Tū Ora
COMPASS HEALTH

Balancing Accessibility and Sustainability

Tū Ora position paper on fixed fee arrangements in general practice

May 2019

Better Health Outcomes
through Great Primary Care

1. Summary

Ready access to primary health care is a vital ingredient in the development of a successful health system. However, affordability needs to be balanced with sustainability, and Government policy on capped co-payments is an important aspect of both. This position paper outlines the Tū Ora Compass Health view on capped charges in general practice.

Tū Ora Compass Health supports:

1. Affordable access to primary care, but not at the cost of sustainability.
2. Targeting subsidies in accordance to need and ability to pay.
3. Applying a discount off approach in preference to capped fee approaches.
4. Giving practices discretionary hardship funds that can be used in more exceptional cases.
5. Applying subsidies in such a way as to continue to incentivise enrolment.
6. A capitation price review mechanism that is linked not just to broader cost indices, but also to DHB relativity and to primary care specific cost structures.

2. Context

The controversy over GP fees is not a new one. The 1935 Labour Government encountered opposition from the New Zealand branch of the British Medical Association when they sought to introduce free general practice care in the 1930s. At that time the dispute was settled with an agreement that the Government would pay 7 shillings and sixpence per consultation (about $32), with GPs free to charge more if they wished, but most did not initially. However, the rates were not increased with inflation, and user part charges increased consistently over the next few decades.

Following the 2001 Primary Care Strategy the 4th Labour Government initially sought to achieve a capped co-payment fee in return for the new capitation subsidies. This was resisted by organised general practice and the compromise agreement was that:

- GPs would lower their fees to pass on to patients the benefit of the new capitation subsidises;
- the amount they could charge would increase annually based on an independent assessment of cost increases;
- practices with higher than average cost increases could increase fees by a larger amount, but could be subject to a fees review.

Subsequently additional capitation amounts for Very Low Cost Access (VLCA) practices were made available conditional on an agreement not to charge more than a certain amount. A further extension of capped (at zero $) fees for all those aged under 6 years was introduced by a labour Government in 2007, and later extended to free under 13s, by a National Government.

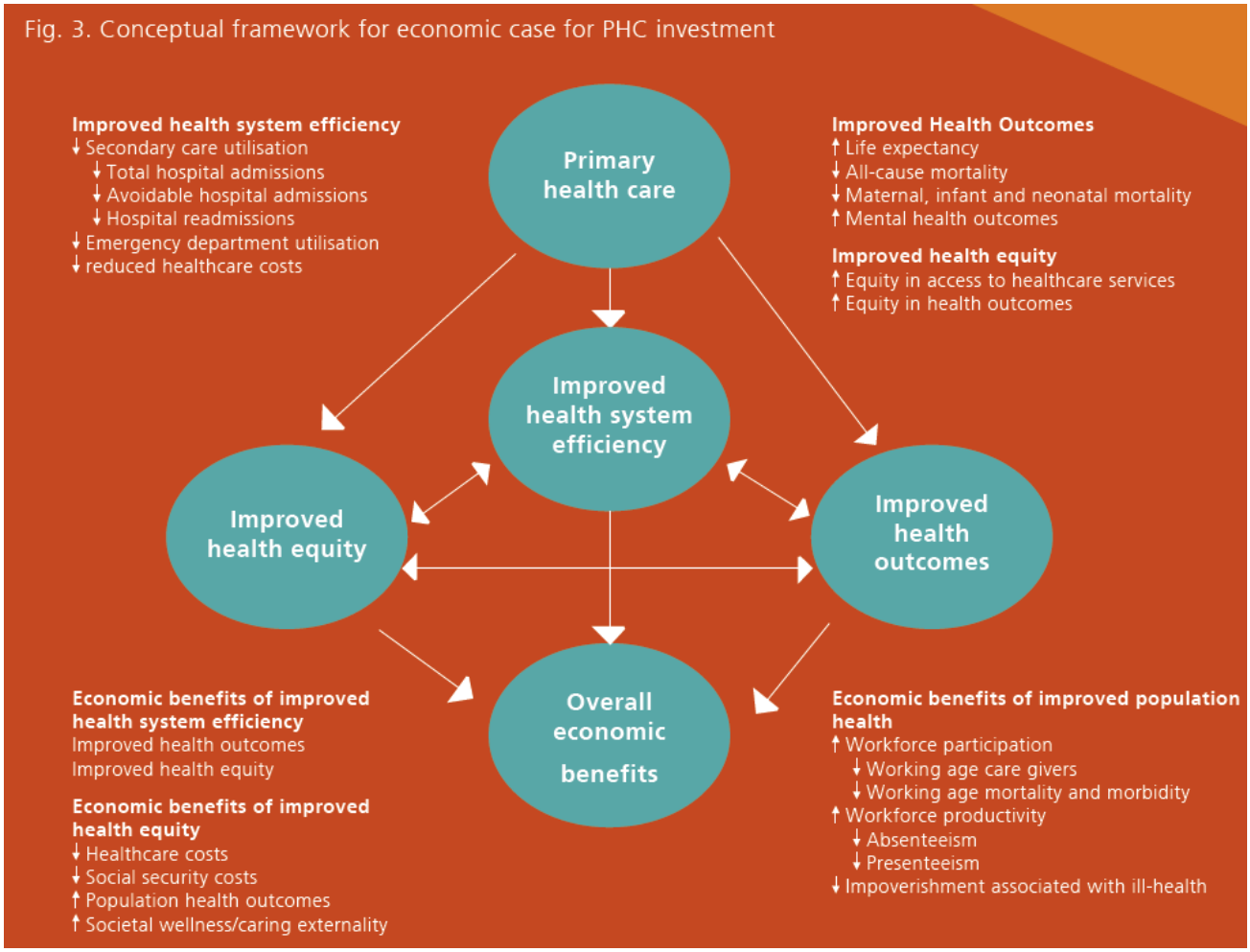
In 2018 a subsidy was made available to all practices for community service cardholders subject to agreement not to charge more than $18.50 for adults ($12.50 for teens). At the same time as the Free under 13 scheme was extended to cover those under 14.

