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DISCUSSION DOCUMENT

**HOW CAN PRIMARY HEALTH CARE CONTRIBUTE BETTER TO
HEALTH SYSTEM SUSTAINABILITY?**

A TREASURY PERSPECTIVE

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FOREWORD

This paper is intended to stimulate discussion on ways in which the objectives of the Primary Health Care Strategy may be further progressed. It has made available to the Ministry of Health to serve as a resource for ongoing policy work. The paper provides a high-level discussion of a range of future directions for the Strategy, largely within the current institutional framework. It does not advocate a particular direction.

The paper focuses on options for developing better contractual relationships between PHOs and primary health care providers as a way of altering behaviours, while recognising any change in this complex area needs to be part of an overall approach that covers a number of other dimensions in parallel, including public expectations, system performance information, clinical governance and PHO analytical and purchasing capability, and workforce. We acknowledge that the paper does not reference all performance information or innovation currently occurring in the sector.

ACKNOWLEDGEMENT

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SUMMARY

Five years into the implementation of the Primary Health Care Strategy (PHCS), a significant increase in funding for primary health care has been rolled out to 81 newly-established Primary Health Organisations (PHOs). Although there is evidence that patient fees have reduced and that consultation rates have increased, it remains unclear as to what extent primary health care is providing value for money – in terms of improving health outcomes or helping to manage long-run fiscal pressure in health.

There is a need for ongoing policy development to ensure the Strategy yields the health benefits commensurate with the increase in public spending on primary health care and to ensure that the national health targets are achieved, including those on ambulatory sensitive hospitalisations, diabetes screening and management, and increased elective surgery.

Why primary health care matters for health system performance

- In general, countries with better developed primary health care systems tend to have better population health at lower cost (e.g. relatively less use of costly hospital-based technologies).
- Literature suggests that primary health care has the potential to moderate the future rate of increase in health expenditure in New Zealand through earlier intervention and better management of long-term health problems (e.g. diabetes). While this has not been an overt goal of the Strategy, primary health care will be highly significant in shaping the government's future investment choices.

Progress in implementing the Primary Health Care Strategy

- The main effect of the investment to date has been to replace private, out of pocket payments with public subsidies. The additional funding has also been associated with an increase in patient consultation rates. There is little evidence that the funding has changed the content and delivery of first contact primary health care services.
- Most funding is still directed at contributing to the costs of consultations with GPs for episodic illness and responding to presented symptoms.
- Limited progress has been made with longer term objectives such as services that improve population health, keep people well and coordinate their care (which would reduce unnecessary reliance on more costly hospital care).

Limitations of the current arrangements

(i) Weak financial incentives to adopt new forms of care

- Comprehensive capitation (per patient pre-funding) should encourage providers to focus on keeping patients healthy, thereby reducing demand on provider budgets. Yet the fundamental incentives in the primary health care system have changed little. The majority of funding is tied to reducing practice fees for individual patient consultations, but without any clear contractual expectations as to what practitioners should be achieving in the reduced fee environment that they were not doing previously.
- The incentive effects of public payment by capitation towards population health improvement are undermined by the fact that, on average, a significant proportion of practice income continues to come from patient charges. Furthermore, the bundle of services covered by capitation for first contact services is not defined, and District Health Boards (DHBs) remain the residual risk holder - for example, for ambulatory sensitive hospitalisations. As a result, practices continue to give a high priority to making GPs available to providing demand-driven services rather than making more efficient use of a team including medical and nursing staff – inhibiting the emergence of new models of service delivery.

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- A relatively small amount of new funding is devoted specifically for the management of people with chronic conditions (e.g. diabetes) which has the potential to avert expensive needs for care at a later stage.

(ii) Less than fully formed accountability relationships

- PHOs are charged with leading the development of primary health care but have under-developed relationships with practices:
 - PHOs do not normally own the practices they are nominally responsible for funding, and the practitioners have no stake in the PHO;
 - PHOs do not bear or share any of the financial risks facing the practices;
 - PHOs manage only a minority of public funding flowing through into their practices and lack contractual levers to influence service delivery; and
 - where PHOs can retain and use new funds for primary health care, they lack access to capital to develop joint ventures with practices.

(iii) Considerable variation in PHO capability

- The rate and extent of progress towards Strategy goals has been variable, partly due to PHO management capability, and their ability to use some of the new funding to develop new, more proactive, population-oriented services. Underlying questions about capability include:
 - whether smaller PHOs will be viable as separate funders and planners of services in the long term; and
 - whether some PHOs are predominantly 'post boxes' through which funds pass directly to practices (rather than working with providers to improve the delivery of care to their enrolled populations).

(iv) An unrealised contribution to wider system efficiency

- There is evidence that the contribution of primary health care to the wider health system is hindered by the relatively restricted access that practitioners appear to have to diagnostic radiology services – contracted and budgeted for by DHBs. A working party found that this tends to lead to unnecessary referrals of patients to hospitals for specialist assessments.
- The variation in standardised ambulatory-sensitive hospitalisation rates among DHBs suggests there is scope for PHOs to make better use of multi-disciplinary teams in the management of chronic conditions in the community.
- Neither PHOs nor practices/practitioners bear any of the financial risks associated with their patients' use of referred specialist or community services, thus they have little incentive to consider the most appropriate mix of patients for referral.

(v) Potential exposure to fiscal risk

- Trying to secure lower patient charges by increasing the level of public funding in the presence of substantial, only partially regulated, patient fees is not without risk – the evidence indicates that patient fees are likely to be lower than they would have been without the new funding since 2002, but that this has been obtained at a high price
- The realisation of government aspirations toward encouraging (and maintaining) lower patient cost primary health care may depend on its willingness to increase the gross incomes of practices – especially in the absence of information on practice cost structures and pressures (i.e. the options available to providers to improve efficiency).

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- The problems in determining 'reasonable' price increases private providers that are partially publicly-funded have similarities with the issues in other policy areas, for example, early childhood education.

Some potential options for developing the primary health care sector in the future

There are no easy options in this area. Given that most of the available new funding for primary health care has already been spent on lowering user charges, there are limited levers to encourage new ways of paying for, organising and delivering care. Further change will have to be gradual and will involve working with those practitioners who are interested in alternatives to the small business, fee-for-service model of general practice that has predominated to date. Trends among medical graduates suggest that GPs of the future may expect a wider range of ownership models and ways of working. This should provide opportunities to bring new organisational, financial and ownership forms into the sector and new service contracts, which should make it easier to achieve the objectives of the Strategy.

This paper presents three stylised policy directions for discussion. Although the focus here is on trying to develop better contractual relationships between PHOs and providers, we recognise that any changes to contractual or reimbursement arrangements need to be part of a considered approach that covers a number of other dimensions in parallel (including public expectations, performance information, clinical governance and a workforce strategy).

Options 1 and 2 are based on gradual change within the current policy settings underpinning the Strategy, but with different levels of ambition in the long term. Option 2 is somewhat more complex and would place some pressure on the leadership and analytical capability of PHOs, but it probably offers the clearest path towards the objectives of the Strategy (especially for PHOs with more than 30,000 enrollees, which comprise 86% of all enrollees).

Option 3 is a redesigned targeting regime, which represents somewhat of a return to a model of individual targeted public subsidies. Each option is an initial formulation only, requiring further investigation and development. By contrast, Option 3 signals a much more targeted approach to change, which could be contemplated if it proves too difficult to make sufficient progress with Option 1 and/or Option 2, or if the government decided to place less weight on achieving universally low copayments.

Option 1: Modified status quo – towards new service models

- Better organised PHOs develop new services by holding back some of the new money for first contact care and attempting to negotiate specific contracts with volunteer practices and other providers for new services to their enrolled populations (e.g. extensions to the current chronic disease management programmes)
- PHOs and DHBs step in to provide primary health care where gaps in services occur, for instance, due to retirements or where practitioners leave the market. This can be either by direct provision, or on contract from conventional general practices or alternative primary care providers. PHOs would need access to specimen contracts that they could adapt for their specific circumstances.
- Allowable patient fee increases are related to the Future Funding Track for Vote Health. Higher increases are not tolerated by fee review committees. Practices that claim that they are not financially viable within allowable fee increases are offered business support to identify opportunities to control costs, such as sharing facilities and back office services, mergers with other practices, or the sale of practices to other providers. Such support would be provided with a view to evolving the sector towards more efficient models of organisation consistent with permanently lower patient fees and sustainable increases in the public funding of primary health care.

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Option 2: A 'blended payment' contract

- This option is a longer term way forward since it involves changing the way that primary health care providers are paid in more fundamental ways.
 - The development of a provider contract with PHOs based on: a risk-adjusted payment per enrolled patient (80-85%); an information management component (5-10%); risk-adjusted performance bonuses (5-10%); and a small amount of fee-for-service payment (5-10%).
 - The risk-adjusted capitation funding of larger PHOs includes not only primary health care, but also referred services (such as pharmaceutical expenditure), with possible deductions for 'ambulatory-sensitive' admissions to hospital. Any efficiency 'savings' are shared between PHO and practices.
- Options with regard to patient copayments include: copayments set at a proportion of public capitation and unrelated to individuals' use of services; low patient copayments in return for higher public capitation payments; or the PHO receiving all copayments (possibly prospectively) and using its combined public capitation and patient fee revenue to fund the blended payment contract with each practice.
- This approach would be gradually offered to PHOs and practices interested in new ways of working to develop primary health care. For example, where retirements and gaps in local primary health care services occur, PHOs might use the blended payment contract as the basis of inviting tenders from new providers including conventional practices and new entrants (for example, larger provider organisations able to guarantee lower or no fees because of economies of scale and scope not accessible to smaller traditional practices).

Option 3: A redesigned individual targeted subsidy regime

- This option represents a return to the broad approach before the Strategy was adopted, and involves reviewing the previous pattern of subsidies and changing them to meet the criticisms levelled at the regime before 2001. If well designed, the system may produce better targeting in relation to need, or the ability to benefit of patients, than the previous targeting system.
- As under the pre-Strategy system, the government contribution to primary health care services is capped at a fixed amount, but the basis of the contribution is carefully reviewed. A new system of individual subsidies could be developed as better individual level data are generated within primary care, allowing, for example, targeting particular diagnosed medical conditions or risk factors rather than simply patients with high use of GP services or on low incomes.
- Existing chronic care management programs could be retained (or even enhanced) alongside a system of targeted individual subsidies for first contact consultations.

1. WHY PRIMARY HEALTH CARE MATTERS FOR SYSTEM PERFORMANCE

There is considerable, system-level comparative evidence that a well functioning primary health care system is necessary for an effective and efficient health system. In this context, ‘primary health care’ refers to a range of first contact acute, continuing care, diagnostic and preventive health services delivered to patients in ambulatory (non-hospital) settings by a range of medical, nursing and other staff coordinated (often led) by a physician generalist (in New Zealand, the general practitioner or GP). Countries with more comprehensive, accessible primary health care tend, all other things being equal, to have better population health status at lower cost (Starfield and Shi, 2002; Starfield, Shi, Macinko, 2005; Ferrer, Hambridge and Maly, 2005) (see Figure 1).

Figure 1: Scatter plot of countries’ per capita health care spending against strength of primary health care

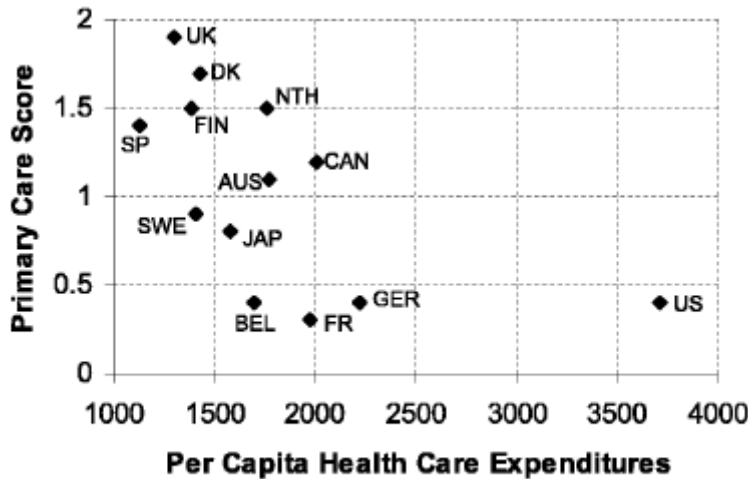


Fig. 2. Primary care score vs. health care expenditures, 1997.

Source: Starfield and Shi, 2002

Higher use of primary health care is also associated with lower rates of hospitalisation for ‘ambulatory care-sensitive’ conditions (Starfield, Shi and Macinko, 2005). One of the striking differences between health systems with strong primary health care and those with weakly developed primary health care lies in the availability and use of costly medical technologies (i.e. higher use in systems with less developed primary care services). Furthermore, hospital intervention rates tend to be higher in systems where the medical generalist and primary care team role is less developed, generating higher costs. For example, the care of people with common illnesses in the US is less expensive if provided by generalists in primary care rather than specialists, with no detriment to patient outcomes (Whittle, Lave, Fine, Delaney, et al, 1998). Such evidence suggests that the primary care generalist and team contribute, in part, by steering patients through the system in more efficient ways than systems based on

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direct access to specialists. In the early 1990s, New Zealand's primary health care system was ranked below that of the UK, above that of the US and similar to Canada and Australia by Grant, Forrest and Starfield (1997) in terms of characteristics necessary for the practice of good primary care – suggesting that there was scope for further development.

The Treasury's interest in primary health care arises from two main considerations: our interest in cost-effective ways of improving the nation's health; and our interest in the managing projected long-term growth in expenditure. The Treasury has modelled public expenditure on health to increase from around 6% of GDP in 2005 to 12% by 2050 (the 'base' case), with a range of 9-16%. The future scenarios depend on assumptions about the drivers of growth (income-driven demand, technology costs, coverage decisions, demographic changes, and health status). The greatest impact on future spending patterns is likely to come from a focus on non-demographic factors, such as: continuing to seek ongoing improvements in the performance of health system; managing the adoption of new technology; and seeking better outcomes through earlier and simpler interventions. (Treasury, 2006)

The international evidence cited above indicates that it is reasonable to expect improvements in the performance of the primary health care system to contribute to a moderation of future increases in public expenditure on health. Specifically, the evidence internationally suggests that a well-developed primary health care system has the potential to contribute to reducing unnecessary use of expensive health services and to improving health outcomes, and, thereby, moderating the rate of increase of system costs by:

- *Improved management of long term (chronic) health conditions*, via a population-based approach to earlier interventions, and by supporting patient self-care, thereby averting some of the expensive and costly complications associated with these conditions – for example, averting some of the blindness and serious kidney problems associated with diabetes. (Box 4, below, summarises the main elements in a best practice chronic disease management programme.) In the short term, costs may rise from responding to the unmet need revealed by better screening and earlier intervention, but in the longer term there is a reasonable expectation of costs being moderated and net societal benefits from improved chronic disease management (Beaulieu, Cutler and Ho, 2003);
- *Improved management of the demand for costly hospital services* in the medium term by providing alternative community-based packages of care, and by ensuring patient referrals to specialist services are consistently appropriate. A number of New Zealand

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case studies show that a substituted primary care-driven service can be as effective, but cost considerably less, than the same intervention delivered in a hospital setting (see: Wellingham et al, 2003; Barker et al, 2006; Central TAS, 2007).

- *Improved use of the work force* by making better use of scarce staff when reimbursement incentives support this. For example, when primary care practices are paid on the basis of GP consultations, practices tend to invest in GPs and make GPs available even if a proportion of that work could be undertaken at least as well, if not better, by practice nurses and other staff. When more of a practice's reimbursement is in the form of a payment per patient (capitation), it is likely that more use will be made of nurses and other staff to deliver services previously delivered by GPs. Evidence suggests that first contact, general consultations with practice nurses are as effective but not necessarily less costly than GP consultations because nurse consultations tend to be longer and referral rates higher.(Venning et al, 2000, Laurant et al, 2007)., Yet if recruiting GPs becomes increasingly difficult, it is feasible that the efficiency of nurse consultations will improve as new roles and clinical guidelines for nurses become established. A model of primary care more reliant on nurses might well be more sustainable than a wholly GP-centric model of care.

Although these are the potential benefits of a well-developed primary health care system, achieving them requires resources, trained staff, appropriate reimbursement incentives, appropriate institutional arrangements and new relationships between medical professionals and organisations. The question is whether the current and emerging primary health care system in New Zealand is well positioned to deliver these benefits over the next decade.

2. PROGRESS IN IMPLEMENTING THE PRIMARY HEALTH CARE STRATEGY

As noted above, countries with a well developed primary care sector tend to have better outcomes and lower costs than systems with less well-developed primary care. This suggests that primary care can make a key contribution to the long-run sustainability of the public system in New Zealand. In 2001 the government introduced the Primary Health Care Strategy to provide a clear direction for the future development primary care (Minister of Health, 2001). The stated aim of the Strategy was to improve health and reduce health inequalities by altering the nature of the primary care provided and by making primary care more accessible. District Health Boards (DHBs), which are responsible for managing resources and service delivery to meet their populations' health and disability needs, would be guided by the Strategy to achieve health gains through primary health care.

New institutions, Primary Health Organisations (PHOs), were called into being and publicly funded according to the number, and relative health need, of patients enrolled with their general practitioners. The Strategy envisioned that DHBs would work through their PHO(s) to achieve health goals locally. The Strategy has been accompanied by a new funding framework that has gradually replaced the previous system of public subsidies for GP and practice nurse consultations. Patient user charges per GP consultation have remained, although various measures have been used to try to reduce their level – particularly for high need groups (see below).

The Strategy stated that over five to ten years a new vision would be achieved:

“People will be part of local primary health care services that improve their health, keep them well, are easy to get to and co-ordinate their ongoing care.

Primary health care services will focus on better health for a population, and actively work to reduce health inequalities between different groups.

