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TREASURY WORKING PAPER

00/17

Management of Key Purchaser Risks in Devolved Purchase Arrangements in Health Care

Jackie Cumming

Contract to the Treasury*

ABSTRACT

This paper examines the key risks and risk management strategies associated with devolving the purchase of publicly funded health care to non-governmental organisations, where the aim is to maintain at least the current level of equity of access. The key risk is greater 'cream-skimming' or risk selection, particularly with competitive purchase models based on patient choice of purchaser. The paper also examines the risks of poor purchaser performance and cost shifting. Minimising these risks would require considerable government regulation.

This paper was commissioned and carried out to inform Treasury's thinking in helping develop health policy under the National Party Government that was in power from August 1998 to November 1999. It is a background paper and does not provide policy advice, nor does it propose any particular course of action. The Treasury has chosen to make it publicly available in order to encourage public discussion.

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Disclaimer: The views expressed are those of the author(s) and do not necessarily reflect the views of the New Zealand Treasury. The Treasury takes no responsibility for any errors or omissions in, or for the correctness of, the information contained in these working papers.

Management of Key Purchaser Risks in Devolved Purchase Arrangements in Health Care

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About the Health Services Research Centre

The Health Services Research Centre aims to promote excellence in academic research, to encourage interaction between researchers and policy makers and to mount policy-focused research as well as evaluative research. The Centre is a joint venture between the Institute of Policy Studies, Victoria University of Wellington and the Wellington School of Medicine, University of Otago. The Health Services Research Centre gratefully acknowledges the role of the Health Research Council of New Zealand in providing core funding for the Centre.

Disclaimer

The views expressed in this paper are those of the author alone. No other individual or organisation takes responsibility for any errors or omissions in, or for the correctness of, the information contained in this report.

EXECUTIVE SUMMARY

This paper was commissioned by The Treasury to provide an overview of the key risks associated with devolved purchasing arrangements and purchaser competition in health care in New Zealand.

For the purposes of this paper, devolved purchasing is defined as any purchasing strategy or policy which allocates responsibility for purchasing groups of services (for a particular population) to non-government organisations other than the Health Funding Authority (HFA). Organisations other than the HFA then become responsible for negotiating contracts with other providers and for funding such services from budgets allocated to them. In some cases, the range of services for which purchasing is devolved may be rather limited (e.g., to primary care services) or it may be comprehensive (e.g., cover all health care services). Examples of organisations which might take on this devolved purchasing role include general practitioners (GPs), independent practitioner associations (IPAs), hospital and health services (HHSs), or Iwi organisations, community providers or health insurers.

Purchaser competition occurs where people can choose which of a number of devolved purchasing organisations (DPO) has the responsibility to arrange for some or all of their care.

The paper does not discuss in depth the overall merits and demerits of moves to devolve purchasing in New Zealand. The paper also does not discuss in detail the potential benefits of purchaser competition, the transaction costs that might arise with such competition, nor the transition issues in establishing purchaser competition. Rather, the author was asked to focus on the following key risks:

- ***cream-skimming*** – which occurs when health providers or DPOs – either deliberately or by chance – enrol a favourable mix of members, i.e. those with good health and hence a lower chance of making a claim or needing care than the average person;
- ***poor purchaser performance*** – which occurs when DPOs as agents fail to meet the objectives of principals (e.g., the HFA, the government, taxpayers or communities.); and
- ***cost-shifting*** – which occurs when costs are charged against a budget that differs from that intended, or from that traditionally charged.

Cream-skimming

In the current financing environment, successful cream-skimming in New Zealand could lead to: increased overall expenditure; pressure for additional expenditure; inequitable access to services and quality care; limited incentives for technical efficiency and cost-effectiveness; and high levels of profits for some DPOs while others struggle.

Cream-skimming has the potential to be a serious problem in New Zealand if we move to payment systems which place providers at greater financial risk and which maintain or further encourage competition between providers or devolved purchasers. The likely extent of cream-skimming cannot be judged at present. One gauge of the significance of the issue, however, is the attention that is being given to regulatory

reforms in the United States to reduce its prevalence: this suggests that if cream-skimming were to become widespread, each of the risks mentioned above is likely to be significant, both in a financial and political sense.

Poor purchaser performance

The risks associated with poor purchaser performance – relative to good performance – are potentially many. These include: higher overall expenditure for a given level of care or a lower level of care for a given level of expenditure; lower access to services and reduced quality of care; reduced equity of access; increased private financial responsibility for care; limited improvements in health status; and higher overall expenditure as expenditure is shifted to the private sector, which may be less able than the public sector to contain overall costs.

The likelihood of such risks is difficult to judge. Any losses from poor performance in delivering value-for-money are difficult to estimate – from all perspectives. The size of the health care market means that systematically poor purchaser performance will lead to significantly lower levels of health or higher expenditures than necessary. This, however, may be balanced by having multiple agencies involved in the delivery of health care: failure on the part of a purchaser to perform may not necessarily be reflected in poor service delivery.

Cost-shifting

The key risks associated with cost-shifting are also potentially numerous. They include: increased government expenditure on votes other than Vote: Health; increased expenditure for publicly-owned purchaser and provider organisations were costs and patients to be shifted to publicly-owned purchasers and providers; increased private expenditure and resource use were purchasing authorities to make decisions which shift responsibility for financing onto private budgets; increased shunting of patients; higher overall expenditure, if claims in the private sector increase with more care provided privately at higher cost; reduced equity of access if those who cannot obtain publicly-funded care are unable to afford private care; difficulties in planning and budgeting in areas where costs are shifted to; and inappropriate market signals which might arise as a result of cross-subsidies.

As far as the author is aware, there is no New Zealand research evidence on the extent of deliberate cost-shifting or its impact. However, cost-shifting is widely believed to take place here.

Recommendations

Future analysis and research

There are a number of areas where further analysis would enable a better judgement to be made about the benefits of further reform in New Zealand health care. Regarding devolved purchasing and purchaser competition, it is recommended that:

- the Treasury undertake further analysis of the potential advantages and disadvantages of moves towards integrated care and devolved purchasing in New Zealand. This analysis should compare current purchasing arrangements with devolved purchasing in relation to: purchasing expertise; local responsiveness (of

providers to DPOs and of DPOs to communities); the removal of the purchaser-provider split which is proposed with devolved purchasing; accountability and governance; conflicts of interest; and levels of transaction costs. Further analysis should involve a) a detailed literature review of United Kingdom and United States experiences with devolved purchasing; and b) formal evaluations of integrated care pilots in New Zealand: these evaluations should draw on key issues noted in this report.

- the Treasury complete a more detailed literature review and give more critical thought to the advantages and disadvantages of purchaser competition in New Zealand. This analysis should draw on previous work undertaken for the Health Services Taskforce as well as more recent evidence. Careful attention should be paid to:
  - i the design features of purchaser competition. This should include careful analysis of the implications for equity, efficiency and other goals of: allowing individuals to top-up their government contribution with private financing; ensuring a minimum standard of care; alternative regulatory structures, including the number of standard packages of care;
  - ii the implications for private medical insurance in New Zealand; and
  - iii the transition issues in shifting to purchaser competition.

- the Treasury encourage clearer signals to be given about the future direction of New Zealand's health services, in particular, whether purchaser competition is to be encouraged and what the regulatory arrangements might be with such competition. This will allow providers and emerging DPOs to plan with full knowledge of the future regulatory environment.

Cream-skimming

It is recommended that if devolved purchasing is thought to be appropriate to develop into competition between providers or competition between DPOs:

- the services specified in the HFA's Service Coverage Document should continue to be incorporated into contracts with providers. This promotes accountability and ensures that provider groupings which compete with each other are required to make available the same set of services[1];

- current work on specifying services (and eligible patients) continues, adding detail (e.g., condition/treatment pairs; practice guidelines; clinical assessment priority criteria) in relation to services where rationing is most common[2]. In a competitive purchasing environment, this will promote accountability; promote equity of access; and reduce local service specification and service delivery choices as sources of

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1 Some consideration will need to be given to the advantages and disadvantages of standardising user charges (Enthoven 1988, p. 104), to prevent both cream-skimming and cost-shifting.

2 This assumes that the funding of health care in New Zealand remains at present levels and that rationing of particular services (e.g., heart transplants, liver transplants) continues.

cream-skimming[3]. It may be that with experience we gain a better understanding of which services need to be specified tightly and which can remain more loosely defined in order to encourage diversity;

- an explicit list of services that are not currently purchased by the HFA be developed – this will assist in clarifying boundaries between public and private financing. Such services may need to be specified in some depth (e.g., condition/treatment pairs; practice guidelines; clinical assessment priority criteria). The private insurance market is likely to welcome this development and some further assessment of its impact is essential. This approach makes more explicit the fact that those unable to get or afford private health insurance may miss out on care they might benefit from;

- responsibility for technology assessment and national guideline development activities for particular services (e.g., high cost, high volume, experimental services) should be allocated to an existing or new agency. The agency's roles would be to facilitate guidelines to be used in conjunction with service specification and to implement such guidelines. Again, the role of such guidelines would be to promote accountability and equity of access and to prevent local service specification and service delivery in ways that promote cream-skimming. Possible agencies include: the National Health Committee (incorporating its Guidelines for Guidelines project); the HFA; or a new agency such as the United Kingdom National Health Service National Institute of Clinical Excellence (NHS Executive 1999); and

- funding be allocated to DPOs using a risk-rated capitation formula, where the level of funding is either: a) sufficient to cover a broadly defined range of services such that care is available to all those who are deemed likely to benefit, i.e. requiring additional resources in the health sector depending on an assessment of current levels of unmet need[4]; or b) sufficient to fund a set of services which are defined in detail. The second approach is likely to be required in order to i) remain within current funding levels[5]; ii) promote equity of access around the country; iii) promote accountability and iv) prevent opportunities for under-servicing and cream-skimming[6].

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3 It will also reduce avenues for under-servicing.

4 The recent experience in relation to booking systems for elective surgery gives an indication of how greater explicitness and the setting of an entitlement may lead to unmet need surfacing (e.g., in New Zealand where a large number of people are waiting to see specialists for assessment) (Kennedy 1998)). See also Light (1998) who argues that the United Kingdom NHS is 'doubly underfunded' in that in addition to those already on waiting lists there are likely to be thousands of patients with similar needs who are being kept off waiting lists because their GPs thought the lists were too long (p. 7).

5 This is partly because service specification in and of itself, accompanied by a move to the delivery of care by private agencies engaged in making profits or surpluses, may lead New Zealanders to view the services specified as an entitlement to care and to become more wary of not getting services in a timely way.

6 Contracting with devolved purchasers in terms of volumes of service may not be sufficient to reduce incentives to cream-skim or under-service.

Beyond service specification, it is recommended that:

- contracts with providers and DPOs signal the likely development of a regulatory regime which at the very least includes open enrolment, guaranteed renewal and ways of monitoring and publicising quality of care;

- further analytical work be undertaken to consider the costs, benefits and ability to interpret data on quality of care, disenrolments and consumer complaints and satisfaction;

- the risk profiles of providers or DPOs on capitated contracts be assessed and appropriate ways to risk-rate payments or to compensate those with a riskier population be further researched; and

- an independent agency is established to provide information to consumers to facilitate consumer choice of provider or plan and to market information on behalf of providers or plans.

Poor purchaser performance

It is recommended that:

- a set of purchaser and provider performance indicators be further developed, drawing on current and international approaches, with the information required to monitor indicators to be stipulated in contracts. Such indicators might be used in developing rewards and sanctions; benchmarking performance; or in providing information to facilitate competition between purchasers. Care needs to be taken, however, that information requirements do not impose significant, additional costs on the sector and that indicators can be adjusted by health status in ways which are generally acceptable to all stakeholders;

- further analytical work be undertaken to identify the service areas where practice guidelines or audit might more appropriately be used to monitor performance (e.g., hospital standards; acute admission audits). This should include a literature review on approaches to audit and attention should be paid to the literature on optimal practice guideline development and implementation; and

- a review be undertaken of New Zealand's experience with rewards and sanctions and the problems and potential of such tools for improving performance, particularly in the context of designing incentives for a monopoly purchaser or (regionally-based) purchasers.

Cost-shifting

It is recommended that in designing devolved purchasing contracts, consideration be given to budget boundaries, including whether contract and referral guidelines can be used as means by which cost-shifting can be prevented.

1 INTRODUCTION

The aim of this paper is to provide an overview of the key risks associated with devolved purchasing arrangements in health care in New Zealand. Devolved purchasing is defined as any purchasing strategy or policy which allocates responsibility for purchasing groups of services (for a particular population) to non-government organisations other than the Health Funding Authority (HFA). Organisations other than the HFA then become responsible for negotiating contracts with other providers and fund such services from budgets allocated to them. In some cases, the range of services for which purchasing is devolved may be rather limited (e.g., to primary care services) or it may be comprehensive (e.g., cover all health care services). Examples of organisations which might take on this devolved purchasing role include general practitioners (GPs), independent practitioner associations (IPAs), hospital and health services (HHSs), or iwi organisations, community providers or health insurers[7]. The paper also considers risks associated with devolved purchasing where there is purchaser competition – a further policy step which may be taken in New Zealand. Purchaser competition occurs where people can choose which of a number of devolved purchasing organisations (DPO) has the responsibility to arrange for some or all of their care.

The paper provides a high level summary of the key risks associated with devolved purchasing and purchaser competition. Key risks are: cream-skimming, poor purchaser performance, and cost-shifting. The report provides an overview of the policy approaches that might most effectively manage these risks, and an outline of the advantages and disadvantages of each policy approach. The nature of theory and empirical evidence on these topics is such, however, that much of the analysis is based on *a priori* theory and only partial empirical evidence, often from other countries. This suggests that if, based on a further assessment it is believed that further change is desirable, New Zealand should adopt approaches which allow 'learning by doing', evaluation of key changes, and policy adjustments over time as evidence on performance becomes available.

The paper does not discuss in depth the overall merits for New Zealand of moves to devolve purchasing or introduce purchaser competition, nor the additional transaction costs and transition issues we would face in implementing such policies. Rather, the author was asked to focus on the key risks of cream-skimming, poor purchaser performance and cost-shifting which might be associated with such policies. Further analysis of the benefits of these policies is required to weigh up against the risks set out here.

Following this introduction, the paper is divided into the following sections:

- Section 2, discusses devolved purchasing in more detail, focusing on the forms of devolved purchasing which are currently emerging in New Zealand;

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7 Devolved purchasing is related to integrated care, but goes further than some integrated care models by allocating responsibility for the purchasing of services from a devolved budget to organisations other than the HFA.

- Section 3, discusses three key risks associated with devolved purchasing: cream-skimming, poor purchaser performance and cost-shifting;

- Section 4, analyses the main approaches for managing each risk; and

- Section 5, summarises the discussion and provides some concluding comments.

References to the report are set out in Section 6.

Nine appendices are attached to this report. Appendix A provides a glossary of terms and abbreviations used in the report. Appendix B details the techniques and organisational forms of integrated care, some of which are relevant for devolved purchasing. Appendix C describes proposals for purchaser competition. Appendix D notes particular issues associated with further moves towards purchaser competition in New Zealand. Appendix E notes reasons why purchaser competition proposals include a standard package of benefits, beyond reducing the ability to cream-skim. Appendices F-H provide examples of service specification in European and United States legislation. Appendix I sets out the requirements of the Health Employer Data Information Set (HEDIS), used to assess the performance of health plans in the United States.

1.1 Methods

The project has involved a detailed review and analysis of the international literatures on health policy reform, particularly the material on integrated care and managed competition. Much of this material is focused on the United States health system, and a key task has been to assess the relevance of United States experience for New Zealand. A number of other countries, for example the Netherlands and the United Kingdom, have also developed proposals in recent years which are relevant to integrated care and managed competition in New Zealand and their proposals and experiences have also been considered in this paper.

Discussions with Julie Signoff, Kaiser Permanente, have proved useful in providing further detail on United States experiences and regulations, particularly those in California. A number of background papers provided by the Treasury were reviewed: this included a number of papers written for the Health Reforms Directorate and the National Interim Provider Board in 1992/93 (when the New Zealand 1993 health reforms were being implemented) and recent papers on service coverage and devolved purchasing (Clayton and Scott 1998; Minister of Health 1998).

2 DEVOLVED PURCHASING IN NEW ZEALAND

New Zealand's health care sector has undergone significant change since 1993. Key reforms have included the splitting of purchasing and provision functions, the establishment of hospitals along business lines, the introduction of competition in provision and the increased use of contracts in relationships between purchasers and providers. As a result of these reforms, general practitioners (GPs) have increasingly grouped together in horizontally integrated Independent Practitioner Associations (IPAs), and a number of other organisations and networks have also developed (e.g., Health Care Aotearoa, (see Crampton 1999); Mâori purchasing organisations (see Crengle 1999); MATPRO – a Wellington-based vertically integrated consortium of midwives, GPs and specialists involved in maternity care).

Until 1997, the purchaser-provider split in New Zealand allocated responsibility for purchasing to four regional health authorities (RHAs). RHAs were responsible for purchasing a comprehensive range of services for each of their populations. Such services have been purchased from a number of providers, ranging from independent GPs and small voluntary organisations through IPAs and hospitals (formerly crown health enterprises or CHEs). In early 1998, the four RHAs were combined into a national organisation, the Health Funding Authority (HFA), which is now responsible for such purchasing.

2.1 Integrated care

As a result of the reforms, some New Zealand providers – and the HFA (Health Funding Authority 1998) – are aiming to further promote *integrated care*, sometimes called managed care. Integrated care has many definitions. In New Zealand, integrated care has been argued to span 'a spectrum ranging from integration within a group of related services using shared clinical protocols and information systems within current contracting arrangements with the funder to large scale integration across all primary and secondary services under a capitation payment' (McKenzie Webster 1997, p.5). In a recent review of managed care arrangements in California, the following definition was used: 'any system of health service payment or delivery arrangement where the health plan attempts to control or coordinate use of health services by its enrolled members in order to contain health expenditures, improve quality or both' (Physician Payment Review Commission 1996, cited in Managed Health Care Improvement Task Force, 1998).

These definitions encompass both *techniques for integrated care* and *organisational forms which promote integrated care*.

Key *techniques for integrating care* include:

- financial incentives at an organisational or provider level, usually involving capitation, some form of risk sharing or budget integration;
- techniques for managing clinical activity – utilisation review, medical or practice profiling, disease management, clinical guidelines; and

- patient-focused techniques – gatekeeping[8], case management, queuing and watchful waiting, primary prevention, encouraging self-care (Robinson and Steiner 1998).

Key *organisational forms of integrated care* include:

- health maintenance organisations (HMOs) – staff model, pre-paid group practice, network model, IPA and mixed model versions have been separately identified in the literature;
- preferred provider organisations (PPOs);
- point of service plans (POSs);
- primary care case management (PCCM);
- social health maintenance organisations (SHMOs); and
- programme for all-inclusive care of the elderly (PACE) (Robinson and Steiner 1998).

These key techniques and organisational forms of integrated care are discussed in further detail in Appendix B.

2.2 Integrated care and devolved purchasing in New Zealand

New Zealand's health care system already features a number of the techniques for integrated care (e.g., case management, GPs acting as gatekeepers to specialist services). Integrated care developments in New Zealand are occurring in relation to financial incentives (e.g., capitation and budget holding in primary care), techniques for managing clinical activity (e.g., developing guidelines across non-integrated providers) and limited forms of HMOs (e.g., the development of devolved purchasing organisations or DPOs). DPOs in the New Zealand context are groupings of insurer and/or provider organisations, aiming to take responsibility for the care of particular populations, and having a budget devolved to them from the HFA to fulfil such obligations. Examples include: arrangements proposed in 1998 by P*rime*Health in Tauranga (P*rime*Health Ltd 1998); MATPRO; the Marlborough Health Trust (Hyndman 1998) and emerging Mâori Integrated Care Organisations (Crengle 1999).

Moves towards capitation (including the general medical services benefit as well as other subsidy payments such as practice nurse, pharmaceutical and laboratory subsidy payments and potentially, community and secondary care services), budget-holding (for referred services) and DPOs are likely to involve some devolution of the purchasing role, i.e. providers or other agents taking responsibility for allocating resources not only to consumers/patients but also across services. The move in 1998 to a single national funder is also likely to encourage such devolution: the HFA may

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8 For example, in New Zealand GPs act as gatekeepers to secondary care services. This contrasts with more direct access to specialist care in other countries.

find that it is too remote from consumers/patients to purchase services which best meet consumer/patient needs – one way of improving local responsiveness might be to devolve some of its purchasing responsibilities[9].

2.3 Integrated care and purchaser competition

Moves towards devolved purchasing in turn increase the potential for a move towards competition at the purchaser level, i.e. for a number of DPOs each to take on responsibility for arranging the care of populations registered with them and to compete with each other for individual members. It is difficult to judge how imminent such changes may be[10], but it is important to consider, at a policy level, the implications of such a development. For the purposes of this paper, this further step is labelled 'purchaser competition'. Details of potential approaches to purchaser competition are set out in Appendix C.

2.4 Devolved purchasing arrangements in New Zealand

The main devolved purchasing arrangements likely to emerge in New Zealand are set out below[11]. In all cases the financing of the New Zealand health care system is assumed to remain as is (i.e. a largely tax-based system with taxes collected and distributed by the government, with user charges for some services, particularly primary care[12]), with crown ownership of the HFA and some providers or DPOs in all arrangements. DPOs can take any of the integrated care organisational forms discussed above (page 5 above, and see Appendix B). Throughout this paper, it is assumed that current levels of spending are maintained and that any efficiency gains

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9 For example, the HFA noted in its document 'The Next Five Years in General Practice' that primary health service organisations 'need to be able to relate to their local communities and be flexible in their response to local problems' (Health Funding Authority 1998, p. 7).

10 Many of the current proposals would fit within a model where the HFA continues to have overall responsibility for purchasing a comprehensive set of services for New Zealand as a whole, with specific contracts with DPOs devolving a purchasing role for particular disease categories or regions (McKenzie Webster 1997). Furthermore, many IPAs have become quite large and have developed around geographical areas so that, in theory, they could become regional monopsony DPOs.

