The ongoing evolution of capitation funding for primary care: the December 2018 PHO capitation funding changes for Community Services Card holders

Peter Crampton

ABSTRACT

AIM: To 1) consider the possible impact on equity of the recent policy to support people on low incomes to access primary care using the Community Services Card (CSC), and 2) identify questions that will need to be answered in order for the policy and funding changes to be evaluated.

METHODS: Review of publicly accessible reports, papers, media releases and websites to detail and examine the funding changes made in December 2018 to implement the CSC policy.

RESULTS: CSC possession is an important new determinant of eligibility to low-cost access to primary care for many people. As the funding changes are complex, the equity effects cannot be fully understood until further detailed modelling is carried out, and specific questions are answered.

CONCLUSIONS: The December 2018 PHO capitation funding policy changes represent a further step towards universal low-cost primary healthcare. The effects of those funding changes should now be evaluated in order to understand their effects on equity. It is the responsibility of the Ministry of Health to ensure that an evaluation of the changes takes place.

Barriers to access to primary care take many forms, one of which is cost.\(^1,2\) In the 15-plus years since the implementation of the Primary Health Care Strategy, positive progress has been made in reducing financial barriers to access to primary care. Cost, however, continues to be a barrier for many people, particularly for Māori, Pacific and low-income individuals, whānau and communities. For example, the 2016/17 New Zealand Health Survey revealed about one in seven adults (15%) reported not visiting a general practice due to cost in the past year, which is not significantly different from 2011/12. About 20% of those living in the most socioeconomically deprived areas indicated cost as a reason.\(^3\) Similarly, recent surveys conducted by the Health Quality and Safety Commission indicate that cost barriers to accessing primary care affect Māori, younger and more deprived populations disproportionately and have done so consistently for the past five years, despite changes in public health funding to reduce these barriers.\(^4\) Māori are 1.4 times more likely than non-Māori to identify cost barriers to accessing primary healthcare.\(^4\) By way of international comparison, a 2016 Commonwealth Fund survey showed 18% of New Zealand respondents reporting cost-related barriers to care, behind only Switzerland (22%) and the US (33%). Only 7% of UK and German respondents reported such barriers, with the Netherlands and Sweden on 8%.\(^5\)
While this paper focuses on cost barriers to access, other barriers, for example cultural and travel/distance barriers, have important compounding effects and deserve separate policy attention.1,2

The vision articulated in the Labour Government's 2001 Primary Health Care Strategy stated that "A strong primary healthcare system is central to improving the health of New Zealanders and, in particular, tackling inequalities in health".6 In other words, the mainstream primary care system was redesigned with an explicit focus on reducing 'health inequalities'. One of the aims of the Strategy was to provide all New Zealanders with access to low-cost primary care. Because of the magnitude of the funding increases necessary to achieve this objective, implementation was to be phased in over a five- to eight-year period, and the government decided to introduce universal low-cost access in areas with high-need populations first.7 Primary Health Organisations (PHOs) that had an enrolled population with at least 50% defined as 'high need' (Māori and/or Pacific and/or NZDep decile 9/10) were funded under the Access capitation formula, which included levels of funding to enable low-cost access for all enrolled persons. Providers serving populations with fewer 'high need' enrolees were funded via a lower-rate Interim capitation formula with the intention that funding would evolve to Access levels over time.7

With the roll-out of capitation funding, practices funded by the Access formula had their fees capped, and practices funded by the Interim formula were required to reduce their co-payments by a prescribed amount,8 with the result that the differential in fees for non-Access practices that existed before the implementation of the Strategy has been maintained. The regulation of annual co-payment increases is outlined in the PHO Service Agreement.9 The agreement provides for an independent statement of “reasonable fee increases” that sets a maximum annual increase in co-payments on a percentage basis.10 Capitation funding (a form of population-based funding for primary care services) has been used to some extent in New Zealand since the 1940s11–13 and, following the implementation of the Primary Health Care Strategy, has been the predominant funding mechanism for PHOs. The PHO capitation funding formulas have been described in more detail elsewhere7,14–17 and, as indicated above, changes to the formulas since the initial implementation of the Primary Health Care Strategy have been incremental and evolutionary. Some of the key capitation formula policy milestones over the past 18 years are listed in Table 1.

