Funding primary care to the tail of the bell curve

A CASE STUDY

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New Zealand

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Session outline

- Context
- Data & methods
- Results
- Policy implications

Primary care context

- **PHC Strategy 2001**– move from targeted to more universal funding
- Reduce health disparities & improve health outcomes
- Blend of state subsidies & patient co-payment
- PHO Performance Programme - incentives

PHOs **Non-profit**

For-profit primary care
GP owned

Non-profit primary care
Community owned

Capitation introduced

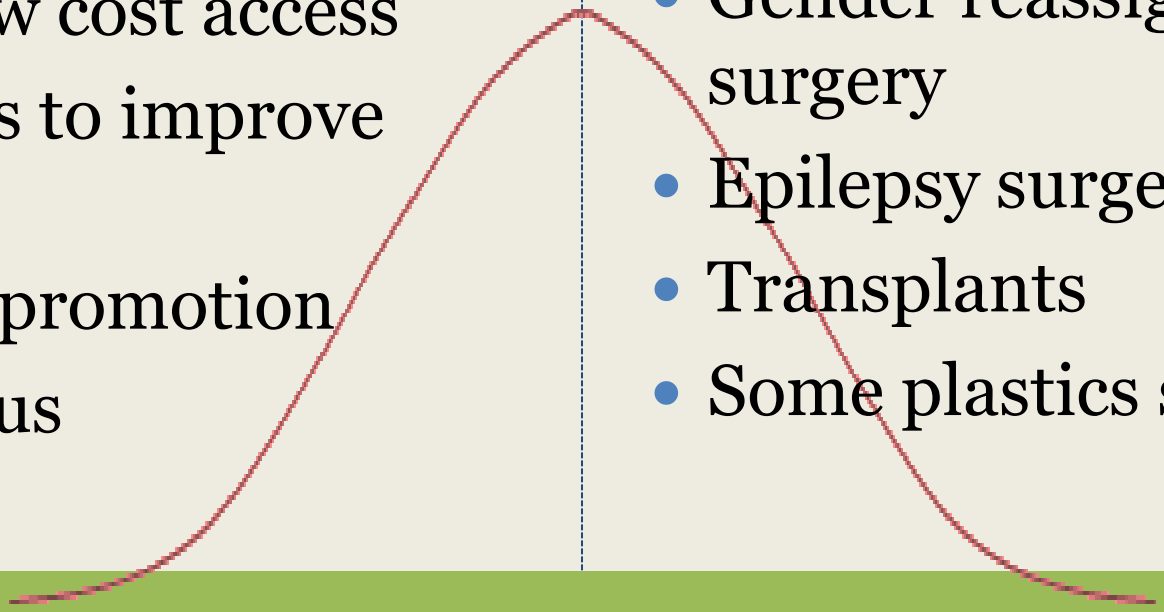
Funding the tails

Targeted funding

- Ethnicity
- Deprivation
- Very low cost access
- Services to improve access
- Health promotion
- Care Plus

High-cost treatment pool – one-off treatments not otherwise funded

- Surgery for various A-V malformations
- Gender reassignment surgery
- Epilepsy surgery
- Transplants
- Some plastics surgery



The case

- Te Aro Health Centre
- Non-profit
- ~1450 enrolled
- Must have CSC or be in assisted accommodation
- Co-payment of $12.50 if seen at 331 Willis Street
- Outreach rooms adjacent to DCM
- Soup kitchen
- Night shelter
- Highly skilled staff – RN x3.5, NP x1, GP x1

Mission: Provide low cost, high quality, accessible health care to those with a CSC

