At what cost?

A business guide to support general practice service developments

GENPRO

General Practice Owners Association of Aotearoa New Zealand

Foreword

The sustainability of the New Zealand health system is increasingly reliant upon a strong primary care sector to help manage the country's on-going rise in long-term conditions and to assist with broader demand management initiatives aimed at reducing avoidable hospital admissions.

Individual patients and local communities are benefiting from more services closer to home which serve to increase access, reduce inequity, improve patient outcomes and, strengthen the efficiency of the wider health system.

However, there is anecdotal evidence that some already stretched, frontline owner-operated general practices are potentially being taken advantage of, knowingly or unknowingly, by a health system which is under increasing financial pressure.

PHOs are part of a health system which mandates their population health responsibilities ahead of their responsibility to represent their general practice providers. Similarly, PHOs are increasingly being tasked with supporting the reduction of DHB deficits and this is manifesting itself in increasing pressure upon general practice providers to deliver extra services for patients without appropriate funding.

GenPro believes that as privately run businesses being asked to support what is right for patients, general practices need to also consider what is right for the sustainability and viability of their own businesses to ensure that they can continue to provide such essential services for their communities into the future.

This guide, entitled "At what cost?" is intended to help GenPro members better understand the cost of services they are being asked to provide, or accommodate, in order to inform the associated contractual arrangements they are committing to.

Dr Tim Malloy

Interim Chair

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Introduction

It has long been the case that the New Zealand health strategy has relied upon a strong primary care sector which supports the Government's desire to keep New Zealanders healthy and out of hospital. That is certainly one of the main tenets of the New Zealand Primary Health Care Strategy published almost 20 years ago in February 2001.

"Care closer to home" is a similar key underlying principle which, as a priority for the Ministry of Health, often translates to getting care into the community.

Increasingly, health services that used to be provided solely in hospital settings are being made available in the community as the health system has become more focused on keeping patients healthy (Care closer to home. *Ministry of Health, February 2014. ISBN 978-0-478-41553-7 online) by:*

- Identifying and treating health issues to avoid admissions to hospital
- Providing better support for patients discharged from hospital, to reduce the likelihood of readmission
- Delivering more and better community-based services to help patients manage their long-term conditions at home.

Additionally, new thinking and developments in health care provision are leading to a welcome increase in community-based services and associated health professionals seeking to improve patient outcomes, improve equity, and improve the effectiveness of the wider system by, once again, reducing demand upon the secondary care and hospital sector. Recent examples include, but are not limited to, health navigators, social workers, mental health HIPs (Health Improvement Practitioners), and primary options for acute care (POAC) such as skin lesions, minor surgery and vasectomies.

Predominantly, service developments of this kind within the community are centred around, and often located within, general practices (including for example, Health Care Homes) where patients are enrolled and where continuity of care for the patient is supported across the wider primary care team.

The overwhelming rationale for this broad approach is that it is the right thing to do for the patient. That is hard to deny and the rationale is strongly supported, in principle, by GenPro.

However, just because it is the right thing to do from a patient perspective, does not mean it is a good thing to do from the business perspective of New Zealand's network of predominantly owner-operated general practice providers across the country.

Contracted providers are not public bodies (although there are a small number of exceptions) and do not have the Treasury or Government underwriting their expenditure or business risk in the way that District Health Boards (DHBs) and, to some extent, Primary Health Organisations (PHOs) do. Contracted providers have been established at great personal cost, and continue to operate at a great financial risk to the underwriting owner-operator general practitioner, the nurse owner-operators, the entrepreneurial business managers, the altruistic community trusts and the corporate employers, amongst others, upon whom more than 16 million annual health consultations and associated essential public health services for New Zealand depend.

To ensure the sustainability of those providers to be able to continue to provide essential health care for their enrolled patients, their business owners need to ensure effective and prudent financial management, which at its very basic level, requires that business income covers all associated business running costs.

This guide is intended to assist GenPro members to consider the consequences of adopting and supporting service developments, particularly when they may feel under pressure by Government agents or funding bodies (e.g. DHBs and PHOs) to "do the right thing for patients" when the financial terms being offered may not be the right thing for the sustainability of their business.

This guide therefore highlights a number of factors which contracted providers should consider when approached to support new service developments (or when separately considering doing so as part of their own innovative business model).

Caveats and limitations

This guide is not legal advice and should not be relied upon as such. It is however published in good faith and intended as a guide for contracted providers and to use as a reference during service development discussions and the associated contract negotiations.

This guide does not take precedence over any existing contractual terms and obligations which the contracted provider may have already entered into or signed. As a strong guiding principle, contracted providers should not sign any such contracts or agreements without being fully cognisant of their responsibilities, risks and liabilities – even if under strong pressure to do so or because "it is the right thing to do for patients".