11 This paper does not assess the relative advantages and disadvantages of each approach. An assessment of the advantages and disadvantages would include identifying the extent to which each approach facilitates: the assessing of needs; obtaining information on services; influencing providers; promoting patient choice; and the ability to undertake priority setting, including an assessment of effectiveness and values. In addition, the likely extent of transaction costs associated with each model requires further analysis. See Mays and Dixon (1996) for further discussion.

12 It is assumed throughout this paper that competition would occur in relation to the government's share of health care funding in the form of a voucher which would not be able to be topped up with private funding. However, key policy issues for further consideration are a) whether to allow individuals to top-up the government's contribution for care beyond the specified core and b) what the equity, efficiency, and cost-shifting implications of this are likely to be. See also Plank (n.d).

from devolved purchasing come in the form of improved processes of care for patients, more services and financial savings[13].

The devolved purchasing arrangements considered in this paper are:

Monopoly HFA – This model represents the status quo. A monopoly purchaser – the HFA – is responsible for the purchasing of a broadly defined range of services for the entire New Zealand population. The HFA contracts with a range of providers to ensure such services are delivered. The HFA uses a mix of contracting arrangements, including contracts with integrated providers, who are paid largely on a capitation basis, and contracts with non-integrated providers who are paid on a fee-for-service basis or who are paid according to price-volume contracts with budget caps.

Monopoly HFA with specialist purchasing of particular services[14] – Where the HFA devolves responsibility for some specific services to particular DPOs, who then become responsible for purchasing those services. Examples might include care for consumers with disabilities. Carved-out services are assumed to be paid for on a capitation basis[15]. The HFA retains responsibility for purchasing all other services.

Regional monopoly integrated purchasers – Where a number of regional monopoly purchasers are responsible for the purchasing of a broadly defined range of services for their regional or sub-regional populations. These purchasers are largely integrated with a few external contracts. It is assumed that such purchasers would be funded on a capitation basis[16].

Choice of partially integrated DPO – Where individuals make their own choices for coverage, choosing between a wide range of competing DPOs. DPOs arrange for <u>some</u> care only (e.g., primary care or primary care with some secondary care services), and are either publicly- or privately-owned. The HFA contracts for other services (e.g., tertiary services) on behalf of the entire New Zealand population. The DPO market is managed by one or more agencies, through which government funding is channelled. These agencies register DPOs, monitor DPO performance and provide

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13 Further work is required to determine whether or not these assumptions would hold with devolved purchasing.

14 Known as 'carve-outs' in the United States literature.

15 In some United States examples, carve-out purchasers are often paid an administration fee (based on capitation), and are not subject to financial risk – providers are often paid on a fee-for-service basis. The carve-outs appear to involve very close management of care, e.g. ongoing concurrent review (Goldman, McCulloch et al. 1998; Ma and McGuire 1998). The two papers cited here refer to mental health benefits in employment contracts, ie. for the general population. Whether or not the same arrangements are applicable for those with ongoing serious mental health needs is not clear.

16 An example of this arrangement might be the Marlborough Health Trust model (Hyndman 1998).

consumers with information on DPO performance. Agencies might include the HFA, employers or regional purchasing co-operatives[17].

Choice of fully integrated DPO - Agency approach – Where individuals choose between competing DPOs – however, their choices are framed by an agency, through which government funding is channelled. Agencies make the first cut of choices between a range of competing DPOs (e.g., they may seek tenders or choose a narrow range of DPOs), and they monitor, and provide consumers with information on, DPO performance. Agencies might include the HFA, employers or regional purchasing co-operatives. DPOs arrange for comprehensive care, are fully integrated, and are either publicly- or privately-owned.

Choice of fully integrated DPO - Individual approach – Where individuals make their own choices for coverage, choosing between a wide range of competing DPOs. Government funding is allocated to DPOs on the basis of consumer choice. DPOs arrange for comprehensive care and are fully integrated, and are either publicly- or privately-owned. The DPO market is managed by one or more agencies, through which government funding is channelled. These agencies register DPOs, monitor DPO performance and provide consumers with information on DPO performance. Agencies might include the HFA, employers or regional purchasing co-operatives.

2.5 Devolved purchasing and policy risks

Many of the techniques for devolving purchasing pose little risk on their own. Key uncertainties, however, include: whether any additional transaction costs from devolved purchasing[18] are offset by improvements in care or cost-effectiveness; and whether integrated care techniques lead to overall higher costs because of improvements in quality of care, e.g. where clinical guidelines lead to more service and better quality of care. These risks are not discussed here.

Devolved purchasing does however raise two important issues: how to provide incentives for purchasers to perform; and how to reduce the potential for cost-shifting where financing/budgets for different types of care remain separate[19].

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17 Regional purchasing co-operatives are agencies which purchase health care on behalf of employer or other organisations. The concept appears to be a United States one, designed to reduce the costs of purchasing for small and medium sized firms and to enhance purchaser power over providers.

18 For example, the savings on transaction costs were one reason given for the move from four purchasing authorities to one purchasing authority in New Zealand. The one purchasing authority should be cheaper to run than four, while provider groups which operate in more than one region should also find their transaction costs reduced as they need only deal with one agency rather than four.

19 For example, the Marlborough model included private insurance in its financing arrangements. How will it be made clear what is paid for by government funding vs private insurance financing? What will happen with user charges if further services – beyond those currently paid for by the general medical services subsidy – are delivered by general practitioners?

Additional risks are also likely with the moves towards placing providers and devolved purchasers at increasing levels of financial risk. The most important of these are in relation to under-servicing and cream-skimming. The former is dealt with in this paper under the issue of purchaser performance; the latter is considered as a stand-alone risk.

3 RISKS ASSOCIATED WITH DEVOLVED PURCHASING

3.1 Cream-skimming (risk-selection)[20]

Cream-skimming occurs when health providers or DPOs – either deliberately or by chance – enrol a favourable mix of members, i.e. those with a lower risk of making a claim or needing care than the average person[21]. It is a particular problem where there are capitated payments made to providers and plans, where there is competition between providers and plans to serve particular markets, and where – because premiums for an individual's care do not necessarily equate with *ex ante* or *ex post* financial risk – there is an opportunity for the provider or DPO to make profits/surpluses from selecting patients.

In New Zealand, cream-skimming is a risk where a) contracts with providers are on a capitation or budget-holding basis and b) there is competition between providers or DPOs. Although New Zealand has some limited experience with capitation and budget-holding, the extent of cream-skimming in New Zealand is not known.

Cream-skimming has been found to offer opportunities for large profits in both the United States and the United Kingdom (Newhouse, Manning et al. 1989; van Vliet and van de Ven 1992; Matsaganis and Glennerster 1994; van de Ven, van Vliet et al. 1994)[22]. Risk-selection can therefore be a very profitable undertaking. It is, however, very difficult to prove that it is occurring. There is anecdotal and research evidence that cream-skimming occurs frequently in the United States, but little more than anecdotal evidence of its occurrence in the United Kingdom[23,24].

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20 In this paper, cream-skimming is distinguished from under-servicing, ie. providing fewer services than appropriate. Although under-servicing may be used as a means of cream-skimming, incentives on purchasers and providers to under-service also arise where fee-for-service payments are averaged across a category of care (as in the Diagnostic Related Group payment system). The problem of under-servicing is considered in the section on purchaser incentives.

21 Strictly speaking, compared with the average person within any broad risk pool, e.g., within any particular age-gender pool.

22 In the United States, for example, the Alpha Center notes that insurance statistics consistently show that 35 per cent of people purchasing health insurance will not file a claim in the following five years, while 5 per cent account for more than 50 per cent of health expenditures in the same period (Alpha Center 1997). Similarly, in the United Kingdom Glennerster et al found in their study of one GP fund-holder that the entire fund was expended on 27 per cent of the patients, with the most expensive five patients taking 68 per cent of the expenditure (Glennerster, Matsaganis et al. 1994).

23 The United Kingdom experience in relation to fundholding is in part explained by researchers as a result of: generous budgets; GPs not being at personal financial risk; stop-loss provisions (Le Grand, Mays et al. 1997); the use of historical budgets rather than pure capitation rates to set budgets (Audit Commission 1996); while further explanations could include cultural factors specific to the United Kingdom and not found in the United States.

24 Recent research has found evidence of an increase in the proportion of patients removed from GP fundholders' registers in Northern Ireland at general practitioners' requests. Comparisons were made with removals prior to fundholding and with non-fundholders. This may be a means of cream-skimming; equally it may be related to the additional workload and pressures of fundholding (O'Reilly, Steele et al. 1998).

The key ways in which competing providers and DPOs can cream-skim include:

- specifying benefit packages in particular ways (e.g., including comprehensive maternity care to encourage young couples to enrol; excluding mental health benefits to discourage the enrolment of people likely to suffer from such problems; excluding pre-existing conditions from coverage to discourage those with health problems from enrolling);

- refusing coverage altogether to particular individuals or to people employed in certain industries or occupations; or offering coverage at prohibitively expensive premiums;

- contracting with providers in particular ways (e.g., not contracting with specialists known to specialise in high-risk conditions; recruiting new specialists with limited patient following); or contracting with providers in particular locations but avoiding others who practice in higher-risk localities (e.g., inner-city areas);

- marketing DPOs in particular locations or to particular groups to attract people in good health (e.g., in gyms); and

- offering poor quality care, under-servicing, making patients wait for care or developing more stringent protocols for referring patients to specialists for some types of conditions, in order to drive consumers to another DPO.

(See: Enthoven and Kronick 1989; Ellwood, Enthoven et al. 1992; Congressional Budget Office 1993; Gauthier, Lamphere et al. 1995; Swartz 1995; Luft 1996; Newhouse 1996; Alpha Center 1997 for further detail.)

Risks associated with cream skimming

Successful cream-skimming in New Zealand would lead to the following risks[25]:
Crown risks

- Increased overall expenditure.

This might arise if the approach being used in California to fund care for people shifting from Medicare Cost (traditional fee-for-service insurance) to Medicare Risk (managed care) were used in New Zealand. Medicare Risk premiums are based on the fee-for-service DPO premiums: Risk plans receive 95 per cent of the fee-for-service plans' premiums. Some Risk plans are obtaining extremely favourable mixes of members when compared with the risk profile of the Cost members. As a result, Risk plans could earn large profits on the premiums they are being paid by

25 It is assumed that government financing of health care remains and that every person is covered by at least one DPO. In an unregulated, privately financed model, cream skimming would mean some people would be unable to obtain any insurance coverage at all, or would only be offered coverage at extremely high premiums.

Medicare[26]. This would seem to imply that overall expenditure on Cost and Risk plan members will increase: as favourable risks sign up with Risk plans, the average risk in the Cost plans rises, leading to increases in Cost plan premiums and therefore further increases in Risk plan premiums.

- Pressure for additional expenditure.

This may occur if providers or DPOs successfully cream-skim by offering additional services or higher quality care for some people than would otherwise occur[27]. This might result in pressure to widen coverage and increase quality of care for all New Zealanders.

Consumer risks

- Inequitable access to a broad range of services and quality care.

Cream skimming raises equity concerns, as it reduces the choices of provider or DPO and coverage offered to some people. It may also lead to poor care for some groups where poor quality care or reduced coverage are used as means of cream-skimming.

Access to care and quality of care may also be adversely affected for some people if providers or DPOs with an unfavourable mix of risks are forced to reduce services or quality in order to remain within budget.

Health sector risks

- Diminished incentives for technical efficiency and cost-effectiveness.

Cream skimming does this: a) by allowing DPOs to segment the market, thereby reducing the likelihood of individuals switching providers or DPOs because of cost; b) because cream-skimming is likely to be more profitable than promoting efficiency and cost-effectiveness[28]; and c) because good providers or DPOs may go out of business if they are unable to provide good quality care due to a poor mix of members.

- High level of profits for some providers or DPOs while others struggle.

Providers or DPOs which successfully engage in cream-skimming may earn above-normal profits, while others face considerable losses. This is likely to engender

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26 In practice, Medicare rules prohibit HMOs from earning more profit on their Risk clients than their commercial clients. If the Health Care Financing Authority (HCFA) estimates capitation payments will lead to excess profits, plans must reduce premiums, out-of-pocket expenses, offer additional benefits or return money to the HCFA. Most decide to reduce premiums or offer additional benefits (General Accounting Office, 1995, p. 8).

27 See footnote 26 above for reasons for why this is happening in California.

28 As noted by the Alpha Center, 'health plans offer their products knowing that the health or sickness of the people they sell to will have a greater impact on their annual per capita costs than any changes they can make to improve the efficiency of health care delivery' (Alpha Center 1997, p. 5). See also the points made above (page 18) about the profitable nature of cream-skimming.

discontent amongst some providers and DPOs. In addition, efficient, high quality DPOs may be driven out of the market.

Likelihood and significance of risks

Cream-skimming has the potential to be a serious problem in New Zealand if we move to payment systems which place providers and DPOs at greater financial risk, and maintain or further encourage competition between providers or devolved purchasers. The likely extent of cream-skimming cannot be judged at this point in time. Although the New Zealand system may appear to be characterised by socially-responsible individuals and agencies, the financial incentives inherent in a more commercial and risky environment may change attitudes and behaviour. In the United Kingdom, with the move to fundholding, little evidence of cream-skimming has been found: incentives for cream-skimming may well be muted, however, by the limited financial risks faced by providers. On the other hand, cream-skimming appears common in the United States. One gauge of the significance of the issue, however, is the attention that is being given to regulatory reforms in the United States to reduce its prevalence: this suggests that if cream-skimming were to become widespread, each of the risks discussed above is likely to be significant, both in a financial and political sense.

3.2 Poor purchaser performance

The New Zealand health care sector is characterised by a series of agency relationships. For example, the HFA acts as an agent of the government (the principal) in purchasing health care services and in designing contracts to promote efficiency and to minimise Crown risk. Any devolution of purchasing responsibility similarly involves the development of agency relationships.

A key task of any principal – the Crown, the HFA, owners or consumers – is to ensure that agents strive to meet the objectives of the principal. Poor performance by a purchaser will therefore mean that the principal's objectives are not met.

Key purchaser objectives include:

- to make purchasing decisions which promote technical and allocative efficiency (e.g., maximising health status for the money made available) and equity (e.g., to improve Mâori health status; to promote fair access to care);
- to purchase a mix of services appropriate to the population's needs by assessing population needs and responding to those needs;
- to remain within budget and control costs;
- to contract in ways which promote technical efficiency and cost-effectiveness and which limit risk; and
- to contract in ways which are fair and transparent, and which minimise transaction costs.

Risks associated with poor purchaser performance

Thus, the risks associated with poor purchaser performance – relative to good performance – might include:

Crown risks

- Higher overall expenditure for a given level of care or a lower level of care for a given level of expenditure[29].
- Need to implement and enforce a regulatory function, including oversight of performance.
- Pressure to bail out or take-over purchasers which fail to perform.
- Pressure to provide additional operational funding to government-owned providers which suffer financial losses in the event of a purchaser failure (e.g., bankruptcy)[30].
- Legal action against government-owned purchasers which fail to undertake contracting in fair ways.

Consumer risks

- Higher levels of taxation for a given level of care; or lower access to services and reduced quality of care as a result of poor decision-making or contracting.
- Reduced equity of access if particular purchasers perform poorly relative to other purchasers.
- Increased private financial responsibility for care: this will also reduce equity of access as care is increasingly only available to those able to pay.
- Unresponsive purchasers.
- Health status fails to improve or worsens.

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29 As the services to be purchased in New Zealand are often unclear, the government is able to shift some of this risk onto consumers (e.g., reduced services, longer waits for health care).

30 If for example a privately-owned purchaser were to run up substantial losses, the government may have to step in to finance government-owned providers which run the risk of large losses as a result.

Health sector

- Inefficiencies in the delivery of publicly-financed health care, i.e. lower value for money than can be obtained by improved performance.

- Excessive profits or losses being made by providers where purchasers fail in their contracting role.

- Higher overall expenditure with third-party insurance arrangements which operate in the private insurance sector.

Likelihood and significance of risks

The likelihood of such risks are difficult to judge relative to the status quo. For example, although New Zealand purchasers have failed to deliver on some issues (Ministry of Health 1999) it is much more difficult to establish if purchasers are failing to deliver optimal value-for-money.

Any form of poor purchaser performance which results in the failure of a major purchaser or provider is likely to result in Crown action and potentially expenditure. Business failures in the private sector may impose largely private costs but governments may feel obliged to intervene even where the purchaser or provider is privately-owned. This is because of the importance of health care to the population (and hence the politically sensitive nature of health care), the monopoly positions which purchasers and providers often have in New Zealand, and the fact that most health care expenditure in New Zealand comes from the government.

Judging the individual significance of each these risks is also difficult. Any losses from poor performance in delivering value-for-money are difficult to estimate – from all perspectives. The size of the health care market means that systematically poor performance will have a serious impact. This, however, may be balanced out by having multiple agencies involved in the delivery of health care: failure on the part of a purchaser to perform may not necessarily be reflected at a provider level.

3.3 Cost-shifting

Cost-shifting occurs when costs are charged against a budget which a) differs from that intended or b) differs from that traditionally charged[31]. The objective of cost-shifting is to avoid cost-controlling budgetary restrictions and, sometimes, to find ways to increase overall spending. It appears to be easier to achieve where there are open-ended budgets to shift costs to. Key budget boundaries in the current New Zealand health care system between which costs can be shifted are:

- financing boundaries – public financing, private insurance, user charges, out-of-pocket payments and charitable donations;
- government budget boundaries – health, social welfare, ACC, and other government votes;
- within-HFA boundaries – personal health, disability support, public health, Pharmac;
- contractual boundaries – between individual organisations (hospitals, IPAs) and between contracts within organisations (e.g., within hospitals); and
- budget boundaries within organisations (e.g., clinical budgets in hospitals; separate pharmaceutical budgets within IPAs).

Cost-shifting can be of two main forms. First, it occurs when patient care is inappropriately charged against a particular budget (pure 'cost-shifting') or where the location or type of care is changed in order for care to be charged against a particular budget. (This is sometimes called 'patient-shifting' (Donaldson and Gerard 1993).) Second, it is defined in some international literature as occurring when the costs of a particular episode of care, or the costs of insurance, are lower for some people and higher for others than is strictly accurate (perhaps known in New Zealand more commonly as 'cross-subsidisation').

Examples of the first kind of cost-shifting in New Zealand might include:

- classifying non-accidents as accidents in order for care to be charged to ACC[32];
- hospitals supplying prescriptions rather than medication in order to shift costs from hospital budgets to the pharmaceutical tariff;

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31 This definition implies that explicit policies which shift costs from, for example, government responsibility to private responsibility are just as much cost-shifting as when costs are inappropriately (e.g., against the spirit of particular legislation or contracts) charged against particular budgets. Light calls the former 'declassifying' (Light 1998, p. 13).

32 Reasons for this might be because of lower user charges for primary care or because there is subsidised care available through ACC but not through vote:Health (e.g., physiotherapy and acupuncture are not publicly-financed for non-accident related injuries).

- GPs who face fixed fee-for-service payments or who are on capitated budgets referring patients to secondary care providers for care which could be undertaken by the GP;

- encouraging patients to obtain care privately in order to reduce waiting lists[33];

- shortening lengths of stay in hospitals, which makes any costs of continued care a private responsibility;

- Pharmac policies which reduce the government subsidy on medication such that individual patients must pay an increased charge to continue using that medication;

- patients using hospital accident and emergency services rather than GP services in order to avoid GP user charges;

Examples of the second kind of cost-shifting include:

- charging wealthier patients more for GP visits in order to pay for care for lower income or sicker patients;

- charging higher premiums for health insurance for wealthier consumers in order to reduce costs for lower income or sicker patients; and

- charging higher costs for some patient hospital care in order to cover the costs for patients who cannot pay or to cover losses from other services.

Key risks associated with cost-shifting

The key risks associated with cost-shifting are:
Crown risk

- Increased government expenditure on votes other than vote:Health (e.g., ACC, justice, social welfare); some of which may be offset by reduced spending or extra services in health.

- Increased expenditure for publicly-owned purchaser and provider organisations where costs and patients are shifted to publicly-owned purchasers and providers.

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33 Whether or not this is strictly cost-shifting will depend on whether the individuals and the government believe the care should or should not be financed within the publicly financed health care sector. As the services expected to be delivered to consumers are not clear, it is difficult to identify whether cost-shifting occurs when patients are encouraged to obtain private care. For example, it could be argued that present moves to take individual patients off waiting lists and return them to the care of their GPs are a form of cost-shifting from government-financed health care to private responsibility; on the other hand, it could be viewed as formalising and making more explicit the care which has always been available in the government-financed health care sector.

Consumer risk

- Increased private expenditure and resource use where purchasing authorities make decisions which shift responsibility for financing onto private budgets (e.g., reduced services leading to increasing waiting times leading to more private expenditure; early discharges from hospital leading to more time off work for people caring for those discharged early; higher user charges for patients).

- Increased shunting of patients between providers as providers attempt to shift costs.
- Increased private expenditure as wealthier patients are charged more for care (cross-subsidisation between higher and lower income patients).

Health sector risk

- Higher overall expenditure, as claims in the private sector increase with more care provided privately at possibly higher cost.

- Reduced equity of access as those who cannot obtain publicly-funded care are unable to afford private care.

- Reduced cost-effectiveness. For example, where GPs refer people to a hospital service in order to save costs on their own budget and where the hospital service is more resource-intensive than the GP service.

- Improved cost-effectiveness. For example, if accident and emergency departments in public hospitals shift costs by refusing to see some people who might more cost-effectively be seen by their GPs.

- Difficulties in planning and budgeting in areas where costs are commonly shifted to.

- Inappropriate market signals which might arise as a result of cross-subsidies[34].

Likelihood and significance of risks

As far as the author is aware, there is no New Zealand research evidence on the extent of deliberate cost-shifting or its impact. However, cost-shifting is widely believed to take place in the ways described above. For the Crown, the effects of cost-shifting are sometimes likely to be positive: e.g., where the lack of specification of what the government-financed health care sector pays for makes it easier to shift costs from the Crown to individuals. In other cases, the effects may be negative: e.g., the shifting of costs into the secondary care sector may increase overall costs.