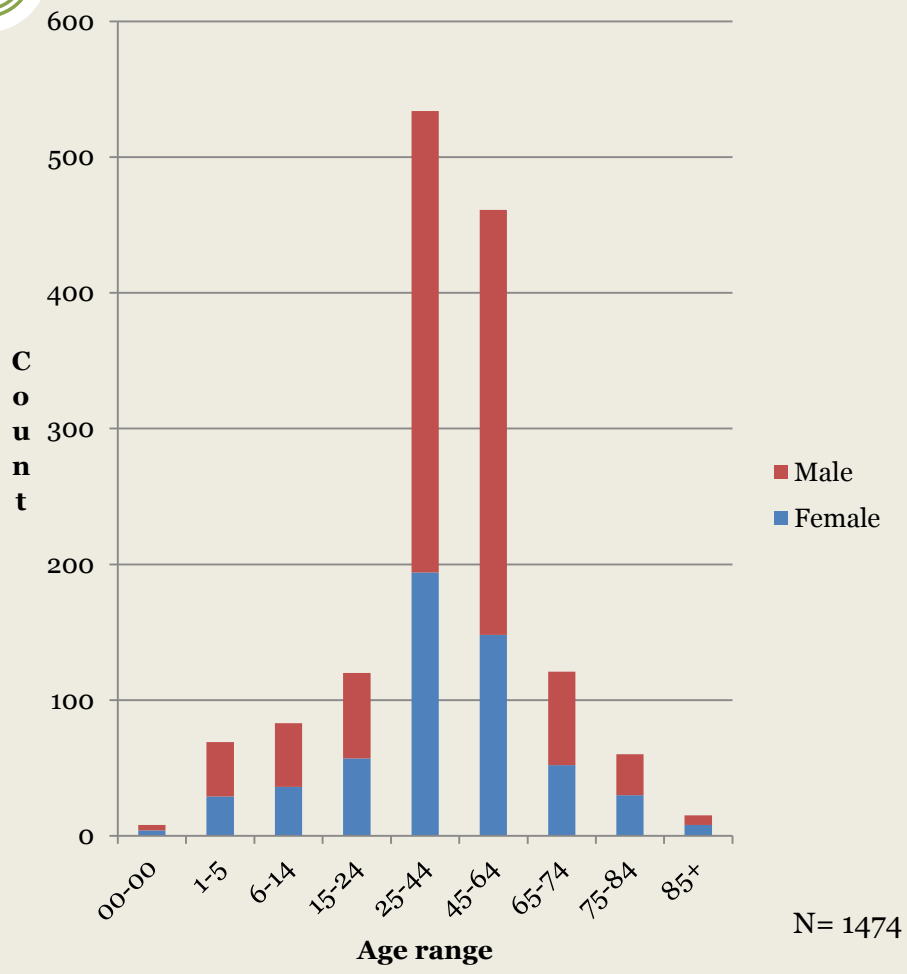
Data & methods

- Data obtained from the PMS at the clinic
- 2011/12 financial year
- Basic descriptive statistics
- Data compared to available funding streams

