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Prepared for General Practice New Zealand

# Primary care funding – a discussion paper

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## Executive summary

This discussion paper has been commissioned by General Practice New Zealand (GPNZ) for the purpose of supporting discussion among its members and the wider primary health care sector, and the development of a GPNZ position on primary care funding models.

At a high level, the questions of subsidy, copayment regulation and targeting are determined by matters of principle which depend upon the particular stance of those involved in the debate. But there are distinct patterns and frameworks which can help to shape the issues which lie underneath these problems. The first issue is to be clear about why subsidy or redistribution of resources is important in the first place, and what is to be achieved. Whether this is motivated by egalitarian or by economic considerations then sets some of the parameters for deciding upon the balance between universalism and targeting. Moreover, whatever the principled position on targeting, much is determined by the realities of the mechanisms available, and how effective they are in practice.

An analysis of copayments finds the following distribution for non Very Low Cost Access practices by age band.

Age group	Average copayment	Standard deviation	Median copayment	Maximum copayment
Under 6 years	\$0.70	\$3.80	\$0	\$47.00
6-17 years	\$28.70	\$9.10	\$29.00	\$60.00
18-24 years	\$46.50	\$16.20	\$48.00	\$88.00
25-44 years	\$39.80	\$7.80	\$40.00	\$66.00
45-64 years	\$39.90	\$7.90	\$40.00	\$66.00
65 years and over	\$49.50	\$16.70	\$49.00	\$91.00

An analysis of the population coverage of Very Low Cost Access practices with lower fees finds that just over half (56%) of the high needs population was with a VLCA practice. Conversely, 44% of high needs population – approximately 563,000 people – were enrolled in a non-VLCA practice.

Furthermore, of the approximately 1.277 million patients enrolled in VLCA practices, 556,000 or 44% did not fit the definition of the funding policy’s “high needs” population. This number is similar to the 563,000 “high needs” patients who were enrolled in non-VLCA practices and therefore ineligible for additional funding to further reduce copayments. The mechanism of targeting high need funding at the level of practice rather than patient has resulted in poor targeting, with higher levels of government subsidy supporting a large

number of lower need people, and not supporting approximately half of the currently defined high need population it is intended to benefit.

The current copayment regulation regime, based upon an inflation indexed increase in the allowable copayment, has significant drawbacks:

- Copayment regulation is based upon maintaining real copayments on a national average basis, but significant parts of the country and different sectors of the population, have seen income grow more slowly than co-payments, meaning that for many people copayment regulation has not succeeded in the policy goal of containing the real cost of access to general practice;
- Where practice costs are determined by a national labour market for professional services and there is a mismatch with local ability to pay increased consultation fees, there is a dilemma for practices where costs are increasing faster than their ability to increase copayments;
- Fees reviews provide a safety valve for practices who can justify an increase in fees on the basis of costs, but this can only work where populations can bear such fee increases. Practices serving high need/low income populations are likely to have the least ability to increase fee revenue under this mechanism, particularly in parts of the country which are facing lower income growth.

The fundamental issue of the current copayment regulation approach is that since the majority of practice cost growth is driven by national (and international) labour markets, but the real price to patients is determined by local and sector based income effects, there is a mismatch between the two sides of the regulatory equation for much of the population. The clearest way to address this issue is to focus subsidy patterns and copayment rules more specifically upon individuals, families, and their particular economic circumstances.

The future options for targeting are, at a high level, to continue with a form of practice or population level targeting of funding, as is the case under the current scheme, or to develop a new approach based upon targeting resources towards individuals. In an environment of limited funding increases for health services, more carefully focussed targeting is likely to be required if those with high levels of need are not to face increased costs of access to primary health care in the future.



# 1. Purpose and approach

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## 1.1 Purpose of this paper

This discussion paper has been commissioned by General Practice New Zealand (GPNZ) for the purpose of supporting discussion among its members and the wider primary health care sector, and the development of a GPNZ position on primary care funding models. The paper focuses on the following issues:

- equity of funding – for populations with different need, and in particular the impacts of the Very Low Cost Access (VLCA) funding mechanism on equity, access and competition in primary care;
- copayment regulation – the consequences of the current regulation mechanism for practices and patients, and options for different approaches to copayment regulation;
- fully subsidising consultations – issues arising from full subsidies for different age groups; and
- possible mechanisms for targeting funding to certain groups of patients.

## 1.2 Approach taken

Our analytical approach draws on principles of distributive justice and on economic theory. It has also been informed by an analysis of the distribution of practice fees or copayments, using a dataset provided by GPNZ. This dataset contains the copayments for general practitioner (GP) consultations posted by 964 practices in 2013/14 – equivalent to 94% of practices.<sup>1</sup> The copayments relate to the six age groups used for capitation funding.<sup>2</sup> As part of this analysis we have:

- analysed the average level and distribution of copayments faced different age groups in VLCA and non-VLCA practices; and
- examined the copayment regulation regime and modelled maximum annual increases over time using different copayment starting points and different mixes of public and private revenue.

We have supplemented this analysis with a review of recent and relevant published material, media reports, and with our own observations from working with practices as part of the Integrated Family Health Centre (IFHC) programme.

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<sup>1</sup> There were 1,029 general practices in New Zealand as at April 2014; Ministry of Health statistics <http://www.health.govt.nz/nz-health-statistics/health-statistics-and-data-sets/primary-care-data-and-stats>

<sup>2</sup> The age groups are: under 6 years; 6-17 years; 18-24 years; 25-44 years; 45-65 years; and 65 years and over.

## 2. Subsidies and targeting

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### 2.1 Subsidising access to primary care

At a high level, governments in New Zealand and other countries have powerful reasons for subsidising primary health care services. The rationale includes the following elements:

- the cost of primary care – many patients would otherwise face financial barriers and access less care than they need, regardless of the presence of a private insurance market;
- health system impacts – ensuring that people have a health care home, is important for managing downstream demand (and cost) impacts on a publicly-funded hospital system;
- wider social benefits – from ensuring that the population can access primary health care, and thereby, maintain their health and contribute to society; and
- a duty of care to the most vulnerable members of society, e.g. young children.

For these reasons, most governments make a choice to subsidise primary care access at some level for some sections of the population (e.g. Medicare, Medicaid and Veteran's Affairs schemes in the US), by implementing universal subsidy (as seen in the UK) or by providing forms of social insurance (e.g. Germany and the Netherlands, or ACC in New Zealand). Subsidising primary health care services has become a common and fundamental role for governments in developed countries although the particular mechanisms by which that subsidy takes place vary significantly.

### 2.2 Distribution of health care resources

#### 2.2.1 Theoretical principles

At a high level the issue of using health care resources in a universal or a targeted fashion is one of distributive justice. The enormous literature on this subject reflects the fundamental role which principles of distributive justice play in policy, economics and jurisprudence. The question of how to identify a socially just distribution of goods in society applies to public services, pensions, market regulation, tax policy, charitable activity and numerous other aspects of society. Several well-known twentieth century philosophers, such as Rawls and Nozick, and economists, such as Sen and Deaton, have considered these problems.

A brief summary of the high level perspectives which are debated in distributive justice are:

- strict egalitarianism, in which equal goods should be allocated to all members of society;
- Rawls' difference principle, which allows for divergence from egalitarianism where this will make the least advantaged better off;
- welfare principles (utilitarianism, the foundation of modern economics, is a welfare principle), in which goods should be distributed not as ends in themselves, but only in so far as they maximize welfare or utility across the population;
- libertarian approaches tend to argue that any interventionist principle from the list above cuts across the more fundamental demands of liberty or self-ownership, which have a moral force in themselves.

## 2.2.2 Interpretation

While these theoretical approaches may seem abstract, the different stances they embody are closely relevant to the practical problem of how to fund health services. The different theoretical viewpoints produce, in practice, very different positions on how public services should be subsidised. A brief summary of these different positions is:

1. Strict egalitarianism would argue that everybody should have the same portion of government resource to fund their health care, whatever that might be. This position is strong in terms of entrenching people in their role as citizens, equal in what they can expect from their society but in practice is rarely strictly implemented in public services, although some services are not far from it. In New Zealand state funded education is historically founded in this approach, as is state superannuation, the single biggest component of New Zealand's social welfare spending. Egalitarianism can have the downside of sometimes being inefficient (since some people may benefit from public resources more than others), and unresponsive to inequalities in society.
2. Rawls' difference principle is an adaptation of egalitarianism, in that it argues that a fair allocation decided by a disinterested party (someone behind the "veil of ignorance" about how the decisions affect their own personal interests) ends up with those with the least receiving the most of the available resource. It accepts the existence of inequalities, and recognizes that the very existence of inequalities means that some degree of redistribution is possible to those who have the least. This set of principles supports strongly targeting subsidy resources to those who have the least ability to pay for their own care.
3. Welfare principles underpin modern economics. The argument is essentially that the maximum utility of a range of goods is inherently the best distribution in society (maximized welfare for society as a whole) – which is why whoever values a good the most is the person who will pay the most for it in a market. The difficulties with this view are a) that sometimes markets don't work because participants are not fully informed, and that b) sometimes people systematically underestimate the utility they will derive from a good. The former issue of market failure is a classic problem in health care, and other professional services where a consumer is purchasing a service which is sometimes hard to quantify and estimate the value of. The latter issue becomes a problem when people or communities accept poor health states as normal, and consequently undervalue the services which will help them.
4. Libertarian views of justice argue that each individual's share of a resource is inherently fair, so long as they were entitled to it in the first place. It places a high priority upon individual responsibility (looking after one's own health), and facing the consequences. In a health context, it could be used to justify subsidy of health services in reparation for an unfair allocation or impact on health (eg where people suffer from environmental or occupational disease, or their health is not a consequence of their own choices). Libertarian approaches appear to avoid overarching theoretical judgements about what is fair, found in other approaches to justice. But the consequence is that it results in a lot of detailed analysis and sometimes arbitrary judgement of the fairness of particular individual circumstances.