This vision involves a new direction for primary health care with a greater emphasis on population health and the role of the community, health promotion and preventive care, the need to involve a range of professionals, and the advantages of funding based on population needs rather than fees for service.”

It went on to outline some key priorities for early action,

“The Strategy will evolve over the next few years and may not be fully realised for five to ten years. During this transition there will be flexibility about how new initiatives develop, and tolerance of short-term teething problems. Key priorities for early action are:

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- reducing the barriers, particularly financial barriers, for the groups with the greatest health need, both in terms of additional services to improve health, and to improve access to first-contact services
- supporting the development of Primary Health Organisations that work with enrolled populations
- encouraging developments that emphasise multi-disciplinary approaches to services and decision-making
- supporting the development of services by Māori and Pacific providers
- facilitating a smooth transition to widespread enrolment of Primary Health Organisations through a public information and education campaign to explain enrolment and promote its benefits for communities.”

The Strategy specified that PHOs are to be community owned and governed, not for profit, and are to include other primary care professionals and communities in their governance processes. The first PHOs were formed in mid-2003, and by late 2004 over 95% of New Zealanders belonged to a PHO, via their enrolment with their primary health care provider.

Funding as a lever for driving change

The main lever for driving change has been additional public funding, primarily aimed at reducing patient out-of-pocket fees (copayments) and at changing the culture of the primary care system towards a more proactive, preventive and disease management focus. The level of funding rolled out under the Strategy represents a significant step-change in public expenditure on primary health care services.

The existing subsidy per consultation system (or fee-for-service) was replaced by capitated funding. Two formulae were initially used for the main First Contact funding stream. To improve care for deprived and/or higher need populations more quickly, an ‘Access’ formula was used to provide public funding to the 37 PHOs with a majority of Māori and Pacific people or other deprived groups among their enrolees. Funding was made available for these PHOs to offer reduced consultation fees for all age groups from October 2003. Other PHOs were funded under an ‘Interim’ formula, with a progressive roll-out of reduced fees to different age groups over the subsequent four years as additional funding became available. Additional funding to extend low cost access has been rolled out as follows:

- 1 April 2004 - funding for low cost pharmaceuticals for enrolees in Access-funded PHOs, and 6-17 year olds enrolled in Interim-funded PHOs (maximum charge of \$3 per item on subsidised pharmaceutical prescriptions);

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- 1 July 2004 - funding to lower the cost of general practice consultations and pharmaceuticals for people aged 65 years and over enrolled in Interim-funded PHOs;
- 1 July 2005 - funding to lower the cost of general practice consultations and pharmaceuticals for people aged 18-24 years enrolled in Interim-funded PHOs;
- 1 July 2006 - funding to lower the cost of general practice consultations and pharmaceuticals for people aged 45-64 years enrolled in Interim-funded PHOs; and
- 1 July 2007 - funding to lower the cost of general practice consultations and pharmaceuticals for people aged 25-44 years enrolled in Interim-funded PHOs. This final roll-out brought funding for Interim PHOs broadly in line with Access PHOs.

Three other capitated funding streams were established – to improve patient access, to fund health promotion programmes, and to cover PHO management costs. In addition, funding for the Care Plus programme was rolled out nationally in July 2004. Care Plus provides additional funding to PHOs for patients needing frequent care because of a chronic condition, such as diabetes or heart disease (for up to 5% of the national population). The programme aims “to improve chronic care management, reduce inequalities, improve primary health care teamwork and reduce the cost of services for high-need primary health users”.¹

Despite the increase in funding, and in order to secure GP cooperation, the government has not regulated patient copayments by statute. However, PHOs are required to agree appropriate copayment increases with their local DHB(s) and to publicly list their fee schedule. If the DHB considers copayment increases at specific practices or across an entire PHO to be too high, it is able to refer the matter to a regional fee review committee. If the increase is judged to be unreasonable, the DHB may reconsider its contractual relationship with the PHO.

It is important to note that a mixed system of capitation and appreciable patient copayments per GP consultation is significantly different from the system that prevails in other countries that have adopted capitation funding for primary care. Accordingly, any assessment of the current primary care funding arrangements in New Zealand needs to take into account the ‘mixed economy’ of public capitation and private patient copayments.

In addition to the capitated funding streams PHOs receive funding for a number of other programmes or initiatives, such as Care Plus (chronic disease management) and performance payments (for participation in a performance management programme). DHBs

¹ Ministry of Health; <http://www.moh.govt.nz/moh.nsf/indexmh/phcs-projects-careplusservice>

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also receive some Strategy funding to cover the reduced cost of publicly-funded prescriptions at pharmacies and the increased utilisation of laboratory services. Table 1 below outlines the budget in 2007/08 for the capitated streams (\$730m) and the various other initiatives (\$88m).

Table 1: Primary Health Care Strategy Budget, 2007/08 ²

	Funding Stream	\$million	Percent of total budget
Capitation-Based Funding [\$730.0m or 89%]	First Contact	520.5	63.6
	Pharmaceutical subsidy	126.3	15.4
	Services to Improve Access	39.1	4.8
	Health Promotion	9.1	1.1
	Management Fee	31.8	3.9
	Laboratory subsidy	3.2	0.4
Other PHCS Initiatives [\$ 88.8m or 11%]	Care Plus	30.2	3.7
	Performance Payments	29.2	3.6
	Rural Health	12.6	1.5
	Mental Health	7.3	0.9
	Other Items	9.5	1.2
Total Budget 07/08		818.8	100.0

Achievements to date

In the first five years of the implementation of the Strategy, the main focus has been on improving access for groups in the population that regarded as being most likely to face barriers to access – either due to user fees or lack of practitioner availability. By the end of 2005, 81 PHOs had been established with an enrolled population of 3.9 million people (95% of the total population). Approximately 30% of the enrollees belonged to an Access-funded PHO. Enrolments are made via patients' usual source of primary medical care, rather than directly with the PHO.

Consultation rates ³

Consultation rates, or the average number of patient visits to general practice per year, increased for all age groups between 2001/02 and 2004/05 (see Figure 2 and Table 2, below). During this period, people aged 65 years and over experienced the largest increase (of 1.68 visits or 24%), while most other age groups experienced more modest increases.

² Adapted from the Ministry of Health website: <http://www.moh.govt.nz/moh.nsf/indexmh/phcs-funding>

³ All data in this section is from Cumming and Gribben (2007). Data is derived from a national sample of 129 practices amounting to 10.4% of the NZ population, with some over-representation of Access PHO practices. (Cumming and Gribben, 2007)

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Figure 2: Consultation rates by age group, 2001/02- 04/05

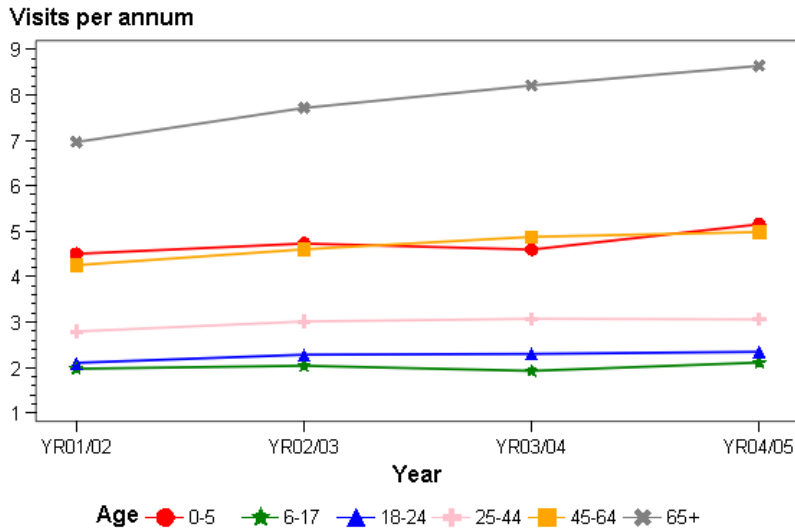


Table 2: Consultation rates by age group, 2001/02- 04/05

	2001/02	2002/03	2003/04	2004/05	Yr1 to yr 2	Yr2 to yr 3	Yr3 to yr 4	Whole Period
0-5	4.5	4.73	4.59	5.15	0.23 (5%)	-0.14 (-3%)	0.56 (12%)	0.65 (14%)
6-17	1.97	2.04	1.92	2.11	0.07 (4%)	-0.12 (-6%)	0.19 (10%)	0.14 (7%)
18-24	2.1	2.28	2.3	2.34	0.18 (9%)	0.02 (1%)	0.04 (2%)	0.24 (11%)
25-44	2.79	3.01	3.07	3.06	0.22 (8%)	0.06 (2%)	-0.01 (0%)	0.27 (10%)
45-64	4.25	4.6	4.87	4.98	0.35 (8%)	0.27 (6%)	0.11 (2%)	0.73 (17%)
65+	6.96	7.71	8.21	8.64	0.75 (11%)	0.50 (7%)	0.43 (5%)	1.68 (24%)

As the additional funding was rolled out different to Access-funded and Interim-funded PHOs (as noted above), it is worth looking at the changes in consultation rates by PHO type. Consultation rates increased for all age groups in Access PHOs between 2001/02 and 2004/05, as can be seen in Figure 3 and Table 3. The highest increases occurred among those aged 65 years and over, and in the 0-5 year and 45-64 year age groups.

Each age group in Interim PHOs experienced an increase in consultation rates between 2001/02 and 2004/05 (Figure 4 and Table 3, below), although not to the same extent as those enrolled in Access PHOs. Those aged 65 and over in Interim PHOs, a group which received additional funding during the evaluation period, experienced an increase similar to the same age group enrolled in Access PHOs. Table 3 shows that consultation rates also increased for Interim PHO age groups that had not yet received the additional funding. This suggests that other factors, besides copayment levels, influence consultation rates.

Figure 3: Consultation rates by age group, Access PHOs, 2001/02- 04/05

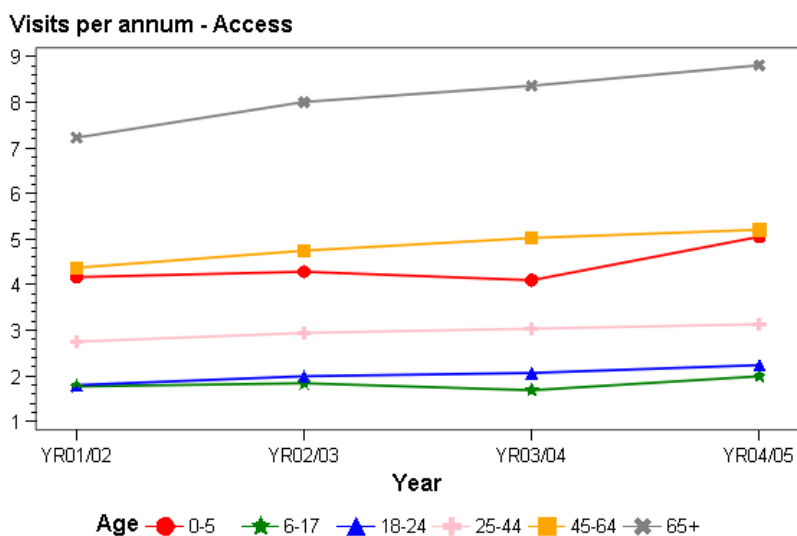


Figure 4: Consultation rates by age group, Interim PHOs, 2001/02- 04/05

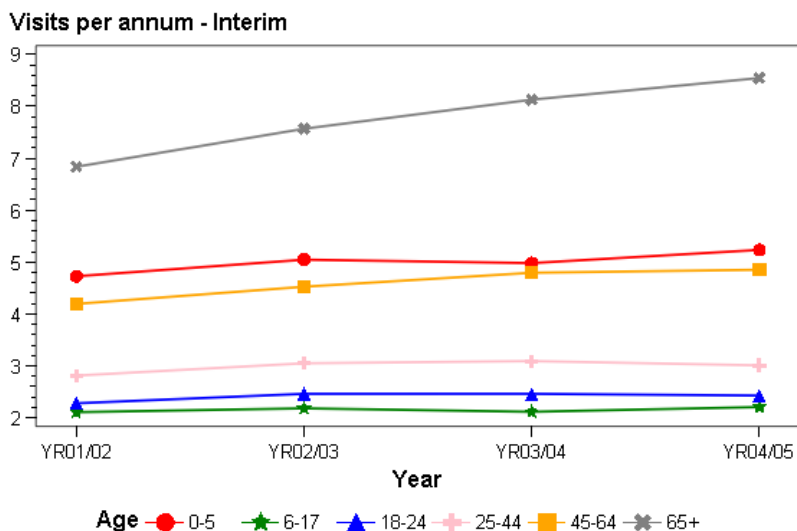


Table 3: Consultation rates by age group and PHO type, 2001/02- 04/05

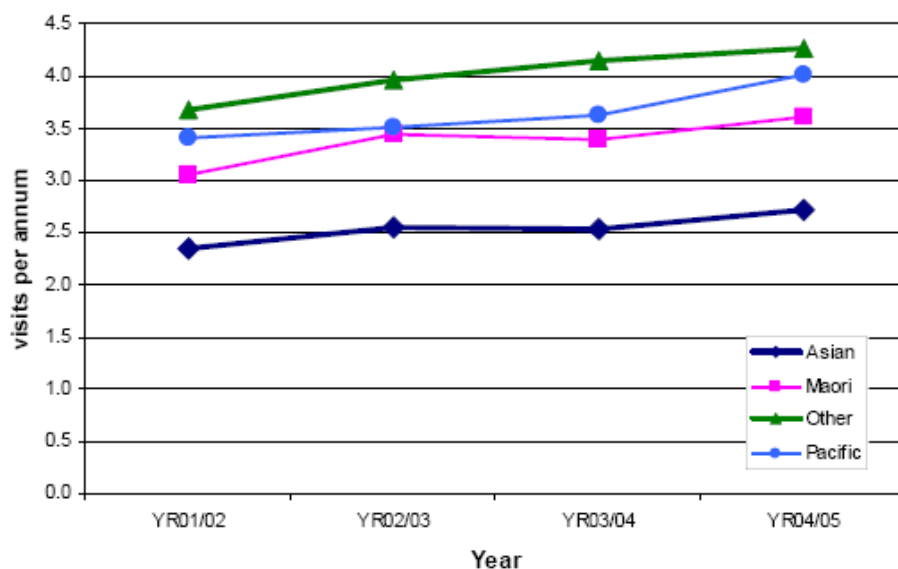
Type	Age	YR01/02	YR02/03	YR03/04	YR04/05	Yr1 to yr2	Yr2 to yr3	Yr3 to yr4	Whole period
Access	0-5	4.2	4.3	4.1	5.0	0.10 (2%)	-0.20 (-5%)	0.90 (22%)	0.80 (19%)
	6-17	1.8	1.8	1.7	2.0	0.00 (0%)	-0.10 (-6%)	0.30 (18%)	0.20 (11%)
	18-24	1.8	2.0	2.1	2.2	0.20 (11%)	0.10 (5%)	0.10 (5%)	0.40 (22%)
	25-44	2.7	2.9	3.0	3.1	0.20 (7%)	0.10 (3%)	0.10 (3%)	0.40 (15%)
	45-64	4.4	4.7	5.0	5.2	0.30 (7%)	0.30 (6%)	0.20 (4%)	0.80 (18%)
	65+	7.2	8.0	8.4	8.8	0.80 (11%)	0.40 (5%)	0.40 (5%)	1.60 (22%)
Interim	0-5	4.7	5.0	5.0	5.2	0.30 (6%)	0.00 (0%)	0.20 (4%)	0.50 (11%)
	6-17	2.1	2.2	2.1	2.2	0.10 (5%)	-0.10 (-5%)	0.10 (5%)	0.10 (5%)
	18-24	2.3	2.5	2.5	2.4	0.20 (9%)	0.00 (0%)	-0.10 (-4%)	0.10 (4%)
	25-44	2.8	3.1	3.1	3.0	0.30 (11%)	0.00 (0%)	-0.10 (-3%)	0.20 (7%)
	45-64	4.2	4.5	4.8	4.9	0.30 (7%)	0.30 (7%)	0.10 (2%)	0.70 (17%)
	65+	6.8	7.6	8.1	8.5	0.80 (12%)	0.50 (7%)	0.40 (5%)	1.70 (25%)

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Consultation rates increased for all ethnic groups during the evaluation period (see Figure 5, below). Pacific peoples, Māori, and Other experienced similar increases (of 0.5, 0.6 and 0.6 consultations per year respectively, equating to 16-18%). The smallest increase was among Asian populations (0.3 consultations on average per annum, or a 13% increase).

The increase among Māori and Pacific peoples is consistent with data from the national diabetes Get Checked programme, which shows that over the last five years the proportion of Pacific peoples with well-controlled diabetes increased by 8 percentage points to 56%. The corresponding increase for Māori has been more modest (an increase of 2 percentage points to 60%). The corresponding rate for non-Māori/non Pacific remains much higher at 78%. (Ministry of Health, 2007)

Figure 5: Consultation rates by ethnicity, 2001/02- 04/05⁴



The evaluation found that consultation rates for people holding a Community Services Card⁵ (CSC) generally remained higher than people without a card, particularly at older ages. This finding applies to both Access and Interim PHOs. Consultation rates increased for both CSC holders and non-CSC holders in each age group, although CSC holders tended to have a slightly larger increase than non-SCS holders. Similarly, people living in more deprived areas tended to have higher consultation rates than those living in less deprived areas (in both Access and Interim funded practices) – suggesting that consultation patterns still tend to be broadly driven by relative need.