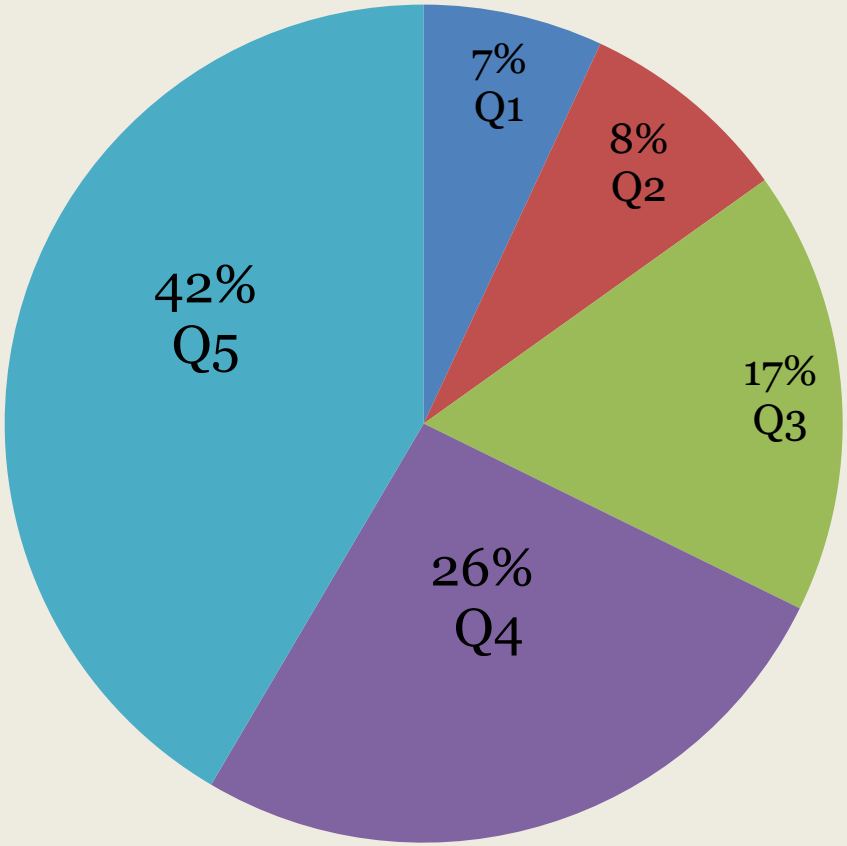


Results
Age and sex

- Inverse distribution pattern
  - Usually more children and older people
- Fewer women of child-bearing age
- Age is the primary demographic variable that influences funding rates
- Least amount of money for the 25 – 64 age groups, and even less for men.