### 2.2.3 Application to health care

In practice, most developed countries apply some mixture of Rawls' difference principle and market welfarism to subsidising health services. These result in various forms of differential state subsidy for those who have the least ability to pay for their own care, higher levels of subsidy for those who are likely to have the greatest need for services, but with some degree of egalitarian influenced policy applying to patient contributions.

It is important to be clear that there are two dimensions of state resource distribution which are relevant for health care (and many other social services): (a) the matching of resource to the level of service which an individual needs in order to derive optimal benefit; and (b) the trade-off of state resource with an individual's ability to pay with their own resources.

#### **To what extent should differences in state subsidy be determined by need?**

- Strict egalitarianism would argue that people should have the same share of a subsidy, regardless of differences in need.
- In some respects need is a difficult and fundamentally uneconomic concept, in that it wraps up aspects of what a patient demands, what they can afford, and what a health professional judges can best be done for them, and tends to disregard notions of individual valuation. Higher need should generally result in higher state subsidy under a Rawlsian view, because an uninterested party would be likely to take the insurance perspective that a safety net is needed for those with the fewest resources. It is worth noting that on this perspective those with higher need but also greater personal resources should probably not receive such a great subsidy.
- A more libertarian view would be that higher subsidies should be accorded to those with certain classes of need generated by factors outside their own control, eg environmentally caused health problems, some classes of accidents, and possibly some kinds of age related care. Otherwise, the use of resources for health care should be determined by individual choice in the context of a market.
- A classical economic approach would argue that need is properly thought of as demand, determined by how much an individual values a good. Subsidy to individuals should therefore take place to the extent that markets fail to do a good job of matching supply and demand, whether because of asymmetries of information or other market imperfections. The practical upshot of this is that because pure markets often don't work very well in health care, largely because of information problems, some degree of subsidy is needed but it should principally for people who would not seek optimal care under an unsubsidized market arrangement. As a principle this might seem straightforward, but it immediately begs the question of who decides what constitutes optimal care, and whether knowing that a safety net exists will distort market behaviour even further, making it essentially impossible to determine whether an individual is genuinely willing to pay for a service or not.

#### **To what extent should differences in subsidy be determined by whether individuals can afford to pay for care themselves?**

- A strongly egalitarian view, in which equal citizenship and equal rights to the care of the state are important principles, would support equal individual payment (whether zero payment or some other, low, predetermined level). Many Northern European health systems adopt this approach, with universal low or zero copayment for services. In New Zealand we adopt this approach for state funded hospital services – however much state resource is devoted to an individual in hospital, which hopefully matches

their need for that resource, the copayment is identical and zero. In primary care we adopt this principle in part: we acknowledge that copayments may vary from practice to practice and population to population, but require that patient payments be the same within those practice or population groupings.

- A classical welfare economics perspective would argue that payment is important as a token of what people value, and to help determine how much benefit they expect to receive from the service. There are strong aspects of this approach in the argument that copayments appropriately reduce demand for low value services.
- A Rawlsian approach to this question would not necessarily argue for universally identical copayments, but would require that copayments be set at a fair level for each individual according to their differential ability to pay, however that was determined.

Taking a stance on the distribution of health care resources for different people therefore depends upon a set of value judgements. How you think need is best determined, how you believe that ability to pay is best assessed, to what extent you believe that people have equal citizenship interests in public services, and whether you believe that the state should only engage in what people cannot control for themselves are all stances of principle which influence a preferred approach to distributing health care resources, and to determining what contribution individuals should appropriately make to the cost of their own care.

Although there is no single right answer to these complex questions, starting with some of the higher level principles and approaches can help in developing a coherent and consistent view on how health care resources should be used.

## 2.3 Targeting and universality

Once an agreement in principle has been made to target resources to particular groups or individuals, and, by implication, whether copayments are involved for some individuals, the question then becomes a more pragmatic one of how best to do determine who sits where in the scheme of things. The logistics of particular mechanisms can impact upon the effectiveness of subsidy regimes, and upon public perceptions of fairness.

Most targeting regimes for public services have the problem that some people will inevitably be right at the margin of a threshold for subsidy or copayment, and therefore that two people who are close to the threshold but on different sides of it might have quite similar personal circumstances but be treated differently. This can be mitigated by having several different levels of subsidy or copayment, meaning that the effect of moving from one level to another is less severe than an all or nothing impact, although such an approach comes at the cost of added complexity. Issues at the threshold also create abatement problems, in which a small increase in income (for example), can result in the loss of a greater amount of subsidy or other benefit, distorting incentives for an individual. This is a common problem with targeted income subsidy systems. Universal subsidies or copayment levels get around some of these complexities and potentially arbitrary aspects of a targeting system, but typically achieve this goal at the cost of greater use of state resources across the population, or reduced efficiency of subsidies.

Another important issue in targeting resources is the decision about the level at which to discriminate – whether among individuals, families, or larger populations. Targeting across larger populations, whether defined geographically or according to demographic characteristics such as age or ethnicity tends towards more nearly universal approaches.

A more aggregated approach to targeting therefore has similar strengths and weaknesses to universal subsidy, but with less complexity and fewer issues for people at the margins. It also has less ability to ensure that resources are applied where they will have the greatest benefit, leading to less efficient use of resources overall.

Targeting mechanisms can therefore have a substantial impact upon the real effect of a subsidy regime. Whatever the higher level principle and intent, the specific mechanism used to direct resources can mean that the practical effects of a subsidy or transfer are quite different from the intent. Being clear about the principle and objectives behind a subsidy regime therefore provides a framework for choosing the preferred targeting mechanism, as well as for the broader parameters of a subsidy system.

## 2.4 Government direction in primary care

The Primary Health Care Strategy set a direction for primary care services in New Zealand in 2001. The major implication of the strategy for funding was that contracting with a Primary Health Organisation was a prerequisite for practices to access capitated funding streams, which were increased significantly in subsequent years. One of the explicit goals for those funding streams, held by the government of day, was to reduce patient copayments, and thereby reduce barriers to access for care for the population as a whole. As bulk-funded capitation subsidies increased for the whole population copayments remained, but their rate of growth was capped under a regulatory scheme that defines a “reasonable” annual increase.

The intent of government at the time was very clearly to move as far towards universal subsidies as feasible within government budget constraints, and to reduce copayments for the population as a whole. Subsidy levels for much of the population were set on the basis of historical utilisation rates for standard general practice consultations, with some level of additional weighting for high need populations for High User Health Card subsidy.

Universal copayment regulation, with differential subsidy weighting for need has elements of the approach described by Marmot and colleagues as “proportionate universalism”. This analysis is based upon the view that in order to reduce inequity, actions in health care should be universal, but with a scale and intensity proportionate to the level of disadvantage. It can be argued that fixing copayments across the population, with differential subsidies on a need basis, reflects the kind of approach that Marmot had in mind.

Government policy during the 2000s was specifically focused upon using subsidies to reduce copayments, on the argument that copayments were an important barrier to accessing health care for many people. A high level re-examination of principles for subsidising health care could step back from this specific focus and consider a broader review of what barriers exist to accessing primary care, and how those barriers play out across the population. Copayments are clearly a major barrier for some individuals and populations, but are not the only barriers.

### 3. Copayment levels and distribution

Our analysis of copayment data from 2013/14 is based on a simple ‘practice count’ view – i.e. the practices are treated equally rather than being weighting the number of enrolled patients. Future analysis could consider linking copayment data to patient register data in order to increase the accuracy of these estimates of copayments across the population.