<table>
<thead>
<tr>
<th>Year and following</th>
<th>Policy milestone</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002 and following</td>
<td>Progressive introduction of new capitation funding formulas: 1. First Contact (Access) 2. First Contact (Interim) 3. Services to Improve Access 4. Health Promotion 5. Care Plus 6. Management Services</td>
<td>Significant new investment in primary care between 2004 and 2008 was required to support these funding changes and their associated policy objectives. The Interim formula initially left the average fee-for-service per capita subsidy unchanged in aggregate. Initially, on average an Access practice received approximately 60% more than the same practice would under the Interim formula. This differential has diminished over time and is now minor (around 3%).</td>
</tr>
</tbody>
</table>

Table 1: Selected PHO/practice funding formula policy milestones.7,12,14,17,19–23
Table 1: Selected PHO/practice funding formula policy milestones (continued).

| Year | Event Description | Details
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>2006</td>
<td>The Very Low Cost Access (VLCA) Scheme was introduced in response to ongoing concerns about barriers to access to primary care services.</td>
<td>VLCA was initially a voluntary opt-in scheme. For those practices that opted in, a funding top-up was provided over First Contact capitation funding along with the requirement that all adult patients be charged the same low co-payment. Initially 218 of the 1084 general practices joined the VLCA scheme. By 2009, 316 practices participated in the scheme (covering 29.3% of all PHO enrolees).</td>
</tr>
<tr>
<td>2008</td>
<td>Introduction of the Zero Fees for Under Sixes Scheme to provide free in-hours doctors’ visits for children under age six years.</td>
<td>Non-VLCA practices were eligible to apply for the under-sixes payment if they committed to providing free standard consultations to children under six. Practices that received the VLCA payment were not eligible to apply for the under-sixes payment.</td>
</tr>
<tr>
<td>2009</td>
<td>The eligibility criteria for VLCA practices changed, whereby eligibility was restricted to practices that had at least 50% enrolled patients Māori and/or Pacific and/or living in NZDep quintile 5 areas.</td>
<td>Practices that were already in the scheme that did not meet the new criteria could remain in the scheme.</td>
</tr>
<tr>
<td>2010</td>
<td>The Flexible Funding Pool was introduced (in some districts, but not fully in all).</td>
<td>The Flexible Funding Pool groups together some or all of the funding for Services to Improve Access, Health Promotion, Care Plus and Management Services. Administration of the pool is the responsibility of the PHO/DHB Alliance. The scheme was first introduced as a pilot and then rolled-out nationally in 2013.</td>
</tr>
<tr>
<td>2013</td>
<td>The Minister of Health announced the VLCA Practice Sustainability Initiative in response to VLCA sustainability issues.</td>
<td>The initiative included a sustainability fund of $4 million and one-off funding to employ graduate nurses. The Fund was discontinued from 30 November 2018, and the funding used to support the new primary healthcare initiatives that took effect from 1 December 2018.</td>
</tr>
<tr>
<td>2015</td>
<td>The Zero Fees scheme for general practice visits and prescriptions for children less than six years of age was extended to children up to and including age 12 years.</td>
<td>This policy applied to all VLCA practices and was opt-in for non-VLCA practices. Additional funding was provided for practices that opted in. Uptake was reported to be approximately 96% of all practices during 2015.</td>
</tr>
<tr>
<td>2018</td>
<td>The PHO Services Agreement was amended to reintroduce differential subsidies for CSC holders and extend Zero Fees to 13 year olds.</td>
<td>These changes are largely focused on CSC as an eligibility mechanism. See text below for details.</td>
</tr>
</tbody>
</table>
The latest set of changes, effective from 1 December 2018, were brought in to implement the Government’s policy intention of addressing cost as a barrier to primary care access, particularly for those on low incomes, through the use of the Community Services Card (CSC) and extending free care to 13-year-olds.18

The aims of this paper are to: 1) consider the possible impact on equity of the recent policy to support people on low incomes to access primary care using the CSC, and 2) identify questions that will need to be answered in order for the policy and funding changes to be evaluated.

Inevitably some of the issues raised in this paper speak to the larger and more complex issue of whether or not wholesale reform of primary care funding is required, and the form any such changes might take. It is not the intention of this paper to address these larger questions, but rather the paper focuses on some of the implications of the recent CSC changes from an equity perspective.

Methods

Data for this paper were obtained from reports, papers, media releases and websites publicly accessible around the time of the December 2018 funding changes.