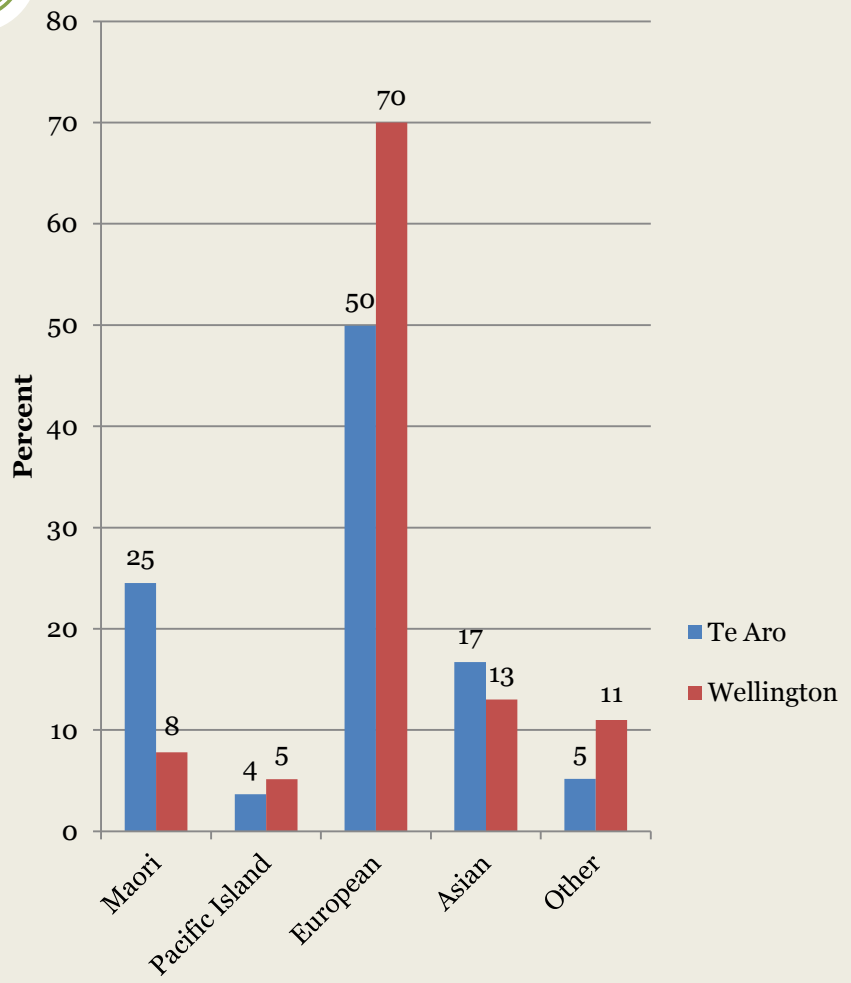
Deprivation quintile



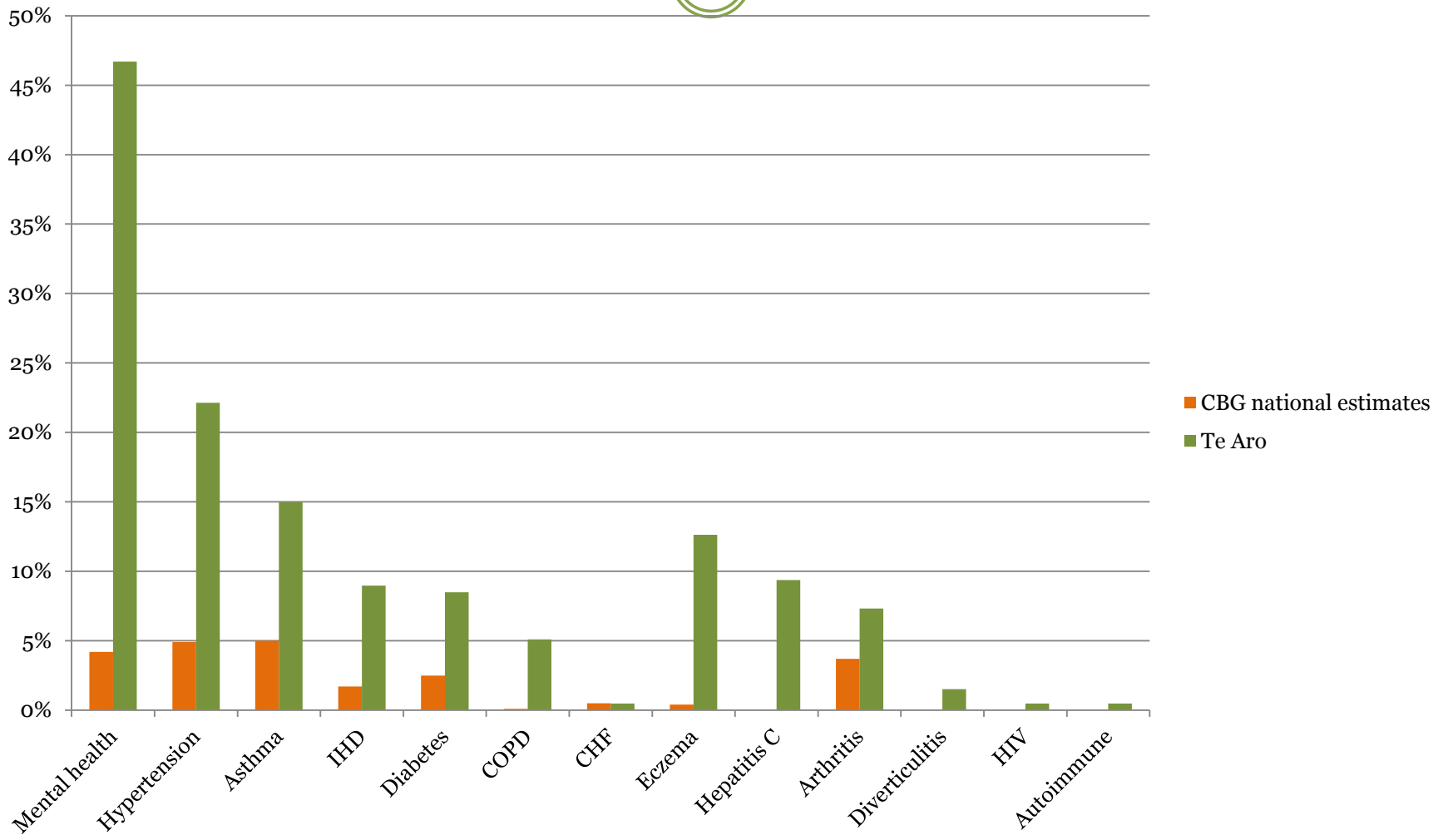
- Quintiles 4 and 5 are the most deprived
- Comprise 68 percent of enrolments
- Extra funding for high levels of deprivation
  - health promotion (HP)
  - services to improve access (SIA)
  - very low cost access (VLCA).

Ethnicity

- HP, SIA and VLCA funding streams are weighted for high-need as measured by ethnicity and deprivation, and favour Maori and Pacific enrolees.

