

VIEWPOINT

Patient enrolment with co-payments: implications for patient choice in general practice

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NZ Med J 1999; 112: 473-4z

New Zealand's new general practice strategy¹ proposes to introduce 'block funding,' or capitation, of general practice for an enrolled population. Considering consultation feedback,^{2,3} the Health Funding Authority (HFA) will revisit and refine different aspects of the strategy. Assuming that enrolment will occur, this article considers some of the implications, especially for patient choice.

According to the strategy, practices will be paid according to the health care needs of their population rather than for each consultation or intervention. The range of funded services will vary, the vision being to form primary health service organisations from a number of practices in order to provide general practice services and manage population-based and referred services (pharmaceuticals and laboratory tests). A number of organisations, including some Independent Practitioner Associations (IPAs), are already managing these three types of services and bulk-funding of practices is achieving momentum. Impetus for the growth of bulk funding has come mainly from the Midland division of the HFA: 45 per cent of its general practitioners (GPs) were bulk-funded as of June 1997 whereas the percentages in other regions ranged from 4.8 to 12.^{4,5}

The strategy will require patients to enrol with, and seek most of their general practice care from, one practice of their 'choice.' Patients may 'choose' not to enrol with any practice or to consult practices with whom they have not enrolled but 'casual' consultations seem likely to be discouraged. The implications for patients are defined, in part, by an awareness both of the likely consequences for the HFA and general practice and of why the strategy is being driven forward.

For the HFA, patient enrolment will cap primary care expenditure, though the government, whose influence is expanded by bulk-funding, has stated its commitment to increasing the funding for primary care. Budget management strategies are expected to reduce the wide variation in the volume of annual per capita expenditure between practices⁵ but, so far, only modest savings have been achieved.⁵ Bulk-funding also passes risks from the HFA to GPs who could be asked to pick up services that the HFA withdraws.³ A small number of large primary health service organisations win lessen contracting costs for the HFA and patient co-payments will achieve cost-sharing.

For providers, patient enrolment offers some benefits. By delineating the eligible patient population for which each practice has defined responsibilities enrolment with block-funded practices should give GPs predictable cash-flows. However, maintenance of accurate enrolment systems is associated with high time/dollar costs² and absorbs GPs in administration.³ Nevertheless, enrolment and bulk-funding should facilitate delegation in practices, for example to practice nurses, and increase the community-orientation of service delivery. They are also expected to facilitate measurement of practice activity and research, improve coordination of care, reduce duplication of services and lessen GP fear that occasional conflict with patients may lose them to other practices.²

According to the HFA, patient enrolment will also strengthen personal relationships between GPs and their patients by increasing longitudinal care (person-focused care over time, regardless of the problems or needs of patients, except for referrals). The HFA states that most patients already use one GP for their care and that increased longitudinality of care will improve this care significantly.¹ However, it neither cites evidence of net benefits of longitudinal care for patients nor demonstrates a stated awareness of the limitations. As a basis for future dialogue and debate, this article discusses how patient enrolment may limit patient choice and some of the implications of that erosion of choice.

Patient choice

The first contact, or gatekeeping, role of general practice limits patient choice of provider. According to Starfield⁶ (p 1131), this constraint can be offset by "free choice of primary care source." However, the general practice strategy undermines this choice by limiting patients' freedom to receive longitudinal care from more than one practice and idiosyncratic care on a per visit basis with no patient history or expectation of continuity. Enrolment may disadvantage patients who want a second opinion in a different practice and patients who do not wish to discuss a particular problem, for example an embarrassing one, with their own GP or another one in the same practice. The range of available services will be reduced for patients enrolled in organisations too small to provide population-based services and manage budgets for referred services. Choice will also be limited by variations in the services purchased from budget savings. Patient co-payments will further limit choice and perpetuate variations in access to care. They will provide an incentive for GPs to see only patients who can afford co-payments and indeed to over-service these patients.

Consequently, patient enrolment with co-payments is anathema to a conception of patients as consumers who have equal access to primary care. The proposed strategy discourages access to multiple providers, even though much care in general practice involves a high degree of uncertainty⁷ and is based on uncontrolled studies or expert opinions that have been proven to be variable and unreliable.⁸ These difficulties are reflected in variations in care between practices. It is also uncertain that most patients want to receive primary medical and nursing care from one practice only.

