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Annual statement of reasonable GP fee increases - 2022/23 update

Report prepared for TAS

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June 2022

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Executive summary

This report contains the 2022/23 update of the annual statement of reasonable GP fee increase. The reasonable patient co-payment increase in 2022/23 is **2.38 per cent.**

This figure is based on a weighted average increase in input costs of 2.38 per cent. This is the third year in which revised weights resulting from a stakeholder review were used, so comparison with the last two years' figures is possible. The revised weightings place more emphasis on the labour component of costs (see Table 1).

Table 1 Revised index weightings

Index	Previous weight	Revised weight
PPI-Inputs Health and Community Services	20%	15%
LCI-Health care and Social assistance	70%	80%
CGPI-Non-residential buildings	5%	2.5%
CGPI-Plant, machinery and equipment	5%	2.5%

The government-provided funding increase is 2.38 per cent (down from 2.78 per cent last year). This year an additional 0.62 per cent has been included in first contact funding, bringing the total government increase for 2022/23 to 3 per cent. However, for the purposes of this process, the relevant figure is 2.38 per cent.

As the relevant government funding increase matches the increase in input costs, the reasonable patient co-payment increase is the same for all practices, regardless of the share of revenue the government provides to respective practices. This is the fifth year in a row that the respective increases have been the same.

The stakeholder review also recommended that DHB MECA salary rates be used in place of the Labour Cost Index (LCI) for comparative purposes. Using cost shares of 64 per cent (Medical), 23 per cent (Nursing) and 13 per cent (Admin) and the median value across all steps in the relevant salary scales results in an estimated labour cost change figure of 1.83 per cent for the MECA-based approach. The labour cost change figure for the last year, using the LCI, was 2.05 per cent.

The divergence in the respective labour cost change numbers is a function of how collective agreements work (i.e. they cover multiple years, cover more than just salary rates and take time to negotiate). Timing is important.

For this year's calculations, the SMO MECA resulted in no increase when previously the figure was 1.9 per cent last year and 3.4 per cent for the previous year. The reason for the nil increase in the current period is that the MECA expired on 31 March 2021 and is still under negotiation, so there has been no movement in salary rates since last year. The situation is the same for the Clerical (Admin) MECA which expired on 28 March 2021 and a new agreement has not been reached.

Thus, all of the changes to labour costs using the MECA approach have come from the nurses MECA, which spans the period 2 August 2020 to 31 October 2022. The latest nurses MECA contains salary

adjustments around pay equity, meaning that the change in salary rates witnessed in the current period is made up of 'normal' MECA increases as well as the pay equity jump. Combined, these factors saw the relevant salary rate for nurses rise 7.95 per cent in the latest year.

1. Introduction

1.1 Purpose of the annual statement

This report presents the update of the annual statement of reasonable GP fee increase for the 2022/23 period.

1.2 Background

In 2006, a project team from LECG Asia Pacific (now renamed Sapere Research Group) was commissioned by DHBNZ to develop a methodology for setting the annual statement of reasonable GP fee increases. The team worked under the guidance of an Advisory Group, involving representatives from DHBs and the primary health care sector. Once the methodology had been developed, Sapere produced the first annual statements relating to the 2005/06 and 2006/07 June years. Subsequently, Sapere has produced further update reports on an annual basis for DHBs' National Primary Care Team, which now sits in TAS.

Further background on the application of the annual statement and the processes within which it is used can be found at http://www.tas.health.nz :

1.3 Review of methodology in 2019/20 results in greater weighting for labour costs and inclusion of comparator

In 2019/20, a review of the Annual Statement of Reasonable Fee Increase (ASRFI) process was conducted by a working group comprising representatives from primary care, DHBs and the Ministry of Health.

A range of different alternative options was canvassed around the calculation of the annual fee increase, including:

- construction of a bespoke index to improve representativeness of data
- introducing a forecasting element to reduce time lags
- using Ministry-collected DHB financial data to improve both timing and representativeness of data
- using cost data from negotiated Multi Employer Collective Agreements (MECAs) to improve representativeness of data

The working group made two recommendations to alter the calculation process. The first recommendation was to increase the weighting of labour costs relative to other costs. Table 2 compares the previous weightings used to those recommended by the working group.

