The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

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Social Unemployment Insurance Tripartite Working Group
Ministry of Business, Innovation and Employment
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By email: incomeinsurance@mbie.govt.nz

Tēnā koe

RNZCGP Submission – A New Zealand Income Insurance Scheme

Thank you for the opportunity to provide comment on the MBIE Consultation on the proposed New Zealand Income Insurance Scheme (the Scheme).

The Royal New Zealand College of General Practitioners (the College) is the largest medical college in New Zealand. Our membership of 5,675 general practitioners comprises almost 40 percent of New Zealand's specialist medical workforce. The Rural Division of Hospital Medicine also sits within the College's academic remit of vocational training of doctors working in rural hospitals. Our kaupapa is to set and maintain education and quality standards for general practice, and to support our members to provide competent and equitable patient care.

NZ Income Insurance Scheme – desired outcomes

Work by the New Zealand Government, Business NZ and the Council of Trade Unions to develop a New Zealand Income Insurance Scheme (the Scheme) is a mutual commitment by society and government to close the gap for people displaced (made redundant) from work through no fault of their own. We note that the universal Scheme proposed by ACC intends to address inequities between levels of income and to support workers who lose their jobs due to redundancy, or who must stop working due to a health condition or disability. The Scheme estimates more than 115,000 people are displaced annually with sudden falls in income due to these circumstances.

The Scheme intends to impose a levy of 2.77 percent on salaries and wages split 50/50 between employers and employees each paying 1.39 percent. The Scheme will replace 80 percent of lost income for six months, with employers paying an initial bridging payment of 80 percent of their income for the first four weeks.

College – overarching comments

During the consultation phase the College met with MBIE and ACC to discuss their joint work to develop and implement the new Scheme. We suggested the proposal would have benefitted from involving key stakeholders during the design rather than at the general consultation phase.

The College response does not attempt to address the social merits or otherwise of the proposed Scheme, but it does seek to provide input on the potential business impacts to our Specialist general practice and Rural Hospital Medicine members, and to General Practice as a Small and Medium Sized Enterprise (SME), that operates in a pseudo 'private/public' partnership arrangement with government.

The College would stress the need for further detailed analysis to inform the proposal for the Scheme. There is a heightened risk of unintended consequences in the way the Scheme has been proposed, that would likely reduce, if not prevent the Schemes delivery of its overarching objectives.

The College recognises and supports the evidence for returning people to work and participation in everyday life. It is good for health, wellbeing and recovery, and is generally supportive of a Scheme designed to improve the inequity that currently exists in New Zealand between those people who suffer income loss due to an accident compared to those who suffer income loss due to acute or chronic health conditions. However, the Scheme would need to ensure that it does not entrench inequity for some populations, such as the possibility of implementing a 'two-tier' system of financial benefit for people suffering the same chronic health or disability condition based on their immediate pre-employment status, as this may be an unintended consequence requiring further consideration.

The College has concerns about the proposed Scheme and its application for those displaced from work, as it would appear to particularly advantage the higher earning populations and increase the equity gap for people on low incomes. For general practice sustainability we are not concerned about the standard contractual obligation of a four-week notice payment but are concerned about the proposed 80 percent payment on the employer for the first four weeks.

Specialist General Practitioners are a workforce under pressure and having to deal with medical certification for people who may be eligible for the Scheme is an added burden. Timing of the implementation will also create additional capacity issues for General Practice. Our members report patient delays in accessing care due to the Covid pandemic and ongoing serious workforce shortages across the motu. In rural areas, Rural hospital doctors and Specialist GPs report the most vulnerable people would be doubly disadvantaged in the Scheme, due to under investment in local health systems.

Key points raised by the College Membership

- The proposal states that 'a claimants' medical practitioner would assess work capacity, with final eligibility assessed by the Scheme administrator to certify fitness to work'. General Practice will be the main point of contact for people seeking an assessment from a Specialist General Practitioner.

- Specialist General Practitioners may also be an employee or an employer and a business owner of a SME, who would be impacted by the proposal to pay an employee 80 percent of their salary for four weeks because they are sick.