Results

The December 2018 PHO capitation funding changes

The changes introduced on 1 December 2018 resulted from negotiations carried out by the PHO Services Agreement Amendment (PSAAP) Protocol Group. This Group negotiates the national agreement for funding and delivery of primary care services, and comprises PHOs, contracted providers (mainly general practices), DHBs and the Ministry of Health.26

The changes reflect, in modified form, some of the recommendations contained in the 2015 report of the Primary Care Working Group on General Practice Sustainability.13 For example, the Working Group recommended that the “CSC be reinstated as a funding variable and eligibility thresholds be reviewed, access be simplified, issuance of the card be automated and CSC data be available within the National Enrolment Service”, and “CSC, ethnicity and deprivation be used as factors to reallocate the existing VLCA top up payment to individual high-need patients wherever they are enrolled”.13

The Ministry of Health website summarises the policy changes as including:26

- Access to low-cost general practice visits to all CSC holders, including injury-related visits (ACC).
- CSC eligibility to all people receiving the accommodation supplement or who are tenants in public housing.
- Zero-co-payment general practice visits and exemption from the standard prescription co-payment charge (usually $5 per item) on subsidised prescription items for children aged 13 and under. This includes after-hours services and injury-related visits (ACC).

In reality the funding changes to implement the policy initiatives are somewhat complex and the financial implications for any given practice need to be modelled in order to be understood (see Tables 2 and 3). Full details of the PHO capitation changes are contained in the PHO Services Agreement Version 6.0 (1 December 2018).9

In summary, funding changes for practices in the Very Low Cost Access (VLCA) scheme are:

- CSC possession by enrolled patients results in additional funding to practices. (VLCA practices receive the same CSC-holder funding as non-VLCA practices.)
- An estimated additional net gain of $17.9m per annum has gone into VLCA practices as additional funding for CSC holders.27
- The VLCA sustainability fund was discontinued.
- VLCA practices no-longer receive Access first contact rates for children under 14 years.19
- VLCA payment rates for children aged 12 and under have been reduced to those of the Zero Fees scheme.

Funding changes for non-VLCA practices are:

- Non-VLCA practices can choose to opt-in to the new CSC funding scheme.
• CSC possession by enrolled patients results in additional funding to practices.

• For non-VLCA participating practices, the VLCA co-payment caps now apply for CSC holders: CSC holding adults now have a capped co-payment of $18.50 and for youth (14–17 inclusive) the cap is $12.50. By way of example, to compensate non-VLCA participating practices for lowering their fee to $18.50 for a CSC holder aged 65-plus, the practice receives $219.42 on top of base capitation for males and $205.31 for females.

• Non-VLCA practices previously participating in Zero Fees for Under 13s have automatically been transferred to Zero Fees for Under 14s.

• Non-VLCA high-needs practices have kept their Access funding for children under 14 years.

• A total budget of $100m per annum has been estimated to cover the CSC changes (with $17.9m estimated for VLCA practices).

**Table 2:** Additional capitation funding for VLCA practices (in addition to the base capitation).

<table>
<thead>
<tr>
<th>Age group</th>
<th>Gender</th>
<th>Old rates</th>
<th>CSC Yes</th>
<th>CSC No</th>
<th>CSC Yes</th>
<th>CSC No</th>
</tr>
</thead>
<tbody>
<tr>
<td>00–04</td>
<td>Female</td>
<td>$108.10</td>
<td>$81.07</td>
<td>$81.07</td>
<td>-$27.03</td>
<td>-$27.03</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>$113.81</td>
<td>$85.36</td>
<td>$85.36</td>
<td>-$28.45</td>
<td>-$28.45</td>
</tr>
<tr>
<td>05–14*</td>
<td>Female</td>
<td>$54.63</td>
<td>$62.58</td>
<td>$58.51</td>
<td>$7.95</td>
<td>$3.88</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>$53.99</td>
<td>$62.44</td>
<td>$58.35</td>
<td>$8.45</td>
<td>$4.36</td>
</tr>
<tr>
<td>15–24</td>
<td>Female</td>
<td>$31.02</td>
<td>$56.13</td>
<td>$31.02</td>
<td>$25.11</td>
<td>-$0.00</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>$17.07</td>
<td>$34.12</td>
<td>$17.07</td>
<td>$17.05</td>
<td>$0.00</td>
</tr>
<tr>
<td>25–44</td>
<td>Female</td>
<td>$27.25</td>
<td>$78.09</td>
<td>$27.25</td>
<td>$50.84</td>
<td>$0.00</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>$17.62</td>
<td>$86.01</td>
<td>$17.62</td>
<td>$68.39</td>
<td>-$0.00</td>
</tr>
<tr>
<td>45–64</td>
<td>Female</td>
<td>$37.33</td>
<td>$155.51</td>
<td>$37.33</td>
<td>$118.18</td>
<td>-$0.00</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>$27.88</td>
<td>$159.71</td>
<td>$27.88</td>
<td>$131.83</td>
<td>$0.00</td>
</tr>
<tr>
<td>65+</td>
<td>Female</td>
<td>$64.33</td>
<td>$205.31</td>
<td>$64.33</td>
<td>$140.98</td>
<td>$0.00</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>$55.48</td>
<td>$219.42</td>
<td>$55.48</td>
<td>$163.94</td>
<td>-$0.00</td>
</tr>
</tbody>
</table>

* The relatively small differences in funding for this age band reflect the fact changes only apply to 13- and 14-year-olds (zero fees for 13 years and under, plus CSC funding changes that affect 14-year-olds).


