PAYING FOR THE DOCTOR’S STRIKE AND THE WAITING LIST CULL AT THE GP’s SURGERY

PRESENTED AT LEANZ
7 AUGUST 2006

Bronwyn Howell

Lecturer, Corporate Management
Victoria Management School
http://www.vuw.ac.nz/vms/

Research Associate
http://www.iscr.org.nz
bronwyn.howell@vuw.ac.nz
CONTEXT

Primary health care reforms 2002

GP payments
  • capitation paid to PHOs replaces fee-for-service paid to GPs
  • capitation payments for GP and nurse services ‘passed through’ by PHOs to GPs under PHO-GP contracts
  • GP right to charge patients directly is retained
    • albeit with the threat of regulatory intervention

Government contribution to primary care increased
  • policy expectation that gradual capitation increases will be ‘passed through’ to patients via lower ‘out-of-pocket’ fees
CONSEQUENCES

Fundamental change in

- the role of the government subsidy
  - from treatment benefit to insurance premium
- financial risk-bearing
  - GPs become risk underwriters (‘insurers’)

Changes the entire business model for the sector

- different ‘rules of engagement’ necessary
  - price-setting by GPs
  - competitive interaction
  - regulatory requirements

Changes in industry structure

- Ownership
- Workforce incentives, quality of human capital
ILLUSTRATED BY

Junior doctors’ strike, hospital waiting list cull

• GP demand increases due to factors entirely outside of GP control

Threatened price regulation by the Ministry of Health and DHBs

• exacerbates the effects of ‘uncontrollable’ financial risks faced by GPs as a consequence of capitation

Increases in capitation subsidies compulsorily passed through as (regulated?) reductions in patient payments

• patient payments must rise even for patients not receiving the subsidy increases
SUBSIDISED HEALTH CARE SYSTEMS

Adapted from Van der Ven and Ellis (2000:761) and Rochet and Tirole (2002:552)
CAPITATION SYSTEM (NZPHCS)

Off Market

Health Insurance/Risk Management/ Health Care Provision Market

Government

capitation payment - premium subsidy

taxes

Group A - All Individuals

balancing via political trade-offs

PHO/insurers

capitation payment - premium subsidy

Group B - III Individuals

Group of insurers

service provider/
insurers

out-of-pocket patient payment
EXAMPLE I: WAITING LIST CULL

Consultation costs = $50
Patient payment = $20
Deficit for each additional consultation = $30
Patient charges rise for all patients to cover DHB policy costs (demand-shifting)
The more patients referred back to the GP, the greater the deficit
  – all patients of ‘unlucky GPs’ with more individuals/sicker individuals on the waiting list pay more than those of ‘luckier’ GPs
EXAMPLE II: DIFFERENT CAPITATION CLASSES

High-capitated 65+ year old - $15 patient payment
Low-capitated 25-44 year-old - $48 patient payment
Deficit for 65+ patient referred = $35
Deficit for 25-44 patient referred = $2

The higher the proportion of higher-capitated patients referred back, the higher the deficit, and the larger the increases in patient payments to recoup additional losses

High-capitated patients (elderly, young, chronically ill) disproportionately represented in waiting lists

- patient payment increases to meet DHB demand-shifting will not be trivial
ILLUSTRATION III: PATIENT LIST MIX

Access practice – average patient payment $20
Interim practice – average patient payment $35
Each have 20 patients referred back
Each provide the same number of consultations Q
Access deficit = 20 x $30 = $600
  • increase = $600/(Q+20) per consultation
Interim deficit = 20 x $15 = $300
  • Increase = $300/(Q+20) per consultation

The Access practice price increase per consultation is twice that of the Interim practice
  • ‘higher-need’ Access practice patients bear a disproportionately higher share of the costs of the DHB policy than ‘lower-need’ Interim practice patients
ILLUSTRATION IV: CAPITATION ROLLOUT TO ANOTHER GROUP

Assume 1000 patients initially unsubsidised.
All pay $50 (Group A patient payment)
On average, each makes 4 visits a year – 4000 consults
GP costs = $50 × 4000 = $200,000
Half (Group B) now provided a ‘capitation subsidy of $100 per year
Pass-through means their co-payments are expected to be $25 per visit – regulator fixes Group B price at this level
ILLUSTRATION IV: CAPITATION ROLLOUT TO ANOTHER GROUP (cont)

But Group B individuals now (with lower prices) make on average 5 visits per year – 4500 visits in total

GP costs now $50 \times 4500 = $225,000
Group B patient payments $25 \times 2500 = $62,500
Capitation income = $100 \times 500 = $50,000
Group B total income = $112,500

Difference to recoup from Group A = $225,000 - $112,500 = $112,500

Cost per Group A consultation = $112,500/2000 = $56.25

Pass-through obligations mean Group A prices rise, even though Group A receives no subsidy
WHY DO THESE ‘ANOMALIES’ OCCUR?

