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Did the 2014 Budget provide enough for Health?

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Summary

This analysis compares the 2014 Budget with the analysis the CTU carried out prior to the Budget, which found that $499 million was required to just keep operational expenditure up with rising costs, population growth, and ageing.[1] This analysis includes an updated CPI estimate, adjusting the required funding to $493 million. It also examines the detail of the key policy initiative to enable children under 13 to have free access to GPs and free prescriptions.

- The Health Vote in the 2014 Budget is an estimated $232 million behind what is needed to cover announced new services, increasing costs, population growth and the effects of an ageing population.
- While the Budget listed services that will receive more funding, and new initiatives such as the move to enable children under 13 to have free access to GPs, these will be paid for by cutting funding to other services.
- District Health Boards (DHBs) are underfunded by an estimated $94 million just to cover increased costs and demographic changes. When the costs of new services which the DHBs are expected to provide are taken into account, the shortfall is likely to be well over $100 million.

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[1] "How much funding is needed in Budget 2014 to avoid the condition of the Health System worsening?" by Bill Rosenberg and Lyndon Keene, Working Paper on Health No. 11, 13 May 2014. Available at http://union.org.nz/health-working-papers

- Centrally managed national services such as National Disability Support Services, National Elective Services, National Emergency Services, National Mental Health Services and Public Health services received $89 million below what they needed to cover cost increases and demographic changes, and $134 million below needs when the costs of additional services are included.
- The Ministry of Health itself was underfunded by $3.4 million.
- The cost of the policy initiative to enable children under 13 to have free access to GPs and free prescriptions from 1 July 2015 could cost closer to $40 million per year rather than the $30 million in the Budget estimates.
- For the year to June 2015 (financial year 2014/15) Treasury is forecasting health to have a real growth of negative 2.3 percent, which on their figures we calculate represents a shortfall of $360 million. Greater cuts are forecast for the following three years. It warned in the preparation of the 2013 Budget that such cuts would require major changes to our health services. This could include "more targeted services and funding" which implies dropping services, making some available only to certain groups, or introducing user charges.

The analysis the CTU carried out prior to the Budget assumed that CPI would rise by 2.1 percent in the year to June 2014, wages would increase by 1.8 percent (1.5 percent in the DHBs), and an increase of 1.64 percent for the growing and ageing population. See the report on that analysis for further details. For this analysis, the CPI increase has been slightly adjusted, to 2.0 percent, based on the most recent forecasts to June 2015.

How much did the Health Vote increase?

The Health Vote increased by only $307.9 million in operational funding overall between Budget 2013 and Budget 2014 (from $14,134.6 million to $14,442.5 million). This is $185.6 million short of the $493.5 million we estimate is required just to keep up with costs without providing for new and improved health services. However the Budget in addition introduced "new policy initiatives" costing a net $46.4 million in 2014/15, bringing the total needed to $613.5 million. The total shortfall is therefore $232.0 million.

The Vote listed $421.7 million in "new policy initiatives", of which $314.0 million were partial recognition of cost and population increases. This was offset by "savings" totalling $73.6 million including $56.7 million that are not explained, plus a reduction in the provision for risks such as epidemics or natural disasters of $17.0 million. These notionally come from the Health Services Funding appropriation which provides "Funding to respond to emerging health sector risks, provision for DHB structural deficit support, and contingency funding for Government priority health policy initiatives." In other words, it allows the Minister to announce further initiatives during the year and is a contingency for emergencies and DHB deficits. The "savings" therefore reduce the space for initiatives for the incoming Government post-election. The reduction in provision for risk is part of a continuing withdrawal of risk funding totalling $50 million over the next four years. It means that if those risks become a reality and exceed the lower provision, the funding will have to be found from somewhere in the government's finances.

The $56.7 million of savings is described as "NDE [Non-Departmental Expenses] Funding Reprioritised in Budget 2014 Four Year Plan". This therefore appears to be accumulated "savings" from the DHB and National Services appropriations. These have been identified in the increasingly demanding pressure in Budget rounds to reduce expenses to fit appropriations which are insufficient to cover rising costs and demands for new services from Ministers. It is impossible to identify whether or not these are real savings or in fact reductions in services, and we treat them at face value as true savings.

