NEW ZEALAND INSTITUTE FOR THE STUDY OF COMPETITION AND REGULATION INC.

INJECTING CHANGE INTO PRIMARY HEALTH CARE:

the NZ Experience

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

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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

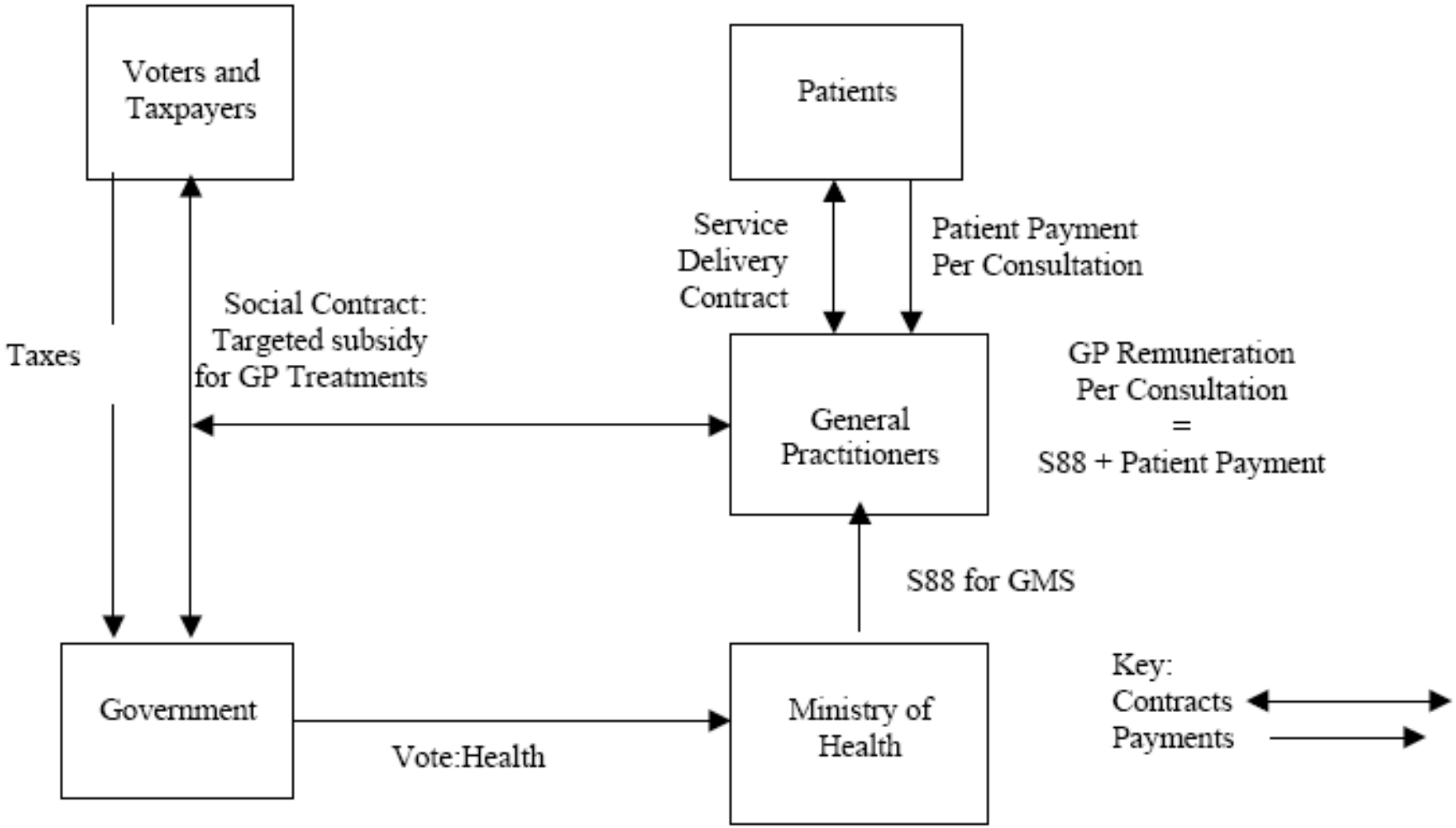