- Implementing the Scheme during a pandemic could impact negatively on the general practice workforce. The timing and speed of implementation is not feasible and will increase the level of burnout experienced by general practice teams, and compromise patient access.

- The Scheme does not cover job loss due to poor employee performance, gross misconduct or resignation. Exclusion criteria in a universal scheme is an anomaly which may increase inequity, create compliance costs, and introduce potential for blame or gaming.

- The College recommends the removal of eligibility criteria to facilitate equity and reduce the administrative burden. It would simplify the Scheme and focus assessment on its intent to increase equity.

- To support an assessment, Specialist General Practitioners need clarification and a definition of 'fully unfit for work'.

- The Scheme will put extra financial pressure on general practices as there is no additional resource or capacity to absorb additional time, tests or administration costs within current funding envelopes, effectively they will be subsidising the Scheme.

- Income inequalities in New Zealand significantly contribute to health, mental health, reduced wellbeing and ability to work.[i] A fairer and more progressive system would be to put a cap or upper limit on pay outs to address systemic inequality.

Potential gaps related to inequity, emerging changes and uncertainty [ii]

To prepare for expected intensification of global social, economic and environmental challenges and uncertainty, the Scheme needs to be future focused and strategically work with key stakeholders to plan an adaptive and flexible system informed by data to support and manage the sustained and escalating burden on the health system.

As an example, the College identifies outcomes of the Covid-19 pandemic as having long term effects on the New Zealand population, equity, economy, health system sustainability and potentialy and impact on the proposed Scheme. According to World Health Organisation[iii], the Covid-19 pandemic triggered a 25% increase the prevalence of anxiety and depression worldwide, and affected a persons ability to work. This coincided with severe disruptions to mental health services and impacted on other people accessing care.

- In New Zealand during 2020-2021 191,053 people accessed specialist mental health services or adddiction services, and 152,993 people accessed a GP for mental health services.[iv] An Australian study also showed GPs were the main point of contact for people seeking mental health advice during Covid-19. They reported psychological conditions as the most common reason for patient presentations across, age, gender, geographic location, and socioeconomic disadvantage.[v]

- The Covid-19 pandemic has also impacted on some industries and some populations being more at risk of job losses, for example, primary industries remained steady, while accommodation and food services, administrative and support services, transport, postal and warehousing had the highest number of job losses.[vi] Some industries have high numbers of of low-to-medium skilled workers in areas who may need to retrain or upskill.[vii]

- We suggest strategies to proactively confront rapidly changing circumstances would inclue the factors that impact on health and wellbeing, including employment, income, aging populations, population increases and subsequent demand for more services,

- As a matter of good practice outcomes of KPIs would be reported to support improvement and sit within a quality framework. This would provide transparency for the New Zealand public to understand the return on their investment in the Scheme.

Addressing specific points of the proposed Scheme

1. Implementing the Scheme during a Covid pandemic

As the College was not involved in the design phase of the Scheme, the impact on the general practice workforce and capacity constraints related to integrating new processes during a pandemic were not considered.

Within this rapidly changing Covid-19 situation, general practices are recognised as 'anchor organisations'[viii], physically, economically and socially connected to the communities they serve. Despite under investment within the health system, general practices have continued to provide medical services during the pandemic, often at a cost to the general practice workforce personally and to the sustainability of general practice.

Placing further burden on general practice while the pandemic continues in the future is far from ideal. As the virus adapts and evolves over coming years, the need for ongoing management of virus care in the community, and semi-regular Covid-19 vaccination campaigns, principally supported by general practice is how pandemic management will evolve.

Should 115,000 patients, or even half that number, attend an annual consultation for a certificate to state they met the criteria for sickness or disability to get their payment, is additional work at a time the when the workforce is working at capacity. The assessment also needs to be fully funded.

