Not-for-profit health services and hybridisation

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Introduction

This issue of the *Journal of Primary Health Care* (JPHC) looks at the hybridisation tension between the goals of not-for-profit organisations and the expectation that they behave more like businesses.[1] There is tension between the goals of a not-for-profit health service like Newtown Union Health Service (NUHS) and the requirements placed on the service by government. It is too simple to say it is a tension between providing high-quality, patient-centred care and running a viable business, or that business practices are necessarily in conflict with providing good patient care. I have worked at NUHS for the past 25 years and will illustrate my arguments from my experience there. The views expressed are mine alone and do not necessarily reflect those of NUHS.

Any Non-Government Organisation (NGO) working in this space has to have efficient business processes in order to be able to do the best they can for their patients.

From the outset, NUHS introduced many 'business' features to the service that were uncommon at the time of establishment:[2]

1. The service appointed a manager with management skills and experience to run the service, rather than it being run by the doctors.
2. There is a constitution with goals and objectives and a planning process to determine how to meet those goals.
3. NUHS was one of the first capitated practices and, as a result, has a predictable income and budget of how the money will be spent.
4. NUHS publishes an annual report providing transparency on the work done and how money is spent.[3]

NUHS is currently engaged in becoming a Health Care Home,[4] a project to introduce 'Lean Thinking';[5] some of the elements of which are proving really helpful.

In my view, the major tensions NUHS faces are between a small not-for-profit health service and a low trust, payment-minimising, nationally focused, politically driven environment with a limited understanding of the complexity of the work that we do.

Low trust

Accountability provisions should vary according to the extent to which there is congruence between the goals of the funder and the goals of the provider. If a provider's major goal is profit maximisation, then the funder will need to take care that goals of service quality are met. The goals of NUHS are completely congruent with the stated government goals; even explicitly including the Primary Health Care Strategy.[6] Any budget surplus goes to providing more services. Of NUHS's income of NZ$3 million, 89% comes from Capitation and PHO contracts.[3] The government is by far the majority funder of the service. Not only must the service be provided, but the detail of what is done has to be documented as evidence. There is no problem with this if the data are already being collected for NUHS purposes. NUHS has always kept detailed records of immunisation, cervical smear history, smoking and other drug use, and accurately coded conditions such as diabetes, mental health diagnoses and cardiovascular disease. Detailed information is gathered on ethnicity (long before it became a government requirement) and whether an interpreter is needed. The data are not always complete, but the service puts effort into getting it as good as possible. However, for funding purposes, extra fields have to be completed if a patient is seen urgently, if they are asked about smoking (even if smoking status is already recorded) and if they are under 24 years old and sexual health issues are discussed. In addition, separate forms

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have to be completed if intravenous antibiotics for skin infections are provided, or if someone with renal colic is cared for. If the service is provided but the forms are not completed, nothing is paid. Finally, if data collection targets are not reached, money can be deducted. The irony is that the amount of money for each of these services is out of proportion to the documentation required to receive that money. The funder does not trust NUHS to do what it is funded for.

Payment minimising

There are many instances of the government not acting in good faith. They announce a programme, the service is delivered and then the government fails to fund the full cost of the programme. This is a problem for all practices, but it is a particularly acute problem for NUHS because patients cannot afford to pay increased fees. In my experience, the list of programmes this applies to is long (and arguably it is the norm) but, for example, one issue of '*New Zealand Doctor*' (14 December 2016) documented three.

1. The PRIME (Primary Response in Medical Emergencies) scheme was set up to provide urgent care in rural areas. It has been 'Under review' for the last 10 months. *'Twizel Medical Centre faces an annual funding shortfall of $196,400 to provide an after-hours and PRIME service 24/7'.*[7]
2. Treatment for hepatitis C was introduced and it was announced that GPs could do this. *'Auckland GP, John Arcus, says the treatment involves a package of care…cost between $300 and $500'; 'The RNZCGP …called for funded GP visits. The Ministry of Health responded by saying treatment will be managed under existing capitation funding arrangements'.*[8]
3. The Government has failed to maintain the level of patient subsidy to primary care over the last 9 years. There is an annual shortfall of $36.82 million and a cumulative shortfall of $250.3 million since 2007.[9]