Limited New Zealand data are available on patient preferences for longitudinal care in general practice. A review of the medical notes of a sample of West Auckland GPs during late 1995 indicated that 13 per cent (n = 5544) of patients had attended another primary medical care provider during ordinary surgery hours over the previous year.⁹ This figure is likely to be an underestimate since "patients will see other doctors without this fact being recognised by practice staff"⁹ (p 17).

Australian data on use of multiple providers are also available. Like New Zealand, Australia operates a fee-for-

service health system that gives freedom of choice of GP for each consultation. Slightly more than half of all consulting patients in Australia's general population have been reported to visit two or more GPs each year.¹⁰ The extent to which these visits occur within the same practices is unstated but the finding suggests that many patients value, and do not want to relinquish, their right to care from more than one doctor, even if they choose not to exercise it.

In New Zealand, the same conclusion can be inferred from the popularity, among patients, of clinics for health services including family planning, travel medicine, and accident and medical care. Assuming an annual mean of four visits by each patient, McCormick (Report to North Health Board, 1997) estimated that 4.5 per cent of general practice-type visits during 1996 were in free-standing accident and medical centres in the Auckland Metropolitan Area. These centres offer immediate access to extended hour, even 24-hour, care. In Australia, this type of service has been popularised by clinics that require no appointments and offer short waiting times and bulk-billing (acceptance of the government rebate as full payment for services).

The foregoing services, some health promotion initiatives such as national breast screening programmes and endorsement of community pharmacists as important sources of advice on medicines^{11,12} are sending a mixed message about the value of longitudinal care. So too are the fees (approximately NZ\$35-40 per visit) for services received by most adult patients in general practice. Maintaining these fees as patient co-payments under block funding arrangements will continue to discourage patient use of general practice services. Co-payments will also diminish many advantages of capitation without patient co-payments, for example, increases in preventative health care.

The formality of choosing, or transferring from, a practice will increase. Thus, patients are likely to find changing their practice more cumbersome than at present.¹³ This obstacle will disadvantage, for example, patients with high levels of residential mobility, such as some Pacific people, for whom distance from the practice may necessitate re-enrolment, and patients who become dissatisfied with the nature of their relationship with their GP or practice.¹⁴ Indeed, difficulties in changing practice may discourage patients from taking this action, thereby potentially concealing dissatisfaction. Not only may patients enrol with only one practice but also limiting their experience to that practice will progressively weaken their knowledge of the potential benefits of enrolment with a different practice.¹⁵

In sum, patient enrolment with co-payments undermines patient choice and imposes longitudinal care on patients and GPs even though the value of longitudinality depends on their shared commitment to it. As McWhinney¹⁶ (p 20) states, "it is difficult (for a doctor) to feel continuing responsibility for a patient who does not value it". These constraints on patient choice might only be justified if there were evidence that concomitant increases in longitudinality of care would produce net improvements in patient care. However, although primary care is uniquely longitudinal,¹⁷ longitudinal care has not been proven to improve patient health outcomes including morbidity and mortality. According to Richards et al,¹⁸ (p 2) the "benefits of continuity are hard to quantify". Most are intuitive and experiential and have not been consistently demonstrated empirically. In part, this is due to the application of

different definitions and measures of longitudinality, but it may also reflect the small size of quantifiable benefits.

Conclusion

The decision to proceed with patient enrolment and co-payments should reflect a critical awareness of the reasons for, and likely implications of, the proposed change. Alleged benefits include an increase in longitudinal care, yet it is unclear that patients want such provider continuity. Assertions that longitudinal care is good for patients are based on an article of faith, both because evidence of its net benefits is sparse and because there are dangers in generalising to New Zealand the experiences of health systems that have been organised and financed in different ways.

Consequently, it is difficult to justify the weakening of patient choice that patient enrolment with one practice would produce, not least because Bill English, when Minister of Health, had stated that choice is important.¹⁹ Indeed, the diminution of choice is not limited to patient enrolment with co-payments. Progressive reductions in the numbers of both GP providers of obstetric care²⁰ and fully subsidised drugs also illustrate variations in patient access. As stated by the vice-president of the Researched Medicines Industry, "We are always concerned about patient choice being eroded and I guess this is the real issue with the delivery of health care in New Zealand, full stop".²¹ Options that would preserve patient choice, whilst offering many of the benefits of enrolment, need to be explored before a wholesale leap of faith based on enrolment with individual practices.

Acknowledgements. This article was written during the tenure of a Repatriation Fellowship of the Health Research Council of New Zealand. The author is grateful to Associate-Professor Ross McCormick and Professor Gregor Coster for their comments on an earlier version of this article.

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