2. Impact on the Specialist GP workforce - There is no capacity to take on new work as the GP workforce is 'in crisis'[ix]

The pandemic highlighted the escalating workforce capacity issues within general practices. Covid and related illness coincided with unprecedented numbers of people seeking care in 2021, resulted in over 14 million consultations recorded in general practice. Increases in the number of people presenting with complex health conditions, enduring mental illness, and the pandemic coincided with a rapid increase in New Zealand's population (5,127,200 million)

The Covid situation exposed threats to long term sustainability of general practices and sustained under investment in the Specialist GP workforce. In 2021, the number of Specialist GPs in the workforce was 74.4. per 100,000 of the national population, by comparison with Australia at 116 per 100,000 of the population.[1]

The burden of increased pandemic related consultations has impacted substantially on routine care of chronic long-term conditions and screening and prevention programmes. One example is childhood immunisation rates that for under 5-year-olds was over 90% in 2019 and has declined to 71% in 2022. High patient numbers presenting with complex chronic health conditions, and mental health issues has impacted on clinical and administrative responsibilities. Recently, the Office of the Health and Disability Commissioner and Medical Protection Society identified administration associated with management of patient test results and patient records as areas of high-risk for general practices and patients when workloads are at capacity.[2]

The College surveyed members to understand the impact of the pandemic within general practice teams and 30% reported a higher-than-normal reported rate of burnout, particularly in areas where patient populations are living on low-incomes with higher health needs, and in rural areas.[x]

Recently there have been unprecedented staff shortages due to clinical and administrative staff taking up to seven days off to isolate. Rural Hospital Doctors and Specialist GPs also report, staff illness, burnout and equity issues amplify in rural settings. They do not have access to the level of resource needed to support patients, which increases the risk of patients missing out on access to timely assessments, equitable care and additional resources or services needed. People living in rural areas face double risk of inequity due to lower incomes.

Addressing the known and anticipated unmet health needs is the immediate focus in general practice, within the limitations of a general practice workforce in crisis for the near future. This means any additional burden placed on general practice could result in further deterioration for both equitable patient care and the wellbeing of the general practice workforce.

3. A conundrum determining eligibility in a Universal Scheme – 'exclusions', 'fit for selected work', 'fully unfit' criteria

While the proposed scheme is to have universal access, we note the there is an upfront exclusion to the Scheme which needs clarification.

We also identify the risk of damage to the doctor patient relationship if a patient is denied access to the Scheme, or if the stakes are raised by the prospect of receiving 80% of previous income for six months on the basis that a Specialist GP signs the certificate.

We seek clarity on how people would be excluded from the Scheme in the first instance. GPs will need clear definitions to assess and certify work capacity, so that final eligibility can be determined by the Scheme administrator, such as racism. We consider the proposed upfront exclusion criteria within a universal scheme is unfair, and the breakdown of an employer-employee relationship should not be sufficient reason to make a person ineligible for the scheme.

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[1] E Jo. Presentation to RNZCGP on Health Workforce Models. 2021.
[2] HDC and MPS Advice to the College.

The College is willing to provide advice on based on our experience of the current ACC Scheme, and considers the points below need clear definitions

- Exclusions may further disadvantage people who could benefit from retraining or other options for help.

- Exclusion criteria may further disadvantage and compound inequity for people who suffer complex health and/or mental health conditions, or social and environmental determinants that affect health and wellbeing.

- Regardless of the health condition, the Scheme should treat people equally to reflect the parity of the self-esteem principle in the Pae Ora legislation progressing through Parliament, however, it will be difficult to determine if someone with mild mental health issues fits this Scheme.

- There may be genuine reasons for not returning to work (which is why definitions are important). However return to work is something the College supports as all the health indicators point to work being a key component of good health.

The Scheme will require Specialist GPs to certify incapacity, 'fit for selected work' or 'fully unfit', to enable weekly compensation. Our members consider that in a universal scheme only those claimants with identified chronic, long-term, or serious health and wellbeing concerns should be required to undergo a GP assessment. We recommend that the current definition of 'fully unfit'[3] pertaining to ACC Medical Certification process[xi] be reviewed to ensure compensation and resources support a person's ability to return to work.

