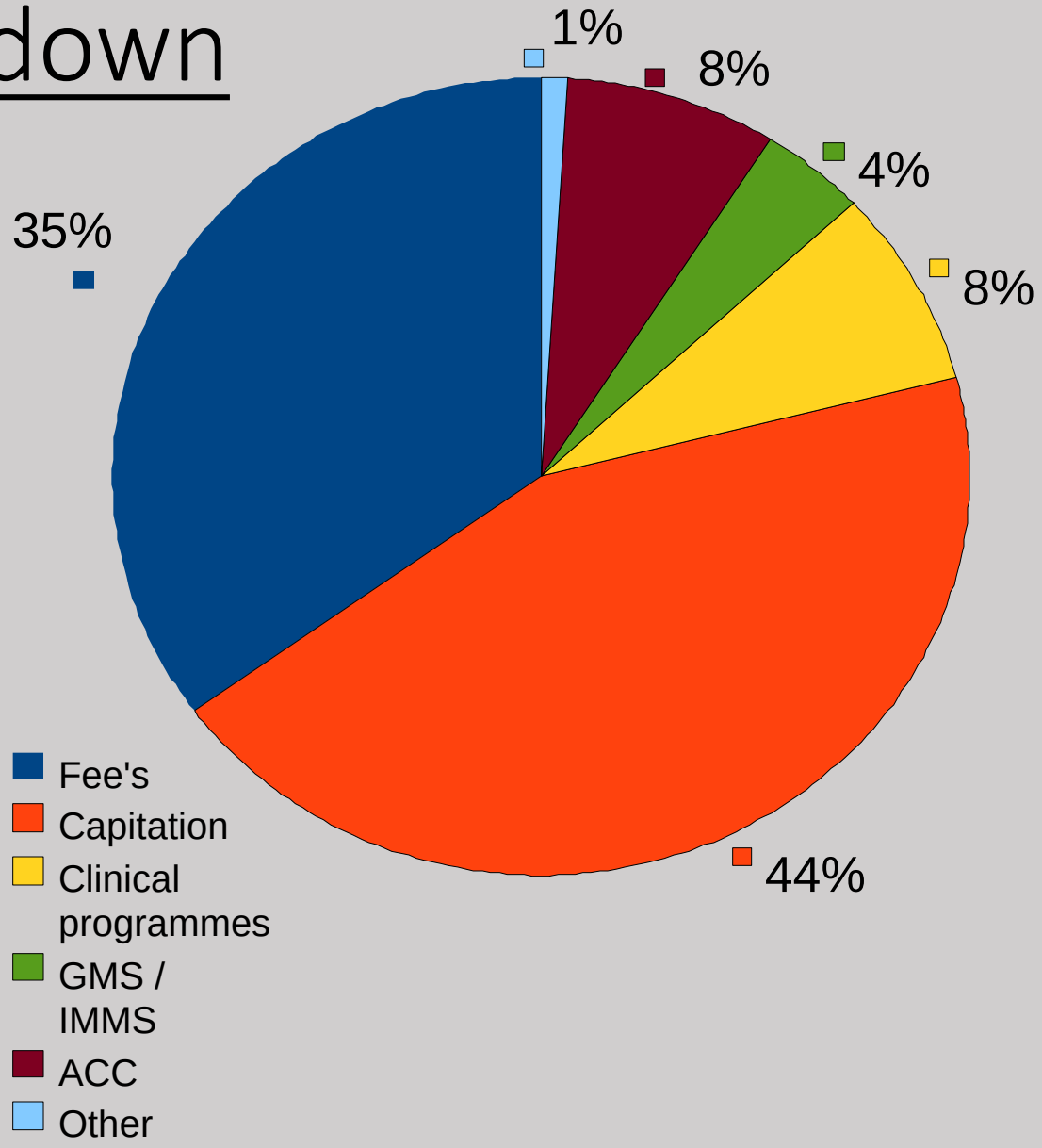
Rural ranking score of Rural Practitioner	$ per Enrolled Person GST exclusive
35-40	$7.72
45-50	$11.60
55-65	$15.46
70 +	$19.31

High Use Health Card (HUHC)

- Seen > 12 times /previous year
- Application submitted by the practice on the patients behalf
- The HUHC lasts for 1 year
- Funding automatically stops after 1 year unless reassessed

Enrolled Person		Annual rate High User Health Card	
Age Group	Gender	N	Y
00-04	F	$395.9588	$591.8876
	M	$416.8892	$591.8876
05-14	F	$125.3340	$379.5048
	M	$117.3144	$379.5048
15-24	F	$115.6512	$365.5776
	M	$63.6512	$365.5776
25-44	F	$101.6272	$365.5776
	M	$65.6932	$365.5776
45-64	F	$139.1972	$400.3948
	M	$103.9652	$400.3948
65+	F	$239.8772	$429.4092
	M	$206.8680	$429.4092

Income Breakdown



Key Points

Practice's are incentivised to

- Keep patients well and self managing in the community
- Utilise funding streams to target services and reduce cost barriers
- Utilise the depth and breadth of clinical expertise within the team (model of care)
- Utilise IT and other technologies

Capitation and Clinical Services Funding

- Linked to services provided not provider type
- Supports prevention and wellness model
- Provides additional funding support for LTC Management (CP, SIA, HP, HUHC)

The Opportunities

Identify

- Population groups to target
- Barriers and risk to access
- Possible / appropriate funding streams

Plan

- Business case
- Service delivery model
- Evaluation / outcomes