The funding has changed

– We need to change the business model

Carolyn Gullery

Carolyn Gullery *has worked in the health sector and in conjunction with general practice for 20 years. The first seven as Division Manager of a pharmaceutical company, the next seven as a funder in the RHA, THA and HFA responsible for, amongst other things, Primary Care Services, and the last six as an independent consultant working with a variety of organisations across the health and disability sectors. One of her current roles is as Chief Executive of a large PHO, Partnership Health Canterbury – Te Kei o Te Waka – which encompasses six IPA/PCOs, 109 general practices and 332 000 enrolled people.*

In Germany, physicians are paid on the basis of individual services provided. In India, government physicians are salaried. In the Netherlands, general practitioners receive a fixed amount for the year per patient from the sickness funds. Why do countries adopt such different provider payment mechanisms? What effect do payment mechanisms have on health care? Experience from many countries reveals that payment methods generate powerful incentives that affect how providers produce health services. Depending on the nature of these incentives and the market and institutional contexts in which they exist, payment mechanisms may induce movement toward or away from improved efficiency, equity, consumer satisfaction, and health status. For these reasons, changes in how health service providers are paid form a central part of broader health reforms.

In New Zealand we have just undergone a radical change in how general practice services are funded by the government. There has been a great deal of debate about the practicalities including the basis of the two funding formulae, the level of co-payment to be charged, the provision of after-hours services and other peripheral mechanisms such as 'clawback'. The rhetoric has been about the opportunity for changing the way general practice is delivered by removing the focus on GMS and therefore doctor consultations. But there has been little discussion about the impact of the changes to incentives on service delivery and particularly within the context of the existing general practice business model. Consequently we are seeing some changes around the edges, such as an increase in the range of services available and being charged for, and an increasing role for other health professionals, particularly practice nurses, but much of that was already happening and fundamentally general practice is still delivering a 'fee for service' product based on face to face consultations between a health professional and a patient. As the pressure on this model increases, along with patient expectations (the baby-boomers are getting older and needing more health care and we know they are the most demanding generation yet), general practitioners are feeling more dissatisfied with their income and their work load and although some have seen how to get out of the trap, many still see the only part they have any control over is the fee they charge.

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I don't claim to have the answers to this dilemma, but I think we need to start asking the right questions. In the 20 years that I have worked with general practice in a number of roles there have been amazing developments such as the introduction of health centres often including a range of health professionals, after hours cooperative services and their purpose built facilities and importantly (also astonishingly in the context of a small business model) the development of organised general practice generally in the form of IPAs.

The debate over the funding of general practice in New Zealand has generally been characterised as a choice between Fee-For-Service (FFS) and Capitation (or hybrids of either). As payment mechanisms these are more similar than at first appearance. Both pay a set amount for each unit of service. What differs is the nature of the service being purchased and therefore the nature of the incentives created.

Under 'FFS' the service purchased was, and still is in the case of 'clawback', a consultation between a doc-

tor and a patient. The consultation may be the first presentation in a particular episode of care, or a repeat visit. It may be a preventative checkup, diagnostic in its focus, or to continue a previously commenced treatment.

Under 'capitation' the service purchased is the care of a patient for a period of time. The payment is usually for services provided by the general practice team (i.e. it excludes referred services), but it is not restricted to a consultation. It may include no consultations or many. Contact between the patient and the clinician is not restricted to face-to-face encounters, but can be by phone, in writing, or by email. The care can be directly managed by the general practitioner, by other members of the general practice team or delegated outside of the team to another service provider.

Under both FFS and capitation the amount paid per unit of service can vary on the basis of a similar range of criteria, including:

- Proxies for the patient's need (e.g. High User Card, age, deprivation. ethnicity, Community Services Card)
- Proxies for the patient's ability to pay (e.g. Community Services Card)
- The location of the service provision (e.g. rural loadings).

Thus the payment mechanisms are very much the same – a payment for each unit of service delivered, with the payment adjusted to attempt to reflect the expected resource intensity of the care. As previously stated, what differs is the nature of the service being purchased and therefore the nature of the incentives created.

The question facing general practice now should not be how much do we charge for the service, but what service should we be providing?

The shift to capitation for the government portion of the funding provides an opportunity to review the general practice business model. General practice is not the only professional service facing this issue. I have also discussed service and pricing models with lawyers and accountants who are finding the 'hourly' rate approach limiting. Fundamentally if we accept an hourly rate or a fee per consultation we limit the potential of the service to the amount of hours we ourselves are able to invest. This equation of income directly related to the hours input is a major contributor to reducing the attractiveness of general practice to potential new entrants.

How did we get here and where can we go?

Historically the various iterations of government funders have purchased components of care in the primary sector. They purchased consultations from GPs, tests from laboratories and medications via pharmacies. Other components of care, despite evidence of their effectiveness in appropriate circumstances, were not purchased – for example physiotherapy or dietician services in the primary sector. All these services are what are often called 'inputs'. They are a smorgasbord of options that could be assembled into a package of care by a general practitioner, in consultation with other health professionals.