It is also worth noting that whilst seeking to support and assist contracted providers, the statutory responsibility of funding agencies such as PHOs, is primarily to support the population health responsibilities of the Government and their local DHB. Such a conflict of interest should prompt contracted providers to seek their own legal opinion or advice before acting.

Additionally, this guide is a high-level advisory paper only and should not be relied upon to highlight every potential consideration that may be needed to support each proposed service development. Similarly, for larger service developments (e.g. where significant capital investment or infrastructure changes are required) this guide should not replace the good practice associated with a robust business case process – for which the internet can provide access to many recommended templates and robust health examples.

Primum non nocere

First do no harm. The contracted provider should ensure that it has the capacity and capability to safely and effectively provide the service.

Secondary care clinicians (e.g. employed under national ASMS terms and conditions) receive paid training, protected (and paid) time for training and CPD, employer-funded insurance and risk management cover. Where those same secondary care clinicians take on additional responsibility (e.g. new services/increased workload) it is generally reflected in more reward and/or reduced workload elsewhere.

Those clinicians will be subject to regular re-accreditation and any associated costs and refresher training are generally covered within their terms and funded by their employer (e.g. the DHB).

Clinical supervision will similarly be in place as part of a robust clinical governance framework (e.g. clinical governance committees) to ensure patient safety and the effectiveness of the services being offered. Once again, all such arrangements and costs are generally covered by the employing DHB.

The development of services within a primary care setting (or their transfer from secondary care) should be treated no differently. The business case, costings and/or contractual arrangements for the provision of such services should ensure that all of the above patient safety and clinical governance arrangements are included and fully funded (e.g. including the GP's or health practitioners training costs and training time).

Employment status

Anecdotal evidence received by GenPro points to an increasing desire by funders (e.g. DHBs and PHOs) to directly employ any new health professionals required for new service developments in primary care – even when those health professionals are intended to be located, and provide their service to patients, from within an existing contracted provider's premises (e.g. a general practice).

In some ways the employment status should not matter. The patient has little or no concern as to the employment arrangements, provided they are receiving high quality care with a seamless pathway across health care practitioners working as part of an integrated 'patient centred' service.

From a business perspective however, there are important factors for the contracted provider to consider if being asked to accommodate a new health practitioner who may be directly employed by the local PHO or DHB.

The legal liability can become confused. Who is the service provider and who is legally responsible? At what point does relevant insurance cover (e.g. ACC premiums, premises and public liability insurance) stop being the responsibility of the funder and become the responsibility of the general practice?

The responsibility for supervision of the health practitioner can also become confused, and should be clarified, both from a clinical perspective as well as day-to-day management. If the contracted provider is responsible for day-to-day management, such activity should be costed accordingly.

The general practice should be aware of the potential risk to its business reputation. GenPro has heard anecdotal feedback of situations where a DHB or PHO employed health practitioner based within a specific consultation room at general practice premises has only been available for patient appointments at limited times and has increasingly been absent from the practice to attend DHB or PHO meetings (or other commitments). Patients who are unable to access such a service or member of the primary care team are potentially likely to consider that a failing of the general practice provider hosting the service.

There are associated on-costs with the hosting of any health practitioner – even if the salary costs are covered by the funding agency. Such costs should not be allowed to be conveniently overlooked by funders (see below).

It is therefore GenPro's recommendation, unless there are strong mitigating circumstances, that any associated health practitioner providing a new service through a funding arrangement with the DHB and/or PHO and based within (or working from) general practice premises, should be directly employed by that contracted provider.

Where this is not the case, a legally binding, commercial rate contract or tenancy agreement should be developed which offers full protection and market rate income to the contracted provider – in the same way that rooms may currently be rented or leased to independent providers such as physiotherapists or pharmacies (see also "opportunity costs" below).

Fully costing the service

Staffing

The cost of any required health practitioners is the most obvious cost associated with a new service. However, it is important to ensure that such costs are appropriately included and any calculation should therefore include all on-costs such as annual leave, sick leave, HR and payroll costs, statutory/mandatory training and management costs. Including only the staff members salary costs within the calculation is insufficient.

Similarly, staffing costs are only part of the cost of the service and should never be considered in isolation when agreeing any service development or contractual/financial framework.

Premises

Premises costs should be applied to all new service developments – particularly as space is often hard to come by and will have a significant opportunity cost (see below).

The premises costs, if not based on a commercial local market rate, should include a per square metre rental cost based on the annual premises costs (including capital financing charges – such as mortgage repayments or indicative capital charges) plus a share of power bills, insurance, cleaning, car parking and the costs of shared/communal areas (e.g. waiting rooms, elevators, stairs, kitchen and toilets).

The cost of any specific premises adaptations or site accreditation requirements should also be included in full – for example if a laminar airflow system or security locks are specifically required for the new service.

