# Briefing

Health New Zealand
Te Whatu Ora

## General Practice investment options to improve access

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| **Due to MO:** | 14 February 2025 | **Reference** | **HNZ00079149** |
| To: | Hon Simeon Brown, Minister of Health | | |
| From: | Prof Lester Levy, Commissioner<br>Dr Dale Bramley, Acting Chief Executive | | |
| Copy to: | | | |
| Security level: | In Confidence | **Priority** | Urgent |
| Consulted | n/a | | |

| **Action sought** | **Action required by** |
|---|---|
| **Note** the proposed funding package designed to improve the performance of general practice | |
| **Discuss** the proposals with officials | 24 February 2025 |

**Contact for further discussion (if required)**

| **Name** | **Position** | **Phone** | **1st contact** |
|---|---|---|---|
| Martin Hefford | Director Living Well, Planning, Funding and Outcomes | S9(2)(a) | |
| Dr Dale Bramley | Acting Chief Executive | S9(2)(a) | x |

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## Purpose

1. Access to primary care is currently constrained resulting in poorer population health outcomes and increased health system costs.
2. The Government is currently considering a package of measures (the primary care tactical action plan) to improve access to primary care by boosting the primary care workforce and by additional funding for on-line and in-person urgent care and overflow services.
3. This briefing outlines our initial thinking on a complementary investment in to improve performance of core general practice which includes:
   a) A base enhanced capitation payment to practices that meet pre-conditions focused primarily on access to services
   b) An additional outcomes-based enhanced capitation payment linked to performance against key targets
   c) Activity based funding to deliver more specialist interventions in primary care settings.
4. We consider that this mixed model would provide both the resources required and the incentives to boost timely access for patients.

## Recommendations

Health New Zealand | Te Whatu Ora (Health NZ) recommends that you:

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|---|---|
| a) **Note** this briefing outlines a proposed funding package to improve the performance of general practice to complement the primary care tactical action plan initiatives | **Noted** |
| b) **Note** the package outlined includes three components:<br>a. An enhanced capitation payment for practices that meet new access to care performance standards;<br>b. An outcomes payment based on performance against key quality targets;<br>c. Activity based funding to support health targets by delivering more specialist interventions in primary care settings. | **Noted** |
| c) **Note** S9(2)(f)(iv) | **Noted** |

S9(2)(f)(iv)

| **Cumulative spend** | **Budget 25** |
|---|---|
| **Component** | $m |
| Enhanced capitation to improve access | $60 |
| Funding for quality outcomes | $30 |
| Planned Care Targets | $5 |
| **Total** | **$95** |
| *Additional annual investment* | *$95* |

| | |
|---|---|
| d) S9(2)(f)(iv) | **Noted** |

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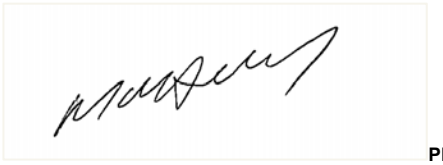
| e) | **Note** that the proposed investments would be internally funded through Health NZ baselines through reprioritisation. | **Noted** |
| f) | **Discuss** the proposals outlined here with officials | **Yes / No** |



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**Martin Hefford (on behalf of)**

**Dr Dale Bramley**

**Acting Chief Executive, Health NZ**

Date:

**Hon Simeon Brown**

**Minister of Health**

Date:

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## Background

5. In 24/25 Health NZ expects to spend about $1.5 billion on Primary Health Organisation (PHO) services through the national agreement, of which some $1.2 billion is capitation funding for primary medical services. PHO capitation represents about 5.7% of the total Health NZ appropriations spend. Every year there are some 22 million patient encounters with GP teams – eclipsing the 1.4 million ED visits and 1 million outpatients visits a year.
6. In 2023, a widely reported paper by Sapere Research Group estimated that general practice capitation lagged $137m behind a sustainable level. A later internal Health NZ estimate updated this to $173 million.
7. Capitation funding for primary care was introduced in 2002. The funding formula was developed based on use patterns at the time and has not been updated to reflect changes in both use of care and life expectancy.
8. A multivariate regression analysis on data from over 2 million individuals has identified that, in addition to the existing age and sex variables, deprivation, multimorbidity (measured using a pharmaceutical index), rurality, and ethnicity are all statistically significant predictors of primary care activity and costs; S9(2)(f)(iv)