It is also difficult to assess whether the overall effects of cost-shifting on cost-effectiveness are negative or positive. For example, in the case of pharmaceutical policy, efficiency may be being enhanced if patients' needs can still be adequately met with the remaining fully subsidised medicines or if drug companies cut their prices and become more efficient. On the other hand, if costs are mostly shifted to patients, not

34 Although such cross-subsidies may also enhance equity of access.

only is equity affected, but if individuals choose to take out insurance to cover their increased costs, overall efficiency is likely to be negatively affected. This is because New Zealand's private health market operates largely on a third-party reimbursement system, which tends to be more expensive than more tightly controlled systems (Barnum, Kutzin et al. 1995). In other cases, the incentives for individuals in terms of user charges reinforce cost-shifting towards care which is free for the consumer (e.g., hospital care) rather than to more cost-effective care (e.g., GP care).

The second form of cost-shifting is unlikely to survive long in a competitive market: competition is likely to drive costs and premiums for particular types of care and for particular patient groups to a competitive level[35].

35 In recent years, the reduced levels of voluntary community rating in private health insurance in New Zealand is an example of how the market may drive out such cost-shifting (Consumers' Institute 1999). In the United States, policies to reduce costs have also made it harder to cost-shift in the form of cross-subsidisation of poor consumers by wealthier consumers (or the uninsured by the insured) (Managed Health Care Improvement Task Force 1998, p. 190). As a result, equity is likely to have worsened as some people now find it even harder to obtain care.

3.4 Risks and devolved purchasing in New Zealand

Table 3.1 summarises the risks in the devolved purchasing arrangements likely to develop in New Zealand in the next few years. The table is based on the discussion above (sections 3.1-3.3).

Table 3.1
Summary of risks in devolved purchasing arrangements in New Zealand

	Cream-skimming	**Poor purchaser performance**	**Cost-shifting**
Monopoly HFA	• Not an issue at HFA level - as there is no competition, cream-skimming in the form of refusing coverage cannot occur. • Increased use of capitation in competitive provider markets raises possibility of cream-skimming (e.g., general practitioners, DPOs). • Likely proportion of providers engaging in cream-skimming and the population affected is unknown, difficult to measure. • Where cream-skimming does occur on a large scale, the risks appear to be serious.	• Poor performance by purchaser may or may not translate into specific risks. • Where poor performance does translate into specific risks, systematic poor performance has significant consequences for health care in New Zealand.	• Potential cost-shifting between providers on separate contracts. • Probability and value of risk unknown.
Monopoly HFA specialist purchasing of particular services (carve-outs)	• As above. • Where carve-outs are paid on a capitation basis, cream-skimming is an unlikely risk because it is those in most need of care who are likely to have their needs met by the carve-out purchasers.	• As above. • Potential for significant under-servicing risk for some consumers in carve-outs.	• As above. • Definition of Carve-Out /HFA boundary becomes very important. • Cost-shifting from carve-outs back to HFA may be an issue.
Regional monopoly purchasers	• As there is no competition, cream-skimming in the form of refusing coverage cannot occur.	• Significant risks if purchasers perform poorly. • Risks may be reduced compared to Monopoly HFA as there are more purchasers. • Risks may be greater compared to Monopoly HFA if purchasing skills are more thinly spread. • Comparisons between purchasers are possible – raises performance measurement issues.	• Integration may reduce cost-shifting within budgets/organisations compared to status quo.

Table 3.1 (cont.)
Summary of risks in devolved purchasing arrangements in New Zealand

	Cream-skimming	Poor purchaser performance	Cost-shifting
Choice of partially integrated DPO, with HFA purchasing of other services	• Potential, significant risks at DPO level.	• Significant risks if purchasers perform poorly. • Risks may be reduced compared to Monopoly HFA as there are more purchasers. • Risks may be greater compared to Monopoly HFA if purchasing skills more thinly spread. • Comparisons between purchasers are possible – raises performance measurement issues.	• Definition of DPO/HFA boundary becomes very important. • Cost-shifting from DPOs back to HFA may be an issue.
Choice of DPO - agency model	• Potential, significant risks.	• Significant risks if purchasers perform poorly. • Risks may be reduced compared to Monopoly HFA as there are more purchasers. • Risks may be greater compared to Monopoly HFA if purchasing skills are more thinly spread. • Comparisons between purchasers are possible – raises performance measurement issues.	• Integration may reduce cost-shifting within budgets/organisations.
Choice of DPO - individual approach	• Potential, significant risks.	• Significant risks if purchasers perform poorly. • Risks may be reduced compared to Monopoly HFA as there are more purchasers. • Risks may be greater compared to Monopoly HFA if purchasing skills are more thinly spread. • Comparisons between purchasers are possible – raises performance measurement issues.	• Integration may reduce cost-shifting within budgets/organisations.

4 MANAGEMENT OF RISKS IN DEVOLVED PURCHASE ARRANGEMENTS

4.1 Managing the risks associated with cream-skimming[36]

Key approaches to reducing opportunities for cream-skimming include:

A. Encouraging large risk pools.
B. Compensating for risk.
C. Limiting risk.
D. Defining service entitlements (i.e. standard packages of benefits).
E. Regulating the insurance or provider market (including enrolment regulations).

This report discusses each of these approaches, but focuses in particular on approaches D and E.

A Encouraging large risk pools

A first approach to minimising the risks of cream-skimming is to encourage large risk pools. This allows risk to be spread across a greater number of people, and hence to reduce the effects that a few high cost patients have on overall financial risk. This should assist in making providers and DPOs indifferent to the utilisation and costs which might be associated with particular patients.

Encouraging large risk pools is particularly important where purchasers are responsible for comprehensive coverage. In New Zealand, any policy approach which aimed to encourage large risk pools may also limit competition and local responsiveness. (For further discussion on this, see the sections below (4.2D) on purchaser competition in New Zealand, which also includes estimates of the likely required size of risk pools for comprehensive and more limited service coverage.)

However, United States experience suggests that even large risk pools are insufficient tools for preventing cream-skimming: there remains a significant financial gain to be made from successful cream-skimming where DPOs are competing for consumers.

36 A key option for managing cream-skimming is to limit competition between purchasers. The discussion in this section relates to markets where there is competition between purchasers.

B Compensating for risk

The main approaches to compensating for a higher or lower than average risk are:

- risk-rating capitated premiums. A number of tools have been developed to undertake such risk rating. These include socio-demographic models (e.g., the Adjusted Average Per Capita Cost model used in Medicare in the United States, which adjusts for age, sex, welfare status, institutional status; the population-based funding formula used in New Zealand); prior-use models; self-reported health status models; and disease/diagnosis models (e.g., Ambulatory Care Groups; Diagnostic Cost Groups; Chronic Disease Scores) (Alpha Center 1997; Bowen and Sigoloff 1998). Disease/diagnosis models are argued to provide more accurate estimates of likely cost. Risk assessment and adjustment may take place retrospectively, prospectively or concurrently, at pre-determined intervals.

- using a fee-for-service payment mechanism which includes levels of payments adjusted for complexity (as in the DRG approach used in secondary care)[37] or moving to blended payment systems which combine elements of capitation and fee-for-service (Newhouse, Beeuwkes Buntin et al. 1997)[38].

These approaches are not discussed in this paper in any depth; those who are interested are referred to the references supplied here and material from the Treasury workshop held on October 14-15 1998 (Bowen and Sigoloff 1998).

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37 A disadvantage of this approach is that it compensates plans directly for what they do, with payment levels based on average existing costs, i.e. Incorporating with new payment levels any existing inefficiencies. Ambulatory Care Group and Diagnostic Cost Group approaches also incorporate current service use information within them, for use in adjusting for higher levels of 'risk' (i.e. poorer health status).

38 The more technical literature on incentives in procurement suggests that a mix of payment systems is an efficient means of promoting quality in service delivery (Laffont and Tirole 1993). Hence, such an approach would not only reduce incentives for cream-skimming, but also under-servicing (Newhouse, Beeuwkes Buntin et al. 1997).

C Limiting risk

The following approaches can be used to limit risk, and hence to reduce the incentives to cream-skim:

- Establishing separate risk pools (including carve-outs). For example, individuals with particular conditions (e.g., disabilities) or requiring particular care (e.g., kidney dialysis, organ transplants) may be covered by a separate financing arrangement. DPOs or providers may get paid on a fee-for-service basis to provide such care, or such care may be paid for by an alternative agency (e.g., the HFA or the Ministry of Health in New Zealand). van Barneveld, van Vliet and van de Ven have proposed a similar approach for the Netherlands, where plans would predetermine a small fraction of members whose costs would be pooled and reimbursed separately (van Barneveld, van Vliet et al. 1996). These approaches have the advantage of limiting the financial risk that plans or providers may take on if they register particular individuals. Hence, incentives to cream-skim may be reduced. Without clear boundaries, however, cost-shifting becomes a risk, while alternative systems must also be established to fund and administer separate schemes.

- Limiting financial risk[39]. In this case, a financial limit may be placed on the risk an individual provider or DPO is responsible for in regards to particular patients. For example, the United Kingdom general practice fundholding scheme limited risk to £5,000 initially: the District Health Authority became responsible for care costing beyond this amount. This approach may, however, fail to reduce incentives to cream-skim for patients likely to cost a lot, but less than the financial limit. Cost-shifting may be an issue if the limit is set such that it provides few incentives for considering the costs and cost-effectiveness of care.

- Establishing separate clinics. This final approach allows those unable to obtain good care to choose a separate clinic to provide care. For example, in the United States those without insurance coverage can obtain emergency care from state-financed and state-owned hospitals: however the care tends to be too little, too late. It is possible to imagine that specialist clinics might be established for those with particular conditions to ensure quality care is provided (e.g., for mental health or alcohol and addiction services). The care may be paid for separately (as above) or costs sought from an individual DPO or provider. Separate payments will reduce the incentives to cream-skim. However, cost-shifting could become a significant problem; a separate system is needed to administer the arrangements; those accessing care in this way may feel stigmatised by the need to access such care; and access to care may be viewed as inequitable if quality of care differs from care available to others.

D Defining service entitlements

Service specification – in the form of a standard package (or standard package*s*) of benefits – is an important tool for reducing opportunities for cream-skimming. Service specification prevents plans or providers from specifying or offering services in ways which encourage particular groups to enrol or disenrol, or which discourage particular

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39 Sometimes known as an outlier or reinsurance scheme.

groups from enrolling. Hence, wherever there is competition between plans or providers where benefit design can influence risk selection, service specification is an important tool for reducing at least one avenue for cream-skimming[40].

Service specification at a broad level is common in many health care systems[41], and a standard package of benefits is largely viewed as an essential element of proposals which promote competition between purchasers (see for example Enthoven and Kronick 1989; Pauly, Danzon et al. 1992; The White House Domestic Policy Council 1993; Enthoven 1994; White 1995).

Service specification is not common in countries like New Zealand and the United Kingdom[42]. The reasons for this may be that coverage is intended to be fairly comprehensive; that expenditure determines service availability rather than service specification determining expenditure; and that government ownership of key providers (e.g. hospitals) promotes accountability in place of service specification. Although New Zealand has developed a set of service obligations in the past few years (Health Funding Authority 1998; Shipley undated), these obligations do not guarantee an entitlement to care: purchasers have limited budgets and must make choices between services set out in service obligations (Cumming 1994).

Approaches to specifying services

Services can be defined in a number of ways. The main approaches and their advantages and disadvantages are set out in Table 4.1[43].

No specification

A first approach is to have no specification at all. For example, New Zealanders may have a broad understanding of the services not covered by the publicly financed health care system (e.g. most adult dental care, optometrist services, most cosmetic services), but little clarity about the services which are actually provided, the circumstances under which specific services are or are not available (e.g. kidney

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40 Other reasons for service specification are set out in Appendix E.

41 European countries often specify broadly the services to be made available under social insurance schemes (see Appendix F for the Netherlands example). Canadian provinces each specify service coverage (Health Canada 1997). In some countries, service specification takes the form of fee schedules. For example, Australia's Medicare system has a Benefits Schedule, as does Germany's main social insurance system. Many countries also have specified pharmaceuticals lists which act as a form of service specification. See also Glaser (1991); Lenaghan (1997) for examples of service specification.

42 New Zealand has some aspects of service specification, e.g. the pharmaceutical tariff; fee-for-service payment schedules in primary care.

43 The material here focuses on the specification of *services.* It is also possible to specify access requirements (e.g., travel times, user charge maximums, waiting times) and standards for quality of care (including for example access to medically qualified doctors rather than simply nursing staff and access to specialist care rather than generalist care alone). Such further specification would improve accountability and comparability of plans, but would increase the costs of specification and remove some aspects of access and quality of care as aspects of care on which plans could compete. Politically, however, governments may find it extremely difficult not to include such aspects of care in specified coverage.

dialysis, heart transplants), and the time they might wait for care. Most decisions about who gets what care when are, with this approach, taken by medical professionals.

This approach does not require the administrative costs which might be incurred through service specification. It also allows plans or providers to decide on relative priorities at service and patient levels and allows flexibility in the choice of care provided (e.g., choices between medications; choices between hospital care or care at home).

Table 4.1
Approaches to defining services[44]

Possible approaches	Advantages	Disadvantages
No specification.	• Low administrative costs. • Providers or DPOs determine priorities and services. • Consumer flexibility in choice of care.	• Difficult to determine capitation amounts which are related to coverage expectations. • Lack of accountability in terms of what is covered and whether individual consumers will receive care. • Likely differences in access to and the type of care available in different regions, localities, DPOs and providers. • Consumers find it difficult to compare DPOs. • Offers the ability for providers and DPOs to under-service those consumers whom they wish to discourage from joining or encourage to leave.
Publicly specified in terms of providers.	• Low administrative costs. • Providers or DPOs determine priorities and services. • Consumer flexibility in choice of care – though limited to particular providers.	• Limits service delivery to particular providers: this may reduce cost-effectiveness. • Difficult to determine capitation amounts which are related to coverage expectations. • Lack of accountability in terms of what is covered and whether individual consumers will receive care. • Differences in access to and the type of care available in different regions, localities, DPOs and providers. • Consumers find it difficult to compare DPOs. • Offers the ability for providers and DPOs to under-service those consumers whom they wish to discourage from joining or encourage to leave.
Publicly specified quite generally.[45]	• Establishes broad range of services covered. • Allows for better estimation of capitation amounts (taking into consideration coverage). • Offers opportunities to consider breadth of service coverage (e.g., what is in and what is out).	• Lack of accountability for providing care to individual patients in particular circumstances and in relation to modalities of treatment. • Consumers may still find it difficult to compare DPOs if they perceive there to be differences in care actually offered. • Offers the ability for DPOs to under-service those consumers whom plans wish to discourage from joining or

44 There is the potential for one or more plans to be devised. Care would need to be taken that different plan structures do not encourage differences in health status. The more plans, the greater the administrative costs – both in designing plans and in ensuring consumers receive only the care they are entitled to under the plan they have chosen. In addition, in each case, providers or plans may or may not be allowed to offer services in addition to those specified and to offer better quality of care than that set out in regulation. This would provide incentives to improve coverage, but may be to the detriment of equity goals and may be used to cream-skim.

45 Represents the present situation in New Zealand.

		encourage to leave. • Politicisation of decision-making process and political risks in specifying coverage. • Some administration costs in defining services, monitoring compliance by plans, and establishing review procedures. • Limits choice by individuals to decide on coverage which best suits their needs.

Table 4.1 (cont.)
Approaches to defining services

Possible approaches	Advantages	Disadvantages
Publicly specified in detail (e.g., with practice guidelines).	• Promotes clarity of entitlement for consumers. • Promotes accountability at a detailed level. • Allows for detailed estimation of capitation amounts. • Facilitates detailed comparisons between competing plans. • Offers opportunities to consider effectiveness and efficiency in designing the core – i.e. allows a much greater focus on the health benefits associated with particular services, reducing excessive use of technologies, and taking into account wider societal costs. • Analysis of effectiveness and efficiency undertaken only once – at a national level. • Promotes equity of access for equal need.	• Administratively complex. • Politicisation of decision-making process and political risks in specifying coverage. • Reduces choice and flexibility at patient level. • May not be fully feasible given information gaps. • Limits choice by individuals to decide on coverage which best suits their needs. • May view such detailed specification as an entitlement.
Privately specified.	• Allows consumers to choose packages which best meet their needs (health care and affordability).	• Allows specification in ways which may promote cream skimming – likely to be more profitable than improving efficiency. • High administrative costs as each DPO specifies own package. • Consumers may find it difficult to compare DPOs – may reduce incentives for efficiency if -in the absence of good comparative information – consumers use price or coverage as a guide for choosing between plans. • Competition between DPOs may lead to excessive use of new, unproven technologies if consumers choose plans based on availability of new technologies.
Principles specified (e.g., medically necessary services).	• Flexibility for individual providers and consumers/patients.	• Leaves final determination up to a regulatory or legislative body • May involve costly litigation.

However, in a budget-constrained system which cannot always be comprehensive and with long waiting times, a lack of specification makes it difficult to determine budgets and capitation amounts for plans or providers. This is because it is unclear exactly which services should be made available and when they ought to be provided. The lack of clarity can lead to arguments about whether the funding is adequate or whether the DPO or provider is failing to deliver adequate care. Hence, this approach can also make it difficult to hold plans or providers to account.

Having no specification of services leaves decisions about service priorities and the care which individuals are offered in the hands of professionals or managers. This may provide flexibility, but it may also mean that community values about priorities are not adequately considered.

In a competitive system with multiple plans or providers paid on a capitation basis, a lack of specification makes it very difficult for consumers to compare plans and it allows plans and providers to offer services in ways which promote cream-skimming[46].

Publicly specified in terms of providers

In many health care systems, it is common to define services publicly, usually in law or regulation. In addition, it is also common to define the types of providers from whom care is available rather than the specific services which are available. For example, specification may be in terms of 'physician services' or 'hospital services' (see for example, Glaser 1991; Health Canada 1997; Lenaghan 1997).

This approach has the advantage of low administrative costs for governments: costs are limited to specifying – in law – groups of providers from whom covered care can be obtained, and to covering any administrative and legal costs which arise in monitoring, auditing or challenging providers and plans who appear to be not complying. Individual patients may also incur costs in seeking compliance.

In addition to the disadvantages under the no specification approach (see the section on 'no specification', above), this method of specification limits service delivery to particular providers. This may reduce cost-effectiveness if alternative providers who can provide care equally or more effectively but at lower cost are excluded from coverage[47].

Publicly specified in general terms

A third approach has public specification (in the form of legislation or regulations), but with services specified in general terms. For example, coverage may include 'maternity services', 'dental services', 'diagnostic services', 'medical and surgical services including referral services' and 'preventive services'. This approach is close

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46 In practice, in an unregulated private market, competitive plans define their own packages of benefits.

47 For example, if nurses can provide more cost-effective care than doctors for some conditions; if dental therapists can provide check-ups and clean teeth more cost-effectively than dentists.

to that used in New Zealand in the Service Coverage document (Minister of Health 1998).

This approach: establishes the broad range of services covered; allows for better estimation of capitation amounts; and offers governments the opportunity to consider the breadth of service coverage[48]. If there is compulsory coverage, this approach also ensures that everyone is covered for a broad set of services: there can be no free-riders.

One disadvantage with this approach (as with the above two approaches) is that it leaves decisions about the modalities of care (e.g., specialist vs generalist care) in the hands of plans and providers: this may generate public concern at inadequate care which might be offered by some plans or providers. It also leaves decisions about the actual services made available to specific patients in the hands of plans and providers (e.g., is post-natal home care available within the maternity service?; are heart transplants available?; which patients can obtain kidney dialysis services?). Not only might this lead to under-servicing in any health care system, but in a competitive, capitation model: consumers may still find it difficult to compare plans; and it provides a means of cream-skimming (through selection of specific services to encourage or discourage particular groups from joining and through the ability to under-service).

In addition, the approach requires some administration in defining broadly the services to be covered. This approach is likely to result in politicisation of decision-making[49]. Consumers' choices of the package which best suits their financial and health needs will be limited by this approach.

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48 For example, the Netherlands government has tried in recent years to remove physiotherapy services and in vitro fertilisation services from coverage of the Health Insurance Act (Mulder 1995). Dental care was also proposed to be removed but the government had to reinstate it (personal communication, Nicholas Mays).

49 In the Netherlands example given above, the government has found it very difficult to remove some services due to strong provider and public resistance (Mulder 1995).

Publicly specified in detail

With this method, public specification in legislation or regulations continues, but the services are specified in some detail. This might include: the modalities of care which are available (e.g. medical and surgical services delivered in a hospital by specialists); the specific services which are available (e.g., pre-natal care, labour care and post-natal care within a maternity service; immunisation and cervical cancer screening within a preventive care service); the number of visits or length of care (e.g., six pre-natal sessions; post-natal care for two weeks after the birth of a baby); condition/treatment pairs (e.g., Xenical for defined levels of obesity but not for those who are just 'over weight'); clinical guidelines (e.g., a series of steps to try before a patient is offered expensive hypertension medication) or priority criteria (e.g., for elective surgery. See for example (Hadorn and Holmes 1997; Hadorn and Holmes 1997)).

Such detailed specification promotes good clarity of entitlement for consumers and accountability of plans and providers. With detailed utilisation information, it will allow for improved estimation of capitation payment amounts. Within a competitive environment, this approach facilitates consumer comparison of plans because the detailed service specification will reassure consumers that all plans must offer the same care (i.e., a cheaper DPO is not one which is offering narrower coverage). As the service specification process is undertaken publicly only once, administration costs are reduced compared with a private approach (see below). In addition, the process of specifying services offers opportunities to consider at a detailed level the effectiveness of services and the mix of services which promotes allocative efficiency[50]. Equity is promoted to some extent because every individual is entitled to the same set of services[51].

This approach is administratively complex. It requires a process for considering services and for specifying them at a detailed level; for updating the list; and requires monitoring, audit and complaints mechanisms if the specification is to have any force. This means the approach may be very costly, particularly if practice guidelines are developed as part of the service specification[52]. Designing a specific set of services will involve politicisation of a decision-making process; and it may reduce individual

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50 For example, a practice guidelines approach allows consideration of the circumstances under which particular services are offered to individual patients; and the overall process enables society to consider the trade-offs between particular services such as having a new preventive service or more heart transplants.

51 Promoting equity of access would also require specifying the details for accessing care, e.g. travel time to specific services, waiting times.

