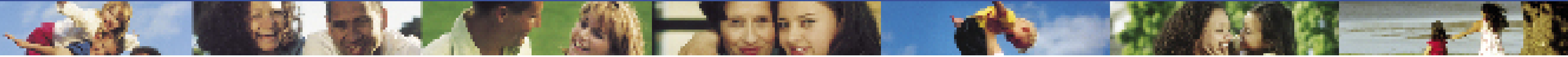
Government funding of primary care - impact on health insurance

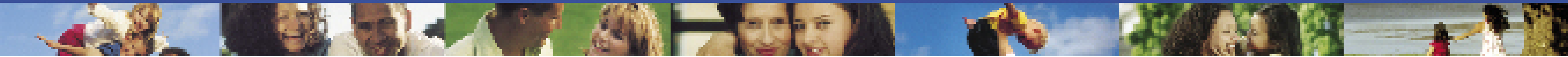
NZSA Conference - Nov 2004

Introduction



- What is primary health care?
- How has government funding changed in NZ? And what future changes have been announced?
- Impact on co-payments
- Health insurance impact on claims
- Unanswered questions

What is primary health care?



- First point of contact of health system
- Basic clinical services
- Available to all

Primary health care

- Eg GP (general practitioner), nurse, pharmacy, laboratory.
- This paper on GP and pharmacy.
  - Government funding of both these is changing significantly.

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Government health strategy

- Primary health care strategy launched early 2001. Priority area for government (in recent years a large proportion of increased government health spending).
- Improve health of NZers.
- Reduce inequalities in health.
- Delivery through PHOs (Primary Healthcare Organisation).

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PHOs

- Voluntary for GPs and other providers to join/establish (but financial incentive to do so)
- Funded by local DHB
- Specific (extra) funding for services to improve access and health promotion
- First established July 2002, by October 2004 3.7million NZers enrolled

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PHO funding

- 2 types
- Access - higher level of government funding
- Interim - initially intended neutral but increase to Access funding levels over time

Access PHOs

- High deprivation (low socioeconomic status) and/or high proportion Maori/Pacific Islander
- Eg Northland, Rotorua/Taupo, Gisborne, parts of Manukau City
- Condition of higher funding is must agree a low/no co-payment with DHB

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Interim PHOs

- Can have individual practices funded on Access basis (where the practice qualifies but PHO as a whole does not)
- Most of NZ now covered except Palmerston North
- Condition of higher funding (when provided) is must agree a low/no co-payment with DHB

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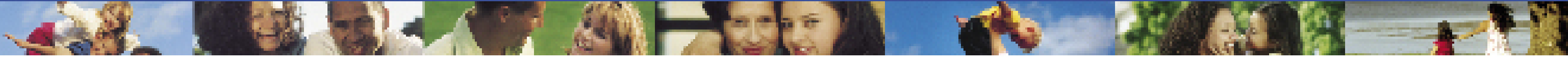
PHOs



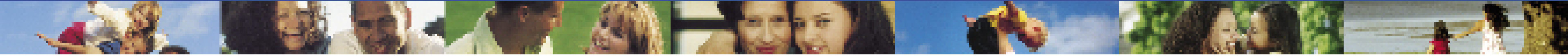
Roll Out of PHOs

4,000,000
3,500,000
3,000,000
2,500,000
2,000,000
1,500,000
1,000,000
500,000
0

Jul-02 Oct-02 Jan-03 Apr-03 Jul-03 Oct-03 Jan-04 Apr-04 Jul-04 Oct-04

Access | Interim with access | Interim

PHO funding



- Capitated ($ per person per annum)
- Rating factors
  - Access/Interim
  - Age, Gender, Deprivation, Ethnicity, High Use, Community Services Card
- First access, service to improve access, health promotion
- Annual CPI adjustment

PHO capitation - first access

- Based on FFS (fee for service) equivalent - rates as at July 04 CPI

	Access	Interim						Not PHO
		02/03	Oct-03	Jul-04	Jul-05	Jul-06	Jul-07	
0-5	$ 36.44	$ 36.44	$ 36.44	$ 36.44	$ 36.44	$ 36.44	$ 36.44	$ 35.00
6-17	$ 26.03	$ 15.62	$ 26.03	$ 26.03	$ 26.03	$ 26.03	$ 26.03	$ 15.00
18-24	$ 26.03	$ -	$ -	$ -	$ 26.03	$ 26.03	$ 26.03	$ -
25-44	$ 26.03	$ -	$ -	$ -	$ -	$ -	$ 26.03	$ -
45-64	$ 26.03	$ -	$ -	$ -	$ -	$ 26.03	$ 26.03	$ -
65+	$ 26.03	$ -	$ -	$ 26.03	$ 26.03	$ 26.03	$ 26.03	$ -

- Extra for High Use and Community Services cards

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More on capitation

- Capitated rate = FFS equivalent times assumed utilisation
- Utilisation varies according to the rating factors
- Access formula has higher utilisation - allows for both actual higher use as well as "unmet" need

Care Plus

- Additional funding for those with high health needs (defined criteria)
- Extra brings total to level of funding for high use card holders
- Based on expected numbers
- Phased in based on enrolments in Care Plus

Prescriptions

- Similarly increases in government funding for prescriptions.
- Amounts are expressed as maximum co-payment for fully subsidised drugs (subsidy varies based on drug cost but maximum co-payments are fixed)
- Part (or non)-subsidised drugs may have larger co-payments