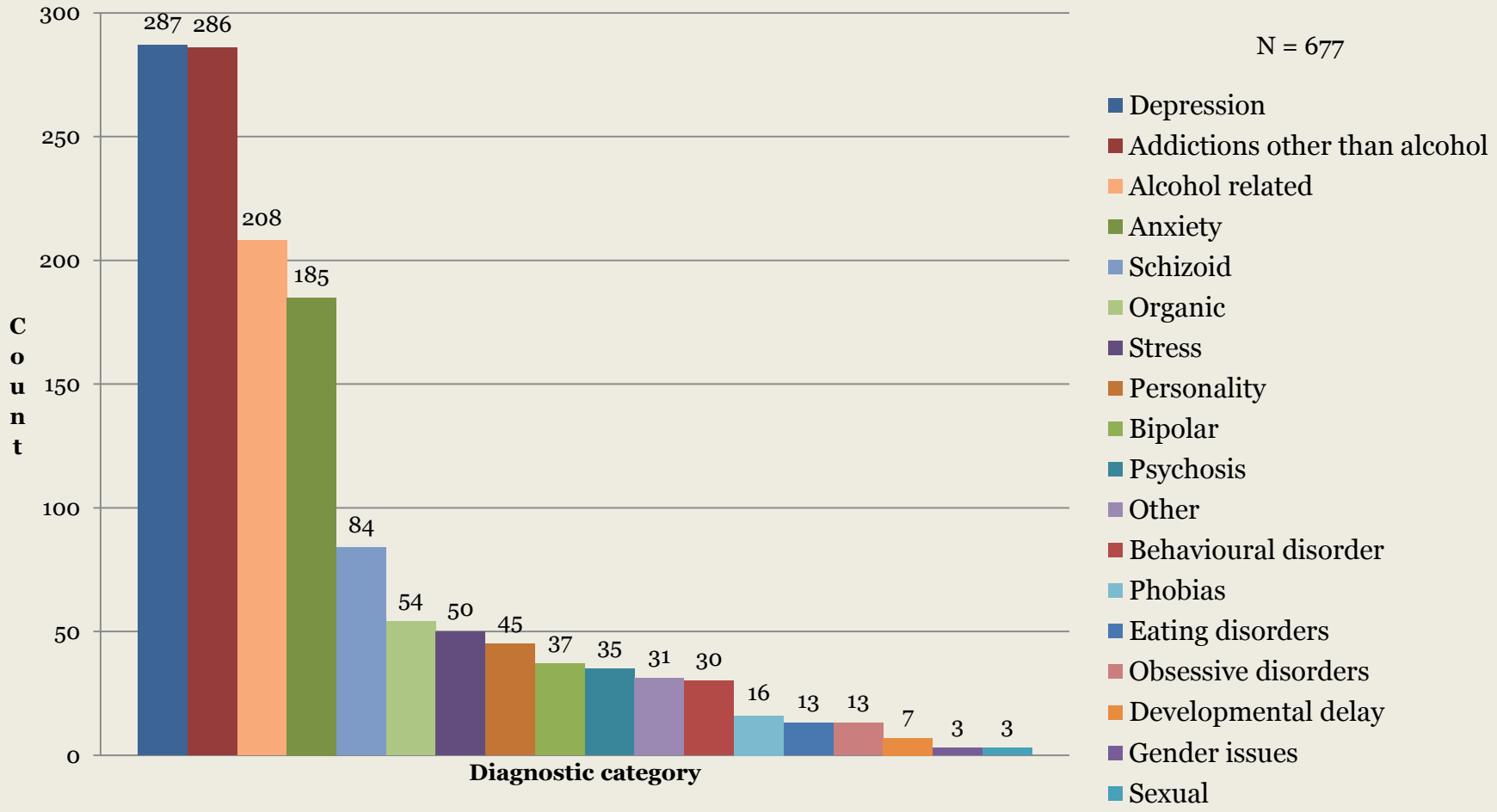


Most common chronic conditions in CBG* 2006 national estimates matched to Te Aro