52 Consider for example that the National Health Committee has developed a number of practice guidelines in New Zealand, each of which involved a number of clinicians and others. Off-the-shelf guidelines from overseas might cut the costs in New Zealand; however, such guidelines might not be used if clinicians do not have ownership of them. New Zealand has the advantage of being relatively small so that almost all clinicians might be involved in designing guidelines in their specialty areas; on the other hand, the costs of guidelines cannot be spread over a large population.

and consumer choice of particular services[53]. The approach may not always be feasible: a lack of evidence on effectiveness, cost-effectiveness and public values, for example, is likely to obstruct attempts to define all services in detail and to be sure that those services covered are those which promote allocative efficiency (from a societal perspective). If only one standard package of benefits is allowed, patients will also be unable to purchase the packages of care which best suit their financial and health needs. Finally, the greater the detail in the service specification, the more patients may view the services as entitlements. From a government perspective, this may lead to difficulties in restraining utilisation and costs or to tension between the capitation amounts and the services which are part of the package (for example, in the form of budget blowouts). From a consumer/patient perspective, the more knowledge they have about their eligibility to care, the more certainty they have over access to care and the more they can hold organisations to account for the provision of that care.

Privately specified

With private specification, individual plans or providers establish a set of services for which their customers/patients are covered. The services can be specified in terms of provider groups; at a general level, or at a detailed level.

A key advantage of this approach is that it enables consumers to choose packages which best meet their needs. However, in a competitive model it allows for specification in ways which promote cream-skimming; and consumers will find it very difficult to compare plans. Incentives for efficiency will therefore be severely compromised.

This approach will also involve large administrative costs if each provider or DPO designs their own package, and it may lead to excessive use of new, unproven technologies if consumers choose packages on the basis of availability of new technologies rather than effectiveness or cost-effectiveness[54]. A private approach will also make it harder to promote any equity goals as individuals may be covered by completely different packages. Individuals may also choose limited packages, hoping to free-ride by obtaining charity or other care they are not covered for in the event they need it.

Principles specified

A final option is to specify a set of principles which should apply in considering the services which are available. For example, legislation may argue that plans and providers must offer ‘medically necessary’ services. This begs the question as to what is medically necessary: the evidence on variations in practice suggests that this is not always an objective approach. Often, plans in other countries do not have to cover ‘experimental’ services: these too are usually not defined in any meaningful way[55].

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53 For example, a patient who does not qualify for care may desperately want care, and may benefit significantly from such care.

54 Constrained financing may reduce the extent to which this might happen.

55 As Belk (1991) notes: ‘health insurance contracts often exclude coverage for experimental treatments. No accepted definition of experimental treatment exists, however, and insurance

The advantage of this approach is that it allows flexibility for individual plans, providers and consumers/patients. However, the approach fails to provide accountability and it may leave the final determination of what should be provided up to a regulatory or legislative body. This incurs administrative and legal costs as well as a great deal of uncertainty for patients (particularly for life-threatening conditions); financial barriers to legal advice may limit access for some people; and it may lead to the increased use of particular services in the health care system.

E Regulating the insurance or provider market

Other regulations which are discussed in relation to cream-skimming are summarised in Table 4.2, along with their advantages and disadvantages.

Many proposals for health reform along competitive lines state that at the very least plans should be required to:

- cover all pre-existing conditions or at least limit the time period during which pre-existing conditions are excluded from coverage (e.g., to say three years). This promotes universal coverage of all consumers, ensures that choice is retained for all those with pre-existing conditions, and aims to prevent exclusion of pre-existing conditions as a means of cream-skimming. However, if health insurance coverage is not compulsory, if plans offer different coverage options, or if consumers can opt in and out of plans often, the regulation to force coverage of all pre-existing conditions may allow greater adverse selection on the part of patients. This may include 'hit and run' opportunities i.e. where a patient signs up with a particular DPO in order to obtain a particular service and then opts out of that DPO for (probably) a cheaper DPO. This disadvantage can be eliminated by standardising packages of coverage and by limiting opportunities to opt in and out of plans (e.g., every one or two years as planned in New Zealand (Upton 1991); once every year plus during an annual open season as is planned in Medicare from 2001 (General Accounting Office 1998, p. 4).);

- take on all those who apply for care to be covered by any particular DPO (known as open enrolment). This regulation aims to ensure that plans or providers cannot refuse any individual coverage, thus reducing opportunities for cream-skimming;

- guarantee that all individuals may remain with a DPO even if their utilisation or costs rise or their health status deteriorates (known as guaranteed renewal). This regulation aims to ensure that plans or providers cannot force individuals to leave a DPO[56];

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contracts rarely define the term. Although experimental treatment exclusions are necessary and desirable, insurers may easily manipulate undefined exclusions to exclude treatments on inappropriate bases such as cost'. At the very least, Belk argues that insurers should be forced to 'enunciate in insurance contracts the processes and criteria used to assess and characterize experimental treatments' (Belk 1991, p. 809).

56 Often, however, this regulation will be meaningless if plans or providers can raise premiums to encourage an individual to go elsewhere.

- community rate premiums or limit premium variations within groups (e.g., age-gender groups). This regulation aims to reduce the imposition of high premiums for some risks (which may leave some people without affordable coverage or with limited choices); and presumably to ensure that guaranteed renewal regulations are not undermined by the ability to set high premiums. The approach also allows redistribution from low risk to high risk individuals. On the other hand, such regulations provide an incentive to cream-skim because the DPO or provider cannot charge a risk-rated premium[57];

- monitor and publicise rates of disenrolment, consumer complaints, and consumer satisfaction[58]. Such regulations aim to indicate practices which may signal cream-skimming (e.g. if it is largely those with particular conditions or likely higher risk who are disenrolling) and provide information in order to assist consumers in making choices between providers or plans. Such information allows consumers to make choices which will promote quality of care and efficiency by allowing consumers the opportunity not to choose plans which are not viewed as offering a good service; and

- monitor and publicise quality of care. This allows consumers access to information about the actual care which is delivered, something which is not always readily available reliably via word-of-mouth. Once again, it promotes quality of care and efficiency by allowing consumers the opportunity not to choose plans which are not viewed as offering a good service.

With the last two types of regulation, systems are required which standardise definitions and reporting frameworks in order for meaningful comparisons to be made between plans and providers. Sufficient numbers are needed for statistical robustness: this may be a problem in New Zealand with such a small population and a relatively small number of services delivered in each service category. This issue is made worse by the likely desire of consumers to consider performance of plans or providers in their localities or in relation to specific medical conditions. An audit and dissemination agency is also likely to be required to oversee the development of measures and to interpret them. Thus, significant administration costs are likely to be required to accompany such regulations. A key issue for further consideration, however, is the ease with which such measures are meaningful and whether they can be interpreted sensibly[59]. (See the section below on purchaser performance for further discussion on issues relating to measures of quality of care.)

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57 This issue is not relevant if the government is financing the premiums fully.

58 See Williams, Coyle et al. (1998) for a discussion on how service users evaluate services. The authors conclude that expressions of 'satisfaction' on one particular satisfaction survey hid a variety of reported negative experiences.

59 For example, in a 1998 report the United States GAO notes that 'the data indicate that competing plans vary widely in their ability to retain members but do not reveal why. Disenrollment rates that are high relative to rates at competing plans could, for example, be caused by plans' poor marketing practices, less-generous benefits, higher beneficiary out-of-pocket costs, or inferior services' (General Accounting Office 1998, p. 2). They noted for example that disenrollment may have tended to be higher in areas where competition is strong or where beneficiaries are unused to managed care. The report noted that HCFA 'is interested in making disenrollment information

Table 4.2
Regulations to reduce cream-skimming

Regulation	Advantages	Disadvantages[60]
Limits on pre-existing conditions	• Promotes coverage for individuals for all illnesses.	• If coverage is not compulsory, encourages adverse selection (including 'hit and run' opportunities).
Open enrolment	• Aims to ensure that all those.applying are accepted. • Stabilises the market by having enrolment periods when people can switch plans (every one or two years).	• Reduces the ability for plans to refuse coverage in cases of adverse selection and 'hit and run'.opportunism, thereby increasing the cost of coverage for plans. • Reduces choice to the enrolment period.
Guaranteed renewal	• Aims to ensure all those who wish to stay with a DPO are offered continued coverage and to prevent plans taking coverage away from people.	• Reduces the ability for plans to select out consumers who are high cost, thereby increasing the cost of coverage for plans.
Community rating or limiting premium variations within groups	• Reduces imposition of high premiums for some risks, which would leave some people without affordable coverage or increase government subsidies required to ensure coverage.	• Provides incentives for cream-skimming (compared to a model where premiums are based on individual risk).
Monitoring and publicising quality of care	• Provides information on quality of care.	• Requires standardised format for comparative reporting, sufficient numbers for statistical robustness. • May require audit or collection/dissemination agency.
Monitoring and publicising rates of disenrolment	• Provides information on disenrolments.	• Requires standardised format for comparative reporting, sufficient numbers for statistical robustness. • May require audit or collection/dissemination agency.
Monitoring and publicising consumer complaints and satisfaction	• Provides information on consumer complaints and satisfaction.	• Requires standardised format for comparative reporting, sufficient numbers for statistical robustness. • May require audit or collection/dissemination agency.
Each of the above	• Reduces abilities to cream-skim • Promotes choice for all consumers.	• Requires regulatory structure – including audit function, complaints mechanisms, sanctions (publicity, fines, removal of license to offer care).

Conclusions

One group of approaches to reducing incentives to cream-skim is to encourage large risk pools; compensate for risk; or limit risk. The first of these requires further consideration, given New Zealand's small market and the likely trade-offs between large risk pools, competition and local responsiveness. The second, in particular, is unlikely to be sufficient to reduce incentives for cream-skimming.

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more meaningful by developing a disenrollment survey to determine why beneficiaries leave HMOs' (General Accounting Office 1998, p. 9).

60 The costs associated with each of these recommendations are not assessed here. Some of these regulations will lead to costs for plans higher than would otherwise occur. For example, it is reported that significant premium increases have followed regulations for guaranteed renewal (along with a three-month pre-existing condition exclusion clause and following removal of a high risk pool) in Washington; and also in Massachusetts (Managed Health Care Improvement Task Force 1998, p. 56). These represent the costs associated with ensuring universal coverage.

Service specification – in the form of a standard package (or standard package*s*) of benefits – is an important tool for reducing opportunities for cream-skimming. Service specification prevents plans or providers from specifying or offering services in ways which encourage particular groups to enrol or disenrol, or which discourage particular groups from enrolling. Hence, wherever there is competition between plans or providers where benefit design can influence risk selection, service specification is an important tool for reducing at least one avenue for cream-skimming. Even where risks have been reduced by large risk pools, compensating for risk or limiting risk, service specification is a powerful tool for promoting accountability.

Services can be defined in a number of ways. The key trade-offs between the approaches are between tighter and looser definitions. Tighter definitions will restrict the extent to which providers and DPOs can use service specification (and delivery) to cream-skim, and promote tight accountability, ensure equity of access to a similar set of services, and facilitate consideration of effectiveness and allocative efficiency. However, with tighter the definitions, there is more administrative complexity and higher administrative costs, and the less individuals and providers have choice in terms of the services actually able to be delivered. The fewer the number of packages, the less administrative complexity: this applies in relation to both public specifications (e.g. by the government) and private specifications (i.e. the more individual providers or DPOs are involved in specifying their own sets of services, the greater the costs involved). Fewer packages also reduces consumer flexibility to choose the coverage which best suits their needs.

In addition to service specification, many proposals for health reform along competitive lines have regulations to promote consumer choice. Without them, plans and providers can engage in cream-skimming and will leave significant numbers of vulnerable people without choice. However, systems are required which standardise definitions and reporting frameworks in order for meaningful comparisons to be made between plans and providers.

All the above regulatory approaches will reduce incentives to cream-skim and will promote choice for all consumers. The extent to which this occurs will of course depend on the actual regulations and the ways in which they are administered. Costs will be incurred by the government in order to establish regulations, audit compliance, provide complaints mechanisms, prosecute miscreants and impose sanctions. In practice a combination of policies is likely to be desirable: a level playing field between plans and providers will be created by such regulations and consumers will feel more confident about the system, while providers would be encouraged to promote efficient care rather than to cream-skim.

4.2 Managing the risks of poor purchaser performance

The key approaches to managing these risks are:

A. Monitoring and benchmarking purchaser performance (using health outcomes, health care outcomes, health outputs or health inputs[61]).
B. Using sanctions and rewards to provide incentives to purchasers to improve their performance.
C. Promoting competition for the market at periodic intervals (franchising).
D. Promoting competition between purchasers and allowing consumer choice of purchaser.
E. Investing in purchaser expertise and knowledge (developing 'smart' purchasing).

A Monitoring and benchmarking purchaser performance

The most common approach to managing the risks of poor purchaser performance is to establish a set of accountability arrangements. New Zealand has experience of this approach: the performance of specific tasks is monitored to ensure the 'work' of purchasers is undertaken (e.g., spending additional resources for mental health; developing a prioritisation framework); the level of inputs or outputs expected to be made available is monitored, and so on. Where possible, comparisons have been made between different purchasers: this offers a benchmark against which to assess an individual purchaser's performance. In all cases, monitoring requires clear goals and objectives to be set, and because there are any number of goals or objectives which might be chosen, those goals should reflect the priorities of the sector.

Health outcomes

There are significant problems which arise in attempting to monitor purchaser performance by using health outcome measures, as purchasers may not always be able to influence factors which contribute to these outcomes. Broad health outcomes – such as mortality and health-related quality of life – will be affected by economic and social developments outside the health sector and this makes it difficult to demonstrate the separate contributions which health care interventions – and therefore the role of purchasers and providers – have on health status (Cumming and Scott 1998).

Health care outcomes

The opportunities for holding purchasers accountable for health *care* outcomes appear more promising (examples of health care outcomes include improvement in mobility following a hip replacement operation, improvement in eyesight following a cataract

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61 A health outcome is defined as an improvement in health status or maintenance of health status which would otherwise deteriorate. Measures of health outcome usually include mortality, morbidity and quality of life (including self-evaluation of health status by individuals). A distinction is made between health (an outcome) and health care outputs and processes. A process is a particular type of service, for example a physiotherapist treatment, while an output is an episode of treatment, for example the number of people admitted with rheumatoid arthritis in a year (Hall, Sheill et al. 1993).

operation). A significant amount of work is underway to develop health care outcome indicators to monitor the performance of providers (Bowling 1991; Benson 1992; Wilkin, Hallam et al. 1992; Jenkinson 1994; Boyce, McNeil et al. 1997) and these same indicators could be used to monitor the performance of purchasers[62].

However, there are also problems in using such measures to monitor either provider or purchaser performance. First, it is difficult to determine the contribution that care makes relative to no intervention at all. Second, an accurate assessment of health care outcomes relies on adequate adjustment for differences in health status. Some adjustments – age and gender – are relatively straightforward. Usually proxy measures are used to adjust for different levels of need, e.g. socio-economic status indicators, although the development and use of such tools are in their infancy. Stronger adjustments using case complexity, severity and co-morbidities are, however, increasingly argued for: these require reasonably detailed patient-based information systems. Without such adjustments, the relative importance of case mix and health care is difficult to judge. Unfortunately, administrative data sets often do not contain sufficient information for adequate health status adjustment[63]. Third, as health care outcome measures are usually disease-specific – and as New Zealand has a very wide range of services covered by the health vote (including disability support services) – it can be very difficult to build up an overall picture of a provider's or DPO's performance.

There can also be prolonged delays in the data being released and problems with a small number of cases – with resultant statistical limitations, especially once particular diagnoses are considered individually (Iezzoni and Greenberg 1994). In the United States there is also considerable concern about the costs associated with initiatives to adjust for differences in health status (Iezzoni and Greenberg 1994).

Health care outputs, processes and inputs

Given the problems noted above, monitoring the performance of purchasers might be more appropriate at the output and process level. As with health care outcomes, adjustments are still needed, however, at the registered population level to compare the level of outputs delivered to those registered with different providers or DPOs. Such adjustments are made to identify different likely levels of need which might explain differences in, for example, utilisation of particular services.

The monitoring of levels of outputs is easier the more comprehensive is the care within an organisation's sphere of responsibility. With fragmented providers, for example, comparing levels of outputs (and health care outcomes) requires an understanding of the context in which care takes place: a hospital which admits patients who are dying will have different rates of output (and different rates of

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62 Using such indicators at the purchaser level gets around some of the problems of using indicators for monitoring the performance of non-integrated providers, where the performance of one provider may be affected by the circumstances in which the care takes place (Brown, McCartney et al. 1995).

63 This raises the question of who collects the data. For example, clinicians would have to hand out questionnaires to consumers, ensure they are filled in accurately and are returned; the data then needs to be analysed and interpreted carefully.

mortality) than one where patients are cared for at home or in a hospice. With a comprehensive purchasing agent, however, such problems are minimised.

Another alternative is to monitor inputs, although this, at least in terms of capital and labour inputs, has been out of fashion for some time (Trebilcock 1995). In New Zealand, inputs are still used to monitor performance in relation to community mental health services (Performance Management Unit 1998), while the Health and Disability Commissioner used input measures as part of her inquiry into care at Canterbury Health's Emergency Department (Health and Disability Commissioner 1998).

Recent work on practice guidelines – many of which specify patient characteristics or symptoms which are identified as leading to specific outcomes – suggests that holding providers accountable for the steps they undertake in deciding what care to offer to service users, or to whom they deliver services, is important in promoting effectiveness, and therefore allocative efficiency. The increasing interest in practice guidelines suggests a role for a new approach to accountability and monitoring of provider performance in the form of audit to ensure compliance with guidelines (Sheldon and Borowitz 1993). It is possible to imagine holding devolved purchasers accountable at this level of detail, in order to assess performance in promoting effectiveness.

Furthermore, with measures of outputs, processes and inputs, some agency needs to take responsibility for ensuring those outputs, processes and inputs purchased have been shown to, or are believed to, contribute to desirable health outcomes.

A key issue in holding purchasers accountable for outcomes, outputs, processes or inputs relates to the sheer number of potential outcomes, outputs, processes or inputs which are produced in the health sector. This problem is worsened when it is recognised that different groups – e.g., health professionals, service users, carers, families or society – may view outcomes in different ways. Specifying a large number of measures in order to ensure all services are being provided or to track through changes in service delivery over time may prove expensive and time-consuming. On the other hand, specifying a limited number of measures may encourage purchasers to focus their attention only on those measures, to the detriment of other measures and services, and conceal changes in the distribution of resources which may be viewed by society as undesirable.

HEDIS[64]

At a purchaser level, the most well known performance monitoring approach is that of the United States National Committee for Quality Assurance Health Plan Employer Data and Information Set (HEDIS). HEDIS 'is a set of standardised performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans' (National Committee for Quality Assurance 1997). HEDIS has one key advantage

64 Light also notes the existence of the so-called Primary Care Assessment Survey (PCAS), for use in monitoring primary care quality and service, noting it is an inexpensive and patient-based approach to monitoring care processes.

over approaches based on provider-focused administrative data sets: it is based on population measures rather than encounters between physicians and service users; in other words, the measures go beyond those who selectively choose to visit a physician (Hanchak 1996). (See Appendix I for the 1999 HEDIS measures.)

HEDIS is a relatively recent innovation. Hanchak (1996) notes a number of serious limitations, including problems with the data sets and collection methods and continued differences of opinion over the adjustment factors for risk and for different demographic factors such as socio-economic status (Hanchak 1996). (See also Borfitz (1995).) Kenkel (1996) notes that after some 'five years and millions of dollars were spent…a pilot report card project in 1994 …revealed the inability of most health care organizations to collect and record patient information accurately'.

Another issue in relation to measurement tools such as HEDIS – which apply also to comparisons of mortality and morbidity – are that the individual scores 'seesaw up and down depending on the polling techniques used. Even the season in which a survey is conducted may skew results' (Kenkel 1996).

Such analysis suggests it is very difficult to be fully certain that differences in health or health care outcomes are attributable to the care offered by purchasers or providers. This is particularly the case in terms of outcomes indicated by many performance measurement systems, which cannot be relied upon on their own to provide good information on the relationships between outputs and outcomes. A broader evaluative approach is often likely to be necessary to tease out underlying factors (Iezzoni and Greenberg 1994; Brown, McCartney et al. 1995): investigation rather than castigation being the more appropriate goal.

Conclusions

Much of the literature in this area is moving towards a view that the on-going analysis of data using administrative data bases is expensive. Such measurement tools require numerous quality control measures in terms of definitions and data coding, while also needing much greater information on patient and provider or DPO characteristics than is currently collected in New Zealand. It is not yet clear that the benefits from such measurement tools are worth the expense involved. Furthermore, the need for further investigation limits the use of such tools as measures of accountability in the short-term.

It appears better to identify and focus on particular priority areas, covering a range of different attributes of DPO performance, and to identify if there are meaningful outcomes measures which can be used in contracts with purchasers and providers[65]. Desired outcomes should be within the control of purchasers, they must be meaningful and not able to be gamed, and they must reflect sector priorities.

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65 The first step is to identify outcome measures which are appropriate and meaningful (e.g., percent smokers in a population); a second step is to gather information from purchasers on current outcomes levels; a third step is to set a target which is meaningful and achievable and which, if it requires additional resources, is a priority.

In the absence of outcome measures, continued monitoring of outputs is required. Priority outputs should be monitored, and developed into a reporting framework such as HEDIS. Once again, however, adjustments must be made for differences in health status or health need in different communities. Measures must not be able to be gamed and they must reflect sector priorities.

Monitoring of performance against practice guidelines (i.e. audit) may also be an appropriate step to take in New Zealand. Provided that appropriate care is generally agreed and based on whatever evidence exists, this approach may allow for the faster identification of problems. Adopting this approach will however be seen as reducing doctor autonomy and intruding into the doctor-patient relationship.

Finally, we can continue to monitor performance against particular tasks which purchasers are expected to undertake, such as minimising their own costs, consulting widely with providers and the public, undertaking contract negotiations in good faith, developing and implementing guidelines and so on.

