Health care and a new primary medical care model

– lessons from the United Kingdom and Australia

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Introduction

The World Health Organization defines health as a *'complete state of the mental, physical and social well being of the individual/family and not merely the absence of disease'*. To enhance its meaning two further additions are made, that is, cultural well-being and the relationship the individual/family has with the environment. Health therefore becomes *'a dynamic interaction of the mental, physical, social and cultural well being of the individual/ family with the environment they live in.'* An aspect of this definition is the absence of disease or disorder, but when such a disease or disorder does become evident then a further definition emerges. That is the definition of ill health, which may be described as a failure to adapt to the environment or yet to be affected by the environment. As well as environmental factors, there may be genetic factors which may contribute to the ill health of the individual/family. The paradigm in this context now deals with a relationship between being healthy and the potential of the healthy becoming ill resulting in some form of disease or disorder. The current health care system appears not to have a clear understanding of the relationship between disease and disorder processes and the environment. Moreover, the current system has largely focussed on a service care system which deals with the disease or disorder with little attention given to environmental and/or genetic factors.

The primary care strategy has become complex in its design and yet has failed to recognise the skilled health professional; the general medical practitioner, the nurse, the physiotherapist, the pharmacist and others when dealing with such diseases or disorders. The skills of these professionals enables them to identify presenting concerns, medications, family history, social history, work history and other issues as being important health determinants whenever a management plan is being discussed with the individual/family.

Primary care strategy

What the implementation of the primary care strategy has uncovered is a number of process issues yet to be resolved. Funding is central to these issues with enrolment, capitation, after hours and health needs costs attracting much debate. It is government's belief that cheaper access to general practitioner care will mean that the community will get the services they need and hence enhance their well-being. Unfortunately the current enrolment scheme, with its two tier funding, access and Interim, discriminates against some patients who may need just as much access to care as the targeted access group. The scheme assumes that patients are not itinerant and will remain enrolled with one practice. However, if the government required all citizens to register with a general practice then that requirement could strengthen the primary care strategy.

Some of the difficulties that the government is experiencing result from the overall structure of the New Zealand health care system.

The health care system

Within the last few years some attention has been paid to the socio-economic determinants of health with the Ministry of Health publishing papers on the topic.[1] However, the primary care strategy is designed around the delivery of health care services rather than viewing community health and well-being from a wider perspective, which will include the socio-economic determinants of health. The current system could be described as a 'dual public health system', made up of:

1. local government; district, city and regional councils, regional public health services, and
2. central government; the Ministry of Health.

Funding is derived from ratepayers who pay district/city and regional councils for such health services as water supply (fluoridation is determined by local councils and yet the cost of non-fluoridation rests with the health delivery services – funded by the Ministry of Health); sewerage serv-

ices; air and other environmental services... However, of the Health Vote for the year 2004/2005 ($9 billion), 76.6% was allocated to district health boards for health delivery services including hospital care, 23% to national health services, (disability support services, capital appropriation and other non-departmental services), 2.89% was allocated to public health and 3.37% to primary care and other health services. The paucity of funding allocated to both public health and primary care is very disappointing and more so when it is likely that most of the costs go into administration rather than to the interface between the individual/family and the health professionals.

A new but simplified health system needs to be established taking into account the definitions outlined above and the relationship between the individual (family) and the environment.

A health authority

It is therefore suggested that a new single Health Authority (HA) be established in each provincial boundary in order to reduce this extensive fragmentation of the health care system. The HAs would replace the current district health boards and be responsible for total public health services currently undertaken by the other local authorities. In addition the HAs would oversee the activities of primary care and hospital care. The HAs would be funded from vote health through the Ministry of Health with a contribution from ratepayers to the extent that is currently being levied through rates.

The present primary health organisations (PHOs) would be replaced by primary care trusts (PCTs) whose responsibilities would be to fund and support primary medical care practices. In addition to the PCTs, service care trusts (SCTs) would be established in each HA. The SCTs would establish specialist programmes to support the primary medical care practices. Specialist programmes could include mental health, occupational health, elderly outreach care, palliative care and special needs for Maori, Pacific Islander and migrant individuals/families.

What is public health?

In order to justify the value and importance of what public health means, it is defined as the immediate health needs for both individuals and their families through healthy living in quality housing, access to a potable water supply, availability of healthy nutrition, clean air, personal hygiene, safe waste disposal, sanitation and the opportunities for social interaction.

What is primary care?

It is the immediacy of care needed by the individual (family) where acute ill health problems arise. The primary medical care practice with its general medical practitioner, nurses and other personnel provides this skilled service. Past governments have not recognised these skills and indeed the role of the primary medical care practice in this context of care.

