The potential effect of proposed changes to the funding of general practice in New Zealand

Ken Buckingham
Health Services Research Centre
Victoria University
Wellington
Phone 0064 4 463 6564
e-mail ken.buckingham@vuw.ac.nz

Section 1 - Introduction

In New Zealand, patients pay the GP by fee-for-service. GPs are usually self employed and are free to charge whatever they choose. This is usually somewhere between $30 and $40 (£10 - £13) per consultation. Consultations by low income people are subsidised to make access more equitable. The subsidy is fixed at $15 per consultation. The patient pays the remainder of the fee. 'Community Services Cards' provide proof of eligibility. Other subsidies are provided for children and frequent users of GP services.

Over the past few years there has been some discussion about changing the way that subsidies are paid. Suggestions have been made that the funding authority would pay the general practice (or other primary care organisation) a fixed amount per patient (capitation)[1,2,3]. In March 2000 the Hon. Annette King, New Zealand's Minister of Health, published a discussion document[4] that asked for comments on proposals for changes in primary care funding. These changes include: i) the evolution (from existing organisations) of new Primary Health Care Organisations (essentially GP umbrella organisations) ii) reimbursement of GP consultation subsidies by capitation and iii) payment for some other universally available primary care services by capitation (eg preventive services and health promotion).

My main concern is with the proposals as they affect low income subsidies for GP consultations. Although the proposals to not do so, I think it is essential, for analytical reasons, to distinguish the reimbursement of subsidies (which are targetted at the needy) from payments for universally provided services such as preventive medicine and health promotion.

Mrs King is a member of a recently elected Labour coalition government. Prior to its election in December 1999, there had been National Party (Conservative) governments for the preceding 9 years. The Minister's document is critical of previous approaches to the organisation and delivery of primary health care, particularly those that place emphasis on 'competition and secrecy', those where 'public funds are applied to personal or shareholder profit rather than for improving health' and 'any where private health insurers are owners or governors of organisations managing large blocks of public primary care funds.' She also comments, 'Nor is it appropriate in the health system to have organisations that lack meaningful involvement by their community or that are dominated by one professional group to the exclusion of other important practitioners.'

The aim of this paper is to attempt to analyse the potential effects of the proposals as they relate to the funding of primary health care. Section 2 presents a general discussion of the 'theoretical' characteristics of capitation and fee-for-service. Section 3 outlines the Minister's

discussion document. Section 4 discusses the proposals in the light of the analysis of capitation and fee-for-service. Section 5 concludes.

Section 2 – A comparison of capitation and fee-for-service funding

The Cochrane collaboration is due to publish a systematic review of capitation and fee-for-service in the near future, and I hope to make use of their findings. My own unsystematic review seems to suggest that the various systems will be influenced by many factors. For example, in a United States study, primary and secondary care providers are sometimes the same person, possibly confounding the effects of payment method. In New Zealand, a medical culture in which all people have paid, and been treated equally may delay changes in which people would be treated differently.

There are a number of ways in which reimbursement by capitation and fee-for-service may differ. However, there is an important distinction to be drawn between capitation as a mechanism for budgetary control and capitation as a method of reimbursement. This is considered first.

Capitation and budgetary control.

Budgets are targets against which actual expenditure can be judged. 'Budget holders' are responsible for trying to ensure that the target is met, but they do not carry personal responsibility for that expenditure. The risk the budget holder carries is that of some form of administrative or managerial sanction (for example tighter subsequent budgets or loss of employment prospects). This can be thought of as 'quasi-risk bearing'. Another form of 'quasi-risk bearing' is a 'fund manager', ie, an agent who is called upon to look after the resources of the principal.

Capitation can be used to determine budgets. This sort of capitation has been applied to the determination of Health Authority budgets in the UK. My view is that Health Authorities should really be regarded as departments within the NHS and the funds that they manage should be regarded as departmental budgets.

Arrangements that bear more resemblance to fund management have applied to some pharmaceutical and laboratory budgets in New Zealand. In such cases, the Independent Practitioner Associations (IPAs) agree to take administrative responsibility for pharmaceutical and laboratory budgets. Any savings are 'shared' between IPA and the funding authority, however they do not usually constitute income for the IPA and are intended to be used to provide benefits for patients.

Note that 'under-performing' on a budget can be as undesirable as 'over-performing', for example, if the aim of the budget is to distribute resources equitably.