#### 3.1 Average copayments at practices

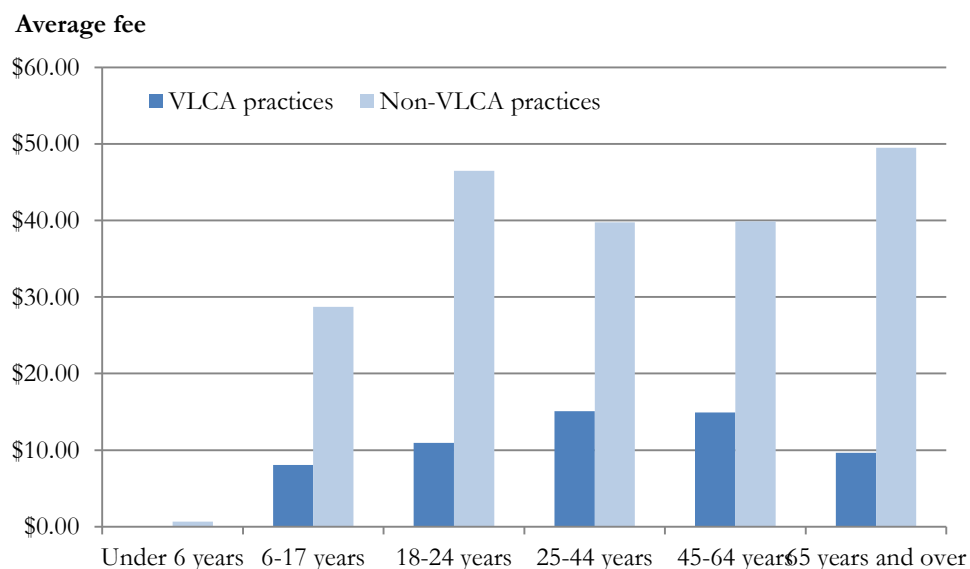
Figure 1 shows the average copayments by age group, differentiated by VLCA practices and non-VLCA practices. A couple of points stand out.

Firstly, as would be expected, average copayments among VLCA practices are much lower than those among non-VLCA practices due to the limits imposed under the VLCA scheme. The differential is -\$21 for those aged 6-17 years, -\$36 for 18-24 years, -\$25 for 25-44 years and 45-64 years, and -\$40 for 65 years and over. As a proportion of the average copayment at non-VLCA practices, average copayments at VLCA practices vary from being only 20% for patients aged 65 years and over to 38% for those aged 25-44 and 45-64 years.

Secondly, the average copayment tends to increase with age. Among VLCA practices, the average copayment increases from zero among patients aged under 6 years to approximately \$15 for those aged 25-44 years and 45-64 years. For non-VLCA practices, the average copayment increases from less than \$1 for patients aged under 6 years, to \$49 among those aged 65 years and over, with a noticeable spike among those aged 18-24 years.

Thirdly, the very low average copayments for those patients aged under 6 years reflect the high uptake of the ‘zero fees for under 6s’ policy, with 97% of practices offering zero fees.

**Figure 1: Average copayments at VLCA and non-VLCA practices, 2013/14**



**Source:** Copayment data set provided by GPNZ; Sapere analysis

## 3.2 Distribution of non-VLCA copayments

Looking beyond the headline indicator of average copayments, Table 2, presents a series of charts that illustrate the distributions by age group among non-VLCA practices (see Appendix 1 for VLCA copayment distributions). Points of note include:

- Under 6 years – practices are heavily clustered within the \$0-\$5 band, reflecting the fact that 97% of practices have opted onto the ‘zero fees for under 6s’;
- 6-17 years – shows a distribution approaching a normal distribution, that is, fairly evenly distributed on either side of an average copayment of \$28.70;
- 18-24 years – the wider distribution of copayments around the average of \$46.50 is reflected in the standard deviation being relatively higher at \$16.20;<sup>3</sup>
- 25-44 years and 45-64 years –these working age groups share a similar picture, with copayments being relatively tightly distributed around the average copayments of \$39.80 and \$39.90, respectively; and
- 65 years and over – again, a relatively wide distribution of copayments around a high average of \$49.50.

Summary indicators of these non-VLCA copayment distributions are shown in Table 1. Also shown is the median copayment or the midpoint practice within the sample – its similarity to the average in most cases suggests the practices are approaching a normal distribution. The maximum copayment for each age group is also shown.

**Table 1: Copayment statistics at non-VLCA practices by age group, 2013/14**

Age group	Average copayment	Standard deviation	Median copayment	Maximum copayment
Under 6 years	\$0.70	\$3.80	\$0	\$47.00
6-17 years	\$28.70	\$9.10	\$29.00	\$60.00
18-24 years	\$46.50	\$16.20	\$48.00	\$88.00
25-44 years	\$39.80	\$7.80	\$40.00	\$66.00
45-64 years	\$39.90	\$7.90	\$40.00	\$66.00
65 years and over	\$49.50	\$16.70	\$49.00	\$91.00

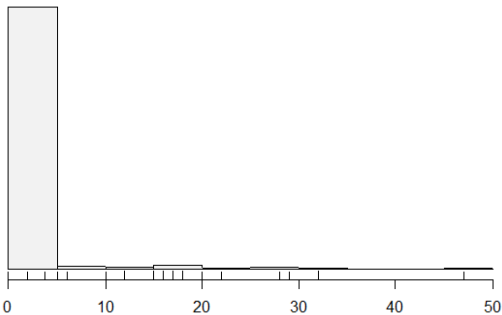
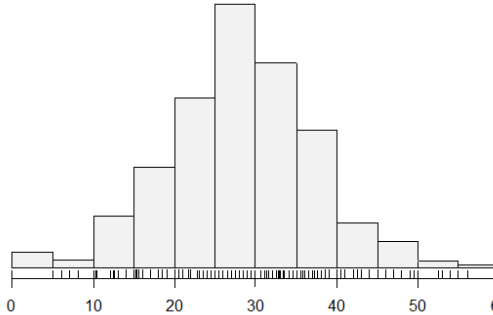
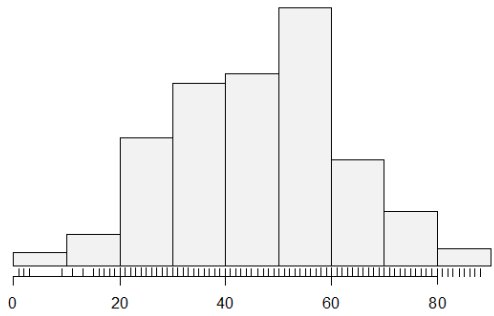
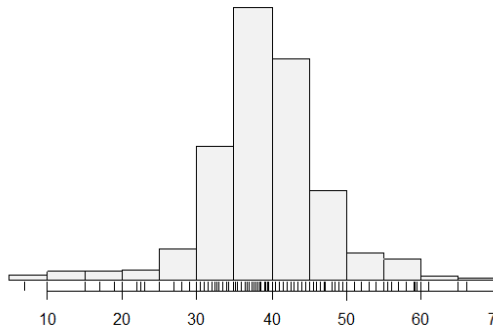
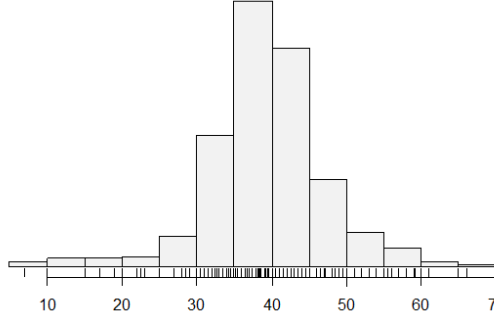
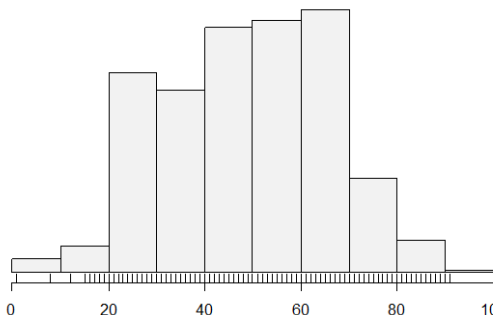
**Note:** Figures rounded to one decimal place.

**Source:** Copayment data set provided by GPNZ; Sapere analysis

<sup>3</sup> The standard deviation is a measure of distribution around the mean (average). The majority of observations or practices (68%) will be distributed around the mean within plus or minus the standard deviation. A lower standard deviation suggests the majority of practices are more closely distributed around the mean.



**Table 2: Distribution of copayments by age group for non-VLCA practices, 2013/14**

<p><b>Under 6 years</b></p>  <p>Mean: \$0.70 Standard deviation: \$3.80</p>	<p><b>6-17 years</b></p>  <p>Mean: \$28.70 Standard deviation: \$9.10</p>
<p><b>18-24 years</b></p>  <p>Mean: \$46.50 Standard deviation: \$16.20</p>	<p><b>25-44 years</b></p>  <p>Mean: \$39.80 Standard deviation: \$7.80</p>
<p><b>45-64 years</b></p>  <p>Mean: \$39.90 Standard deviation: \$7.90</p>	<p><b>65 years and over</b></p>  <p>Mean: \$49.50 Standard deviation: \$16.70</p>

**Note:** The horizontal axis represents copayments in at five-dollar intervals; the vertical axis shows relative numbers of practices at each five-dollar interval.