Now there are two questions that need to be asked; firstly, to what extent can the role of general medical practice be better defined within this new health care strategy and, secondly, could a different capitation model be formulated for primary medical care? A new model is proposed in order to answer both questions.

A primary medical care model

The model describes the basic triad of continuous, comprehensive and accessible care being available at the time of need as the central theme. These attributes are considered to be inherent in the proposed model; however, it is assumed that the model is soundly administered and that a cost-benefit analysis has been determined on behalf of the needs of the consumer (individual/family). The model also recognises values such as a more user-friendly paradigm so that patients will better appreciate the services provided by their primary medical care practice. This idea should enhance communication skills between the patient (individual/family) and the practice.

There is, however, a need to monitor the progress of the model and its establishment both within the primary care environment and that of public health, both entities being well recognised within the health authority. One feature of the health care system in New Zealand, which has probably had an impact on current access care policy, is the variability of continuity of care with many patients attending several primary medical care practices at different times. The system has encouraged patients to 'shop' around for a cheaper deal and, of course, the cheapest is the hospital emergency department. The capitation formula does not take into account overheads, staff payments, maintenance costs, but is merely a subsidy on behalf of the patient dependent on the community card status of the individual. Since the capitation fund is inadequate to meet these additional costs, patients must expect to pay higher fees. Clearly, what is needed is to have a capitation formula which is weighted for such variables as staff payments, maintenance costs, medications and supplies and overhead costs. The United Kingdom National Health Service is currently seeking public input into the weighted capitation fund.[2]

Structure

The United Kingdom structure[2] could be modified to suit our cultural values in New Zealand. These values are based on that of Maori thinking of health and the whanau and that of New Zealanders being independent and creative. In the United Kingdom the National Health Service addresses both the health and social needs of the community. This structure could be considered in New Zealand, bringing together both ministries into a single entity as the Ministry of Health and Social Development. The contribution from the Ministry of Social Development would focus on 'social health' with its funding being added to the health vote. A health entitlement card would replace the community services card.

A National Health Insurance Commission would replace Healthpac and every New Zealand citizen would be given a 'National Health Insurance Card'. The card would display the in-

dividual's full name and national health index number. The health insurance scheme would provide protection for individuals/family with cover for free access to public hospitals, nominal medical fees for access to primary medical care practices and pharmaceutical benefit subsidies.

The Australian Medicare system has an insurance scheme in which public hospitals are fully funded and private specialties partially funded. The scheme provides free access to public hospitals and free or subsidised access to primary care. For individuals/families who have private health insurance, a rebate scheme of 30–40% is directly payable.[3] The concept of a 'health insurance scheme' is worthy of consideration and a further study of the Australian scheme might be helpful.

Primary medical care practice

The administration would be under the care of a practice manager. The career staff would include general medical practitioners, receptionists, nurses, physiotherapists, midwives, social workers, and pharmacists.

Most of the costs to the practice including staff payments would be included in the weighted capitation fund. Payment for doctors might be contracted or salaried and incentive bonuses would be an additional payment on the basis of specified criteria. Patients aged between six and 65 years would pay a nominal consultation fee and for prescriptions.

A practice could employ from 10 to 15 general practitioners and have a register of 20 000 to 30 000 patients. Where there are geographical regions whose populations may be sparse the funding principles are maintained but additional support is defined for such situations.[3]

The practice would need to be accredited by the Health Authority and the Royal New Zealand College of General Practitioners, as would hospitals. The features of this type of practice are that there are no claw-backs, nor any enrolment issues. If a patient were to seek care elsewhere, rather

Box 1. Proposed structures

Ministry of Health and Social Development

Minister of Health and Social Development

Associate Minister for Health — Associate Minister for Social Development

National Health Insurance Commission (NHIC)

Director – General of Health
Division of Public Health
Division of Hospitals and Pharmaceuticals
Division of Primary Care
Division of Information and Administration

Chief Executive Officer for Social Development
Office of Senior Citizens (Gold Card)
Office for Youth Development
Office for Health Entitlement Registration

Provincial Health Authority – (HA)

An elected board with a ministerial appointment
Director: A Public Health Physician
Public Health – (HA); Primary Care Trusts (population based) – (NHIC);
Hospitals – (HA)
Service Care Trusts - (HA)
Primary Medical Care Practices funded by the PCTs – NHIC)
Community (Individual/Family)

Role of the Health Authority – NHIC

- To coordinate and integrate, public health, primary care, hospital care and social health.
- To fund public health, hospital care and service care trusts.
- To be accountable for the dispersing of funds in public health, hospital care and service care trusts.
- To undertake accreditation for hospitals and primary medical care practices.
- To provide an annual report to the Director-General of Health.
- To appoint a Public Health Physician as its Medical Officer of Health.
- To seek public submissions on 'health issues' from time to time.
- To elect and receive appointments to a board.

