



The Sustainability of
**Very High-Needs
Primary Care Practices
in a Capitated Environment**

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Web Edition

National
Hauora Coalition



National
Hauora Coalition



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This report was compiled by Neil Woodhams and builds on previous work Neil undertook in his capacity as Chief Executive of a Primary Health Organisation. Neil has an accountancy background and has held senior executive roles within the planning and funding environment of District Health Boards as well as Primary Health Organisations.

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Tereki Stewart⁴ provided additional written content and edited the final report.

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¹Jonathan Murray, (MBA, PGDipBus, DipBusComp, MinstD) is the Manager of the Primary Care Network at the National Hauora Coalition.

²Dr David Jansen (FRNZCGP, MBChB, BHB, DipTeach, GradCertClinTeach) is the Clinical Director at the National Hauora Coalition.

³Dr Laura Broome (MSc, PhD) is a Project Manager at the National Hauora Coalition.

⁴Tereki Stewart (MA (Hons), PGDipClinPsych, CertCompDirection) is the Director of Operations at the National Hauora Coalition.



Contents

Executive Summary	4
Background	5
Current Annual Capitation Rates from 1 July 2015	6
How VLCA is calculated	7
Total subsidy	8
Reviews of the Capitation Formula	9
Underfunding of Māori and other 'High-Needs' Practices	10
Primary care and 'high-needs' populations	11
Factors adversely impacting the sustainability of Very 'High-Needs' Providers	13
The Capitation Formula is based on averages	14
Average ethnicity	14
Average age	18
Average number of visits per annum	19
Sustainability issues facing VLCA practices serving 'high-needs' patients	23
'High-Needs' Providers have higher-than-average Fee for Service (FFS) deductions	25
'High-Needs' Providers have higher-than-average patient turnover	29
'High-Needs' Providers derive smaller proportions of income from patient co-payments	31
Consultation complexity and proportion of 'high-needs' patients	31
Other evidence of disadvantage	34
Clinical workforce	35
Conclusion	36

Executive Summary

The purpose of this report is to articulate equity considerations regarding the sustainability of very 'high needs' Primary Care practices in a capitated environment. It is contended that the base capitation formula is based on incomplete and unreliable data which does not adequately account for access issues and differential health need by ethnicity. Therefore, the current capitation funding arrangements including the Very Low Cost Access component (VLCA), are not appropriate or sustainable for those with high numbers of 'high-needs' patients. This poses an unfair cost burden on those practices that is ultimately unsustainable both fiscally and clinically, for the provision of optimal care. This paper is conceived in response to ongoing commentary and consideration of the VLCA funding contribution to capitation. Some explanation, analysis and demonstration of the capitation and VLCA capitation formula and impacts are provided. Overall it is suggested that the current focus on reviewing the VLCA funding in isolation from the greater pool of capitation funding continues to ignore the inequities experienced by primary care providers serving very 'high needs' populations.

The base capitation formula is based on incomplete and unreliable data which does not adequately account for access issues and differential health need by ethnicity.

Background

Since it was first introduced in 2003, there has been much debate about the appropriateness of capitation funding generated by the Capitation Funding Formula to meet the costs of practices serving very 'high-needs' populations.⁵

It is generally conceded that the information the Capitation Formula was based on was old data (GMS claims and visits from 2001/2002, and the practice nurse subsidy) and that these were unreliable. Further, it has always been recognised that the Capitation Formula did not adequately reflect the costs of providing primary care health services to Māori, Pacific and other 'high-needs' groups.

The funding for primary care has been negotiated between the Ministry of Health (MOH), District Health Boards (DHBs) and representatives of primary care through a process known as PSAAP.⁶ The original National PHO Agreement negotiated in 2003 required the Ministry of Health to review the Capitation Formula by the end of June 2004. This was deferred by the Ministry on the basis that there was no more robust information and data available to it then, than the original 2001/2002 data.

Recently, the Very Low Cost Access funding contribution to capitation was the subject of review and comment by the Primary Care Working Group appointed by the Minister of Health to review General Practice sustainability.⁷ A number of recommendations were made in the Working Group's report relating to capitation subsidies and the targeting of 'high-needs' that have re-ignited sector wide debate on the capitation funding formula, including the Very Low Cost Access contribution.

⁵High-needs' populations are defined as those of Māori and/or Pacific descent, and/or those living in the poorest quintile (Q5) in areas of New Zealand.

⁶PSAAP is the PHO Service Agreement and Amendment Protocol group (a national group of PHO, Ministry of Health, and District Health Board members that negotiate the PHO Head Agreement).

⁷Primary Care Working Group on General Practice Sustainability (2015). A Report to the Minister of Health, Unpublished Report.

As a contributor, commentator and regular advocate for Māori and other 'high-needs' populations, the National Hauora Coalition commissioned Neil Woodhams to assist in analysing relevant data from 26 practices within the NHC's primary care network to determine the current capitation funding formula's impact on the sustainability of Very 'High-Needs' Practices, most often those practices with a very high number of Māori patients and those of Pacific descent. This report should be seen in the context of contributing and adding to the current debate on the appropriateness of capitation funding in the primary health sector and its impact on Very 'High-Needs' Providers.

The following information in Table 1. provides an overview of the current capitation funding rates, and includes the amount of funding provided under the capitation system for each gender and age group on an annual basis under the assumption of a specific number of average visits per year.⁸

Current Annual Capitation Rates from 1 July 2015

Table 1: First level health services by access practices for enrolled persons⁹

Access First Contact				
Age group (years)	Gender	Without HUHC plus zero fees 0–13	Amount per visit	Increase since 2010
00–04	F	\$473.5592	\$49.33	24.8%
	M	\$498.5917	\$51.94	24.8%
05–13	F	\$170.3596	\$60.84	41.9%
	M	\$162.1848	\$57.93	44.3%
14–24	F	\$115.6512	\$44.48	4.4%
	M	\$63.6512	\$24.28	4.4%
25–44	F	\$101.6272	\$42.34	4.4%
	M	\$65.6932	\$27.37	4.4%
45–64	F	\$139.1972	\$38.66	4.4%
	M	\$103.9652	\$28.88	4.4%
65+	F	\$239.8772	\$34.76	4.4%
	M	\$206.8680	\$29.98	4.4%

⁸The average number of visits were assumed as follows: 00-04 years 9.5 visits, 05-13 years 2.8 visits, 14-24 years 2.6 visits, 14-24 years 2.6 visits, 25-44 2.4 visits, 45-64 years 3.6 visits and 65+ 6.9 visits.

⁹The Capitation figures are taken direct from the MOH website, with the exception of the "Amount per visit" column which represents the Total Annual Capitation by age and gender divided by the number of visits allowed for in the MOH capitation calculations as disclosed in the Deloitte report "The Sustainability of Māori and Small PHOs and their Practices 2010". The percentage increase is the increase in the Capitation Rates for Non High Use Health (HUHC) cards in the five years between 1 July 2010 and 1 July 2015. The rates for the 0–13 age band have had added the additional subsidies for zero fees for these age groups introduced since 2010. The rates for HUHC have been ignored given the very low take-up rate and the disincentives imposed on practices to enrol patients in them.

The inequity of the capitation funding formula was supposedly addressed in part by the introduction in 2006 of the Very Low Cost Access (VLCA) payment. How this payment was calculated and whether it bears any correlation with the actual costs of providing services to Māori and Pacific people has never been analysed or explained. Moreover, a comprehensive equity assessment of the likely impacts of the VLCA payments was not evidenced at the time of commencement.

When VLCA payments were introduced, practices and PHOs had to agree to limit patient co-payments to \$15 for an adult visit, \$10 for patients aged 6–17 and no co-payment for children aged under 6. Subsequently, limited increases have been agreed so that patient co-payments are now free for patients aged 0–12. \$12 maximum for children 13–17 years, and a \$17.50 maximum for adults 18 years and over.

It is generally agreed that the uptake of the VLCA scheme was far greater than the Ministry had calculated and budgeted for. This was in part because the scheme created fiscal incentives for practices with relatively low proportions of 'high-needs' patients to enter the scheme for marketing purposes because the capped patient co-payment gave such practices a key advantage over other practices in their vicinity that did not adopt the scheme. The impact has been that funding that should have gone to help genuine 'high-needs' practices and patients has been diverted to patients who have a much greater ability to pay higher co-payments. To provide further context the VLCA payment calculations are presented in Table 2.

How VLCA is calculated

Table 2: Very Low Cost Access payment¹⁰

Individual practice component of payment available to each eligible PHO practice – annual rates

Age group (years)	Gender	Annual rate	Amount per visit	Increase 2010–2015
00–04	F	\$103.4676	\$10.78	9.3%
	M	\$108.9356	\$11.34	10.2%
05–14	F	\$52.2740	\$18.67	77.0%
	M	\$51.6556	\$18.45	86.7%
15–24	F	\$29.6752	\$11.41	9.0%
	M	\$16.3328	\$6.28	9.0%
25–44	F	\$26.0764	\$10.87	9.0%
	M	\$16.8564	\$6.80	9.0%
45–64	F	\$35.7164	\$9.92	9.0%
	M	\$26.6764	\$7.41	9.0%
65+	F	\$61.5504	\$8.92	9.0%
	M	\$53.0804	\$7.69	9.0%

¹⁰These figures are taken directly from the MOH website except for the "amount per visit". For the purposes of this paper the amount per visit has been calculated by dividing the Annual VLCA payment by the number of visits by age and gender allowed for in the Capitation Formula as disclosed in the 2010 Deloitte report.