**Source:** Copayment data set provided by GPNZ; Sapere analysis

## 4. Regulation of copayments

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As noted earlier, the introduction of capitated funding streams to reduce patient copayments was accompanied by a regulatory regime to limit their subsequent growth. The aims were to protect the government's investment in the reduction of copayments and to ensure that financial barriers at the point of service remained relatively low to support patient access.

This regulation of prices is not unique. Governments intervene in a range of markets to set prices for a number of reasons. Such interventions tend to be in industries where a natural monopoly or limited competition exists, or in services where there is a mix of public and private funding and where the user charge is capped (e.g. provision of legal aid, public transport, and tertiary education).

### 4.1 Statements of 'reasonable' fee increase

The regulation of annual copayment increases is outlined in the PHO Service Agreement. The agreement provides for an independent statement of "reasonable fee increases" that sets a maximum annual increase in copayments on a percentage basis. These statements have been produced since 2006 and are based on an agreed method with the following elements:

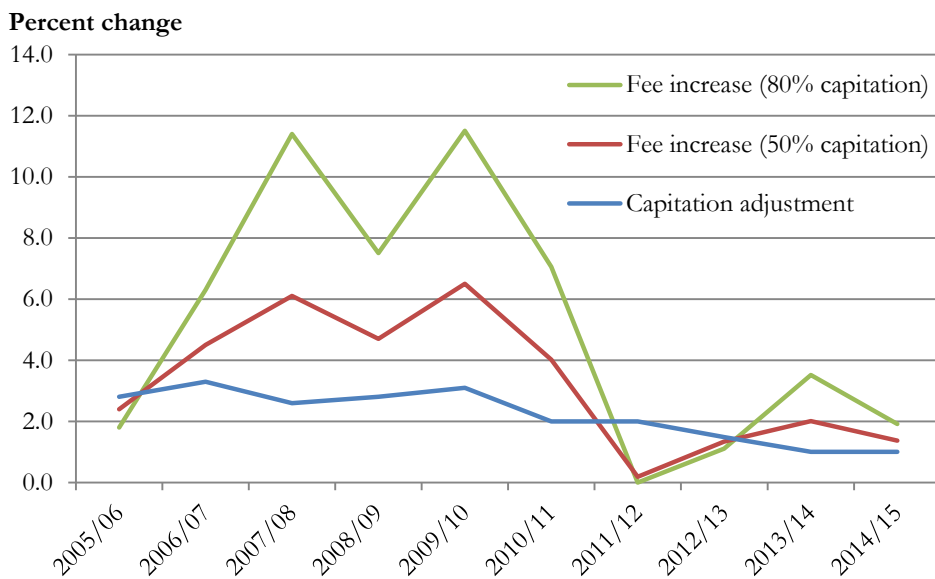
- average cost growth face by practices is estimated using official indices for labour, consumable inputs and capital. The formula does not include a discount factor for any expected efficiency gains;
- the annual increase in capitated funding is then considered alongside these average cost pressures. Capitation funding is generally considered to account for between 50% and 80% of practice revenue for First Contact Care services, depending on the structure of the practice and, its model of care and schedule of copayments;
- the extent to which copayments can be increased to compensate practices for average cost growth beyond the capitation adjustment differs according to the proportion of revenue derived from capitation.

Figure 2 shows the trends in the reasonable fee increase for practices since 2005/06 – the baseline for the introduction of the regulation – along with the annual percentage increases in capitation (i.e. the First Contact funding stream).

The annual increase in capitation is a government policy decision that is typically informed by forecast price inflation, although there is no fixed formula for this. This increase has generally been low relative to the cost growth measured by the agreed formula. Therefore practices where capitation forms a higher proportion of revenue have generally been permitted a higher annual increase in copayments – with the annual increase in copayments essentially acting as a safety valve to offset cost increases faced by practices.

It should be noted that these figures are averages and do not necessarily reflect actual changes in copayments, which are likely to be informed by the costs pressures specific to a practice, the practice's recent price path for copayments and a judgement about what a practice's enrolled population (and the wider market) will accept.

**Figure 2: Annual percentage change in capitation and reasonable fee increases**



**Source:** Davies (2014) *Annual statement of reasonable GP fee increases – 2014/15 update*

## 4.2 Provision for fee reviews

There is provision for practices that propose a higher increase in copayments to be referred to a Regional Fees Review Committee – for an independent assessment of their case for a higher rise in copayments, in light of the annual cap, the practice’s previous price path, and financial information about the sustainability and viability of the practice. The Committee may make a recommendation as to whether the proposed higher increase is reasonable.

It has been reported that the number of fee reviews has declined since the first years of the regulatory regime. Nationally, there were 19 reviews undertaken each year in 2011 and 2012 compared with 90 practices being referred for review in the first year of the regime. A number of reasons have been offered by stakeholders within the health sector as to why fewer fee reviews are being carried out, such as:

- practices being more likely to make small annual increases – prior to the introduction of regulation and fee reviews, not all practices would regularly alter their fees;
- practices have improved business process for managing growth in costs;
- changes in the way care is delivered – trends for care being delivered by nurses and for extended GP consultations may mean less emphasis on the standard consultation;
- DHBs being less likely to pursue a fee review – the costs involved and/or stronger links with primary care may mean agreements are reached outside the formal review process;
- less focus upon the standard consultation for which copayments are regulated, with multi-disciplinary consultations, or multi-modal consultations using electronic and other means increasingly a part of primary health care.<sup>4</sup>

<sup>4</sup> Topham-Kindley, Liane (2013) “Fees reviews down to a steady trickle” *New Zealand Doctor*, 13 February 2013

Conversely, there have also been recent reports of practices that had proposed an increase in copayments beyond the annual cap subsequently backing down, following a DHB decision to decline the increase and to refer the practices to a Fees Review Committee.<sup>5</sup>

### 4.3 Impacts of copayment regulation

The regulatory regime, as an annual percentage-based approach, ends to lock in the historical structure of copayments because practices have similar scope to raise copayments on a percentage basis. Table 3 shows that over the ten years to 2014/15 since statements of ‘reasonable fee’ increases were produced that the aggregate increase has been 38%.

The nominal dollar impact for practices with different copayment starting points is stark. A ‘low fee’ practice charging a \$25 copayment would have been able to increase that by a nominal amount of \$9.60 over ten years, whereas a ‘high fee’ practice charging \$50 copayment would have been able to increase by \$19.10.

**Table 3: Modelled growth in copayments over ten years of regulation**

Example practice	Base year copayment 2004/05	Year 10 copayment 2014/15	Aggregate increase (\$)	Aggregate increase (%)
‘Low fee’ with 50% capitation increase calculation	\$25.00	\$34.60	\$9.60	38%
‘High fee’ with 50% capitation increase calculation	\$50.00	\$69.10	\$19.10	38%

**Source:** Davies (2014); Sapere analysis

While the ratio of the fee for a high and low fee practice remains constant, since they are both increasing at the same rate, the absolute difference between them increases in nominal dollar terms. Whether this nominal increase matters depends upon income growth across the population.

In the long run, given economic growth and productivity increases, wages increase faster than inflation. This has generally been the normal economic state of affairs in developed countries for sixty years, with the exception of a number of short lived recessions. If this is true, then a nominal increase in the difference between low and high fee practices doesn’t matter, since they will both become cheaper in real terms for patients.

If incomes have not kept pace with inflation, then an increase in the dollar difference between high and low fee practices becomes a real increase for patients, rather than just a nominal increase. Overall, Statistics New Zealand data shows that average weekly earnings have increased by 41% from 2004 to 2014. Over the last decade, on average, incomes have increased by slightly more than the increase in practice fees, meaning that across the whole population the divergence in fee structure should not in principle be an issue.

<sup>5</sup> Olds, Jeremy (2013) “Seven practices abandon fee rise after DHB rejection” in *New Zealand Doctor*, 9 October 2013

However, this conclusion reflects an average. Where particular regions or subpopulations have had a slower increase in income, then the increase in practice fees becomes real, and the divergence between high and low practice fees begins to create a new differential in access.

Table 4 shows the considerable variation across New Zealand in terms of income growth over the past decade. The real impact of general practice copayments will have a highly variable impact for different parts of the country, and for different parts of the population, with varying experience of income growth over the past decade.