Table 2 Revised index weightings

Index	Previous weight	Revised weight
PPI-Inputs Health and Community Services	20%	15%

LCI- Health care and Social assistance	70%	80%
CGPI-Non-residential buildings	5%	2.5%
CGPI-Plant, machinery and equipment	5%	2.5%

The second recommended change was to use cost data from relevant MECAs instead of the LCI, as a comparator. Using cost shares provided by primary care representatives of 64 per cent (Medical), 23 per cent (Nursing) and 13 per cent (Admin) and the median value across all steps in the salary scale results in an estimated labour cost change figure of 1.83 per cent for the MECA-based approach, compared to an annual change of 2.05 per cent for the LCI-based (existing) approach.

Using the MECA-based 1.83 per cent figure in the existing weighted average calculation process would result in an input-cost related adjustment figure of 2.21per cent for the 2022/23 year.

2. Recap of methodology

2.1 Indices used

Calculating annual fee changes is driven by weighted average changes to prices of three key inputs used to produce the services provided by GPs. Together the three indices provide measures of the extent to which changes in business input costs put pressure on the output prices charged for goods and services.

2.1.1 Labour Cost Index

The price of labour is a major driver of potential changes in operating costs and hence the fees charged by practices. The measure used is the *Labour Cost Index – All Salaries and Wage Rates* (LCI), which gives a measure of movements in the cost of labour. The index covers jobs filled by paid employees in all occupations and in all industries except for private households employing staff. As outlined further below in section 2.2, the component of the LCI used in the calculation process is that which is deemed most relevant to the provision of primary care services (i.e. Health Care and Social Assistance).[1]

2.1.2 Producer's Price Index

The *Producer's Price Index - Inputs* (PPI-I) is a measure of the change in prices of items such as: materials; fuels and electricity; transport and communication; rent and lease of land; building, vehicles and plant; commission and contract services; business services; and insurance premiums less claims. It excludes labour depreciation costs and GST. The relevant component of the PPI-I used for this exercise relates specifically to the Health sector (previously known as Health and Community Services).

2.1.3 Capital Goods Price Index

The *Capital Goods Price Index* (CGPI) is a measure of the change in the general level of prices for physical capital assets (for example, buildings). It excludes large value items (such as aircraft) and second-hand equipment. The relevant components of the CGPI used for this exercise relate to Non-residential Buildings and Plant, Machinery and Equipment.

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[1] Note that this category was previously referred to as Health and Community Services, both in the LCI itself and past annual statement updates. It is a name change only. We note that Statistics New Zealand is currently reviewing the weights used to construct the LCI. The intention of such a reweighting exercise is to ensure that the index remains "fit-for-purpose" over time (i.e. to reflect changes in the way resources are used). Our assessment is that the effect of such a reweighting will be similar to the re-basing that took place previously. It will make comparison with previous years difficult, but will still reflect the important and relevant cost factors used in our calculations. We will comment further in any subsequent reports, once the reweighting exercise is complete.

2.2 Annual statement calculation

As described in previous reports, the process of calculation takes place sequentially, involving two components - the change in input costs component and the change in capitation-based Government funding received (i.e. First Contact funding). The latter was previously known as the Future Funding Track (FFT) and has also previously been referred to as a “cost pressures adjustment.”

The first step involves determining the annual percentage change for the relevant components of each index and averaging over the previous 12 months.

Following this, we apply weightings agreed to by PSAAP following a recent review of: 80 per cent labour (LCI); 15 per cent other inputs (PPI-I); and five per cent for capital (2.5 per cent for each component of CGPI).

Using this weighted average, we assess the effect of input cost changes on total fees (i.e. GP fees in the absence of capitation payments). From this, we use the known Government funding contribution to derive the reasonable level of co-payment increase.

We use the March, June, September and December quarters of the preceding calendar year for these calculations.

3. Changes in indices

3.1 Data sources

All data used in the production of this statement has been sourced from Statistics New Zealand. The relevant files can be accessed directly from the Statistics New Zealand website[2].

3.2 Overview of trends across indices

A summary of movements in relevant indices is provided below in Table 3. The change from the December 2020 quarter in the Health Care and Social Assistance component of the LCI was slightly above the average for all industries (i.e. 2.9 per cent versus 2.6 per cent for all industries combined). Also of note was the strong upward pressure on capital goods indexes, though given their low weightings in the calculations the impact of such changes is minimal.