Capitation for reimbursement

Capitation can be used to determine levels of reimbursement. It has been used in this way to determine much of GP income in the UK. It has also been used in contracts with Health Maintenance Organisations in the United States. When used as a method of GP reimbursement, the GP has a personal financial interest in the capitation and bears a real risk. If additional services have to be provided he or she has to provide them out of the capitated income. Whatever the GP does not spend, he or she keeps. (Risk management is very different under fee-for-service. If more patients need to be treated, the risk is borne by whoever pays the fee).

The services to be provided under capitation contracts can be specified in various ways. This may be important if unregulated capitation would result in a reduction in the level of service. If this is the case, regulation may, for example, specify hours of opening, out of hours availability, etc.

Motivation under capitation

Ideally subsidies should be structured so patients are neither 'over treated' nor 'under treated'. That is to say, they should have access to general practitioners when the benefits they gain, whether as reassurance, diagnosis, treatment or specialist referral are greater than the cost of the consultation.

CAPITATION MAY ENCOURAGE GPS TO ENROL PATIENTS BUT NOT TO SEE THEM

With capitation, doctors get money when they enrol patients, but not when the patient consults. The immediate financial incentive is, therefore, to enrol the patient but not to see them. We must look for other mechanisms that encourage consultation.

MOTIVATION UNDER CAPITATION – FINANCIAL EFFECTS

The doctor is encouraged to see a patient if the expectation of lost future income is high. The doctor's expectation of lost future income might include, not only the expectation that the patient would enrol elsewhere, but also that family members and friends would do so also. Competition increases the probability that patients will enrol elsewhere. Where local competition is keen, we would expect greater responsiveness to the demands of the patient and possibly product differentiation in terms of a more personal service, better opening hours, décor, etc. Conversely local monopoly power might reduce incentives for doctors to see patients once they have enrolled. Incentives to see the patient are also reduced in the case of sick patients, because they are likely to make high future demands on doctors' services. In a system where some patients are capitated, and some pay by fee-for-service, the opportunity cost of seeing a capitated patient will be high if there is a strong demand from those private fee paying patients.

To summarise, the purely self interested doctor might be expected to encourage the patient to visit if:

$$E(\text{Capitation income}) > \text{Opportunity Cost of visit} + E(\text{Future Opportunity costs}) \quad (i)$$

Where E is the expectations operator

And where

$$\text{Capitation Income} = C(\text{Monopoly power}) \quad (ii)$$

$$\text{Opportunity cost of visit} = O(\text{Spare capacity}) \quad (iii)$$

$$\text{Future opportunity cost} = F(\text{patient symptoms}, E(\text{future spare capacity})) \quad (iv)$$

This analysis would suggest that it makes financial sense for doctors to engage in 'cream skimming' the 'best' ie the fittest patients, unless expected capitation income exceeds the total opportunity cost of a visit.

(The theoretical response to cream skimming is to make the patient more 'attractive' to the practice by increasing the subsidy for high risk patients. The difficulty for the funding authority is to know just how much extra the doctor needs to be paid to appropriately allow for the fact that a particular patient is likely to attend more frequently. It has been argued

{reference required} that the doctor is always in a better position to determine the patient's risk of attending than the funding authority, since they are able to take a medical history before accepting a patient. The funding authority, on the other hand, will only have quite crude indicators of the patients risk status, such as the patient's age, or where they live, as a proxy for their social class, and indirectly for their health. If the doctor is in a better position to know the likely burden that a patient will place on a practice, he or she will be tempted to accept low risk patients and reject high risk patients.)

MOTIVATION TO SEE THE PATIENT UNDER CAPITATION – PROFESSIONALISM

Doctors can be motivated to see patients because they believe it to be the professional thing to do. It is likely that this professional imperative will operate more strongly in those (particularly country) areas where patients have no alternative source of medical care.

MOTIVATION UNDER CAPITATION – ADMINISTRATIVE CONTROLS

If market incentives and professionalism are insufficient motivation for doctors to provide levels of service that are acceptable to the purchasing authority, administrative regulations can be used. However regulation cannot easily allow for local circumstances. Neither is it easy to control interpersonal behaviour, which can have an important influence on whether people choose to access services.

MOTIVATION UNDER CAPITATION – CO-PAYMENTS

Co-payments introduce an element of fee-for-service into a capitation system and as such provide a motivation for the doctor to see the patient. Under co-payments inequality (i) would be modified as:

$$E(\text{Capitation income}) + \text{Co-payment} > \text{Opportunity Cost of visit} + E(\text{Future Opportunity costs}) \quad (i)$$

AN ASIDE – DETERRENCE UNDER CAPITATION

If the doctor is motivated to deter patients from visiting once they are registered, it might be worthwhile considering the strategies that could be adopted to achieve that end. My (probably inadequate) search of the literature did not reveal much evidence. Shimmura[5] suggests that capitation funding 'may lead doctors to hastier and less courteous care than a fee-for-service system'. Hearsay and personal experience reveal a variety of possible stratagems, for example, inconvenient appointment times, distant appointment times, surly receptionists and unfriendly doctors. I should also say that I have met friendly receptionists (though not often), friendly doctors (more often) and quick and convenient appointment times (in quiet rural practices).