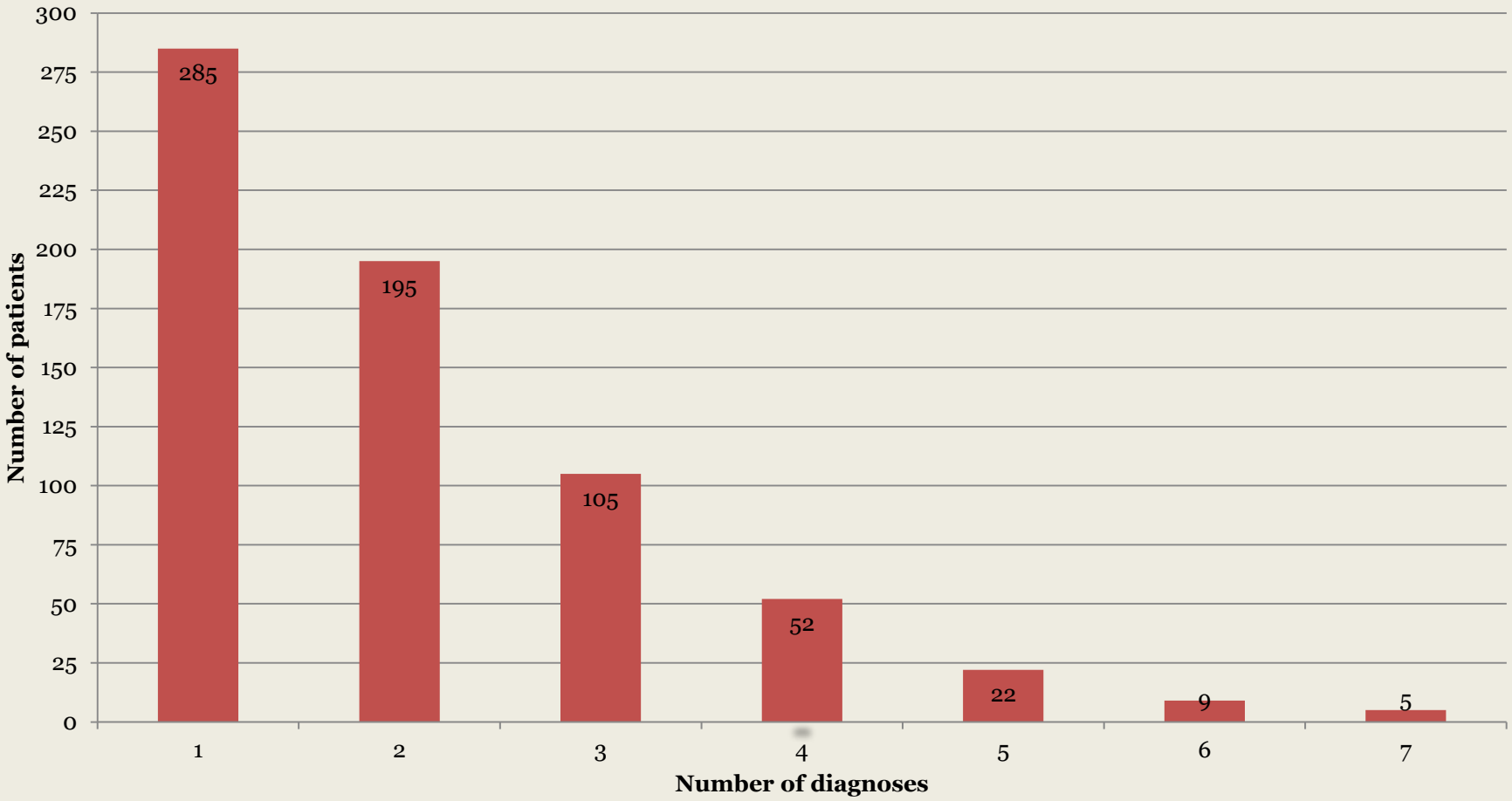


*CBG Health Research. (2006). *Review of the implementation of Care Plus*.