The most recent capped fee arrangements have led to significant concerns about erosion of autonomy and sustainability. These concerns have culminated in the development of this position paper.

3. The policy problem

3.1 Why do Governments seek to cap fees for general practice services?

The World Health Organisation published in 2018 a report titled “Building the economic case for Primary Health care” which sets out the argument that easy access to primary care has a number of economic benefits as set out below in the schematic reproduced below.



It concludes that “*Powerful evidence suggests that primary health care (PHC), particularly primary care, can produce a range of economic benefits through its potential to improve health outcomes, health system efficiency and health equity*.”

Accessibility has a number of dimensions, including geographical access, opening times, service capacity, cultural acceptability, and affordability. Capped fee policies are intended to reduce or eliminate affordability barriers to accessing primary care. This is particularly important for low income families, because research shows that those on lower incomes are more likely to forgo GP visits when costs are higher. The effects of affordability on access to primary care can be expected to have flow on impacts on early diagnosis and treatment of disease, and on access to hospital level care. In short, capped fees are intended to ensure that people do not miss out on important primary care services.

4. The problem with the policy: issues associated with fixed fee levels

Tū Ora Compass Health ran a series of provider forums in late 2018 and early 2019. In workshop discussions the following issues were raised with capped fees.

4.1 Loss of value over time

Many providers have had experience of fees not being adjusted to adequately reflect changes in provider costs. This results in an erosion of value, which, with a capped fee cannot be recouped from patients, and eventually undermines the sustainability of the primary care service. Examples in recent times include:

- Immunisation rates
- Primary Maternity Services rates
- General Medical Subsidy rates

Unless a contract contains a guaranteed adjustment annually, funders will tend to take the opportunity to increases rates by less than health cost inflation as a way of saving money. Even where an annual adjustment is in place, as in the case of the current PHO agreement, the basis of the calculation may not reflect the actual costs impacting on providers.

4.2 Increased demand over time

A capped capitation rate contains another embedded risk; that demand for services will increase over time. A capitation rate indexed to, for instance, health sector labour costs per unit indexes, will not be increased as the population ages and becomes more complex, requiring more units of labour to meet their needs. In New Zealand, current capitation adjustment formulae do not take account of the change in the numbers of the very old (over 85), resulting in these individuals being under funded.

In this way a capped capitation rate is more 'risky' for providers than capping a fee for service item such as immunisation.

4.3 Lack of recognition of different cost structures

General practices do not all have the same costs structure, due to local variations in:

- lease costs / land costs
- mix and availability of workforce
- models of care
- levels of bad debt / patient ability to make payment
- additional funding amounts from DHBs / ACC and others
- opening hours
- patient expectations; and
- the age and complexity of enrolled patients.

The more fees are capped and set externally, the less the provider can reflect their own unique cost structure in the fees they charge. A single fee may advantage some providers and be unsustainable for others.

4.4 Loss of professional autonomy and patient choice

Some clinicians indicated that when fees are capped they lost some of their professional autonomy to practice as they saw fit. For instance, providers may be constrained to use less medical or less nursing time than they considered clinically appropriate, to live within the available income.

