INJECTING CHANGE INTO PRIMARY HEALTH CARE: the NZ Experience

PART I
PATIENT SUBSIDIES: FROM CO-PAYMENTS TO INSURANCE PREMIUMS

Bronwyn Howell

Victoria Management School
http://www.vms.vuw.ac.nz

Research Associate
http://www.iscr.org.nz
bronwyn.howell@vuw.ac.nz
INTRODUCTION

Background to the research

Context

health reforms worldwide

the New Zealand reforms

An objective assessment of the economic implications of the strategy

informed by three years of operation
AGENDA: TONIGHT

The New Zealand primary health care strategy
  contractual changes
  institutional changes

Research methodology
  economics of contracts

Economics of health care markets
  demand for health care
  risk management and insurance markets
  contractual responses – international experience

Application to the NZ strategy
AGENDA: THURSDAY

The NZ primary health care strategy
  focus on institutional changes

Competition: theories and implications

Governance: theories and implications

Application to the NZ strategy

Conclusions
  implications for the future
  alternative models
HISTORICAL PERSPECTIVE

Social contract
between government and taxpayers
tax-payer-funded welfare benefit
paid per unit of service consumed
universal (1938-1991) then targeted (1991-2002) based upon financial and health need characteristics

Service delivery via public-private partnership
between government and service delivers contracts with alternative providers (post 1994)
Pre NZPHCS Primary Health Care Contracts

Voters and Taxpayers

Taxes

Social Contract: Targeted subsidy for GP Treatments

Government

Vote: Health

Patients

Patient Payment Per Consultation

Service Delivery Contract

General Practitioners

GP Remuneration Per Consultation = S88 + Patient Payment

S88 for GMS

Ministry of Health

Key:
Contracts
Payments

NEW ZEALAND INSTITUTE FOR THE STUDY OF COMPETITION AND REGULATION INC.
THE PRIMARY HEALTH CARE STRATEGY 2001

Perceptions:
- financial and service-related barriers for specific populations
- variations in health states between different groups

A desire to increase:
- the proportion of government funding in primary care
- the range of service types available to patients
- co-ordination of patient care amongst a range of providers
- information quantity and quality
- service innovation
INSTRUMENTS OF THE STRATEGY

Institutional instrument: PHOs
- nonprofit entities
- geographically based – community focus, linked to DHBs
- co-ordinating contracts for service provision with providers on behalf of registered population
- mixed governance – providers, community

Financial instruments
- capitation funding
- differential funding based upon registered PHO population characteristics (age, ethnicity, financial deprivation)
- progressive increases in government capitation funding over time (age-related)
Figure (ii) NZPHCS Primary Health Care Contracts

Key: Contracts Payments

Average Service Provider Remuneration Per Consultation

\[ \frac{(\text{Agreement Remuneration} + \sum \text{Patient Payments})}{\sum \text{Patient Consultations}} \]
KEY FEATURES

PHOs as ‘other party’ to social contract
   central entity
   change in allocation of property rights to government funding

Change in the basis of government funding
   focus on rewarding registration activities

Freedom for PHOs to enter into contracts with service providers
RESEARCH METHODOLOGY

Contracts are pivotal
  delivering objectives and aspirations
  delivering ‘value for money’

PHOs pivotal contracting entities

PHO contracts examined
  funding contracts (tonight)
  governance contracts
  interaction between PHOs and other sector entities
    (competition)
CONTRACTS, INSTITUTIONS AND INTERRELATIONSHIPS

Economic contracts
  agreement with obligations
  specify terms of relationships (e.g. governance)

Contracting process
  search, negotiation, terms, monitoring and enforcing performance
  a competition processes

Efficient contracts
  minimise transaction costs
  limit opportunistic behaviour
  allocate risk
  facilitate investment in specific assets
  allocate property rights
CONTRACTS IN HEALTH CARE MARKETS

Different characteristics from other product

Information asymmetries
  service deliverer knows more than patient

Service
  consumption good
  once consumed cannot refund
  difficulties in ascertaining quality

Derived demand
DERIVED DEMAND

Unpredictability of falling ill => demand uncertainty
  uncertainty for consumer – how much to save
  uncertainty for service providers – how much to invest to meet uncertain demand

‘Solution’ to uncertainty = insurance instruments
  large numbers – pooling reduces costs of demand uncertainty
  consumers – premium paid regularly when well to ascertain access to funds for treatment when ill
  providers – likelihood of payment when patient seeks treatment
INSURANCE AND HEALTH SYSTEM DESIGN

Separation of service delivery and funding/purchasing
Two products/markets to consider:
  financial risk management (insurance products)
  health service delivery

Insurance entity enters into two types of contract:
  receives premiums/taxes from patients/taxpayers (funding)
  contracts service deliverers to treat patients when they are ill (purchasing)