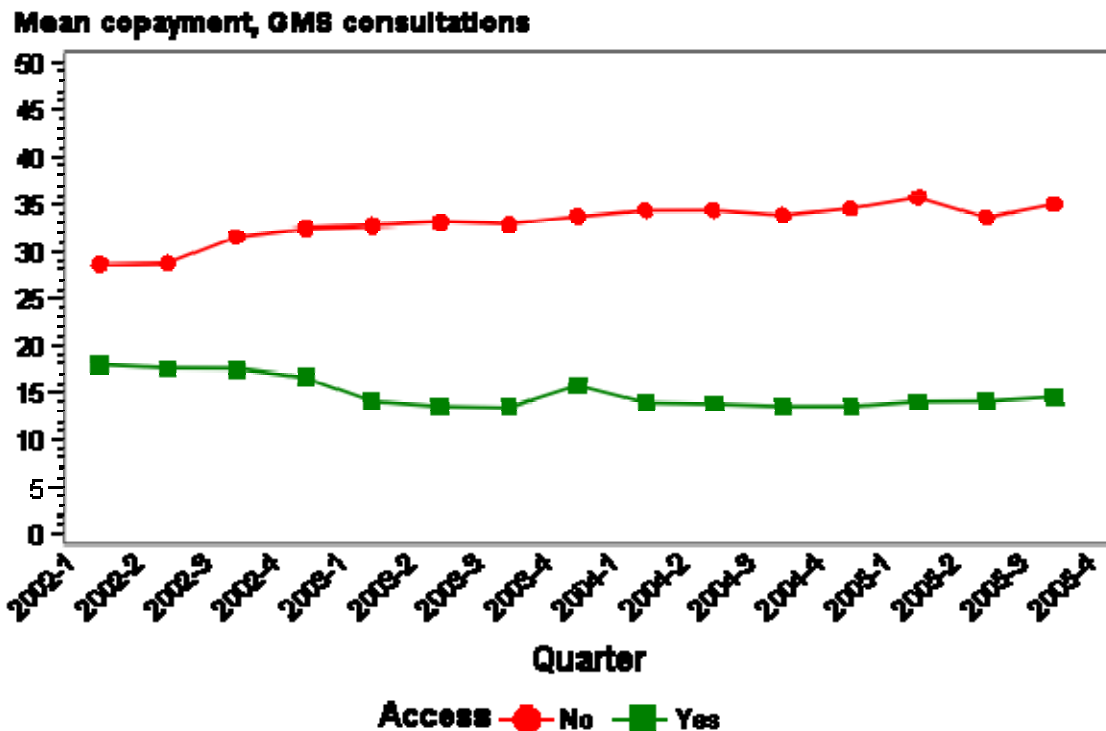
⁴ Source: Cumming and Gribben, 2007

⁵ CSC holders were already eligible for lower fees under the previous subsidy regime

Patient copayments⁶

The national evaluation of practice data shows that patient copayments, or fees, are generally lower in Access PHOs than in Interim PHOs (Cumming and Gribben, 2007). As well as operating in different local markets, practices belonging to Access PHOs were initially funded at a higher rate per enrollee, initially, in order to be able to offer lower fees earlier in the roll-out of Strategy funding. This is because, on average, Access PHO enrollees were expected to have higher health needs.

Figure 6: Trends in mean copayments for Access and Interim PHO patients, 2002-05

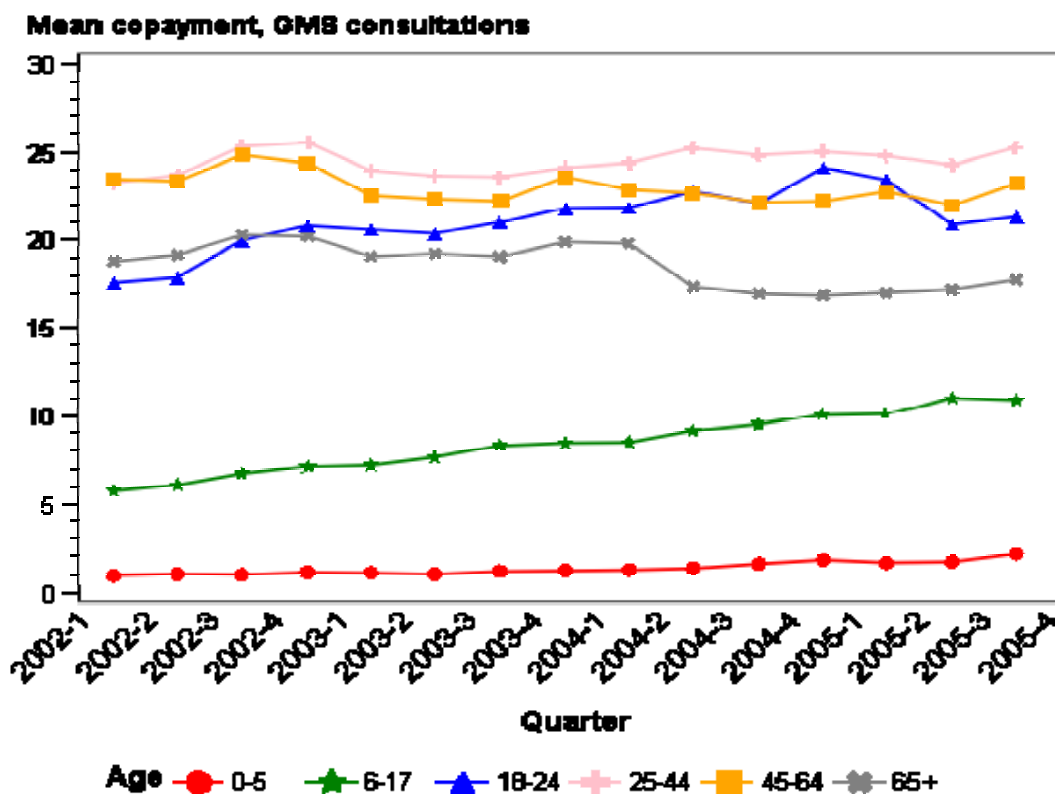


In all population groups, people enrolled in Access practices paid lower copayments, in line with the funding roll-out. Access practice copayments were largely stable in nominal terms across the period 2001-05, suggesting a real terms reduction in fees. Interim practice copayments tended to rise over time, except in the over-65s (Cumming and Gribben, 2007).

Taking Access and Interim PHOs together, the 6-17 age group has been exposed longer than any other to extra public funding for low cost access (since October 2003) and so should give a good indication of the effectiveness the Strategy in reducing fees paid. Mean copayments for general medical consultations in this age group rose consistently from the first quarter of 2001 to the final quarter of April 2005 resulting in a doubling of the nominal fee paid from approximately \$6 to around \$11 (see Figure 7 below).

⁶ Quarterly data in this section is sourced from the draft version of Cumming and Gribben, 2007. Note that 'GMS' label refers to general medical services – i.e. first contact consultations

Figure 7: Trends in mean patient copayments, 2002-05



A similar pattern was observed in the 18-24 years age group, although the proportionate increase was lower (approximately \$17 to \$22). Sudden reductions in fees paid were also observed following the introduction of extra tranches of funding targeted on specific population groups (e.g. a fall in the mean copayment for over-65s in the third quarter of 2004 and for 18-24s in the third quarter of 2005).

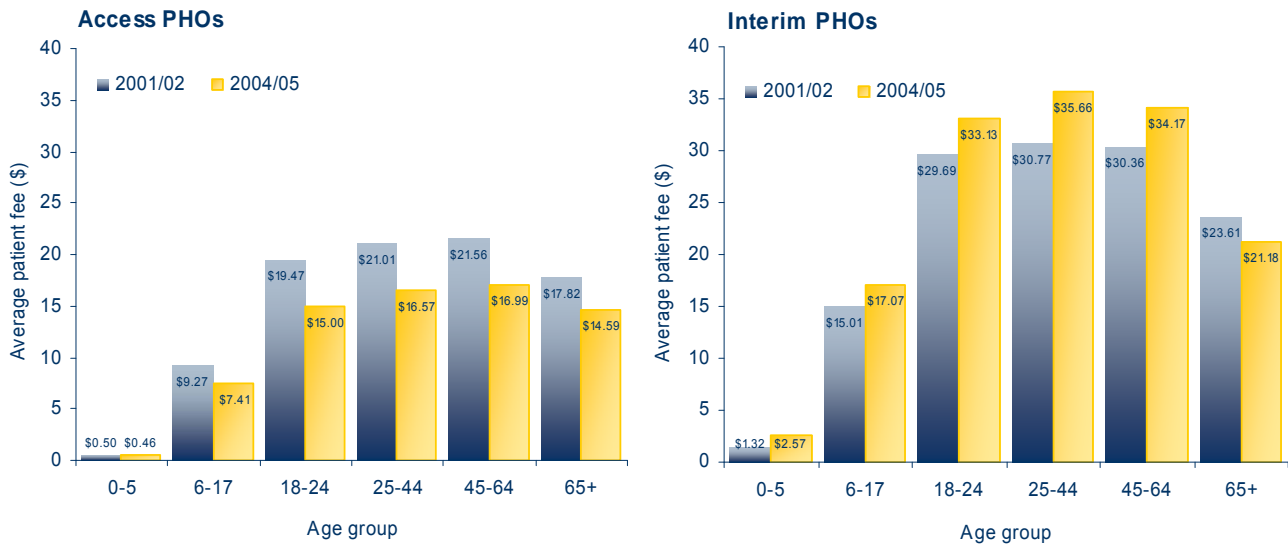
Fees for the under-sixes were low and stable between January 2002 and December 2005, (efforts had been made before 2001 to reduce fees for this age group). Fees for the over-65s were relatively stable until the third quarter of 2004 when increased subsidies for this age group were introduced (Cumming and Gribben, 2007).

Figure 8, below, illustrates the changes in average fees, by age group, in Access and Interim PHOs between 2001/02 and 2004/05. Average fees charged by practices in Access PHOs fell for all age groups across the study period (2001/02 - 04/05). There was a slight reduction in the average fee for people aged 0-5 years, a group that already faced relatively low fees. For other Access age groups, average fees fell by between \$1.86 and \$4.57 per consultation – equating to a reduction of between 18-23%.

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Average fee levels at Interim-funded practices for people aged 18-64 years increased slightly in each year of the study – reflecting the fact that additional funding had not yet been rolled-out to these groups. Of the two age groups in Interim PHOs that did receive additional funding, the overall reduction in average fee for people aged 65 and over was 10%, while the average fee for the 6-17 years of age increased by 14% over the period.

Figure 8: Mean patient copayments in Access and Interim PHOs, 2001/02 and 2004/05 ⁷



Taken together, these findings suggest that financial barriers to access were lowered, modestly, for those groups which were targeted with additional funding in the first three years of the Strategy. The observed increases in consultation rates suggest some improvement in equity of access, for example, for those aged 65 years and over. A more complete evaluation of patient access, in future, will include the subsequent funding roll-outs to the remaining groups, which were completed in July 2007.

Unanswered questions

Although the additional funding has generally reduced fees, an unanswered question is whether the observed reductions represent value for money. It is not clear whether the fee reductions are commensurate with the level of additional funding, or that the proportion of funding retained by practices as increased income is in line with what might have been anticipated during the policy development stage.⁸

⁷ Source: adapted by Treasury, from Cumming and Gribben, 2007 (see T2007/1853)

⁸ The impact of increased funding may be partially reflected in a survey by the University of Waikato, which found that the median income of working general practice owners almost doubled between 2001 and 2006, to \$186,600. More generally, an unresolved issue within the health sector, and across the state sector, is the appropriate level of income for private providers operating in an environment dominated by public funding.

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As virtually all practices have now joined a PHO, it is difficult to assess what would have happened to the level of fees without the additional funding. The evaluation report cites the nominal annual growth in consultation fees of 5.8% between 1996/97 and 2002/03. Assuming this period reflects 'usual' growth, the evaluation posits that it may not be unreasonable to have expected an increase of 18% in fees across the period of 2001/02 - 2004/05, if there had been no additional funding. Furthermore, people aged 18-64 years in Interim PHOs, who did not receive additional funding, experienced fee increases of between 12-16% during the evaluation period. The evaluation then goes on to conclude that people enrolled in Access PHOs "are benefiting substantially from the Primary Health Care Strategy expenditure".

In terms of the wider vision of the Primary Health Care Strategy, the reduction of financial barriers to access is only one of the objectives – which raises the question of whether the current approach to funding and implementation will succeed in delivering other important objectives such as improving health (through health promotion), maintaining health (through early detection), keeping people in good health for longer in their lives and coordinating their care (so as to reduce unnecessary reliance on more costly hospital care).

3. LIMITATIONS OF THE CURRENT ARRANGEMENTS

The five to ten year vision of change set out in the Primary Health Care Strategy envisaged a major shift in the focus and nature of primary health care services (Minister of Health, 2001). Box 1 below outlines some of the differences between existing arrangements and the new vision for primary health care services.

Although there are PHOs, general practices and other primary health care providers where the ‘new’ model is developing, it is arguable whether the situation has changed greatly for the typical general practice and average patient after five years. This may be due to a mix of three reasons: changing clinical behaviours takes a considerable time in the best of circumstances; there is insufficient consensus on what the direction of travel should be; and not all the necessary incentives are yet in place for such change to be effected.

Box 1: Primary Health Care Strategy (2001) – broad differences between the existing arrangements and the new vision

Old	New
Focuses on individuals	Looks at health of populations as well
Provider focused	Community and people-focused
Emphasis on treatment	Education and prevention important too
Doctors are principal providers	Teamwork – nursing and community outreach crucial
Fee-for-service	Needs-based funding for population care
Service delivery is monocultural	Attention paid to cultural competence
Providers tend to work alone	Connected to other health and non-health agencies

One of the Strategy’s objectives has received major, sustained attention in terms of the allocation of funding – reducing financial barriers to accessing first contact care. But despite the changes in consultation rates and out-of-pocket payments reported in the evaluation of the Strategy (Cumming and Gribben, 2007), there is little available evidence, as yet, that the reformed primary health care system is making a major contribution to the health care system commensurate with the large increase in public funding.

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A number of limitations are apparent with the current arrangements, including:

- i. *Weak financial incentives to adopt new forms of care* – fundamental system incentives have altered little, partly because the shift to capitation is for an ill-defined bundle of services, and partly because DHBs remain the residual risk holders;
- ii. *Less than fully formed accountability relationships* – the key relationship between PHOs and practices is under-developed;
- iii. *Considerable variation in PHO capability* – impacting on how the Strategy is being implemented;
- iv. *An unrealised contribution to the wider system* – primary care providers could be better encouraged to develop their contribution to the efficiency and effectiveness of the health system as a whole; and
- v. *Potential exposure to fiscal risk* – the focus on achieving and maintaining reduced patient fees carries a greater level of fiscal risk than the previous focus on a fixed public subsidy.

These limitations are discussed in more detail in the sections below. Our analysis of the current situation and subsequent discussion of ways forward largely focuses on the reimbursement framework and on the incentive effects on PHOs and primary health care providers. We also recognise that any changes to contractual or reimbursement arrangements need to be part of a considered approach that covers a number of dimensions in parallel – noted in more detail on p.38.

(i) Weak financial incentives to adopt new forms of care

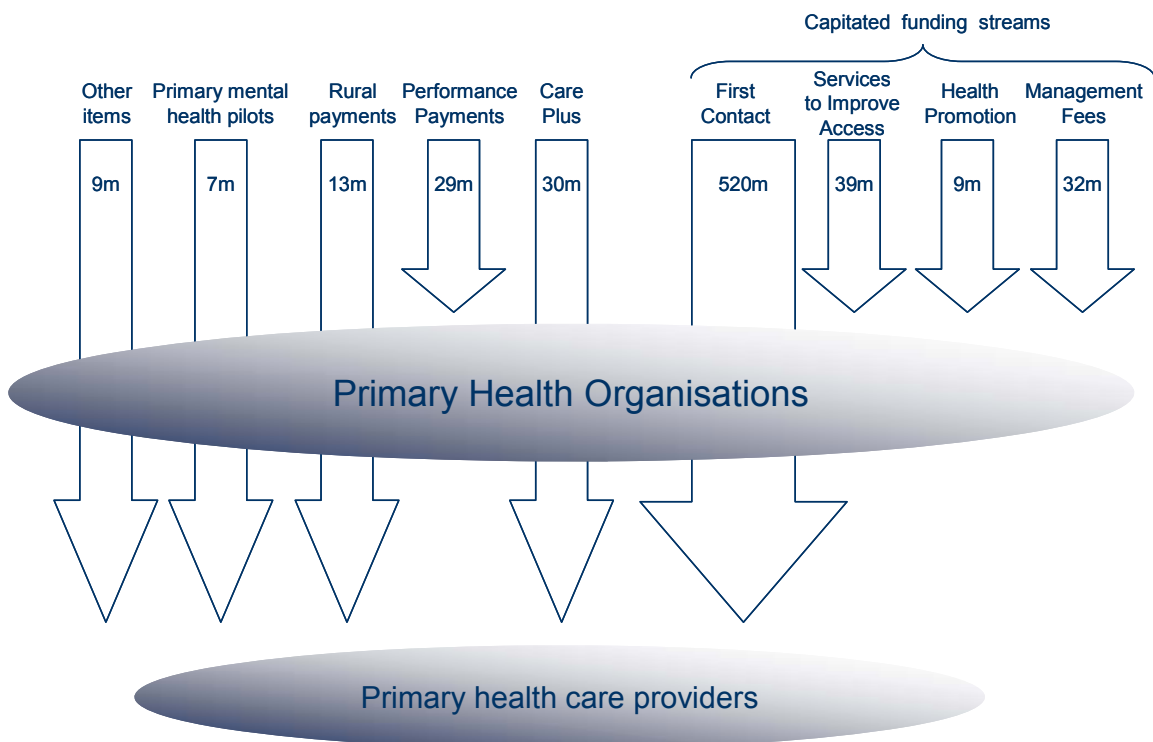
In theory, primary care providers with a capitated budget have a positive incentive to keep their population well (e.g. intervening to minimise the risks of disease progression) so that avoidable use of health care is reduced, and to use their workforce more efficiently than a system that ties reimbursement to the activity of particular groups of staff (Box 5, below, outlines elements of such an approach). Under the former fee-for-service system, GP services received public subsidies for which nurse-led services were not eligible even if nurses could have provided those services as or more effectively. The nature of fee-for-service reimbursement also tends to encourage individual consultations in response to presented symptoms. Capitation, on the other hand, in principle, encourages efficient activities such as specialisation of labour within a practice, for example; by making greater use of nurses for the maintenance care of people with long term conditions, greater use of GPs for more complex diagnostic work, and greater use of telephone consultations for more routine care.