4. Payment for a 15-minute consultation does not enable general practice to absorb costs

Initial consultations for determining capacity to work need to be 30 minutes, and funded accordingly, to enable an appropriate opportunity for assessing the complexity of health or mental health and addiction issues.

The proposed Scheme will have a significant impact on general practice sustainability. The proposed payment structure assumes that costs will be absorbed within the existing general practice funding model, i.e. funding for a standard 15-minute consultation. The Scheme does not account for the costs of a complex assessment or additional time for people presenting with mental health or long-term conditions. If related tests or investigations are ordered for a patient the model assumes that costs would be within the capitation and co-payments budgets. Essentially, general practices would be subsidising the Scheme – an outcome that is not sustainable, acceptable or equitable to general practice owners. For such a costly Scheme, the expectation that a Specialist GP would make a complex decision that might involve a potential $52,000 pay out for example, and be completed in 15 minute consultation, is dubious.

The general practice funding model is determined by government, with no ability to attract additional funding for Specialist GP services provided. General practices have two main sources of income with no control over the amounts determined for either co-payments or capitation:

- 50 percent from a government subsidy, (VOTE Health), toward the cost of services for each patient registered with the practice. Annual funding is set by the Ministry of Health without fair negotiation with contracted providers of services. The application of the 'capitation' model is based on an average of two to three consultations a year and the Scheme will add to that number with no additional amount for capitation.

- 50 percent of income is derived from fees (or co-payments) payable by individual patients. The level of fees chargeable are capped by the Ministry of Health.[xii] Many patients in the high needs category,

[3] ACC – current definition of 'fit for selected work' (2020) - The risks of returning to work are excessive and the work environment poses a risk of serious harm to the person or someone else; The available work tasks will aggravate the injury; Unable to travel to and from work (even with assistance); Total inability to work, e.g., admitted to hospital.

struggle to pay the minimum co-payment charge. This can result in patients on a minimum or living wage having to pay $19.50 for a usual consultation which is equivalent of an hour's work. Delays in patients presenting to a practice affects their health, and general practices often need to provide free health services to those patients who are unable to meet the cost.

5. Other areas that affect implementation of the programme in general practice

ACC Certification process

Our members raised concerns about the potential use of the current ACC Certification process and request that new criteria are needed for the new Scheme. The ACC 2020 review[4] [xiii] [xiv] also notes that the system is not equitable for everyone, and that the certification process needs clarification for people with mental health conditions or a disability.

Assessment of capacity – Universal versus targeted

People with more complex needs are more disadvantaged in a universally applied approach and it complicates the assessment. It is likely that more than one consultation would be required for people with complex health issues. We suggest that a targeted and graduated or progressive assessment approach would be more equitable.

GPs are also concerned that the focus on retraining is not possible for all people. Although Case managers support people to return to work, not all people may be able to return to work.

Supply of Medical Records and impact on volume, time and cost

The current ACC medical certification process for 'Fitness to work' requires access to patient medical records to inform an assessment, and it is common for ACC assessors to seek years of medical records to prove that a client had a pre-existing health condition. The volume of information required for assessments materially impacts on General Practice staff time and resources.

The impact of mental health and addiction

41.5% of people enrolled in general practice experience underlying mental health challenges. This means the volume of people with mental health and/or addiction issues accessing the Scheme has the potential to be high. Mental health issues often require more time to effectively deal with, especially in an assessment phase, and it is likely that additional appointments would be needed in some cases.