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Prescription co-payment

- Rates as at July 04

	Access	Interim						Not PHO
		02/03	Oct-03	Jul-04	Jul-05	Jul-06	Jul-07	
0-5	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6-17	$ 3.00	$ 10.00	$ 3.00	$ 3.00	$ 3.00	$ 3.00	$ 3.00	$ 10.00
18-24	$ 3.00	$ 15.00	$ 15.00	$ 15.00	$ 3.00	$ 3.00	$ 3.00	$ 15.00
25-44	$ 3.00	$ 15.00	$ 15.00	$ 15.00	$ 15.00	$ 15.00	$ 3.00	$ 15.00
45-64	$ 3.00	$ 15.00	$ 15.00	$ 15.00	$ 15.00	$ 3.00	$ 3.00	$ 15.00
65+	$ 3.00	$ 15.00	$ 15.00	$ 3.00	$ 3.00	$ 3.00	$ 3.00	$ 15.00

- Less for High Use, Community Services and Pharmacy Subsidy cards

Impact on GP co-payments

- Survey average co-payment
  - Access PHOs adults $14 & $17 (CSC and non-CSC respectively), 6-17 $8, 0-5 $1
  - Interim PHOs over 65s (non-CSC) $48 pre July 04 & $25 post
- Higher co-payments at Interim PHOs for over 65s even though same funding
- Higher for after hours & casual visits

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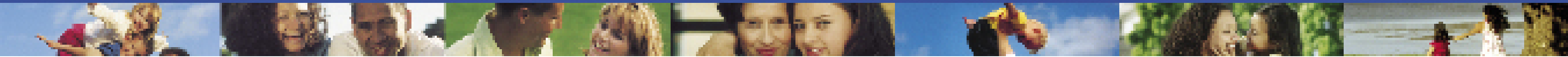
Impact on co-payments

- So GP co-payments reduced as funding rolled out, but still significant for most.
- Pharmacy co-payment reduced to token amount (for fully subsidised drugs) as funding rolled out.

Impact on health insurance claims



- Consider 3 groups of people
  - no health insurance
  - major medical cover
  - comprehensive cover (ie includes primary)
- Consider effects on
  - primary utilisation and co-payment
  - flow on effects for surgical treatment

Primary health care utilisation

- NZMA paper (Robinson) estimated overall 28% increase (varies by age & health status), based on US RAND study & assuming no co-payment
- MoH assumed 6% increase when setting capitation rates for over 65s
  - many over 65s are CSC and HUHC card holders with already low co-payments

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Primary utilisation continued

- But limited supply of GPs (in many areas) so may ration a potential higher workload by increasing charges
- Lower co-payment not relevant for insureds with comprehensive cover
- => little effect on number of GP visits claimed under insurance policy

Primary co-payment continued

- Reduces cost of insurance claims (for primary care) as funding rolls out
- Initially minimal effect as very few insureds with comprehensive cover are in Access PHOs

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Primary health care co-payment

- The recent change for under 18 and over 65s at Interim PHOs has modest effect due to utilisation rates and also CSC & HUHC cards (low co-payment previously for many)
- The changes over next 3 years will have bigger effect on insurance claims
- Doesn’t reduce cost of after hours claims

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Surgical utilisation

- US RAND study also showed that lower co-payments for GP visits increases surgical utilisation by 20% of the increase in GP visits
- Presumably this is effect on referrals
- Longer term impacts due to detecting health problems earlier and hopefully improved health status

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Earlier surgical treatment

- Less acute => more likely private
- Easier to treat => cheaper
- But chronic conditions treated longer => more expensive

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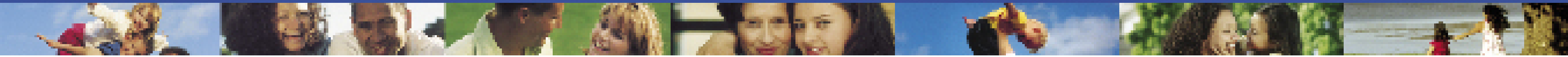
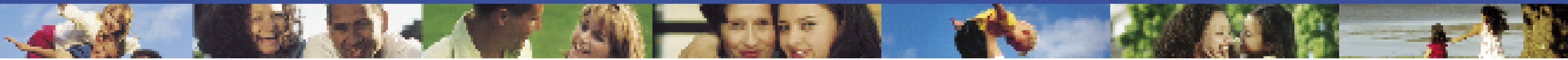
Improved health status



- Should reduce health care costs, but only in the long term (decades?)
- More impact on uninsureds and those who can't afford private surgery

Effect on insurance - summary



	Currently with no Health Insurance	Comprehensive Policy	Major Medical Policy
Primary			
Co-payment	Reduced	No change	Reduced
Utilisation	Increase	No change	Increase
Secondary			
Acute	Reduce	No change	Reduce
Non-acute	Increase	No change	Small increase
Insurance			
Cover	Easier sell of Major Medical Insurance	Reduce	Same or increase
Claims	N/A	Unknown	Increase

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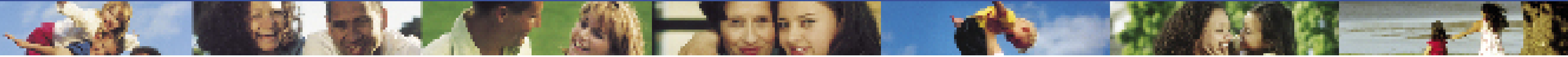
Some questions

- How will GPs cope with more demand?
- Will MoH respond to discrepancy in co-payments for Interim PHOs?
- Will public sector become (more explicitly) provider of preventative and acute care, leaving “elective” for private?
- What will happen to public-private balance - short term and longer term?

More questions



- Are the effects enough to offset other factors? Eg
  - new technology, increased life expectancy
- Is health insurance more important in future?