B Rewards and sanctions

There are a number of ways in which employees and firms can be motivated to perform. In addition to the profit incentive (see below), the following methods can be used to motivate people and organisations:

- rewarding achievement;
- recognising good performance;
- providing new challenges;
- providing an interesting job;
- giving responsibility to employees;
- providing advancement (promotion); and
- rewarding using salaries and benefits (Osborne and Plastrik 1997, p.147);

Tools for performance management include:

- performance awards – e.g., non-financial recognition;
- ‘psychic’ pay – e.g., paid time off, new equipment, study leave, research funding;
- bonuses – to individuals or teams;
- gain sharing – gives a guaranteed portion of financial savings as long as specified targets are met;
- shared savings – gain sharing for organisations, or teams;

- performance pay – links pay to performance;
- performance contracts and agreements – gives the opportunity to get rid of non-performing managers or organisations;
- efficiency dividends – reducing agencies' budgets by a small amount each year, while maintaining output levels; and
- performance budgeting – outputs and outcomes specified along with a budget (Osborne and Plastrik 1997, p.146).

All of these approaches might be used in non-competitive markets, e.g., in the case of the HFA, DPOs or hospitals. In all situations, however, key performance expectations must be established, they must be realistic and information is required to measure performance against those expectations. Hence the issues raised in the section on benchmarking performance need to be considered at the same time as rewards and sanctions[66].

Much of the attention in recent years in health care has focused on financial rewards and sanctions. Budget-holding in New Zealand and the United Kingdom, for example, involves the setting of a budget and offers providers the ability to use savings for new services.

There is a reasonable amount of evidence which suggests that health care agencies do respond to financial incentives – although the same literature also notes that 'doing a good job' and 'recognition by one's peers' are also powerful incentives (see the material reviewed in Cumming 1996).

Research into individual provider behaviour does suggest responsiveness to changing financial incentives. For example, Mooney reports on changes in moving from a capitation to a mixed capitation/fee-for-service payment system in Copenhagen: doctors provided many more services in their own surgeries and reduced referrals and hospital admissions, in response to receiving fee-for-service payments for specific conditions (Mooney 1994). The key issue here is: are the changes efficient? Given our limited knowledge of the relative efficiency of providing services in hospitals compared to doctors' surgeries, this is unclear. This is a key problem in health policy: we need to be clear about what we are trying to achieve and to be sure that the incentives support those goals.

Research on GP fund-holding in the United Kingdom suggests: that fundholders reduced the rate of growth in prescribing rates in the early stages of fundholding; mixed evidence in relation to changes in rates of referrals to hospitals and emergency care; and a rise in the number of clinics provided in GP practices (Goodwin 1998). Other studies have found more muted responsiveness to financial incentives. Whynes

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66 Once performance information systems begin to be used for financial rewards, or to award contracts to particular providers or plans, they must be robust enough to withstand legal challenge.

and Baines cite evidence of equivocal results, and argue that GPs, for example, have limited ability to directly respond to income incentives (Whynes and Baines 1998).

In relation to hospitals, United States evidence suggests that payment methods – such as the prospective payment system (PPS, using diagnostic related groups or DRGs) – can lead to reduced costs when compared with traditional payment methods (such as reimbursement of actual costs). However the evidence on quality of care is less comprehensive, and suggests that in some cases, quality of care has worsened. Furthermore, there is also evidence of undesirable effects – for example, cost-shifting to budgets not included in caps; and DRG-creep, where the case complexity of the service mix provided increases as coders choose the most expensive code against which to charge care[67].

Financial incentives have clearly made a difference in the United States insurance market. HMOs are widely recognised as reducing costs, although the separate impact of financial incentives from practice style are hard to identify. Furthermore, such gains may well have been easier to make in the bloated United States system. The worst fears of the impact of HMOs on quality of care have perhaps not been realised: there are HMOs which provide better, the same or worse care than indemnity plans (Robinson and Steiner 1998). There is, however, a concern that poor care may be more likely for those who are chronically ill, low income enrollees in worse health, impaired or frail social HMO enrollees and Medicare home health patients, many with chronic conditions and diseases (Managed Health Care Improvement Task Force 1998, p. 104).

Conclusions

Any method of rewarding or sanctioning providers or DPOs provides both positive and negative incentives. The key steps are to determine the priority goals and objectives for providers or DPOs, to identify meaningful measures or indicators, to negotiate rewards and sanctions in the event that goals and objectives are or are not met, and to monitor carefully any potentially undesirable effects (e.g., on classification, health care outcomes, or in relation to cost-shifting). Some baseline monitoring of service outputs or processes may be required to ensure that providers or DPOs do not skimp elsewhere. However, although these approaches seem to be easily implemented they are in fact complex and require careful thought and implementation.

C Competition for the market: franchising

Franchise bidding takes financial incentives one step further: by rewarding purchasers with the opportunity to take an entire market. Thus, the ability to earn extra revenue and the threat of loss of business may provide powerful incentives to minimise costs and to provide quality care.

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67 As the DRG system is based on current resource use and average cost, the extent to which it promotes efficiency is questionable – an approach based on identifying better practice may be a more appropriate starting point (Donaldson and Gerard 1991; Donaldson and Magnussen 1992).

Williamson, in his work on the economic institutions of capitalism, noted that uncertainty and the complexity of health care services may mean that franchising in health care is difficult (Williamson 1985). In spite of an exhaustive literature search, I was unable to find much evidence about franchising in the health literature.

One example of franchising in health care is however the Arizona experience. In 1982, Arizona was the first state in the United States to get approval to develop and implement a mandatory statewide Medicaid managed care system. Prior to this, health care for low-income people was provided and funded by county governments, with care provided by county hospitals and clinics or through contracted providers. The managed care programme, Arizona Health Care Cost Containment System (AHCCCS), began with acute medical care services, based around prepaid capitated financing of private health plans[68].

The programme initially had a number of problems: Jacobson (1992) suggested that making utilisation information publicly available would allow an increasing number of participants into the franchise bidding process and would perhaps assist in reducing the potential for insolvencies. According to the General Accounting Office (GAO) (1995), the programme has gradually improved its administrative performance, bidding had become very competitive and the approach has grown to encompass a wide range of services (including long term care for people with disabilities)[69,70]. It is also estimated to have made significant savings. The programme does, however, involve higher administration costs compared to other states, although these costs in the Arizona case 'more than pay for themselves in net program savings' (General Accounting Office 1995, p. 2).

Although the Arizona experience appears to suggest franchising via a bidding approach can be successful, it is not clear how relevant this experience is in the New Zealand environment. The Arizona population was 3.75 million in 1990, about the same population as New Zealand has now. However, details of the previous health payment system – with which the savings from the AHCCCS approach are compared – are not clear. Further, the Medicaid market is only a part of the entire market in which health plans operate: hence loss of the Medicaid market may not

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68 Although all Medicaid beneficiaries may specify which available plan they will join, only about 56 per cent actively pick a plan. The rest are assigned by AHCCCS (General Accounting Office 1995).

69 In the bidding process, more weight is given to access and quality factors than to capitation rates (i.e. the price bid); plans are required to meet certain standards for primary care coverage and financial and operational performance is routinely monitored. The bidding process considers: the extent of health plan's provider network, including number, type, geographic location of physicians; member and provider services, quality management and administrative tasks; and financial ability to meet contract terms. A minimum allowable capitation rate is also established, prohibiting low bids that might force health plans to curtail services and adversely affect the quality of care provided. At the time of the 1995 GAO report, a new quality management system was to be implemented.

70 Contracts stipulate the type and location of providers in each county, with minimum provider-enrollee ratios. The State also requires that plans make transportation available where necessary. The State limits the number of contracts awarded in each county: to increase the chances of missing out and therefore increasing the incentives to submit low bids.

necessarily imply that a firm loses all its market share. This may mean that entry is relatively easy and exit from the market not catastrophic: in the New Zealand situation if the whole population were covered by this arrangement, entry and exit may not be as easy and hence competition much more limited. It is interesting that the approach allows consumers to choose between plans, but that only a slight majority of the population chooses to make a choice. This may indicate the strength of an approach relying on a bidding process run by a regulatory body in addition to consumer choice.

D Purchaser competition

Market-based reforms in health care begin with an assumption that competition amongst providers and/or amongst purchasers will provide incentives for good performance. In the market for providers, where consumers buy services directly and purchasers buy services on behalf of consumers, competition is argued to provide price information so that comparisons can be made between alternative providers. Those providers offering quality care at a good price will be offered additional work, and will thrive. This process is argued also to offer incentives for reducing costs and encouraging cost-effectiveness and good quality care.

Similarly, in the market for health plans, consumers are argued to make choices based on price and perceived quality of care offered by a health DPO. Those plans which offer good quality care at a reasonable price will expand their market share and profitability and all plans will have incentives to reduce costs and encourage cost-effective and good quality care.

The most developed proposals for competition between purchasers are those designed in the United States. Many of these proposals envisage a significant role for some agencies in managing the market in order for it to operate in ways which promote allocative and technical efficiency and equity.

The key question for consideration here is: to what extent will competition between purchasers reduce the risks of poor purchaser performance, without placing significantly greater risks on the sector? The following sections consider evidence on the effects of competition in health care to assist in answering this question. Unfortunately, in answering this question for New Zealand, the key problem is that much of the experience of the effects of competition between providers and purchasers comes from the United States, which is moving towards competitive models from a very different environment to that which exists in New Zealand. Thus, any benefits of competition in the United States are usually compared to the previous United States system: this does not supply us with good information about how purchaser competition might compare with the status quo in New Zealand. This is particularly the case when we are sure that further moves to devolve purchasing will lead to higher management costs in New Zealand. Thus there needs to be significant quality or efficiency gains to offset these costs.

Competition at the provider level

In many countries, the use of competition as an incentive in socially-organised health care is relatively new, particularly beyond primary care services. The United States has the most extensive experience of competition, but much of this evidence comes from provider markets[71].

Studies in the 1980s of the effects of competition between hospitals focused on traditional competition in the United States hospital markets. This involved hospitals competing for physicians who would undertake to admit their patients to a particular hospital, guaranteeing hospitals a number of patient admissions. Such competition was based largely on amenities and technology. Price competition played little role in such a market as a result of the third-party payment system. The effects of competition between hospitals in such circumstances would depend on the relative bargaining position of hospitals and physicians. The more hospitals, the higher expenditures may be in order to attract physicians; the more physicians, the lower expenditure as hospitals need not compete as much to attract physicians and their patients (Zwanziger and Melnick 1996). Many cross-sectional studies did indeed find evidence of higher expenditures in areas with more hospitals (for a review see Cumming n.d.). In addition, there was evidence of increased duplication of equipment and specialties in competitive markets as compared to non-competitive markets (Bruce and Jonsson 1996).

In the late 1980s, in the United States, the introduction of selective contracting and prospective payment[72] altered incentives in the hospital industry. Once again, the effects in theory depend on the relative bargaining position of three parties: purchasing authorities, physicians and hospitals. In this case, the greater the number of hospitals the more credible are threats to shift contracts between hospitals; the greater the competition between insurers, the less dependent are hospitals on any one particular insurer and the better the hospital's bargaining position; the greater the competition between physicians and the less 'bonding' between hospitals and physicians, the greater the ability for hospitals to reduce expenditure without fear of losing physician loyalty. In addition, insurers must consider the effects on consumers of changing contracts; who in turn will take into consideration 'switching costs', i.e. the costs of changing insurers in order to remain with a particular physician and the costs of changing physicians in order to remain with a particular insurer (Zwanziger and Melnick 1996).

Thus, provider competition in the United States – in the presence of selective contracting and a massive oversupply of beds – is reaping benefits in the form of cost reductions. There is also evidence of competition improving performance at the hospital level where GP fundholders in the United Kingdom have threatened to move

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71 Providers in the United States have traditionally not operated within a cash-constrained environment.

72 Selective contracting is where a purchaser is able to select particular providers to contract with to provide care. The opposite approach – universal contracting – occurs where a purchaser must contract with 'all willing providers'. In the United States, prior to about 1983, universal contracting was the norm. Prospective reimbursement occurs when providers are paid in advance for care to be provided. The DRG system is an example of a prospective reimbursement system.

contracts elsewhere. This pressure may have been successful as a result of the attractiveness of marginal income available through cost per case contracts (Le Grand, Mays et al. 1998).

Provider competition in New Zealand

It is unclear if the experiences of the United States and the United Kingdom can be replicated in New Zealand, particularly when considering hospital markets. Greater competition in New Zealand amongst hospitals in the presence of selective contracting may provide incentives for improved performance in the longer term, but increased competition in the form of more hospitals may lead to higher average prices: if occupancy rates fall; where expensive equipment is duplicated in particular centres; and if specialists' earnings are evened out over the private and public sectors.

Evidence on economies of scale in New Zealand suggests that significant gains could be reaped by down-sizing larger hospitals and merging smaller hospitals (Devlin and O'Dea, 1998), suggesting that in rural areas, competition between hospitals is unlikely to be efficient. The implications for competition of down-sizing larger hospitals are unclear – given uncertainties over the effects of duplication and lower occupancy rates. In any event, the results may not apply to particular services, especially where the relationship between outputs and outcomes may be strong. Competition in New Zealand is thus more likely to be efficient amongst primary and community care providers; growth in the availability of secondary care beds in the private sector may, however, signal that some competition at the margins is possible in elective care also (see Appendix D), particularly if there is significant spare capacity in the private sector.

The effects of competition in provision of care are relevant when considering the potential effects of introducing competition at the purchaser level. With a limited number of hospitals providing secondary and tertiary services, combined with a limited supply of specialists, some hospitals will have monopoly power in negotiations with purchasers; while specialists will have monopoly power in negotiations with hospitals: competing purchasers may therefore find it more difficult than a monopsony purchaser to restrain costs.

Competition between health plans – what is the evidence?

A number of studies have examined differences in utilisation, expenditure and quality of care between traditional indemnity insurance plans and HMOs (for reviews see Miller and Luft 1994; Luft 1996; Robinson and Steiner 1998). These studies clearly show, in comparison with traditional plans: HMOs have lower utilisation rates for intensive services, lower costs and no worse health outcomes (except in mental health); fewer HMO enrollees are satisfied with the quality of care and patient-physician interactions; and HMO enrollees have greater satisfaction with costs.

Of more interest in this context is the effect of managed care competition on traditional indemnity insurance activities and costs[73]. Miller and Luft in 1994 noted there had

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73 Some commentators note that HMO activities have spread to traditional indemnity insurance. Robinson and Steiner for example cite reference to a new type of organisation 'managed indemnity insurance' (Robinson and Steiner 1998, p. 18).

been no studies on the impact of managed care plans on national or regional area health care expenditures and inconsistent results concerning effects on hospital expenditures. One study concluded a 10 per cent increase in HMO market penetration reduced hospital costs per admission by 9.4 per cent, and was greatest in areas with substantial market competition. A more recent study has found that high managed care enrolment is now associated with: lower growth in hospital spending; in some years, lower growth in total spending including physician and drug spending; and even reduced diffusion of medical technologies (Cutler and Sheiner n.d.). In another study, there was evidence of a relationship between systemwide HMO market share and declines in Medicare fee-for-service expenditures (Baker and Shankarkumar n.d.).

In the United Kingdom, a number of studies have researched the effects of health authority purchasers and budget-holders on hospital and specialist behaviour. Overall, the results suggest that purchasers have found it more difficult than budget-holders to switch expenditure between services or providers, and that providers have been more responsive to the demands of budget-holders than to non-budget-holders (Le Grand, Mays et al. 1997)[74]. However, the results appear to be related to the degree of competition for elective care which exists between closely located hospitals, which suggests that such gains may be more difficult to achieve in New Zealand. In addition, the transaction costs associated with budget-holding have been higher than those associated with health authority purchasing, and the potential for worsening inequities in access to care greater under budget-holding than under health authority purchasing (Le Grand, Mays et al. 1997). This suggests that devolving purchasing is likely to result in higher transaction costs and that concerns may arise over the impact on equity goals.

However, the effects of competition between HMOs compared to no competition remain unclear, as do the implications of the combination of competing HMOs and a number of competing hospitals compared, for example, to a situation of bilateral monopoly. These are the issues which are relevant in New Zealand.

How many competing health plans could New Zealand sustain?

New Zealand may find it hard to promote competition between comprehensive health care plans because of the small size of the population and its distribution. Competition between plans would be more likely to succeed if limited to common primary and community care services (such competition currently exists anyway), and perhaps some secondary care.

Clearly, the extent of choice that consumers face will depend on the form of health care plans, as well as on the regulatory structure implemented. Key drivers are: whether individual providers are able to work or contract with more than one DPO; how access is defined in regulation; and the comprehensiveness of service coverage required by plans.

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74 The authors note however that 'while budgetary control appears to be desirable for achieving changes in the desired direction, it is clearly not sufficient on its own….It seemed that…it was only the innovative practices within fundholding which transformed patient care' (Le Grand, Mays et al. 1997, p. 60).

If providers can only contract with one DPO, and access is defined in regulation such that each DPO must provide access for example in rural towns, the extent of competition between plans in some parts of New Zealand may be limited, along the lines of the extent of provider competition that currently exists[75]. Allowing providers to contract with more than one DPO – at least for some specialties and in smaller towns – is a precursor to encouraging competition between plans in New Zealand. Under such circumstances, those in smaller towns may have a choice of DPO, but (as exists now) little choice of provider (unless they are prepared to travel)[76]. Yet the more plans each provider has a contract with, the greater transaction costs are likely to be and the more limited is each DPO's effect on provider behaviour[77]. Furthermore, potential improvements in choice at the purchaser level may not occur if plans choose not to market in smaller towns, and if they fear that they will not be compensated adequately for any higher costs if the population is thought to be more at risk of poor health (e.g., lower income or Mâori communities) or for care which is more expensive to provide in rural areas than on average (e.g., if it costs more to contract with providers in rural areas).

Just how many plans might a country like New Zealand be likely to be able to sustain?. This is firstly a function of the comprehensiveness of the coverage. In their United States study, Kronick et al used the ratio of physicians to enrollees in large staff-model HMOs to estimate the population needed to support health organisations with various ranges of specialty services. They assumed adequate competition would require at least three plans[78]. They found, assuming United States levels of spending:

- a health care services market with at least 1.2 million could support three fully independent plans (i.e., where each DPO owns its own hospitals and all staff are employed by only one DPO);

- a population of at least 360,000 could support three plans which independently provided most acute hospital services, but they would have to share hospital facilities and contract for tertiary services; and

- a population of 180,000 could support three plans which provided primary care and many basic specialty services, but which shared inpatient cardiology and urology services and engaged in substantial sharing of inpatient facilities with other plans (Kronick, Goodman et al. 1993).

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75 At the extreme, only one plan is possible for the full range of services currently provided in New Zealand (ie. including liver transplants where there is only one provider).

76 Clearly, the regulations here too may have implications for competition between plans. If plans must contract with GPs for each town, rather than nurses for example, then competition may be more limited.

77 For further discussion on this, see Appendix D.

78 Kronick et al also noted that each plan would also be seeking opportunities to grow, which may affect the calculations.

Thus, in the United States, competition of the first kind would be possible for 42 per cent of the population; of the second kind, 63 per cent; and of the third kind, 71 per cent.

On the basis of the approach used by Kronick et al, only the Auckland region[79] (including around 27 per cent of the population) could sustain competition of the first and second kinds; even then people living in South Auckland would face significant travel times to, for example, the North Shore. Christchurch and Wellington fall just below the 360,000 population mark, so may also be able to sustain competition of the second kind (increasing coverage to 45.6 per cent of the population). Populations between 140,000 to 180,000 might also allow competition for Hamilton-Cambridge-Te Awamutu (adding a further 4.4 per cent of the population). Reducing the level to 100,000 also adds in Napier-Hastings and Dunedin (a further 6 per cent). At most, New Zealand could sustain competition of the third kind (i.e. three competing plans providing primary care and basic specialty services) for 56 per cent of the population[80]. (Contact the author for the data from which this information was drawn.)

In their report, Le Grand et al reported the following illustrative population sizes for purchasers, on the basis of risk management and expertise of purchasers:

Type of service	**Examples**	**Population size**
Rare services	Organ transplantation, neurosciences, secure units, trauma care, forensic psychiatry.	> 250,000*
Common and expensive	Emergency care.	50,000-250,000**
Common	Elective treatments and routine tests and investigations, palliative care, services for those with serious mental healthproblems, learning difficulties.	10,000-50,000
Common and cheap	Community health services.	3,000-10,000

79 The data are reported on a main urban area basis. Data are from the 1996 Census. Auckland encompasses Northern, Western, Central and Southern Auckland main urban areas. More detailed analysis would generate more accurate figures. Consideration should also be given to other differences between the United States and New Zealand which may affect these figures, e.g. the level of spending and spare capacity in the United States compared to New Zealand.

80 This analysis assumes that quality care requires the same mixes of physicians as in staff-model HMOs and the ratio of 2 beds per thousand population, where the population under 65 years of age uses 350 hospital days per year per thousand enrollees and the population over 65 years of age uses 2340 beds per thousand population (13 per cent of the population). Hospital occupancy is 85 per cent. The analysis assumed a family practitioner ratio of 1 family practitioner to 2000 population, or 50 per 100,000 population. In New Zealand, at a former area health board level, there were between 72 and 112 general practitioners per 100,000 population, with an average of 87 (New Zealand Medical Council n.d.) in 1997. However, the populations in the HMOs whose data were used for this analysis may be younger and possibly healthier than the general population. Thus, Kronick et al argued that smaller health markets could support managed competition with a higher proportion of elderly patients (although they were not particularly clear as to why this was the case; presumably however it is because older people use more services).

Source: Le Grand et al (1997).

* The authors note in the text that such services may require between 500,000 and 2 million people to spread risk across such services.

** The authors note in the text that such services may require between 50,000 and 500,000 people to spread risk across such services.

On the basis of these crude estimates, and extrapolating them to a situation where three such plans are required to promote competition, populations of around 30,000-150,000 could have competition between three plans, but each would only responsible for delivering the more common services. With 30,000 population, all main urban areas could sustain competition between three plans (2,510,400 people or 69% of the population); with 150,000, at most 56 per cent of the population live in areas which might sustain such competition.

Hence, competition between plans in New Zealand appears unlikely to be feasible if plans must cover all services. It would appear to be better to promote more limited coverage[81]: even then, however, a good proportion of the population would find their choices limited.

