Primary health care funding for children under six years of age in New Zealand: why is this so hard?

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ABSTRACT

The intention of this viewpoint article is to prompt discussion and debate about primary health care funding for children under the age of six. While New Zealand offers a superb natural environment for childhood, our child health outcomes continue to be poor, ranking lowest amongst 29 countries in a recent report by the Organisation for Economic Co-operation and Development. Since 1996, various funding arrangements have been introduced with the goal of achieving free primary health care for children under six years of age and nearly 80% of practices now offer care to this group without charge. Universal no cost or very low cost access for young children, however, remains elusive, particularly for after-hours care, and this is important given that at least one in five children lives in poverty.

We are under no illusions about the complexity of primary care funding mechanisms and the challenges of supporting financially-sustainable systems of after-hours care. Good health care early in life, however, is a significant factor in producing a healthier and more productive adult population and improving access to primary care lessens the impact of childhood illness.

We suggest that reducing cost barriers to primary care access for young children should remain an important target, and recent examples show that further reductions in cost for primary care visits for young children, including after-hours, is possible. Further funding is needed to make this widespread, in conjunction with innovative arrangements between funding authorities, primary care providers, and emergency departments. We encourage further debate on this topic with a view to resolving the question of whether the goal of free child health care for young children in New Zealand can be realised.

Introduction

Despite a superb natural environment for childhood, New Zealand has a disappointing record in child health compared to many other developed countries. In a recent report of 29 member countries of the Organisation for Economic Co-operation and Development (OECD), New Zealand ranked lowest for health and safety indicators of child well-being, and was noted to spend less than half as much on children under six as for 12–17-year-olds.[1]

Access to care is recognised as an important element in promoting child health and reducing disparities in health.[2,3] In New Zealand, two foundation documents on primary care[4,5] highlight the importance of access, and the potential for cost to be a barrier to access. Since the introduction of the 'Free Child Health Care Scheme' (FCHCS) in 1996, significant success has been achieved in reducing cost barriers to primary care for children under six years of age. Despite excellent use of this and subsequent funding packages, the goal of universal free care remains unmet, particularly for after-hours care, and may be contributing to poor child health statistics in New Zealand.

This article aims to review attempts at, and challenges to, removing financial barriers to primary care for children under the age of six. We wish to open and progress debate amongst practitioners

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about why achieving low or no cost funding for children under six years of age in New Zealand should be so hard.

Background

The FCHCS is popularly assumed by the community to be a policy that ensures all children under the age of six receive free health care.[6] Yet it was never designed to guarantee free access to primary care: at its initiation, the scheme offered an increased subsidy of $32.50 per consultation for children under six, but successive governments have not wished to remove professional rights to charge co-payment.

Although the FCHCS provided a significant investment in children's health care, it offered no commitment to ongoing funding for increased operational costs or inflation, and contained two pieces of incomplete policy detail. The first area of uncertainty was the level of co-payment that practices might be expected to add, both at the time and into the future. The second relative policy vacuum concerned the funding of after-hours care. Today the FCHCS remains part of a complex system of primary care funding and patient co-payments.

Further initiatives have been made to maintain low or zero fees for the under-sixes. The 'Very Low Cost Access Scheme' was introduced in 2006 to support, encourage and reward Primary Health Organisations (PHOs) to deliver low cost primary care. To be eligible for this scheme, practices had to commit (amongst other measures) to free consultations for the under-sixes.

In 2007 the Government announced the 'Zero Fees For Under Sixes' package, which provided additional funding totalling $8.25m for practices that 'commit to providing free care to the under sixes'.[6] Alongside annual adjustment of capitation by the Government, this brought total funding to $45.70 per notional visit.