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However, the current arrangements do not generate these incentives to anything like the extent that could be expected, because the majority of Strategy funding (\$520 million, or 64%, in 2007/08) is devoted to First Contact care (i.e. continuing to fund acute, episodic, responsive, undifferentiated care rather than care devoted to proactively improving population health). As a result, the main effect of the increased public funding to date appears to have been to replace patient copayments with public subsidies without greatly affecting the pattern of care. Furthermore, the bundle of services covered by First Contact capitation is not specified, and DHBs remain the residual risk holder – for example, for ambulatory sensitive hospitalisations. Some First Contact funding is undoubtedly used for consultations that contribute to chronic disease management, which has the potential to avert expensive needs for care at a later stage. But it is currently impossible to estimate how much. In 2007/08 around \$33 million, or 4%, of Strategy funding (the Care Plus and Get Checked programmes) is devoted specifically to the management of people with chronic conditions (e.g. diabetes).

Figure 9 depicts the various funding streams associated with the implementation of the Strategy. It attempts to represent which funding streams usually pass straight through the PHO to the practice, and which are more likely to be managed by the PHO. This may vary by PHO. Some funding streams are allocated to PHOs by the Ministry of Health, while others (such as the capitated streams) have been devolved to DHBs. Funding streams not identified in the diagram include those for immunisation and screening programmes.

Figure 9: Sources of funding for primary health care, 2007/08



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The First Contact funding passes straight through the PHOs to the practice-level. This situation is partly determined by the nature of the funding model, which is built on notional consultations multiplied by notional fee subsidies (i.e. based on the principles of the former fee-for-service subsidy system), and partly by the expectations resulting from promises to patients of specific reductions in copayments.

Only the relatively small Services to Improve Access and Health Promotion funding streams (\$39m and \$9m, respectively⁹) appear to be usually available directly to the PHO to develop new services. As a result, PHOs have limited influence the overall pattern of services provided, since the dominant First Contact budget is linked to reducing patient copayments by a specified amount for different population groups (as if the former targeted subsidy regime were still in place). Practices argue that they need to receive the full amount of this capitation funding directly if they are to afford to provide responsive services at a reduced level of copayments. This arrangement locks the new funding into the old pattern of subsidising GP visits and reinforces the public perception that the role of government is, as traditionally, predominantly to reduce the levels of copayments.

The expected incentive effects of the shift to capitation funding of PHOs are further weakened by the fact that patient copayments (set by practices, not the PHOs) remain a substantial proportion of the revenue of a typical practice at between 20% and 40%.¹⁰ As a result, practices are not incentivised to alter their current business and service model. Practices will tend to continue to give high priority to maintaining GP availability for demand-led, first contact care rather than making more efficient use of the primary health care team since fees to see a GP are customarily set far higher than practice nurse visit fees.

Regardless of how patient fees are regulated, the evidence suggests that partial capitation in the presence of appreciable fee-for-service payment will not deliver the intended effects in terms of changing clinical behaviour, particularly when fees are determined autonomously by the provider (i.e. general practice) not the insurer/funder (Conrad et al, 1998; Rosenthal et al, 2002; Robinson et al, 2004; Goroll, et al, 2007). In effect, the financial risk of managing demand is passed down to the practices (rather than the PHO) via capitation funding, but the practices can always pass the risk of over-spending (or of lower-than-desired incomes) to their patients (subject only to risking losing patients to rival practitioners).

⁹ Combined, these streams equate to 6% of the PHCS budget in 2007/08. See Table 1, above.

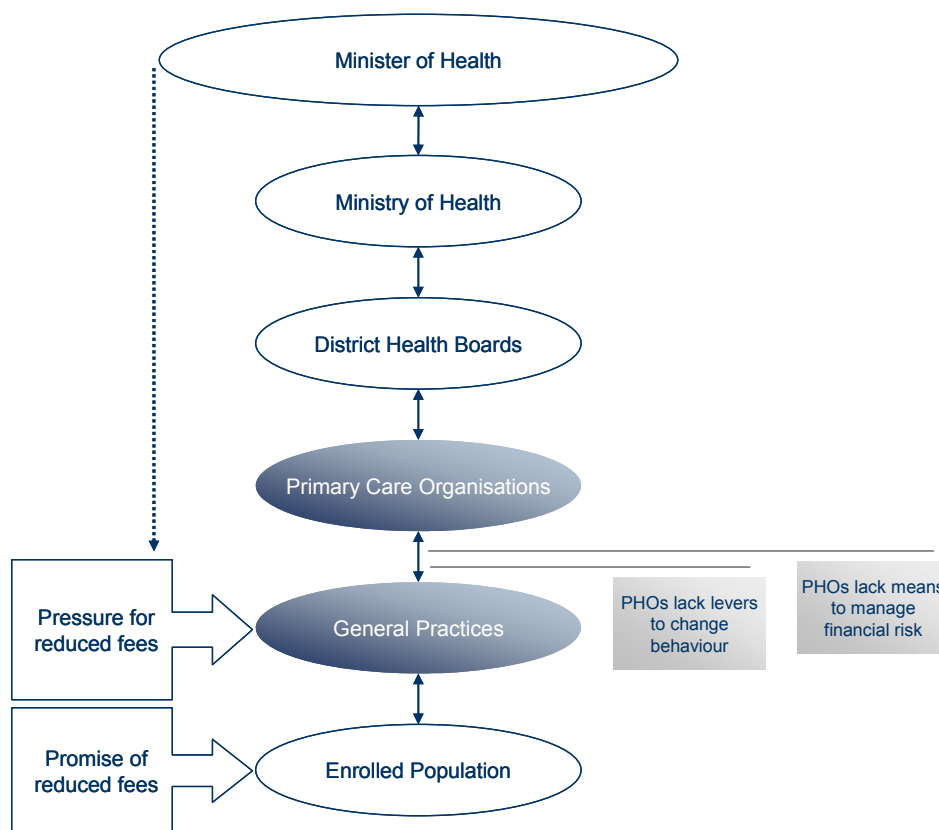
¹⁰ There are a number of estimates of the proportion of practice revenue obtained from patient fees.

- The 2006 LECG report on general practice fees estimates a likely range of 20%-40% and notes that a 'reasonable' proportion of practices obtain close to 30% of revenue from patient fees.
- The *IPAC 2006 General Practices Business Study* of 34 practices found that the proportion of practice revenue obtained from patient fees ranged from 9%-70%, with a mean of 40%.

(ii) Less than fully formed accountability relationships

Looking at the series of relationships, from the Minister of Health to the patient, that together constitute primary health care policy and delivery (see Figure 10, below), probably the most important for changing the nature of the services provided lies between the PHOs and their practices. Yet, this key relationship has received little attention in policy development since 2001, possibly in part, because PHOs, unlike DHBs, are not Crown Entities.

Figure 10: The policy ‘chain’ in primary medical services



Most PHOs appear to have little or no direct means to influence the behaviour of their providers for a number of reasons, including:

- PHOs do not normally own the practices they are nominally responsible for funding and the practitioners have no stake in the PHO;
- PHOs do not bear or share any of the financial risks facing the practices;
- PHOs effectively control only a minority of the public funding going into practices;
- As funders, PHOs receive the public funding element in primary health care but do not control or have direct knowledge about the patient contribution (if they did, the PHO-practice dynamic would be very different); and
- Where PHOs can retain and use new funds for services, they lack access to capital to develop joint ventures with practices.

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PHOs lack contractual levers to influence the services provided by their practices because they have to pass on the vast majority of public funding to practices to enable them to levy reduced fees. As a result, there are few clear contractual requirements from PHOs as to what practitioners/practices are expected to achieve in the new reduced fee environment that differs from what they were working towards previously. In addition, most of the 81 PHOs do not have the managerial capability to negotiate detailed contracts for service with practices and practitioners. This is a skilled, specialised role and experience in New Zealand is limited – exemplified by the tendency for the boards of many PHOs to contract out administrative and/or planning functions to Independent Practitioner Associations (IPAs).

Currently, the largest funding stream (First Contact) passes through PHOs directly to providers using the same capitation formula that is used to determine the overall allocation to the PHOs. However, it is unclear whether a formula designed to produce a budget for an organisation with a population ranging from 4,000 to 340,000 is appropriate for calculating budgets for practices with typical populations of 2,000-3,000 patients. Although Care Plus funding for patients likely to impose higher than average costs on practices is available in addition to the First Contact funding, thereby offsetting some of the financial risks associated with exclusive capitation funding at practice level, Care Plus funding is relatively small compared with the First Contact budget (\$30m and \$520m, respectively, in 2007/08). As a result, the main financial risk management tool available to practices remains their ability to levy user charges. In turn, this means that provider remuneration is not determined after negotiation by the insurer (i.e. the public funder), but by the service providers – predominantly GPs (Howell, 2005).

(iii) Considerable variation in PHO capability

There is no doubt that some PHOs and their primary health care providers are bringing about changes in services consistent with the objectives of the Strategy. However, the rate and extent of change appears to have been variable. This is exemplified, for example, by the slow uptake of programmes that make additional patient funding and/or information available - such as Care Plus and the PHO Performance Management Programme.

One reason for variation in implementation may be the huge variety in the make-up of PHOs. Most obviously, PHOs vary considerably by enrolled population size, from 354,000 (Partnership Health Canterbury) to 3,200 (Whangaroa PHO in Northland). Similarly, the number of general practices associated with PHOs ranges from over 100 to just a handful of practices. Figure 11, below, illustrates the distribution in size of PHO enrolled populations. Over half of PHOs (44 out of 81) have enrolled populations of fewer than 30,000.

Figure 11: PHOs, distributed by enrolled population size ¹¹

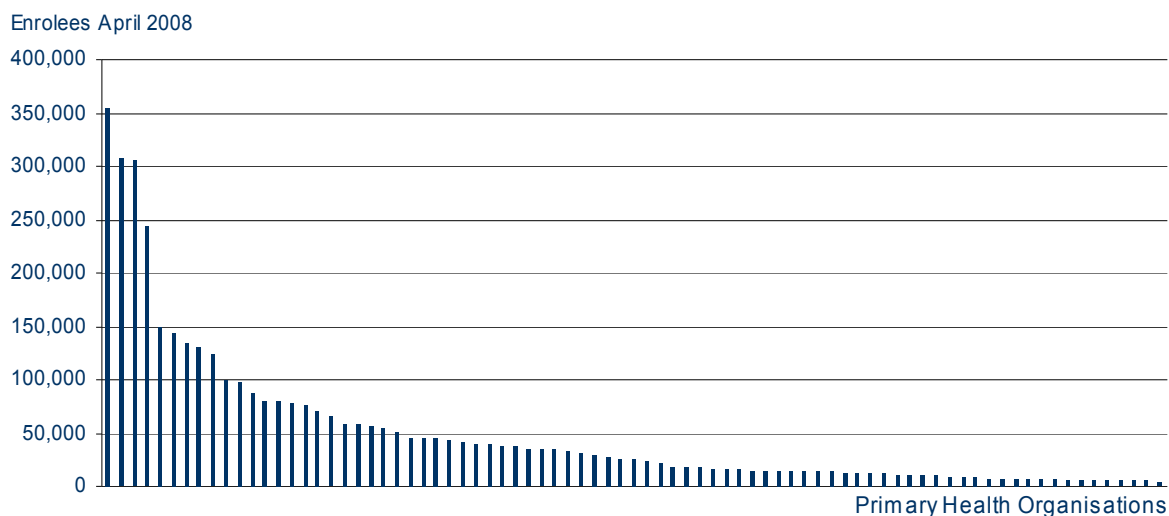


Table 4 groups PHOs by enrolled population size. Almost a third of the national population are enrolled in the four PHOs with enrolled populations of 200,000 or more. Together, PHOs with fewer than 30,000 enrolees account for just 14% of the enrolled population nationwide. DHBs also face varying situations in terms of the number of PHOs serving populations within their district. Table 5 shows that the majority of DHBs negotiate with, and support, more than one PHO. Nine DHBs have between five and seven PHOs responsible for providing primary care services to their populations, which invites the question as to whether this number of planning and purchasing nodes is leading to coordination problems.

Table 4: PHOs by size of enrolled population

PHO population size	Number of PHOs	Aggregate population	Percent of enrolees
less than 30,000	44	557,533	14%
30,000 - 99,999	27	1,457,498	36%
100,000 - 199,999	6	784,771	20%
200,000 or more	4	1,211,140	30%
Total	81	4,010,942	100%

Given this variation in size, in terms of population and practices, PHOs cannot all fulfil the same functions. Small PHOs have the advantage of cohesion and closer links between the PHO and those providers delivering the service. Some of the 44 PHOs with less than 30,000 enrolees may be better regarded as primary care provider organisations (large practices) rather than as funders and organisers of primary health care.

¹¹ Source: PHO enrolments data set as at April 2008: www.moh.govt.nz

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Table 5: Number of PHOs per DHB

District Health Board	No. of PHOs	District Health Board	No. of PHOs
Counties Manukau DHB	7	Hawkes Bay DHB	3
Auckland DHB	6	Taranaki DHB	3
Capital & Coast DHB	6	Lakes DHB	2
Hutt DHB	6	Nelson Marlborough DHB	2
Northland DHB	6	Tairāwhiti DHB	2
Waitemata DHB	6	Whanganui DHB	2
Bay of Plenty DHB	5	South Canterbury DHB	1
Canterbury DHB	5	Wairarapa DHB	1
Otago DHB	5	West Coast DHB	1
MidCentral DHB	4		
Southland DHB	4		
Waikato DHB	4		
		Total	81

Large PHOs could act more effectively as developers of new services and as managers of financial risk. Yet most of the financial risk within PHOs is segmented among the individual practices, which operate as independent businesses. If PHOs are to increasingly plan and fund new models of care, it is worth noting that literature suggests that populations of 30,000-40,000 tend to be the minimum for viable financial risk-pooling in health care. Martin, Rice and Smith (1997) show that a risk-bearing health care organisation with a fixed budget and an enrolled population of 10,000 has a 1 in 3 chance of incurring expenditure of more than 10% above its acute hospital target, compared to a 1 in 400 chance for an organisation with an enrolled population of 100,000).

While PHOs vary greatly in obvious features such as size of enrolled population, they also vary in less observable characteristics such as their ability to use some of the new primary care funds for primary care to develop new, more proactive, population-oriented services.

The Victoria University-led evaluation of the implementation of the Strategy notes that smaller PHOs (<20,000) were more likely to comprise Access-funded practices. (Cumming et al, 2005). The evaluation goes on; "...it would be fair to say that PHOs made up of such Access-funded practices already possess many of the qualities and provide many of the services mandated by the Primary Health Care Strategy." The evaluation notes that some large PHOs, comprising mainly Interim-funded practices, are leading the way in needs analysis, public health and health education initiatives, and the provision of new clinical services. Yet the evaluation also notes there may be a risk that some Interim-funded practices, with established infrastructure, may see little need to make changes beyond compliance with the reporting needed for remuneration. Table 6, sourced from the evaluation, presents some of the characteristics likely to be associated with PHO size.

Table 6: Characteristics of PHOs (simplified)

Small (< 20,000 enrollees) Inadequate management resources	Large (>20,000 enrollees) Well resourced, efficiently managed
Access-funded History – Previous NGO, capitated Low investment in IT, premises Salaried doctors	Interim-funded History – Previous IPA, fee-for-service Established IT, premises etc Doctor’s own practice
Low co-payments Full/increasing use of nurses Established community governance Māori and Pacific focus	Higher co-payments Use of nurses dependent on workload Establishing community governance General population focus

Source: (Cumming et al, 2005)

In addition to variations in the structure and size of PHOs, there is variation in uptake of the various programmes under the Strategy such as Care Plus (additional funding for the management of patients requiring intensive management due to a chronic or terminal disease)¹². The variable uptake of Care Plus funding is due to the fact that, in order to participate, each practice needs to take part in continuing medical and nursing education, and have a good patient information system, space to hold nurse-led clinics, adequate GP time and a viable primary health care team.

An independent review of PHO management services (Jordan et al, 2004) provides further evidence of variable PHO capability. PHO management services include board governance, business planning, contract management, community liaison, and performance monitoring and reporting. The review found that medium-sized PHOs (between 20,001 and 75,000 enrollees) were better able to meet these requirements than small PHOs (fewer than 20,000 enrollees), which generally struggled because they did not have the staff needed to undertake all the requirements. The review also found that if PHOs are not part of a network or shared service arrangement, it was estimated that management service fixed costs could be \$364,000 (or \$18.20 per head) for the small PHO and \$579,000 (or \$7.72 to \$11.58 per head) for the medium-to-large PHO. Shared service arrangements could reduce these costs considerably – down to \$280,000 (\$14 per head) in the case of small PHOs.

Although changes have since been made to the funding formula for the PHO management services, an underlying question remains as to whether smaller PHOs will be viable as separate funders and planners of primary health care services in the long term. A further

¹² An evaluation of the implementation of Care Plus found that, even in practices that had been delivering Care Plus for some time ‘enrolment growth has been slower than expected’. Of those PHOs that had started Care Plus by April 2006, only 39% of predicted eligible patients had been enrolled in the programme. (CBT Research, 2006)

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question, also related to the PHO capability, is the extent to which some PHOs are predominantly 'post boxes' through which funds pass directly to practices, rather than developing closer relationships with their providers and developing new primary health care programmes focused on improving the health of their enrolled populations.