The role of consumers in purchaser competition

The little research which has been undertaken in relation to consumerism[82] in choosing between providers choice suggests a distinct lack of consumerist behaviour, including limited seeking of health information, exercising of independent judgement in accepting advice, or cost-seeking behaviours (see the references cited in Barnett and Kearns 1996). Possible reasons include: the sporadic nature of care; that urgent treatment usually precludes the possibility of shopping around; the passive patient role from which many patients seem unwilling to move away, perhaps due to the asymmetry of information between doctor and patient and the high degree of faith and trust in physicians; the availability of a range of alternative providers (Barnett and Kearns 1996); perhaps that the highest users of care are young children and the elderly, many of whom find it difficult to travel long distances for care; and that personal relationships and continuity of care are important qualities of health care services[83].

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81 Many New Zealanders currently are able to choose their GP from a range of competing GPs. However, competition between plans may well *reduce* the choices that consumers have for GPs if plans introduce selective contracting.

82 For the purposes of this paper, a consumer is someone who purchases or uses a good or service, regardless of whether direct payments are involved. A consumerist is 'a person who purchases a good or service and is actively assertive, critical and prepared to shop around for the best deal', cited in Barnett (1996, p. 1055). Note, however, that the nature of the doctor-patient relationship, for example, makes the nature of consumerism in health care somewhat special (Evans 1984).

83 Thanks to Nick Mays for making these last two points. The importance of continuity of care is outlined by Managed Health Care Improvement Task Force (1998, p. 20): 'studies have shown that patients staying with the same physician for long periods are less likely to be hospitalized, more likely to have lower costs, and more likely to be satisfied'.

In New Zealand, Barnett and Kearns similarly found little evidence of consumerist behaviour in their study of Auckland private accident and medical clinics. Accessibility (proximity) and availability (opening hours) were the most important factors in choosing to attend such clinics; with very few (3.1 per cent of respondents) mentioning price (Barnett and Kearns 1996). Barnett and Kearns thus conclude: 'it appears that few patients, especially those with lower incomes, actually shop around for a GP even when they have the freedom to do so' (Barnett and Kearns 1996, p.1072)[84].

Perhaps of more concern is the conclusion Barnett and Kearns draw that unlike the 'discount doctors' surgeries', which characterised the early corporate intrusion into primary health care, more recent entrants into the market have played down the cost of their operations because of the negative connotations associated with lower cost care' (Barnett and Kearns 1996, p. 1072). This refers to the early foray by corporate medicine in the Auckland market; a failure in the sense that a number of such clinics did not survive: one did not last beyond five weeks! The reasons cited for this include: a perception of 'Kentucky Fried Medicine', along with doctor-management conflicts and high turnover; the siting of clinics in affluent areas where cheaper care was not wanted because of the perception it would not be quality care; and the limited size of catchment areas in lower income areas where consumers do not have access to good transport (once again, see the references cited in Barnett and Kearns 1996).

Thus, there is a concern that consumers may view a lower priced provider or health DPO as evidence of poor quality, thereby reducing the potential effects of consumer choice on improving efficiency. If consumers choose providers or plans on the basis of facilities, for example, then competition may well lead to higher costs overall.

Consumer information in purchaser competition

If consumers are to make choices based on efficiency they must have access to information on more than just the price of coverage. Efficiency not only means efficiency in production (providing outputs at least resource use); but also cost-effectiveness (providing outcomes at least cost); and quality of care (including appropriateness, cultural acceptability, facilities available, courtesy, etc)[85]. Cost-effectiveness in the delivery of particular health care outcomes[86] is not usually obvious, nor is such information reliably gained by word of mouth. Information must be provided as to the relative cost-effectiveness of alternative plans. Poor information is likely to lead to consumers using proxy measures of cost-effectiveness and quality of care, and this may include settling for a higher-priced DPO. Such use of proxy signals may thwart incentives for efficiency and cost-effectiveness.

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84 A requirement for patients to register with one GP or practice may further inhibit shopping around for care.

85 It is assumed here that efficiency is defined with respect to a particular societal view: individual consumers may not agree with societal views on an efficient mix of services, however.

86 Examples of cost-effectiveness may include: nurses being available to deliver immunisation services rather than doctors; GPs being available to provide services for people with on-going mental health needs rather than more expensive psychiatrists.

As Luft notes, however, aggregate performance of a DPO may be of little assistance to consumers: they are likely to want to know about the performance of a DPO in their own locality. Reporting at this level, however, raises problems associated with small sample sizes (Luft 1996).

Luft also notes that innovation may occur at the provider rather than the purchaser level, and that plans may find it impossible to channel consumers towards such providers because the consumers sign up with the DPO not providers (Luft 1996)[87]. Thus, the integration of purchaser and provider may make it harder to reward innovative providers than with the purchaser-provider split model, unless consumers are offered financial incentives to choose particular providers within any of the integrated models.

In terms of health plans, choosing one health DPO over another has implications not only for coverage of health care (the benefits DPO), but also dimensions of health care provision, i.e. quality and location of providers.

Reinhardt also notes that consumer choice implies the 'full disclosure of credible information' about the various products, and that the information 'to be made available…ought to be retrieved and structured by someone economically unrelated to the various health plans or networks competing with one another' and that when information is supplied by the competitors themselves 'it should be subject to rigorous external audit' (Reinhardt, 1997 p. 45, emphasis in original)[88].

About managed competition in the United States, Reinhardt states:

> In theory, the new American health system was to afford employees a well-informed choice among several competing private health plans…..In practice, …the typical American was thrust blind-folded into a raw, commercial free-for-all among the would-be private regulators…With very few exceptions - most notably in California - the typical American today knows no more about the quality of the health-care regulation likely to be performed by competing health plans than do British individuals about the health-care regulation likely to be performed by competing GP-fundholders. It is the reason why Americans now beg the federal and state governments for increased government-regulation of the private health-care regulators. In so doing, they are reacting angrily to an alleged 'consumer-choice' revolution that put the cart (competition) before the horse (disclosure of the pertinent information) (Reinhardt, 1997, p. 58, emphasis in original).

Reinhardt also queries the extent to which individuals can be enlisted to promote effective quality[89] and cost competition between health plans[90], or whether the

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87 Unless providers are associated with only one plan.

88 Such information should include: clinical outcomes, immunisation rates etc, patients' satisfaction, geographic location, background of physicians, information on clinical experts employed by the plans (Reinhardt, 1997, p. 45).

89 Ie, beyond consumer satisfaction alone.

90 Not all Americans have a choice of plan: 48.2% of United States employees nationally have a choice of plan through their own employment (the figure is 54.5% in California) (Managed Health Care Improvement Task Force 1998, p. 37).

establishment of professional purchasers – as in the United Kingdom and New Zealand – might not be a more effective means of challenging the performance of providers (Reinhardt, 1997, p. 63)[91]. The relative advantages and disadvantages of each approach deserves further consideration – and piloting – in New Zealand.

As the section on cream-skimming discussed, it is likely that the incentives on purchasers or health plans to perform will very much depend on the extent to which cream-skimming is profitable and how well health plans can segment the market. Success at this may leave some consumers with very few choices in relation to coverage, and may result in consumers choosing packages of care based on coverage rather than price.

A key issue in designing managed competition relates to the role of financial incentives for consumers in choosing between health plans. An early version of managed competition envisaged competition only in relation to quality of care. In other versions of managed competition, however, consumers would pay some of the cost of coverage: for example, only the cheapest DPO might be fully subsidised, with consumers paying additional amounts for the same coverage offered by the more expensive plans. This is argued to provide a financial incentive to choose carefully; but might also be seen as compromising 'social solidarity' objectives depending on the extent to which choice becomes affected by ability to pay (Reinhardt 1997).

An issue which is not covered to this point is, however, that of the responsiveness of organisations to changing tastes and technologies. In spite of the considerable importance that might be attached to this concept of efficiency, the literature does not make much of it in the context of competition. Of considerable interest is the extent to which competing health plans and providers respond more quickly to market signals than in a non-competitive environment; and whether or not such responsiveness is compatible with any health maximisation or cost-containment goals.

A final point is also the extent to which consumer responsiveness is improved by competition. Clearly, some insurers in United States markets are viewed as responsive to some needs: however, the same responsiveness may be viewed less positively if used to cream-skim and to sell ineffective and allocatively inefficient services. The Managed Care Improvement Task Force in California noted that consumers who have a choice of plan are more likely to be satisfied with their plan than consumers with no choice (Managed Health Care Improvement Task Force 1998, p. 205). This needs to be balanced against the limits on choice due to a) restricted use of providers and b) the effects of increasing levels of 'management' of individual care. In addition, the more vulnerable populations are unlikely to be beneficiaries of increased choice (Managed Health Care Improvement Task Force 1998, p. 128).

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91 It is likely, however, that arguments will be made about the extent to which purchasers can adequately represent consumer views in purchasing health care, and about how to promote good purchaser performance.

E. Investment in purchaser expertise and knowledge

As a final point, Light raises the issue of how to promote effective commissioning. Using evidence from the United States, he argues that:

- commissioning organisations need to be large and strong – requiring marketplace clout to take on inefficiencies and a large population base across which (i) to configure clinical services in cost-effective ways, (ii) to bear risk, (iii) to support a highly skilled team to undertake contracting, (iv) to spread administrative and transaction costs, (v) to avoid inequalities and service fragmentation and (vi) to advance prevention and health gain aggressively;

- commissioning teams need to be smart, well trained and technically supported;

- re-engineering clinical care for cost-effectiveness takes time and money; and requires more attention to be paid to the diffusion of successful and cost-effective new ways of doing things; and

- commissioning through primary care has serious drawbacks, because they do not have: sufficient clout; technical skills and infrastructure; time and training; and the ability to address inequities and wasteful practices in primary care itself (Light 1998).

These issues need further serious consideration in the New Zealand context if we are serious about ensuring good purchaser performance. In particular, more attention needs to be paid to developing the purchasing skills of both professionals and managers. There is no guarantee that good purchasing will develop of its own accord.

Conclusions

Managing the risks of poor purchaser performance is complicated by the information problems which plague the health and disability sector. The move in 1998 to a single purchaser makes it difficult to benchmark purchaser performance in New Zealand (even though one strong purchaser may be better than having a number of weaker purchasers), while the lack of a clear counterfactual – what would have happened if there were a 'better' purchaser – makes assessment of a purchaser's performance difficult. The current purchaser performance framework monitors particular tasks which the HFA is expected to complete, and monitors changes in the levels of outputs over time.

Each of the first four approaches set out here for managing purchaser performance – monitoring and benchmarking performance; using sanctions and rewards; franchising; and competition between purchasers – requires identification of priority goals and the collection and interpretation of indicators. A significant investment is required to establish indicators, and to adjust them adequately for different levels of health status. A focus on health care outputs and processes is more likely to be feasible in both the short and long terms. An approach based on practice and other guidelines offers advantages in using evidence on effectiveness and best practice, but requires auditing at an individual practitioner or institutional level.

Having identified key performance goals and indicators which are tightly defined and audited, performance rewards and sanctions can also be designed to ensure that purchasers focus on these goals. Care needs to be taken that purchasers do not neglect activities in services which are not monitored, however. The literature suggests that financial incentives can have an important effect on behaviour, but the existence of a myriad of health sector goals can make it hard to ensure that all goals are met with the same set of incentives.

Increasing the number of purchasers may reduce the risks of poor purchaser performance if a single purchaser is systematically performing poorly, but smaller purchasers may not have the same level of expertise or power over providers in order to challenge provision.

Competition for the market provides an alternative approach to managing purchasing risks. At present, this would seem an unlikely scenario, given the limited expertise in purchasing in New Zealand. Even in the longer term, the small size of the New Zealand market may limit opportunities for franchising to primary care purchaser/providers. The costs involved in managing a franchise process may not be worth the gains which might be made.

Full-scale purchaser competition in New Zealand – between plans offering comprehensive services – appears an unlikely scenario, given our small and widely dispersed population. Competition between plans may well improve incentives for better performance, but competition requires much better information to be collected and to be made available at a local level. It is not clear if the risks associated with such competition would be worth the potential gains involved (see Appendix D), even if cream-skimming and cost-shifting risks can be minimised. Further analytical work, drawing on the international literature, comparing the potential benefits of a national purchaser with competition between purchasers is needed urgently to inform this debate.

4.3 Managing the risks associated with cost-shifting

Key approaches to managing the risks associated with cost-shifting include:

A. Integrating budget responsibility.
B. Clarifying boundaries between budgets.
C. Developing practice and referral guidelines.
D. Private ownership of purchasers and providers.

A Integrating budget responsibility

In New Zealand, the move in 1993 to integrate primary, secondary and disability support funding for health care was in part due to concerns about cost shifting[92]. Theoretically, this integration of budget responsibility might encourage the purchaser to ensure that inefficient cost-shifting (within the budget) does not occur. Whether this happens will depend on a) the incentives on the purchaser to provide the best value for money and b) the purchaser's specification and monitoring of contracts (and use of the techniques set out below).

It could be argued that introducing competition at the purchaser level will provide greater incentives to ensure that inefficient cost-shifting does not occur within the purchaser's budget, and such incentives will be further enhanced if financial incentives at the provider level to support this (e.g., via ownership pressure, bonuses). So, for example, a fully integrated purchaser-provider, with staff on salaries with bonus incentives or as part-owners, competing against other similar organisations, might have incentives to minimise cost-shifting within the organisation. Staff-model HMOs in the United States and budget-holding arrangements in New Zealand and the United Kingdom, for example, are based on this approach[93].

What is less clear is how individuals within organisations react if, for example, separate budgets and budget responsibility within an organisation are established. Even within an organisation which holds a budget across a wide range of services, as soon as a key incentive is to remain within a budget, cost-shifting may become both an internal and external management problem.

However, even if integration did reduce cost-shifting within a DPO or organisation, there is potential for cost-shifting outside the DPO or organisation. Furthermore, the integration of budgets is unlikely to occur at the higher levels of the system: i.e. between personal health, disability support and public health; between government votes; and between public and private financing.

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92 Originally, ACC health care was also to be integrated into the RHAs' budgets, but this never occurred.

93 There is some United Kingdom evidence on the potential of fund-holding to alter the pattern of service use across previous budget boundaries (personal communication, Nicholas Mays).

B Clarifying boundaries between budgets

One way of reducing the potential for cost-shifting is to clarify boundaries between budgets. This requires clear definitions of what is publicly financed vs privately financed; between personal health, public health and disability support; and between contractual responsibilities[94].

In a number of other countries, the boundary between what is publicly financed and what is privately financed is clearer than in New Zealand[95]. But countries like New Zealand, the United Kingdom and Spain do not clearly specify the services which are to be covered by their national health insurance systems. They are not entitlement-based systems but they do attempt to be comprehensive. The general level of specification of contracts between purchasers and providers and between the government and its citizens, combined with a lack of guarantee for access and with budget caps, means that cost-shifting between budgets can occur easily. Hence, an important way in which cost-shifting may be discouraged is to better define the boundaries associated with publicly financed health care. Although this can partly be achieved by ensuring people or services are only covered by one set of arrangements (e.g., those over a certain income can go private if they wish), it also requires better boundaries between core coverage and supplementary insurance. This is discussed in more depth in the section above on service specification (also see the discussion below on practice guidelines).

Similar issues may arise if alternative risk pools are established. For example, GP responsibility for care for an individual patient may be capped at a particular amount. Clearly, this is a fairly clear boundary, which can be audited[96]. Risk pools established in other ways may not have such clear boundaries. These may be based around particular diseases (e.g., renal care, AIDS)[97]; past use of services; or there may be completely separately funded providers who offer care in particular areas (e.g., to those living in low income areas). All are problematic: the first and second offer

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94 Reducing cost-shifting between government votes would probably require complete budget integration, or allocation of responsibility for flow-on costs to each sector. For example, if health fails to keep a person with a psychiatric problem out of trouble and the individual ends up in prison, the costs could be charged against the health budget.

95 For example, in Germany and the Netherlands, those insured are covered fully by either the private or the public system. They cannot straddle both insurance systems, except for supplementary coverage for amenities. Only those below a certain income level must belong to the social insurance system; those above can choose the private system, but they then cannot return to the social insurance system. In Canada, an individual could choose to stay outside the public system, but he or she would then be responsible for paying for all their own care. Private insurance for services covered under the national health insurance system is prohibited. In the United States Medicare system, the definition of coverage is such that the boundary between Medicare and Medigap insurance is clear: the latter covers things such as: co-payments for particular services; foreign care; care in the home; preventive care services such as cholesterol and diabetes screening and prescription drugs.

96 This approach may require a definition of appropriate care however to ensure that the care offered is not frivolous nor outside a concept of core.

97 As in the United States: renal care is funded through Medicare for all United States citizens.

incentives to diagnose more cases and to offer more services; the third requires a boundary to prevent plans or providers from neglecting certain areas in the knowledge that care will be made available by someone else.

Cost-shifting in relation to user charges is also a potentially large problem in New Zealand. Pharmac may simply be shifting costs onto individuals with its reference price scheme, although if patients' needs can still be adequately met with the remaining fully subsidised medicine or if drug companies cut their prices and become more efficient, Pharmac policies are indeed improving overall efficiency. With a move to capitation payments for GP care for those with community services cards, general practitioners who feel they are earning insufficient revenue to cover costs have the ability to shift costs to those continuing to pay fee-for-service charges: these charges are limited only by competition, the effects of which are uncertain in New Zealand. Furthermore, attempts to shift care out of hospitals and into GP offices may also increase cost-shifting to those paying user charges.

Cost-shifting to those paying user charges might be reduced by:

- regulating all user charges by putting a zero or maximum amount that can be charged per visit or episode of care. For example, in the United States, HMO legislation limits user fees for care and it is illegal for physicians and patients to contract privately for the provision of services already covered by Medicare. Physicians and hospitals must accept Medicare's scheduled fees for these services. This approach would have the additional advantage of maintaining affordability of care. GPs in New Zealand have shown great reluctance for these charges to be eliminated or regulated, however, and the approach of eliminating user fees would in all likelihood result in higher expenditure for the government, at least in the short term[98]; and

- putting in place incentives not to charge user fees. For example, in Australia, general practitioners are encouraged not to charge patients additional fees. Doctors can accept the 85% Medicare reimbursement of the schedule fee as full payment. Alternatively, the doctor can charge the patient a fee: however, the amount above the government's fee cannot be privately insured against (Donaldson and Gerard 1993).

C Developing practice and referral guidelines

In many circumstances, it may be possible to develop practice or referral guidelines which set out the responsibilities of different providers in caring for patients with particular conditions. This approach may not only reduce inappropriate cost shifting, but may also enhance quality of care and reduce under-servicing. In developing the lead maternity carer approach in New Zealand, a set of protocols was attached to provider contracts setting out the circumstances under which patients were to be transferred to specialists. Thus an attempt was being made to clarify the boundaries between providers. To my knowledge, no research has been undertaken to determine the effects of these guidelines, but the approach appears to offer some promise.

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98 In the longer term, if good care is provided in the primary care sector, hospital admission rates may fall as a result of such a policy.

Shared care plans developed between hospital services and GPs in caring for people with ongoing mental illness provide another example: if the plans are developed based on agreed parameters, and can be monitored, the opportunities for cost-shifting could be reduced. The approach relies on good communication between providers as well as goodwill in following the guidelines through in practice, and in negotiating around any difficulties which occur. Financial incentives might accompany such guidelines if necessary, and may be accompanied by an audit process to ensure they are being followed.

D Private ownership of purchasers and providers

In New Zealand, many hospitals are currently owned and operated by the government. Within the current environment, public hospitals have residual risk passed on to them: they argue they must treat most of those coming through their doors (especially urgent cases), but they do not get paid for service levels above those contracted for. The government bears this financial risk, in the form of deficits. Potentially, this financial risk could increase if competing providers and DPOs are able to cost-shift to public hospitals.

A similar situation may arise at purchaser level: where the government-owned HFA is in competition with privately-owned DPOs, and where particular care were left to the responsibility of the HFA or as a result of cream-skimming.

Thus, if the approaches laid out above are not successful at preventing cost-shifting, the government may be tempted to argue for privatisation in order to shift residual risk to the private sector (at a price, of course). Yet governments play a significant role in health care in all developed countries. Even in the United States, nearly 50 per cent of health care is funded by government agencies. Furthermore, governments play key roles in regulating health care: for example, by requiring hospitals to provide care to all urgent cases or regulating the growth of expenditure or premiums. These key government roles suggest that even if all purchasers and providers are privately owned, governments may find it difficult not to become involved where purchasers or providers are in trouble.

Conclusions

Integration of budgets may reduce incentives to cost-shift within organisational budgets, and this may especially be an effective approach to managing cost-shifting where financial incentives also support cost containment within the overall organisational budget. Yet there appears to be no available evidence to support this.

In any case, cost-shifting outside of the organisational budgets will remain a problem. The key approaches to managing cost-shifting appear to be to design contract boundaries in ways which discourage cost-shifting. Regulatory or contract approaches may well be the simplest approaches, whereby contract boundaries or referral guidelines could be used to monitor cost-shifting.

5 CONCLUSIONS

The discussion in the previous chapters has focused on the key risks associated with general moves to devolve purchasing in New Zealand. In this section, a summary table (Table 5.1) is provided of the key risks that might arise in each of the devolved purchasing arrangements which may develop in New Zealand. Conclusions are then drawn about each of the risks discussed above, both in general and in the context of the information summarised in Table 5.1.

5.1 Cream-skimming

Moves to capitate primary care providers or place them at increased financial risk, along with moves to promote competition between primary care providers and DPOs, will provide incentives to cream-skim. The likely extent of such cream-skimming is unknown, but if it does occur systematically it has the potential to increase overall expenditure, encourage pressure for additional expenditure, lead to inequities in access and quality of care, provide diminished incentives for technical efficiency and cost-effectiveness, and lead to differences in profitability for DPOs.

Cream-skimming is not an issue in regional monopoly DPO models, and may not be a problem with carve-out purchasers, but it is likely to become an issue within the monopoly HFA model (as primary care providers are moved onto capitated or other risk contracts), and particularly with models which offer consumer choice between DPOs.

Methods to control cream-skimming include encouraging larger risk pools; compensating for risk; limiting risk; defining service entitlements and regulating the purchaser or provider market. This paper has focused particularly on defining entitlements and regulating the insurer or provider market.