**Table 3:** Additional capitation funding for CSC-participating non-VLCA practices (in addition to base capitation).

<table>
<thead>
<tr>
<th>Age group</th>
<th>Gender</th>
<th>CSC Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>00–04</td>
<td>Female</td>
<td>$0.00</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>$0.00</td>
</tr>
<tr>
<td>05–14</td>
<td>Female</td>
<td>$4.07</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>$4.09</td>
</tr>
<tr>
<td>15–24</td>
<td>Female</td>
<td>$56.13</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>$34.12</td>
</tr>
<tr>
<td>25–44</td>
<td>Female</td>
<td>$78.09</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>$86.01</td>
</tr>
<tr>
<td>45–64</td>
<td>Female</td>
<td>$155.51</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>$159.71</td>
</tr>
<tr>
<td>65+</td>
<td>Female</td>
<td>$205.31</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>$219.42</td>
</tr>
</tbody>
</table>

Take up of these new funding arrangements has been estimated as 85% of non-VLCA practices as at 1 January 2019.\textsuperscript{29}

Implications of the December 2018 funding changes

CSC possession is now an important new determinant of eligibility to low-cost access for many people: if you have a CSC and are enrolled with a practice that has joined the CSC scheme, you are entitled to low-cost, capped co-payments. Before the introduction of the Primary Health Care Strategy it was estimated that around half the population were eligible for a CSC.\textsuperscript{16} The Ministry of Social Development has reported the number of card holders (not including dependents) from 1997 to 2018 inclusive: in 1997 there were 1,061,048 card holders, about one-third of the population (120,494 (11.4%) of whom were Māori), and in 2018 there were 818,479 (163,565 (20%) of whom were Māori).\textsuperscript{30} It has been estimated that, as a result of the December policy changes, there will be an extra 80,000 people newly eligible for a CSC on the basis that they receive an accommodation supplement or income-related rent subsidy.\textsuperscript{28} The latest eligibility thresholds are shown in Table 4.\textsuperscript{31}

Since its introduction in 1992,\textsuperscript{32} concerns have been expressed about the CSC as a health benefit targeting mechanism.\textsuperscript{13,33,34} The initial intent of the fifth Labour Government (1999) had been to phase out CSCs as a basis for targeted subsidies in favour of a more universal approach to funding access to first contact care\textsuperscript{7} (noting that targeted versus universal approaches is itself a debated issue). Concerns regarding the CSC have focused on low uptake of CSCs by eligible people, high transaction costs associated with administering CSCs, the inadequacy of CSCs to capture the complexity of low socioeconomic position, the low income threshold for CSC eligibility (for example, the current threshold for a single person without an Accommodation Supplement and living alone ($28,322 per annum) is well below the minimum wage ($36,816.00 per annum)\textsuperscript{31,35}), and the poverty trap at the low end of the non-eligible population. The Ministry of Health is working with the Ministry of Social Development to enhance the automatic issuing of CSCs, which will help mitigate the problem of low uptake by eligible people, and to facilitate the linkage of CSC details to patients in the National Enrolment Service to further lift matching rates.\textsuperscript{36}

Table 4: Income thresholds for CSC eligibility.

<table>
<thead>
<tr>
<th>Family composition</th>
<th>Annual income (before tax) is less than:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single - living with others</td>
<td>$26,688</td>
</tr>
<tr>
<td>Single - living alone</td>
<td>$28,322</td>
</tr>
<tr>
<td>Married, civil union or de facto couple - no children</td>
<td>$42,352</td>
</tr>
<tr>
<td>NZ Superannuation single, sharing accommodation</td>
<td>$27,571</td>
</tr>
<tr>
<td>NZ Superannuation single, living alone</td>
<td>$29,299</td>
</tr>
<tr>
<td>NZ Superannuation married, civil union or de facto relationship - no children</td>
<td>$43,872</td>
</tr>
<tr>
<td>Family of 2</td>
<td>$51,730</td>
</tr>
<tr>
<td>Family of 3</td>
<td>$63,675</td>
</tr>
<tr>
<td>Family of 4</td>
<td>$73,461</td>
</tr>
<tr>
<td>Family of 5</td>
<td>$83,074</td>
</tr>
<tr>
<td>Family of 6</td>
<td>$93,653</td>
</tr>
</tbody>
</table>