Some of the "savings" are in fact $48.0 million of unspent money from the 2013/14 financial year's Health Services Fund, which is being "recycled" into contingency funding for future years.[2] Such "recycling" of unspent funds is a regular feature of Health Votes. The Estimates of Appropriations show that the $48.0 million has been allocated to 2015/16 ($28.1 million) and 2017/18 ($19.9 million), not the coming financial year. A further $18.7 million has been "recycled" in this way, though its purpose and allocation is unclear.

While the Budget lists funding for "new policy initiatives", most of that funding is in fact to contribute to increased costs and demographic changes for DHBs and centrally managed national services. Nor does the "new" funding indicated under these "initiatives" necessarily equate to an increase in the appropriation of the same size. For example, on the face of it National Elective Services appear to be receiving $35.5 million in new funding in "new policy initiatives", but the appropriation in fact only rises $20.4 million from the previous Budget (and only $5.9 million after supplementary appropriations). Worse than that, we calculated it needed an additional $10.4 million to meet rising costs and population growth, so only $10.0 million is available to pay for the $35.5 million worth of additional operations.

District Health Boards

Budget appropriations show funding allocated to DHBs is just $300.4 million more than in the 2013 Budget (increasing from $11,104.3 million to $11,404.7 million). This compares to the $394.4 million that we estimate they need just to cover increased costs, population and ageing. They are therefore underfunded by $94.0 million.

In a Budget day media release the Minister stated that "District health boards will have about $320 million available next year for extra services and to help meet cost pressures and population changes."[3] This is less than accurate. Of the $320 million, $275 million is indeed an increase for DHB cost pressures and population changes, but the Ministry of Health advises that the remaining $45 million is for additional services for elective surgery and aged care. The surgery ($35.5 million) comes from the National Elective Services appropriation and the aged care ($10 million) is part of the Health Services Funding appropriation. The DHBs are paid for providing these services from these appropriations (though it is possible that the aged care funding will be effected by a transfer of the appropriation), but they are not part of DHB funding and do not necessarily have to be used to 'purchase' services from the DHBs – they could be provided by a private provider.

In any case, given that the additional $35.5 million worth of surgery is only funded by $10.0 million additional funding in real terms (as described above), in practice these additional services come at the expense of additional financial pressure on the DHBs who have to find the resources to provide them. The same may apply to other services provided by the DHBs through National Service funding.

Just what proportion of these additional services becomes the responsibility of the DHBs' is not known. However, it is clear that when these services are taken into account, the DHBs' total funding shortfall in practice is likely to be well over $100 million.

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[2] Ministry of Health advice.

[3] "Health budget increases to a record $15.6b", Tony Ryall, 15 May 2014, available at http://www.beehive.govt.nz/release/health-budget-increases-record-156b

National services

The centrally managed national programmes such as Child Health Services, Emergency Services, Māori Health Services and Public Health, in total gained just $5.7 million in operational funding (rising from $2,810.6 million to $2,816.2 million), which is $88.9 million below what is needed to stand still on cost, population and ageing pressures alone.

In addition, however, the providers of these national services, which include non-government organisations and health agencies as well as DHBs, have to provide new services costing $118.8 million. This includes not only ones listed in the Budget papers as "new policy initiatives" but also an entirely new national service, called the National Health Information Systems which funds "the provision of information technology services for the New Zealand health and social sectors". In 2013/14, $9.5 million was found for it from other appropriations, but in the new financial year it takes $12.4 million of the Health Vote. Accepting the $73.6 million in savings described above at face value, that leaves a net additional $45.1 million that must be found. The total budget shortfall for national services is therefore estimated to be $134.0 million, which will be felt by providers of these services such as DHBs.

As noted above, National Elective Services (contracted mostly to DHBs) is required to provide $35.5 million worth of services but has only $20.4 million more than in Budget 2013, and in addition has to cope with an estimated $10.4 million increase in costs and population. Other national services are in a similar position, as outlined in the following table:

Cost of additional services and funding provided in the Budget ($000)