Recent discussion in New Zealand has been generally in favour of capitation and has focussed on the possibility that doctors will wish to deter people from consulting by trying harder to keep them well. In doing so they would reduce the need for patients to consult so frequently. Of course the implication is that they do not try sufficiently hard to keep patients well under fee-for-service, which might in turn imply that professionalism is not always sufficient to ensure appropriate medical behaviour.

Motivation under fee-for-service

In some respects the incentives under fee-for-service are the opposite of those under capitation. Some evidence suggests that fee-for-service encourages general practitioners to 'over treat' the patient[6]. This result is intuitively plausible since doctors' income will increase the more frequently they see the patient. Over treatment is possible if, for example, doctors can persuade patients to return more frequently than necessary to monitor their conditions.

Again, the professionalism of the doctor is important in determining just how frequently the patient should be seen.

Doctor patient relationships under capitation

It is possible that there will be differences in the relationship between doctor and patient under capitation compared with fee-for-service. Relationships under capitation may be poorer between doctors and those chronically sick patients for whom the expected opportunity cost of future treatment is high . The balance of financial motivation makes it less likely that the doctor would wish to encourage visits by such patients.

More generally, an expectation of a continuing contractual relationship may also influence how the parties to a consultation view one another. A continuing relationship is more probable under capitation because of the effects of enrolment and its associated transaction costs. While the patient is more likely to regard the practice as 'their' practice, so the doctor is more likely to regard the patient as 'their' patient. However some evidence from dentistry suggests that this may not always be the case. Holloway et al[7] in a study of 'per visit' remuneration report that, 'Parents *(the patients were children – ed)* had a stronger allegiance to the fee-for-service than the capitation dentists.'

Doctor patient relationships under fee-for-service

In New Zealand, and with the existing competitive fee-for-service system, the patient may visit whichever practice is the most convenient at the time. The patient does not necessarily feel any ongoing commitment to the practice and may well resent any implication that the practice has the right to assume one. Anecdotally the encouragement of competitive attitudes in the New Zealand health care system has altered attitudes about enduring relationships between doctor and patient.

The more frequently a patient visits the doctor the more income the doctor gets. Provided the fee is sufficient, we can suppose that the doctor is happy with the arrangement. We might expect doctors to ensure that the practice was more attractive (both in terms of the premises and the attitudes of staff) under fee-for-service, and hence (possibly) better relationships with the doctor.

Administration costs and side effects under capitation

The administrative implications of fee-for-service and capitation funding are quite different. Capitation funding requires patients to enrol with a health care provider so that the provider can claim payment. Enrolment results in the provider having a list (or register) of patients. The lists can be used to manage the health of the population more effectively, for example by keeping records of whether patients have been vaccinated, screened or had a regular check up.

In addition to administrative costs, further costs may be necessary to prevent fraud and malpractice. Patient registers need to be checked to ensure they do not include people who have died, have registered with another practice, or simply do not exist.

Administrative costs and side effects under fee-for-service

Under fee-for-service there are more likely to be good records about patient contacts. This is particularly true where there is a need to claim subsidies. Many practices combine clinical and administrative computer systems that automate prescriptions and billing to the patient and to the funding authority.

Again there needs to be a mechanism to prevent fraud. In New Zealand, under fee-for-service, there is a random audit of patients who are contacted to confirm that consultations, for which subsidies have been claimed, did in fact take place.

Risk bearing under capitation

Under capitation providers bear risk. For example during an influenza epidemic doctors would see more subsidised patients, but the subsidy would remain the same. This is a real financial risk for the doctor whose expenses will increase if patients require treatment. (Note though that the GP is probably in a good position to manage risk. For example during an epidemic he or she might reduce the time spent with other patients to share out the available resources.)

Risk bearing under fee-for-service

Under fee-for-service, the person or organisation who pays the fee bears the risk of illness. Where the state provides part subsidies of visits, it bears part of the risk.