Total subsidy

Table 3 highlights the idiosyncrasies of the way the Capitation Formula and its add-ons have developed. This has produced – at a per-visit subsidy level – a number of inexplicable variations. For example, the highest level of subsidy is for females aged 6–13, at \$79.51 per visit, compared with males aged 14–24, where the subsidy is \$30.56. The subsidies for both male and females aged 45 and over, which ranges from \$36.39 to \$48.58, would appear low when considering that in ‘high-needs’ practices this is the age bracket when chronic complex illnesses commonly set in.

Table 3: Total subsidy paid per visit

Age group (years)	Gender	Capitation subsidy per visit	VLCA subsidy per visit	Total subsidy paid
00–04	F	\$49.33	\$10.78	\$60.11
	M	\$51.94	\$11.34	\$63.28
5–13	F	\$60.84	\$18.67	\$79.51
	M	\$57.93	\$18.45	\$76.38
14–24	F	\$44.48	\$11.41	\$55.89
	M	\$24.28	\$6.28	\$30.56
25–44	F	\$42.34	\$10.87	\$53.21
	M	\$27.37	\$6.80	\$34.17
45–64	F	\$38.66	\$9.92	\$48.58
	M	\$28.88	\$7.41	\$36.29
65+	F	\$34.76	\$8.92	\$43.68
	M	\$29.98	\$7.69	\$37.67

The large variation in some age groups between the subsidy paid for females as opposed to males is also difficult to explain on a per-visit subsidy basis; for example, in the 14–24 age group, the payment is from \$30.56 for males compared with \$55.89 for females, which is a difference of \$25.33 per visit, that is, a 56% variation.

These variances are exacerbated when utilisation and co-payment issues are included. These are dealt with later in this report.

Reviews of the Capitation Formula

As part of the PSAAP negotiations, there was agreement to increase the payments under the Capitation Formula every year by an inflation factor that takes into account increases in the costs faced by primary care. Some commentators have been surprised that the Ministry would have agreed to an annual inflation adjuster as this is not common across health sector contracts. However, it is probable that mainstream PHOs would have never agreed to the National PHO Contract in 2003 without it.

The Labour Government became concerned that increases in the Capitation Formula were not being reflected in lower co-payments in non-VLCA practices. As a result, there was an enormous effort made to attempt to control patient co-payments through a fees approval process.

As part of that process, independent consultants, Law and Economic Consulting Group (LECG), were employed to determine what a fair annual increase in co-payments would be. LECG undertook this review, adopting an agreed methodology which measured primary health sector costs using several different measures.

An interesting by-product of this annual review has been to bring into very sharp focus the impact of the assumptions made in calculating the Capitation Formula, in particular the percentage of income a practice receives from patient co-payments. This is dealt with in more detail later. The review demonstrated that the Capitation Formula makes the assumption that a practice receives approximately 50% of its revenue from co-payments. Work by the LECG showed that the adjustment for inflation is extremely sensitive to that percentage. For example, when co-payment percentages of 10–30% of total revenue were used (which is more normal in Very 'High-Needs' Practices), the adjustment for inflation needed to be much higher.

In 2006, the Ministry and DHBs undertook a process to review the Capitation Formula, and a wide range of people from primary care, DHBs, Ministry of Health and academia were involved. The work undertaken by this Working Party clearly indicated that the current formula did not recognise the higher use of primary care by Māori and Pacific people, especially those aged between 45 and 64, although there was general agreement that this should happen. In other words, the formula does not recognise the onset of chronic cardiac, respiratory and diabetic disease that impacts Māori and Pacific people 10 to 20 years earlier than the non-Māori, non-Pacific population.¹¹

The Ministry made it clear to the participants that it was not within the scope of the Working Party's mandate to recommend a solution. Recommendations to the Minister were to be the preserve of the Ministry. Despite this, there was some work done to measure the impact of re-allocating the total capitation funding to allow increased funding for Māori and Pacific people aged between 45 and 64. The projected impact of reducing capitation for practices and PHOs with small numbers of Māori and Pacific people and correspondingly increasing capitation for those PHOs and practices that had high proportions of Māori and Pacific people was profound, with a suggested shortfall in the vicinity of tens of millions of dollars in 2007.

The Working Party participants were never involved in the subsequent advice to the Minister and the recommendations of the review were never implemented.

¹¹Langton, J. & Crampton, P. (2008). Funding of primary health organisations: Are enrolled populations being funded according to need? *New Zealand Medical Journal*, 121(1272), 47–58.

Underfunding of Māori and other 'High-Needs' Practices

Running parallel to the National PHO negotiations was a claim to the Waitangi Tribunal – the Wai 1315 claim – by five Māori-led PHOs for compensation based on a large number of issues arising from the Ministry of Health's and DHBs' implementation of the Primary Care Strategy, which the claimants alleged was in breach of the Government's obligations under the Treaty of Waitangi. The Wai 1315 claim has not progressed far.

However, the Wai 1315 claim has resulted in two other pieces of work commissioned by the Ministry which are relevant to this report. Firstly, in 2006, the Ministry commissioned a report from Deloitte to put a figure on the likely cost of addressing the underfunding of Māori and other 'high-needs' PHOs and primary care practices. There were substantial delays in agreeing the terms of reference for the report and, in the end, the consultants had approximately nine days to undertake the work and make recommendations to the Ministry who needed the information as part of the process to establish the 2007 Budget. The timeframe severely restricted the amount of research Deloitte were able to undertake but they did work with at least two of the Treaty claimants. Their report has never been released. However, anecdotal evidence and discussions at the time led some to believe that the figure required to address the deficit funding was in the region of \$25–\$30 million in 2007 terms.

A follow-up report was commissioned by the Ministry and, late in 2010, Deloitte delivered a report to the Ministry titled "The Sustainability of Māori and Small PHOs and their Practices".¹²

This paper draws on some of the findings of that report, together with an analysis of 26 practices within the NHC, and the observations of key NHC participants in the PSAAP process for most of the period from 2003 to 2010.

¹²Deloitte (2010). The Sustainability of Māori and Small PHOs and their Practices. Unpublished report commissioned by the Ministry of Health.

Primary care and 'high-needs' populations

There has been considerable debate on the issues of providing care to 'high-needs' populations and the potential remedies available to Government and the sector to address these issues. In 2008, the Ministry limited providers with fewer than 50% 'high-needs' patients (being Māori, Pacific and those living in decile 9 and 10 areas) from joining the VLCA scheme, but did not exclude existing providers below the 50% 'high-needs' threshold.

Since 2010, free primary care visits have been funded for, initially, 0–5 year olds and then 6–13 year olds, by increasing both the capitation rates and the VLCA rates for those age groups (See Tables 1 and 2.)

There is clear evidence that there is a group of practices with large numbers of Māori and Pacific patients that are struggling to remain financially and clinically viable.

There has been recent agitation to change the way VLCA is distributed, from being limited to VLCA practices, to a subsidy following the patient. This means that all Māori and Pacific and those living in decile 9 and 10 areas would attract a subsidy to the practice treating them, wherever the practice is located.

The principal argument in favour of this change is that approximately 50% of 'high-needs' patients receive primary care from non-VLCA practices, and those patients and practices are, therefore, financially disadvantaged.

While there is general acceptance that there are some merits in that argument, it ignores several key points as outlined below.

- The capitation payment is a subsidy based on averages. For every practice that is relatively disadvantaged by this there are other practices that are significantly advantaged. A practice with, say, 15% 'high-needs' patients and able to charge co-payments of \$40–\$60 per visit has the financial capacity to lower or waive fees for those few patients who cannot afford to pay. There is some anecdotal evidence that this is currently happening.
- Those advocating change ignore the large number of mainstream practices that are relatively better off under the arrangements because their enrolled populations do not mirror the New Zealand average in terms of ethnicity, age, etc.
- The 2006 Review Group concluded that the major issue with the Capitation Formula was its failure to recognise the differential health needs by ethnicity and increased costs accordingly associated, both in terms of the number and the complexity of those visits.
- The fundamental false assumption made that practices which receive the subsidy would derive 50% of their income from the subsidy and the other 50% from patient co-payments.

- Current policy makes little attempt to stratify and differentiate those VLCA practices with relatively low numbers of 'high-needs' patients (say, fewer than 50% 'high-needs' patients) from those with more than 80% 'high-needs' patients. This paper clearly demonstrates the difference.
- Total capitation payments exceed \$600 million while total VLCA payments total about \$60 million, or 10% of the capitation total. It follows that small changes in the Capitation Formula would produce the same results as a major change to VLCA, without the same adverse impact on Very 'High-Needs' Practices.
- There is clear evidence that there is a group of practices with large numbers of Māori and Pacific patients that are struggling to remain financially and clinically viable, even with the current VLCA subsidies. This paper considers some fresh evidence to support this contention. For the purposes of the analysis, which is the focus of the remainder of this paper, 26 practices which form part of the National Hauora Coalition (NHC) were considered.

Total capitation payments exceed \$600 million while total VLCA payments total about \$60 million, or 10% of the capitation total.

- The capitation subsidy is still based on the GMS claims made in the 2000/2001 financial year. No attempt has been made to recognise changes that may have occurred in primary care usage patterns in the intervening 14 years.
- The Government has obligations to Māori and Māori providers under the Treaty of Waitangi that are arguably not being met under the current policy settings and which are subject to a current Treaty of Waitangi claim.

Factors adversely impacting the sustainability of Very 'High-Needs' Providers

The remainder of this paper focuses on what can be termed Very 'High-Needs' Providers, and utilises information from 26 practices that form part of the NHC. In this paper, those practices have been categorised into three bands:

- practices with fewer than 50% 'high-needs' patients
- practices with 50–79% 'high-needs' patients
- practices with more than 80% 'high-needs' patients.

This latter group have been called "Very 'High-Needs' Providers".

