Offering the right incentives

Reforming the health system is an intricate task. Why is it that the best-intended reforms don't always work? Elizabeth Savage explains the impact of reforms on consumer behaviour.

IT IS NOT easy to reform the health system. Often a proposal that appears quite sensible, even to insiders, has unexpected impacts. Reforms that aim to reduce expenditures can increase them; intended beneficiaries may not gain; there may be undesirable impacts on intensity of use and mix of services and on access and distribution across the population. The most frequent cause of predictions being well wide of the mark is the assumption that consumers and providers will behave in the same way after a policy change as before. Here's a few examples.

The Australian Medicare Safety Net

The Medicare Safety Net was introduced in 2004 to improve access and affordability of outpatient care, especially for those with chronic conditions. Under the policy Medicare funded 80 per cent of out-of-pocket costs above a specified annual threshold. These were set at $300 a year for families either with concession cards or eligible for Family Tax Benefit Part A and $700 per year for all other families.

The Government estimated the Safety Net would cost $440 million over four years. However, there was a budget blow-out to $1 billion and an unexpected distribution of Safety Net benefits both spatially and by type of service. Obstetrics, providing 0.6 per cent of services, received 13 per cent of safety net benefits. IVF, with only 0.1 per cent of services also received 13 per cent of benefits. In addition, it appears that a large part of the safety expenditures went to providers rather than patients.

The predictions were wrong because they ignored the way changed incentives would impact on behaviour. For providers, the Safety Net made it easier to increase fees without affecting demand. For patients, additional services became more affordable because the Government paid 80 per cent of the fee above the threshold. (van Gool et al, 2006)

US examples

Between 1967 and 1982 the US Medicare program faced 10 per cent annual growth in hospital costs. In response, in 1983, the way providers were reimbursed was changed from fee-for-service to a Diagnosis Related Group (DRG) based, prospective payments scheme. At first the policy seemed successful: about 3 per cent annual growth between 1983 and 1988. But then the trend reversed. Why? Provider behaviour changed in response to the new incentives. There was DRG creep as hospitals re-labelled conditions with higher return DRGs. There was also substitution from acute care to rehabilitation which remained fee-for-service.

In 1985 US Medicare allowed enrolees to move from Medicare providers to a Health Maintenance Organisation (HMO) where patients faced lower co-pays and deductibles and received cover for prescription drugs. By reimbursing the HMOs only 95 per cent of the average cost of Medicare enrolees, the government expected to save money. But they lost money. They had assumed that those who moved to the HMO would be the same as those who stayed with Medicare but it was healthier over-65s who selected the HMO option. As a result, the reimbursement to HMOs was too high and the Government was left with the more expensive patients.

Scotton's proposal for Australian health care reform

In any health care system there are many heterogeneous agents with often competing objectives. Reforms to the system must address behavioural incentives and selection problems. The most prominent Australian proposal for major health reform is Dr Richard Scotton's version of managed competition which was the subject of the 2002 Productivity Commission Workshop, Managed Competition in Health Care. During the workshop the proposal was described as "one of the few coherent and well thought-out health reform policy prescriptions currently on the table in Australia".

Elizabeth Savage

The Scotton model aims to improve efficiency using market incentives while retaining universal access to basic care. The proposal separates purchasing and provision of health care. Competitive at-risk public and private budget holders receive risk-adjusted enrolee capitation payments from the Australian Government to fund basic care (the public health budget incorporating Medicare, public hospital funding, pharmaceutical benefits, nursing home benefits, home and community care, mental health and other community-based programs). All individuals choosing only basic care would be assigned to the public budget holder for their region. Private budget holders, which might be health insurers under the current arrangements or new intermediaries such as HMOs, collect premiums for their enrolees to cover administration and services beyond basic cover.

The government mandates outcomes and quality of the basic public package provided by both public and private budget holders. Providers compete to sell services to budget holders. State governments establish and manage public sector budget holders and act as their guarantors. They also plan, regulate and operate public health care providers. Scotton argues this would eliminate the current public/private divide – the share of the population choosing public or private budget holders would be irrelevant.

Does it address current problems?

The major factor driving increasing health expenditures is technology, including pharmaceuticals. Much of the dissatisfaction with the health system focuses on public hospitals. Budget caps result in long wait times, overcrowding, closed operating theatres and wards, and understaffing. Scotton's proposal addresses all existing problems by putting all the money for basic care in one pot and making providers compete for patients. There would be a fixed public health care budget where several components of the financing system are open-ended.

It is expected that the single pool of funds would make the mix of health care services more efficient. This places great faith in market incentives when the only bin response to different mixes of service and cover of above-basic care. Basic care is mandated and enrolees with public budget holders are assigned geographically.

Mandating outcome and quality control standards requires contracts. Contracting is more likely to be successful when the service can be very well-specified. Can the government write contracts which guarantee delivery and quality of basic care when purchased for patients by private budget holders?

Can the health outcomes of basic care be written into a contract?

What about selection? If we look at those with private health insurance at present, we might expect those enrolled with private budget holders to be a different selection of the age-sex part of the population (higher income, higher health status). This would leave a higher risk group with public budget holders. Paying average risk-adjusted capitation payments would over-fund private and under-fund public fund holders, create incentives for lower service levels from public budget holders and reinforce the selection problem.

> "Reforms that aim to reduce expenditures can increase them; intended beneficiaries may not gain..."
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Is the purchaser-provider split sustainable? What mechanisms discourage providers from taking over private budget holders and increasing fees for above basic care? To provide correct incentives and control costs, consumers must vote with their feet and move to public budget holders. This may be very unlikely with the kinds of selection problems that could arise.

Even with incremental change, there are many challenges involved in getting the incentives right and improving the system. A big bang approach looks very courageous. H&h

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