Equity under capitation

There are various concepts of equity relevant to health care. For example, 'equal treatment for equal need', or 'equal access for equal need'. Funding authorities frequently try to ensure 'equal resources for equal need'. It is sometimes argued[2] that capitation funding lends itself to this sort of equity, because the fixed amount of money that is allocated to the care of the individual can be calculated to reflect the individual's relative need for services. The process is not easy, but resource allocation formulae, based on assessments of individual need, are in use in several countries and provide deprivation payments to adjust the basic capitation amounts.

Under capitation as a method of reimbursement, there is no guarantee that the deprivation payments will result in more services. Existing practices may simply regard deprivation payments as compensation for working under the more stressful conditions that exist in deprived areas. To influence the availability of services in deprived areas, deprivation payments might have to be sufficient to encourage new practices to establish. Capitation as reimbursement may therefore be a weak method of achieving an equitable distribution of services.

This is very different from capitation used to determine budgets. With budgets, the budget holder is expected to spend the resources (no more and no less) on the provision of additional services.

An example of a deprivation adjustment, applied under capitation as a method of reimbursement (real risk bearing), is 'Jarman payments'. These are used in England to determine additional payments for general practices that provide services to deprived populations. Jarman payments form part of the doctor's personal income. They are a real financial compensation for working in deprived areas. Practices are at liberty to regard these payments as a 'supplement' that is paid for the increased cost and inconvenience of working in deprived areas.

Equity under fee-for-service

Achieving equity under fee-for-service might be thought of primarily as a question of deciding who should pay the fee. If the patient pays, then access will depend upon income and will not generally be equitable. If the state pays the full cost of GP care for those who

would find it difficult to meet the cost, then it is more likely that there will be equity (by most criteria).

Practice location under capitation

This section considers the provision of general practice services and where general practitioners choose to locate them. We are talking here about the income doctors get for themselves, ie of capitation as a means of reimbursement.

The location of general practices is important for several reasons. Firstly because difficulty of access is likely to deter people from consulting. Secondly and consequently, because general practice is the gateway to secondary care and other services. If general practice is difficult to access (either because of geography or for financial reasons), those people with inadequate access are likely to have inadequate access to secondary care and other services.

In a system that does not regulate where doctors can practice, the location of GP surgeries will depend both on doctors' preferences about where they would like to work (locational preference), and their expected level of income. Under capitation as a means of reimbursement, income depends on people enrolling with the practice. If capitation is appropriately weighted to reflect 'need' and is universal, and if doctors are indifferent to location, we might expect practices to be reasonably evenly distributed as the market responds to fill in gaps in areas that are relatively under served. If some places are more attractive to work in than others, we might expect to see some trade-off between income and location, with a consequent relative under supply in less attractive areas. In the United Kingdom, the response to this phenomenon has been to apply controls to prevent doctors practicing in relatively over supplied areas and to provide inducements, in the form of deprivation payments, to encourage them to practice in under supplied areas.

Practice location under fee-for-service

Under a system of fully subsidised fee-for-service, we might expect doctors to practice where there is the greatest demand. This demand would reflect levels of patient perceived need in an area, and not simply the number of people living there. The result should be similar to weighted capitation. Doctors would locate in areas of high demand. However, the distribution would also partly reflect locational preferences. As under capitation, we might expect some additional intervention to ensure a distribution of GPs that fully reflect population health care needs, either by control or inducement.

With unsubsidised fee-for-service, demand for doctors would reflect not the level of self perceived need, but the level of effective demand, with effective demand depending upon affluence. General practices would tend to locate in areas where there were relatively affluent patients. Again locational attractiveness would influence the geographical distribution of practices. There are now two reasons why doctors might choose to work in attractive areas, because their patients like to be there, and because they like to be there.

Since there is a relatively free market in primary health care in New Zealand, and since subsidies are not sufficient to eliminate the access barrier to poor people, the distribution of GPs in New Zealand tends to reflect the distribution of wealth.

Section 3 – Minister's discussion document 'The Future Shape of Primary Health Care'

The main features of the proposals as they relate to funding

Primary health care will:

- 'Ensure that resources are fairly distributed according to need' p. xiii
- 'provide appropriate and accessible services' p.13
- be of the highest quality consistent with available resources (my emphasis – ed) p.13
- be such that 'People will be encouraged to .. affiliate with their chosen organisation, and nominate a preferred practitioner …' p. xiv
- be such that 'Primary care organisations will be funded for taking responsibility for a defined population, rather than for delivering specific items of service.' P. xv
- be such that 'Primary health care providers may still charge some users for access to
  xv
- be such that 'All primary health care services will need to meet agreed quality

The proposals indicate that subsidised patients will continue to pay a contribution towards the fee-for-service for visits to primary care, that unsubsidised patients will continue to pay themselves by fee-for-service at each visit, but that the government will now pay its subsidy by capitation. It is this mixture of payment techniques that gives me some concern and which is the focus for much of my analysis.