9. Various ad hoc changes have been introduced to compensate for weaknesses in the existing capitation formula. These changes have complicated the funding model and created some perverse outcomes without resolving the core issues. This will be rectified if a new capitation model is introduced with updated weights.
10. Budget 22 funded $35M in 24/25 to pay for comprehensive primary care team roles including paramedics, pharmacists, etc in primary care. The purpose of the funding was to provide enhanced capacity and diversity of workforce in practices, as part of the solution for GP shortages. These roles have been well received and are improving access – particularly in difficult to staff areas. S9(2)(f)(iv)

## The case for performance-based capitation funding

11. The objectives of enhanced capitation and performance-based funding would be to:
    a) improve timely access to routine general practice;
    b) improve proactive care for people with long term conditions such as diabetes;
    c) improve childhood immunisation rates; and
    d) enable a greater primary care contribution to planned care targets, faster cancer treatment, and shorter stays in ED.
12. We consider that there is a strong case for linking additional funding for general practice to the delivery of enhanced access and making it partially subject to achievement of desired outcomes. This would encourage providers to focus on enhancing access to primary care by recruiting additional staff, expanding premises, expanding service offerings, and modernising digital infrastructure, rather than simply using the extra funding to improve their financial returns.

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13. We do not recommend a simple capitation uplift without performance related measures.

14. S9(2)(f)(iv)

15. S9(2)(f)(iv)

16. The proposed approach would be to make additional capitation-based funding available in two streams:

    a) An enhanced capitation payment for practices that meet performance standards in regards timely access to care

    b) An outcomes payment based on performance against key targets.

*Enhanced capitation based on meeting access related performance criteria*

17. Specifically, our proposal is that practices would qualify for the access related capitation premium when they offer the following (these are initial proposals subject to further refinement):

    a) same day triage and appointments for patients with urgent care needs

    b) patients are able to make a routine appointment within 5 business days 90% of the time

    c) the practice is open for at least 2 hours outside usual business hours to support convenience for patients

    d) online access for patients through patient portals including bookings, access to notes and results, secure messaging, and repeat scripts

    e) meets minimum standard re being open for new enrolments (noting that enrolments may need to be curtailed for temporary periods if staffing falls below a minimum level, but that newborns, family members and those new to the area should always have a place to enrol)

    f) use of an approved modern secure Patient Management System (to keep data safe and support interoperability)

    g) provision of data to HNZ for the shared care record and data repository, and to monitor performance

    h) agreement to public reporting of outcomes (for practices exceeding a certain patient threshold) to allow patients to choose practices based on actual performance data.

18. Practices meeting these access criteria would be required to maintain performance against the standards to obtain the additional funding. The premium would be in the order of 12% of current capitation.

*Outcomes-based payments based on performance against key targets*

19. The outcomes-based capitation payment stream would be paid on a sliding scale based on actual performance against specific indicators. Specific targets for each indicator would evolve

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over time. Initial thinking is reflected in the table below. Primary indicators are bolded.

| Health Target | Possible Indicator / target | Rationale |
|---|---|---|
| Childhood immunisation | **% of children fully immunised at age 2 – improve towards 95% excluding decliners**<br><br>% of newborns enrolled at 3 months | GPs provide 87% of all childhood immunisations. With good processes they should reach nearly all children that do not specifically decline immunisation.<br><br>Newborns not enrolled have lower immunisation rates and higher hospital presentations. |
| ED shorter stays | **Cardiovascular Risk Assessments (improve toward 90%)**<br><br>Rates of triage 3-5 ED self-presentations - relative reduction over time toward best quartile performance. | Better management of cardiovascular risk reduces acute presentations from stroke, heart disease, and diabetes.<br><br>Access to GP services and online services should reduce the number of people presenting to ED because of primary care barriers. |
| Shorter wait times for FSAs and elective treatment | **Indicators for optimal management of long-term conditions such as diabetes and gout; for CVD triple therapy medication maintenance; and for diabetes, glycaemic control, blood pressure management, and cholesterol medications**<br><br>Hospital admission and readmission rates for specified ambulatory sensitive conditions – relative reduction over time<br><br>Outpatient referral rates (consistency) | Better management of long-term conditions reduces hospital system use and improves outcomes.<br><br>If the primary care system can reduce the volume of acute admissions going through hospitals, this will free up beds and staffing resources to meet elective targets.<br><br>If GPs can provide more comprehensive care this will free up specialist resource for more complex patients. |
| Mental Health targets | **80% of people accessing primary mental health and addiction services through the Access and Choice programme are seen within one week.** | Collocated services or cross referral arrangements facilitate timely access. |
| Faster Cancer treatment | **Cervical, bowel, and breast screening rates (improvement over time)** | Earlier detection reduces treatment complexity and improves outcomes. |

