Original Scientific Paper

General practitioners' actual and scheduled charges for consultations with children and the elderly in South Island PHOs

Murray Tilyard MBChB MD FRNZCGP, Elaine Gurr Professor of General Practice, Dunedin School of Medicine; Susan Dovey MPH PhD, Analyst, South Link Health Inc., Associate Professor, Dept of General Practice, Dunedin School of Medicine, and Vanessa Krebs BA, Research Assistant, South Link Health Inc.

Correspondence to: murray.tilyard@stonebow.otago.ac.nz

ABSTRACT

Aims

To compare changes in scheduled general practitioner fees before and after the introduction of capitated funding and to describe actual charges made for consultations following capitation in South Island Primary Health Organisations (PHOs).

Methods

One hundred and eleven general practices supplied Southlink Health with data on scheduled fees before and after capitation funding and actual fees charged for consultations with patients aged six to 17 years and 65 years and over after capitation. Actual charges were classified as 'zero charge', 'less than agreed fee', 'agreed fee', or 'greater than agreed fee'.

Results

Information on 194 089 consultations (post capitation) was collected. In 66.4% of consultations charges were 'zero' or 'less than agreed fee' for the six to 17 year age group (61.3% in the 65+ age group). The average agreed fee in the six to 17 age group was $22.22 compared to the average actual fee of $11.54; for patients aged >65 years, the average agreed fee was $25.57 and actual fee was $15.31. In only 25.4% of consultations with six to 17-year-olds was the consultation charge the amount agreed as the normal fee. Patients >65 years were charged the agreed fee 28.6% of the time.

Conclusion

The introduction of capitation funding in the six to 17 and 65+ age groups aimed to lower the cost of access to general practice. This study demonstrates that general practitioners charge a range of fees for their services. This study reinforces findings from earlier studies even though the policy environment has changed.

(NZFP 2006; 33:184–187)

Introduction

One of the reasons for the introduction of Primary Health Organisations (PHOs) was to reduce financial barriers to access for general practice care.[1] Previous studies have found that New Zealand's health care system sets higher financial barriers to accessing primary health care than many other developed countries.[2,3] Health outcomes in New Zealand also lag behind several comparable countries and improved access might be expected to contribute to better health outcomes.

With the development of PHOs, government policy produced two funding streams: low cost Access PHOs must have an enrolled population of at least 50% Maori, Pacific Island, or socially disadvantaged patients. The capitation funding for these PHOs was set at a higher level to lower the cost of access for all patients. In contrast, Interim PHOs were funded at a lower level, providing little margin to allow fees to be reduced. In October 2003, government announced increased funding for interim PHOs for the six to 17 year age group and, in July 2004, for the 65+ age group to increase the level of capitation funding to that of Access PHOs. Government's expectation was that general practice fees would be reduced

Table 1. Average agreed and actual fee charged by DHB and age group

	6–17 years		65+ years	
	Average Fee Agreed	Average Fee Actually Charged	Average Fee Agreed	Average Fee Actually Charged
NMDHB	$21.55	$12.28	$26.27	$16.04
ODHB	$24.92	$11.55	$25.09	$15.31
WCDHB	$16.50	$6.40	$22.50	$12.19
CDHB	$20.00	$11.07	$23.16	$14.56
SCDHB	$20.00	$11.52	$25.53	$16.53
SDHB	$21.00	$11.53	$27.00	$15.02

NMDHB = Nelson Marlborough DHB; ODHB = Otago DHB; WCDHB = West Coast DHB; CDHB = Canterbury DHB; SCDHB = South Canterbury DHB; SDHB = Southland DHB

to a level reflecting the increased subsidy.

General practices had to advise the government of the co-payment they charged patients for a 'normal' consultation during weekday office hours. However there is a range of services provided during a 'normal' consultation for which a range of fees may be charged. The reluctance of general practice to charge the same fee for every consultation created tension with the government with regard to the patient co-payment fees setting process.