(iv) An unrealised contribution to the wider system

There are a number of ways in which PHOs and practices can, and do, contribute to the efficiency and effectiveness of the health system as a whole. As well as potentially moderating demand for relatively costly hospital care through better/earlier management of chronic disease conditions in the community¹³, PHOs and their practices/practitioners manage referrals for a range of community-based and hospital-based specialist services.

General practitioners may refer patients to both community-based and hospital-based specialist services for a variety of reasons, including diagnosis, treatment, or reassurance for the GP and/or the patient (Piterman and Koritsas, 2005). The range of referred health services for which general practitioners act as gatekeepers for demand represents a significant share of health service spending, but one for which PHOs or practitioners bear none of the financial risk. Major categories include community pharmaceuticals (\$660m for the Pharmaceutical Schedule and \$250m for pharmacy-based dispensing in 2006/07¹⁴), community laboratory services and community diagnostic services. In each case, DHBs play the role of the third party payer – bearing the costs of publicly-funded laboratory and radiology services, and predominantly bearing the cost of pharmaceutical use (patients bear a \$3 copayment for items on the Pharmaceutical Schedule). As the main point of entry to community-based care, PHOs and their practitioners are well-placed to manage the level and quality of referrals for these services – assuming they possess the information and incentives to do so.

In some ways, the contribution of primary care to the management of resources in the wider health system has actually reduced since 2001. For example, PHOs are not involved in managing the budget for referred services (an area in which some primary care organisations, particularly the IPAs, were active in the late 1990s). The first report of the national evaluation of the Strategy emphasised the importance of the link between PHOs and practices, and with other services provided outside hospitals such as laboratory tests and pharmaceutical prescriptions, while pointing out the lack of incentives on practitioners and PHOs to manage the use of these services (Cumming, Raymont et al, 2005: 29, 31).

¹³ See Rea, McAuley, et al (2004) for the impact of chronic care management in Counties Manukau

¹⁴ DHBNZ memo on pharmaceutical costs in 2006/07

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There is evidence that the contribution of primary health care to the wider health system may be somewhat hindered by the relatively restricted access that practitioners appear to have to diagnostic radiology services – which are contracted and budgeted for by DHBs. Radiological investigation (e.g. x-rays and scans) is a basic element of primary health care, yet PHO access to radiology services in New Zealand is inconsistent and is frequently hampered by long waiting times (in the case of outpatient referrals) or considerable financial barriers (in the case of private referrals) (Crampton and Bhargava, 2006). A health sector working party (Ministry of Health, 2006) found that this limited access tends to result in unnecessary referrals to hospital for specialist assessments when, instead, all these patients may need is access to a simple radiological examination ordered by the GP (see Box 2 below). The working party also speculated that the shifting of some hospital care to alternative health care providers in the community is hindered because of the incentives on DHB provider arms to hold onto work (and, thereby, funding), thereby potentially reducing the efficiency of care from a system perspective (see Box 3 below).

The Community Referred Radiology Scheme at Capital and Coast DHB is a useful case study of access to community-based radiology services. Since 2000, the scheme has involved private community-based radiology clinics funded by Capital and Coast DHB. The rationale has been to increase access to radiology services by making a service available outside hospital but at no or low costs to patients, and thus promote more efficient use of hospital resources by reducing the burden on public hospital outpatient radiology clinics. In their evaluation of the scheme during 2003/04, Crampton and Bhargava found that 117 types of radiology investigation were ordered by GPs, of which the chest x-ray was the most common. Clinicians viewed the scheme as producing a number of benefits, including:

- Improved GP ability to diagnose and manage conditions, and to make more appropriate referrals to secondary care ;
- Lower demand for hospital radiology services, leading to a dramatic decrease in hospital waiting times; and
- Improved access to community radiology services for people who would otherwise have found access difficult for financial reasons. (Crampton and Bhargava, 2006).

Overall, general practitioners reported high levels of satisfaction with the scheme, suggesting that improved access to community-based radiology services would allow PHOs to make a greater contribution to the efficiency and effectiveness of the wider health system.

Box 2: Addressing disincentives to efficient resource use – current diagnostic service settings

Improved GP access to diagnostics would potentially benefit the efficiency of both DHBs' and PHOs' use of resources. In 2006, a Ministry of Health / DHB / PHO working party identified less-than-optimal GP access to diagnostic services, such as community radiology, as leading to unnecessary delays and congestion within the health system (Ministry of Health, 2006).

For example, when a GP determines a need for a diagnostic investigation, such as bone densitometry x-ray, ultrasound, magnetic resonance imaging (MRI scan) or computed tomography (CT), the current pattern is for the patient to be referred to the relevant hospital outpatient clinic, rather than to a community-based radiology service. Furthermore, as hospital inpatients tend to receive higher priority for diagnostics delivered within a secondary care setting, some specialists may be reluctant to discharge a patient to the GP with a request for a diagnostic test. The resulting negative impacts on system efficiency include unnecessary first specialist assessment (FSA) attendances, an unnecessarily long inpatient stay, and unnecessary congestion impacting on elective surgery volumes. The working party considered insufficient access to community diagnostic services to be a key disincentive to maximising elective service delivery.

Improved GP access to diagnostics would allow a greater proportion of patient diagnoses and/or condition severity to be confirmed in the community. Potential benefits from improved GP access to diagnostics would include increased throughput of higher priority patients, and shorter waiting times for both diagnostic tests and elective procedures.

Recommendations from the working party include that DHBs review community radiology budgets, and that where possible the budget be devolved to the PHO to refer patients using agreed access criteria; that DHBs review their capacity to deliver enhanced diagnostic services; and that the Ministry of Health consider facilitating the development of national referral access criteria.

Box 3: Addressing disincentives to efficient resource use - increasing the appropriate use of primary care after hospital discharge

Financial disincentives may hinder the shifting of some hospital care to alternative health care providers in the community, thereby reducing the efficiency of care. At many DHB provider arms, the level of funding is linked to the delivery of specific patient activity or service outputs, for example, clinic attendances or admissions for inpatient activity. Innovation within DHB provider arms to manage patients in alternative ways between secondary and primary care settings may, therefore, incur a financial penalty (such as a reduced budget) without a corresponding reduction in patient demand.

A 2006 sector working party report on disincentives to efficient care noted a general reluctance among specialists to discharge patients back to primary care once a secondary treatment was complete (Ministry of Health, 2006). This delay may result in outpatient follow-up attendances that could potentially be managed by the patient's GP, at a lower cost to the system.

Given the limited resources and capabilities in both primary and secondary care to meet demand for elective services, DHBs are under pressure to identify cost-effective ways of managing patients across the primary-secondary divide. The working party recommended a number of practical steps, including:

- A joint exercise between secondary and primary providers to identify:
 - core work to be retained in a secondary setting,
 - work that can be performed by alternative providers (eg: removal of minor skin lesions);
- DHBs and PHOs support training programmes to improve GPs' ability to manage patients within their scope of practice; and
- DHBs adopt a transparent process for developing proposals to support innovative ideas.

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'Best practice' chronic disease management involves a team effort by specialists, GPs and nurses (see Box 5 on p.46). PHOs and their practices could make better use of multi-disciplinary teams in the management of chronic conditions in the community – this is identified as a key element in the Strategy. According to the Commonwealth Fund international health survey in 2006, only 30% of New Zealand general practices reported routinely operating as a primary health care team – versus 50% in the Netherlands and 81% in the UK (see Table 7). This suggests that there is a considerable distance to go before general practices are geared up to provide chronic disease management according to 'best practice' models.

Table 7: Use of non-medical workforce in primary care in seven countries

This table shows the responses as a percentage

	AUS	CAN	GER	NETH	NZ	UK	US
Practice routinely uses multidisciplinary teams:							
Yes	32	32	49	50	30	81	29
Practice routinely uses clinicians other than doctors to:							
Help manage patients with multiple chronic diseases	38	25	62	46	57	73	36
Provide primary care services	38	22	56	33	51	70	39

Source: Commonwealth Fund (2006) *Survey of primary care physicians in seven countries*. New York.

The rate of ambulatory-sensitive hospital admissions is often used as a measure of the effectiveness of the interface between primary and secondary health care. The assumption is that better management of chronic conditions such as diabetes and cardiovascular disease within local communities has the potential to reduce the number of avoidable hospital admissions (and to moderate demand on hospital resources). The age-standardised rate of ambulatory-sensitive hospitalisations per 100,000 admissions remained relatively unchanged for Māori, Pacific and Other (non-Māori, non-Pacific) ethnic groups between 2002/03, when the Strategy began to be rolled out, and 2005/06 (Ministry of Health 2007). The variation in standardised rates among DHBs, and the fact that the rates for Māori and Pacific are much higher than Other ethnic groups (1.67 and 1.9 times higher, respectively) suggests there is scope for more shared learning among PHOs, and for primary health care to make a greater contribution to overall system efficiency and effectiveness.¹⁵

¹⁵ Ambulatory-sensitive hospitalisations were included as a National Health Target from July 2007

(v) Potential exposure to fiscal risk

From a purely fiscal perspective, the previous fee-for-service subsidy allowed flexibility for the government to manage increases in primary health care funding because the entitlement was a fixed public subsidy per visit, irrespective of the total charge levied by the practice. Except for a policy of 'free' care for under-6s, the government did not commit to patient fee levels. Under the current arrangements, the commitment to maintaining reduced patient fees may lead to the publicly-funded contribution coming under pressure – from trends in costs faced by providers, their ability to run their businesses efficiently, and the income levels needed to keep practitioners active in the local health care markets.

Achieving reduced patient copayments

The trends observed do not suggest that the injection of public funding has had a major effect so far (at least by the end of 2005) on the nominal GP fees for groups which received additional funding. The evidence indicates that fees are likely to be lower than they would have been without the new money injected since 2002, but that this has required substantial public funding (see earlier discussion, pp.19-20).

Trying to reduce patient charges by increasing the level of public funding in the presence of substantial, only partially regulated, user charges set by individual providers is clearly not without risks. It is possible that the combination of substantial increases in public funding and gradually rising user fees set by practices has led to increases in provider take-home pay, but without necessarily improved provider performance (see footnote 8, p.19). The realisation of government aspirations toward encouraging (and maintaining) lower costs to patients for primary health care may depend on the government's willingness to increase the gross incomes of practices – especially in the absence of information on practice cost structures and pressures (i.e. the options available to providers to improve efficiency).

Maintaining reduced patient copayments

Maintaining a reduced level of patient out-of-pocket payments carries a fiscal risk. The 'First Contact' funding stream is subject to increases by the Future Funding Track (FFT), a proxy measure of economy-wide price growth designed to maintain the purchasing power of Vote Health against inflation. However, general practices, as independent businesses bearing financial risk, may seek to offset additional cost pressures via increases in patient copayments. This situation means there is potential either for the purchasing value of the capitation funding to erode over time, or for the government to be pressured to top up the public funding stream if it is not willing for copayments to adjust to compensate practices for perceived shortfalls in, or potential risks to, their incomes.

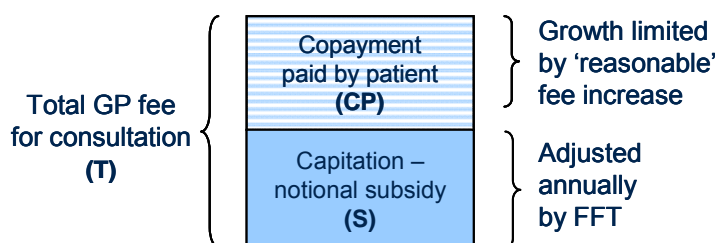
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In order to manage this situation, the Ministry of Health has supported DHBs to establish regional fee review committees to moderate any annual increases, and thereby to maintain reduced levels of patient fees. In 2005, DHBs commissioned an economic consultancy to develop a method for determining an annual statement of what 'reasonable' fee increases would look like for 2006/07, and 2007/08 (Davies, Hope, and Moore, 2006).

The resulting method estimates the average annual change in input costs faced by general practices, using a weighted average of official price indexes produced by Statistics New Zealand: 70% Labour Cost Index (Health and Community Services component); 20% Producers' Price Index (Health and Community Services component); and 10% Capital Goods Price Index. As Figure 12 shows, the total 'notional fee' for a GP consultation (i.e. the total cost faced by the provider) can be split into:

- *Capitation subsidy* (a notional subsidy, since the public capitation component is paid to PHOs on a per-patient basis, not per consultation), which is adjusted annually by the health sector's general pricing adjustment known as the Forecast Funding Track (FFT); and
- *Patient copayment*, subject to an annual DHBNZ statement of reasonable increases.

Figure 12: Applying 'reasonable' fee increases to GP consultations



Source: Davies, Hope and Moore, 2006

The reasonable fee increase for a particular practice depends on the ratio of publicly-funded capitation income to private patient fee income at that practice. Table 8 below, taken from the LECG report, shows the calculated adjustment to the overall GP consultation price for 2006/07 was 3.9% (based on the movement in price and labour indices). As the 2006/07 FFT increase on the capitation contribution was 3.3%, the resulting reasonable fee (patient copayment) increases ranged from 4.8% to 6.3%, according to the proportion of practice revenue derived from public capitation funding. For example, for practices with a 70:30 ratio, a reasonable patient fee increase would be 5.3% – approximately 2% above the increase indicated by the prevailing sector-wide price adjuster (FFT) of 3.3%.

Table 8: Results of calculation of 'reasonable' fee increases, 2006/07

(S:CP)	Adjustments to fees and components		
	T% (LECG est.) Total fee adjustment	S% (Govt.) Subsidy adjustment (FFT)	CP% Co-payment % increase
60:40	3.9%	3.3%	4.8%
70:30	3.9%	3.3%	5.3%
80:20	3.9%	3.3%	6.3%

Source: District Health Boards New Zealand (2007)

Practices that intend to increase fees over the reasonable increase threshold are referred to independent review committees by their DHB. DHBs and PHOs have established the committees to determine the acceptability of proposed increases above the level set in the statement of reasonable fee increases. Factors taken into consideration include evidence of the practice facing unusual cost increases, of plans to invest in the business in a way that will advance the Strategy, and of the sustainability of the practice being at risk. By late 2007, 90 practices had been referred for fee review. Of the 63 completed reviews, 53 (84%) resulted in the committee supporting the increase proposed by the practice (*NZ Doctor*, 15.08.2007).

Given that DHBs, and most PHOs, usually have little information about the cost structure of practices, it is unclear whether the announcement of 'maximum allowable' fee increases generates an incentive for practices to consider automatically raising their fees by that amount, as a way of future-proofing their revenue. It is questionable whether the review process should only focus on trends in the costs facing practices without making any allowances for expected efficiency gains. Without robust information on the cost structure and cost drivers within the different forms of primary care practice, and some consideration of what represents an adequate profit, it will remain difficult to determine what really represents 'reasonable' fee increases.

In health systems such as the NHS in the UK, where primary health care is publicly funded and free at the point of use, the government negotiates the rate of increase in practice remuneration with national representatives of practices on the basis of assuring a 'target' take-home income for practitioners from their contracts with the NHS. These contracts take into account a range of different practice circumstances, patient mixes and patient list sizes.

4. SOME POTENTIAL WAYS FORWARD

It is a great deal easier to identify the limitations in the current arrangements than to devise acceptable and feasible ways forward. There are no easy options for getting from the current position to one which ensures better progress towards the objectives of the Strategy and increases the government's confidence in what is being secured for the expenditure. Most of the additional funding available for the Strategy has already been spent on lowering user charges. This means that there are limited opportunities to encourage new ways of paying for, organising and delivering primary health care. A consensus for further change will therefore need to be built over time.

An obvious policy response to the limitations of the status quo discussed in the previous section is to try to develop better contractual relationships between PHOs and primary health care providers. However, changing contractual or reimbursement forms alone will not be enough to fundamentally alter behaviours. Any contractual changes need to be part of a considered approach that covers a number of dimensions in parallel, including (but not limited to):

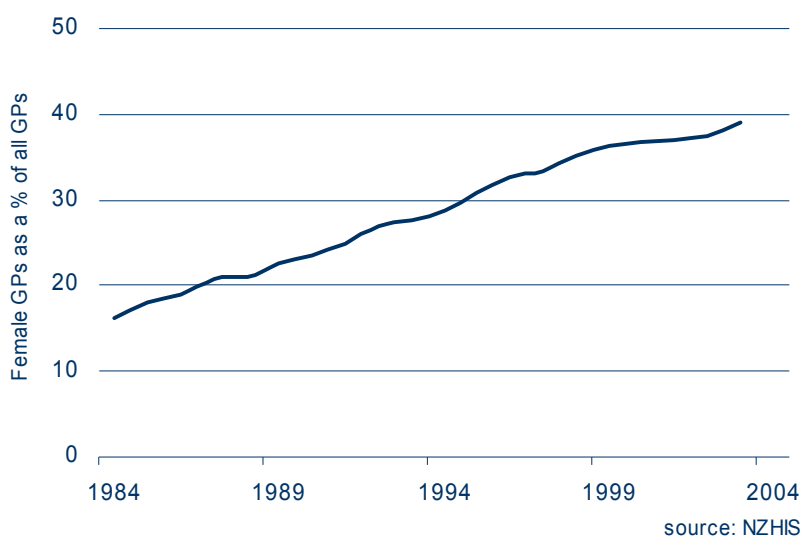
- changing public expectations about what primary health care should provide;
- sharpening accountabilities between practice, PHO, DHB and the Ministry of Health;
- strengthening the range and quality of system-wide performance information;
- promoting stronger clinical governance and information sharing;
- building PHO analytical and purchasing capability;
- building the national research base with regard to innovative and cost-effective models of care; and
- a clear workforce strategy with new clinical roles and training pathways.