National Service	Required for rising costs/ population	Appropria-tion	Shortfall on rising costs and population	"New Initiatives"	Shortfall after initiatives	Shortfall after "savings"
Health Services Funding	93,426	75,336	18,090	10,000	28,090	-45,541
Health Workforce Training and Development	177,073	173,714	3,359	1,704	5,063	5,063
Monitoring and Protecting Health and Disability Consumer Interests	27,145	27,096	49	0	49	49
National Advisory and Support Services	347	260	87	0	87	87
National Child Health Services	81,978	82,183	-205	0	-205	-205
National Contracted Services - Other	29,923	23,897	6,026	1,000	7,026	7,026
National Disability Support Services	1,144,420	1,117,547	26,873	29,627	56,500	56,500
National Elective Services	287,762	297,827	-10,065	35,500	25,435	25,435
National Emergency Services	96,481	93,739	2,742	0	2,742	2,742
National Health Information Systems	0	12,409	0	0	0	0
National Māori Health Services	7,920	7,308	612	0	612	612
National Maternity Services	144,243	147,166	-2,923	0	-2,923	-2,923
National Mental Health Services	62,164	55,876	6,288	6,770	13,058	13,058
National Personal Health Services	97,427	85,062	12,365	3,682	16,047	16,047
Primary Health Care Strategy	185,616	169,741	15,875	4,082	19,957	19,957
Problem Gambling Services	18,401	17,533	868	0	868	868
Public Health Service Purchasing	450,782	429,528	21,254	14,000	35,254	35,254
Totals	**2,905,109**	**2,816,222**	**101,296**	**118,774**	**207,661**	**134,030**

National Disability Support Services, Primary Health Care, and Public Health are among the services most heavily impacted by funding shortfalls, which is consistent with a move away from a universal and preventative healthcare focus towards targeted medical services available to certain groups.

The shortfall in Health Workforce Training and Development funding is in a context of continuing international recruitment of qualified health practitioners, significant unemployment of new nursing graduates and large unmet training needs in the growing residential care workforce.

The Ministry, capital funding and the total appropriation

The Ministry of Health itself received $193.1 million. This is $1.8 million more than last year but we estimated it needed an additional $3.9 million to cover increased costs and in addition it is required to provide for $1.3 million in "new initiatives". Its total shortfall is therefore $3.4 million. Ministry funding has been cut severely over several years. In the 2009 Budget, for example, it received $217 million. Other operational expenses (international health organisations, legal expenses and provider development) received no increase over last year's Budget, despite needing an estimated additional $0.6 million to cover increased costs.

Capital funding rose sharply: from $520 million in Budget 2013 to $1,114 million in Budget 2014. This follows a significant increase in capital expenditure last year. In the 2012 Budget, $289 million was budgeted for capital. Capital provision has therefore increased by $825 million between the 2012 and 2014 Budgets although in practice, operational savings are often converted to capital. While the increase in capital funding is much needed, increased capital assets create additional costs for DHBs, which are not taken into account in government funding of DHBs. As Treasury noted in 2013 Budget papers "new capital builds are more likely to result in large deficits for DHBs". Between the 2009/10 and 2012/13 financial years, with very modest increase in capital expenditure, DHBs' costs for depreciation, capital charges and interest payments increased from $570 million to $605 million.[4] These costs will escalate with the substantial increases in capital expenditure seen over the last two years.

Treasury forecasts

As we have noted in the past, our estimates of funding shortfalls in Vote Health have been conservative in comparison to previous Ministry of Health forecast shortfalls. A Treasury spreadsheet released with this year's Budget estimates "real growth of health" for each year using CPI for all costs and its own calculation of demographic pressures. For 2014/15 Treasury is forecasting health to have a real growth of *negative* 2.3%, which on their figures we calculate to represent a shortfall of $360 million. It corroborates our assessment of a significant shortfall in real terms.[5] Over the June years their estimate of Health shortfalls are as follows:

Treasury estimates of real falls in Health funding after costs and population growth
(Fiscal Strategy Model, 2014 Budget)

Year to June	2014	2015	2016	2017	2018
Percent	-0.6%	-2.3%	-3.7%	-3.6%	-3.1%
$million	-$82m	-$360m	-$587m	-$559m	-$488m

[4] DHB Consolidated Accounts.

[5] Treasury 2014. Fiscal Strategy Model, fsm-befu14.xls ("BEFU 2013" tab), available at http://www.treasury.govt.nz/government/fiscalstrategy/model.