The aim of this study was to determine the fees general practices actually charged to patients following the introduction of increased government funding for the six to 17 and 65+ age groups, and how these fees related to the notified fee schedule.

The reluctance of general practice to charge the same fee for every consultation created tension with the government with regard to the patient co-payment fees setting process

Methods

Each study practice provided information on their scheduled fees to their District Health Boards (DHBs) prior to the introduction of capitation. The fee schedule had to reflect current fee intentions and proposed fee reductions following capitation. We used anonymised practice schedules by DHB to determine changes in fee structure.

Table 2. Frequency of charges entire survey

	6–17 yrs	65+ yrs
No charge	19,985 (25.4%)	18,411 (15.9%)
<Agreed fee	32,262 (41.0%)	52,373 (45.4%)
Agreed fee	20,051 (25.5%)	32,999 (28.6%)
>Agreed fee	6343 (8.1%)	11,665 (10.1%)
Number of consultations	78,641	115,448

Data extraction searches were designed for MedTech, MedCen, and Houston practice management software systems. A computer disk to hold downloaded data and a sheet detailing the design of the relevant search query for each practice's software system was posted to practices with an invitation to contribute to the 'Fees and Charges' data collection. This query was given to practices in the 11 PHOs (in six South Island DHBs) for which South Link Health Inc. has the management services contract. The PHOs did not include Partnership Health (Christchurch), Hurunui/Kaikoura (Canterbury), and Mornington Health Centre (Dunedin). Practices choosing to participate then ran the query and the data information disk was returned to South Link Health. Practice and PHO identifiers were added and the entire file was loaded onto a central database in SPSS format. This central file contained patient identifiers, dates of birth, consultation dates, patient age at the date of consultation, and the fee charged. The individual practice's fee policies for both age groups were also added to this file.

Data involving consultations subsequent to the practice's PHO join date were included in the analysis. The database was then further edited to include only consultations for the relevant policy dates: 1 October 2003 for six to 17-year-olds; 1 July 2004 for patients 65 years and older. From these data, each consultation fee was categorised as: 'normal agreed', 'less than normal', 'no fee charged', or 'greater than normal' fee charged.

The 'agreed fee' was defined as the amount agreed by the practice, PHO and the DHB as the fee to the patient for a 'normal' consultation at the surgery during weekday office

hours. Charges relating to telephone prescriptions and other non face-to-face consultations were excluded. We calculated the proportion of consultation charges falling into each category for children aged six to 17 and adults 65 and older.

Results

The schedule fee analysis involved 120 practices in six South Island DHBs. Of these, 111 practices (92.5%) returned data about actual fees charged. The data included 194 089 consultations (78 641 from the six to 17-year-olds; 115 448 of the 65+ age group).

The overall average agreed fee for six to 17-year-olds was $22.22 (range: $10–$30). The average fee actually charged to this age group was $11.54. For the 65+ age group, the average agreed fee was $25.57 (range: $15–$35), while the average actual fee was $15.31.

Table 1 shows the average agreed fee and the average fee actually charged for both the six to 17-year-olds and the 65+ groups in the six South Island DHBs. Children in the six to 17 year age group were charged 48% less than the agreed fee on average. For the 65+ group, the average fee actually charged was 40% less than the agreed fee.

Table 2 shows overall frequencies of each fee category for both six to 17-year-olds and the 65+ age category. In 25% of consultations by six to 17-year-olds and 16% of consultations by the 65+ age group no fee was charged: 66% of six to 17-year-olds and 61% of the 65+ age group were charged less than the normal agreed fee or no charge at all.

Figures 1 and 2 display the relative proportions of charges for the six to 17-year-old age group (Figure 1) and the >65-year-old age group (Figure 2) by DHB.

The proportion of regular fee consultations ranged from 0% at some practices to 78% at another for six to 17-year-olds. For the 65+ age group, practices' regular fee consultations ranged from 0% to 80%. Only 8% of charges were greater than the normal fee for six to 17-year-olds – for the 65+ age group this figure was 10%.