Any profound transformation of primary health care will need to be implemented gradually, for example, by offering opportunities for new forms of relationship between the public funder (PHO) and practices, and other primary care provider organisations interested in developing alternatives to the small business, fee-for-service model of general practice that has predominated to date. Piloted innovations should be accompanied by rigorous evaluations of implementation process and impact, to assess their suitability for wider implementation.

The history of attempts by government to drive change in the relationship between GPs and the state is not auspicious, particularly when this has involved attempting to intervene in the user fees set by practices. However, there are some encouraging signs of future openness to change. While the majority of the current GPs might be resistant to entering into full contractual links with the public funder, and to forego their ability to set their own

copayments, new entrants to the profession may find alternatives to the current subsidised small business model more attractive. As retirements occur, and with the increasing proportion of female general practitioners (see Figure 13, below), it is possible that PHOs and DHBs will have opportunities to innovate with new organisational, financial and ownership forms that could make it easier to achieve the objectives of the Strategy and to improve the quality and efficiency of the wider health system.

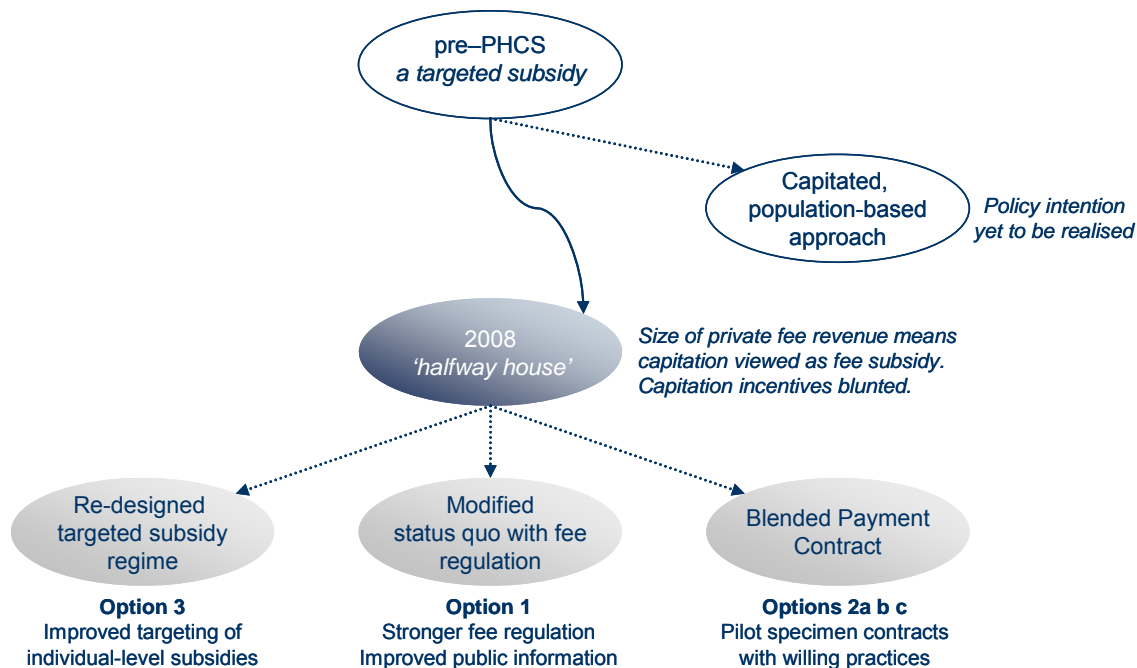
Figure 13: The increasing proportion of female general practitioners in New Zealand



This paper presents three stylised policy directions for discussion, shown in figure 14 below. Option 1 and Option 2 are an initial attempt at sketching possible future developments in terms of developing better contractual relationships between PHOs and primary health care providers. In each case, it is recognised that other enablers and drivers of change need to be addressed in parallel (noted earlier in this section). Both options are based on the idea of gradual change, but embody different levels of ambition in the long term, and so could be pursued in parallel. Option 2 has three sub-options differentiated by whether any patient copayments are paid directly to practices or paid to the PHO. Option 3 – a redesigned individual targeting regime – is a more targeted approach to change, and could be contemplated if it proves too difficult to make sufficient progress with Option 1 or Option 2, or if the government decided to place less weight on achieving universally low copayments.

Presented as distinct options for convenience, the design choices discussed here can be broadly thought of as sitting on a continuum in terms of the extent to which services are subsidised or purchased at the level of the individual through to a population approach. While high level design is proposed in each case, it is apparent that the actual impact would rely, to some extent, on further design detail and the actual approach to implementation.

Figure 14: Relationship between potential policy directions



Any new contractual and reimbursement forms proposed for primary health care should be evaluated rigorously to determine their impact on the pattern and quality of services provided, and their ability to contribute to key system goals. In addition, there may be scope for policy learning and development across areas facing similar challenges (such as early childhood education and legal aid) in relation to accountability, fee setting and regulation of private providers which are in receipt of public funding, but continuing to be able to levy private user fees.

Detailed policy thinking, consultation and discussion will be needed before any of the three options can be presented as the next stages in the implementation of the Strategy, but they are outlined here to encourage debate about what the next stages might look like.

Option 1: Modified status quo – towards new service models

This scenario assumes that: current policy settings broadly continue; the number and variable size of PHOs remain the same; the multiple public funding streams become embedded into the sector's outlook; practitioners and practices continue to receive public capitation funding and private fees from patients; and DHBs continue to try to establish reasonable fee increases through regional fee review committees. Underlying trends include the changing composition and expectations of the GP workforce. In essence, this option represents a twin strategy of trying to find better ways to regulate increases in patient fees to ensure good patient access while continuing to encourage innovations in the nature of primary care to improve resource use and outcomes.

Managing patient fee increases

As discussed earlier, the continued focus on fee levels as a proxy for patient access has the potential to: (i) stimulate greater fee increases than would otherwise be the case; and (ii) prolong the traditional fee-for-service mindset at the level of general practice. Whether patient fee increases can be adequately restricted under current arrangements, or not, it remains important to continue to focus on developing ways to ensure that neither fees nor public funding increase unsustainably or unjustifiably.

DHBs have signalled their intent to notify GPs annually of consultation fee increases considered to be reasonable, with the regional fee committees reviewing and regulating annual increases. This may have an unintended result of stimulating price inflation, however modest that effect may be. Assuming that, on average, patient fees still account for between 20% and 40% of practice revenue (DHBNZ, 2006), general practices may be incentivised to future-proof their revenue stream by automatically raising their fees by the maximum allowable limit at every allowable occasion – whether or not a particular practice is significantly affected by recent or prospective cost increases.

If annual limits to fee increases continue to be informed by proxies for health sector inflation (with no adjustment for expected efficiencies), and public funding streams continue to be subject to the increases determined by FFT, there is potential for patient copayments to increase faster than the publicly-funded contribution for first contact services. This is because the health and community services components of the labour cost and consumer price indices tend to track at a higher level than the economy-wide annual change in these indices (on average, 0.7% higher since 2002).

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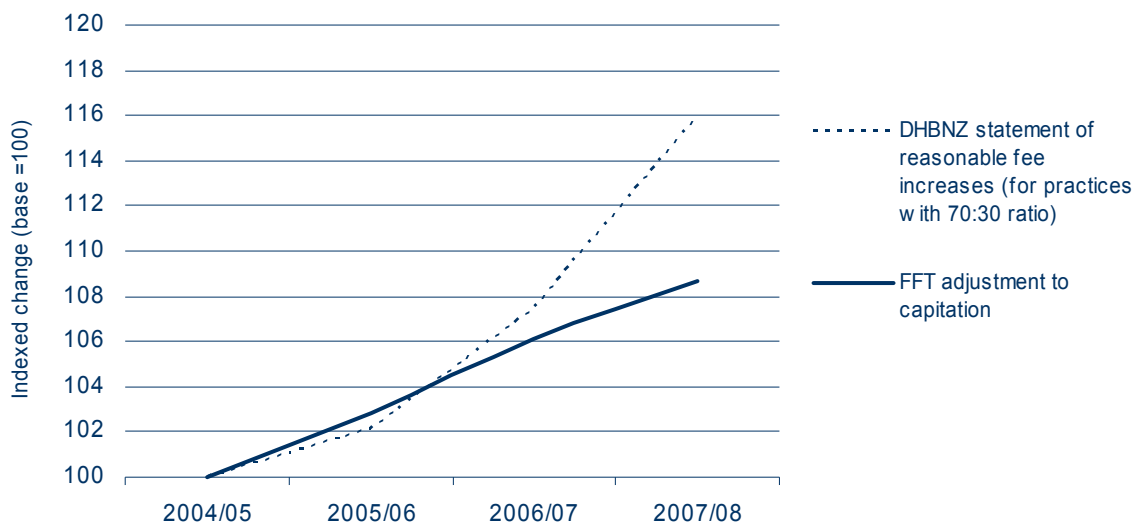
Table 9 compares the statements of reasonable fee increases (for practices with a 70:30 split of capitation subsidy versus patient fee) with FFT increases passed on by DHBs for 2005/06 to 2007/08. In 2006/07 and 2007/08 the statement for reasonable copayment increase outstripped the FFT adjustment to the public funding stream because FFT was below the 'reasonable' adjustment factor for the input cost increases for the consultation 'total fee'. A continuation of this trend would raise questions about the sustainability of the investment in lower cost access to services via the First Contact capitation stream. Figure 15 shows the relative growth of each revenue stream between 2004/05 and 2007/08.

Table 9: 'Reasonable' fee increases and FFT, 2004/05- 07/08

(Assumes 70:30 ratio for public funding to patient user fee)

	2005/06	2006/07	2007/08
Input-related adjustment factor for total fee	2.6%	3.9%	4.4%
FFT adjustment to capitation	2.8%	3.3%	2.6%
DHBNZ statement of reasonable patient copayment increase for practices with: <i>70:30 capitation - copayment split</i>	2.1%	5.3%	8.5%

Figure 15: Indexed growth of FFT adjustments and statements of reasonable fee increases, 2004/05- 07/08



Source: (Adapted from DHBNZ, 2006, 2007)

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Under Option 1, practices would continue to go to fee review committees to determine reasonable fee increases and fees would continue to be paid by patients to practitioners, not to PHOs, but with a number of developments in the management of fee increases.

- Allowable patient fee increases could be related to the rate of increase of FFT, potentially with some smoothing between years. Fee review committees would not approve increases above FFT. Alternatively, patient fees could be fixed at a percentage of the public capitation, or capped so that patients met the first \$n of the costs of a specified range of services with the public purse meeting the rest (similar to an 'excess' in motor insurance).
- Practices and practitioners that claimed that they were not financially viable with allowable fee increases scaled to the rate of increase of Vote Health (FFT), or other sustainable benchmarks, would be offered business support to identify opportunities to control their costs. These might include sharing facilities and back office services, mergers with other practices, sale of practices to other providers, or changes to staff mix. The aim would be to evolve the sector towards more efficient models of organisation consistent with permanently lower patient fees and sustainable increases in the public contribution to primary health care. This approach would have some similarities with the innovation funds and change management support offered to tertiary education institutions facing financial difficulties to help them redesign their services (courses) to become more sustainable. Given the wide variety of structures of general practice and primary care providers at present in New Zealand (see Box 4) there is likely to be some scope to secure these efficiency gains.
- Fee review committees could have their membership broadened to include primary health care professionals and possibly also patient representatives in order to build legitimacy for the principle of fee regulation and trust in its institutions (the committees). This would also encourage GPs, in particular, to 'own' a new social contract with patients not to 'over-charge' in the context of increased public funding (see final section of this paper for more on this).

Box 4: What is known about the business structure of general practice?

General practice is based on a wide range of ownership structures. This diversity can be seen in the 2006 IPAC survey of general practice, which covers 36 practices (7 in Access PHOs), 201 GPs, and 206 practice nurses. Models include variations on the sole trader model (sole traders sharing joint costs, GP with own company), joint models (GPs own one company employing all staff, GPs in legal partnership employing all staff), and practices owned by DHB, trust or district council.

Of those practices surveyed in 2006, patient fees were the largest single income source – comprising 40% of practice income, on average. Capitation funding accounted for 35% of practice income. Other sources of income included rural funding and ACC payments. As might be expected, personnel costs accounted for the majority of expenditure (73% on average).

Main sources of practice income

Income source	Average share of practice income
Patient fees	40%
Capitation funding	35%
Rural funding	12%
ACC payments	10%
Immunisation	3%
Casual GMS	3%
Special PHO projects	3%
Maternity payments	1%

At PHO level

PHOs within a region may increasingly work together, with larger PHOs potentially taking a stewardship role in developing new services and contracts with community providers that can be picked up by neighbouring PHOs. Most PHOs are unlikely to become budget holders of any significance. The majority will continue with some marginal purchasing functions in relation to ‘Services to Improve Access’, and ‘Health Promotion’. Specifically, it is envisaged that under this option:

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- Better-organised PHOs would develop new services by holding back some of the future funding increases for 'First Contact' care and attempting to negotiate contracts with volunteer practices and other providers for new services to their enrolled populations. This could include, for example, extensions to current chronic disease management programmes. Holding back funds may only be possible if the PHO and the practice can manage costs increases to below the rate of FFT adjustment, unless DHBs were willing to give primary care higher priority in order to fund new services.
- PHOs and DHBs step in to provide primary health care where gaps in services occur, for instance, due to retirements or where practitioners leave the market, either by direct provision or on contract from conventional general practices or alternative primary care providers. PHOs would need access to specimen contracts that they could adapt for their specific circumstances – see Option 2.

At primary care provider level

Practices remain bearers of financial risk, in terms of first contact capitation. Current signs of difficulties in replacing retiring GPs in some areas mean some PHOs will be presented with opportunities to innovate with alternative general practice business models. In other cases, DHBs and PHOs may be forced to develop new service delivery and/or business models.

Advantages

This option has the advantage of feasibility in the short term since it emphasises working with practitioners and organisations open to the idea of change, rather than attempting to make large scale change across a broad front. Another advantage is the likelihood that this option will improve the ability to manage both the publicly and privately financed increases in primary health care expenditure. The option also allows scope for further developments in new programmes (e.g. chronic disease management) that would lie alongside conventional fee-for-service general medical services. The approach begins to build the idea of a new 'social contract' between primary health care providers, the government and the public.

Potential difficulties

By its very nature, this option makes it likely that developments will be patchy since it is explicitly based on gradual change among a selected range of providers. Innovation may only be possible where gaps in service appear and can be turned into opportunities for change. As a result, this option risks leaving 'mainstream' general practice largely unchanged. It also risks not sending out a clear message concerning the direction of reform and the sort of primary health care system that is desirable in the long term.

Box 5: Elements in a well-organised chronic disease management programme

1. A well specified model (e.g. the Chronic Care Model – Rothman and Wagner, 2003) of the continuing monitoring and care to be delivered to different patient groups (e.g. patients with, or at risk of, diabetes, chronic obstructive pulmonary disease, asthma, heart disease, heart failure, depression, etc.).
2. A wide-ranging programme dealing with the full spectrum of patients from those without symptoms to the chronically ill, and not confined to single diseases (given the prevalence of people with co-morbidities and complex health problems).
3. A 'bundled', or 'blended' method of paying providers using a range of instruments linked together to encourage continuing, 'cycles' of care for an identified (enrolled) population. For example, to offset the disadvantages inherent in each of the basic payment modalities (salary, fee-for-service and capitation) and to help providers manage financial and clinical risk, payment should be based on risk-adjusted per patient enrolled payments, plus an allowance for practice management costs, plus some element of performance-related funding and/or payment for demonstrable use of 'best practice' clinical protocols across the prevention to long term management spectrum.
4. The balance between the different payment methods should depend on the precise pattern of behaviours sought (e.g. the balance between finding new cases, managing existing patients or managing the fluctuations in the costs of providing chronic disease management).
5. Possible patient inducements to participate (e.g. gift vouchers since there is evidence that even modest incentives can produce positive responses in hard-to-reach populations) and/or reduced barriers to access, including financial barriers. Any fees paid by users have to be subject to mandatory control.
6. A care team that involves GPs and nurses specialised in chronic disease care, supported by medical specialists.
7. Publicly available information on the performance of providers of chronic care, adjusted for the risk profile of their enrolled patients.
8. Evaluation of different ways of staffing, organising, and reimbursing providers.

Option 2(a): Development of ‘blended payment’ contracts with dual public and private funding, but mandatory patient fee controls

This option is based, among other things, on recent thinking and experience with different ways of paying for primary care designed to get away from the encounter (visit)-based system widely prevalent in the United States (and traditionally in New Zealand) and shift towards a system largely, but importantly not exclusively, based on per patient capitation payments to providers (Davis, 2007; Goroll et al, 2007). The fee-for-service element is generally seen as an obstacle to achieving effective, co-ordinated and efficient care. Box 5, above, summarises this current thinking in relation to what a well-structured chronic disease management programme might look like.

The broad approach outlined under this option is also consistent with the thinking underlying the Primary Health Care Strategy. The approach builds on the existing patient enrolment with PHOs and/or primary health care providers, provider affiliation with PHOs, reducing patient copayments in primary care, and payment for primary care on the basis of patient characteristics rather than per visit or activity. It is also consistent with an emerging focus in health policy on payment for performance – as shown by the recent allocation of a funding stream for modest payments to PHOs, based on performance against a range of quality indicators.¹⁶ Finally, it is consistent with the way that public funders manage their relationships with other primary care providers such as pharmacists, where there are national contracts to specify what is provided in return for public funding (see Box 6, below). New contracts would be developed with willing PHOs and practices/practitioners in the first instance, in order to build experience and confidence in new approaches, and to be able to conduct suitable evaluation.