There are four factors referred to in the Deloitte report which impact on the profitability of Very 'High-Needs' Providers. Although Deloitte in their report make no attempt to link these factors, it is almost certain they are inextricably linked and need to be considered together. The four factors are:

1. The Capitation Formula is based on averages:
 - a) average ethnicity
 - b) average age
 - c) average number of visits per annum.
2. Very 'High-Needs' Providers have higher-than-average Fee for Service (FFS) deductions.
3. Very 'High-Needs' Providers have higher-than-average patient turnover.
4. Very 'High-Needs' Providers have a smaller percentage of their income generated by patient co-payments.

It is important to stress that these factors have clinical, financial and administrative impacts on Very 'High-Needs' Providers.

The four factors are discussed in more detail below, in relation to 26 practices of the National Hauora Coalition.



The Capitation Formula is based on averages

Average ethnicity

The Capitation Formula does not make sufficient allowance for differential health need by ethnicity. Robust evidence widely available shows that Māori and Pacific people still have significantly lower levels of life expectancy at birth compared with the general New Zealand population, irrespective of their socioeconomic status. Whilst there have been small reductions in the life expectancy gap between Māori and non-Māori, life expectancy at birth, this has remained largely static since 1980's while non-Māori life expectancy has continued to increase.^{13 14}

There is anecdotal evidence of Māori and Pacific patients being refused enrolment in mainstream clinics and referred to marae and other 'high-needs' clinics.

The corollary of this is that the impact of chronic diseases, such as diabetes, heart and respiratory disease, occurs 10 to 20 years earlier in Māori and Pacific populations than in the general New Zealand population. This means that primary care providers that have large numbers of Māori and Pacific patients are disadvantaged when compared with providers that have much smaller numbers of these patients. There is anecdotal evidence of Māori and Pacific patients being refused enrolment in mainstream clinics and referred to marae and other 'high-needs' clinics. The reason for this is clear. Some mainstream practice owners have identified that Māori and Pacific patients are 'unprofitable'. The findings of this report support that view. The extent to which a provider has proportions of Māori and Pacific patients enrolled greater than the proportion of these populations in the general New Zealand population defines the level of disadvantage.

It is acknowledged that Services to Increase Access (SIA) funding, which is adjusted for ethnicity, is available to 'high-needs' practices. The more Māori and Pacific patients a practice has, the higher the SIA payment. It is noted, however, that SIA payments are payable to the PHO and not to the practice, and that the funding may not reach the practice generating the SIA funds. It has been a condition of this funding up until now that it has not been available to be used to meet the costs of 'high-needs' practices to provide GP and practice nursing services. Instead, SIA funds have had to be used to provide other additional services with

¹³Life expectancy at birth in 2013:73.0 years for Māori males compared to 80.3 years for non-Māori males and 77.1 years for Māori females compared with 83.9 years for non-Māori females.

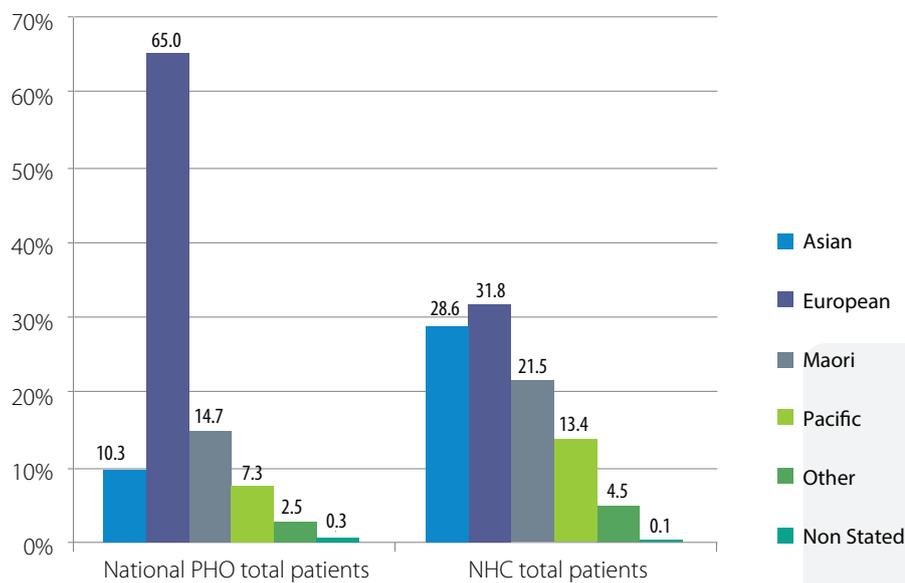
¹⁴Ministry of Health. 2015. *Tatau Kahukura: Māori Health Chart Book 2015* (3rd edition). Wellington: Ministry of Health.

their associated additional costs. Further, since 2012, the SIA payment has been placed in the Flexible Funding Pool and may not always be available to providers to meet the higher costs of delivering services to Māori and Pacific patients. Practice varies between PHOs but it is reasonably common for some PHOs to retain up to 25% of the SIA payment to cover their management costs. In addition, funds in some instances have been used to fund services other than those for Māori, Pacific and other 'high-needs' patients for whom SIA funds were originally intended. This appears to be more common in many alliancing arrangements that use the Flexible Funding Pool (FFP) to fund general programmes of activity rather than activity targeted to 'high-needs' populations specifically. In Auckland, for example, FFP funds are used to fund programmes such as Clinical Pathways that have no clear or evidenced link to addressing health disparities.

One of the features of 'high-needs' practices; is the very high levels of Māori and Pacific and decile 9 and 10 people enrolled.

Figure 1 clearly demonstrates the variation in ethnicity between the national enrolled population and patients enrolled with the NHC. Overall, the patient population within the NHC is far more highly weighted to Māori, Pacific and Asian ethnicities. Māori and Pacific patients make up 22% of the national enrolled population while within the NHC they make up 34.9%, and Asians comprise 10.3% of the national enrolled population but 28.6% of the NHC population. Māori, Pacific and Asian populations are known to have higher demands for health services than the general population.

Figure 1: National enrolled patients by ethnicity vs NHC practices (Q4 2014/15)



Patient ethnicity within the NHC enrolled population shows significant variation as well. See Figure 2.

Figure 2: NHC practices by patient ethnicity (Q4 2014/15)

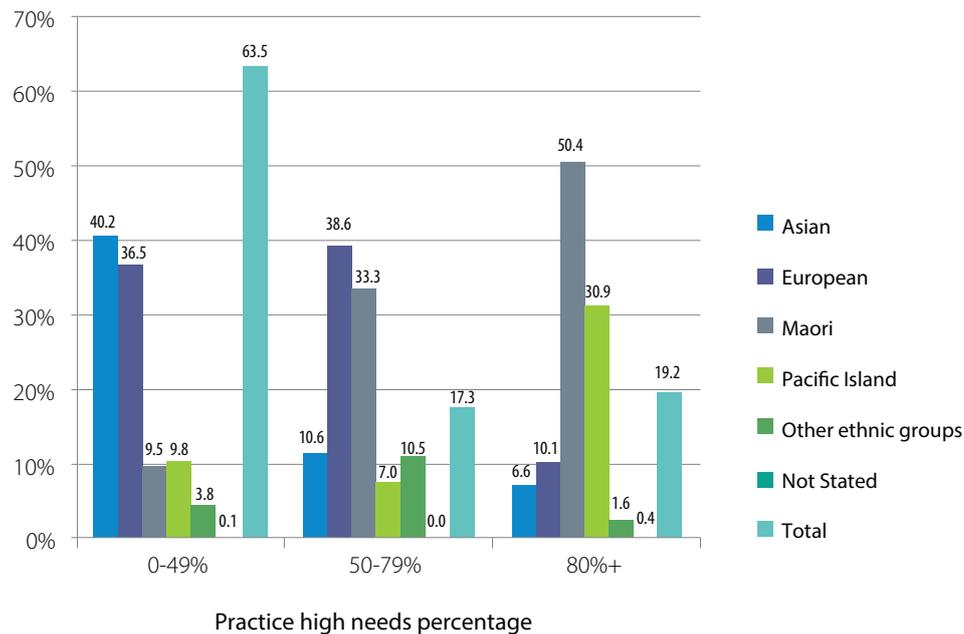


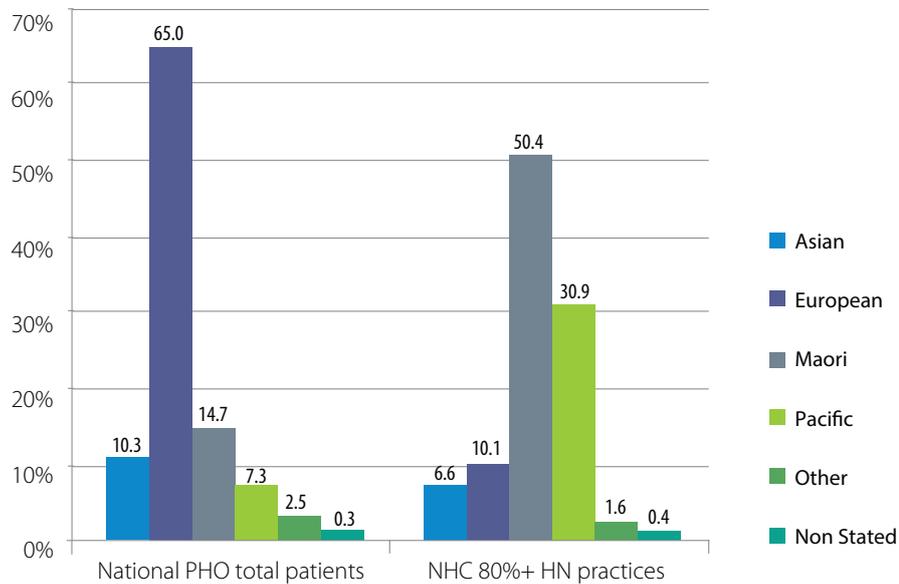
Figure 2 clearly identifies the significant variations in ethnicity within the NHC practices across the three 'high-needs' bands. Figure 2 and 3 combined illustrate that the NHC very 'high-needs' practices combined have disproportionately larger Māori and Pacific populations just over three times the proportion Māori and Pacific in the overall national PHO patient population.