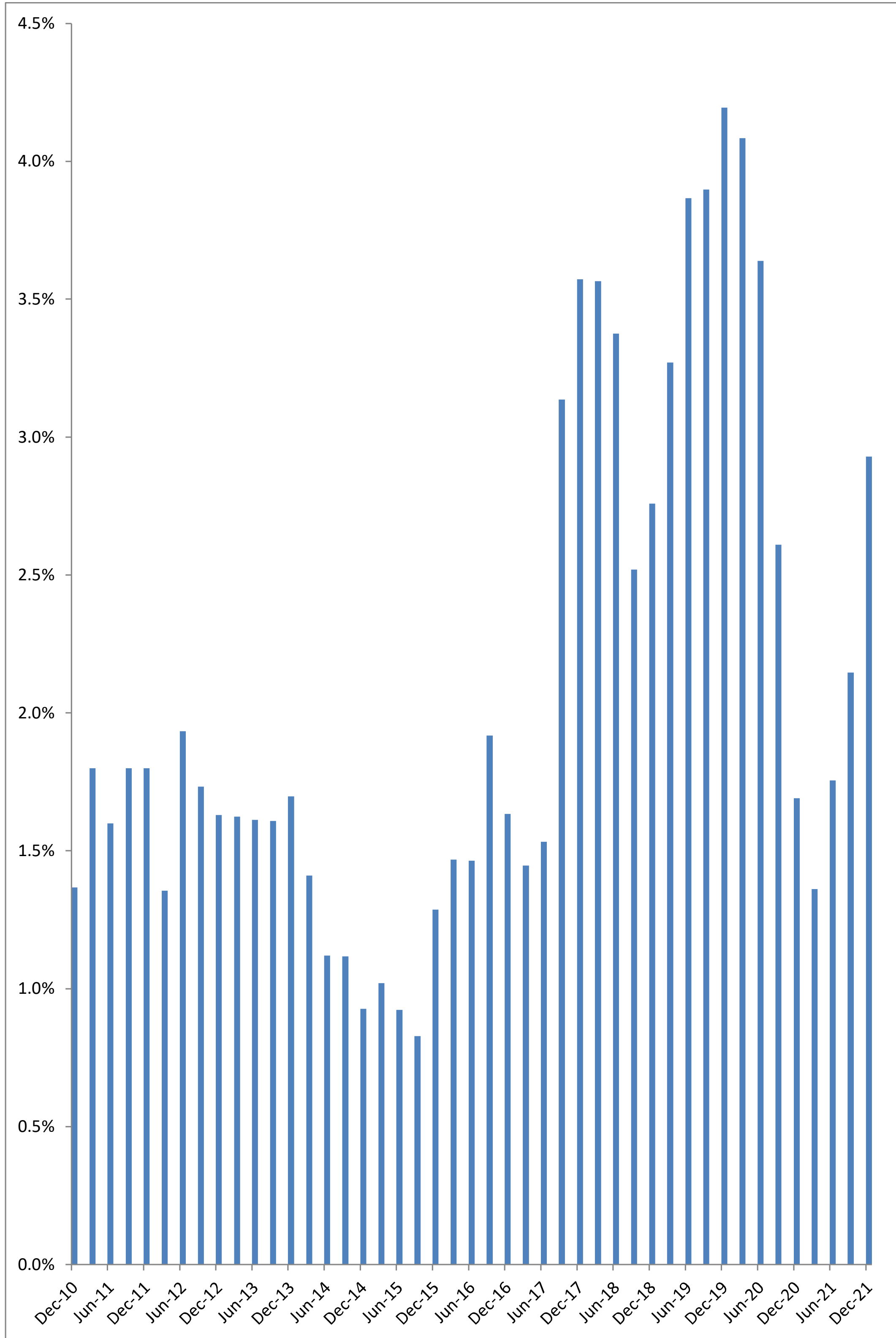
Table 3: Index movements up to December 2021 quarter

Index	Change from previous quarter (from September 2021 qtr.)	Change from same quarter previous year (from December 2020 qtr.)
PPI Inputs Health	0.2%	3.7%
LCI Health Care and Social Assistance	1.2%	2.9%
CGPI Non-residential Buildings	2.2%	7.7%
CGPI Plant, Machinery and Equipment	2.4%	5.3%

Figure 1 shows the annual per cent change for each quarter in the LCI since December 2010. As shown, the growth in the recent past (due to pay settlements) is prominent, and the latest observation suggests stronger growth is likely in the next few years.

[2] http://www.stats.govt.nz

Figure 1: Annual percentage change in LCI



4. Calculation of the annual statement

4.1 Step 1: Input-cost related adjustment rate

Using the process outlined in section 2.2, we generate a total fee adjustment rate of **2.38 per cent** for 2022/23. This weighted average figure represents the **input-cost related change** to the total fee for a given year, a crucial intermediate input into the annual statement determination. Given relative weightings, it is closely related to the LCI.