Relevance of the Community Pharmacy Dispensing Contract and National Pharmacist Service Framework

There are some interesting parallels between general practice and community pharmacies, yet each group is currently subject to different approaches in public funding and contractual requirements. Historically, both groups of health professionals have retained independence as private business owner-operators, tended to remain relatively isolated from other health care providers and endeavoured to balance a tension between an independent business model and the provision of professional service.

¹⁶ From January 2006, PHOs have been eligible for \$29m of performance-related payments as part of the PHO Performance Management Programme. All PHOs had enrolled in the scheme by July 2007.

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A key difference between these groups of primary care professionals is that DHBs, as funders, have negotiated a national contract with pharmacies that specifies the level of patient copayment for an item on the Pharmaceutical Schedule, whereas there are no such comprehensive contracts (local or national) with general practices.

DHBs consult collectively with the Pharmacy Guild on a 'base' pharmacy contract, but negotiate final contracts individually at district level with approximately 900 community pharmacies. The contract specifies base dispensing services, advice relating to the dispensing process and the level of fee-for-service payment for this supply function (the 2006/07 base contract was approximately \$240m). The contract precludes pharmacies from adding any surcharge to the \$3 patient copayment per dispensed item from the Schedule. Although the base dispensing fee has remained at \$5.16 per item since 2003, DHB costs for dispensing services have increased due to higher volumes (partially from the widening of primary care access as a result of Strategy implementation) (DHBNZ, 2006).

In March 2007, DHBs proposed to keep the dispensing fee at the same level until 2009. The boards maintained that New Zealand is oversupplied with pharmacies and that many rural pharmacies could be replaced by medicine depots. The set fee level would assist in advancing what some DHBs regard as an overdue rationalisation within the pharmacy sector (Radio New Zealand interview with, CEO, South Canterbury DHB, March 2007).

In addition, DHBs are collectively developing a national service framework that includes specifications and pricing guidance for additional pharmacy services. As well as describing existing services, it specifies five new pharmacy services in detail, which it would be optional for DHBs to purchase, depending on local need and funding priorities. The framework is an attempt to lay a system-wide foundation for the future scope and purchasing of pharmacy services in addition to the traditional dispensing role. Its existence indicates that it is possible to construct frameworks (and contracts) for bundles of services delivered by private primary health care practitioners in New Zealand – in order to realise the government's health objectives.

Box 6: National Pharmacist Service Framework

The framework includes detailed service specifications and pricing guidance for the additional services beyond dispensing, which are grouped into two categories: information services; and medicines review services (DHBNZ Pharmacy Advisory Group, 2007).

Information services include:

- Health education (to patients); and
- Medicines and clinical information support (to practitioners).

Medicines review services include:

- Medicines use review and adherence support (a four-part review assessing the patient's use, understanding, and adherence to a medication regimen);
- Medicines therapy assessment (a comprehensive clinical review of an individual patient's medication as part of a multidisciplinary team); and
- Comprehensive medicines management (case-based management of changes and pharmacist prescribing, as part of a multidisciplinary team).

At PHO level

Under Option 2(a), the larger PHOs, with populations over 30-40,000 patients¹⁷ (therefore, capable of bearing a substantial share of the financial risk of their patients' need for services (see Martin et al, 1995) would be the primary risk managers in the primary health care system and would be funded on the basis of gradually improved methods of risk-adjusted capitation. This would entail making better use of data on diagnoses, previous medical history, health status and past utilisation for their enrolled populations, with a small at-risk element related to their performance in relation to contributing to those national targets able to be influenced by primary care and related services (e.g. targets related to immunisation, diabetes, ambulatory-sensitive hospitalisations, etc).

The budgets for these larger PHOs could gradually be broadened to include not only the costs of their patients' primary health care, but also those laboratory tests, other referred

¹⁷ PHOs with 30,000 or more enrollees comprise about 86% of the enrolled population – see Table 4

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services and pharmaceuticals where costs are generated by decisions in primary care. The budget for some PHOs could also include, on an experimental basis, the cost of elective surgery for the enrolled population. This addition would give the PHO an incentive to ensure that its primary care providers referred patients for assessment for surgery in line with guidelines on appropriateness. If judged successful, the broader scope of budget could be extended to all PHOs.

The use of risk-adjusted capitation funding of PHOs would also be designed to enable similarly risk-adjusted reporting of performance and outcomes from the primary care services provided to the PHO population.

The PHO risk-adjusted capitation funding method would not cover the enrolees' total health care requirements, on the grounds that managing the entire budget is the responsibility of the local DHB. But PHOs could be required to pay a percentage of the cost of each of their patients treated at a hospital for an ambulatory-sensitive condition or one widely regarded as avoidable by timely provision of appropriate care outside hospital. This would mitigate the most obvious forms of shifting of responsibility and costs from the PHO back to the DHB. More importantly, it would give the PHO an incentive to have a dialogue with its primary health care providers about their patients' use of specialist services and would encourage the development of stronger links between primary and secondary care staff relating to the complementary management of patients. This would lead to some rearrangement of care and costs, but without the PHO being financially responsible for the entirety of its patients' resource use - which would remain the responsibility of the DHB.

In order to manage the costs of pharmaceuticals, laboratory tests and other referred services (possibly including electives) the PHO would need to adapt or develop and agree guidelines, algorithms or decision aids with its primary health care providers. Individual practitioners or practices would not be individually at risk for the cost of these services, but the PHO would assist its practitioners collectively to manage the risk, as the former IPAs did in the late 1990s. The incentive for this last behaviour would be the fact that any 'savings' on this part of the PHO budget could be shared between the PHO, the providers and the DHB. The ability to use a share of the savings would encourage practices to assist the PHO in managing a part of the budget which it was not directly accountable for. In return, the PHO would have incentives to support its practices and practitioners to deliver improvements in performance since there would be performance payments available at both PHO and practice levels.

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PHOs would be responsible for holding a budget to pay for patients who received care outside the PHO with which they are enrolled. These payments would continue to be encounter-based, with a patient copayment, thereby incentivising the 'home' PHO to take responsibility for the care of its enrollees and to encourage the patient to use the services of his/her 'home' PHO providers in preference to those of another PHO, since the latter could well attract a higher copayment (assuming patient copayments remain – see below).

At primary care provider level

Under this option, smaller PHOs unable to manage financial risk for primary medical services and referred services, individual general practices, primary care organisations and groups of general practices would be considered as service providers, rather than purchasers and organisers of primary care. Smaller PHOs would be encouraged by their DHB to amalgamate with larger peers in their role as PHOs. Providers would not be put at risk for the full range of services needed by their enrolled populations in order to avoid the situation in which the practice moves to deny necessary care and/or focuses on reducing 'over-use' at the expense of identifying 'under-use'. The costs of hospital and specialist services influenced by primary care would be managed collectively by the PHO working with its providers (see above) to avoid the denial of care that could occur at practice levels due to random variations in morbidity and demand for care.

Despite this, there is a need for a payment system in primary care that encourages and rewards better performance and a focus on the health of the enrolled population, as well as focusing providers on managing their provision of services within a budget. The system also needs to ensure performance information is collected so that the government can be assured that any expenditure to secure a shift to a new payment regime has been well spent. The government may not need to directly pay for all the information collection since some of it will be necessary for provider reimbursement (e.g. if bonuses were to be paid for patient experience and for efficiency) and so providers will have strong incentives to pay for some of this collection themselves (otherwise they will not be able to be paid).

Practices and/or providers able to demonstrate that they have in place the organisational and staff capacity would be eligible to hold a contract for service with the larger PHOs. This would be a national or 'base' contract that could be adapted at the margins to suit local circumstances. It would remove the burden from PHOs of having to devise their own primary care contracts (a task requiring expertise and experience in short supply in New Zealand since the country has little or no previous history of contracting for primary medical services).

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The base contract would build on what is known internationally about primary care contracting and pay-for-performance, predominantly drawn from UK and US experience and research (Goroll, et al, 2007, Robinson et al 2001) The contract would blend a mix of risk-adjusted per enrolled patient payment and performance payments with the intention of mitigating the down-sides of using any single payment method. The contract could contribute to strengthened financial accountability since the elements taken together would amount to a global budget comprised of elements within providers' control.

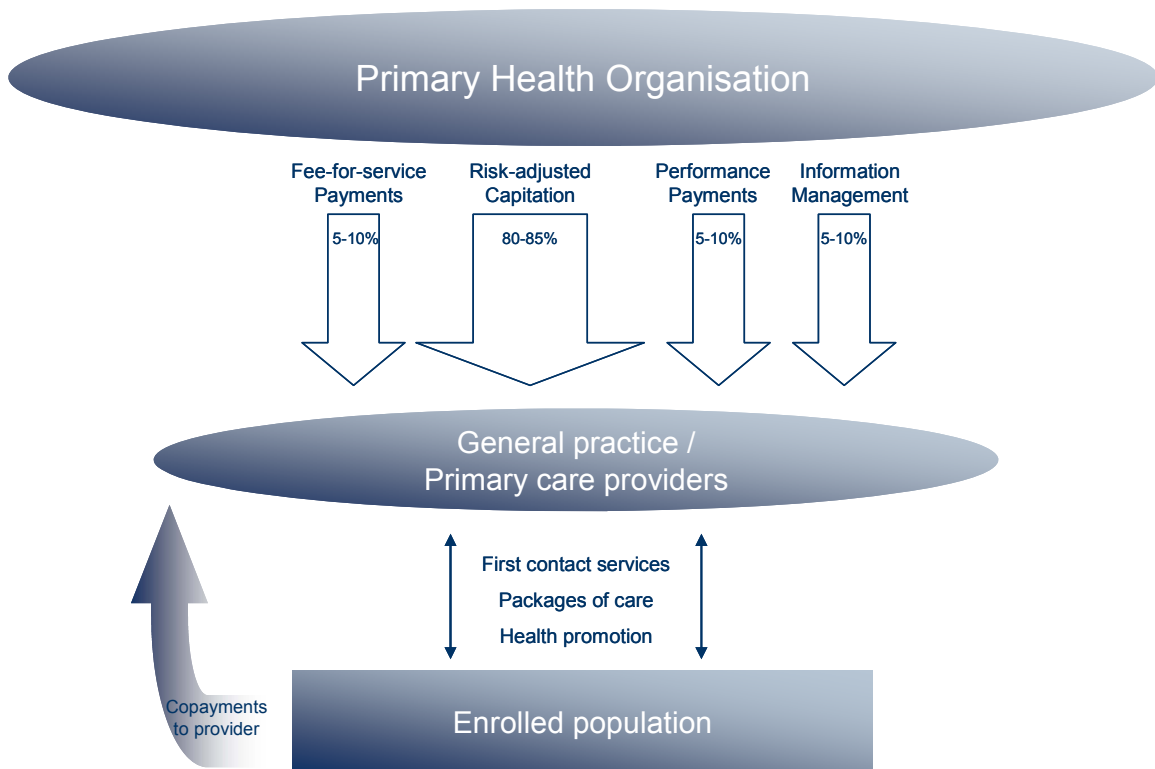
In outline, the base contract could be structured as follows:

- A needs/risk-adjusted comprehensive payment per enrolled patient to the practice/provider organisation replacing the existing First Contact, Services to Improve Access (SIA), Very Low Cost Access and Care Plus payments and amounting to perhaps 80-85% of the public funding for primary care to the practice;
- An information management and technology payment (approximately 5-10% of practice funding);
- Risk-adjusted performance bonuses for achieving specific performance standards or targets (approximately 5-10% of practice funding); and
- The possibility of a limited amount of fee-for-service payment to practices by the PHO to, for example, incentivise the provision of under-provided services to neglected patient sub-groups in places where this is a problem (approximately 5-10% of practice funding). There would be no user charges for such services since the goal would be to increase their utilisation.

Figure 16, below, represents one way in which such a contract might be structured. The contract would require a prior definition of what constituted comprehensive care for typical patients (e.g. expectations of the pattern and nature of care to be offered to different patient sub-groups in terms of primary and secondary prevention, continuing care, etc.), but the allocations would not be derived from an expected number of GP visits or by costing particular patients' current care in detail. Instead, the budget would be constructed by attempting to estimate the number and mix of staff needed in a practice or primary care provider organisation to provide 'comprehensive', evidence-informed primary care for patient lists of various sizes and designed to allow practices a reasonable likelihood of being able to meet widely agreed performance criteria. The fact that the large majority of the payment to practices would be made on the basis of a risk-adjusted per patient payment should provide an appropriate incentive for practices to accept high-need patients with a likelihood of imposing high costs on practices while at the same time encouraging them to strive to keep

their populations as healthy as possible to avoid the risk of unnecessary costs cutting into practice profits. Practices would be incentivised to do this in the most cost-effective way which should widen the role of practice nurses and increase their share of the workload¹⁸. A mix of output and health outcome information would be required to monitor performance, and would be obtained via a performance payment system. PHOs could also adapt the basic contract structure to suit their local situation.

Figure 16: Option 2(a) A blended payment contract between PHO and provider



Future of user charges (patient fees)

Managed care organisations (which, arguably, is what PHOs are intended to be, since they nominally have fixed capitation allocations from which they are to meet the (partial) health needs of an enrolled patient population) typically control all parts of their providers' remuneration using contract terms. All revenues whether from capitation payments or copayments from enrolees are usually managed collectively by the managed care organisation. If there are any copayments by patients paid directly to providers, they are tightly regulated and usually structured as a fixed deductible (an 'excess' in New Zealand

¹⁸ Venning et al (2000) found that the clinical care and health service costs of nurse practitioners and general practitioners were similar. Patient satisfaction was slightly higher for nurse practitioner consultations. The authors conclude that if nurse practitioners are able to maintain these benefits while reducing their return consultation rate or shortening consultation times, they could be more cost effective than general practitioners.

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insurance terms in which the patient pays the first \$n of the cost of the service) and determined by the managed care organisation. They are not structured as a fee set by the individual service provider to cover costs, since the incentives inherent in any provider contract with a managed care organisation (or PHO) are undermined if the provider has the independent ability to recover any costs not provided by the contract remuneration. In particular, incentives to change the nature of services and to alter provider behaviour (e.g. away from responsive, first contact care towards proactive, health promotion and disease prevention) are blunted if this is permitted. Furthermore, the contractual incentives to improve the efficiency of business models are dissipated since the provider can pass financial risks onto patients (or to DHBs) rather than managing them internally.

This analysis suggests that if a user contribution to the costs of primary health care is to be retained (for example, to limit the costs to the public purse), then the current arrangements for patient copayments will need to alter if progress towards the Strategy's goal of a proactive, population-based approach is to be secured. There are a number of ways of doing this, depending on how the copayment is to be set and to whom any payment is made (Option 2b, below outlines an approach in which the patient's contribution is paid to the PHO and not to the service provider, thereby fundamentally altering the underlying pattern of incentives). In order to obtain the benefits of the contract form outlined above, the level of the user contribution should ideally be set by the funder (PHO) and not by individual providers autonomously. Both approaches outlined below assume this to be the case.

Firstly, the new copayments to practitioners could be set as a percentage of each patient's risk-adjusted comprehensive care payment made to the practice/provider organisation by the PHO on behalf of the government, thereby enabling increases in patient contributions to be managed in relation to increases in the public funding of primary health care (this could also be developed as part of Option 1, above). These patient contributions could be paid either annually or in instalments, depending what the minimum enrolment period is.

This approach contrasts with the current situation in which the government has limited control over how much public money is needed to guarantee these levels of patient charges levied by practices, since charges levied by practices are largely at their discretion and are only indirectly related to the government's contribution. As a result, it is difficult for the government to guarantee that the differences in patient fees between practices and areas will be unchanged or will reduce over time.

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In order not to penalise patients with likely greater needs (since they tend to be poorer as well as sicker), the percentage copayment could be lower for patients who generate higher per patient payments to the practice from the PHO and higher for lower need patients. Such an arrangement would also partly mitigate any potential disincentive facing practices to make their higher need patients healthier (thereby shifting them potentially into lower per patient payment categories) since any loss of per patient public payment would generate a higher proportionate user charge.

Since any remaining copayments made by patients under this option would be unrelated to use of services, they would need to be paid periodically, perhaps in relation to the minimum enrolment period with the practice. If information systems were well organised it would be possible for lists of enrollees and their health profiles to be updated each month, in which case a minimum enrolment period could be one month.

Secondly, patient copayments could be structured like the 'excess' on home or motor insurance so that patients pay the first amount of any 'claim' (this too could be part of Option 1 above). This would fix the patient contribution for different types of use of primary health care and could also be used to signal which were high value services (i.e. the 'excess' could be varied depending on the type of service used). The disadvantage of this approach to user charging is that it still risks encouraging PHOs and providers to focus on providing more services in order to increase income (as with current arrangements) rather than improving outcomes, since it is not based on pre-payment.

If the government wished over time to continue to reduce copayment levels – for example, to further reduce access barriers, better direct the use of primary care resources, or to increase the focus on areas of greatest likely health gain at least cost – then volunteer practices could be offered higher per enrolled patient public payments in return for very low copayments. This option would most likely work best if the government were willing to pay the average practice more (i.e. raise average incomes), but only in return for substantial changes in the pattern of services and outcomes achieved brought about by a far higher proportion of practice income coming from public sources. Another advantage of working with volunteer practices or primary care organisations in this way would be to generate information on the cost of providing new packages of care in a range of settings across the country.

Performance payments

The performance-related part of the contract would include payments directed at the contribution of primary health care to national targets as well as other high priority areas for

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improvement, where primary care can potentially make a large contribution. In order not to discourage practices starting from a baseline of low performance, lower performing practices (this would need to be defined more precisely) would be paid for improvements in performance on a sliding scale and higher performing practices would be paid for maintaining and/or improving their level of performance. Any differences in levels of payment would need to be carefully determined since it is not self-evident that poorer performers would necessarily find it harder to improve from a low base than better performers would find it to improve from a high base. Arguably, better performers face 'ceiling' effects which may be tricky to overcome (e.g. sub-groups of their enrolees who are unwilling to immunise).