People may then lose the opportunity to select a model of care or approach that they prefer; which for some would be a lower cost model, for others a higher cost model of care. This reduces patient choice.

4.5 Undermining of enrolment

The free under 13 schemes have the impact of undermining the financial incentives for families to enrol their children. This risks disrupting continuity of care, results in less preventative care being provided, and has an adverse impact on health outcomes. For instance, if children are taken to the local Accident and Emergency when a child is sick, rather than having a regular GP, then they risk missing out on immunisation recalls and on other preventative services. Enrolment is the key enabler for most population health activity in primary health care.

4.6 Free or very low cost fees may result in the service being perceived as of low value

Clinicians have argued that providing a low cost service reduces the value people place on general practice. This effect is well recognised in the marketing sector. A higher price may taken (all other things being equal) as an indication of higher value. As one GP put it:

> *"I'm worth more than a cup of tea and a muffin"*

Clearly this is a social construct, as the same reasoning does not tend to apply to valued-but-free hospital services.

4.7 Partial fee capping concentrates the ability to charge freely on a small segment of the enrolled population or on additional services.

Currently (except in VLCA practices) only certain services/populations are subject to capped co-payments, including: services for those aged under 14, immunisation services, services for community service card holders. As capped fees are extended, practices wishing to reflect their unique cost structure in their fees will end up charging more and more to a smaller base. Alternatively, they may start identifying small subservice components and charging large additional amounts for them. For instance, double appointment charges, nurse appointment additional charges, triage charges, etc.

For VLCA practices there is no ability to charge extra for part of the population. Hence all the capped rate risks are magnified for these practices.

4.8 Inadequate funding results in reduced access and makes primary care less attractive as a profession

The impact of inadequate funding in a capped environment goes well beyond reduced profitability. Practice owners are forced to restrict the amount they pay their staff, and themselves, resulting in primary care being less attractive for GP and nurse trainees, and for management and admin staff.

Further the experience in VLCA is that when funding is inadequate, and fees are capped, providers are unable to staff up to meet demand, resulting in long waiting times and increased risk of

avoidable adverse outcomes. A policy that is intended to improve accessibility (VLCA capped fees) can have the opposite effect, because the subsidies are insufficient to provide enough resource to meet demand, resulting in long waiting times for routine care.

4.9 Capped funding reduces the ability to invest in capital to grow and maintain high quality primary health care

Most of the 980 practices in NZ are privately owned. Building developments, fitouts, and investments in ICT capability are funded by practice owners. The value of this private capital investment in making locally accessible healthcare probably exceeds $500 million. An inability to charge a price that reflects the cost of new facilities or other capital investments, puts at risk the ongoing maintenance of the capital stock and reduces the likelihood of future investments.

5. Balancing affordability, sustainability, and autonomy

5.1 What's good about increased capitation for providers?

Increasing the relative contribution of the funder / Government through capitation relative to fee for service payment does have potential positive impacts on provider sustainability as well as on equity. Specifically, increased capitation enables a shift away from traditional face-to-face visits with a GP towards use of alternate communication channels (such as e-consults) or towards increased use of the non-medical workforce (for example, nurses, pharmacists). Capitation also lends itself to better population health management for an enrolled population.

5.2 Alternative ways of enabling access for low income / high need groups

Practice owners suggested a number of options to address the sustainability and other risks associated with capped fees, including:

- Government buyout: some providers were of the view that with autonomy reducing so much that they would be better off insisting that the Government should buy their practices and put them on specialist contracts. This would move the risk associated with capped fees to the Government.
- Discount-off approach: this option would involve the Government stating the reduction in standard fees they were willing to 'buyout' and practices discounting this amount transparently off their usual co-payments. For instance, if the extra subsidy for a Community Services Card (CSC) holder is say $28 per visit on average, then the practice would discount their usual fee by $28 for CSC holders.
- Discretionary hardship funding: Tū ora provides practices with a small discretionary fund that they can use to discount fees for patients that have difficulty paying.

6. Tū Ora Policy Position

Tū Ora Compass Health supports:

1. Affordable access to primary care, but not at the cost of sustainability.
2. Targeting subsidies in accordance to need and ability to pay.
3. Applying a discount off approach in preference to capped fee approaches.
4. Giving practices discretionary hardship funds that can be used in more exceptional cases.

5. Applying subsidies in such a way as to continue to incentivise enrolment and continuity of care.
6. A capitation price review mechanism that is linked not just to broader cost indices, but also to DHB relativity and to primary care specific cost structures.