**Table 4: Average weekly earnings by region, 2004 to 2014**

Region	2004	2014	Increase
<b>New Zealand Total</b>	<b>\$552</b>	<b>\$780</b>	<b>41%</b>
Northland Region	\$463	\$664	43%
Auckland Region	\$626	\$805	29%
Waikato Region	\$540	\$718	33%
Bay of Plenty Region	\$489	\$701	43%
Gisborne/Hawkes Bay Regions	\$488	\$661	35%
Taranaki Region	\$498	\$797	60%
Manawatu-Wanganui Region	\$488	\$646	32%
Wellington Region	\$584	\$901	54%
Tasman/Nelson/Marlborough/West Coast Regions	\$504	\$733	45%
Canterbury Region	\$540	\$808	50%
Otago Region	\$459	\$799	74%
Southland Region	\$513	\$808	58%

**Source:** Statistic New Zealand NZ Stat Table Builder: <http://nzdotstat.stats.govt.nz/wbos/index.aspx>

Overall, copayment regulation as it is currently practiced has several important limitations:

- Copayment regulation is based upon maintaining real copayments on a national average basis, but significant parts of the country, and different sectors of the population, have seen income grow more slowly than copayments. For significant parts of the population copayment regulation has not succeeded in the goal of containing the real cost of access to general practice;
- To the extent that practice costs are determined by a national labour market for professional services, there is likely to be a mismatch with local variation in consumer incomes and ability to pay increased fees. Again, this undermines the effectiveness of copayment regulation in achieving its stated goal, and creates a dilemma for practices where costs are increasing faster than their ability to increase copayments;
- While fees reviews provide a safety valve from the point of view practices who can justify an increase in fees on the basis of costs, this can only work where practices operate in markets which can bear such fee increases. Practices serving high need/low income populations are likely to have the least ability to increase fee revenue under this mechanism, particularly in parts of the country which are facing lower income growth.

In general, the effectiveness of copayment regulation should be considered in terms of the costs and revenue of general practice, but also in terms of the real impact on the communities which the policy is intended to benefit. The current system for copayment regulation in general practice appears to be problematic both in terms of achieving its stated goal of containing copayment costs for consumers, as well as in terms of providing sustainable revenue to support stable general practice services. The problems in this regulatory regime appear to be greatest for communities with the lowest incomes, and for the practices which serve those communities.

The more fundamental issue of the current copayment regulation approach is that since the majority of practice cost growth is driven by national (and international) labour markets, but the real price to consumers is determined by local and sector based income effects, there is inevitably a mismatch between the two sides of the regulatory equation for a substantial part of the population. The clearest way to address this issue is to focus subsidy patterns and copayment rules more specifically upon individuals, families, and their particular economic circumstances.

## 5. Targeting low cost access

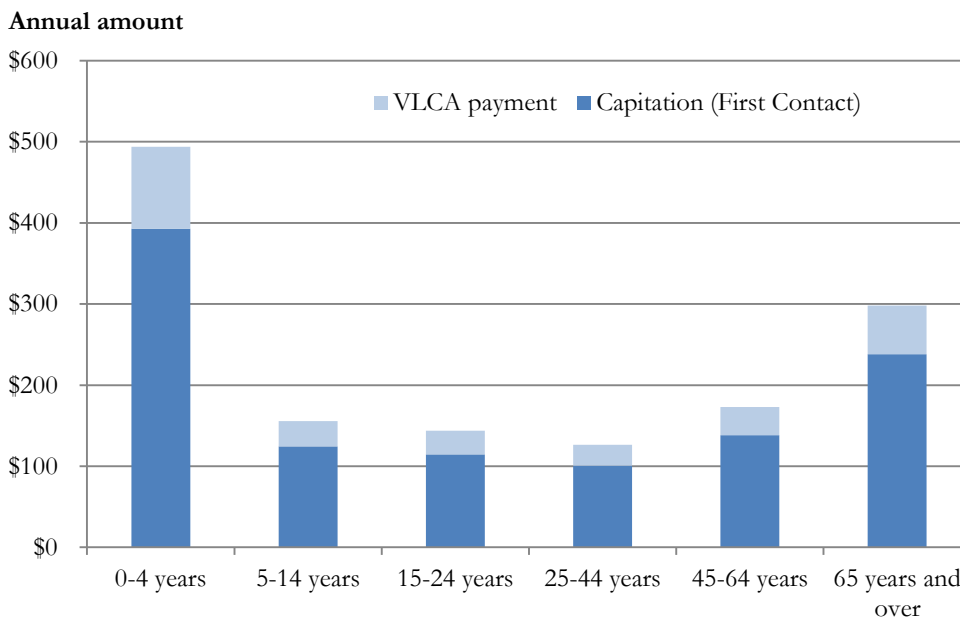
### 5.1 Very Low Cost Access

The VLCA scheme was introduced into the PHO Services Agreement via Compulsory Variation notice in 2006 with the aim of further reducing copayments to a capped level. Initially, any practice could choose to opt in and accept additional funding in return for capping copayments. The criterion that 50% of patients enrolled with a practice be “high needs” – defined as being Māori, Pacific or New Zealand Deprivation Index quintile 5 – was subsequently introduced in September 2009. The policy has the aims of “keeping fees low for the people who can least afford primary health care” and “improving health outcomes for those most likely to have the worst health”. It also refers to the extra funding as being “recognition of the extra effort involved in providing services to high need populations”.

The maximum allowable copayments apply to all enrolled patients at the practice and are set at zero for children aged under 6 years and capped at \$11.50 for patients aged 6-17 years and at \$17.50 for those aged 18 years and over. The annual VLCA payment is shown in context of First Contact capitation payments in Figure 3. VLCA funding generally represents an increase of 25% over base first contact funding.

In principle practices can opt on or off the scheme on voluntary basis, although whether a practice could realistically move off the scheme without alienating its patient population is open to question. As at April 2014, 294 general practices were participating in the VLCA scheme, representing 29% of practices. Enrolled patients in VLCA practices totalled 1.3 million people or 30% of the enrolled population.

**Figure 3: Annual VLCA payments and capitation by age group (female rates)**



**Source:** Data sourced from Ministry of Health [www.health.govt.nz](http://www.health.govt.nz); Sapere analysis

## 5.2 Equity of access considerations

Given that the aim of the VLCA scheme includes “keeping fees low for the people who can least afford primary health care” – it is worth considering the extent to which the policy delivers additional resources, in the form of lower fees, to the defined “high needs” population. As the subsidy applies to all patients enrolled at a qualifying practice, potentially up to 50% of the VLCA funding to a practice enables fee reductions for patients who are not in the defined “high needs” population.

While this funding may benefit those patients, in terms of reducing financial barriers to access, there are also likely to be large numbers of “high needs” population enrolled in the 70% practices that do not qualify for the VLCA scheme. These high needs patients could form up to 49% of a non-VLCA practice’s population. This raises the question around the equity of the policy.

Turning towards available data on the enrolled population, Table 5 shows that just over half (56%) of the high needs population was with a VLCA practice. Conversely, 44% of high needs population – approximately 563,000 people – were enrolled in a non-VLCA practice.

Furthermore, of the approximately 1.277 million patients enrolled in VLCA practices, 556,000 or 44% did not fit the definition of the policy’s “high needs” population. This number is similar to the 563,000 “high needs” patients who were enrolled in non-VLCA practices and therefore ineligible for additional funding to further reduce copayments.

This suggests that the same level of funding available for the VLCA policy could be sufficient – or close to sufficient – to provide reduced copayments to all “high needs” patients if the funds could be more accurately targeted to that population.

**Table 5: Enrolled high needs patients by practice type, 2012/13**

Practice	High needs patients	Proportion
VLCA practices	720,728	56%
Non-VLCA practices	563,145	44%
<b>Total</b>	<b>1,283,893</b>	<b>100%</b>

**Source:** Ministry of Health in Cameron (2013) “High-level group tackles Very Low Cost Access”

As noted above, the VLCA funding added to the capitation funding received by practices. It is also worth noting that when this funding was rolled out, the government initially created two funding streams: “Access” practices – those with 50% “high needs” population (i.e. Māori, Pacific or in New Zealand Deprivation Index quintile 5) – received the full subsidy for each age group whereas “Interim” practices received the funding progressively rolled out across age groups. However, in the case of “Interim” practice patients aged 5-14 years, the subsidy was rolled out at a level of 80% of “Access” practices. This has created a differential of \$23-\$26 per patient per annum, relative to those enrolled in former “Access” practices. This anomaly points to wider gap in funding for between high needs patients in VLCA practices and high needs patients in non-VLCA practices that were also “Interim” funded.



## 5.3 Equity among providers

Of the VLCA practices, only 60% (177 practices) had high needs populations of at least 50%, with the remaining 40% (116 practices) having less than 50%. This is because the threshold of 50% was established in October 2009, but was not applied retrospectively to practices that had previously entered the VLCA scheme from its inception in October 2006.