Table 4 below provides the equivalent input-cost related adjustment factors for this and previous years.[3]

Table 4: Input-cost related adjustment rate

	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23
Input-cost adjustment	3.01%	1.09%	1.41%	1.50%	1.18%	1.10%	1.12%	1.57%	2.38%	2.91%	3.51%	2.78%	2.38%

4.2 Step 2: Adjustment for Government funding and calculation of annual statement

We have been advised that a **Government funding adjustment of 2.38 per cent** will apply this (fiscal) year to first level (first contact) services.[4] Table 5 shows how this adjustment compares to previous Government funding adjustments.

This adjustment is combined with the findings from the previous step to determine the reasonable increase to co-payment levels.

Table 5: Annual percentage change in funding for First Level (First Contact) Services

	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23
Government adjustment	3.1%	2.0%	2.0%	1.49%	1.0%	1.0%	0.8%	1.0%	1.82%	2.38%	3.51%	2.78%	2.38%

As shown in Table 6 below, **based on a 50/50 capitation/co-payment revenue split**, the reasonable fee (patient co-payment) increase for 2022/23 is **2.38 per cent**.

[3] The LCI was re-based from a June 2001 base to a June 2009 base. Similarly, the PPI-I was rebased from a December 1997 to a December 2010 base. Therefore, values contained in past annual statements (prior to that period) are not able to be directly compared with the current values. In addition, the revised weightings used in the last three years mean direct comparison with previous years is not possible.

[4] As mentioned earlier, the effective funding uplift from government for 2022/23 was 3%, but for the purposes of these calculations the relevant increase is 2.38%.

Table 6: Annual levels for reasonable increases to GP patient co-payments

	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23
Reasonable fee increase	4.02%	0.19%	1.34%	2.01%	1.37%	1.40%	1.25%	1.32%	2.38%	2.91%	3.51%	2.78%	2.38%

This value is a function of the relativity between (capitation/first contact) funding from the Government and the input-related adjustment factor for the total fee, given an assumed split.[5] When the Government-generated adjustment is greater than the input-related adjustment factor, the co-payment increase will be less than the input-related adjustment factor.[6]

For the fifth year in a row, the government funding increase matches the input cost related adjustment. This means that the 2.38 per cent reasonable fee (patient co-payment) increase for 2022/23 applies across all practices regardless of the capitation/co-payment mix.

Table 7 below provides the annual statement change for various capitation/co-payment splits, compared with the equivalent figures for previous annual statements. Note that figures prior to the 2010/11 year were calculated using a different time period, so are not directly comparable with this year's figure. Similarly, the revised weightings applied in 2019/20 mean direct comparison with previous years is not possible.

[5] The fee template associated with the annual statement gives the opportunity to use practice, or practice group specific data where this split is not appropriate.

[6] This is because the effective weighting attached to the capitation subsidy is greater than that of the co-payment, meaning that when the capitation adjustment is greater than the input-related adjustment factor, there is effectively less work to do by the co-payment in order for the total fee adjustment to match the change in costs faced by practices.

Table 7: Annual statement and general adjustments for different capitation/co-payment splits

	Assuming:	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
Level of reasonable co-payment fee increase	80/20 split	6.3%	11.4%	7.5%	11.5%	7.05%	-2.53%	1.11%
	70/30 split	5.3%	8.5%	5.9%	8.7%	5.37%	-1.02%	1.24%
	60/40 split	4.8%	7.0%	5.1%	7.3%	4.53%	-0.26%	1.30%
	50/50 split	4.5%	6.1%	4.7%	6.5%	4.02%	0.19%	1.34%

	Assuming:	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Level of reasonable co-payment fee increase	Assuming 80/20 split	3.52%	1.92%	2.31%	1.62%	0.57%	2.38%	2.91%	3.51%	2.78%	2.38%
	70/30 split	2.68%	1.61%	1.81%	1.42%	0.99%	2.38%	2.91%	3.51%	2.78%	2.38%
	60/40 split	2.26%	1.46%	1.55%	1.31%	1.20%	2.38%	2.91%	3.51%	2.78%	2.38%
	50/50 split	2.01%	1.37%	1.40%	1.25%	1.32%	2.38%	2.91%	3.51%	2.78%	2.38%

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'Sapere' comes from Latin (to be wise) and the phrase 'sapere aude' (dare to be wise). The phrase is associated with German philosopher Immanuel Kant, who promoted the use of reason as a tool of thought; an approach that underpins all Sapere's practice groups.

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