Admin and support

The administration and support costs associated with new services are often under-estimated. Such costs will vary on a case-by-case basis but are likely to include:

- Booking and appointment costs, call-recall systems
- Reception costs
- IT costs (licensing fees, hardware, consumables)
- Invoicing, accounts & banking
- Data collection, monitoring & reporting (as required for the effective running of the service as well as any separate contract reporting responsibilities)

Governance

The safe, effective and accountable provision of any service requires a level of essential governance. In addition to the clinical governance arrangements outlined above, contracted providers should consider the management and corporate governance costs associated with the development and operation of the service.

These costs are likely to include the development of the service specification and supporting contractual agreement (e.g. the time of the lead clinician/GP and the practice manager), contract meetings with the DHB/PHO and meeting all on-going performance management and reporting requirements.

Opportunity costs

Using premises, staff or any other asset for a specific service always comes with an opportunity cost.

The opportunity cost is the financial benefit (e.g. income) which that asset could be accruing by being used for an alternative purpose. For example, if a consulting room is protected entirely for use by a Health Improvement Practitioner, the opportunity cost is the income that the owner of the premises could earn by renting the room on a commercial market basis to a local independent business (e.g. a private physiotherapist, other clinical specialist or complementary therapist) as well as potential service fees which would accrue to the practice.

The opportunity cost (or lost/foregone income) should always be considered for any service development – and is a legitimate business case cost to the contracted provider.

Income and savings

It is important to consider associated income and savings accruing as part of the service development and where responsibility for, or entitlement to such income sits. There are also further considerations in terms of the fees chargeable to patients.

Patient co-payment / other income

As part of the service development, the funders and contracted providers should consider any fees payable by patients. If patients do not pay for the service in a secondary care setting, is it right that they are expected to pay in primary care? Such an approach can again damage public faith and trust in their general practice if the patient deems the fees unfair. If one of the reasons a DHB may be transferring a service to primary care is to facilitate passing part of the cost to the patient – is does not feel supportive of the Government's approach to increase access to services and removing inequity. Similarly, it is an unhelpful position in which to put the contracted provider.

If patient co-payments are appropriate, clarity will be needed with regards matters such as:

- Responsibility for collecting the co-payment
- Liability for any bad-debt
- Clarification on whether such income offsets the contracted provider's running costs or is payable to the funder
- Whether the fee is adjusted for CSC card holders or VLCA practices as a whole
- Whether there is a fee chargeable for under 14 year olds or where other general practice consultations would be free

Savings

For larger business cases it maybe appropriate to include the wider impact of the service development and how it may affect the whole health system. For example, there are likely to be savings such as reduced patient length of stay (LOS) in hospital (e.g. number of days x cost of bed day).

Similarly, there may be broader social and economic impacts such as supporting independence (less reliance on state social and welfare) and enabling an earlier return to work.

This guide does not cover the full considerations of larger business cases for which further advice and guidance should potentially be sought from local PHO and DHBs. Additional advice may also be available through professional membership organisations such as the Medical Assurance Society.

Profit

It is wholly appropriate, under normal circumstances, to incorporate an element of "risk premium" within the costings and the business case for any service development undertaken by an independent contracted provider. Any personal, business or commercial investment would be expected to secure a reasonable rate of return – general practice business operations should be no exception.

Such a process will ensure innovators and entrepreneurs continue to support population health developments and also recognises the personal risk being taken by the provider.

Managing risk

Fixed and variable costs

Experience during the COVID pandemic and associated lockdown restrictions has highlighted how important it is to understand the split of costs between those that are fixed and those that are variable.

Fixed costs continue to be payable regardless of the level of service provided (e.g. premises costs and employed staff). Variable costs increase as the level of service increases (e.g. consumables and sessional staffing costs such as locums).

The contracted provider should consider the risks of being unable to deliver the full level of anticipated service and what that means to covering the on-going fixed costs.

Where the funding agency requires that there be on-going access to the service but there is a barrier to access that is outside the control of the contracted provider (e.g. Level 4 COVID lockdown), it is appropriate that the contractual arrangements ensure that the funder continues to cover, at least, the fixed costs.

Conversely, where there may be a barrier to access which is deemed the normal business responsibility of the contracted provider (e.g. a fire in the premises), it is appropriate that the contracted provider be responsible for any on-going fixed costs – which should be part of any usual business continuity insurance cover considerations.

It is therefore recommended that all costs are clearly apportioned between fixed and variable costs and that the contractual arrangements are clear (and fair) about associated risk management arrangements in the case of any service disruption.

Insurance

Arrangements should be clear about responsibility for any associated insurance cover as well as inclusion of such costs within the business case and contract paperwork.

