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What do we know about the new government's plans for funding primary health care?

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At the time of writing, the new coalition government has only recently been formed and so far little is known about the detail of their health policies. We have heard about the promised repeal of the current tobacco control legislation, the (slightly ambiguous) commitment to fund a new medical school at the University of Waikato, the intention to 'examine' the affirmative selection policies at the universities of Auckland and Otago, the commitment to close down Te Aka Whai Ora, and the commitment to reintroduce over-the-counter pseudoephedrine. There is also a stated desire to reduce the everyday usage of the reo Māori in the names of government departments and the like.

Hon Dr Shane Reti commences his tenure as the new Minister of Health at the same time as the complex health reforms initiated by the previous government are still in the process of being implemented and bedded in, and at a time of considerable financial pressure within the health system and within the broader economy. It will take time for him to work with his officials and other advisors to develop detailed health policies. One important area where he is on the record concerns primary care funding. He has been reported as saying that he will proceed with implementing the Sapere report[1] on capitation funding.[2] This is good news and he should be applauded for this commitment because the capitation funding formula is a critically important building block in the foundation of primary care and the primary care workforce.

There has been much said and written over the past decade about the need for the capitation formula to be redesigned. These calls have had a growing sense of urgency over recent years. The urgency has its roots in two main problems: first is the contention that primary care is not funded adequately to fulfil the functions that are expected of it; and second is the abiding issue of equity of funding or, to put that another way, that the problems associated with inadequate funding are amplified in communities with the highest level of need, especially Māori, Pacific and low income neighbourhoods. The first problem is to do with the size of the funding cake, and the second is more to do with how the cake is divided up between practices.

The current funding system for primary care has a whakapapa that traces back to the first years of this millennium.[3] The past 20 years have seen various incremental changes to the capitation funding formulas. The process of change reminds me of funding arrangements in the health care system(s) in the US – over the years innumerable patch-ups and tweaks have layered complexity upon complexity. It is, of course, best to design service delivery models first and then the funding models that are tailored to support and enable the intended delivery of services. It is possible that the new government will have in mind some changes to the service delivery models, but even so, my expectation is that much of the primary care system will continue doing its essential work without any major redesigns or disruptions to the core medical and nursing team. Given the funding, workforce and sustainability circumstances within primary care, there is indeed a feeling of urgency that the funding system should be made fit for purpose.

What might a new funding formula look like? I have no insights into any work that may be underway within Te Whatu Ora or Te Aka Whai Ora, but I do have insights that arise from previous work carried out by the Sapere consulting firm for Te Whatu Ora. The report, *A Future Capitation Funding Approach - Addressing health need and sustainability in general practice funding*,[1] was released into the public domain last year. I served on a reference group that provided advice and oversight for Sapere. There were innovative aspects of Sapere's work that should, in my view, translate into any new funding

arrangements. First, the proposed formula was based on empirical measurement of the real costs associated with delivering services. No previous capitation formulas have been able to take this approach because the real costs were unknown at the time. Second, the formula takes a far more robust and empirically-based approach to calibrating the funding differentials for practices that serve high-needs populations with the intention that those practices should be enabled to sustainably provide high quality services to those population groups. Third, the formula makes explicit assumptions about the composition of the general practice team, and applies full costings accordingly. Fourth, the formula pegs GP income to the Senior Medical Officer MECA (Multi Employer Collective Agreement) on the basis that SMO incomes are as good a starting point as any for calibrating GP incomes. The SMO MECA is established on the basis of a robust, negotiated, socially mandated process. There is no equivalent process for non-salaried GPs.

I have two wishes for the New Year. First, I hope that the new government will commit to health and social policies that are actively pro-equity and anti-racist in order to avoid a worsening of already dreadful health and other inequities. Second, I hope we see real progress in the development and implementation of a fit-for-purpose capitation funding formula, and we see the political will to fund primary care adequately so that it can fulfil its foundational role in the health care system in providing sustainable, pro-equity, high quality services to Aotearoa's numerous and diverse communities.

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Conflicts of interest. Peter Crampton is a member of the Public Health Advisory Committee and serves on the Board of Te Tāhū Hauora (Health Quality and Safety Commission). He was a member of the Ministerial Expert Review Panel to review the New Zealand Health and Disability System (2018–2020).

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