Table 3 shows the proportion of charges made to children and the elderly (that meet the study definitions) from two previous studies.[4,5] In 1989 and 1993, practices were not required to notify their fee structure or negotiate with government to set fee levels as they did in 2004. A review of these two studies in the context of the present study's find-

Figure 1. Six to 17-year-old charges by DHB

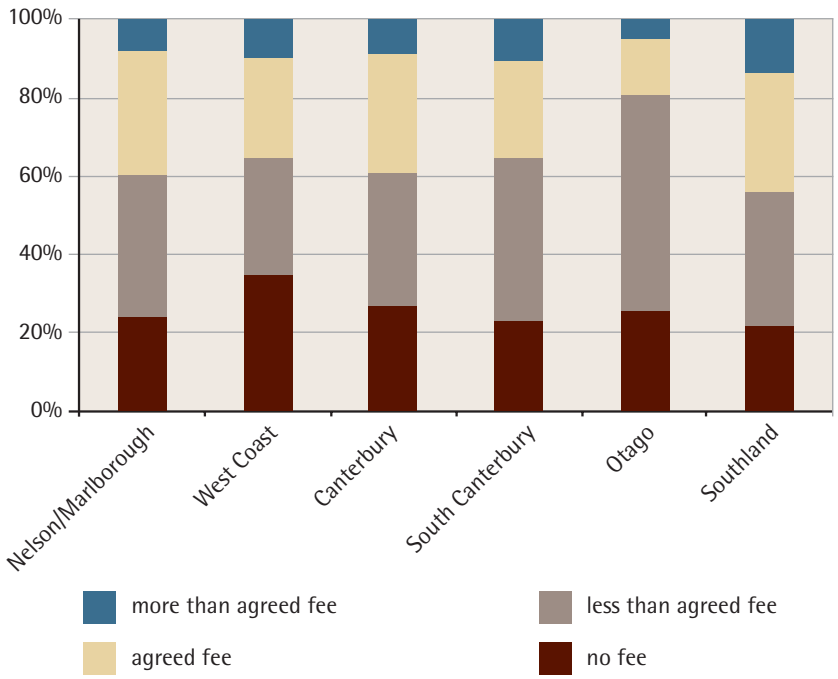

Figure 2. Charges for patients 65 years or older by DHB

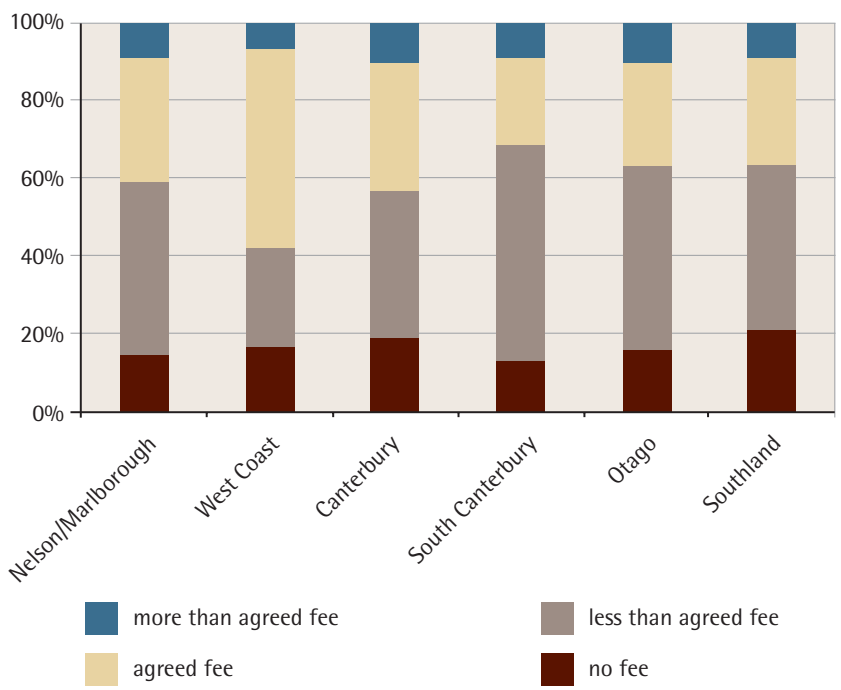

Table 3. Comparison of fees charged to consulting populations 1989,1993 and 2004

	Children			Elderly		
	1989	1993	2004	1989	1993	2004
N consulting patients	24,537	14,023	78,641	31,868	18,915	11,5448
Zero charge	30.0	32.7	25.4	29.8	30.0	15.9
< Advertised or agreed	3.0	11.5	41.0	7.1	21.5	45.4
Advertised or agreed	50.3	45.0	25.5	45.8	32.7	28.6
> Advertised or agreed	4.5	3.9	8.1	5.3	6.8	10.1

ings shows a reduction over time in free to patient consultations, but a marked increase in discounted consultations.

Discussion

Our examination of fees for a large number of general practice consultations made by children and the elderly after patient co-payment regulation in the PHO environment shows a picture of persisting variability in the amounts patients were actually charged for consultations. The actual average fee charged in both age groups was 40% or more less than the agreed fee. There was also a substantial proportion of consultations in which no charge was made to the patient. Where a greater than agreed fee was charged, the charges were for consultations outside the agreed fee policy. These findings applied to both the age groups studied. This study also shows that, placed in the context of earlier studies in 1989 and 1993, the above results could be expected – and perhaps might have occurred regardless of the Primary Care Strategy and heightened fees regulation under PHOs.

Fees for general practice services are a greater concern in New Zealand than in most other developed countries, where more public funding supports primary care. In their comparisons of health care experiences in Australia, Canada, New Zealand, the UK, and the US, Blendon et al.[2,3] consistently identify New Zealand and the United States as the countries most affected by restricted primary care access due to cost. The problem is that regulation alone will not improve access.