For families of more than 6, the limit goes up another $9,490 for each extra person

Widely different views have been expressed recently about the equity consequences of the introduction of CSCs into the First Contact funding formulas. For example, a view expressed by a Ministry of Health spokesperson states that the CSC initiative is aimed at reducing financial barriers for low-income New Zealanders and the Ministry expects that about 75% of Māori will have access to lower co-payments once the initiative has been fully implemented. However, while more Māori may gain access to lower co-payments, the capitation rates in Table 2 show there will be significant differences in practice funding for Māori depending on the individual's CSC status. Therefore an opposing view has been expressed, suggesting that the funding changes will not address and remedy disparities for Māori and Pasifika.

Further detailed modelling over coming months will be required to determine in detail all the consequences of the December 2018 funding changes. For example, it is possible that the changes will result in a net proportional shift of funding from younger age groups to older age groups, with equity consequences for Māori and Pasifika communities. For individual practices the situation is equally unclear. Presumably a practice will join the scheme if it is perceived to be financially advantageous. PHO modelling provides some guidance on this but, as noted by the NZMA GP Council Chair, this guidance is patchy and inconsistent, as some PHOs are better than others at providing this type of support. Patients’ access to subsidies therefore may be partly determined by the quality of support offered to individual practices as guidance to determine whether or not to join the scheme.

Evaluating the impact of the December 2018 funding changes

As a result of the changes brought about by the Primary Health Care Strategy considerable progress has been made in reducing financial barriers to access for many people, particularly for children and young people, with resulting positive outcomes. The latest set of developments, the December 2018 PHO capitation funding changes, arose from PSAAP Group discussions; in other words, important funding policy decisions were made more in the context of provider negotiations than on the basis of an open, principles-based, policy-led process. The effects of those funding changes must now be evaluated. This evaluation should be carried out in the context of wider, and in some cases long-expressed, concerns about the need for further primary care funding changes to address a range of problems.

Specific questions related to how well the CSC changes serve the equity principle

What are the equity effects for Māori, Pasifika and low-income families of the introduction of CSCs into the capitation formula?

- What is the uptake rate of eligible people of CSCs? Is uptake related to age and/or ethnicity?
- Is there evidence that fee caps have been set at a level at which socioeconomically disadvantaged people are more likely to access primary care?
- What are the equity effects, for overall practice funding, of the reduction of VLCA practice capitation rates for children?
- What is the rationale for specific funding rates? For example, practices receive $219.42 on top of base capitation for male CSC holders aged 65-plus and $205.31 for females (in other words, what calculations were used to derive the funding differential?).
- What other factors, over and above CSCs, should be included in the First Contact capitation formula to increase the equity effects of the formula (for example ethnicity and socioeconomic deprivation)?
- What else will/can be done to address or mitigate the historical concerns regarding the CSC?
General questions related to the ongoing sustainability and further development of PHOs/practices

- Will funding provide incentives and opportunities for practices to manage demand for services including providing services in a different way, through a variety of modes of engagement and workforce configurations?
- Will additional funding to VLCA practices through CSC holders be sufficient to ensure the sustainability of practices serving high numbers of high-needs patients?
- Will funding provide incentives for the further development of high-performing, multi-disciplinary primary healthcare teams?
- Does funding support a focus on promotion, prevention and population health as envisioned by the Primary Health Care Strategy?
- Will the complexities of administering the new CSC scheme prove burdensome for practices?
- What is the future role of the High User Health Card and other mechanisms for supporting people with high health need?

Answering these questions will be essential if the equity effects of the funding changes are to be fully understood.

Conclusion

The December 2018 PHO capitation funding policy changes represent a further step towards universal low-cost primary healthcare. The effects of those funding changes should now be evaluated in order to understand their effects on equity. It is the responsibility of the Ministry of Health to ensure that an evaluation of the changes takes place.

Competing interests:
There was no external funding source for preparing this article. The views, opinions, findings and conclusions or recommendations expressed in this paper are strictly those of the author. They do not necessarily reflect the views of the institution where the author currently works. The paper is presented not as policy, but with a view to inform and stimulate wider debate. Peter Crampton is a member of the Government's Health and Disability System Review panel; the views expressed here are his own and not those of the panel.

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