Why We'll All Pay For the Doctors' Strike and the Waiting List Cull at the GP's Surgery

Bronwyn Howell, June 19 2006

A fundamental tactic employed by District Health Boards (DHBs) in recent weeks in order to meet demand that they are unable or unwilling to cater for has been to refer their unsatisfied clients back to general practitioners (GPs) for treatment. This tactic has been invoked both as an emergency management tool in response to situations outside of their control, such as the junior doctors' strike[i], and as a strategic response when removing all patients unable to be seen within six months from the hospital waiting lists[ii]. Such actions impose additional direct costs upon individual patients, who must make out-of-pocket payments to GPs when these primary providers must supply consultations that, if provided by DHB personnel would be at no cost to the patient, not to mention the additional inconvenience for 'waiting list rejects' of having to endure for longer than anticipated the consequences of the condition that necessitated addition to the waiting list in the first place.

However, there is an additional, hidden, cost of the policy. Shifting demand from the tertiary sector to the primary sector will impose additional costs upon all consumers of primary care. As a consequence of changes in 2002 to the way in which primary care is subsidised by the government, it is inevitable that the long-run effect of DHBs shifting the costs of their unmet demand into the primary sector will be increases in the charges GPs levy to all patients when they make a visit to the surgery.

The 2002 change, implemented as part of the New Zealand Primary Health Care Strategy (NZPHCS), resulted in GPs being paid by capitation, rather than the historic fee-for-service system[iii]. Under fee-for-service, GPs received a fee for every eligible patient visit. Together, the government subsidy and the patient payment covered costs. The more of their patients falling sick and seeking appointments, the more fees they received, and the higher their incomes (net of costs). Under capitation, however, they are paid a fixed fee by the Government for all patients 'on the books', irrespective of the number of those patients seeking appointments in a given time period, and the number of visits per patient. Government primary health care payments are no longer treatment subsidies paid in respect of ill individuals, but universal 'insurance premiums' paid in respect of well individuals in order to ascertain access to care at less than cost if and when the individual might require it[iv]. When the capitated patient seeks treatment, a 'top up' fee is paid to the GP. However, this payment

will vary between GPs, even for patients of identical capitation class, dependent upon the number of visits made by all patients on that GP's books. The GP is now an insurer, underwriting variation in patient demand for services, as well as a provider of primary health care services. Patients of GPs with 'sicker than average' populations will pay higher fees, just as the customers of insurance companies whose policy-holders make more claims pay higher premiums[v].

The NZPHCS rationale is that the financial incentives will encourage GPs to engage in more preventative health care and more efficacious treatments, thereby reducing the numbers of visits made by sick people, and GPs' costs. However, the policy also exposes GPs to costs arising from factors that they are powerless to address via clinical practices. As insurers, they are exposed to the financial risks of statistical variation in the distribution of patients of varying health demands amongst practices. GPs incomes are no longer determined principally by the amount of effort (that is, the number of consultations provided), but by other factors such as how healthy the patients 'on the books' are, and the propensity of these patients to seek substantially more consultations for minor ailments more amenable to cheaper treatments (e.g. over-the-counter pharmaceuticals) as the out-of-pocket cost of visiting the doctor declines with increases in government capitation payments (increased consumption by the 'worried well'). For the first time in New Zealand, GPs now face an incentive to 'cream-skim' by declining to take 'onto the books' those patients they know will be higher than average consumers. These patients bring with them higher costs, but only the same amount of government payments as patients who are lower-than-average consumers costing the GP less to serve.

Furthermore, the higher the capitation subsidy paid (e.g. for 'high-priority' individuals aged under 18 and over 65) and the greater the proportion of these higher-capitated patients 'on the books', the greater the financial cost to the GP from being 'unlucky' enough to have a patient list with higher-than-average demand. Associated losses will be exacerbated by the presence of price controls constraining the amount that can be charged to patients to recoup the additional costs, partially explaining GPs' recent vehement opposition to moves by DHBs to regulate patient charges in conjunction with an increase in capitation payments for individuals aged 45-64 years[vi]. 'Unlucky' high-cost GPs prevented by price regulations from recouping costs via patient charges must either reduce the quality of care provided (e.g. shorter consultations), or redress the patient demand imbalance by engaging in more vigorous cream-skimming. Conversely, the rewards for successful cream-skimming increase the higher the proportion of income the GP derives from capitation. Not only do the 'lucky', low-cost cream-skimmers earn more income from capitation, if they can also increase their fees in line

with those charged by the 'unlucky' GPs, they can earn even higher incomes for exerting less effort.