20. Targets would be adjusted to recognise both different starting points and the nature of different populations.

21. To be able to track outcomes, we would need to develop a primary care data repository and

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reporting and monitoring systems.

22. Practices would make their own decisions about the mix of staff they wish to employ, and the model of care they use to achieve the access standards and the targets. Some may choose to have more traditional doctor and nurse model. However, most are likely to expand the mix of workforce to manage costs and to reflect staff availability. Hence, we expect that performance-based funding would support the continuation and expansion of interdisciplinary models in primary care.

23. PHOs would be expected to help practices with change management to achieve the access standards and the outcomes measures.

S9(2)(f)(iv)

## Funding more specialist interventions in primary care settings

25. Current spend on primary options for acute care is in the order of $40m. Much less is used to support planned care in community settings. We consider that more planned elective care can be delivered in primary care settings. For example, a recent report found that a minor gynae funding package of around $3m would reduce gynaecology waiting lists by around 30%.

26. A relatively small investment in a nationally consistent set of interventions with a common pricing schedule would enable a shift in activity from HSS into primary care settings, reducing waiting times for outpatients and procedures. This would also enable more GPs to develop an enhanced role/special interest which is likely to have a positive impact on GP retention. In addition, current acute pathways could be moved into a national schedule.

27. The funding for these services would be combined with existing funding and replace the local district schemes that cause disparate access to services around the motu (thus reducing the 'postcode lottery'). The standard schedule would also include consistent data reporting requirements.

28. Planned care services to add in to national schedule would be optimised to relieve pressure on waiting lists in hospitals (examples pending further clinical discussions):

    - minor gynae (prolapse pathway, abnormal uterine bleeding pathway, etc)
    - musculoskeletal community physiotherapy pathway, steroid injections
    - pre-surgery checks / direct referral pathways / waiting list review
    - skin excisions / other minor surgery with no patients waiting more than 120 days
    - intravitreal injections for macular degeneration
    - chronic pain services
    - infusions / IV therapy (cancer, iron, hydration, etc)
    - domiciliary palliative care services.

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## Financial analysis

29. A number of options exist in regards the mix of access based and outcomes related capitation increases.

30. S9(2)(f)(iv)

S9(2)(i)

S9(2)(f)(iv)

| Cumulative spend | Budget 25 |
|---|---|
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## Risks

*Reprioritisation*

31. Health NZ will need to make further savings on current spending in order to make these investments. The required trade-offs have not yet been identified.

*Comprehensive primary care teams*

32. The proposed capitation uplifts would enable GP providers that qualify to continue the new clinical workforce that was initially funded through Budget 22 comprehensive primary care team funding (paramedics, clinical pharmacists, etc) if they see value in them. However, it does not continue funding for comprehensive teams on a like for like basis. Some are currently employed via PHOs and this would likely change to provider employed roles.

*Annual uplift*

33. We have not included the cost of the usual annual uplift to capitation in the above table. This will be incurred regardless of the proposed capitation package. The annual adjustments for 25/26 have not yet been finalised by Health NZ.

34. S9(2)(f)(iv)

S9(2)(g)(i)

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S9(2)(g)(i)

S9(2)(f)(iv)

## Next Steps

38. Once we have feedback on the initial concepts presented here, we can provide advice on how we could incorporate this component into a full primary care development plan for your consideration. We can also prepare a communication and engagement approach linked to the primary care tactical plan narrative. Overall, we consider the package would be well received by sector leaders.

39. Once decisions are taken we will work on implementation plans including a contracting approach aiming for a July start date.

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