This study was completed soon after the introduction of the increased funding for the six to 17 years and 65+ age groups. Already fees reductions had occurred and the government fees policy may gain greater traction as time develops. This was a South Island study of Interim-funded PHOs. It would be interesting to compare these results with fees charged in the North Island, particularly in Access-funded PHOs, where discounting may not occur to the same extent. A further weakness of this study is that the review we made of our two earlier studies could not use exactly the same definitions: in the 1989 and 1993 studies 'children' were aged 0–18 years and 'elderly' were the 60+ age group.

The main strength of the study is the size of the dataset we used. Study data were comprehensive of all general practice consultation charges made in almost all (92.5%) of the practices eligible to participate. The data are also recent. They reflect the actual charging habits of these practices less than one year ago.

This study demonstrates yet again that a consultation delivered in general practice is not a simple, single, definable item of service

This study demonstrates yet again that a consultation delivered in general practice is not a simple, single, definable item of service. There are many different reasons for consultations and each patient brings to their consultation a different and unique set of circumstances. Patient-centredness is a core value of general practice so it must be expected that general practitioners do set different fees based on the reason for the consultation and the particular circumstances surrounding each interaction.

Competing interests

None declared.

References

1. King A. The primary health care strategy. Wellington: Ministry of Health, 2001.
2. Blendon RJ, Schoen C, DesRoches CM, Osborn R, et al. Inequities in health care: A five-country study. Health Affairs 2002; 21(3):182–94.
3. Blendon RJ, Schoen C, DesRoches C, Osborn R, Zapert K. Common concerns amid diverse systems: Health care experiences in five countries. Health Affairs 2003; 22(3):106–21.
4. Dovey SM, Tilyard MW. Fees charged to a consulting population in general practice. NZ Med J 1991; 104:222–224.
5. Tilyard M, Dovey S. Changes in fees for general practice consultations 1989–1992. NZ Med J 1996; 109:252–4.