6. Equity considerations – the risk of unintended consequences

People likely to benefit most from the Scheme will be those in regular, full-time, well-paid work. After an assessment[5] anyone in regular paid work would have access to an income insurance payment if made redundant.[xv] The Scheme has fundamental inequities relating to the inverse care law,[xvi] i.e., the consultation document showed people most likely to be disadvantaged in the scheme are those on lower incomes, Māori, Pacific, people with complex health or mental health problems. In addition:

- Māori are more likely to be displaced from work at higher rates than Pacific People or Asian and are disproportionately likely to be made redundant relative to their share of employment. Comparatively high numbers of Māori are employed in industries considered more at risk for displacement. Consideration for supporting Māori should be based on understanding that whānau/hapū/iwi health is dependent on the stability of social-economic arrangements and, on the wellbeing of their natural systems.[xvii]

[4] We acknowledge that an outcome of the ACC Review was to award costs for Medical and Other Reports to recognise equity for Specialist GPs in the preparation of reports. The change aligns with the Medical Council of New Zealand (MCNZ) which recognises vocationally trained Specialist GPs. Including the list of specialists contained in Clause 3 of the Accident Compensation (Review Costs and Appeals) Regulations 2002 addresses the gap for vocationally registered GPs.

[5] Assessment criteria is yet to be determined.

- People on the minimum working wage or lower, are not in the workforce, or have more than one job, will be the most disadvantaged by paying a 1.4 percent levy, such as, Pacific, women (particularly caregivers) and people with disabilities.

A progressive levy system could be more equitable as:

- People on higher incomes could protect their incomes with top-ups from private insurance, a cap would make the overall scheme more affordable.
- Levy revenue targeted to those most in need of income protection (low and middle income earners) who are less able to access private insurance.

7. Health and value for health dollar – who should pay?

Funding for the proposed Scheme will be from a levy on employers and employees, generating $3.54 billion New Zealand wide. The Scheme will also increase the cost to the health sector.

- Vote Health is the primary source of funding for New Zealand's health and disability system:
  - In 2021/21, $20.27 billion was allocated through Budget 2020 to the 20 DHBs.
  - Half the DHB funding allocation is spent on salaries for the entire health and disability workforce, including health and care workers employed privately by primary health organisations, and health and care workers employed in the not-for-profit sector.
  - The total cost of salary expenditure for the health and disability sector workforce, is estimated at $13.2 billion per annum (adding the $6.2 billion to the cost of employees in the health sector salary cost and $7 billion non-DHB employee cost).[xviii]
  - Estimates suggest that 136,887 people in the health sector are not directly employed by DHBs.[xix]
  - Based on the on the figures above, VOTE Health would need to fund an additional $171,440,000 (2.77%) per year

8. Financial sustainability of general practices as SMEs

The Scheme as proposed has the potential for broad abuse for work displacement with the unintended consequence of acting as an incentive for invoking redundancy situations for individuals or teams.

The proposed Scheme intends to add an additional 1.39% compulsory levy on both the employer and the employee. In the current environment of escalating inflation and rising interest rates, the ability of employees to sustain a further 1.39% loss in earning will have a substantial impact, particularly on low and middle-income earners.

Employees may look to their employer to cover both the employer and employee levy, meaning that employers will be under extraordinary pressure to fund an additional 2.8% of their total payroll. This comes at a time when many businesses are struggling to navigate the negative impacts of the last two years of Covid-19 disruptions.

The proposed Scheme does not appear to differentiate the injustice and inequity that would occur when a displaced person has a contracted redundancy benefit, essentially a financial bridge to support the person with 80% of their income into their next employment opportunity, compared to displaced people who do not have such a financial benefit.

General practices are SME's with limited ability to influence, or indeed, increase their revenue lines (see earlier paragraph. The lack of sustainability of general practice is now well recognised, and fully exposed during the pandemic response. General practice is unable to sustain any additional costs without full costs being met by additional government funding.

In conclusion

As a key stakeholder in implementing the proposed Scheme, the College is disappointed that we were not consulted at the beginning of the design phase. We are however keen to work with you during further consultation of the merits of the programme to ensure equity issues for patients in accessing assessments are minimised, and the impact on General Practice sustainability is understood.

We would appreciate meeting with the Social Unemployment Insurance Tripartite Working Group to discuss matters raised in our submission.

Should you require further clarification, please contact Maureen Gillon, Manger Policy, Advocacy, Insights, at Privacy of natural persons

Nāku noa, nā

Privacy of natural persons

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