Nationally focussed

NUHS is far from an average practice. There are disproportionate numbers of people from a refugee background, people with enduring mental health problems, people with addictions and the ethnic mix has only 18% of European ethnicity.[3] Most of the funding is calculated on averages. Capitation funding is based on the national average numbers of consultations per year. It is adjusted for age, with more funding for patients under 13 years.[10] There is more funding for 'High Needs Groups', which includes Māori and Pacific people and patients living in deprivation deciles nine and ten, but does not include people from a refugee background.[11] Because funding is a 'one size fits all' model, NUHS often ends up losing out. NUHS prioritises the care provided to its particular practice population, rather than only focusing on the Government priorities. The Government introduced free consultations for children under 6 years of age in 1998. NUHS had been providing this since 1987 (p. 159).[2] NUHS noted that there were many people from a refugee background coming to the practice who had not been through the Mangere Reception Centre, and had thus not been screened for important infectious diseases. They were classified under the 'Family Reunification' migrants. NUHS secured funding to do that work from Capital and Coast District Health Board (CCDHB). As a capitated practice, NUHS had a register and recall system in place to maximise our immunisation rate from 1987. The national immunisation register was not rolled out until 2005.[12] NUHS has systems to try to ensure that all pregnant women receive antenatal care; the Ministry of Health does not publish any information on how many women do not receive antenatal care. NUHS has a long history of innovation; of finding primary care health problems and addressing them…and then applying for funding. This approach worked when the DHB had some funding to put into primary care, but this has been 'refocused' and the NUHS budget was cut by $273,000 in 2012[13] and cut further by $83,000 in 2016.[14] Prior to this, the level of global funding had given the potential to target funding to local needs. One particular need identified was good antenatal care. The national maternity funding formula has no provision for the costs of interpreters, increased home visits for mothers without transport or increased social complexity for mothers with addiction and mental health problems. These were all significant issues for the pregnant women at NUHS. NUHS employed midwives despite significant funding

challenges (p. 68).[2] In order to provide a sustainable midwifery service that avoided burnout, the cost of the service was subsidised from the general budget. As a result of the budget cuts in 2012, NUHS stopped employing midwives.

Politically driven

Provision of health care is an important political issue. We have a 3-year political term, so the Government wants to be able to 'do things' that can either be seen as good in their own right (we increased funding for under 13s) or that can be shown to have an outcome before the next election. The Government thus tends to put money into 'programmes' rather than base funding. Who could not agree with decreasing waiting times in the Emergency Department (ED), or measuring everyone's cardiovascular risk? As a GP, it is hard not to be cynical about these programmes. If I see a patient who I think has a broken arm and I send them to the Emergency Department, there is no charge for the x-ray, but if I send them to the private radiologist, there is a part charge because Accident Compensation Corporation (ACC) does not pay the full charge. Providing me with full funding for all accident x-rays would help with ED waiting times, but it did not happen. The report on cardiovascular risk assessments (CVRA) covers many of these issues. Many GPs felt that funding just to assess risk rather than extra funding for providing continuing care for patient risk as well, was the wrong focus (p. 49).[15] The targets were only met because the rules were changed to allow 'virtual assessments' (p. 40).[15] We were allowed to use blood test results from up to 5 years ago. Consequently, assessments were able to be conducted without talking to the patient. As long as there was a blood pressure reading, smoking status and some blood results (that might be up to 5 years old), a record of data would have been entered. As one key informant said, *'Virtual assessments were… a balance between what was politically palatable and what was clinically credible'* (p. 40).[15]

The current government has effectively cut health funding by a significant amount, possibly as much as $1 billion dollars when taking into account increased population, inflation and announced new services.[16,17] While there is rhetoric about providing more care in general practice, this cannot happen if there is progressively less money to provide care, and a significant amount of the funding goes towards meeting the accountability provisions rather than providing the care.

Complexity

The most important thing primary care clinicians do is develop a relationship with our patients. Without that, very little is possible. The next most important thing is to address the problems that our patients present with, the variety of which is immense. It is very hard to measure the quality of what we do. We know that good primary care is the foundation of good health care.[18] We also know that one-third of people in the most deprived areas reported not attending a GP because of cost or access difficulties in the past year (p. 32).[19] Complex problems are, by definition, not amenable to precise measurement. If accountability is required, then obvious or complicated elements of the task will be measured. In general practice, this only covers a small amount of what we do.

There is another business model embedded in communities that relies on high trust and inter-relationship. We are currently painting our house; this has involved scaffolders, painters, builders, plumbers, glaziers and tilers. For this to work well, there has to be good team work and respect between all the trades. While of course there are 'accountability' provisions…the main one being a quote for the job in advance that becomes the price, there is much reliance on trust. In the course of the job, many extra things came up, which we trusted the team to manage and to charge a fair price for. We have an existing relationship with many of the workers; the painters did our house beautifully 14 years ago, the building company is run by a relative. We were very happy to leave the house open for them to use the toilet and have access to power. We cannot always judge the quality of the work in detail; it looks OK but will it last? We found that if we treat them well, they will go the extra mile for us, especially when we make progress payments on time.

With good tradespeople, there is a congruence of goals. We all want a good job for a fair price. Maybe the tension of 'hybridisation' is much more about a loss of trust and a lack of true congruence of goals. The government has rhetoric about providing comprehensive high-quality primary care, but would appear to be more interested in tax cuts and failing to increase funding to health care to account for inflation, population growth and new programmes.

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COMPETING INTERESTS
The author declares no competing interests.