Advantages

Although much depends on the design details, this option (and sub-options 2b and 2c, below) could enable larger PHOs (i.e. those with 30-40,000 enrolees or more) to make a greater contribution to health system efficiency and sustainability. This option could put the services provided by general practices onto the same basis as other primary health care providers such as community pharmacists. It could enable greater funder control over how resources are used to improve health outcomes by allowing funders to specify more precisely what they would expect to be done for patients in return for public resources. This would increase the government's confidence in the return on its investment in primary care.

The de-coupling of both public and private sources of income at practice level from the individual patient visit could permit the development of funder-provider contracts with a more balanced set of incentives to encourage a simultaneous focus on health improvement, quality of care, efficient use of staff, and accessible first contact care. The more efficient use of staff, including greater use of nurses for a wider range of tasks to which their skills are suited, could assist New Zealand to manage any future GP shortages. This decoupling would also enable greater control to be exercised over the rate of increase of patient fee, while allowing user fees to be retained – thereby protecting the public purse from bearing the full cost of primary health care use.

The changes at PHO level would improve the management of the inter-relationship between demand for primary and secondary care services in that PHOs would, over time, have a greater awareness and incentive to consider carefully their providers' referrals to secondary care and use of other referred services. There should be limited scope for 'cream skimming' (selecting healthier, less costly patients) at both PHO and practitioner level if the improvements in data collected in primary care continue and allow DHBs to set individually risk-rated capitations based on patients' health, risk factor and resource use profiles.

Potential difficulties

The principal disadvantage with this option is the likelihood that contractual relationships between PHO and practitioners will prove contentious and subject to protracted negotiations. This option (and sub-options 2b and 2c, below) requires a large change in the outlook of independent practitioners. Not only will contracts require a robust specification of the nature and range of services which practices are expected to provide in return for public and patient funding, but contracts will need to be carefully monitored, and regularly reviewed and updated. The capitation element of a 'blended' payment control will also work best with good quality individual level data on health and health-related risks. It may well be necessary to pay for these data to be collected.

In addition, it may well be that in order to improve the framework of incentives surrounding primary care practitioners, practitioners would be asked to surrender some of their clinical autonomy and pricing discretion. In return, it may be necessary for the public funder to pay for a larger share of practice incomes and perhaps end up paying more for primary care than is currently the case. Whether this is worthwhile will depend on the gains likely to be produced by introducing contracts and new incentives (e.g. a range of pay for performance elements) –hence the need for rigorous evaluation.

At the PHO level, widening the scope of PHO budgets over time is likely to require an increase in the size of risk-bearing PHOs and the merging or disappearance of some organisations as PHOs. There is nothing to stop former PHOs being contracted as primary care providers.

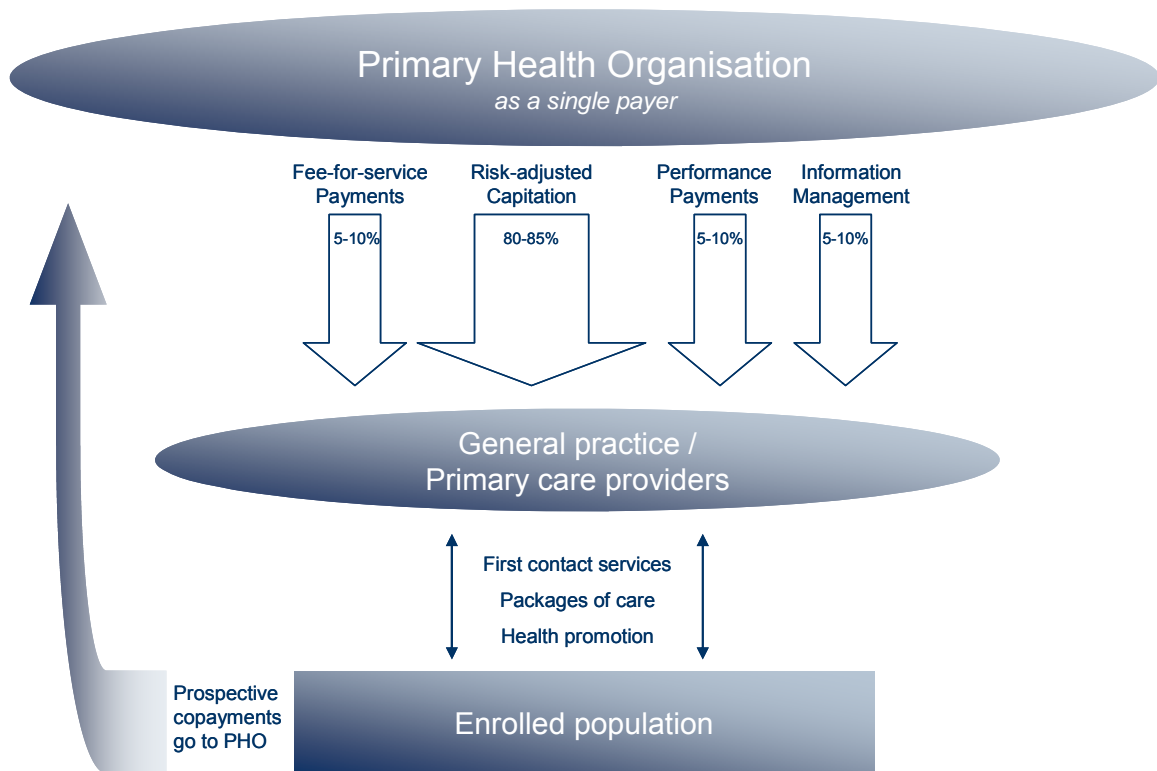
A final risk with the option of a blended payment contract relates to the trade-off between the different aspects of a high quality primary care service. A contract that blends capitation, performance payments, infrastructure support and possibly some fee-for-service (but without practice-determined user charges) is likely to lead to some change in the emphasis of general practices. Specifically, it is possible that as more emphasis is given to disease prevention, screening, early diagnosis, long term management and rehabilitation than in the past, GPs become somewhat less accessible to their patients for responsive, patient-initiated care than they are at present.

Options 2(b) and 2(c): Development of ‘blended payment’ contracts with a single funding source/payer

These sub-options build on Option 2a, but are should be seen as longer-term ways forward that involve significant change to the role and capability of most PHOs and to the general practice business model.

Under Option 2b, patient contributions for primary care services would remain, but would be paid prospectively (and periodically) to the PHO, and regulated by the PHO (see Figure 17 for a representation of the option). Currently, patient contributions are paid to the practice at the point of service. Under this option, the PHO would receive all enrolled patient fees and use its combined public capitation and private patient fee revenue to fund the blended contract with each practice. Effectively, the PHO becomes the single payer to the practice (paying both public and patient contributions). The exact form of the blended contract and the level of practice revenue would be determined through negotiations between PHO and practices/providers. There are some nascent examples of periodic, prospective payment of patient fees already in place in New Zealand (e.g. in the Wairarapa) but these are at practice level rather than involving the PHO.

Figure 17: Option 2(b) PHO as a single payer, with public and private funding



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Option 2c is similar to Option 2b, with the key difference being that the PHO would only receive public funding prospectively and there would be no patient fees. The full cost of primary health care would be met from Vote Health (with the exception of services for injury and accident funded by ACC). Given the high cost of such a direction, this would need to be subjected to rigorous analysis, including of the incentive effects (from a microeconomic perspective), and to what extent this would represent value for money versus other potential investments in health.¹⁹ We are not advocating this option, but it is included here for completeness.

All interactions with general practice and primary care could be free at the point-of-service under both Option 2b and 2c (with the option of some pharmaceutical part-charge). Patients would still be free to change practice within their PHO without altering their regular contributions. Patients could also enrol with another PHO, but not with a practice outside their current PHO (and vice versa).

Advantages

Establishing the PHO as the single payer has a number of potential advantages. A key benefit is that revenue from the patient is de-coupled from a consultation with a GP or nurse. If patient revenue is not based on each patient seeing a GP, practices could be freer to innovate in the delivery of First Contact services. For example, practices could increasingly shift the focus of services from episodic care of presented conditions to the systematic management of long-term chronic disease and still remain financially viable. This new focus would require improved skills in practice management, which could be supported by PHO-wide support services. GPs could focus on detecting, diagnosing and establishing management plans for dealing with health conditions. Patient consultations that are more protocol-driven (such as the routine, on-going management of chronic conditions) would be largely delivered by a practice nurse, specialist nurse, allied health specialist, or via telephone or email.

In order to preserve a reasonable standard of responsive, first contact care, one of the performance related payments in the blended contract could be related to waiting times to see a practitioner. Additionally, practices could, for example, receive performance payments for reducing rates of patients visiting emergency services.

¹⁹ The current volume of patient copayments may equate to around \$400m, depending on assumptions about the impact of funding roll-outs in 2005/06 and 2006/07, and the changes in consultation volumes since the end of national evaluation period (2004/05). The actual cost of reducing patient fees to zero would likely be much higher.

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As the global budget holder, the PHO may well be better positioned to manage financial risk across practices, promote more effective integration between GPs and other community based providers, and target marginal investment at new programmes of care. Another advantage is that patients would develop a stronger connection with the PHO as their funder of primary care services and the agent to which their payments were made. Choice of PHO would then become more meaningful to patients.

Advantages to the practice would include a more stable flow of revenue from a single source, which would be based on the enrolled population (capitation payment stream), delivery of specified services (some fee-for-service payments), and measured progress against agreed intermediate health outcomes (performance payments) in a 'blended payment' contract (as in Option 2a above). This system may also reduce the number of transactions to be recorded at practice level since patients would not be directly billed for specific service use.

The practitioners would also have a stronger interest in developing their links with the PHO. For example, it might be possible for providers to share in any 'savings' produced by more cost-effective use of the total resource available to the PHO. Practices would be free to contract with any PHO, not necessarily on a purely geographical basis. PHOs would be incentivised to offer appropriate contracts to practices and other primary care providers. In the long-term, PHOs might become less geographically-based; for example, PHOs within an urban area might compete to attract both practices and patients.

Potential difficulties

Practical difficulties in implementing Options 2b and 2c include moving a majority of the enrolled population onto prepayment, and how this might be managed if only a minority of an enrolled population chose prospective payment. Under Option 2b, arrangements would need to be put in place to deal with the public and private financial consequences at PHO level of patients transferring to another PHO.

Under Option 2b, decisions would still need to be taken to establish what 'fair' patient contributions would look like (eg: whether it would be necessary to take patients' incomes into account, or their needs, or any other characteristics).

Option 2b and Option 2c place more weight on PHOs driving change, which would require leadership and analytical capability.

Option 3: Redesigned individually targeted subsidy regime

This option represents a return to the broad approach before the Strategy was adopted (see Figure 14, above), and would involve reviewing the previous pattern of subsidies and potentially adapting them to meet the criticisms levelled at the fee-for-service regime before 2001. This option might be considered if managing patient fee increases and developing better contractual relationships between PHOs and primary care providers proves impossible, or if the government were to place less weight on universal assistance for accessing primary health care.

As under the previous system (prior to the introduction of the Strategy) the government contribution to primary health care services would be capped at a fixed amount, which would need to be carefully reviewed. The previous system subsidised visits to the GP for people from households with low incomes (Community Services Card holders) and people with established patterns of high GP consultation rates (High User Health Card holders). There were a number of weaknesses in this model such as the lack of an income taper, the threshold for eligibility for a HUHC, the lack of direct, per-patient subsidy for practice nurse consultations, and the fact that public funding was distributed according to where GPs chose to practise rather than in relation to population health needs. A new system of individual subsidies could be developed as better individual-level data are generated within primary care allowing, for example, targeting of particular diagnosed medical conditions or risk factors, rather than high use of GP services. In certain socio-demographic groups it might be more sensible to target on the basis of *low* levels of prior utilisation (e.g. a higher subsidy for middle aged men to attend for check ups, since they are less likely to attend for preventive care than other groups at risk).

Advantages

This option might be relatively simple to implement, since public subsidies of private fees are familiar to all stakeholders. If well designed, the system may produce better targeting in relation to need, or the ability to benefit of patients, than the previous targeting system. Existing chronic care management programs could be retained (or even enhanced) alongside a system of targeted individual subsidies for first contact consultations.

From the point of view of public spending, this option allows the government to manage primary health care expenditure more easily than the other options presented here, since the policy does not involve a commitment to a particular level or maximum copayment for the whole population. On the other hand, the total amount of subsidy paid out would still be demand-led to some extent, depending on the design details.

Under such a system, it would be possible to introduce new forms of patient incentive to take up high value services (e.g. financial inducements to present for screening or monitoring if in high risk groups in the form of lower copayments or even rewards).

Potential difficulties

The Primary Health Care Strategy is predicated on the replacement of the system of partial, fixed public subsidies for GP visits (and subsequently prescribed pharmaceuticals) with a capitated population-based approach, so this option would represent something of a u-turn in policy terms. It would also retain many of the structural and incentive weaknesses of the previous system described in detail above. Most notably, it risks perpetuating the GP-focused, episodic, responsive pattern of care that is regarded internationally as an inefficient and ineffective way of dealing with the epidemics of chronic disease of the 21st century. A response to this risk would be to continue to develop chronic disease management programmes.

Finally, any system of targeting that is superior to the previous arrangements based on high use and low income would need to be complex, and would likely be more difficult to understand and administer. In addition, it is likely to require detailed data on individual patients in order to be able to identify past use of services, income, ability to benefit from different sorts of interventions and so on. There would also be difficult judgements to be made in relation to targeting. For example, should one target on past high or low use, or both, but in different sub-groups of the population? High use is likely to correlate with complex needs and multiple morbidity, while low use in certain sub-groups can be an indicator of future health problems (e.g. among middle aged men who rarely visit their GPs, minimise symptoms and are reluctant to seek help, but who may be at risk of worse ill-health later in life, or among members of minority ethnic groups who find 'mainstream' general practice care off-putting).

5. BUILDING THE CONSENSUS FOR CHANGE

Given the historic resistance of general practitioners to any control of the fees they charge their patients, and to public funding of their services (as against partial subsidies for individual transactions), there is a need to work gradually to build a broad consensus for further change in the way that primary health care is funded and organised, if the objectives of the Strategy are to be realised. This section sketches some possible steps that could be pursued over the next one to two years to prepare a more favourable environment for change while also doing policy work to flesh out and test the options described above.

The general approach would be to build a set of new institutions in primary health care, such as information and performance reporting systems, accreditation schemes and regulatory bodies. The aim would be to alter public and professional awareness of, and expectations about, the need for and benefits of further change (while focusing on working with those providers willing to develop new ways of working). There would be a particular emphasis on informing patients and the public, and involving them in the debate about what 'good' primary care might look like and to what extent they are receiving it under current arrangements.

Specifically, the Ministry of Health, working with relevant professional bodies, could strengthen the information available to patients and the public about the quality and relative performance of different forms of primary care and different practices/practitioners. This includes the increasing amount of information from the PHO Performance Management Programme. Additionally, fees of all practices in receipt of public funding could be published by the Ministry of Health to inform patients as to what represents a moderate fee.

The aim would be to stimulate a dialogue with patients and the public over the sort of system that they would benefit from in future, and to encourage critical reflection on the merits of episodic, fee-for-service services. A wider debate would encompass Strategy goals, such as improved patient health, coordination of care, and reduced health inequalities.

Another step towards transforming the primary health care system would be to develop an accreditation scheme that identifies practices/providers whose standards, services and behaviours are closest to the ideal represented by the Strategy (e.g. low or no fees, use of pre-payment, evidence of promoting the health of enrolees in an active way, extent of appropriate use of practice nurses, range of services provided, accessibility of services, coverage of screening, quality of care). Practices which met the necessary standards would be able to promote themselves accordingly. PHOs could be rewarded for their proportion of 'Primary Health Care Strategy compliant' practices. Patients would be encouraged to ask

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whether their local practices were operating in line with Strategy objectives and standards, and would be encouraged to seek care with those practices that are doing so. One way for practices to provide this information to patients is via annual practice reports which could be posted on PHO or practice websites for patients to peruse. In this way, reputational incentives could gradually be developed for practices to alter their ways of working.

PHOs and DHBs, with Ministry of Health support, could take opportunities, as they arise, to trial new contractual mechanisms (including performance incentives) and to commission independent evaluations in order to identify the impacts for patients, service delivery and practice viability. Ideally, this trialling of new approaches would occur in a range of practice settings, including those practices serving middle and higher income populations. In this way, comparisons of different approaches to paying for and organising primary health care would be built up over time to improve understanding of what works well in various contexts.

While some innovations could be driven and sponsored from above, there would need to be scope in the emerging system for 'bottom-up' proposals for new ways of working. The Ministry of Health could establish a primary health care development and innovation fund against which practices and provider organisations in primary care could bid to set up new models of primary care. Funding would need to be accompanied by resources for evaluation.

Given that in the short term, fee regulation is likely to remain the most visible part of the Strategy implementation, as far as most GPs and patients are concerned, it remains important to build the legitimacy of the fee review committees and their processes – as well as increasing the level of trust of all parties in their determinations so that they are regarded as binding. One possible way of developing a new 'social contract' over patient fees between practices/provider, and the state on behalf of the public, might be to include health professionals and patient representatives on fee review committees (while retaining financial analysis capability). Any norms or 'rules of the game' generated over time by the committees would be stronger if they are not seen as exclusively the result of the deliberations of accountants on behalf of the funders.

Throughout this preparatory period, it will be important to continue to work on defining and communicating the desired end-point of primary health care reform. While the end-point will itself change over time, since policy and reform are continuous processes without beginning, middle and end, unless there is a clear understanding at each stage of the intended destination, it becomes more difficult to identify aspects of the current arrangements that are likely to act as obstacles to the longer term, desired changes.

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