Table 5.1
Summary of risks and management options by devolved purchasing arrangements

	Cream-skimming	Management Options	Poor purchaser performance	Management Options	Cost-shifting	Management Options
Monopoly HFA (Status Quo)	•Not applicable •However, increased use of capitation to pay providers may see providers engaging in cream-skimming, – see risks below under Choice of DPO – Individual model	•Not applicable •See below, Choice of DPO – Individual model	Crown risk •Higher overall expenditure and pressure for increased government-funded health resources •Pressure to bail out purchasers or providers •Potential legal action Consumer risk •Poor access to care •Poor quality care •Higher taxation •Higher private expenditure •Poor access to care for those unable to afford private care •Lower health status than would otherwise be the case •Under-servicing of some consumers where costs greater than fee paid Health sector •Poor value for money •Excessive profits or losses where contracting is poor •Higher overall expenditure •Likely to generate ongoing policy disputes about monolithic purchaser and no consumer choice	All risks •Monitoring of purchaser by Crown •Use of performance sanctions and rewards •Franchising •Competition between purchasers •Smart purchasing All raise performance measurement and information issues Competition between purchasers raises additional risks (see below, Choice of DPO models)	Crown risk •Greater expenditure in other votes (e.g., ACC, justice, DSW) •Greater expenditure for crown-owned providers where risk is shifted from other providers Consumer risk •Greater private expenditure if access to publicly-funded services is reduced (must go private) •Lower access to care if access to publicly-funded services is reduced (and cannot afford to go private) •Greater shunting of consumers between providers •Greater private expenditure in the form of user charges Health sector risk •Higher overall expenditure as claims in the private sector increase with more care provided privately at possibly higher cost •Reduced equity of access as those who cannot obtain publicly-funded care are unable to afford private care •Reduced or improved cost-effectiveness where the type of care provided is driven by budget constraints rather than need or cost-effectiveness •Difficulties in planning and budgeting in areas where costs are commonly shifted to Inappropriate market signals which might arise as a result of cross-subsidies (although such cross-subsidies may also enhance equity of access).	Crown risk •HFA directed to consider impact of purchasing on other votes and to report on such risks •HFA directed to specify contracts tightly and to monitor service delivery in order to prevent cost-shifting Consumer risk •Crown specify maximum user charges (politically difficult in relation to GPs) •Crown specify and monitor access to services (service specification issues - see text), including protocols for referral Health sector risk •Encourage integration of budgets across substitutable sets of services

Table 5.1 (cont)

Monopoly HFA with specialist purchasing of particular services (carve-outs)	•Carve-out purchasers' consumer profile is likely to be riskier on average than the HFA profile •Carve-out purchasers may try to engage in cream-skimming of the most serious cases with a flat capitation rate – this would seem unlikely however if it is clear which patients are to be cared for by which carve-outs Hence risks may include: Crown risk •Higher expenditure or reduced other services where most serious cases become responsibility of HFA Consumer risk •Must fall back on HFA – may lead to differences in care between those in HFA and those in carve-out care	•HFA clearly specify those covered by the carved-out contracts •Monitoring of risk profile of carve-out purchasers •Limit financial risk associated with higher risk people (see text) •Risk rating •Regulations - contracts, with sanctions (see text)	•As above, but •Overall risk may be reduced if some purchasers perform well while others do not •Ability to make comparisons between carved-out purchasers in different parts of the country, subject to performance monitoring issues (see text)	•Devolved purchaser performance becomes responsibility of HFA •Issues as above for Monopoly HFA	•As above: in particular, carve-outs may try to shift costs elsewhere	As above, Monopoly HFA
Regional Monopoly Purchasers	•Not applicable	•Not applicable	•As Monopoly HFA	•Purchaser performance can be compared with other regional monopoly purchasers •Issues as above, Monopoly HFA	•Integration may reduce cost-shifting; otherwise, as above, Monopoly HFA Consumer risk Purchasers may refuse to care for the sickest consumers from another region - this is unlikely	•Clear specification of purchaser responsibility to care for those from another region
Choice of partially integrated DPO	•As below, Choice of DPO - Individual model	•As below, Choice of DPO - Individual model	•As Monopoly HFA, perhaps limited by consumer choice which may force improved performance	•Purchaser performance can be compared with other regional monopoly purchasers •Issues as above, Monopoly HFA	•Cost-shifting from ICOs to HFA may be a problem - see above, Monopoly HFA	•As above, Monopoly HFA

Table 5.1 (cont)

	Crown risk •Increased expenditures to compensate DPOs with riskier profiles •Pressure for additional expenditure Consumer risk •Some consumers left with limited or no choice of DPO and of coverage •Poor quality of care for some consumers as a means of cream-skimming Poor quality of care for some consumers Health sector risks •Inefficiencies and poor cost-effectiveness •Differences in profitability Other risks •Agency may cream-skim, reducing individual opportunities in the economy (e.g., if employers try to avoid those likely to make more claims)	•HFA clearly specify those covered by the carved-out contracts •Monitoring of risk profile of carve-out purchasers •Limit financial risk associated with higher risk people (see text) •Risk rating •Define service entitlement •Regulations - contracts, with sanctions	Crown risk •Poor value for money •Higher overall expenditure •Pressure for increased government-funded health resources •Pressure to bail out purchaser if it runs up deficits •Pressure to provide additional capital operational funding to crown-owned providers which suffer financial losses in the event of a purchaser failure. •Legal action against government-owned purchasers which fail to undertake contracting in fair ways or which bail out of contracts Consumer risk •Poor value for money •Poor access to care •Poor quality care •Higher private expenditure •Poor access to care for those unable to afford private care •Lower health status than would otherwise be the case •Under-servicing of some consumers where costs greater than fee paid •Agency may limit choice of DPOs •Consumers unable to make choices based on quality or price due to lack of information •Consumers assigned to plans Health sector •Poor value for money •Higher levels of private provision •Greater inequity of access to care •Greater inequalities in accessing quality care •Excessive profits or losses where contracting is poor	•Purchaser performance can be compared with other regional monopoly purchasers •Issues as above, Monopoly HFA	•Integration may reduce cost-shifting; otherwise, as above, Monopoly HFA	•As above, Monopoly HFA
Choice of DPO - Individual model	•As above, but agency cannot cream-skim.	•As above	•As above, Choice of DPO, Agency model	•As above, Choice of DPO - Agency model	•Integration may reduce cost-shifting; otherwise, as above, Monopoly HFA	As above, Monopoly HFA

Defining service entitlements is a crucial step in removing an important mechanism for cream-skimming. It also promotes accountability. However, it has disadvantages in reducing choice (especially if there is one DPO only), it may reduce incentives for innovation and is likely to carry a significant cost in administration. It is unclear how detailed service entitlements would be possible within a system which also aims to reduce increased spending pressures by capping budget. However, without reasonably detailed service entitlements, consumers carry significant risk in relation to both cream-skimming and under-servicing (while providers make profits from the care not provided adequately, and pressure for additional spending builds).

Additional regulation is also required to remove opportunities for cream-skimming and to promote universal coverage (e.g., rules which require organisations to accept all those who wish to join). Such regulation again incurs administrative costs, but is essential for setting out 'the rules of the game'.

In New Zealand, David Plank has argued that standardising quality of care takes away an important goal of reforming health care: using competition to improve quality of care (Plank n.d.). (The same may be said of standardising packages of care.) If good information on quality of care is able to be collected and publicised, and plans are not successful at segmenting the market, competition may provide incentives for improving quality of care. The difficulties in measuring quality of care, however, and the potential for quality to be interpreted in terms of facilities and access to new technologies raises alarm bells, however. Any move towards competition is likely to require improved specification of standards of care and the setting of a minimum standard of care, at the very least to promote greater accountability and to try to minimise under-servicing. Without these, government attempts to shift financial risk onto providers and DPOs may simply find that risk passed on to consumers in the form of reduced services or under-servicing.

5.2 Poor purchaser performance

Poor purchaser performance involves more ethereal risks: in a single, monopoly purchaser situation, risks are difficult to detect, and are more difficult to identify and quantify. However, the risks potentially include higher levels of expenditure and lower level of access for the money spent, and excessive profits or losses being made by provider groups[99].

Poor purchaser performance may be a significant risk with one purchaser: this is however likely to be balanced by the potential clout and experience which one large purchaser can bring to New Zealand's health care sector. All other models run the risk of diluting this clout. On the other hand, the other models may lead to reduced risks of poor purchaser performance if for some reason poor performance was systematic within the HFA.

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99 The first risk also has implications for privately financed health care – which in New Zealand has implications for overall efficiency and equity. However, poor purchaser performance may not be reflected in these risks in practice given the large number and range of providers operating in New Zealand.

Managing these risks involves monitoring and benchmarking performance; using rewards and sanctions; promoting franchising and promoting competition between DPOs. In all cases, information problems will bedevil attempts to promote good purchaser performance. Monitoring performance on the basis of outputs, processes and perhaps inputs appears a more feasible approach at present than monitoring on the basis of outcomes: even then, however, there is likely to be a significant investment in information required to monitor performance because of requirements to adjust for health status.

Empirical evidence internationally shows that rewards and sanctions can change behaviour in the health sector. However, perhaps the real problem is in deciding what we are trying to achieve and what constitutes efficient behaviour which should be encouraged. Furthermore, any set of rewards and sanctions is also likely to involve perverse incentives which must be monitored.

Franchising may well offer improved incentives for performance, but its effectiveness in a market like New Zealand's is unproven. Information issues will again be important in determining which DPO managers are 'best' at promoting sector goals. Until we are sure that there is a reasonable skill base on which to draw, franchising is unlikely to work in New Zealand.

Competition between plans may further improve purchaser performance. However, this approach is untested, and brings with it problems of cream-skimming and potentially significant increases in transaction costs. A key issue in New Zealand is the extent to which competition is feasible. The more comprehensive coverage is, the fewer the plans capable of managing risk; if providers are to be able to contract with only one DPO, there is extremely limited scope for competition.

Finally, consideration needs to be given to approaches which maximise our chances of developing 'smart' purchasers, and to the trade-offs with other goals (such as local responsiveness) that this may entail. Whatever happens, however, further development of purchasing skills is an important issue for New Zealand.

5.3 Cost-shifting

The key risks associated with cost-shifting are also potentially numerous. They include: increased government expenditure on votes other than vote: health; increased expenditure for publicly-owned purchaser and provider organisations where costs and patients are shifted to publicly-owned purchasers and providers; increased private expenditure and resource use where purchasers make decisions which shift responsibility for financing onto private budgets; increased shunting of patients; higher overall expenditure, as claims in the private sector increase with more care provided privately at possibly higher cost; reduced equity of access as those who cannot obtain publicly-funded care are unable to afford private care; difficulties in planning and budgeting in areas where costs are commonly shifted to; and inappropriate market signals which might arise as a result of cross-subsidies[100].

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100 Although such cross-subsidies may also enhance equity of access.

Cost-shifting is likely to be a key issue in the current New Zealand environment. Without clarity about the services available to taxpayers and the services expected to be delivered by providers, it is extremely difficult to detect. In devolved purchasing arrangements, incentives for cost-shifting may be reduced if organisations integrate: however, once incentives are designed – even within organisations – to remain within budget, cost-shifting may remain an issue. Where devolved purchasing involves new boundaries (for example, service-specific carve-outs, partially integrated DPOs, or from moves to limit financial risk in order to restrain cream-skimming), new means of cost-shifting may be developed. New Zealanders may well have particular concerns where governments continue to shift costs to individuals, where GP care which replaces hospital care results in more user charges, and where poorly performing local purchasers are unable to deliver care which results in increased private responsibility (e.g. for elective surgery).

The model of devolved purchasing which involves integrated budgets and no boundaries between contracts (e.g., regional monopoly purchasers; fully integrated DPO models) may not suffer from as much cost-shifting as the present model (with so many fragmented providers), the carve-out model and any approach which divides responsibility up for different types of care (e.g., the partially integrated DPO model; models which limit risk). There will be important trade-offs made between approaches which aim to limit risk in order to prevent cream-skimming and incentives for cost-shifting.

Whatever happens at the DPO or provider level, cost-shifting can also be an issue between publicly-financed and privately-financed care. The present government's intention is to clarify these boundaries in relation to hospital elective care, but as yet no moves appear to have been made to identify the extent of cost-shifting or to put in place policies to prevent cost-shifting via changes in the primary-secondary care interface.

Beyond integration, the key approaches to managing cost-shifting are to clarify boundaries between budgets, or to develop practice and referral guidelines. Monitoring of these boundaries and guidelines will also be required.

5.4 An optimal solution to managing these risks?

There is no one set of optimal solutions to managing each of these risks. Rather, there is a set of trade-offs between the management options. For example,

- Management options for cream-skimming: Encouraging large risk pools reduces the potential number of competitors for benchmarking and purchaser competition but may strengthen purchasers by enabling them to develop expertise. Limiting risk provides opportunities for cost-shifting. Defining service entitlements also reduces opportunities for under-servicing.

- Management options for poor purchaser performance: Benchmarking performance may provide information to detect under-servicing leading to cream-skimming. A desire to develop smart purchasing may however reduce opportunities for purchaser competition.

- Management options for cost-shifting: Integrating budget responsibility may also lead to the encouragement of large risk pools and hence to reduced potential for benchmarking and purchaser competition. Developing practice and referral guidelines should also assist in reducing opportunities for under-servicing and hence also for cream-skimming.

A key question, however, for further consideration is whether or not to promote devolved purchasing rather than a relying on a single purchaser. The disadvantages of devolved purchasing include the key risks identified here: in particular (where there is no competition between purchasers) the risks associated with poor purchaser performance. Further analysis is also needed in relation to the respective system-wide advantages and disadvantages of i) the present situation (a single purchaser), ii) devolved (non-competing) purchasing and iii) devolved purchasing and purchaser competition.

The mechanisms for dealing with poor purchaser performance relating to developing better information systems do not change across these options: although the greater the number of purchasers, the harder it may be to have confidence in the statistical significance of performance analyses. With purchaser competition, the more pressing issues are those related to cream-skimming. In thinking about the advantages and disadvantages of purchaser competition, the analysis here suggests there will be high regulatory costs associated with purchaser competition and large potential effects in relation to equity of access. This paper in particular has focused on the regulatory framework which may be required to ensure an efficient and equitable approach to both devolved purchasing and purchaser competition: this framework now must be considered in the context of the perceived advantages and disadvantages of further moves to devolved purchasing and purchaser competition.

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APPENDIX A
GLOSSARY OF TERMS AND ABBREVIATIONS

Adverse selection	Where individuals choose a devolved purchasing organisations or provider on the basis of the services provided, and some plans or providers end up with a registered population with higher health needs than on average. With a standard, unadjusted capitation formulae, such plans or providers will find it difficult to provide good care within the budget made available.
Capitation	Where individual providers or organisations are paid an amount per person registered with them, for providing care over a period of time (a month, a year). A flat capitation rate is one where the amount paid per person is the same for each and every person registered (e.g., $200 per person per year).
Cost-shifting	Where costs are charged against a budget which a) differs from that intended or b) differs from that traditionally charged.
Cream-skimming (Risk-selection)	Where plans or providers actively engage in practices which lead to a registered population which has lower health needs on average, in order to reduce expenditures. They may do this by encouraging healthy people to join, and discouraging those with poorer health from joining.
Devolved purchasing	Any purchasing strategy or policy which allocates responsibility for purchasing groups of services (e.g., pharmaceuticals, secondary care services, community services) to non-government organisations other than the Health Funding Authority (HFA). Organisations other than the HFA then become responsible for negotiating contracts with other providers and fund such services from budgets allocated to them.

Efficiency[101]	*Technical efficiency* is obtained when effective services are provided at least resource cost, i.e. using the minimum amount of resources necessary. *Cost-effectiveness* is obtained when resources are concentrated on effective services, provided at least cost, that offer the best payoff in terms of health.
Enrolment	Where individuals enrol with a particular DPO or provider, whose role it is to organise the care of those who are enrolled.
Equity	Providing fairer access to care and improving the health of the most disadvantaged.
Health Funding Authority (HFA)	The principal funder of health and disability support services in New Zealand. The HFA is a crown agency, and receives its funding from the Government.
Health Maintenance Organisations (HMOs)	United States health organisations, which receive capitation funding from employers and individuals to insure and arrange the delivery of health care to individual members.
Health Care Outcome	A change in the health of an individual or population attributable to a particular health service, e.g. reduction in blood pressure; restoration of mobility following a hip operation.
Health Outcome	A change in the broader health of an individual or population, e.g. increase in average life expectancy, reduction in vaccine-preventable disease, reduction in cancer rates.
Independent Practitioner Associations (IPAs)	Umbrella organisations representing groups of GPs who negotiate budgets and contracts with the HFA on behalf of those GPs.
Integrated care	See managed care.

101 See Culyer (1991) for further detail.

Managed care	A term used to describe a range of practices and organisations, usually 'any system of health service payment or delivery arrangement where the health DPO attempts to control or coordinate use of health services by its enrolled members in order to contain health expenditures, improve quality or both' (Physician Payment Review Commission 1996 cited in Managed Health Care Improvement Task Force 1998).
Monopsony	Where a single purchasing authority is responsible for purchasing.
Risk-rating	Where flat capitation rates are adjusted for differences in the health status of populations or individuals. For example, payments for older people may be 1.5 times payments for all other people, as a result of having a higher 'risk' of needing health care.
Risk-selection	See cream-skimming.

APPENDIX B
INTEGRATED CARE

There are a range of definitions of integrated care, as well as a range of techniques which might be encompassed by integrated care organisations and a range of organisational forms of integrated care. This section briefly considers the different techniques and organisational forms of managed care. Key techniques are set out in Table B.1; key organisational forms in Table B.2.

Table B.1
Techniques of Integrated Care

Technique	Explanation of technique
Financial incentives *Organisational level* Payment through pre-paid capitation (i.e., in advance, monthly or annually uniform fee per enrollee independent of the level of service provided).	• Designed to provide an incentive to avoid unnecessary use of services. • Defined budget may make it easier to plan for an efficient use of services.
Provider level Range of financial incentives to encourage cost-effective use of resources	
• capitation	• Incentive to economise on use of resources
• discounting with volume guarantees	
• deny payments for services which don't meet pre-specified appropriateness standards	• E.g., where no clinical benefit or where care could be provided in a lower cost setting
• bonuses	• Designed to influence referral behaviour. Commonly paid to primary care doctors who keep referral rates low, ideally by eliminating unnecessary referrals
• penalties	• Applied to doctors with a high number of inappropriate referrals
• withholds	• Percentage of doctor's payment is retained against a potential deficit in the referral fund
• financial risk-sharing through ownership	
- individual risk	• Calculated on the basis of each individual doctor's performance
- ancillary risk	• Assumed when payment for outpatient tests drawn from funds which would otherwise be part of the doctor's income
- specialist risk	• Where a specialist opts to share in the organisation's risk-bonus structure
Techniques for managing clinical activity	
Utilisation review	• These approaches form the crux of integrated care • Attempt to reduce unnecessary care by scrutinising use of services, with a focus on individual cases
• prospective or pre-authorisation	• Requires permission to seek treatment, usually for specified categories of care
• concurrent	• Dominant form in the USA • Assessment of progress against care plans • Typically used to monitor/limit hospital length of stay and to control use of ancillary services
• retrospective	• Audit of individual patient claims and charts • Sometimes there is only feedback; other times financial penalties
• mandatory second opinions	• Sometimes required to confirm that specific treatment e.g. surgery is medically indicated and that alternative approaches are not available which would be more cost-effective
• peer review	• Used as part of the above approaches to ensure credibility with physicians • Peer review panels make decisions about what constitutes effective and appropriate care

Technique	Explanation of technique
Medical or practice profiling	• 'Statistical analysis and monitoring of data…to gain information about the appropriateness of care' (Cave 1995) • Reviews all a doctor's cases over a specified period against a practice-based or standards-based norm • Using such information, efforts are made to change clinicians' behaviour • Some organisations disseminate profiles to all their doctors, others to specific doctors whose behaviour requires modification • Requires standardised data and case adjustment
Disease management	• Involves the development of integrated packages of care across an entire spectrum of disease • Applied particularly in the case of chronic illness • Goal is to reduce the number of patients requiring serious or extended, costly, care • Stages include: • - assessment of alternative interventions to identify and project relative resource costs • - development of treatment guidelines and protocols • - negotiation or risk-sharing and case management agreements between programme partners • -engagement in strategies to modify clinical and patient behaviour, through educational interventions (cited in Robinson and Steiner 1998, pp. 22-23)) • Requires information systems to identify people at risk, intervene with specific programmes and measure clinical and other outcomes
Clinical guidelines	• Represent a consensus approach to the treatment of typical patients with a specific diagnosis • May be developed by an integrated care organisation or by an outside agency • Can be in the form of recommendations or detailed algorithms • Frequently seen as a threat to clinical freedom and a 'bureaucrat's tool which is unable to reflect the complexities of diseases and disabilities as experienced by individual patients' (Robinson and Steiner 1998, p.23) • Much attention devoted to clinician education in order to change behaviour
Patient-focused techniques	
Gatekeeping	• Contrasts with direct access to specialists • Shifted attention to primary care as an entry point to the health care system and often as the final point of treatment • Generalist doctors – general practitioners, family doctors and internists – treat patients for as many services as possible and manage access to secondary and ancillary care
Case management	• Resembles gate keeping as there is a single point of entry into the system, via a person who is responsible for co-ordinating care • However, case manager may not be a direct provider of care • Begins with a formal assessment of social and medical needs
Queuing and watchful waiting	• Techniques to slow the rate of resource use and to limit over-aggressive treatments (e.g., in case a condition is self-limiting)
Primary prevention	• Emphasis on primary prevention aims to promote better health and to prevent costly hospital admissions • Benefits packages include comprehensive range of preventive services, e.g. cervical cancer smear tests,

	mammography, hypertension and cholesterol testing; immunisations; counseling for smoking, diet, stress and exercise
Self-care	• Provision of educational materials and workshops for health promotion and first aid

Source: summarised from Robinson and Steiner (1998).