The proposals and the organisation of the new Primary Health Care Organisations

Neither the new Primary Health Care Organisations nor the District Health Boards with which they will contract exist at present in their anticipated form. However the Minister expects the new organisations to evolve out of ones that do exist at present. There is a variety of types that has developed as a response to local circumstances. In essence they are usually associations of GPs. So one might also expect the new Primary Health Care Organisations to be associations of GPs. The proposals accept that a diversity of organisational structures may persist, however, they will have to meet certain requirements. These include:

- patient and community representation
- representation from constituent organisations (presumably for example from all the practices within a consortium of general practices)
- operating as not-for-profit organisations, using surpluses for the good of patients
- being fully and openly accountable for public funds.

One can speculate that the Minister favours umbrella organisations as a means of reducing transaction costs for the purchaser and as a way of spreading risk.

The proposals and the responsibilities of the new primary care organisations

To quote from the discussion document, primary health care provider organisations will provide the following services (though not all organisations will necessarily provide all services):

- health promotion and education
- population health monitoring
- prevention (including, for example, well-child, immunisation and family planning services)
- patient education, information and support for self-help (for example, phone services, Internet, pharmacy advice)
- early intervention in physical and mental health problems
- assessment of undifferentiated problems (for example, by GPs and practice nurses)
- treatment of most problems without referral (including associated tests and prescriptions)
- first level assessment and treatment in more narrowly focused situations (for example, primary mental health services, disability assessment, maternity care)
- rehabilitation (as appropriate for first level and community care)
- treatment in consultation with experts from secondary services
- support and care for ongoing conditions (including chronic disease and physical and psychiatric disability).
- referral where necessary (when more specialised expertise is needed).

The proposals and the financial responsibility of the new primary care organisations

We can anticipate that Primary Health Care Organisations will receive funds for all the above services. 'Certain services (such as GP care and pharmaceuticals) may be bundled together as at present (*in some trial sites ed.*) and the mix may be extended in future.' Their revenue will be determined ' according to the relative needs of the population served.' p. 24. Their expenditure will be determined by the services that they are contracted to provide.

The proposals and the patient

The proposals make it clear that 'low-income adults' (as well as children and frequent users) will continue to pay 'reduced fees' for primary care services and prescribed medications. So it appears that patients will still to be charged on a fee-for-service basis, while doctors may, or may not, continue to be remunerated on one. (The question of how the new Primary Health Care Organisations choose to distribute the capitated revenue that they receive to the practices that constitute them, is left undecided.)

It is noteworthy that the Minister's proposals avoid the term enrolment, preferring to talk about 'affiliation'. Patients are to be 'encouraged to affiliate to the primary care organisation of their choice'. No one is obliged to enrol or register.

Section 4 – A discussion of the New Zealand proposals

This section attempts to use economic analysis to predict what the consequences of the Minister's proposals might be

Some more background information

Recent media reports imply that New Zealand is suffering a serious medical manpower shortage. Approximately 100 of 302 newly graduated doctors left New Zealand last year. This may partly be explained by high levels of student debt (reported to be commonly in the region of £30,000). Overseas doctors account for one third of the workforce. It may be worthwhile emphasising that New Zealand is a small country of 3.6 million people and with an economy that is growing more slowly than most other OECD members.

New Zealand has a long and acrimonious history of relations between GPs and government on the question of capitation. The health care reforms of 1938 rejected capitation in favour of fee-for-service. When fee-for-service was originally introduced, subsidies covered the full cost of care. However there was no government control over fees and subsequent increases in fees and pegged subsidies led to a reduction in the real value of the subsidy to patients.

Dissatisfaction with lack of access to conventional primary care has led to radical alternative forms of provision (so called 'third sector' approaches). Some Union Health Centres provide cheap health care in areas that have been neglected by other providers. Organisationally this model of care is community owned and driven. They have high ratios of patients to GPs and make more use of nurse clinicians. They have provided a response to the financial barriers, which remain because of patient co-payments under the present subsidised fee-for-service arrangements.