Despite these initiatives, the goal of establishing universal free care for children under the age of six has not been achieved. In 2007, 61% of practices had no charge for children under six during work hours, with a national average of $5 co-payment per consultation.[6] By 2010, 78% of practices were providing free care to the under-sixes (personal communication, Ministry of Health). A Ministry of Health report on after-hours fees presented to Cabinet in October 2007 stated that 'the problem of after hours fees is more widespread than previously thought' and identified 119 locations where after-hours consultations for children under the age of six cost $16 or more (20 of which charged over $41).[7]

The importance of primary care for children

Early childhood is a crucial period for development and well-being. A healthy start to life can not only reduce later morbidity, but also produce individuals who are more able to participate in society.[8,9] Primary care directly influences children's health from provisions of services such as the immunisation schedule and Well Child checks, through to assessment and management of acute and chronic illness. Primary care also has an acknowledged role in reducing differences in child health outcomes between different groups in the population.[10]

The goal of universal free care remains unmet, particularly for after-hours care, and may be contributing to poor child health statistics in New Zealand

Current figures indicate that the health status of New Zealand's children is poor by international standards,[1,11] the disparities between ethnic groups and by socioeconomic status are large,[12] and some preventable diseases have increased in prevalence since the early 1990s, correlated with a marked rise in child poverty.[13] For example, rates of rheumatic fever have failed to decrease since the 1980s; they remain some of the highest reported in a developed country and have increased among Maori and Pacific children over the last 10 years,[14] while hospital admissions for serious skin infections doubled between 1990 and 2006.[12]

The impact of many childhood illnesses is reduced with early intervention, using both prevention and treatment that is available at the primary care level, with access to primary care being pivotal to improving health outcomes.[15,16,17] An all-ages analysis of New Zealand hospital discharge data from 1989 to 1998 suggested that one in three hospital admissions was potentially avoidable,[18] and a 2010 report from the Public Health Advisory Committee recommended implementing free primary health care at all hours for children under six years.[19]

Despite the overall international evidence supporting the role of primary care in improving health outcomes[20] there has been little study of the effectiveness of current primary care arrangements on child health outcomes in New Zealand apart from the example of immunisation.[21]

Some information is available from the initial evaluation of the FCHCS conducted for the then Health Funding Authority in 1997, one year after the scheme's introduction.[22] Despite the short time frame of the study, Sue Dovey and colleagues[23] concluded that, after the introduction of the FCHCS, free care was widely available, especially in working hours, and more children consulted with a general practitioner. There was little information about which families benefited most or any health benefits gained, although the authors highlighted a reduction in hospital admissions for respiratory illnesses. Qualitative analysis of comments made by general practitioners suggested doctors were generally supportive, noting 'better follow-up, less pressure to prescribe and the ability to deal with problems earlier'.

Cost as a barrier to care for children

There is significant evidence that lower socioeconomic status poorly affects health outcomes, including children.[8,24,25] Where cost is a barrier, a family may delay seeking appropriate and timely care, thereby potentially letting the child's illness worsen. For people with financial difficulties, a delay in seeking care is common.[26] The Ministry of Health identified 'high fees' as $15 or more for children aged 0–5 years.[7] But even $15 is likely to represent a barrier for those on the lowest incomes where earnings are insufficient to cover all essentials, and choices must be made between paying for food, clothing, housing, educational costs, transport, and so on.

According to the Ministry of Social Development, child poverty rates are generally worst for younger children and remain higher than in the 1980s,[27] with 19% of New Zealand children living in serious hardship in 2008.[28] Previous harsh economic times have led to increases in poverty and socioeconomic differentials in health.[29] The recent recessionary environment is likely to be no different.[30,31] Those children living in significant poverty are three times more likely to be sick than those from higher income families.[24]

After-hours—the forgotten care

While significant attempts have been made by central government to reduce fees for primary care for children during work hours, no such programmes have been funded for after-hours care. Funding arrangements for after-hours are delegated to individual District Health Boards (DHBs) who have taken a varying degree of responsibility for these. Some initiatives have been undertaken by individual PHOs.

The roughly 75% of each week that is outside the standard working hours of 8am to 5pm can be an important time for access to care for children for two reasons. Firstly, many childhood illnesses typically deteriorate during the course of an evening. Respiratory diseases such as asthma and croup, for example, have a natural pattern of deteriorating nocturnal symptoms. Many other illnesses are unpredictable and may not necessarily cause concern only during working hours, or may arise at the weekend. Secondly, after-hours can represent a sole time for access to care for families, especially those living in poverty. Limited access to transport or parental work constraints can mean that families are not able to seek medical care for their children until after-hours.