In the practice 'high-needs' 0–49 percent band, Māori and Pacific patients total only 19.8% of the register; in the intermediate (50–79%) band Māori and Pacific patients total 40.3%; and in the 80% and over band Māori and Pacific total in excess of 81.3%. The variation is stark.

The other notable figure is the number of Asians enrolled in the 0–49% band of 40.2%. This compares with 10.3% Asians in the national enrolled population (refer Figure 1). While it is beyond the scope of this report, any significant health issues with this population group outside of the average will also create issues for these practices who serve them.

When the Very 'High-Needs' Practices (80% or more Māori and Pacific patients) is compared with the New Zealand enrolled population (see Figure 3), the same stark variation is evident.

Figure 3: National enrolled patients by ethnicity vs NHC Very 'High-Needs' practices (Q4 2014/15)



Māori and Pacific patients have poorer health status and chronic disease impact up to 20 years earlier compared with those of European counterparts.

The key differences hardly need highlighting but by way of summary:

- European comprise 65% of the national enrolled population and only 10.1% of the NHC Very 'High-Needs' Practices;
- Māori comprise 14.7% of the national enrolled population and 50.4% of the NHC Very 'High-Needs' Practices;
- Pacific comprise 7.3% of the national enrolled population and 30.9% of the NHC Very 'High-Needs' Practices;
- Māori and Pacific patients have poorer health status and chronic disease impact up to 20 years earlier compared with those of European counterparts.

Average age

Within the NHC practices, there is significant variation in the age distribution of patients across the three categories of 'High-Needs' Practices (see Figure 4).

Figure 4: Age distribution for NHC practices by practice 'high-needs' category (Q4 2014/15)

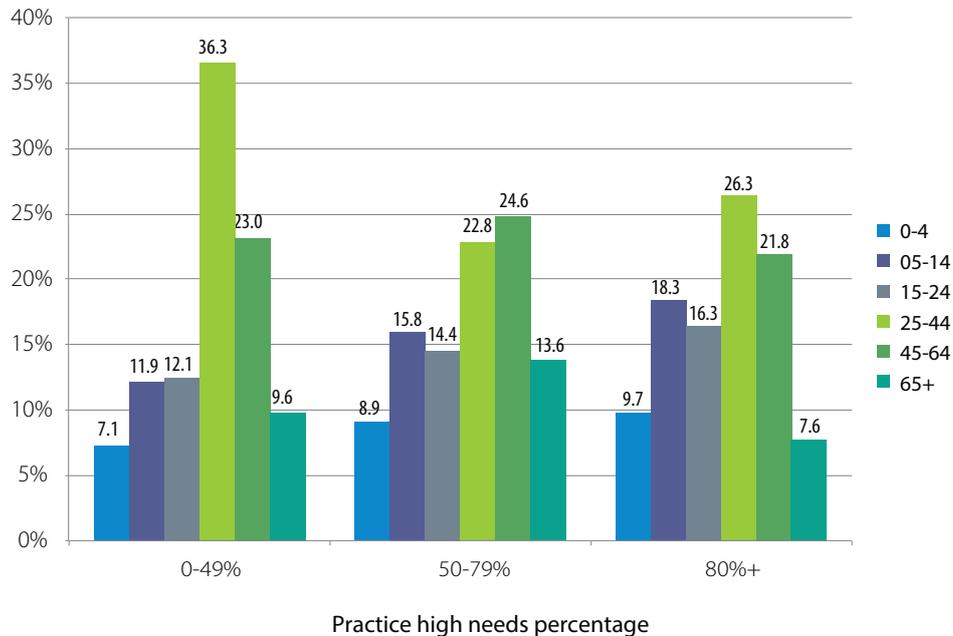
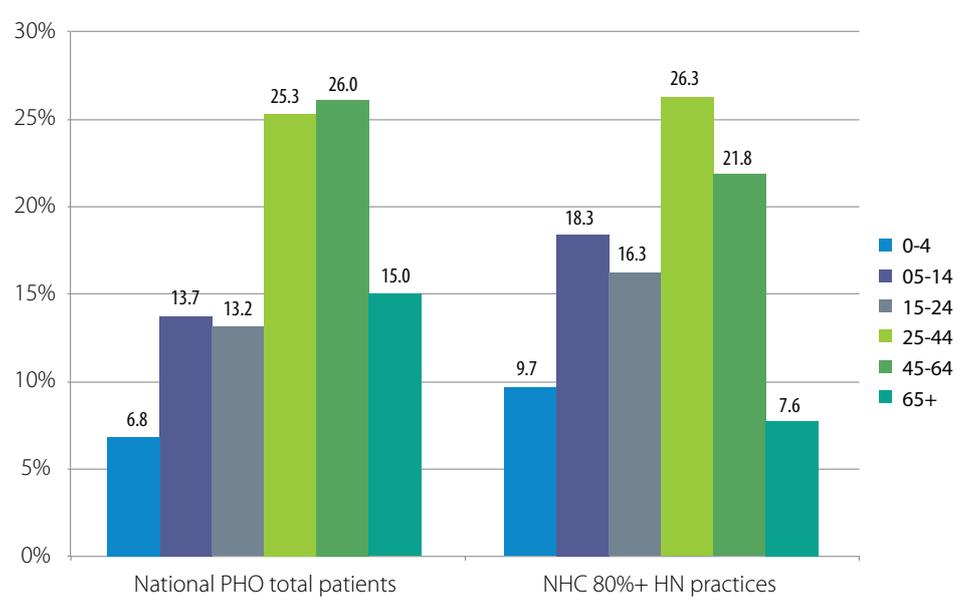


Figure 4 indicates that the patient population in the NHC Very 'High-Needs' (80%+) Practices is generally younger than in the other two NHC practice categories. For example, in the Very 'High-Needs' Practices, 44.3% of all patients are aged 0–24, compared with 31.1% and 39.1% in the under 50% and 50–79% 'High-Needs' Practices respectively. At the other end of the age range, only 7.6% of patients in the Very 'High-Needs' Practices are aged 65 or over, compared with 9.6% and 13.6% in the under 50% and 50–79% 'High-Needs' Practices respectively. This age distribution mirrors the national age distribution; that is, that Māori and Pacific populations are younger than the New Zealand population average with proportionately fewer living beyond the age of 65 years.

Figure 5 compares the age distribution of the national enrolled population with the age distribution in the NHC Very 'High-Needs' Practices.

Figure 5: Age distribution in the New Zealand overall enrolled population vs NHC Very 'High-Needs' Practices (Q4 2014/15)



The population of the NHC Very 'High-Needs' Practices is younger than the national enrolled population. In the Very 'High-Needs' Practices, 44.3% of all patients are aged 0–24, compared with 33.7% in the national enrolled population. At the other end of the age range, only 7.6% of patients in the Very 'High-Needs' Practices are aged 65 or over, compared with 15% in the national enrolled population.

Average number of visits per annum

Table 4: Average number of visits per age group per annum

Age group (years)	Number of visits
0–4	9.6
5–14	2.8
15–24	2.6
25–44	2.4
45–64	3.6
65+	6.9

The Capitation Formula was calculated using GMS claims for 2001/2002 divided into the total payment for GMS claims plus some other funding, such as Practice Nurse funding. The Ministry divided the visits and the funding over a total of six age bands. The numbers of visits used by the Ministry are shown in the table alongside.

The following three tables (tables 5–7) show the actual number of annual visits in each of the three needs categories we have analysed compared with the number of visits subsidised under the Capitation Formula. In addition, the actual number of Fee for Service (FFS) visits has been deducted to reflect the actual subsidies received.

Table 5: Comparison of utilisation of GP and Nurse visits by NHC practices with 0–49% ‘high-needs’ compared with the visits funded by the Capitation Formula (1 July 2014–30 June 2015)¹⁵

Patient age group	GP		Nurse/Other		Total visits	Capitation Formula		Less FFS funded visits	Total over/under funded visits	Average funding per visit (Cap + VLCA) ¹⁵	Funding variance by the formula ¹⁵
	Visits	Utilisation rate	Visits	Utilisation rate		Funded visits	Over/under funded visits				
00–04	18,624	4.41	2,550	0.60	21,174	40,147	+18,973	-3,272	+15,701	\$61.70	+\$968,752
05–14	13,301	1.91	2,001	0.29	15,302	19,687	+4,385	-1,531	+2,854	\$77.95	+\$222,469
15–24	14,059	1.96	3,800	0.53	17,859	18,509	+200	-673	-473	\$43.23	-\$20,447
25–44	53,779	2.56	15,451	0.74	69,230	51,429	-17,801	-891	-18,692	\$43.69	-\$816,653
45–64	51,790	3.87	16,322	1.22	68,112	48,928	-19,194	-671	-19,865	\$42.44	-\$843,070
65+	33,381	6.11	10,600	1.94	43,981	39,013	-5,058	-926	-5,984	\$40.67	-\$243,369
Total	184,934	3.18	50,724	0.87	235,658	217,713	-18,495	-7,964	-26,459		-\$732,318

¹⁵ The calculation for ‘Average funding per visit (Cap+VLCA)’ above has taken the total income per enrollee from Capitation and VLCA for male and females by age band and averaged it. The ‘Funding variance by the formula’ uses the ‘Average funding per visit (Cap +VLCA)’ multiplied by the funded/unfunded visits from the table above.