The allocation of financial responsibility for variations in demand for health care

Inadequate attention given to financial risk-bearing by NZPHCS policy-makers in system design

- **ALL** health systems are insurance systems (even Government-funded ones)
- the insurance element is necessary to manage the unpredictability of knowing who will need treatment and when (and therefore the ability to pay for treatment when it is needed) – Arrow (1963) – Nobel Laureate
- ‘population-based funding’ is simply a synonym for ‘insurance’ (relates to population – Group A) relative to ‘funding for treatments’ (relates to benefit payments, relates to Group B)
IMPLICATIONS

The capitation payment is *NOT* a *treatment subsidy* paid to ill individuals.

Rather, it is a *premium subsidy* paid in respect of well individuals.

Regulating the patient payment as if it is only the ‘top up’ to a treatment subsidy represented by a ‘notional’, ‘averaged’ capitation payment ignores all of the random variations (‘risk differences’) that occur between practices, that will affect GP costs in a system where GPs are both risk managers and care deliverers.

Capacity for DHBs to regulate insurance system?
THE NZPHCS ‘PROBLEMS’

Patient out-of-pocket payment must perform all the roles of
- premium top-up
- co-payment
- treatment benefit
- patient payment

but politicians/policy-makers/DHB contract managers treat it as if it is only a patient payment

Capitation ‘pass-throughs’ mean the single capitation payment is used as both
- a premium contribution
  - addressing a political social wealth distribution objective
- a supply-side cost sharing instrument
  - altering treatment provider behaviour
INCREASING CAPITATION ROLLOUTS EXACERBATE THE PROBLEMS

Each rollout pushes more financial risk onto GPs
GPs are unable to manage this risk by clinical practice alone
Therefore will have to engage in ‘undesirable’ behaviour to manage additional financial risk
• higher patient charges
• active management of the patient list
  • ‘cream-skimming’
• supply restriction
SUPPLY RESTRICTION
FOLLOW-ON IMPLICATION

The higher the proportion of a GP’s income derived from capitation

- e.g. Access vs Interim; or as increases in capitation are ‘rolled out’ to new patient groups

the greater the financial risk to GP incomes (and by extension, the likelihood of variation in patient charges) from random events outside the GP’s control

- e.g. localised epidemics, random variations in the distribution of patient health states (e.g. a large, sick family moves into town) or policy/regulatory actions
CONSEQUENCES

Strong incentives for GPs to ‘cream-skim’
  • ‘stack the books’ with ‘healthier-than-average’ patients
    • not present in FFS system (as no demand variation risk borne)
  • rewards to cream-skimming greater the higher the proportion of GP income derived from capitation
  • conversely, costs from being ‘unlucky’ greater, the higher the proportion of GP income derived from capitation

System constructed to facilitate ‘cream-skimming’
  • sets up high risk Access pools, then rewards cream-skimming
  • access to Interim patient shedding example
  • equal risk-bearing equilibrium
LONG-RUN EFFECTS

No incentives for GPs to work hard
  • implications for new GPs gaining experience

Self-selection
  • hard-working GPs will pursue opportunities in markets that reward effort
  • remaining GPs ‘less ambitious’/less hard-working?
  • slower accumulation of human capital
    • lower quality service relative to other markets

Implications for practice prices and ownership
  • who will provide services in ‘uncommercial’ areas?
  • an ‘employee’ culture?

A two-tier system as per tertiary provision?
LOOKING FORWARD

If persisting with a Managed Care model

• system must be regulated as a full, managed care insurance model
• requires detailed information about individual practice patient risk profiles
• current information collection does not support this form of regulation
• even GPs/PHOs may not be collecting appropriate information to set prices optimally

Does NZ have the skills and/or willingness to go down this path?