The policy may also have had unintended effects, such as working against the agglomeration of practices. One example, cited in the media, related to four West Auckland practices that merged into an IFHC in 2013. Whereas one large practice had received VLCA funding, the addition of the three other practices meant that the “high needs” population of the new IFHC population fell below 50%. This caused the practice to lose VLCA funding and forced it to double its planned copayment levels.<sup>6</sup> As a result, an adjustment was made to the PHO Services Agreement in 2014 to allow for replacement funding for such cases, in the form of Patient Access Subsidy Payment. Notably, the policy allows some flexibility for the practice to apply a higher subsidy to patients with the highest need – something of a departure from the VLCA approach of applying a higher subsidy across the enrolled population.<sup>7</sup>

Furthermore, there are questions over the sustainability of some VLCA practices. An in-depth study found that four out of the five VLCA practices reviewed were showing an operating deficit for the most recent financial year. Other findings from that study include:

- all five practices stated that there is a trade-off between patient charging and ensuring access to services (i.e. higher fees to support the business act as a barrier to access). The five practices stated that they prioritised access over patient charging;
- all five practices noted a trade-off between increased practice fees on the one hand, and reduced access and increased unpaid patient accounts on the other;
- four of the practices noted that there was a direct correlation between patient access to services and patient co-payments as higher co-payments led to fewer patients accessing services. These practices also noted that past increases in co-payments had resulted in a corresponding increase in patient debt.<sup>8</sup>

There may also be competition effects arising from applying the VLCA mechanism at the practice level. One example cited in the media has been in Whangarei, where:

*...two-thirds of practices get VLCA funding, creating a market that drives down fees at practices that do not have enough high-needs patients to make them eligible to join the scheme. Bush Road Medical Centre charges only \$33.50 per enrolled patient but has lost patients to neighbouring VLCA practices because of their lower fees Practice manager [ ] says the patient exodus has stopped but the practice has stopped growing. (New Zealand Doctor, 16 December 2009).*

While a more in depth study would be needed in order to verify such competition effects, it seems likely that applying the targeting mechanism at practice level can disturb the balance of market participation across individual general practices.

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<sup>6</sup> Olds, Jeremy (2013) “Very low cost visits despite ejection...” in *New Zealand Doctor*, 18 December 2013

<sup>7</sup> Taylor, Cliff (2014) “New VLCA-like subsidy for high needs patients” in *New Zealand Doctor*, 7 May 2014.

<sup>8</sup> Brown, Mary and Dr Brian Underwood (2013) *Very Low Cost Access Practice Case Studies: Summary Report for the PHO Services Agreement Amendment Protocol Group*, 21 August 2013

## 6. Full subsidy and some implications

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Full subsidisation of consultations for children under six years is in place under the Zero Fees for Under 6s scheme. The approach is similar to the VLCA scheme, where practices can choose to opt onto the scheme and receiving an additional amount of annual funding per child, in return for setting copayment to zero. Approximately 97% of practices have opted onto this scheme. The Government announced at Budget 2014 that this approach will be rolled out to all children under 13 years and it is not implausible that will be rolled out to other age groups in future. It is therefore worth considering the implications of this shift.

### 6.1 Incentive effects

Methods of payment tend to affect provider behaviours in different ways. Table 6 outlines a summary of the potential advantages and disadvantages, of capitation versus fee-for-service, in terms of the incentive effects – drawing on economic theory and evidence from the NHS. In reality these models are rarely implemented in a pure sense, and New Zealand’s partial copayment model incorporates some aspects of both full funded capitation and fee for service. Other incentives also exist which overlay the basic structure of First Contact Care funding, such as fee for service ACC payments, or payment for achieving targets.

It should be noted that in New Zealand’s mixed funding system - where capitation and fee for service approached co-exist, so the current state represents a balance of these advantages and disadvantages. But the New Zealand example also has a more specific factor affecting the balance of advantages and disadvantages, which is that the fee for service component derives largely from patient copayments, while the capitation payment derives from government subsidies. This modifies the underlying effect of incentives. Reducing copayments to zero has the impact of shifting the incentives and effects from the current state to those which are characteristic of the pure capitation model.

One of the things which Table 6 suggests is that many of the incentive effects of either payment system are quite context dependent. In areas where there is a vigorous competitive market in which practices compete for patients, then the classical incentive effects tend to apply. In areas where there is a less of a competitive market context, then incentive effects are muted, and in some cases even reversed.

The upshot of this is that in a higher income community with a larger number of GPs per head of population, the classic incentives are likely to be quite strong, as practices compete to serve patients who are able to exercise economic choice. In the case of a lower income and/or rural community with fewer GPs per head of population, where practices are less actively competing for patients and patients are less able to exercise economic choice, then the downsides of both capitation and fee for service funding mechanisms are both exacerbated. While it is clear that there is relatively little practice level competition for patients in sparsely populated rural communities, anecdotally it appears to be the case that a number of urban communities also have a low level of general practice on a population basis, and little competition to attract patients. This appears to be particularly, although not exclusively, the case in lower income communities.

**Table 6: Payment methods – advantages and disadvantages**

Payment method	Potential advantages	Potential disadvantages	New Zealand partial copayment context
Fee for service	<ul style="list-style-type: none"> <li>• Supports throughput and responsiveness (i.e. short or no waiting time for patients).</li> <li>• Supports quality and comprehensive care as the provider has no incentive to withhold or skimp on care.</li> <li>• Supports innovation that expands or changes the use of treatments and technologies already on the reimbursement list, which can be reimbursed quickly.</li> </ul>	<ul style="list-style-type: none"> <li>• Care may be short and episodic.</li> <li>• Potential for supplier-induced demand, leading to more care being undertaken and more resources consumed that would otherwise be the case.</li> <li>• Financial barriers can discourage patient use - dependent on subsidy or insurance regimes in place.</li> </ul>	<ul style="list-style-type: none"> <li>• Care may be short and episodic.</li> <li>• Less potential for supplier induced demand except in high income communities.</li> <li>• May limit demand for low value services, and reduce overall demand upon a constrained workforce.</li> <li>• Provides an incentive for providing quality and comprehensive care.</li> <li>• Financial barriers may discourage utilisation in high need communities.</li> </ul>
Capitation	<ul style="list-style-type: none"> <li>• Transaction costs are low.</li> <li>• Cost containment and financial control are strongly incentivised.</li> <li>• Where there is competition for patients, providers are incentivised to attract more patients as money follows the patient, which may in principle incentivise improved quality in dimensions of care that patients value and can observe.</li> </ul>	<ul style="list-style-type: none"> <li>• There is no economic incentive to provide additional or more costly services for patients enrolled, even when needed.</li> <li>• If there is no patient choice of provider, capitation funding provides no incentive for providers to be responsive to patients.</li> <li>• It can create an incentive for providers to discourage patient utilisation by being unresponsive.</li> <li>• If payments are not fully risk-adjusted, providers may avoid patients with high levels of need, or those whose needs are under-compensated for by the weighting formula.</li> </ul>	<ul style="list-style-type: none"> <li>• Provides greater certainty of revenue than pure fee for service.</li> <li>• Transactionally more straightforward than pure fee for service, although systems are now dated and in the process of redesign.</li> <li>• Issues with whether capitation has continued to be accurately risk adjusted as time has gone by.</li> <li>• In areas where there is little competition for patients, less incentive to be responsive.</li> </ul>

**Source:** Adapted from Marshall et al (2014) *The NHS payment system: evolving policy and emerging evidence*

## 6.2 Economic considerations

### 6.2.1 Impacts on practices

The widespread roll out of zero fees to other age groups would likely mean progressively less room to move for managing cost pressures through copayment increases. This is because practices will be relatively more reliant on policy-based increases of capitation funding (even if we assume a voluntary opt-on arrangement). This could create more pressure on the copayment regulation regime, with copayments for the remaining groups (i.e. those not on a zero fees scheme) rising faster as a safety valve as practices seek to manage their business in response to cost increases. This implies that when setting copayments for some population groups, the potential adverse consequences for copayments on other groups should be carefully analysed in light of future cost, inflation and copayment regulation scenarios.

A second practice-level impact of fully removing copayments would likely be an increase in demand. To some extent this is a deliberate act of policy, since the goal of reducing copayments is to remove barriers to accessing care for some patients. But if removing copayments increases the demand for services, then this in turn places increased demands upon the workforce, and greater cost pressures upon practices. Removing copayments therefore requires analysis of the price elasticity of demand for general practice, and is likely to require increased state subsidy to reflect not merely the lower patient contribution to practice revenue, but also the likely increased level of patient demand upon the existing service. Given the considerable workforce constraints under which much of primary care operates, this is a major issue for implementing reduced copayment schemes.

A third practice level impact of zero copayment subsidies, as implemented in New Zealand, is that applying zero fee rules to contracted after hours providers can have the effect of penalizing practices which extend their own after hours services. This can work against the priority of increasing focus on continuity of care.

