



**NEW ZEALAND INSTITUTE FOR THE STUDY  
OF COMPETITION AND REGULATION INC.**

# **PAYING FOR THE DOCTOR'S STRIKE AND THE WAITING LIST CULL AT THE GP'S SURGERY**

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# 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**

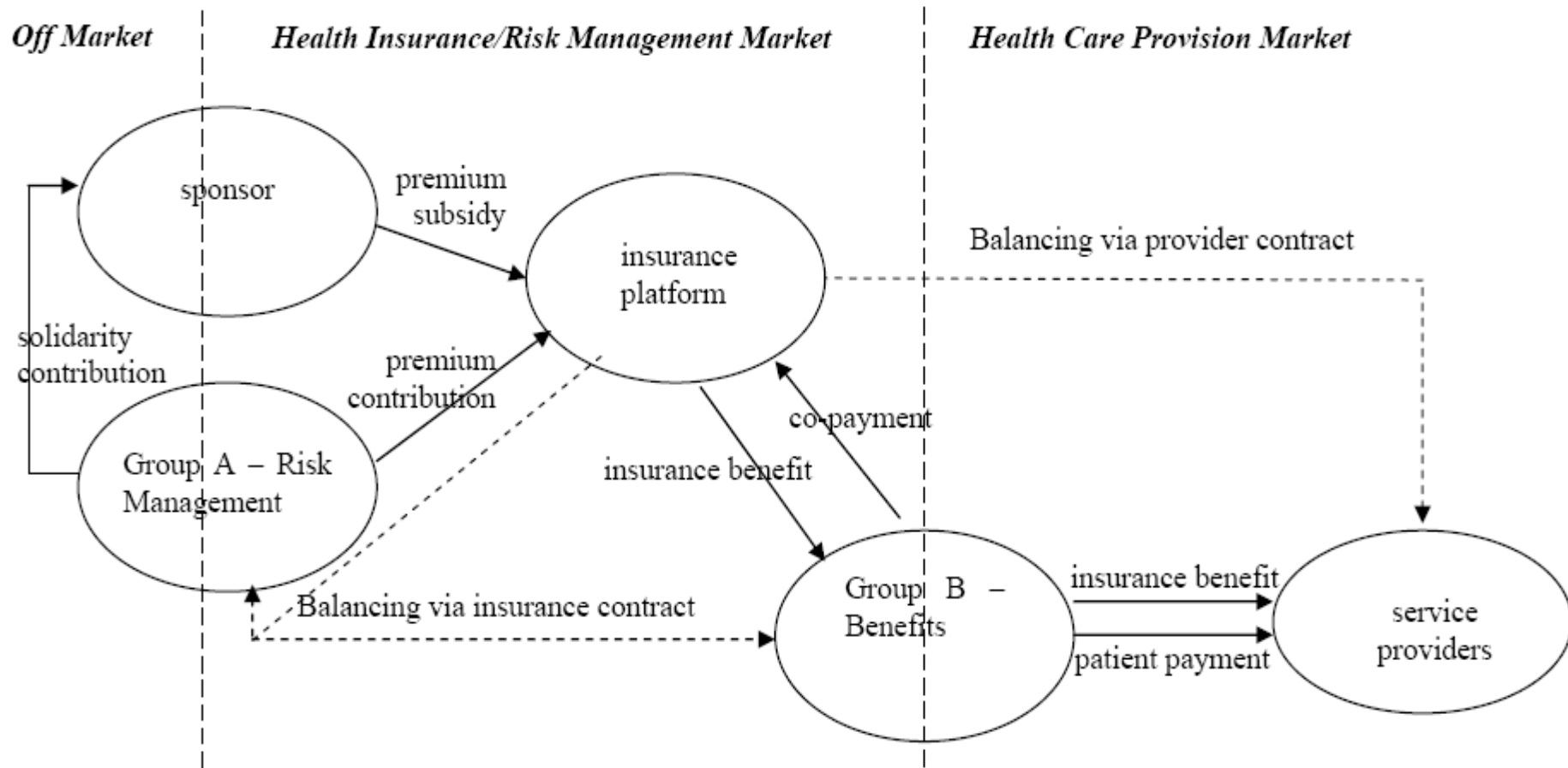
- exacerbates the effects of 'uncontrollable' financial risks faced by GPs as a consequence of capitation

