Dr Keith T Blayney
MBChB (Auck), DipObst, FRNZCGP
General Practitioner

PO Box 447
Hawera, 4800

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Dear Annette King,

Re PHO Baloney

It is probably safe to say that we are unlikely to agree about PHOs, as your perspective is the health needs of the overall population while I deal with the individuals in my practice and their particular needs.

However, what concerns me is your apparent limited reading exposure, if my little piece is the "biggest piece of baloney" you have ever read. What is more, most of it comes directly from what you or Helen Clark have signed on the subject!

I could agree with you that the sections where I directly quoted you are baloney, but I assume you didn't mean that, so I wonder why you don't understand the concern of many GPs which I have tried to express here. Specifically….

- Why you think "management of referred services within a budget" (your words) doesn't mean Managed Care?
- Why you cannot understand that many people object to having ethnicity recorded and used as an indicator of health need? My Maori patients find it very patronising and insulting. But why stop at race or street of residence as indicators of health need? What about religion (some are much healthier than others), gender (men have a much lower life expectancy), or voting habits?
- Why you don't believe that Health Department and DHB management have more control over PHOs than the "community"? Ask any GP in a PHO who makes the rules. Remind me how many versions of the PHO agreement were rejected – I lost count at about 17 or 18!
- Why you believe joining a PHO and being capitated is welcomed by all GPs? If so, why are some PHOs collecting capitation then paying their GPs on a "fee for service" basis? Many in New Plymouth are very angry with their treatment in PHOs (particularly with fee fixing, clawbacks, compliance costs etc) and wish they had the freedom to practise independently. Just read any recent "New Zealand Doctor" letters from GPs (not health academics). **However, if you are so confident GPs like the PHO system, you should have no problems extending benefits to patients outside of PHOs and to patients of any GP who left a PHO – go on, or are you afraid most GPs would want to leave?**
- Why you don't understand that the most important factor in GPs leaving rural and semi-rural practice is stress, followed by low income? Semi-rural (small town) GPs reduce stress by combining after-hours systems, peer-review and other colleague collaboration. However no NZ trained GPs now want to work in rural towns which don't achieve a Rural Ranking Score of 35 (and so qualify for a rural subsidy) and those few of us left have no wish to take on the additional bureaucracy involved in PHO membership, particularly when additional funding is not to pay for the extra compliance costs, but directed to be totally passed on in reduced patient fees (ie a patient, not doctor, subsidy). One local PHO has now had to increase its adult fee above mine to stay viable!
- Why you can't understand that patients who attend non-PHO GPs are disadvantaged? They are denied reduced fees and low prescription costs, although the pharmacist that PHO patients attend doesn't have to be in a PHO, only their GP.
- Why you seem to think that prevention and screening can only occur in a capitated PHO environment? A number of GPs never embraced capitation and didn't join IPAs on principal and have been financially disadvantaged because of that, but we still provide high quality screening and prevention

programs (as proven by CareNET) without the financial incentives that were a feature of IPAs, where these programs are in the interest of our patients. We were, however "allowed" to provide free annual diabetic reviews under an IPA contract without having to be a member of that IPA, but that is in doubt in the PHO environment.

- Why you continue to believe that the answer to New Zealand's health problems is reducing the cost of access to services and not changing poor understanding of health risks? In fact the most important predictor of child health turns out to be maternal education, so it would be wiser to support high quality local educational facilities in Patea than the present plan to close their schools and pay even more for health and welfare in the future.
- Why your secretary/PA believes that GPs earn a lot of money, (the *Listener* lists self-employed Hair Dressers as earning more than GPs) and that non-PHO GPs should be able to match PHO fees out of their own pocket without the subsidies? She told this to a patient of mine who rang. Some GPs in PHOs do earn a lot, by seeing 70 people a day, whereas non-PHO GPs have to provide a quality service or our patients would object to paying and move to the PHO practices, so we can only manage 25-30 a day, which doesn't generate enough income (after expenses) to make General Practice particularly attractive or even viable (so guess what, New Zealand graduates now prefer Australia or Canada).
- Why you can't understand that GPs are being coerced into joining PHOs by discriminating subsidies and public advertising to join a PHO? I drive past a huge billboard every day telling my patients to join a PHO and Helen Clark sent the over 65s a personal letter telling them they should join. My low-income patients without a Community Services Card have to pay full fees at the surgery and the pharmacy, while richer community members attending PHOs have cheaper visits and prescriptions. While there could have been some arguable justification for cheaper prescriptions for those in access PHOs, the only possible justification to excluding patients outside all PHOs is to force their GPs to join. Furthermore, only PHO rural GPs will now get access to rural retention money and more recently only PHO practices are being sent some essential health information.
- Why you don't understand that because of this coercion, the PHO system has gone beyond benign democratic socialism into something more undemocratic and inappropriate for a free country like New Zealand where General Practice is largely run as private enterprise? This is perhaps the only area I feel I might have pushed my concerns to the point that would justify the "baloney" comment, but one has to question if the implementation of this Primary Health Care Strategy hasn't been too authoritarian. The main reason I resigned as a part time MOSS after 10 years in 1990 to work fully in General Practice, was the imposition of managers into hospitals (admittedly introduced under National) and to see this creeping into private General Practice makes me angry and question why I should stay.

I suspect the swing away from Labour is partially fuelled by the average New Zealander starting to object to more loss of personal freedom for a perceived "common good" that they don't agree with. Seeing money given to groups that have high health needs because of their unhealthy choices is another concern I often hear voiced. Forcing GPs into organizations they are not comfortable with will not in any way help the shortage of GPs, nor reduce the high stress levels faced by those who elect to stay in New Zealand.

Your letter, this reply and a Letter to the Editor (photocopy enclosed) are of interest to a lot of people and are available on the Internet at www.drblayney.com/HPolitics.html. Copies have also been sent to the local MP (Jill Pettis), the National candidate (Chester Borrows), and Rodney Hide.

Kind regards,

Dr Keith Blayney