Primary Care in New Zealand
The Capitation Environment

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Introduction

• History
• Funding Streams
• Examples
• Benefits and Challenges
Context

• Various models internationally.
• General debate over FFS, Capitation or hybrid model.
• FFS is based on consultation
• Capitation base on population
• NZ has somewhat of a hybrid, weighted to capitation.
• Capitation typically makes up about 50% of practice income.
NZ History

• Various formulae in NZ over the 1990s
• Community services card introduced 1992 provided eligibility for cheaper primary care
• 21% of eligible adults did not have a CSC by the late 90s
• 1997 about 15% and 2001 22% of GPs on capitated funding
Fees for service incentives

- Access
- Follows mobile populations
- Favours easy, brief access
- Patient health outcomes
- Favours completeness of care
- Also favours over servicing
- Doesn’t encourage preventative approaches
- Overall health care cost
- Less predictable than capitation
- Cost less managed
Capitation Incentives

• Access
• Enrolment establishes explicit carer/patient relationship
• Encourages long term relationships
• Allows greater flexibility, which can aid access
• Rewards enrolling patients
• Patient health outcomes
• Encourages use of preventive and educational methods
• Also favours under-servicing
• Does not incentivise providing complex, expensive care.
• Overall health care cost
• More predictable than FFS
• Cost more managed
NZ History

• HFA commenced development of a nationally consistent formula in 1999

• Objectives were to:
  – improve equity of funding between 4 regions
  – target communities with higher health needs
  – promote enhanced roles for nurses and others
  – Promote management of populations ("denominator management")

• The formula represented a shift from targeting to universality
How does it all work?

• The capitation based payment system is based on the enrolled PHO population.
• PHOs and their general practices are paid according to the number of people enrolled, not the number of times a provider sees patients.
• Acknowledges people need more care at different times in the life span.
Types of Capitation Funding

• VLCA
• Non-VLCA
• First Contact Care
• Health Promotion
• Services to Improve Access
• Claw backs
Capitation Funding

• Average Funding Per Patient for one quarter was $32.64
• Average proportion of claw back was 2.0%
Funding Increase and Co-payment

• Capitation has been CPI adjusted each year to date since its inception in 2004. This is based on national indices such as wage costs rise in electricity etc. It does not take into account local expense issues.

• Practice charge co-payments and govt set reasonable fee levels.
Impact of Capitation

- Patient co-payments have fallen
- Consultation rates have increased
- In “access” practices (those with the lowest fees) rates increased across all age groups
- Lower increases in “interim” practices, except for people over 65 years (where increase was consistent with “access”)
- Primary care delivering more to higher needs populations.
- Practice more profitable and sustainable
Impact of Capitation

• Data quality has improve significantly
• Health targets improved greatly (e.g. Screening)
• Makes Shared Care Record Implementation easier (patients have a home).
What’s the verdict?

- Generally felt that capitation has resulted in better care.
- Is believed that capitation revived Primary Care in New Zealand.
- Can create disincentive to enrol highest need patients.
- Still room for improvement!