## **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

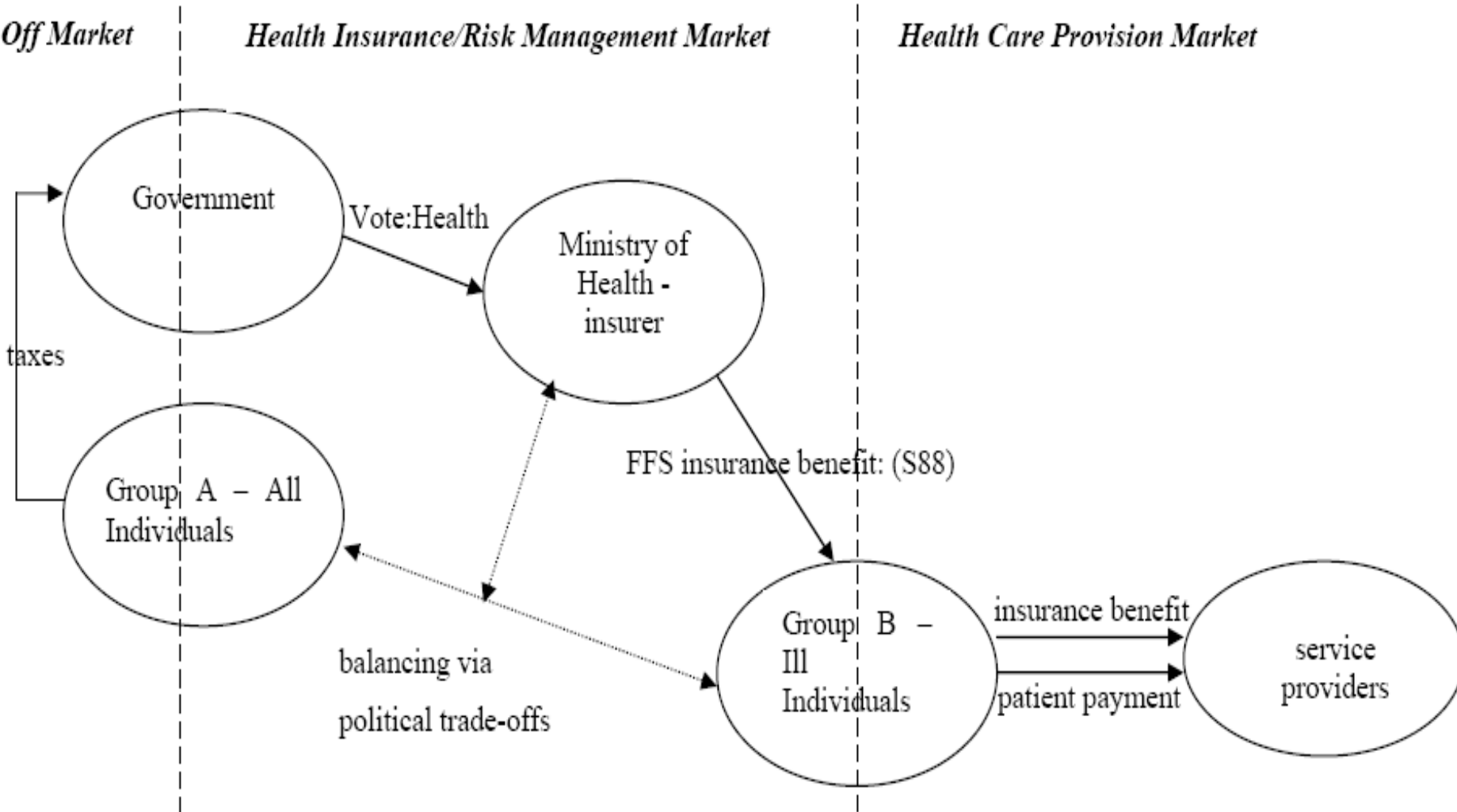


# SUBSIDISED HEALTH CARE