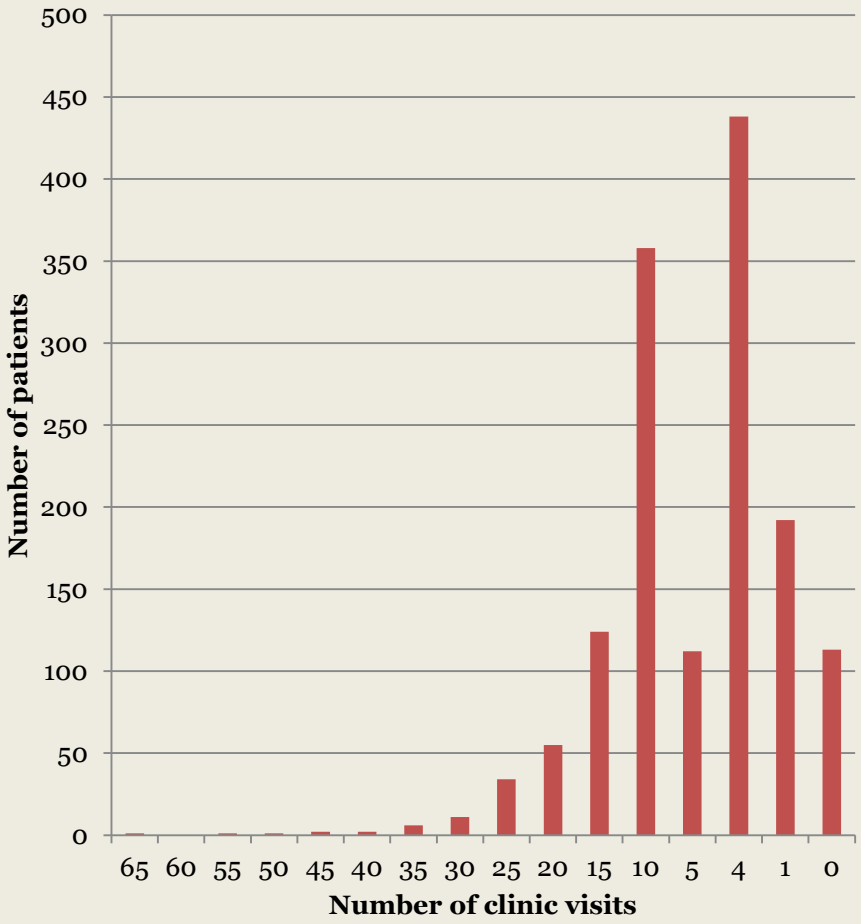
Mental health diagnostic categories



Number of mental health diagnoses/patient



Number of patient visits to the clinic



- Total number of clinic visits = 8932
  - [Copayment received for 4316 visits]
- Overall mean = 7
- Range = 0 to 62
- 44% attended ≥6 times*
  - Mean = 11

Categories of need based on frequency of clinic attendance

Clinic attendance (count)	Number of patients	Percentage of patients	Rounded percentage	Category
>20 (up to 62)	66	4	5	Extreme high need
10 to 19	222	17	20	Medium high need
5 to 9	419	32	30	High need
1 to 4	630	47	45	NZ average
Total	**1,337**	**92**	**100**	

Care Plus

Eligibility

- *Two or more chronic health conditions
- 2 acute medical or MH admissions in last 12 months
- *6 primary care visits in last 12 months, including ED

