Dr Keith T Blayney

MB ChB (Auck), Dip Obst, FRNZCGP.

[PO Box 447 (24 High St) Hawera 4640, N.Z. • work ph (06) 2785189, fax (06) 2786335 •
• mobile 0274 445 135 • Pvt E-mail: KTBlayney@gmail.com •
• Office E-mail: k.blayney2@orcon.net.nz • Webpage: www.drblayney.com] •

1 November 2018

SUSTAINABILITY OF OUR PRACTICE

Over the last 10 years our practice has managed to attract Rural Retention and support funding which has been used to support retention of staff without having to increase patient fees to achieve that.

Four events have changed this situation:

1. Our practice viability has deteriorated to the point that the GP, despite specialist Vocational Registration is now earning under the "living wage";
2. The stress of too many patients, (something that is financially rewarded in PHO subsidized practices but not ours), too little time to adequately deal with the big problems, and increasing bullying and unjustified audits and requirements from the TDHB has increased feelings of "burnout";
3. I have turned 65;
4. The TDHB Planning, Funding and Population Health section have decided they would rather have more control of the practice than continue approving Rural Retention Funding.

As this "rural support" was having the exact opposite effect to what it was designed for, we have decided that it was time to change the practice to be less stressful, more economic and more effective for those patients who value having access to a Private GP and are more interested in their individual personal health maintenance and care than having low fees. Or we could close the practice.

Removing management interference has been successful previously:

A. After the introduction of the PHO model only one GP did not leave South Taranaki, the one who preferred independence over income (myself);
B. When ACC funding for GP services became pathetic, some GPs just referred accidents on (to A&M clinics & EDs) but most wanted to provide good care and have been charging "shortfall" co-payments to patients because ACC doesn't value GPs;
C. When we stopped accepting funding for "free Diabetes Annual checks" because it was costing more for audits than we ever got from a DHB that was more interested in population figures than better individual diabetes control, we found patients were getting better diabetic results with more self-control over their disease;
D. When the TDHB stopped paying a retainer to be available to back-up Independent Midwife Lead Maternity Carers (IMW LMCs) because they then considered me to be similar to an employee, I had better nights, more mothers and babies had to be transferred to Taranaki Base Hospital but the LMCs still called me for serious emergencies;
E. When the TDHB wouldn't allow employed MWs to provide post-natal MW care as they are entitled to and the DHB is paid for (and the MWs were happy to do the work), and the

Government increased LMC payments for IMWs but not GPs and despite there being no children involved in antenatal and intrapartum care - I was required to have Police Vetting to check I wasn't a paedophile, I have decided providing LMC maternity care is just not worth the hassle. Women are now left with no choice, apart from choosing between a "direct access" MW and a Registered Nurse (RN) who then did her MW training. I will be advising the latter, if enough RN MWs stick around!

So I can now almost fully free myself from DHB meddling; I no longer have to be available 24/7 and I can offer both brief (repeat script or single simple problem) and longer consultations for more complex or multiple problems but for appropriate fees, which will be in the same order as the "casual fee" PHO practices charge for seeing casual patients not registered with them.

We will also be able to perform more quality minor surgery, at much lower fees than private surgeons, but I will not be offering procedures I don't feel comfortable and experienced with.

Taking longer to sort out a complex problem, performing more of my own minor surgery, doing less work that is undervalued by a funder and having patients who value service over cost will mean I can avoid burn-out, work with less stress (now I am 65) and hopefully achieve practice viability, and perhaps even match Midwife income!

Our clinical practising is still audited, but by the Medical Council of New Zealand through the Royal New Zealand College of General Practice who ensure I am clinically re-accredited, but the DHB is largely out of the picture, and with any luck both DHBs and PHOs will be phased out in the not too distant future because of both their irrelevance and parasitic cost to the improved health of New Zealanders.

I have lobbied both the Government and the NZMA to improve GMS subsidies for low income (CSC holders) and children as there are well over 300,000 people in New Zealand outside the PHO system, so hopefully our practice low income patients can get Government support they were promised would be for "ALL" New Zealanders, otherwise it may be necessary for some to move to a Very Low Cost Access (VLCA) clinic if they cannot afford our fees. As it is, I have been providing charity for 16 years (and had low income for 38years), so I hope no one feels they have the right to call me greedy. Principled, maybe, or unwise, but not greedy as recent graduate doctors without specialist Vocational Registration working in VLCA clinics are averaging incomes well over $200,000 and I have never heard of even one accepting a lower income to keep their patients' fees down.

So that is the story about the November change.

Dr Keith Blayney