As we described in our pre-Budget analysis, Treasury warned in the preparation for the 2013 Budget that such large cuts will require major changes to the Health sector. If the next Government does not increase its funding of the sector significantly we can expect much greater change to our health services even than those seen over the last five years. This could include "more targeted services and funding" which implies dropping some services, making some available only to certain groups, or introducing user charges. As one paper commented:

> Sustainability of the health system is described as requiring service model changes and productivity/efficiency gains over the four year period that are far larger than those achieved to date. Much of DHBs' success in managing costs to date has been through labour cost constraint, more "passive" savings (eg: lower interest costs, Pharmac savings from patent expiry, exchange rate appreciation), and procurement initiatives (eg HBL) rather than through business model changes of the kind the 4YP [Four Year Plan] says will be required in future. Our view is that more ambitious savings options may need to be pursued to reduce risks (eg more targeted services and funding, accelerated implementation of HBL shared service initiatives, faster moves to regional-level service management).[6]

Effects on DHBs

In such a labour-intensive service such as health care (personnel costs comprise more than 60 percent of health provider budgets), staffing is one of the first areas to feel the impact of increasing DHB funding pressures. This is becoming apparent through a number of recent media reports. In March this year, for example, the *Waikato Times* revealed that routine certification audits last year assessed Waikato, Hawke's Bay, Hutt Valley, and Nelson Marlborough District Health Boards as being at high risk of having staff shortages in specific staffing areas. The Resident Doctors' Association (RDA) said it had "grave concerns" over the safety of hospital patients because of the heavy workloads placed on staff. The warning followed a coroner's inquest into the death of a patient at North Shore Hospital in May last year after an X-ray was missed by his doctor.[7]

RDA national secretary Deborah Powell said the working environment of hospitals around the country was far from ideal. "Both the workloads and the hours resident doctors continue to be asked to work is high. Mistakes are bound to happen if doctors are overworked and tired. It is inevitable that patients will suffer in such circumstances."[8] Nurses and midwives report similar heavy workloads. The New Zealand Nurses Organisation reports that "The increase in nursing positions over the past four years is 4.4 percent. Patient numbers have increased by 16 percent."[9] It expressed concern that this had contributed to reported increases in serious adverse events in hospitals.

Another report concerned an email from Auckland DHB's chief executive to senior managers and clinical leaders, which starts: "We have a problem…the current year is financially unsustainable with an

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[6] "Four Year Plan – Assessment and recommendation on final four-year plans submitted by Ministers to MoF and MoSS", p.4-5, available at http://www.treasury.govt.nz/downloads/pdfs/b13-info/b13-2564298.pdf.

[7] "DHB staff claimed to be overworked and understaffed," by M Mather. *Waikato Times*, 26 March 2014.

[8] Ibid

[9] "Patients suffer when staffing levels are insufficient", New Zealand Nurses Organisation, 21 November 2013, available at http://www.nzno.org.nz/about_us/media_releases/articletype/articleview/articleid/1687/patients-suffer-when-staffing-levels-are-insufficient.

underlying deficit of $12 million…To make a start on next year's savings we need to move from talking about reducing the staffing costs to actually doing it." Specific target areas for cutting down on staffing included surgical services, intensive care, children' services and older people's services. [10]

Association of Salaried Medical Specialists' executive director Ian Powell commented that cutting costs for short-term financial relief at the expense of quality health care or the front line clinical workforce inevitably increases the workloads of medical specialists. "Already the government and DHBs generally are ignoring the fact that entrenched specialist shortages have become the norm in public hospitals. Actions such as not filling specialist or nursing vacancies, for example, will add to the stresses faced by the overstretched specialist workforce. This can only be bad for the standard of patient care." Delaying recruitment because of financial stringencies can also exacerbate the situation.

In May this year a further media report revealed three cardiology transfer patients died after the Southern DHB started to transport patients to Christchurch when no service was available in the South.

The patients who died, in June and July last year, were all transferring from Southland. Following the deaths, the board moved to a full-time interventional cardiology service. The chief medical officer said while the board did not know whether the patients could have survived if a full-time service had been available in Dunedin, "the quicker that patients undergo procedures the better, and the travel time to Christchurch is not ideal for supporting good outcomes".[11]

In another recent report, Capital and Coast DHB chief executive indicated the board needed to make "further efficiencies" in clinical supplies, reducing the use of overtime and a quick holiday for "non-frontline staff". An email to staff said that a "sudden deterioration" in the forecast deficit meant that cost cutting measures must be implemented quickly. Nurses expressed concern at the DHB goal of having 1,000 staff going on leave in a short space of time.

