

Investment in primary care—is it worthwhile?

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The importance of primary care in New Zealand is emphasised in a number of Ministry documents—“A strong primary health care system is central to improving the health of New Zealanders and, in particular, tackling inequalities in health”,¹ and “Better, Sooner, More Convenient Primary Health Care is the Government's initiative to deliver a more personalised primary health care system that provides services closer to home and makes Kiwis healthier.”²

In this issue of the *Journal*, Tan, Carr, and Reidy report on the implementation of the Primary Care Strategy¹ through a Framework developed to guide funding decisions made by the Capital and Coast District Health Board.³ The article demonstrates the strong association between funding levels and improved outcomes, measured by specific outcome markers.

Internationally there is growing recognition of the importance of strengthening primary health care as it is seen as probably the only way to in some way contain burgeoning health care costs.⁴⁻⁶ In addition to downstream costs (or upstream costs—depending on which way it is addressed) in New Zealand, there is evidence of inequality of primary health care provision, and as a consequence, of health care uptake.^{7,8} This has association with geographic location, race, age, and socioeconomic status.

It is now 34 years since the WHO's Declaration of Alma-Ata,⁹ and while this has reference to third world and developing countries, there are underpinning principles which have application to all countries. The goal of primary health care is “health for all” and the WHO-inspired document has identified five key elements to achieving this goal. These are the reduction of exclusion and social disparities, the organisation of health services around peoples needs, integration of health care into all sectors of the population, pursuit of collaborate forms of health delivery, and increasing the stakeholder participation. The latter includes of course the patient who is the principal stakeholder for health care receipt. In the provision of health care an inverse rule applies—those who need the care the most, receive the least.

In New Zealand, primary care must strive for optimal health of the populace at a cost which is affordable, and this must be recognised by Government. The capitation payment for general practice was calculated at just over three services a year for the adult population, with increases in attendance allowance for the young and the elderly. As a consequence of a number of factors, including fee reduction, the consultation numbers have climbed with a consequent decline in the value of the per service capitation.

Accident Compensation Corporation (ACC) levies to General Practice have remained constant for approximately 5 years in spite of sometimes dramatic rises in practice costs, and again as a consequence, ACC part-payments to patients have risen. There are arguments on each side of the fence as to whether primary health care should be

free to all, or at least to some, or whether there should be some cost to the patient. But what is abundantly clear to providers is that the cost should not be a disincentive to attending a doctor. In many cases this is happening at present.

With the introduction of the Primary Health Care Strategy and the formation of PHOs in 2003 the funding for primary care increased significantly. But the important point is that it received the smallest portion—it had an increase of 6 million dollars annually from 2002 till 2007, whereas secondary care increased by 21 million dollars annually. Equally important is that in spite of increased primary care workload and output, there has been overall no shift in resource provision.

If there is an available, affordable, and acceptable primary health care service then as the paper by Tan, Carr and Reidy demonstrate,³ there can be an expected reduction in unnecessary or avoidable hospital use, including admissions, and emergency department utilisation, increased utilisation for disadvantaged patients, and increased patient directed initiatives involving the whole primary health care team. However this outcome was only obtained in the Capital and District Health Board region with sustained investments over and above PHO funding along with a collaborative approach with provider and community input. This will only continue to happen in this country if the sector is adequately resourced.

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