### 6.2.2 Societal impacts

At a high level the societal impact of removing copayments can be considered under the broad distributive justice goals discussed in Section 2 of this paper. Clearly, there are some people in society who do not access primary health care services when they would derive benefit, and arguably, it is a role of the state to help make services available to such people. Removing copayment barriers is one way of doing this, although it should be noted that copayments, while very important, are not the only barriers to accessing primary health care.

Given that society has a legitimate interest in reducing or removing copayments for at least some people in the population, the question then becomes whether it is better to apply this policy broadly across whole population (a more universal approach), or narrowly across specific individuals and communities (a more targeted approach). There are no absolutes—there are a wide range of possible stances between a purely universal approach and a purely individually targeted approach. The current New Zealand policy settings are oriented towards the universal end of the spectrum, but fall considerably short of purist universalism.

There are at least four key elements of societal impact which play out differently across the spectrum from universalism to targeted subsidies. We consider these in turn, overleaf.

1. *Efficient use of resources.* A universal zero copayment approach will inevitably result in some level of subsidy for individuals who would have been willing to pay for the service anyway. In classical welfare economic terms this represents an inefficient use of state health resources, usually represented technically by a deadweight multiplier for expenditure made by the state rather than by individuals. This inefficiency should be compared with the inefficiencies in implementation which can arise from information asymmetries, transaction costs and abatement effects of narrowly targeted subsidy regimes, which are always imperfect. On efficiency grounds, whether a particular age group of patients should receive enough subsidy to enable universal zero copayments should depend upon a) how much that group are able to pay for the service anyway, and b) pragmatically how easy it is to distinguish those able to pay from those who are not, and therefore implement an efficient targeting regime.
2. *Existing level of unmet need.* To what extent is there a general problem of access to primary care services for that population, in which people are not accessing care they could benefit from, or are enduring economic hardship as a consequence of accessing health services? If that existing level of unmet need is highly prevalent, then a universalist approach to zero copayments may be a pragmatic and reasonable response. If the existing level of unmet need is highly variable, then a more targeted approach may be appropriate.
3. *Where do diminishing returns become important?* This is a related point, but in terms of the value derived from subsidising access to a health service, increased levels of access may bring greater average benefits, but decreasing benefits per additional dollar spent. The overall target level of service desired for a given population is always difficult to identify, since it depends upon so many non-measurable factors, but it should be borne in mind that more is not always better. Many health care activities can cause harm, or at the very least inconvenience, and some view on the point at which more care is not better is an important part of the debate about appropriate levels of access.
4. *Is universalism a value in itself?* For some people the answer to this is clearly yes, while for others it is clearly no. This is ultimately a value judgement, based upon considerations such as whether it is important for all citizens to receive benefit from government services, or whether individuals should expect state support only for costs outside their personal control.

## 7. Trade-offs in the targeting of primary care funding

### 7.1 Approaches to targeting resources

The current primary care funding system targets additional resources to patients with relatively higher health needs in several ways:

- at the **practice-level** – e.g. VLCA provides for lower copayments at practices where 50% of enrolled patients meet the definition of high needs population (i.e. NZDep quintile 5, Māori and Pacific);
- at the **patient group-level** – e.g. Zero Fees for Under 6s targets groups of patients on the basis of age, regardless of health need or ability to pay;
- at the **individual patient-level** – e.g. High Use Health Card (HUHC) provides for a higher government subsidy for patients visiting their practice for 12 or more times within a year, with the visits being related to a particular ongoing condition (the funding being designed to allow more time for developing management plans).

These approaches to targeting higher health can be broadly categorised as targeting the provider or targeting the patient. The pros and cons to each approach are explored in a simple framework outlined in Table 7. This assessment suggests that it would be more efficient to target patients (groups or individual patients) – than to target at the practice level.

**Table 7: Targeting health need – framework for considering trade-offs of approaches**

Dimensions of impact	Target at provider level	Target individual patients
Administration costs	Low cost to administer as practices with large numbers of high needs patient can be identified and funded ex ante.	Higher costs incurred to identify individuals with high health needs and to ensure funding follows the patient.
Economic incentives	Patients may follow subsidies and join practices with lower fees.	No incentive for patients to shop around for a higher subsidy.
Efficiency	May be high ‘deadweight loss’ as subsidy is made available to patients who may not be high need, and who may have been willing to pay a standard non-VLCA high copayment anyway.	More efficient as the higher subsidy only goes to patients who fit the criteria of being high need.
Patient access	High need patients who are not enrolled in a VLCA practice (e.g. a lack of choice or information) may miss lower copayments, whereas non-high needs patients will benefit from reduced financial barriers to access.	Reduced copayments improve access for high need patients. The switch to targeting patients means copayments for non-high needs patient in VLCA practices would be higher than currently.

## 7.2 Rationale for improved targeting

The rationale to improve targeting rests on (1) evidence that current VLCA subsidies are poorly targeted relative to the aim of supporting the high need population; (2) evidence that consultation rates continue to be lower in areas of higher health need (as per evaluation of the PHCS by Victoria University), and (3) pressures on the public financing of health care.

The Treasury, in its advice to the Minister of Finance ahead of Budget 2012, considered that there is a case for increased targeting of copayment subsidies based on health and financial need.<sup>9</sup> The Treasury approached this issue from the perspective of there being a limited amount of new money available for funding health care and viewed increased targeting as a way to help protect the disadvantaged – presumably in a world where limited funding leads all copayments to rise faster than would otherwise be the case (as practices manage their business in response to cost growth).

The Treasury has suggested that primary health care subsidies could be targeted at:

- low income and high-risk people to enable them to use more health care than they would otherwise; and
- health services with high marginal benefit which may otherwise be under-used (these were not defined).

These are broad and unspecific strategic directions proposed by Treasury, and it should be noted that they would require considerable work in order to translate into operationally useful definitions of which patient groups and services should be prioritised for targeting. Moreover, as has been seen, much depends upon the practical effectiveness of a targeting regime in the implementation. In some circumstances a complex or ineffective targeting regime may be less efficient than a more universal approach. This means that positions on targeting have to be derived both from principled stances on the effective use of resources, but also pragmatic analysis of the effectiveness of targeting options.

## 7.3 Options for targeting high need patients

At a high level, Table 8 sets out a number of potential targeting mechanisms, with our initial view of some of the pros and cons for each. This is intended to support further discussions, rather than to be a definitive analysis.

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<sup>9</sup> The Treasury (2011) “Improving the targeting of copayments in primary care” Treasury Report T2011/2570 <http://www.treasury.govt.nz/publications/informationreleases/budget/2012/pdfs/b12-2220502.pdf>

**Table 8: Potential targeting mechanisms**

Mechanism	Pros	Cons	Notes
Demographic characteristics: age	<ul style="list-style-type: none"> <li>• Simple, verifiable, administratively straightforward</li> <li>• Transparent to the public.</li> </ul>	<ul style="list-style-type: none"> <li>• Considerable variation within each age group in terms of pre-existing ability to pay, and levels of need.</li> </ul>	<ul style="list-style-type: none"> <li>• These issues play out differently for different age groups.</li> <li>• Children and adolescents generally have little or no financial independence, sometimes need to seek health services independently from their family, and especially among the very young, face a high burden of frequent contact with health services. In these respects existing ability to pay and level of need are relatively clear for the age group as a whole, and there is a relatively strong case for a universal approach.</li> <li>• By contrast, while the elderly also face a high burden of contact with health services, financial autonomy and ability to pay is highly variable. The case for a universal approach is much more complex.</li> </ul>
Working For Families	<ul style="list-style-type: none"> <li>• A pre-existing mechanism for identifying families for financial support.</li> <li>• May not require new infrastructure for identifying people to be supported.</li> </ul>	<ul style="list-style-type: none"> <li>• Doesn't cover beneficiary families.</li> <li>• Doesn't cover people with low incomes but no children.</li> </ul>	<ul style="list-style-type: none"> <li>• It is possible that WFF could be a component of a targeting regime. It would work well for some groups, but its current narrow scope means that it would have to be one of a number of different targeting mechanisms. This has considerable potential for complexity and fragmentation of targeting.</li> </ul>
Community Services Card	<ul style="list-style-type: none"> <li>• Relatively simple income and family size criteria.</li> <li>• Administrative infrastructure still exists.</li> </ul>	<ul style="list-style-type: none"> <li>• A binary status of having or not having a CSC means that it suffers to a high degree from the issues of abatement at the threshold, and arbitrary treatment of people in similar circumstances.</li> </ul>	<ul style="list-style-type: none"> <li>• This approach has the merit of simplicity, and may bring some efficiency gains, but it is still relatively crude and raises some of the issues which come with narrow targeting, as people with similar circumstances are treated differently either side of the targeting threshold.</li> </ul>



Mechanism	Pros	Cons	Notes
Individual recommendation by general practice	<ul style="list-style-type: none"> <li>• Very fine grained individual assessment.</li> <li>• Could apply on a whanau basis as well as to individuals.</li> </ul>	<ul style="list-style-type: none"> <li>• Difficult to ensure consistency and fairness across practices;</li> <li>• Moderating practice variation for equity is likely to be bureaucratic and intrusive;</li> <li>• Clinicians may be reluctant to make a decision that potentially adversely affects patient-clinician relationships.</li> </ul>	<ul style="list-style-type: none"> <li>• This option may have some utility for specific, focused aspects of care (eg. the original proposal for Care Plus was to allow practices to determine which patients should receive the benefit of that additional funding), but this is unlikely ever to be a preferred approach for primary care funding as a whole.</li> </ul>

## 7.4 Other considerations

The debate about targeting primary care funding in New Zealand has historically focused upon identifying which patients should benefit from subsidies. But there is another lens which can be used to think about differential funding, which is the type of service, rather than just the type of patient. It may be in the wider interests to subsidise certain kinds of primary care activity at a higher level, or to remove copayment barriers for some kinds of care preferentially. In particular, this could apply to services which are likely to prevent future secondary care utilisation.