Table 6: Comparison of utilisation of GP and Nurse visits by NHC practices with 50–79% ‘high-needs’ compared with the visits funded by the Capitation Formula (1 July 2014–30 June 2015)¹⁶

Patient age group	GP		Nurse/Other		Total visits	Capitation Formula		Less FFS funded visits	Total over/under funded visits	Average funding per visit (Cap + VLCA) ¹⁶	Funding variance by the formula ¹⁶
	Visits	Utilisation rate	Visits	Utilisation rate		Funded visits	Over/under funded visits				
00–04	5,656	3.85	975	0.66	6,631	13,664	+7,033	-1,712	+5,321	\$61.70	+\$328,305
05–14	4,803	1.79	870	0.32	5,673	7,140	+1,467	-695	+772	\$77.95	+\$60,178
15–24	5,009	2.06	1,241	0.51	6,250	6,022	-228	-322	-550	\$43.44	-\$23,892
25–44	11,724	3.11	2,946	0.78	14,670	8,798	-5,872	-233	-6,105	\$43.69	-\$266,727
45–64	18,524	4.57	4,270	1.05	22,794	14,256	-8,538	-247	-8,785	\$42.44	-\$372,835
65+	14,936	6.48	3,208	1.39	18,144	15,070	-3,074	-297	-3,371	\$40.67	-\$137,098
Total	60,652	3.63	13,510	0.81	74,162	64,950	-9,212	-3,506	-12,728		-\$412,069

¹⁶The calculation for “Average funding per visit (Cap+VLCA)” above has taken the total income per enrollee from Capitation and VLCA for male and females by age band and averaged it. The “Funding variance by the formula” uses the “Average funding per visit (Cap +VLCA)” multiplied by the funded/unfunded visits from the table above.

Table 7: Comparison of utilisation of GP and Nurse visits by NHC practices with 80%+ 'high-needs' compared with the visits funded by the Capitation Formula (1 July 2014–30 June 2015)¹⁷

Patient age group	GP		Nurse/Other		Total visits	Capitation Formula		Less FFS funded visits	Total over/under funded visits	Average funding per visit (Cap+VLCA) ¹⁷	Funding by the formula ¹⁷
	Visits	Utilisation rate	Visits	Utilisation rate		Funded visits	Over/under funded visits				
00–04	4,655	2.64	2,743	1.56	7,398	16,694	+9,296	-2,628	+6,668	\$61.70	+\$41,1416
05–14	4,205	1.31	2,447	0.76	6,652	9,173	+2,521	-1,153	+1,368	\$77.95	+\$106,636
15–24	4,428	1.53	4,040	1.39	8,468	7,553	-915	-422	-1,401	\$43.23	-\$6,057
25–44	11,305	2.45	10,134	2.20	21,439	11,131	-10,308	-486	-10,794	\$43.69	-\$471,266
45–64	16,244	4.33	16,503	4.40	32,747	13,990	-18,757	-402	-19,159	\$42.44	-\$813,108
65+	8,336	6.47	8,399	6.52	16,735	9,398	-7,337	-251	-7,588	\$40.67	-\$308,604
Total	49,173	2.80	44,266	2.53	93,439	67,939	-25,500	-5,342	-30,842		-\$1,080,983

¹⁷ The calculation for "Average funding per visit (Cap+VLCA)" above has taken the total income per enrollee from Capitation and VLCA for male and females by age band and averaged it. The "Funding variance by the formula" uses the "Average funding per visit (Cap +VLCA)" multiplied by the funded/unfunded visits from the table above.

Sustainability issues facing VLCA practices serving 'high-needs' patients

Tables 7-11 and Figure 6, serve to demonstrate the sustainability issues facing VLCA practices serving 'high-needs' patients. Higher than subsidised visits, co-payments pegged at a maximum of \$17.50 and the many instances where their patients cannot afford to pay some or all of the co-payment means that these practices are receiving less than the co-payment paid in non-VLCA practices.

Table 8: Calculation of actual average subsidy per visit for NHC 0–49% 'High-Needs' Practices (1 July 2014–30 June 2015)¹⁸

0–49% 'High-Needs' Practice category					
Patient age group	Funded visits ^a	Average subsidy received per visit ^b	Total FFS deductions ^c	Total visits ^d	Actual average subsidy per visit ^e
00–04	40,147	\$61.70	\$113,494	21,174	\$111.63
05–13	19,687	\$77.95	\$30,660	15,302	\$98.28
14–24	18,509	\$43.23	\$8,590	17,859	\$44.32
25–44	51,429	\$43.69	\$7,067	69,230	\$32.35
45–64	48,928	\$42.44	\$6,561	68,112	\$30.39
65+	39,013	\$40.68	\$11,283	43,981	\$35.83

Table 9: Calculation of actual average subsidy per visit for NHC 50–79% 'High-Needs' Practices (1 July 2014–30 June 2015)¹⁹

50–79% 'High-Needs' Practice category					
Patient age group	Funded visits ^a	Average subsidy received per visit ^b	Total FFS deductions ^c	Total visits ^d	Actual average subsidy per visit ^e
00–04	13,664	\$61.70	\$59,431	6,631	\$118.18
05–13	7,140	\$77.95	\$14,265	5,673	\$95.59
14–24	6,022	\$43.23	\$4,400	6,250	\$40.95
25–44	8,798	\$43.69	\$2,744	14,670	\$26.02
45–64	14,256	\$42.44	\$2,821	22,794	\$26.42
65+	15,070	\$40.68	\$3,741	18,144	\$33.58

¹⁸ a, d From Table 5

b From Table 3, calculated as average of male and female total subsidy paid per visit

c From Figure 7

e Calculated as: (Total funded visits x Average subsidy received per visit) – Total FFS deductions

¹⁹ a, d From Table 6

b From Table 3, calculated as average of male and female total subsidy paid per visit

c From Figure 7

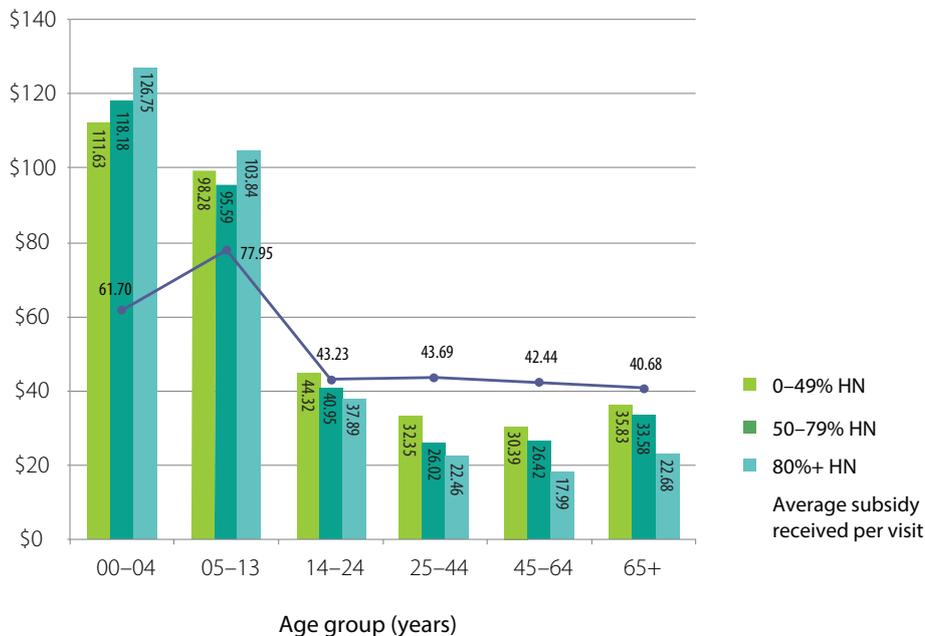
e Calculated as: (Total funded visits x Average subsidy received per visit) – Total FFS deductions

Table 10: Calculation of actual average subsidy per visit for NHC 80%+ 'High-Needs' Practices (1 July 2014–30 June 2015)²⁰

80%+ 'High-Needs' Practice category					
Patient age group	Funded visits ^a	Average subsidy received per visit ^b	Total FFS deductions ^c	Total visits ^d	Actual average subsidy per visit ^e
00–04	16,694	\$61.70	\$92,348	7,398	\$126.75
05–13	9,173	\$77.95	\$24,283	6,652	\$103.84
14–24	7,553	\$43.23	\$5,678	8,468	\$37.89
25–44	11,131	\$43.69	\$4,875	21,439	\$22.46
45–64	13,990	\$42.44	\$4,660	32,747	\$17.99
65+	9,398	\$40.68	\$2,775	16,735	\$22.68

As Figure 6 below indicates, the effect of higher utilisation rates in 'High Needs' and Very 'High Needs' Practices, particularly in the ages above 14 years, results in less subsidy per visit. The difference in the level of subsidy between 'Non-High Needs' and 'High Needs' Practices is stark.

Figure 6: Calculated actual average subsidy per visit compared with MOH average subsidy per visit by practice 'high-needs' category (1 July 2014–30 June 2015)



²⁰ a, d From Table 7

b From Figure 3, calculated as average of male and female total subsidy paid per visit

c From Figure 7

e Calculated as: (Total funded visits x Average subsidy received per visit) – Total FFS deductions

'High-Needs' Providers have higher-than-average Fee for Service (FFS) deductions

In addition to being under-funded through the Capitation Formula, 'High-Needs' Practices suffer higher-than-average FFS deductions. There are several reasons for this.

- The populations they serve are highly mobile. Reasons for this include:
 - They are seeking better housing.
 - They are seeking employment.
 - They have run up unpaid bills for medical treatment at their current provider and are unable to access services until these accounts have been paid.
 - They are avoiding unpaid debts for rent, hire purchase payments, etc.
- 'High-Needs' Practices, for cultural or social reasons, do not aggressively dis-enrol patients who regularly use other practices, thereby incurring higher FFS deductions.
- 'High-Needs' Practices have higher numbers of Community Service Card holders, that incur larger FFS deductions

'High-Needs' Practices, for cultural or social reasons, do not aggressively dis-enrol patients who regularly use other practices, thereby incurring higher FFS deductions.