The particular services appropriate for treating a particular condition may vary dramatically from patient to patient. Therefore, to achieve the best outcome for any patient requires the general practitioner to have the greatest possible discretion in using their clinical skill and evidence of effective treatment to:

- manage the way in which they provide their component of the care to the patient, and
- select the best services to treat the patient.

However, the manner in which government funders have purchased these services fragmented the options available to general practitioners. The general practitioner was effectively told that they can use this 'input' but not that one. The patient may visit the general practitioner but not consult by phone. The general practitioner must take the patient's blood pressure in the clinic but not the nurse at the patient's home and so on. A patient who was able to pay could purchase other services themselves but subsidies for some services and not others still introduced bias into clinical decision making and undermined moves towards service delivery efficiency.

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The underlying problem was that the funder had not delegated sufficient responsibility to general practice and instead exercised strong control over the way in which general practice delivered care to patients. This, in turn, meant that:

- patients did not necessarily get the best care possible
- general practitioners were not able to use resources (especially their own time) most effectively. The total service was therefore likely to cost more than it needed to, and
- different patients with the same needs received different amounts of government assistance because of the variation in practice methods of their respective general practitioners.

Capitation arrived in this environment. The theory behind capitation is that it enhances clinical effectiveness, cost effectiveness and equity by changing the service purchased from general practice. Instead of purchasing consultations from general practitioners, capitation, in theory, purchases (or in our case at least subsidises) a service that equates to the 'management of the patient's care' over time.

In theory the general practice team and the patient should then be free to agree how best to deliver the care that the general practice offers, or to involve others as appropriate.

The result should be that the funder buys what it actually needs from general practice (patient care not the doctor's time regardless of how it is used), and general practice is freed of bureaucratic constraints in how they provide that care. Thus the funder is purchasing 'outputs' not 'inputs'. The decision about which 'inputs' to combine to deliver an 'output' is left to those at the coalface, with the skills and experience to deliver the best result for each patient.

As the funder only pays part of the cost in our model it is expected that patients would in general continue to pay co-payments to their practice.

Under capitation, general practice should be relatively free to construct co-payment arrangements to suit their practice, with significantly more scope for variation than at present. For example, a general practice could charge an annual enrolment fee plus a smaller per visit fee for some patients. A general practice could charge less for certain types and/or timing of services that cost less to provide, thus sensitising patients to the costs of the services they use without the cost becoming prohibitive. General practice could provide a different range of services. General practice could choose to provide the patient with a health management service and also provide a plan of care. Personal trainers could be incorporated to meet the needs of patients with lifestyle issues. General practice could develop family care plans where the costs are averaged across the family and the incentive is for the whole family to enrol with the general practice. Patient care for some individuals could be managed predominantly by email or telephone. General practices could provide a home-based service for a select group of clients to ensure regular contact.

I could actually go on for quite a while about the innumerable options but they all require one thing: a break with the current paradigm of fee for service for 10 to 15 minute episodes of care. A new model requires flexibility in the appointment system, teamwork in the practice and a clear understanding of the cost structures of the business. More importantly it requires a dialogue with the patients. Most businesses adapt to the needs of their clients (within the constraints of what they are willing and able to deliver) and that is how they grow and thrive. General practice, however, has been remarkably responsive to the government funder with an entire service delivery model built around the government's funding model (isn't it remarkable how powerful the funding incentives are given the small proportion the government contributed). The move to capitation can free general practice from some of these constraints but general practice needs to free itself from others, as these constraints are dependent on how the business is organised. While the focus is on how to make a FFS model work, there is little time for investment in developing a model that will work moving forward. This leaves general practice with little room for manoeuvre and stuck in a battle over how high the fees will go.

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I said earlier that I didn't know the answers, but I knew that we needed to ask a different set of questions and we need to focus some time and energy on these questions. Business consultants will advise that to be successful you must spend a significant portion of your time working on the business not in the business. This cannot be about doing more and more activity for less and less income, it has to be about delivering more service (from the patient's perspective) for more income (from the general practice perspective) with less cost from everyone's perspective.

'To build a flourishing private practice is the dream of most hospital consultants, but to achieve this they are almost totally reliant on the goodwill of general practitioner colleagues. There is nothing new in this, except that increasingly I hear GPs complaining about being the poor relation in this lucrative business. To put it bluntly, Mrs Smith may be worth several hundred or even several thousand pounds as she trots up to a private consulting suite underwritten by her health insurance company, but to her GP she can never be worth more than £20.05 per year. GPs know that this is the way of the world, although many are not happy about it. What price ethical purity in an increasingly market driven health service? However, if GPs cannot reap financial benefit from private referrals, they do at least have the ability to decide which of their consultant colleagues will benefit, and some are enjoying the power that this gives them.'

Kandela P. The strange world of private medicine. BMJ 2004;328:355.