SYSTEMS

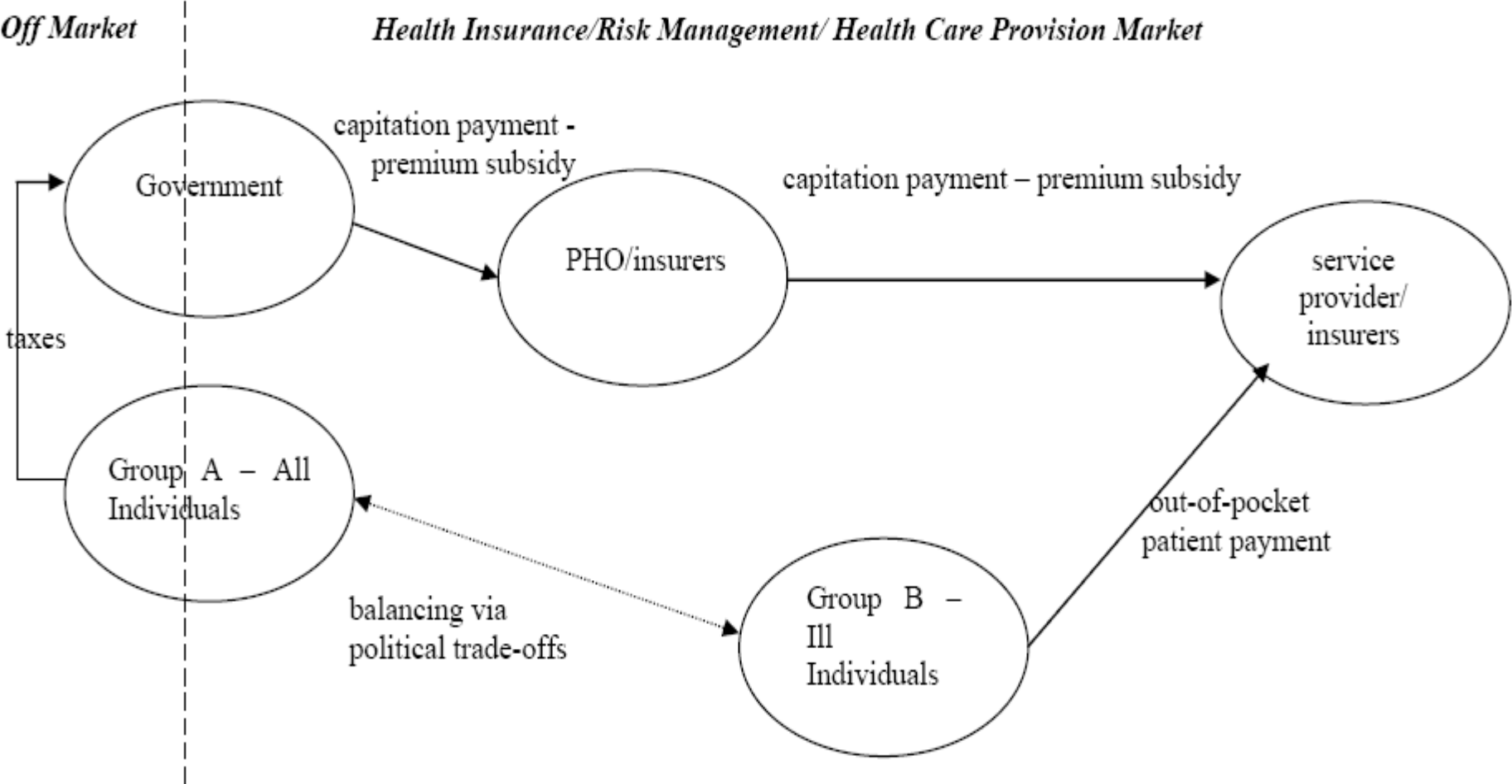


Adapted from Van der Ven and Ellis (2000:761) and Rochet and Tirole (2002:552)