Predicting the effects of the proposals

PREDICTING THE MARKET POSITION OF THE NEW ORGANISATIONS

Fund managers or fund owners

Should we suppose that the new Primary Health Care Organisations are some sort of quasi risk bearer such as budget holders or fund managers or should we suppose that they are real risk bearers or 'fund owners'. With regard to visits to the GP, if the general practices that comprise the Primary Care Organisations are reimbursed by capitation, then practices themselves are real risk bearers and not the Primary Care Organisation. For example, if there is an epidemic that requires more doctoring, the GPs would have to provide it because they have been paid on a capitation basis to do so. However, if the Primary Care Organisations receive money by capitation, yet distribute it by fee-for-service to their constituent general practices, then the matter of whether they are fund managers or fund owners becomes important. Under those circumstances, if there is an epidemic, the GPs see more patients, claim more reimbursement as fee-for-service and the Primary Health Care Organisation is short of funds. The question at this point is whether it is expected to go to the bank to borrow the shortfall or whether the Ministry of Health bails them out. In the end, real risk bearing will only be attractive if there is the potential for real profit to compensate. The Minister's proposals are clear on that point. She tells us that, 'Inappropriate approaches include those that emphasise competition and secrecy, those where public funds are applied to personal or shareholder profit rather than for improving health, and any where private health insurers are owners or governors of organisations managing large blocks of public primary care funds'. It would appear that the new organisations will be fund managers and quasi risk bearers. It seems that the government will only successfully shed that risk if it can persuade GPs themselves to receive payments by capitation.

Apart from visits to the GP, the other large item of expenditure likely to be the responsibility of the new Primary Health Care Organisations relates to expenditure on pharmaceuticals. This is an area over which one might expect GPs to be able to exercise a great deal of control.

If they were able to pocket at least a share of the savings, they might well reduce prescribing expenditure. The Minister's comments above would seem to preclude that option, unless savings could be used for some form of legitimate GP reimbursement. Since the proposals explicitly state that the method of GP remuneration is to be decided by the new Primary Health Care Organisations, the door does seem to be open for schemes to use savings on pharmaceuticals for GP income. The fact that 'Certain services (such as GP care and pharmaceuticals) may be bundled together ..' would make this easier.

Primary Health Care Organisations as purchasing organisations

At one extreme, we could envisage Primary Health Care Organisations as purchasing organisations. They might simply distribute funds in much the same way that funds have been distributed in the past, paying GPs on a fee-for-service basis. We would need to wonder why they would wish to take on the responsibilities that that would entail. Perhaps they would be tempted by the control that it would give them over any savings made on prescribing and laboratory budgets, the other two major areas of expenditure for which they would have responsibility. Personally I've always thought of this as a peculiarly tasteless carrot.

They may be part purchasers, purchasing general medical services from general practices, but providing other services, perhaps health education materials themselves.

Primary Health Care Organisations as associations of providers

The proposals suggest that the new Primary Health Care Organisations will be 'not-for-profit' organisations, but, if as seems likely, many of them develop out of existing (and recently evolved) 'Independent Practitioner Associations' they will be dominated by the medical profession and reflect their interests as private sector providers. If this is the case the new Primary Health Care Organisations could be thought of as associations of providers. Malcolm et al[3] point out that the pre-existing Independent Practitioner Associations (one of the most important existing forms of organisation that are expected to evolve into the proposed new Primary Health Care Organisations) were initially funded by GP shareholder contributions of between $50 and $4,000. If they are essentially associations of providers, it would be unrealistic to expect the sort of real public participation that developed in the 'third sector' alternative models of care.

Independent Practitioner Associations could develop into cartels

The nightmare scenario is that they would form the basis of local cartels, setting the terms and conditions for people receiving publicly funded primary care. In some areas the existing Independent Practitioner Associations are very powerful and dominate the market. Nationally 2123 out of a total of 3159 (67%) of GPs are in Independent Practitioner Associations[3].

As associations of providers, the new primary care organisations might build on the work of the Union Health Centres and provide nurse led clinics for subsidised patients. This would be in keeping with expressed concern about the inefficient use of medical manpower, but it might also be seen as a second class service for state aided patients.

PREDICTING THE EFFECTS ON EQUITY

Equity will be influenced at several levels. Equity of access will be influenced by decisions concerning the location of general practices. Equity will also be affected by decisions about charges and about the way in which services are provided. The discussion under the sections 'Practice location under capitation' and 'Practice location under fee-for-service' suggests that

changing the funding from fee-for-service to capitation will have little effect on the location of general practices. Under either system further measures are likely to be necessary.

Neither is there any promise in the document of a reduction in fees paid by patients. Low income patients presently pay a contribution towards their care. This seems likely to continue.