Future proofing

It is essential that any agreement includes explicit arrangements for how funding will be increased to cover future cost increases. In this regard it is recommended that service costs are separately classified according to the relevant, independent and impartial measure which should be used to automatically uplift the funding at least annually on an agreed date. For example, for general costs it may be sufficient for the annual published CPI measure to be used, but this will not be sufficient for costs such as staffing or health specific areas (e.g. cost of pharmaceuticals) – for which the appropriate alternative and independent measure should be included (e.g. actual MECA pay awards).

It is not sufficient for the agreement to just make a generic or ambiguous statement to the effect that the funding agency intends to ensure funding keeps pace with inflation or rising costs.

About GenPro

GenPro is a not-for-profit membership Association representing the owners of New Zealand's essential General Practice and Urgent Care Centres.

There are more than 1,000 General Practices across the country providing first-contact healthcare for the population of New Zealand. Virtually all of those General Practices are private businesses owned, in whole or part, by partnerships of GPs, nurses, other health practitioners, private individuals or one of a number of larger corporate entities directly investing for the better health and wellbeing of the nation.

As individual private businesses, General Practice owners may not have the time, expertise, resources or even the opportunity to negotiate with the Government, Ministry of Health, ACC or District Health Boards to ensure they are appropriately acknowledged, supported, respected and funded to fulfil their essential role within the New Zealand health and disability system.

Joining the General Practice Owners Association of Aotearoa supports our collective voice and secures a much needed and credible national representative organisation acting solely for the owners of General Practice and Urgent Care Centres.

Our Vision

Sustainable, viable and high-quality General Practice for all New Zealanders

Our Mission

To promote and advocate for sustainable, responsive and high-quality general practice services for the population of New Zealand.

Our Objectives

a. To promote, protect and improve the collective interests of Members.

b. To advocate for and support the sustainability and viability of Members businesses and the services they provide in order to ultimately ensure the continuity of locally accessible and high-quality, patient-centric care.

c. To provide strong, credible and effective national representation for New Zealand's network of General Practice and Urgent Care business owners, including, but not limited to, the country's network of smaller, owner-operated providers.

d. To improve the health of the population of New Zealand and advocate for high-quality, accessible and equitable patient care.

e. To support the productivity and efficiency of the New Zealand Health and Disability System.

f. To promote, protect and support the innovation capability of Members.

g. To help Members promote and improve the efficiency of their businesses.

h. To uphold the professional reputation of Members collectively, and the value of the quality branding conferred by membership of the Association.

i. To provide sector leadership on issues affecting Members by:
   - Providing effective representation of Association members on and to bodies with influence on General Practice and Urgent Care services or associated professions.
   - Influencing and promoting legislation, regulations and policy for the betterment of the interests of the Members or for the accomplishment of any of the Association's objectives.
   - Liaising and co-operating with Government and other bodies and agencies for the accomplishment of any of the Association's objects
   - To act as agent for the Members (either individually or collectively) in negotiation or consultation with Crown Agents or other funding bodies regarding contractual service arrangements and associated funding.
   - To do anything necessary or desirable in pursuit of the above objectives.

Additional Resources

To support this guide GenPro will be providing members with a costing template. New members, or existing members who have not received the template, may e-mail **enquiries@genpro.org.nz** to request a copy (provided electronically).

In addition, the internet is a good source of generic business case templates, many of which are tailored for the health sector and primary care.

If there are additional resources which you would find helpful, or have available and would be willing to share with GenPro members – again please e-mail us at **enquiries@genpro.org.nz**

Q and A

Q. Is the extra workload already covered by the Practice's capitation income?

A. As a general rule of thumb, if the work has previously been undertaken in secondary care or it is a new service through the contracted provider, it will not already be funded through the general practice capitation payment.

Q. What if the PHO only has a certain level of funding?

A. Anecdotally, GenPro has heard of pressure being applied for contracted providers to provide a service where the PHO has only limited funds or has top-sliced the funding. Under such circumstances it is essential that the service specification is adjusted accordingly to ensure that the contracted provider is not subsidising the service and that there is no risk to patient safety through an under-funded service.

Under any circumstances it is wholly appropriate for the contracted provider to request sight of the DHB or PHOs funding envelope and to request clarity around the use of any top-sliced funds or management/ administration charges being applied by the funding agency.

Q. What if the staff are provided by, and paid for by the PHO or DHB?

A. GenPro recommends that health practitioners are directly employed or contracted by the general practice owners who are hosting the service being provided. Where there are strong mitigating circumstances that staff be employed (or contracted) directly by the DHB or PHO, the contracted provider should ensure that all other associated costs (as highlighted in this guide) are covered in the agreement reached with the DHB or PHO. It is not sufficient for the direct salary costs to be funded without the full costs of the premises, admin, governance and business liability/risks also being funded.

Q. Where can I get further advice and support?

A. GenPro members can e-mail additional questions to enquiries@genpro.org.nz. Additional/other sources of advice may include the contracted provider's own business manager, accountants and lawyers.

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