Why is this so hard? The beginning of a debate to find solutions

The funding of general practice and primary care in New Zealand is complex and opinions are diverse and firmly held as to the merits of different

funding options. However, significant progress has been made; the various funding packages support many thousands of New Zealand families, and practitioners and practices involved seem satisfied with the arrangements.

Some, though limited, progress has been made with after-hours care. For example, an Auckland PHO in 2004 created free access at all hours for children under six.[32] A Whangarei PHO dropped after-hours fees to $5 in 2009.[33] These examples demonstrate that further change is possible and we suggest that universal zero fees for under-sixes 24 hours a day seven days a week is an ideal that should be debated. However, it is important that this discussion is not confused with the merits or otherwise of the general debate regarding co-payment as a means of maintaining previous and current agreements between the government and professions over primary care funding. We suggest that the needs of children under six, as a vulnerable group with no active voice of their own, are best served by a system that effectively removes financial barriers to access.

How might a zero/very low cost–fee system work?

Firstly, funding solutions need to be universally applicable so that potential tensions do not arise between different practices and between regular day work and after-hours. Previously suggested solutions have foundered because they do not take into account the economic reality of practice funding.

Given the uptake of the various under-sixes funding arrangements, it is clear that practices in high income areas and in comparable parts of the same city are able to participate in the scheme without apparent financial penalty. It is important that both those who are participating and those who are not debate the rationale for their decision and include both financial and ethical dimensions to their views.

Finding a solution is particularly important with after-hours funding. Some after-hours services are running with minimal, if any, financial viability while others may be able to make a significant income. Experiences such as those at the Whangarei and Auckland PHOs show that solutions are possible, and it is important that these experiences are shared and developed. Additional funding will be necessary to secure free out-of-hours services and DHBs and PHOs should all work to identify the sums of money required. The costs may not be as significant as feared: for example, an estimate from a medium sized North Island DHB indicates nearly $100,000 would be required per annum to secure GP-led after-hours provision for a population of around 13 000 children (personal communication). However, in other areas, particularly those with low throughput, the financial viability of GP-based after-hours, especially overnight, is likely to be unrealistic. These areas may require different creative solutions, such as working more closely with emergency departments or transport options to bigger hubs.

Contracting arrangements will need to be trustworthy and realistic, which has not always been the case in primary care funding. In this area the equivalent of a higher salaries commission might develop an agreed formula for after-hours funding.

It is also important that appropriate local arrangements are developed with emergency departments. Despite indications of pressure on these departments, there is a dearth of information about the proportion of current presentations that might appropriately be managed in primary care instead. There is also a need for constructive joint programmes to both educate the public and agree on referral patterns between emergency departments and after-hours providers. We suggest further modelling of different funding and workload patterns at different geographically-based sites to explore this.

Conclusions

New Zealand has a long-established movement towards providing free health care to the under-sixes. Yet complete implementation of this goal remains elusive. Further information must be sought alongside any changes in access arrangements. Continuing evaluation of the aim of funding arrangements should be incorporated in the consensus about the role of general practice and primary care in child health. It is important that realistic expectations are debated around health

outcomes such as recurrent illness, immunisation rates and hospital admissions. Further research to unravel the interactions between cost, socioeconomic deprivation, and access to primary care in this age group is needed, but developing a more comprehensive approach to primary care funding should not wait.

Appropriate access to primary care is pivotal to the health and well-being of New Zealand's children, and to their future. There are many possible solutions to enhancing access, and they all involve agreement and constructive debate between existing primary care providers, emergency departments, after-hours providers, and funding authorities. Several funding models from health authorities might be possible, varying for each community, but imminent action is needed to establish programmes that enable increased and consistent access for children at all hours.

We ask that this viewpoint article provide a focus for debate of an issue that, while complex and challenging, is not impossible to resolve; New Zealand children are waiting for our answer.

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