To fully appreciate the effect on equity it is necessary to understand the impact that the subsidies will have on general practitioners. Unfortunately the document leaves the question unanswered. Although the new Primary Health Care Organisations would receive money by capitation, they would be free to reimburse their constituent general practices either by fee-for-service or by capitation as they choose. p. 25. The analysis described by inequality (i) would suggest that capitation would result in a reduction in willingness to treat unless GPs were afraid that patients would move to a different practice and thus deprive them of their capitation. However it may be worth noting that the inequality includes a term to represent local monopoly power. To the extent that the new Primary Health Care Organisations are able to operate as provider cartels, we might expect that they would be in a stronger position to discourage attendance by subsidised patients, and therefore increase the pre-existing inequalities. As implied in section 'predicting the market position of the new organisations' one response of the Primary Health Care Organisations might be to provide alternative and cheaper models of care for subsidised patients.

There seems to be a widely held belief that weighted capitation can provide a solution to the problem of equity in New Zealand in the same way that weighted capitation is used in the United Kingdom. To quote from the Minister's discussion document, 'The basic principle here is that public resources should be distributed differentially across the country according to a measure of the needs of the population. This will ensure that those areas that have the highest levels of health need (for example South Auckland or East Cape) receive proportionately more resources than those with less need.' The problem in New Zealand is that much of the money paid for primary health care services is already targetted at low income people through a system of means testing. Reallocating that money as weighted capitation will only weaken the targetting of the benefits giving it to GPs to do with as they think best (rather than tying it to treatment).

If patients are to continue to pay at a subsidised amount, they will need to satisfy some eligibility criteria. They will also need some proof of eligibility when they go for treatment. This implies the continued use of the Community Service Card (or something similar). Capitation might then link reimbursement to the number of Community Service Card holders in the populations. There has been discussion that this might not be the case, but that capitation be linked to other markers of deprivation, in a presumed attempt to get 'better' targetting. However, unless capitation payments are linked to the Community Services Card (or equivalent), it is possible that some Primary Health Care Organisations will have to reimburse GPs for more visits than they themselves receive reimbursement for, while other Primary Health Care Organisations would get correspondingly more reimbursement than their Community Service Card figures would suggest (as would be the case in those areas where the take up of community service cards is poor). There is a danger that those areas that are under resourced will wish to provide cheaper services for subsidised patients.

As an aside, I have been wondering whether people know of any literature about thinking of universal subsidised fee-for-service as operating on the demand side and hence contributing to equity of access, contrasted with weighted capitation as operating on the supply side to try to achieve equality of use.

This section has rambled a bit, but it occurs to me that the most powerful tool for equity of access is to make it free for everyone, the second is make it free to those who are eligible and also claim relief. Capitation under the Minister's proposals will achieve neither of those things and will only reduce the incentive to treat if capitation is rolled onwards from the new Primary Health Care Organisations to their constituent general practices.

PREDICTING THE EFFECTS OF THE PROPOSALS ON HEALTH PROMOTION

The Minister's proposals call for 'greater attention to health improvement and disease prevention as well as early intervention'. Whether the proposals are successful in achieving gains in these areas will, in part, depend on how they are implemented at practice level. The assumption that capitation going right down to practice level will assist in these aims may be incorrect. Special fee-for-service payments may need to be made to meet health promotion objectives. The belief that capitation might result in health promotion as a means of controlling demand is probably over optimistic. For doctors to hope to reduce demand in that way, they would have to believe that health promotion would have an influence on the likelihood patients would consult. Fee-for-service payments for smoking, dietary advice, immunisations, screening, regular review of diabetic and asthmatic patients are likely to be a more certain way of improving the provision of these services. However, if patients are required to make a co-payment to receive such advice, they may be reluctant to attend.

PREDICTING THE EFFECT ON DOCTOR PATIENT RELATIONSHIPS

If the GPs themselves continue to be paid by fee-for-service and if existing arrangements for the treatment of patients continue, we should expect little change in doctor patient relationships. However, if GPs are paid by capitation there is a danger that subsidised patients will be made to feel less welcome. Traditional behaviour patterns, individual differences in style and the level of local competition are all likely to influence this.

If attempts are made to provide cheaper alternative treatment methods doctor patient relations are likely to suffer.

I assume that the new Primary Health Care Organisations will receive a (probably small) capitation fee for all patients (including those who pay their own fee-for-service) to cover health promotion and disease prevention services. To receive such fees, the organisations would have to ensure that patients register. Since there is no great advantage for the unsubsidised patient to enrol, we may speculate that some pressure might be brought to bear. It may be sufficient for doctors to prove that patients consult for them to claim that they are registered. If more active registration is required, presumably it could be tied to other benefits, such as the subsidised prescriptions that all patients are presently eligible for.