The Nurses Organisation's industrial adviser for the DHB sector, Lesley Harry commented, "Providing high quality, safe patient care, where and when it is needed, relies on every member of the team, from cleaners and receptionists right through to the charge nurse managers, being on the ball. Integrated teams are required to deliver timely, quality care in a safe environment. You can't take a couple of roles out of the mix and cross your fingers that everything will be ok." Nurses were also asked to cut back their use of clinical supplies, including bandages, dressings and other medical equipment.[12]

Aside from the mounting pressure on public hospitals, there are media reports of cuts and deterioration in many other services that receive all or part of their funding from DHBs, including aged care, services for mental health and addictions, community health services, public health, primary health organisations and GPs, and diabetes services. There are growing concerns from providers, clinicians and caregivers at the low wages and lack of training in residential care services, which both provide essential care to elderly and disabled people and potentially reduce the use of costly hospital services.

While the Budget increased funding on home-based support and disability support, as shown above, National Disability Support Services will have a substantial shortfall due to underfunding. The Aged Care

[10] "Auckland DHB needs to come clean about its cost-cutting intentions, says ASMS", by I Powell. ASMS media release, 20 March 2014.

[11] E Goodwin. "Death follows transfer delays," *Otago Daily Times*, 8 May 2014.

[12] NZNO media release: "Funding cuts, efficiencies and cost savings are double-speak," 20 May 2014.

Association estimates residential care faces a shortfall of $36 million just to maintain the status quo.[13] In addition there may be additional expenses to pay home support caregivers for their travelling time to and from clients' houses, and for equal pay for caregivers if the current case before the courts under the Equal Pay Act 1972 confirms that they are significantly underpaid. The latter is noted as a new "fiscal risk" in the Budget Economic and Fiscal Update (p.71).

We have previously reported on the pressures facing services providing low-cost access to high need populations, which have experienced severe funding cuts resulting in staffing and service reductions over recent years. Examples are the union health services in Wellington, Porirua and Hutt, whose patients include refugees, state and council housing residents. User charges cannot be increased because of the low incomes of their patients. In September 2013, the Minister announced an increase in funding of $4 million a year to cover such practices. This followed a Ministry of Health review in August 2013 that found many of the country's 300 low-cost clinics faced significant "financial and workforce challenges". However, Ben Gray, a doctor who has worked at Newtown Union for 22 years, said while the extra funding, about $4 a patient a year, would be a nice gesture, it was nowhere near enough to address their increasing needs.[14]

In May this year the *Press* in Christchurch published an article entitled "UK scandal has lessons for New Zealand".[15] It referred to the infamous case at the Mid Staffordshire National Health Service (NHS) Trust where a Healthcare Commission investigation found up to 1,200 patients had unnecessarily died over a period of three years. NHS staffing levels emerged as a key concern of that inquiry. To quote from the inquiry report:

> The [Mid Staffordshire NHS] … appears to have lost sight of its real priorities. The trust was galvanised into radical action by the imperative to save money and did not consider the effect of reductions in staff on the quality of care. It took a decision to significantly reduce staff without adequately assessing the consequences. Its strategic *focus* was on financial and business matters at a time when the quality of care of its patients admitted as emergencies was well below acceptable standards.[16]

Health Minister Tony Ryall was reported in the article as saying the scandal was a "really good reminder" for New Zealand's health sector to remain vigilant on the quality of care. The clear lesson to be learned, however, is that as DHBs face continuing pressure to cut costs, as is reflected in the small sample of media reports above they will be forced into making short-term financial and business decisions that put the quality and safety of care at risk.

In view of the continuing funding shortfalls indicated in this analysis, those risks look set to intensify.

Free GP visits for under-13s

This new initiative, which extends free General Practitioner (GP) visits and prescriptions for children under six to all children under 13 from July 2015, gained much media attention as a positive move to improve children's access to GP services. There were also some questions raised as to whether the

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[13] M Taylor. "Residential aged care not a clear winner in today's budget," media release, Aged Care Association, 15 May 2014.

[14] M Duff. "Low-cost clinics at crisis point as funding dries up," *Dominion*, 20 September 2013.

[15] O Carville, "UK scandal has lessons for New Zealand," *Press,* 11 May 2014.