Funding

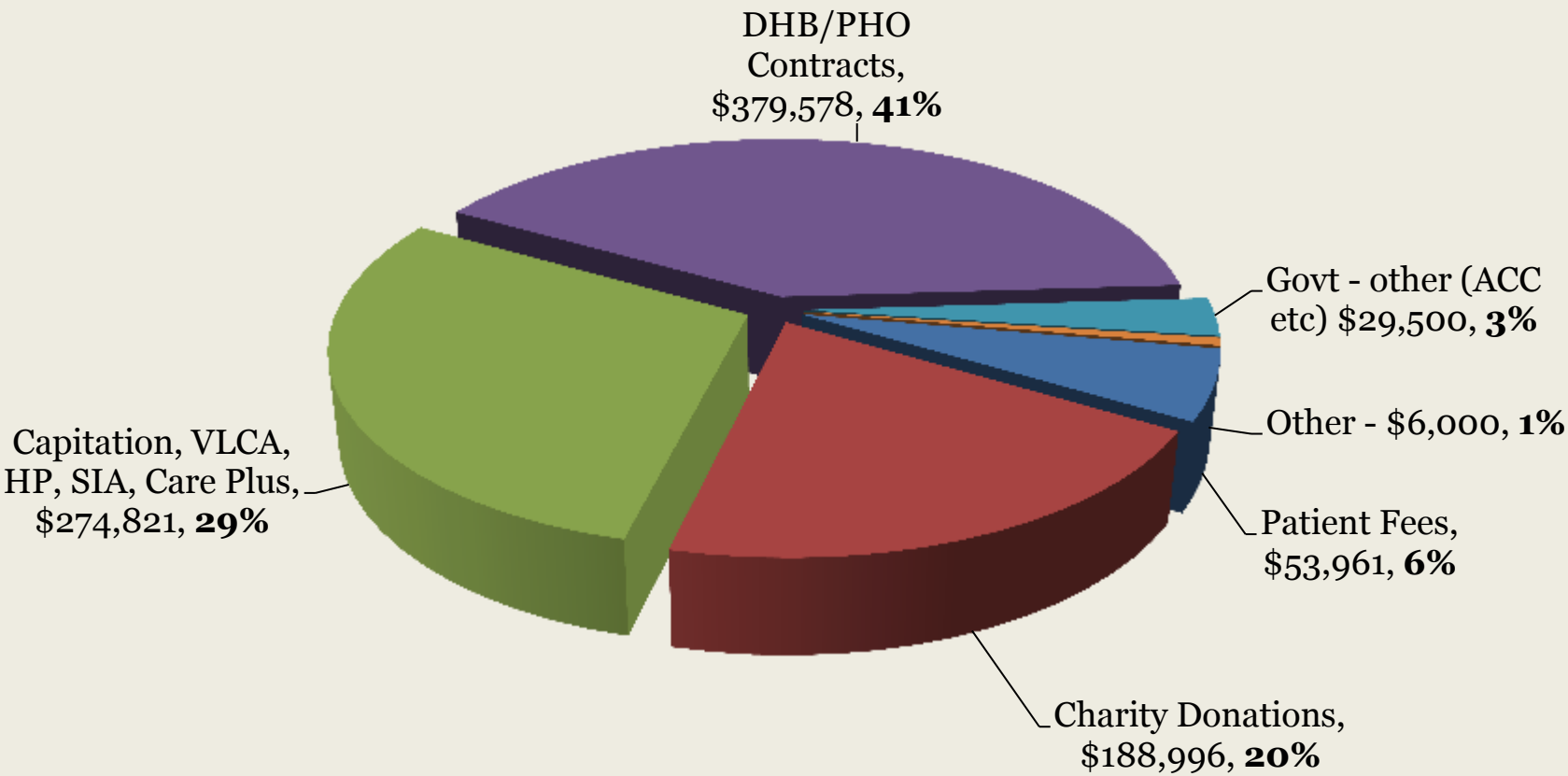
- Overall, 5% of the NZ population can be on Care Plus
- Weighted to ethnicity & deprivation
- Te Aro can claim ~102 patients
- $NZ 244/patient
- No or low co-payment

Te Aro's fit with Care Plus criteria

- Data doesn't tell us overall how many co-morbidities each patient has, but
  - Mental health data shows that 29% (n= 388) have 2 or more diagnoses
- We do know that 44% (n= 595) attended 6 or more times
- Due to ethnicity and deprivation weighting, eligibility for enrolment in Care Plus has increased to 7% or 102 patients.

Where does this leave us?

Breakdown of income by source category



In practice

- For-profit practices have shareholding owners
  - Are financially incentivised to 'skim the cream' (Cumming & Mays, 2011; Howell, 2005).
  - Enrol healthy patients
  - Children, women & older people attract higher capitation payments
  - Co-payment can be >$17 (Wellington ~$30 - $60 adult)
- Non-profit practices are community owned
  - Pick-up those with high needs
  - Face significant funding shortfall.

Policy implications

- Apparent under-estimate of the funds needed for [extreme & medium high] high-needs populations
- Under-funding leads to increases in avoidable hospitalisations (Barnett & Malcolm, 2010)
  - Fund all patients who meet Care Plus criteria in VLCA non-profit practices
- Funding streams based on historical usage and the 'NZ average' demographic are inadequate for clinics at the tail of the curve.

Universal funding vs targeted approach

"A system cannot be considered equitable if some members of society are not realising their health potential, and financing of primary care should remain redistributive until such a time as this objective is attained"
(Langton & Crampton, 2008).

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