A review of the NHC data in Table 11 (also refer to Figures 8 and 9) shows a significant variation in the levels of visits to practices other than where the patient is enrolled (and thus resulting potentially in an FFS deduction). Visits to other practices are much greater for Very 'High-Needs' Practices compared with the other two groups of practices.

Table 11: Comparison of Fee For Service visits as a percentage of GP visits to NHC practices by practice 'high-needs' category (1 July 2014–30 June 2015)

Patient age group	0–49% 'High-Needs'			50–79% 'High-Needs'			80%+ 'High-Needs'		
	Number of visits		% visits	Number of visits		% visits	Number of visits		% visits
	To own practice	To other practices	To other practices	To own practice	To other practices	To other practices	To own practice	To other practices	To other practices
00–04	18,624	3,272	17.57	5,656	1,712	30.27	4,655	2,628	56.45
05–14	13,301	1,531	11.51	4,803	695	14.47	4,205	1,153	27.42
15–24	14,059	673	4.79	5,009	322	6.43	4,428	422	9.53
25–44	53,779	891	1.72	11,724	233	1.99	11,305	486	4.30
45–64	51,790	671	1.30	18,524	247	1.33	16,244	402	2.47
65+	33,381	926	2.77	14,936	297	2.49	8,336	251	3.01
Total	184,934	7,964	4.30	60,652	3,506	5.78	49,173	5,342	10.86

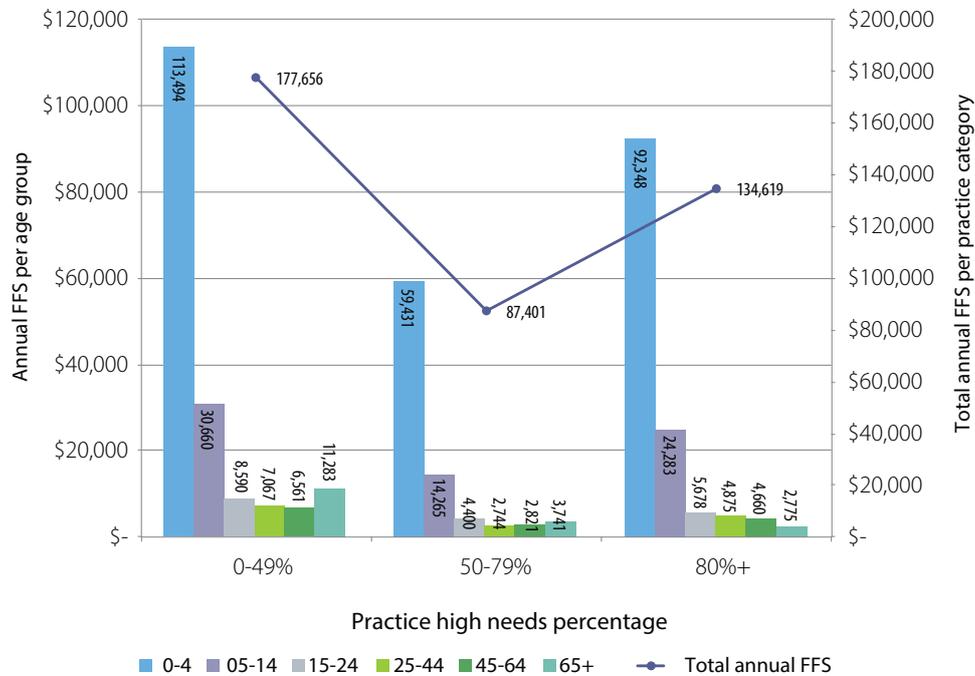
Table 11 shows the number of visits to other practices by age group and practice 'high-needs' band. The variations by 'high-needs' band are significant, with the percentage of visits in the 80%+ 'High-Needs' Practices more than double those in the 0–49% 'High-Needs' Practices. The startling variations are in the two youngest age groups where, in the 80%+ 'High-Needs' Practices, 56% of visits are to practices other than the practice where the patient is enrolled.

There is no research to determine why this might be the case but almost certainly the reasons will be related to at least three factors:

- Parents with sick children do not wait until the practice with which their children are enrolled is open before getting assistance for a sick child.
- The impact of free healthcare for 0–13 year olds both during normal clinic hours and after hours.
- Children enrolled with Very 'High-Needs' Practices are sicker than those in other areas.

Following on from Table 11, Figure 7 shows the significant financial impact of FFS deductions on practices. The impacts are obviously much higher for the 0–4 and 5–13 age groups than for the other age categories.

Figure 7: Annual FFS deductions for NHC practices by age group and practice 'high-needs' category (1 July 2014–30 June 2015)



The dollar impact per enrolled patient per annum can be calculated, with the results as shown in Table 12.

Table 12: Annual dollar impact of Fee For Service visits per enrolled patient per annum in NHC practices (1 July 2014–30 June 2015)

Patient age group	0–49% 'High-Needs'	50–79% 'High-Needs'	80%+ 'High-Needs'
00–04	\$27.14	\$41.44	\$53.10
5–14	\$4.35	\$5.59	\$7.41
15–24	\$1.21	\$1.89	\$1.95
25–44	\$0.33	\$0.75	\$1.04
45–64	\$0.48	\$0.71	\$1.14
65+	\$2.00	\$1.71	\$2.03

Figure 8: Number of FFS visits for NHC practices by age group and practice 'high- needs' category (1 July 2014–30 June 2015)

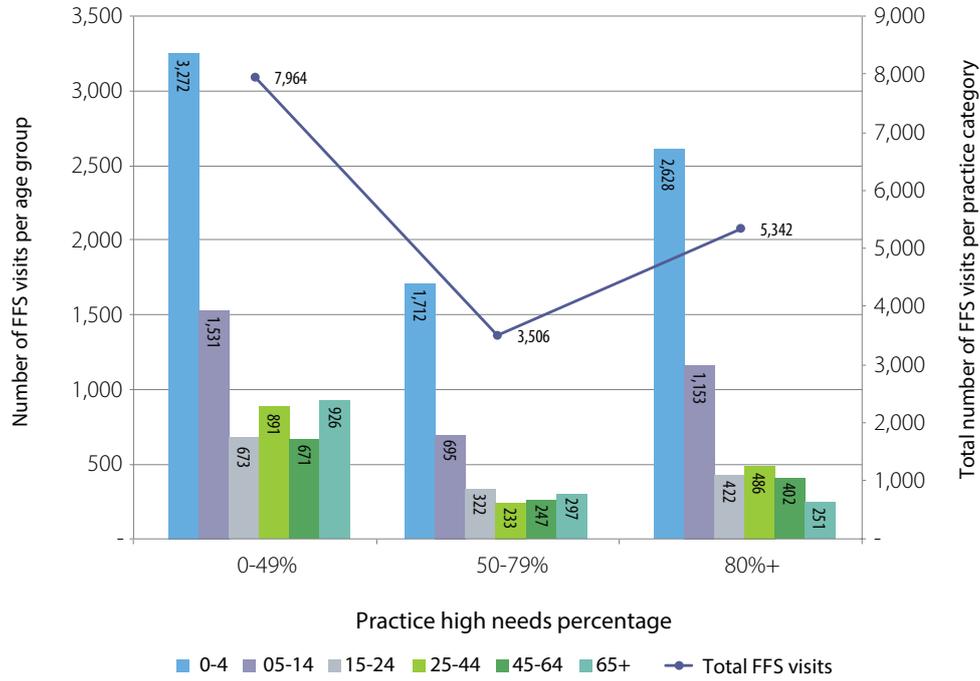
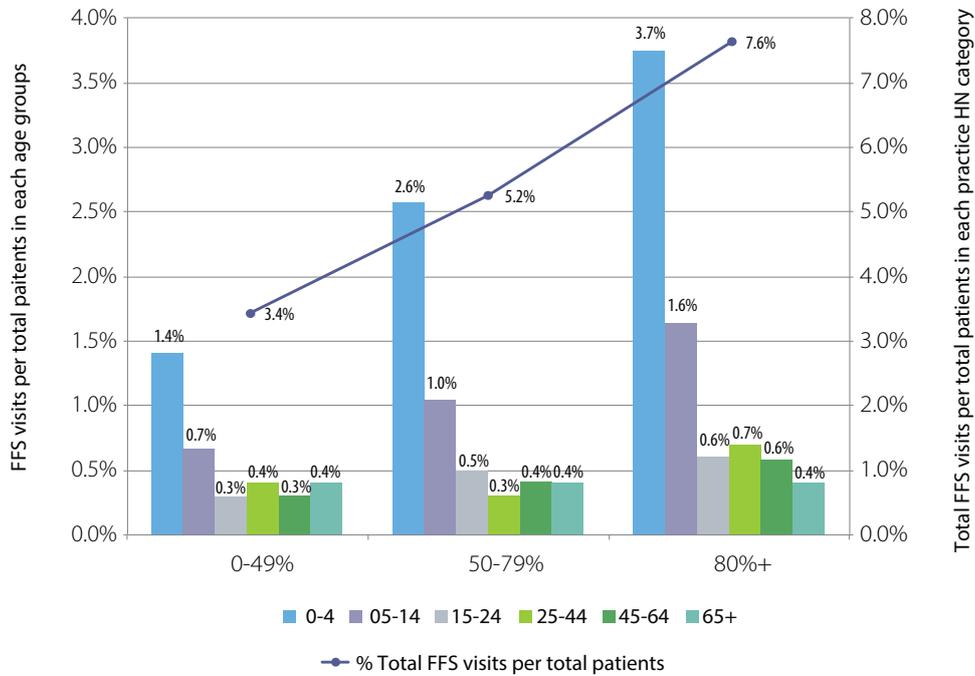


Figure 9: Number of FFS visits for NHC practices as percentage of total patients by age group and practice 'high-needs' category (1 July 2014–30 June 2015)



'High-Needs' Providers have higher-than-average patient turnover

As discussed above, the populations served by 'High-Needs' Providers are highly mobile with the result that patient turnover in these providers is higher than average. The underlying reasons for high patient mobility, are also discussed above.