# FEE-FOR-SERVICE SYSTEM (PRE-NZPHCS)



# CAPITATION SYSTEM (NZPHCS)



# 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 =  $20 \times \$30 = \$600$**

- increase =  $\$600/(Q+20)$  per consultation

**Interim deficit =  $20 \times \$15 = \$300$**

- 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 X 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**

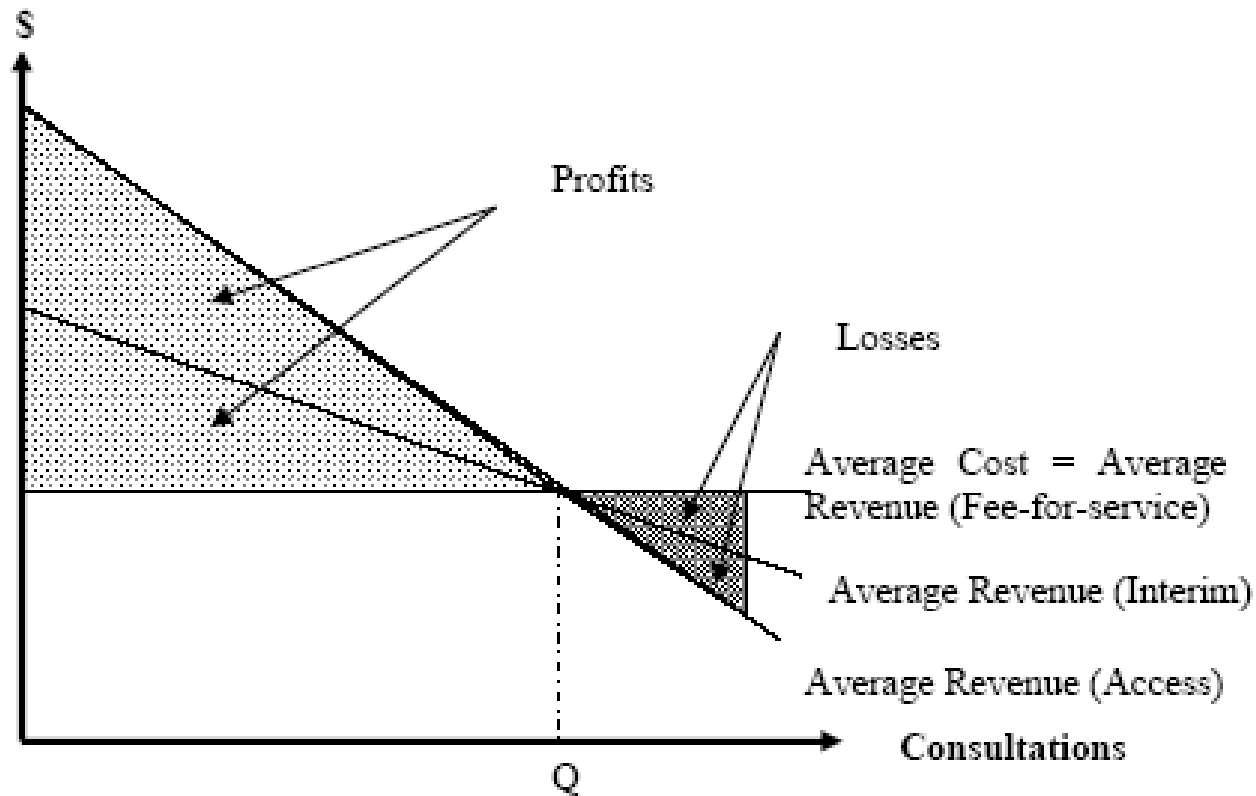
**Therefore will have to engage in ‘undesirable’  
behaviour to manage additional financial risk**

- 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?**