[16] The Mid Staffordshire NHS Foundation Trust Public Inquiry. Available at: http://www.midstaffspublicinquiry.com/

allocated funding was sufficient to implement the policy. Medical Association chair Mark Peterson said GPs will need to examine the figures before they decide whether they will sign up to the initiative.[17]

The Budget revealed little detail about the figures, other than the overall $30 million a year funding allocation for the three years 2015/16 to 2017/18 and that it would benefit more than 400,000 children. Statistics New Zealand's median population projections for children aged six to 12 are: 415,000 in 2015, rising to 427,000 in 2018. Other readily available figures relating to the frequency of visits to the GP for this age group, and the average cost per visit, are varied.

New Zealand Health Survey data from 2011/12 and 2012/13, provided by the Ministry of Health, indicate a mean number of GP visits of 1.9 per year for 6-14-year olds. The survey, however, relies on self-reported use of primary care over the previous 12 months, so accuracy is dependent on recall.

An earlier Ministry of Health-commissioned study frequently quoted in the literature indicates GP users aged 6-17 years visited four times a year on average, which we estimate is closer to three a year on a per-population basis. Like the New Zealand Health Survey data, the study relied on patient recall. [18]

New Zealand Health Survey data indicate the mean charge for a visit to the GP for children aged 6-14 years in 2013 was $19.20 (based on recall of the cost of the last visit). However, a recent survey of 280 practices across the country's 20 DHBs indicates the average fee for 6-17-year-olds is $24 (between nil and $60) in business hours and $44 (between nil and $89) for an after-hours consultation.[19]

Health Survey data show that of the total number of children who visited a GP practice or after-hours clinic over a 12-month period, 26 percent went to the latter. The average charge across normal hours and after-hours visits we therefore estimate as approximately $29.

As a ready comparison, the current business hours fee for 6 to 17 year-olds across 55 Compass Health Primary Health Organisation practices in Wellington, Porirua and Kapiti averages $31.60 (ranging from nil to $53).

Assuming an average fee of $29 and three visits a year, the cost to service a population of 415,000 (in 2015) would be approximately $36 million. In addition, the cost to cover free prescriptions (assuming two prescriptions per child per year and that about two-thirds of visits involve a prescription[20]) would be about $4 million, so the total cost for the initiative would be $40 million – $10 million more than budgeted.

If the cost is based on an average two visits per year, and an average 1.5 prescriptions, the total cost would be about $27 million. However, bearing in mind the policy is intended to boost access to GP

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[17] "Backing for free children's GP visits," Radio New Zealand News, 16 May 2014.

[18] Ministry of Health. 2004. Family Doctors: methodology and description of the activity of private GPs: The National Primary Medical Care Survey (NatMedCa): 2001/02. Report 1. Wellington: Ministry of Health. Nine reports from this study are available at: http://www.health.govt.nz/publication/national-primary-medical-care-survey-natmedca-2001-02-reports; P Crampton et al. "Exposure to primary medical care in New Zealand: number and duration of general practitioner visits," *NZMJ* 15 June 2007, Vol 120 No 1256; R Lay-Yee et al. "Primary Care in and Ageing Society: Developing the PCASO microsimulation model. Technical Report, Compass Research Centre, University of Auckland, December 2011.

[19] Haran C, Ruscoe C. (2013) Primary health care cost for children between 6 years and 17 years in New Zealand. Proceedings of Paediatric Society of New Zealand Annual Scientific Meeting. In Our children, our choice: priorities for policy, MC Dale, M O'Brien, S St John (eds), Child Poverty Action Group, May 2014.

[20] Ministry of Health. 2004. Family Doctors: methodology and description of the activity of private GPs: The National Primary Medical Care Survey (NatMedCa): 2001/02. Report 1. Wellington: Ministry of Health.

services, logically more children will go to their GP more often – a point made by NZMA chair Mark Petersen. [21] The current low-end estimate of two visits per year is therefore unlikely to reflect the actual rate as the policy is implemented.

Regardless of the total cost, the current wide range in fees charged for this age group (up to $89 for after-hours care) indicates many practices will either have to forego income from fees to join up to the policy, or subsidise the cost of children's visits by increasing fees for other patients – as also suggested by Mark Petersen. Negotiations with GPs could therefore take some time, as they did with the introduction of previous free visits.

[21] "GPs eye more cash to join free schemes," by I Davison. *NZ Herald*, 17 May 2014.