Patient register changes (turnover) for NHC practices for the year ended June 2015 are shown in Figures 10 and 11. The NHC experience shows that very high rates of patient turnover exist across all groupings of practices but with, once again, the Very 'High-Needs' Practices showing markedly higher rates of turnover.

Figure 10: Patient register changes (number of patients) for NHC practices by practice 'high-needs' category (1 July 2014–30 June 2015) as at Q4 2014/15

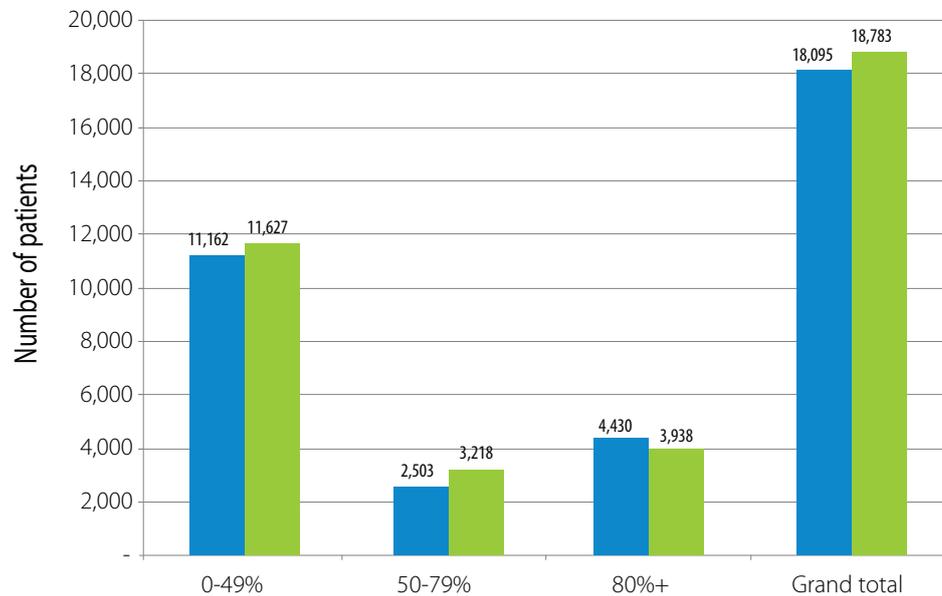
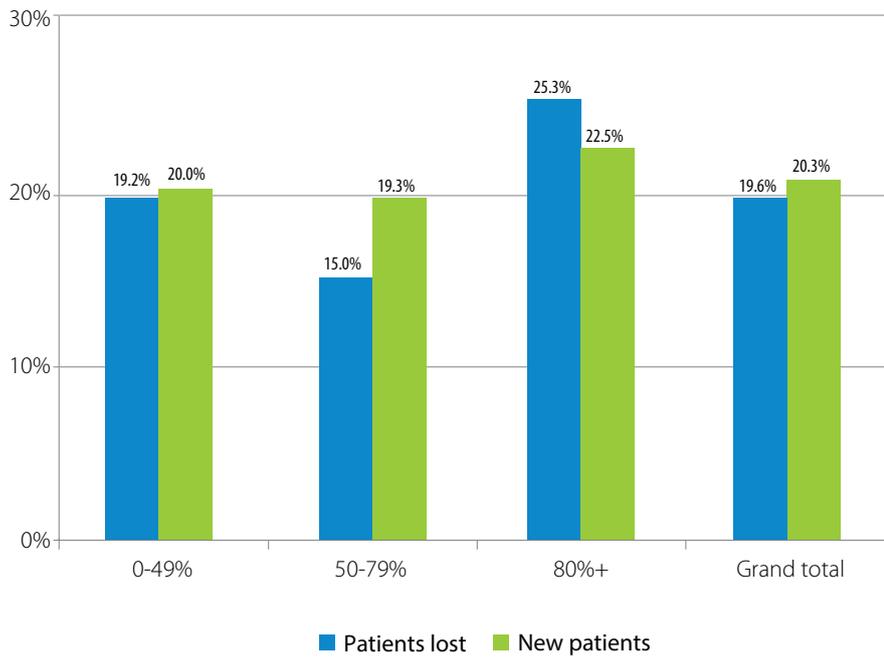


Figure 11: Patient register changes (%) for NHC practices by practice 'high-needs' category (1 July 2014–30 June 2015) as at Q4 2014/15



The Deloitte report fails to address the impact of patient turnaround on the costs of these clinics. The impacts are twofold.

Firstly, there is a significant administrative cost in enrolling new patients, including completing the enrolment form, establishing eligibility and obtaining patient notes from the previous clinic. It is interesting to note that in their paper "Targeting Resources: Strengthening New Zealand's Primary Care Capitation Funding Formula", the PHO Alliance advocates for a higher capitation payment for the first year that a patient is enrolled with a practice, noting: "newly registered patients place a greater cost pressure upon their registered provider for the period immediately following their registration ... we believe this effect should be recognised within the formula for a maximum period of one year and only at a level which does not encourage or incentivise practice hopping".

At the same time, dis-enrolling patients, and concomitant tasks such as sending patient notes to the new clinic, is also a costly process. It is arguable that these costs were never allowed for in the Capitation Formula funding in the first place as such tasks were, by and large, not required in a non-capitated environment. To the extent that a practice has higher rates of turnover than the national average they are clearly disadvantaged. Arguably, a significant number of practices are in this position.

Secondly, there is a significant clinical cost. It is accepted that first visits by a patient to a clinic generally require more time than subsequent visits in order to establish rapport with that patient, and get family and patient histories, etc. If, each year, a clinic is seeing 25% of its patients for the first time, the impact on clinical cost will be greater than in a clinic with a more stable patient register. This places Very 'High-Needs' Practices at a further disadvantage under the current Capitation Formula.

'High-Needs' Providers derive smaller proportions of income from patient co-payments

As recorded above, the importance of this issue really became apparent when PSAAP negotiations were focussed on the annual inflation adjuster calculation by LECG consultants. It was disclosed that the calculations of the adjuster assumed the capitation income was 50% of a practice's total income and that patient co-payments comprised the other 50% of income generated by a patient visit. It is clear that this assumption is not accurate for many providers. For many 'High-Needs' Practices, patient co-payments are as low as 8–12% of total practice revenue. This is because they are limited to charging a maximum of \$17.50 per visit, have larger numbers of young patients aged 0–13 for whom the fees are nil and also have higher numbers of patients aged 14–24 where co-payments are often less than \$17.50. Further, because of their economic circumstances, many of those patients who should pay fees are unable to do so.

The VLCA subsidy payment averages between \$6.28 and \$11.41 per visit (see Figure 2 above) for age categories 14 years and over, where co-payments can be charged. If the maximum co-payment of \$17.50 is added, the total falls well short of the revenue being generated in Auckland and elsewhere for 'non High-Needs' Practices. In these practices, co-payments range between \$34.00 and \$56.00. Because of the nature of non-VLCA practices, the collection rate of co-payments will also be much higher, putting them at a further advantage.

Consultation complexity and proportion of 'high-needs' patients

As a part of contributing to the understanding of the differential 'make-up' of providers (i.e. 'high-needs' compared to 'non high-needs'), Dr David Jansen and Dr Laura Broome undertook to investigate if there are any differences in the complexity or number of patients that present with chronic conditions between a 'High-Needs' Practice compared with a lower needs practice they investigated one hundred consecutive consultations beginning on the 4th August 2015 at two NHC practices.

While this exercise and consequent analysis was limited in its size and scope, it does however provide a 'marker' of the likely differences in factors relating to patient consultation complexity between Very 'High-Needs' Practices and not so 'High-Needs' Practices. The findings indicate that there are large differences between the patient consultations in these providers. The clinic with a very high proportion of 'high-needs' patients have more chronic conditions, are prescribed more medications, but present to clinic less often, and more than half of these patients had a debt owing to the practice.

To investigate if there are any differences in the complexity or number of patients that present with chronic conditions between a 'High-Needs' Practice compared with a lower needs practice, one hundred consecutive consultations beginning on the 4th August 2015 were audited at two NHC practices.

The definition of chronic conditions used is based on the Quality and Outcomes Framework identified by Salisbury, Johnson, Purdy, Valderas and Montgomery in 2011.²¹ Information about these consultations was collected from the Patient Management System (PMS), including demographic data (age, sex, and ethnicity), clinical data (chronic conditions and how many issues were recorded as featuring in the consultation notes) and provider service data (number of consultations in the last three years, and any debt recorded at the provider).

Practice Tahī has 3,000 patients, is owned by a non-governmental organisation and has a high proportion of 'high-needs' patients (Māori, Pacific and quintile 5) comprising 98% of its enrolled register. Practice Two is a privately owned inner city practice of 6,000 patients of whom 42% are 'high-needs'.

Demographics of patient register

Both clinics saw approximately equal numbers of male and female patients. The patients presenting at Practice Two were more likely to be younger (average age 29 years) and of NZ European, Asian or Other Ethnicities (40%, 25% and 25% respectively). The patients presenting at Practice Tahī were more likely to be older (average age 50 years) and of Māori, NZ European or Pacific ethnicities (65%, 13% and 13% respectively).