Patient/Consumer enters into two types of contract:
  with insurer to manage costs/risks of falling ill
  with service provider to deliver services when ill
DIFFICULTIES WITH INSURANCE SYSTEMS

‘Moral hazard costs (individuals and providers)
  Inefficient over-consumption as patient does not pay full costs of treatment
    patient-induced (worried well)
    supplier-induced (over-treatment, most profitable, etc.)
  mitigated by sharing risks/costs of over-consumption
    patient co-payments
    supplier incentive contracts

Adverse selection costs (individuals and insurers)
  high cost/low cost pools (profitability consequences)
  correlated demands
  screening and signaling
  mitigated by individual risk-rating, large numbers, reinsurance, non-exclusion provisions etc.
HEALTH SYSTEM DESIGN CHALLENGE

To constrain moral hazard and adverse selection costs given the existence of insurance markets is inevitable if health sectors are to function efficiently

**Constraining moral hazard:**
- sharing risks with patients
- sharing risks with providers

**Tension:**
- sharing risks with providers exposes providers to risks of variation in patient demand
- providers now become insurers – must manage for random, correlated risks
- how much risk to share with providers and how to share it?
CONTRACTUAL OPTIONS

Fee for service
  insurer bears all risks (cost and demand variation)

Price/volume contracts
  provider bears risks of own cost variations

Full capitation
  provider bears all risks (cost and demand variation)

Partial capitation
  cost and demand variations shared
  but how to design optimal contract?
PARTIAL CAPITATION CONTRACTS

Insurer pays both capitation and fee for service components

- information to balance risks/design efficient contract

Split between insurer and patient

- information for efficient contract design lost
- incentive effects on providers lost (recoup costs from patients)
- distinction between capitation (premium) and fee for service (premium top-up) components
  - premiums paid for all insured, only those seeking treatment pay top-up
  - sicker patients consume more care, pay more premium top-ups

Effect is a perfectly risk-rated system – those who cause more costs (consume more care) pay more top-ups – equity issues
MORAL HAZARD AND ADVERSE SELECTION

Increases in premium subsidies (decreases in patient payments) increases moral hazard costs
Sharing patient risks with providers increases likelihood of adverse selection occurring
Only those patients consuming care pay increased risk costs

patients of high-risk providers will pay higher costs than those of low-risk providers (or low-risk providers can charge same prices as high-risk and keep profits)

higher-than-average consumers (i.e. sicker) pay more of the risk costs than lower-than-average
RISK BEARING AND THE PREVIOUS SYSTEM

Fee for service
Central risk pool (4 million)
‘Welfare benefit’ to pay part of fee, patient pays rest
Self-insurance for all others (paying only own costs)
No scope for adverse selection
Constraints on patient moral hazard
Extent of provider moral hazard?
RISK-BEARING UNDER THE NEW STRATEGY

Government bears no patient demand variation
fixed fee – only variation is number of citizens

77 PHOs are now insurance companies
bear all risks associated with patient demand variation
geographical implications of correlated demand
freedom to contract (can pass risks via contracts to service
providers, who can recoup costs from patients via patient
payments)
absence of prudential monitoring of PHOs as insurance
companies
questions about availability of information to monitor/ manage
population risks (US comparisons)
CONTRACTING BEHAVIOURS

PHOs are passing capitation payments in total on to service providers
very small risk pools (1200-2000)
absence of risk reserves and strong reinsurance markets
strong incentives for adverse selection (especially for higher-subsidised groups) and other risk management practices (e.g. screening)

Strong suggestions of higher risk costs already
variations in patient prices reflect different risk-bearing abilities
higher-subsidised practices have greater risk reserves
higher-risk practices passing costs onto patients
co-payments falling less than average subsidy increases
Care Plus as a response to higher-than-anticipated costs
IMPLICATIONS

Providers’ ‘get out of risk-bearing for free’ card
raises questions about reason for capitation

Patient co-payments
provider recovers costs by charging difference between
  capitation and costs to patients
no additional incentive to manage moral hazard
no additional incentive to innovate
but all the additional overheads of adverse selection,
  administration, regulation, quality control ….

Higher costs in total
  higher gains required from other elements of the strategy
INFORMATION ISSUES

Prices no longer reflect cost of service delivery
Capitation setter cannot design optimal contract
Individual (sick) patients become ‘risk-bearers of last resort’
  least able to bear risk
  entered into insurance arrangement to avoid this
Effect = perfectly risk-rated insurance premium paid by patient
  (or a tax on falling sick)
  implications for health states
INTERNATIONAL COMPARISONS

Competitive markets – United States managed care competition for insurance product
Full funding – England’s NHS
A CHALLENGE FOR NEW ZEALAND