PREDICTING THE EFFECTS ON INTEGRATED CARE

New Zealand's funding authority (soon to be absorbed into the Ministry of Health) has been evaluating the extension of integrated care arrangements. Essentially these transfer some of the responsibility from secondary care to primary care. Since patient co-payments seem set to continue, some part of the cost of care will be transferred to them (unless special arrangements are to be made). If GP remuneration is to be by fee-for-service, any increase in GP consultations would result in an increase in claims from GPs to the new Primary Health Care Organisations, who would presumably try to renegotiate their capitation payments to recover the cost of that increased workload. If GPs are remunerated by the new Primary Health Care Organisations under a capitation system, they would presumably lobby for increased capitation payments, assuming that there was a perceptible difference in their workload (or a perception that it is likely to change).

Workforce management

It has been argued in New Zealand that capitation funding would allow better workforce utilisation than fee-for-service funding[2]. However this is only because of the way that fee-for-service funding is presently organised. Consultations with doctors qualify for a payment, whereas consultations with a nurse do not. This 'distorts' service provision by encouraging doctor consultations at the expense of nurse consultations. An alternative solution would be to subsidise nurse visits in the same way that doctor visits are presently subsidised (at a different rate if this were judged to be appropriate). I cannot see that there is a real issue between capitation and fee-for-service on the question of workforce management.

Section 5 – Conclusion.

I am aware that this paper has been somewhat negative in trying to identify potential difficulties with the proposals. I suspect that the Minister is well intentioned in her proposals. I am worried that capitation is seen by all parties as a 'good' thing. I suspect that the different parties hope to gain different things from it. My fear is that GPs see it as a means of gaining control over budgets and over the health care system more widely. Also with capitation their income is more predictable. I suspect that the capitation is seen as attractive to the government because of a belief that it is in some way more equitable and provides more coherent and continuing care because of patient registration. For them also it makes funding more predictable. However, without universal free service, weighted capitation will not achieve equity of treatment. Those patients who arrive at the GPs door with cash in hand will inevitably bring more of a twinkle to the doctors eye. If GPs (rather than just their Primary Health Care Organisations/Cartels) are capitated then subsidised patients only bring more work, and might not be wholeheartedly welcome in a busy practice. If GPs continue to receive the fee-for-service subsidy, but from their Primary Health Care Organisation rather than from the present funding authorities, then it is hard to see how the system will change substantially, apart from some transfer of quasi risk to those organisations.

I wonder whether another way of thinking about this question might be in terms of how to deal with poverty. Whether we use 'means tested' benefits (of which subsidised fee-for-service is one sort), or whether we use universal benefits (such as free access to general practitioners under a system of capitation payment). The proposals suggested are a sort of mixed system that may gain the advantages of neither. It does not gain the targeting of subsidised fee-for-service, nor does it gain the certainty that all those in need will benefit as under universal coverage). It simply attempts to redistribute a subsidy, which was formerly targeted and not make certain that the doctor actually treats the patient as a requirement of getting paid. All it gains is a weaker incentive to treat, and one must suppose, a reduction in the care provided to subsidised groups, so adding to the disadvantages they face.

I welcome any further thoughts from the audience. Tell me if I am being too pessimistic. That may well be the case!

I am grateful to colleagues at the Health Services Research Centre, and particularly to Pauline Norris, for their helpful comments.

[1] Health Funding Authority 1998, *The next five years in general practice,* Health Funding Authority, Northern Office, Auckland.

[2] Cumming J & Mays N, (1999). Shifting to capitation in primary care: what might the impact bein New Zealand? Australian Health Review, 22(4):8-24.

[3] Malcolm L, Wright L & Barnett P (1999) *The development of primary care organisations in New Zealand.* Ministry of Health, Wellington.

[4] King A (2000) *The future shape of primary health care* Ministry of Health Wellington

[5] Shimmura K (1988) Effects of different remuneration methods on general medical practice: a comparison of capitation and fee-for-service payment Int J Health Plann Manage Oct-Dec;3(4):245-58

[6] Krasnik A, Groenewegen PP, Pedersen PA, von Scholten P, Mooney G, Gottschau A, Flierman HA, Damsgaard MT 1(990); Changing remuneration systems: effects on activity in general practice *BMJ* 300(6741):1698-701

[7] Holloway PJ Lennon MA Mellor AC Coventry P Worthington HV (1990) The capitation study: 1. Does capitation encourage supervised neglect?, *British Dental Journal* vol 168 pp119-21