	Practice Tahī	Practice Two
Age (Average)	50 years	29 years
% Female	53%	52%
% Male	47%	48%

Table 1. Demographics of 100 patients presenting at Practices Tahī and Two

Ethnicity	Practice Tahī	Practice Two
Māori	65%	9%
NZ European	13%	40%
Pacific	13%	1%
Other	7%	25%
Asian	2%	25%

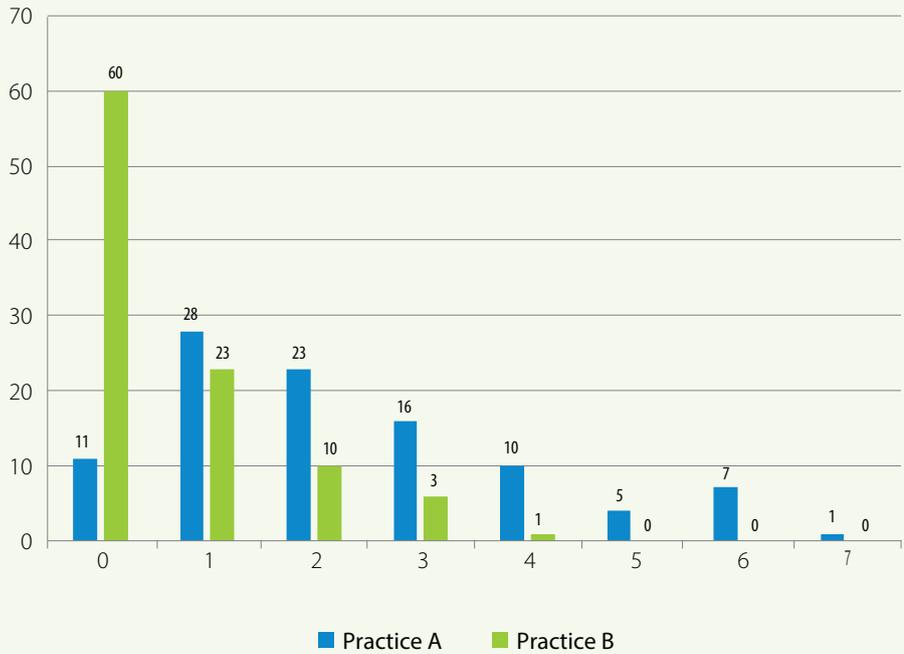
Chronic conditions

Chronic Conditions			
Asthma	Chronic Obstructive Pulmonary disease	Epilepsy	Mental Health
Atrial Fibrillation	Chronic Obstructive airways disease	Heart Failure	Obesity
Cancer	Dementia	Hypertension	Stroke
Coronary heart disease	Epilepsy	Learning Disability	Thyroid disease
Chronic Kidney disease			

²¹Salisbury C, Johnson L, Purdy S, Valderas JM, Montgomery AA, Epidemiology and impact of multimorbidity in primary care: a retrospective cohort study. Br J Gen Pract. 2011 61(582)

On average, patients from Practice Tahī presented with 2.31 chronic conditions per patient compared to 0.59 chronic conditions per patient from Practice Two. For patients from Practice Tahī, 11% had no chronic conditions compared to 60% from Practice Two. For patients from Practice Tahī, 67% had 1-3 chronic conditions compared to 39% from Practice Two; and 22% of patients from Practice Tahī had 4-7 chronic conditions compared to only 1% from Practice Two (see Graph below).

Number of Chronic Conditions



Number of issues discussed and number of medications prescribed at the consultation

At the consult on the 4th August 2015 a similar number of problems were discussed at the two practices (1.11 per person for Practice Tahī and 1.25 per person for Practice Two). More medications were prescribed at this consultation for patients at Practice Tahī (2.61 per person for Practice Tahī and 1.5 per person for Practice Two).

Number of consultations in the last three years

Despite the patients in Practice Tahī having more chronic conditions they were seen less often. The average number of consultations over three years is 14.1 for Practice Tahī and 20.1 for Practice Two.

Debt

Patient debt is recorded in the PMS and there is a very clear difference between the patient populations at the practices. At Practice Tahī, 53% of the patients presenting on the 4th August 2015 had debt owing to the practice (average debt was \$40 and the range was from \$5-\$202). At Practice Two only one patient presenting on the 4th August 2015 had a debt owing to the practice and this was for \$17.50.

Other evidence of disadvantage

Other evidence of the lack of viability and sustainability of Very 'High-Needs' Providers and the PHOs which have supported them, is the history of those organisations since 2002 when the Capitation Formula was introduced.

Since that time, the following Māori and Pacific PHOs have ceased to operate:

- Te Kupenga A Kahu PHO
- Waiora Healthcare PHO
- Tamaki Healthcare PHO
- Te Kupenga O Hoturoa PHO
- Ta Pacifica PHO.

In addition, the following Māori providers have withdrawn – in full or in part – from providing GP-based primary care services:

- Raukura Hauora O Tainui in South Auckland (four clinics)
- Waipareira Trust
- Ngāti Whātua o Ōrākei Health Services (one clinic)

Clinical workforce

It is widely acknowledged that better health outcomes eventuate if health services are delivered in a culturally safe environment. It is also acknowledged that this is best achieved by having appropriate numbers of Māori and Pacific health professionals working in primary care. In 1997, the Clinical Training Agency of New Zealand – then responsible for the post-graduate training of doctors and nurses – set the challenging goal that, by 2020, the proportion of Māori and Pacific doctors and nurses employed in the New Zealand health system would equate the proportion of Māori and Pacific people in New Zealand.

Recent Ministry of Health statistics show how little progress has been made in this area.

Māori make up approximately 14.7% of the enrolled population but 2013 Ministry of Health figures show that of a total of 3,679 GPs only 94 (or 2.6%) were Māori GPs. This represents a shortfall of 446 Māori doctors if the 2020 target is to be reached. The figure for all medical professions is no better, with 345 Māori doctors of all professions out of a total of 12,606 (or 2.7%).

The position for Pacific doctors is, again, no better, with 2013 Ministry of Health figures showing there were 63 GPs (or 1.7% of total GPs) compared with Pacific people comprising 7.3% of the population. In total, there were 226 Pacific doctors or 1.8% of the total number of doctors in New Zealand.

The significant use of nurses by Very 'High-Needs' Practices was highlighted in Table 7. Nursing Council statistics as at 31 March 2015 show there were 11,322 nurses working in primary care. Of these, 1057 (or 9.3%) were Māori, and 323 (or 2.9%) were Pacific. Both statistics are well below the numbers needed to achieve the Clinical Training Agency targets for 2020, and also the numbers needed to ensure Māori and Pacific people receive clinically appropriate care from our primary health services.

Conclusion

It is clear from the analysis of current information provided by NHC practices that the substantial disadvantage identified in 2011 for Very High Needs Practices resulting from the application of the current Capitation Formula have not been addressed or improved. Further, VLCA funding does not adequately address the issues of underfunding for these practices and they remain at a serious disadvantage to 'mainstream' practices.

The analysis completed using data generated by 26 practices within the NHC's primary care network demonstrates that those practices with a higher proportion of high needs patients continue to be challenged by factors impacting their sustainability. These factors result in a higher than average cost structure and include:

- Higher fee-for-service (FFS) deductions (most likely due to the increased mobility of high needs patients and whānau)
- More visits per annum by high needs patients
- Higher patient turn-over (leading to greater administrative costs)
- Lower percentage of income generated by patient co-payments

In addition, the sample review of two practices (one Very High Needs and one Non-High Needs) demonstrated that patients in the Very High Needs Practice presented with nearly four times the number of chronic health conditions than those in the Non-High Needs Practices. Despite the higher number of chronic conditions, these patients were, however, seen less often over the previous three years. While numbers of issues discussed during consultations was similar, medication prescribing was higher for patients in the Very High Needs Practice. In relation to patient co-payments, the sample review also highlighted the considerable difference in patient debt between the two practices, with 53% of the patients in the High Needs Practice owing money to the practice, while only one patient owed debt to the Non-High Needs Practice.

The data generated from both the analysis of the 26 practices within the NHC network and the sample review of a Very High Needs Practice and Non-High Needs Practice in the NHC network provides alarming evidence of the funding disadvantage faced by Very High Needs Practices. The current debate regarding the funding formula has tended toward a predominance to emphasise the assumed importance of the VLCA contribution to funding primary care as an equity adjuster that should be applied to patient subsidies for high needs patients (i.e. the funding should follow the patient). While this has a lot of merit on one level (in terms of reducing financial barriers to accessing primary care for some parts of the population) it ignores the realities and challenges faced by Very High Needs Practices to remain sustainable. Total capitation payments exceed \$600 million per annum while total VLCA payments amount to approximately \$60 million, or 10% of the capitation total. It follows that small changes in the Capitation Formula would produce the same results as a major change to VLCA, without the same adverse impact on Very High-Needs Practices.

It is also important to note that the reduction in the number of Māori provider led primary care practices and the PHOs that supported them, has reduced over time. This points to further evidence of the sustainability issues faced by very High Needs Providers. This coupled with the workforce challenges of increasing ethnic equity across professional health groups exacerbates this disadvantage.

The current prevailing commentary focussing on the VLCA funding, while well intentioned, stands to further erode and undermine the sustainability of Very High Needs Practices if VLCA is redirected as suggested, for example by the recent Primary Care Working Group, without any consideration of the wider funding mechanisms and environment. We suspect the answer to meeting the challenge of appropriately subsidising patient care for individual high needs patients as well as maintaining primary care practice sustainability lies in considering the total funding environment rather than one funding stream in isolation.



National
Hauora Coalition

Post

PO BOX 104221
Lincoln North
Auckland 0654

Head Office Location

Harbourside Business Park
485B Rosebank Road
Avondale
Auckland 1026

Phone (09) 950 3325

Fax (09) 950 3326

www.nhc.maori.nz