To some extent this approach already takes place on an ad hoc basis across the country, as some DHBs pay for free additional services in primary care, seeing this as an investment to help manage acute demand for secondary services. This can be seen within a wider strategic context of shifting use of and need for health resources from acute care, to planned care. There may be scope to broaden the wider debate about subsidy and copayments, and characterize broad classes of care as appropriate for partial or full subsidy. This approach starts to introduce a different perspective to the targeting discussion, and necessarily moves the debate into a more nuanced view of what services are right for which patients, rather than a discussion about who should or should not receive support for accessing health services in general.

This issue should also be considered in the context of a shift in the nature of primary care services, as models of care evolve and there is a greater focus upon general practice as the source of continuity within a wider team of health professionals, and less focus upon subsidy for a single face to face consultation event.

## 8. Concluding remarks

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### 8.1 Limitations and further issues to explore

This analysis has some limitations due to time and data constraints; we noted these here as potentially areas for further exploration in future.

- The empirical analysis of copayments is based on a single year of data (2013/14). While this is a useful snapshot of the distribution of copayments in that year, it does not allow an estimation of the average increase in copayments over time. Obtaining another year of copayment data would allow an examination of how copayments change, on average, relative to the regulated annual increase.
- The copayment data is not weighted for the enrolled population at each practice. Being able to link the practices to a summary of patient enrolments (anonymised and aggregated) and their characteristics would improve the accuracy of our estimation of high needs population groups that pay different fee levels.
- It is possible to reproduce an estimate of the proportion of high need populations enrolled in non-VLCA practices (using an approximate meshblock-based method in the absence of linked practice registers) and estimate the proportion of those high-need patients that face low, medium and high copayments in non-VLCA practices.

### 8.2 Conclusions

At a high level, the questions of subsidy, copayment regulation and targeting are determined by matters of principle which depend upon the particular stance of those involved in the debate. But notwithstanding this, there are distinct patterns and frameworks which can help to shape the issues which lie underneath these problems. The first issue is to be clear about why subsidy or redistribution of resources is important in the first place, and what you want to achieve by it. Whether this is motivated by egalitarian or by economic considerations then sets some of the parameters for how you decide upon the balance between universalism and targeting, and your views upon what constitutes a good targeting mechanism. Moreover, whatever the principled position on targeting, much is determined by the realities of the mechanisms available, and how effective they are in practice.

Our analysis of copayments in general practice, and of the current copayment regulation regime, suggests that there is an increasing problem with the existing general practice funding model. The effectiveness of copayment regulation in containing the real cost of general practice consultations is, at best, highly variable across the population and it appears to place the greatest burden of managing cost increases upon those general practices which serve the highest need populations. On these criteria, the copayment regulation scheme does not achieve the goals for which it was designed.

Beyond the wider copayment regulation issue, the mechanism of targeting high need funding at the level of practice rather than patient has resulted in poor targeting, with higher levels of government subsidy supporting a large number of patients from higher income groups, and not supporting approximately half of the currently defined high need population it is intended to benefit.

Reducing copayments to a level of zero is subject to complex considerations about how the benefit from zero copayment works out for different population groups. Our view is that this issue should also be considered in the context of different types of services, rather than for primary care as an undifferentiated whole.

Two more general issues have been relatively silent in this discussion, but must be kept in mind. One is the continuing move towards service integration around patients, and ensuring that funding models and copayment regimes are the lowest realistically feasible barrier to improved integration. The second issue is the ongoing workforce constraint in primary care. Workforce constraints represent both a direct cost pressure for primary care, as well as a potential loss arising from lack of competition, particularly in high need populations.

Finally, it is worth considering that funding models and copayment regulations operate on a national basis, while important aspects of access to care and the effective functioning of services are locally determined, depending upon local populations and economic factors, as well as historical configurations of services in primary care and more widely. Matching national policy settings to local circumstances is a very difficult problem, and there may, at a strategic level, be some merit in considering local aspects to the issue of funding and copayment regulation in primary care.



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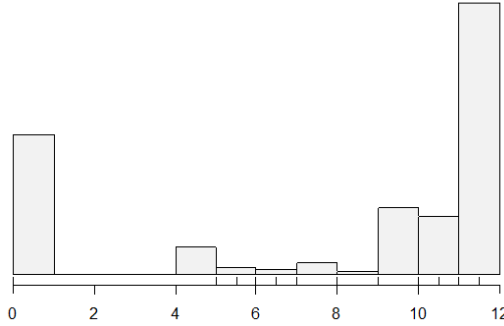
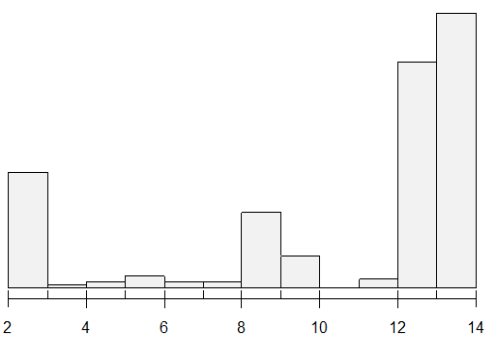
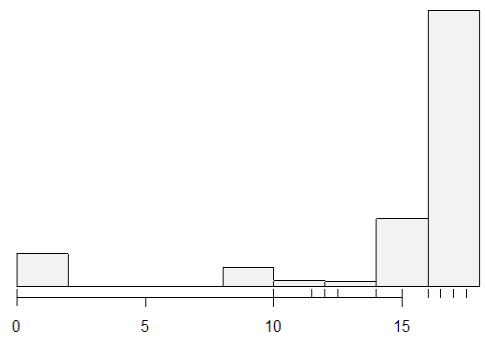
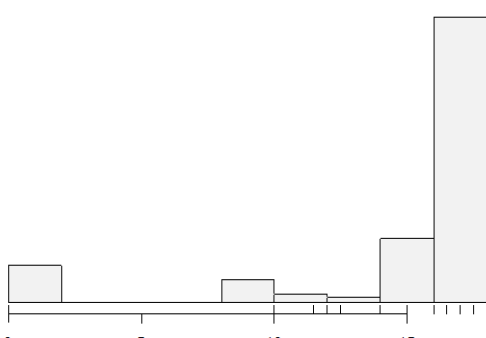
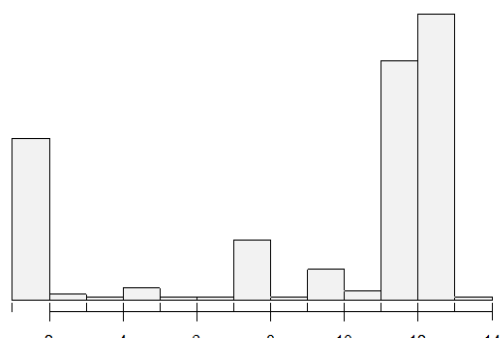
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# Appendix 1: VLCA copayments

<p><b>Under 6 years</b></p> <p><i>No distribution</i></p> <p>Mean: \$0 Standard deviation: \$0</p>	<p><b>6-17 years</b></p>  <p>Mean: \$8.10 Standard deviation: \$4.80</p>
<p><b>18-24 years</b></p>  <p>Mean: \$10.90 Standard deviation: \$4.20</p>	<p><b>25-44 years</b></p>  <p>Mean: \$15.10 Standard deviation: \$4.80</p>
<p><b>45-64 years</b></p>  <p>Mean: \$14.90 Standard deviation: \$5.00</p>	<p><b>65 years and over</b></p>  <p>Mean: \$9.70 Standard deviation: \$4.50</p>

**Source:** Copayment data set provided by GPNZ; Sapere analysis