The degree to which the change to capitation payments exposes GP incomes to factors entirely outside of their control (at least in respect of the amount of health care provided) is illustrated by junior doctors' strike and the waiting list cull. The policy has resulted in an 'uncontrollable' increase in demand for GPs' services[vii]. Under the fee-for-service payment policy, GPs would have been indifferent to the effects of either of these policies as full remuneration would have been received for each additional visit made, from a combination of government subsidy and patient payment. Under capitation, however, GPs must incur the additional costs of providing consultations that they would not have been required to make, had hospital treatment been provided, yet they receive no additional government funding for these additional consultations. Moreover, under the pass-through agreements under the NZPHCS, they must charge the respective patients the 'subsidised' patient charge for the relevant capitation class – which will by necessity be less than the full costs incurred.

As higher-capitated populations (the young and the elderly) are disproportionately represented in hospital waiting lists, and those on the lists are already proven to be ill and needing care, yet make the lowest patient payments, the costs to GPs of the waiting list policy in particular will likely be substantial. The additional costs are most likely to be incurred predominantly in respect of the patient groups paying the lowest out-of-pocket fees. In order to recoup the additional costs imposed by the DHB policies, GPs will be forced to raise their out-of-pocket charges to all patients in all capitation categories. The only other alternatives to manage the deficit are the unpalatable ones of lowering the quality of service provided to all patients, or 'cream-skimming' by refusing to take responsibility for those aspects of care for which the patients have been referred by the DHBs.

Assuming that GPs' ethical obligations make it unlikely that patients will be refused treatment, the costs of increased demand for GP services as a consequence of the DHB policies will be higher out-of-pocket charges for all primary care patients. The additional cost burden will be highest on the patients of those GPs who have more patients, or a higher proportion of higher-capitated patients, referred back. Whereas under fee-for-service, the additional costs would have been met by all taxpayers in proportion with their income, under the NZPHCS, the additional costs are disproportionately borne by sick individuals seeking GP services, because only those falling sick and seeking GP services will pay the extra costs via their out-of-pocket primary care payments. Healthy individuals who do not need to see a GP pay none of the additional costs of the waiting list and doctors' strike policies. In effect, the

additional costs become a 'tax' on falling sick – the more times an individual visits a GP and makes an out-of-pocket payment, the greater the contribution towards the deficit induced by the DHB referral policies.

This appears to be neither a fair nor equitable way of allocating what is essentially a political cost associated with the management of waiting lists and employment disputes.

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[i] See, for example, Full Backup Pledged During Doctors' Strike
http://www.scoop.co.nz/stories/PO0606/S00127.htm

[ii] See, for example, Hospitals Turn Away 9000 cases
http://www.stuff.co.nz/stuff/0,2106,3597538a7144,00.html and
http://www.scoop.co.nz/stories/PA0606/S00003.htm

[iii] The policy is enumerated in Minister of Health. 2001. *The Primary Healthcare Strategy* (available online at www.moh.govt.nz; search under document name).

[iv] The 'premiums' vary according to a complex set of criteria determined by patient (age, gender, family income, past health care consumption) and practice (proportion of registered patients declaring Maori or Pacific Island ethnicity or residing in areas denoted as Decile 9 or 10 in the NZ Deprivation Index) characteristics.

[v] For a fuller discussion on the themes in this piece, see Howell, Bronwyn. 2005. Restructuring Primary Health Care Markets in New Zealand: from Welfare Benefits to Insurance Markets. *Australia and New Zealand Health Policy* 2:20, 2005. http://www.anzhealthpolicy.com/content/2/1/20 and
Howell, Bronwyn. 2005. *Restructuring Primary Healthcare Markets in New Zealand: Financial Risk, Competition, Innovation and Governance Implications.* New Zealand: Institute for the Study of Competition and Regulation. Wellington (available online at http://www.iscr.org.nz/documents/primaryhealthcaremarkets.pdf)

[vi] See, for example, GP Leaders' Forum. 2006. Auckland GP meeting told to reject govt plan.
http://scoop.co.nz/stories/GE0605/S00162.htm

[vii] That is, no amount of GP effort (aside from political lobbying) will alter the number of additional visits that will arise from the policies. This is in contrast to the effect that might (legitimately) be expected under the fiscal incentives of the NZPHCS that some level of GP effort applied to preventative treatments (e.g. vaccinations) and education will (to some extent) reduce that GP's future demand and hence raise profitability.