Social contract

- 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



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

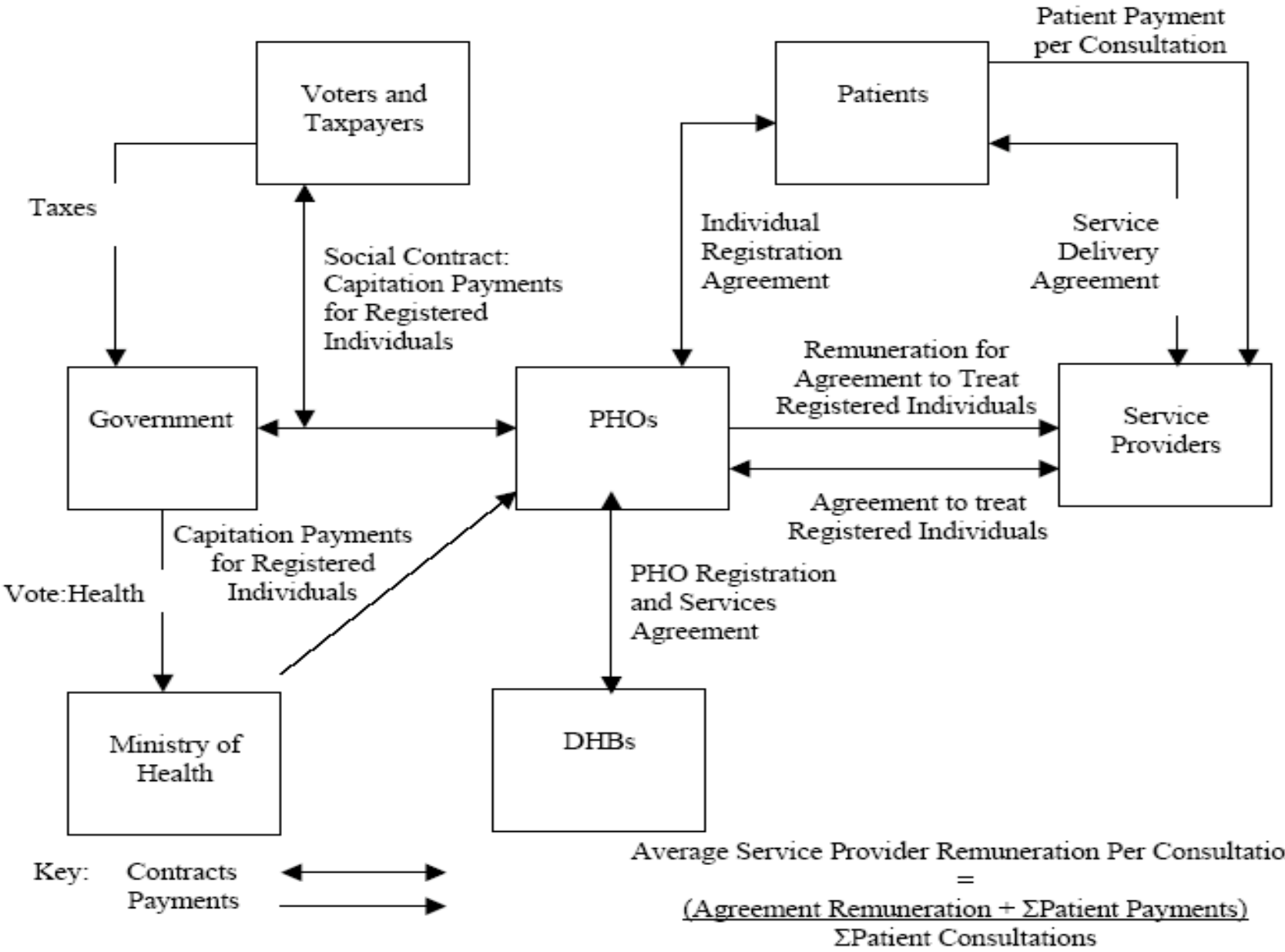
Institutional instrument: PHOs

- 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 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