

The Maori partner of NZSP, Tae Ora Tinana, is active in addressing Maori under-representation in the physiotherapy workforce and supporting Maori already in the profession, for instance through regular hui and through mentoring of students.

In order to make physiotherapy services accessible to all cultures, NZSP has produced a number of resources aimed at improving members' cultural competence. These include *Guidelines for Cultural Competence in Physiotherapy Education and Practice in Aotearoa/New Zealand*, adopted by the Society after development by the Tae Ora Tinana.

Physiotherapy services are funded through two main streams: Accident Compensation Cor-

poration (ACC), currently the main revenue source for private practices, and the Ministry of Health via Vote Health which funds DHB services. The reliance on ACC funding by private practitioners has left them very vulnerable as is evident with the present blow-out of ACC costs, which some are blaming on costs higher than were anticipated for physiotherapy treatment.

The NZ public has been fortunate to have direct access to physiotherapy, which was recognised by ACC in 1999. Physiotherapists are the first point of contact for 14% of ACC claims, demonstrating the strong position they hold as primary health care providers.

## The workforce shortage disadvantages those in greatest need

A primary health care (PHC) workforce shortage inevitably impacts on the primary care of people. We are all aware of the inverse care law: the availability of good medical care tends to vary inversely with the need for it in the population served.<sup>1</sup> Provision of PHC has undergone a number of changes in the last few years that I believe means there is a risk that care for those in greatest need will be disproportionately affected by the workforce shortage.

A change to capitation funding alters the incentives in caring for needy poor people. Under a fee-for-service system, at least the practice got some money each time the patient came in even if it did not receive a patient co-payment. Under a capitation system, a patient who does not pay co-payments becomes more and more of a drain on the practice the more times they visit.

If there is a shortage of doctors, then practices 'close their books'. This disadvantages people who tend to move more often, which affects poorer

people more as they do not own houses and tend to be more mobile.

In my experience, 'closed books' are usually publicly closed but 'opened' at the discretion of the practitioner; for example, for new babies of existing patients, family members moving to join existing patients, possibly returning 'old patients'. If discretion is being exercised then it is more likely that high needs people who cannot afford co-payments will be turned away, to preserve business viability.

The Kapiti Coast is generally considered a desirable place to live, yet they have been unable to attract sufficient practitioners to open practices there. Why would a practitioner set up practice in a poorer suburb instead? Some communities (particularly rural) have addressed the shortage by building facilities to let to practitioners. Poor urban communities are less likely to have the ability and resources to use this strategy. This will inevitably become a bigger problem as the 'Economic Crisis' bites further and unemployment levels climb.

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The new Minister of Health sent a one-page letter to all District Health Board heads: 'Expectations for all district health boards'. Three of the five bullet points related to improving service and reducing waiting times: increasing elective volumes, improving emergency department waiting times and improving cancer treatment waiting times.

I argue that people who are not registered with a PHC provider are the most disadvantaged and that, of all the waiting lists, this is the one that is the most important to reduce. This group is not part of the Minister's priorities because we have no systematic way of identifying these people.

Capital PHO (now Compass Health) has used some 'services to improve access' funding to systematically contact unregistered people who attend the After Hours Centre to help them register with a PHC provider. Such a process will be a good barometer for Wellington City as to whether we have a growing population of unregistered people.

I would suggest every after-hours service and emergency department (ED) should be obliged to routinely report numbers of patients seen who are not registered with a PHC provider and ideally have some case managers responsible for helping these people find a practice. This might be introduced as part of a strategy to control waiting times in EDs, but I would rather it became an activity in its own right.

There is currently a significant drive towards improving quality, almost all of which focuses on existing practices. Whilst these have significant merit, the clinician time and resources spent on these activities may contribute in a small way to the workforce shortage. I argue that a person receiving no primary care is receiving the worst possible care. The marginal benefits of spending resources or time on other initiatives are unlikely to stack up against spending those resources on ensuring everyone can register with, and attend a practice.

#### Reference

1. Hart J. The inverse care law. *Lancet* 1971 Feb 27; 1(7696):405–12.