Role of Public Health – HA

- To provide a service to the community in terms of protecting the environment, enabling clean air policies, surveillance of water catchment, supply and standards, monitoring pollution, maintaining building standards, surveillance of emission standards for motor vehicles, waste disposable and sanitation and such other activities that the Public Health and Disability Act requires.
- To provide an annual report to the health authority.

Role of Hospital Care – HA

- To provide emergency and acute care for patients needing such care.
- To provide specialist care where in-patient care is essential.
- To provide clinic services where support technology is accessible.
- To provide short stay care where procedures require supervision.
- To provide ongoing professional development for its staff.
- To provide an annual report to the health authority.

Role of Primary Care Trusts – NHIC

- To fund and support primary medical care practices.
- To provide professional development programmes in association with the RNZCGP and other professional institutions.
- To be accountable for the funds it disperses to other defined programmes.
- To provide an annual report to the health authority.

than with their own doctor, they would pay a higher consultation fee.

The United Kingdom after hours arrangements have requirements, in terms of competence and accountability, that a designated after hours locum would need to comply with. For after hours care patients would call the medical practices they are registered with for information about the after hours arrangements.

Health Authority

The local authority could follow the boundaries of its province and be named accordingly but each local authority would have responsibilities in public health, which includes environmental, occupational, sanitation and institutional health. The role of the health authority is to provide a service for the public health needs of the community and the environment, whereas the role of primary medical care practice is to provide a response to acute medical problems and provide intervention care as a means of health promotion. Environmental health officers' duties would include inspections of food premises, licensing premises, water standard control, air pollution monitoring, dealing with nuisances and quarantine services.

Funding

Health care funding coming from the Treasury to the Ministry of Health as a health vote[4] and to the Ministry of Social Development as a social development vote[5] could be allocated to public health, primary care, hospital care and social care. Therefore, combining both ministries ought to allow a strengthening of the health care system with social care being a part of public health and primary care. The primary care funding could be determined on a population basis based on patient registration data, service needs and capital costs.

How a UK example could direct our planning

An example of how funding, amounting to £126 million, was spent by the Cambridge City, UK, Primary Care Trust for the 2003/04 period was as follows:[6] Out of the total expenditure general practice spent 24.6% (£31.09m.), which included GP medical services, 6.03% (£7.6m) GP practice running costs, and 6.19% (£7.8m) GP prescribing, 12.46% (£15.7m). General/acute hospital services accounted for 37.3% (£47m), maternity 2.46% (£3.1m) community services, 8.88% (£11.2m), mental health, 17.46% (£22m) and accident and emergency, 2.69% (£3.4m)...

Primary care trusts running costs amounted to 2.69% (£3.4m).The primary care trust holds the National health service budget which supports the health care of about 144 000 people registered with GPs in their area. The Primary Care Trust guides the work of the general practitioner practices and directly provides community health services such as district nursing, child and family nursing. There are services for the elderly and for terminal illness. There is a local delivery plan covering a three-year period (2003–2006) that is updated every year. In 2003/04 the primary care trusts received 9.21% (£8.3m) of additional funding, which was directed at improving access to health care and improving the quality of services for all.

Integrated care

Accountability and sound planning contributes to improvements in the organisation of integrated care based on current evidence-based health care information.[7] More specifically, surveillance of public health issues, epidemiological data monitoring, the workings of the service care trusts and primary care issues.

Summary

What can be learned from the present health care system is that it is complex and fragmented, and this has contributed to most of the process costs. The paucity of funding to public health and primary care clearly undervalues both public health and primary care. A greater appreciation of the value of public health (environment) and its meaning and the role of general medical practice (primary care) would enhance a more accountable health care system. A more structured public health service could influence both economic growth and higher living standards.[8] The contribution from primary care is from well-trained and skilled general medical practitioners, nurses, physiotherapists, midwives, social workers, pharmacists, receptionist and other career staff working as a team. Such an arrangement provides an opportunity for a user-friendly paradigm that benefits both patients and the service.

Merging the Ministry of Health with the Ministry of Social Development would strengthen the health care system. A National Health Insurance Commission would become the funding agency of the ministry and also would oversee the allocation of a National Health Insurance card for every New Zealand citizen.

The Health Entitlement Card would replace the community health card and would be means tested for those who need such a card. It is suggested that the health and social development vote be appropriated and that 20% be allocated to public health, 60% to hospital care, 10% to primary care and 10% to administration.

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