Table B.2
Organisational Forms of Integrated Care[102]

Organisational Form	Key characteristics
Health Maintenance Organisation (HMO)	• A population defined by enrolment in the plan • A contractual responsibility to deliver a defined range of services • Prospective budget based on capitation payments to the plan • HMO acts as a purchasing agent in negotiating terms of payments with doctors • Restricted choice for patients between providers • Financial risk shared with doctors • Fixed annual or monthly payments to doctors • Control over doctors' practice and referral patterns
Staff model HMO	• Full integration of insurance and service delivery • HMO employs own doctors and pays them a salary – gives ability to employ doctors with particular practice styles • May own hospitals or contract with them • Usually doctors do not bear financial risk
Pre-paid group practice HMO	• HMO has exclusive arrangement with one or more large capitated medical groups • Insurance and service delivery separated but work closely together
Network model HMO	• Insurance and service delivery separated • Arms length relationship; does not contract exclusively with medical groups • Each medical group treats only HMO enrollees
Independent practice association (IPA) HMO	• One version: • Insurer contracts directly with multiple solo or small-group practices • Second version: • Solo or small-group practices form a practice association which then contracts on a non-exclusive basis with an insurer. • Degree of risk-sharing varies • Degree of management control also varies
Mixed model HMO	• Insurer makes different contractual arrangements with provider organisations and networks • Arrangements may or may not be exclusive
Preferred Provider Organisation (PPO)	• Insurance plans which offer lower premiums because they negotiated fee-for-service discounts with particular doctors and hospitals in return for a guaranteed volume of work, within a utilisation-controlled environment • Typically a third-party insurer; sometimes a large employer, government, broker or provider • Usually doctors are solo or small group practice practitioners • Enrollees continue to have choice of provider, but co-payments are usually higher for non-preferred providers
Point of Service plan (POS)	• Hybrid model, ranging from open-ended HMOs to PPOs with a gate-keeper function • Essential feature is that when an enrollee needs service, this may be obtained from an out-of-network provider, in return for a substantial co-payment (e.g., use POS panel member, no co-payment; out-to-panel provider, 20 per cent co-payment) • Panel doctors usually paid on a capitation basis; out-of-panel doctors on a fee-for-service basis
Primary Care Case Management (PCCM)	• Medicaid managed care organisation • Central feature is gate-keeping, i.e. referrals for services other than primary care • All primary care provided by doctor of choice or where enrollee assigned to a specific doctor • Aims to improve primary care, improve continuity of care, reduce unnecessary emergency room use

102 Robinson and Steiner note that the HMO represents the 'quintessential form of United States-managed care'. HMOs date back to the 1930s and 1940s, but their growth accelerated in the 1970s and 1980s. In recent years, it is the IPA form of HMO which has shown the most growth in HMO enrollees. However, the choice of provider offered by PPOs has seen PPO arrangements encouraging the most rapid growth in enrollee numbers in the 1980s (Robinson and Steiner 1998, pp. 9-12).

	• Case managers strongly accountable • Range of other characteristics

Organisational Form	Key characteristics
Social Health Maintenance Organisation (SHMO)	• Demonstration projects • Involves 'non-physician case co-ordinators' • Combines social and health care, both acute and long term, into a single case-managed delivery system • Targeted at elderly Medicare beneficiaries (65 years or over) • Aims for an integrated approach to older people's health and social care to improve appropriateness of care and to reduce long-term care expenditure • Co-ordinators assess needs and arrange for provision of services • Salaried co-ordinators are subject to utilisation review but bear no financial risk • Constrained by range of services included in SHMO package, but is comprehensive as includes: hospital, physician and home health services; chronic care benefits such as personal care, homemaker services; nursing home coverage; expanded benefits such as prescription drugs, eye glasses and dental care • SHMO is able to limit the number of highly dependent new enrollees
Programme of All-Inclusive Care for the Elderly (PACE)	• PACE enrollees are all at risk of nursing-home placement • Most are low income, 55 years or over • Members are enrolled on a Medicaid capitation basis, with Medicare covered services billed on a fee-for-service basis • Each site may negotiate Medicaid/Medicare capitation payments with providers • Sites may develop benefit packages not allowed under existing programmes • Full range of primary, acute and long-term services • Multi-disciplinary case management and day case centres feature predominantly
Vertically- integrated providers	• A new form of organisation • Same group owns and manages services in primary, secondary, post-acute and sometimes long-term care sectors • Such groups contract with insurers (usually fee-for-service) to offer services along full continuum of care • Referrals generally made within the system • Overall clinical practice is managed centrally • Designed to promote delivery of care in the most cost-effective manner possible • Use range of integrated care techniques, especially utilisation review

Source: summarised from Robinson and Steiner (1998).

APPENDIX C
PURCHASER COMPETITION

Purchaser competition – where DPOs compete with each other for members – is only rarely promoted without a significant regulatory framework around it to promote equity and efficiency. Most commonly, purchaser competition is debated in the form of 'managed competition'.

The managed competition literature is largely focused on reform proposals for the United States, although other countries have adopted aspects of the model. In the United States, the idea of encouraging competing pre-paid, capitated integrated networks of purchaser/providers was first put forward by Paul Ellwood in 1971 (Ellwood, Anderson et al. 1971). Among the first formal proposals were those suggested by Herman and Ann Somers in 1972 and 1973; their proposals included a top-down global budget and was entitled 'regulated competition'. The more well-known managed competition proposals were developed by Paul Ellwood and Alain Enthoven and a group known as the 'Jackson Hole Group'. Members of the group have been meeting since the mid-1970s and have developed a comprehensive set of policy proposals for managed competition reform (Ellwood, Enthoven et al. 1992; Ellwood and Enthoven 1995). Much of their work informed the Clinton plan (known formally as the President's Health Security Plan), other United States Federal reform plans which were hotly debated in the early 1990s, and some United States health care reform at the State level.

Managed competition

'Management' (or regulation) of competition occurs in various ways in these proposals, but usually includes:

- the establishment of purchasing co-operatives. Such co-operatives are designed to: allow the pooling of risk by taking on the responsibility for managing the market for health plans for individuals and people employed by small firms; achieve economies of scale; cut the administration burden for small firms by offering an informed purchaser who can act on behalf of small firms; offer choice of plans to consumers; and manage competition amongst plans. Their roles include: selecting health plans for consumers to choose between; providing information to consumers about, and monitoring the performance of, health plans; interpreting benefits contracts; and resolving complaints (Enthoven 1993);

- the encouragement of vertically integrated purchaser/providers ('health plans', i.e. DPOs), with providers employed by or contracted to health plans. In some versions, each provider (especially primary care physicians) is only employed by or contracted to one health plan, in order that provider practice be influenced by only one plan[103];

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103 Enthoven (1988) describes the following inefficiencies if an IPA model were used with each physician belonging to ten plans: 'each doctor would have to deal with the utilisation controls and fee

- consumer choice of health plan, i.e. competition between health plans for consumers, which might also involve some form of consumer contribution towards premiums in order to encourage cost-conscious choice. In most proposals, consumers would have the choice of switching plans only once every year;

- mechanisms to ensure that health plans take on all consumers who apply, to ensure that everyone is covered and that health plans don't exclude consumers for e.g., pre-existing conditions ('open enrolment');

- standard packages of benefits. Some versions would prohibit balance billing and supplementary insurance covering co-payments and additional services;

- financing arrangements in which individuals pay premiums which are community rated, i.e. which are the same within age-gender bands, or where variations in premiums are limited;

- pre-paid capitation payments to health plans in order to encourage efficiency in the use of resources;

- in some managed competition models, an expenditure cap would also be placed on total health expenditure. There is however some controversy about how the cap would fit with managed competition proposals, which are designed in part to help determine an appropriate level of health expenditure. However, some commentators believe that without an expenditure cap, limits on expenditure growth will not be guaranteed by managed competition alone; and

- strong relationships between plans and providers of health services. In some cases, purchasers and providers may be integrated into the same organisation; in other cases, contractual arrangements link purchasers and providers. These relationships are often assumed to include arrangements which share risk with providers (see Appendix B, Table B1.2 for examples of the organisational forms of integrated care organisations).

(See for example Enthoven 1988; Enthoven 1988; Enthoven and Kronick 1989; Pauly, Danzon et al. 1991; Pauly, Danzon et al. 1992; Congressional Budget Office 1993; Enthoven 1993; Enthoven 1994; Ellwood and Enthoven 1995; Enthoven and Singer 1995; White 1995).

These arrangements imply the development of health plans and the provision of information to consumers to help them choose between health plans. Usually, they are also structured to ensure that all people are covered: hence the requirements for open enrolment.

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schedules of ten health plans, none of which would command his [sic] loyalty. If one health plan persuaded a doctor to adopt a more efficient health practice, the benefits would be likely to be spread immediately over all ten plans, reducing the incentive of any plan to make the effort to pursue innovation at the provider level'.

Premium payments under managed competition

In addition, proposals usually note that in a competitive market with profit-maximising insurers, consumers will be charged premiums based on individual and family risk. Many proposals break the link between financing and payment to health plans at this point: either by collecting premiums via taxes or social insurance schemes and allocating them to plans via a separate process; or by requiring community rating of premiums (i.e. not based on risk). These arrangements are designed to promote equity by improving affordability, but they have their own risks: chiefly the encouragement of cream-skimming. If capitation payments to health plans are not adjusted for the risk associated with individual consumers, then plans have an incentive to exclude higher risk consumers from joining up (an *ex ante* approach); and incentives to actively encourage consumers found to be high risk to disenrol (an *ex post* approach).

The policy response to these problems varies in proposals for managed competition, in large part relating to the relative weight that analysts place on market versus regulatory responses.

Benefits of managed competition

The perceived (theoretical) benefits from managed competition are usually stated in contrast to the existing United States health care arrangements. Benefits for the United States are universal coverage, and enhanced incentives for promoting efficiency arising from the integrated nature of the health plans; the prospective payment system which would replace fee-for-service medicine; competition between plans; and the expenditure cap. In the United States context, the reforms may lead to less choice (or provider), more limited access to providers, fewer services and slower access to new technologies, greater involvement of plans in provider practice and lower provider incomes (Congressional Budget Office 1993).

There are, however, some uncertainties about the extent to which competition between competing health plans will promote innovation, improved efficiency and improved services and choice for consumers. This will depend on the way in which the plans choose to compete and to contract with providers and the extent to which competition can develop for different population groups, including high risk groups and those in geographically isolated communities (Congressional Budget Office 1993; Plank n.d). Furthermore, a key driver of improvements in care will be the choices that consumers make in relation to plans. A lack of experience in choosing between plans and a lack of good information on plan performance may limit any potential benefits of competition.

APPENDIX D
PURCHASER COMPETITION IN NEW ZEALAND

Characteristics of the existing New Zealand health care system

The implications of devolved purchasing and purchaser competition must be considered in relation to the context in which such changes takes place. New Zealand's health care sector has some unique features which must be carefully considered in analysing the risks and benefits of such moves. These features include:

- largely government financing of health and disability care, with an increasing proportion of expenditure financed privately. For the purposes of this paper it is assumed that health care in New Zealand will continue to be financed via a mildly progressive tax system and that government spending will remain at around 75 per cent of total health care spending. Thus, the issue of ensuring that all New Zealanders have access to health care becomes one of ensuring that all New Zealanders are registered with an DPO, that there is an DPO on which they can fall back or which is charged for unregistered consumers who need care[104];

- historically, a health care system which is government financed and organised with the aim of maximising the welfare of society. Consumer choice is largely limited to choice of primary care provider; whether to purchase private insurance; and whether to pay privately for care not covered by the publicly funded system (e.g., osteopathy, acupuncture, chiropractic). Where moves are made to devolve purchasing responsibility which requires registration with only one primary care provider, this will involve New Zealanders in a new way of thinking about health care. Similarly, in thinking about purchasing competition, New Zealanders are not used to an insurance-based model which offers choices in coverage or purchasing agent, while providers are only just becoming used to a contracting model;

- a small, geographically dispersed population. This may offer limited opportunities for competition between DPOs. There are likely to be trade-offs between the need for large plans to manage risk where there is comprehensive coverage (i.e., including secondary and tertiary care, long-term care), and a desire for competition, a range of DPOs to suit culturally diverse populations,

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104 It is possible for the system to move to a social insurance model, with premium payments rather than taxes. These can be set at a set percentage of income or can be adjusted for risk (as is done with ACC). It is also possible to remove the government from the financing role, with DPOs collecting premiums themselves. These options would change the nature of financing of health care. Key disadvantages would include issues of affordability the more premiums are determined based on risk, and rising transaction costs from each DPO having to collect its own premiums. See (Upton 1991) for a discussion on financing issues.

and networks in which individual practitioner decisions have more than just small consequences (Haas-Wlison and Gaynor 1998)[105];

- a large number of providers, particularly in primary and community health and disability care. These arrangements are often argued to result in duplication, gaps and a lack of continuity of care. The implications of this for New Zealand are a) there are likely to be high transaction costs in encouraging DPOs to contract for a comprehensive set of services (for example, without further integration in management or ownership, DPOs (just like the RHAs and HFA) would have to contract with numerous providers; considerable amalgamation of largely independent providers is required to move to comprehensive DPOs if complex and costly contracting arrangements are to be avoided; and b) continued separation of providers offers opportunities for cost-shifting;

- a lack of horizontal integration of providers; an ability for some providers to charge patients unlimited fees in the form of user charges; and an availability of supplementary insurance coverage. Each 'boundary' offers excellent opportunities for cost-shifting;

- a small number of secondary care providers, largely government-owned; there are very few tertiary providers (e.g., for organ transplants); and in some rural areas there may also only be few providers (e.g., GPs). This also raises issues about the likely extent of competition, and suggests there may be high transaction costs where competing DPOs contract for comprehensive care (e.g., the more specialised hospitals will have to have contracts with a number of DPOs);

- significant user charges for some groups in the population for primary care. This raises issues relating to affordability of primary care, and may act to prevent improvements in cost-effectiveness because patients will resist attempts for more care to be delivered in primary care settings. This boundary also provides opportunities for cost-shifting;

- good cost control over government-financed secondary and tertiary care; demand-driven primary care which leads to uncontrolled primary care expenditure[106];

- beyond licensing requirements, a limited government regulatory framework for health care. The lack of regulation in New Zealand health care may make it more difficult to introduce new regulations where they are seen as appropriate;

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105 Luft notes that since market reforms have been introduced in California, health maintenance organisations have been consolidating, such that in 1996 four large plans accounted for 66% of total enrolment (Luft 1996). Haas Wilson and Gaynor note that it is predicted that within the next 5-10 years there will be only three to seven health care networks in California (Haas-Wlison and Gaynor 1998).

106 The HFA is currently consulting on plans to shift GPs from fee-for-service to capitated contracts. Pharmac is also presently using market mechanisms to reduce pharmaceutical expenditure. Both improve the government's ability to contain its health care expenditure.

- poor information systems and a lack of integration between systems. Although secondary care providers are used to providing detailed information on outputs, primary care providers appear to be somewhat reluctant to share such information;

- the inclusion of disability support services (DSS) in the New Zealand health care system. This may have implications for risk pooling and the spreading of risk; and

- government ownership of key hospitals, with private ownership in primary care and disability support. This distinction may offer opportunities for cost-shifting, while a public distaste for further private involvement in health care is likely to make further moves to integrate care politically unpopular.

Implications for purchaser competition

The studies reported in the main body of the paper suggest that the effects of competition between health care providers is heavily dependent on the market structure – the relative position of insurers, physicians and hospitals -, and approaches to contracting. Given the right circumstances however – including a large number of competing hospitals, a good supply of physicians and selective contracting – competition can lead to reduced prices. There is however limited evidence on the effects on quality of care, while the United States evidence is very likely to reflect a massive oversupply of beds, built up in earlier times when costs were simply reimbursed. In relation to purchaser incentives, it appears that HMO competition has altered the approaches used by traditional insurers; however, the implications of competition between HMOs compared to no competition remain unclear, as do the implications of the combination of competing HMOs and a number of competing hospitals compared, for example, to a situation of bilateral monopoly.

A key question for consideration in New Zealand is: how much competition between providers and purchasers might develop in New Zealand?

Competition in New Zealand health care

There are a number of characteristics that markets must fulfil to be called ‘competitive’: freedom of entry and exit, perfect information about prices and quality; and a large number of firms and consumers. Whether or not a market is ‘competitive’ contrasts to whether or not a market is ‘contestable’, that is whether or not there are significant barriers to entry that prevent new providers entering the market.

Provider competition

New Zealand is a small country with a geographically dispersed population. Thus, there is likely to be little competition for the most technologically advanced hospital

services; in fact, the Tertiary Services Review has suggested that positive and strong relationships between outputs and outcomes warrant fewer hospitals providing such care (Ministry of Health 1995). Thus, for liver transplants, for example, only one provider (Auckland Health Care) exists in New Zealand.

The National Interim Provider Board considered in 1992 that competition in 24-hour acute hospital care was limited, and may well stay that way given the need for 'continuous provision of staffing, spare beds and equipment capacity to cope, at zero notice, with unpredictable needs' (National Interim Provider Board 1992, p. 56). This situation remains so today.

It would appear that the potential for competition for medical and surgical services is greater now than at the beginning of the 1990s. Medium-sized private hospitals offering a range medical and surgical services appear to be available in: Whangarei; Auckland (Epsom, Glenfield); Hamilton; Tauranga; Rotorua; Matamata; New Plymouth; Napier; Palmerston North; Wanganui; Wellington (Newtown; Lower Hutt, Crofton Downs); Masterton; Blenheim; Christchurch; Dunedin; Invercargill[107]. The level of service offered at each of these hospitals requires further research, however. In addition, the Calan Group is currently building a state-of-the-art hospital in Ellerslie, in Auckland.

In their 1997 paper, Ashton and Press examined the degree of market concentration in selected secondary care services: tonsillectomies or adenoidectomies; prostatectomies; hip replacements; knee replacements; cataract removal; angioplasties; and coronary artery bypass grafts. They considered the geographic area from which each provider draws its patients and the extent of market concentration within those areas using the Hirschman-Herfindahl index. They found the seven markets to be reasonably concentrated, although none consisted of a monopoly provider, but noted that these results confirmed 'the expectation that patient flows generally reflect residential patterns' (Ashton and Press 1997, p.54).

Ashton and Press concluded that potential efficiency gains from competition might be expected to be less under this concentrated market structure than under a more competitive structure. They noted however the ability of the then four RHAs to wield monopsony power, which might constrain providers to some extent. In a market with competition at the purchaser level as well however this ability would be weakened and we might expect more concentrated markets to have higher prices than less concentrated markets.

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107 Private hospitals offering medical and surgical care, listed in Ministry of Health (1998). In addition, there are specialist clinics in Auckland for eye surgery, endoscopy; and special day surgery clinics at the North Shore, Whangarei, Tauranga, Rotorua, Hastings and Christchurch. Southern Cross owns hospitals in Auckland (3), Hamilton, Tauranga, Rotorua, Napier, New Plymouth, Wanganui, Palmerston North, Wellington, Christchurch and Invercargill (Southern Cross Healthcare 1994). The Ministry of Health report does not provide detail on the services provided beyond 'surgical, medical'. It is not clear for example if some of these providers offer largely cosmetic surgery.

As noted by Ashton and Press, increased participation of the private sector in health care markets in New Zealand could reduce concentration. In making purchasing decisions, the RHAs were able to engage in competitive tendering for some secondary care services. However, their experiences with such competition were mixed. For example, prices sometimes rose as a result of competitive tendering, because CHE deficits continue to be subsidised by the government and CHEs sometimes sought to fully cost their services and add a further margin of around 5-10 per cent when tendering for additional contracts (Lovatt 1996). Private sector prices were often been uncompetitive (Wilson 1995; Ministry of Health undated). There were also concerns over potential discontinuities in service delivery (Foster 1994; Lovatt 1996; Ministry of Health undated), difficulties in specifying the services RHAs wish to buy with sufficient precision (Organisation for Economic Co-operation and Development 1996), and difficulties in defining the boundaries between contracts (Lovatt 1996).

Secondary care markets might be argued to be likely to become more competitive only in the main centres. The entrance of the Calan group into the Auckland market certainly suggests that barriers to entry may not be as great as might have been expected. Yet the question remains as to the overall effect of such competition on prices in the sector. Duplication of expensive equipment and falling average numbers of patients treated with such equipment can lead to rising prices per patient treated, and in the extreme cases, to falling quality as the expertise and experience is reduced in each centre as numbers treated fall.

An additional factor is the extent to which more cost-effective ways of treating patients can develop as a result of competition between, for example, hospitals, GPs and other providers. International trends here include the shift from inpatient to day-patient and out-patient care; the movement of elderly people into nursing homes; the movement of people with ongoing mental health needs into communities in many countries; using generalists rather than specialists to provide care for people with serious mental illnesses; and the increasing ability of professionals to undertake surgical operations in smaller clinics. There is limited evidence that each of these trends is cost-effective, with much work to be done to evaluate such changes fully[108]. Reinhardt for example argues that much of the perceived improvement in cost-effectiveness in the United States comes from not fully considering the differences between marginal and average costs and that 'many transfers to alternative sties often would not make sense at all if the were evaluated on the basis of truly <u>incremental</u> costs' (Reinhardt 1997, p. 38, emphasis in original). This suggests that hospitals will continue to bear the overhead costs, and will either try to recover them via higher prices, including across other services, or will incur ever increasing deficits until they are able to reduce the overhead costs themselves. This analysis is, however, only applicable in the short-run. In the longer term, as hospitals are able to close wards completely and quit buildings, it may well be more efficient to have care delivered in the community. This may take a number of years to achieve.

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108 Some of these changes, for example the move in the United States to outpatient care rather than inpatient care, are the result of changes in payment methods and cost shifting to uncapped budgets.

Perhaps a key issue in New Zealand is the supply of specialists. Work is currently underway to reduce barriers to the supply of specialists in New Zealand; this work will be crucial to expanding choice and competition. However, it is not clear to me that we will ever be in a position of over-supply of specialists. In the presence of selective contracting – either from primary care providers or purchasers – competition between specialists may well improve quality of care. Whether or not it will reduce costs in the publicly funded health care sector may depend on changes in the salary levels of specialists. Currently specialists earn much higher rates of income in the privately-funded sector than they do in the publicly-funded sector: any moves to a situation where they must work in one or other sectors will probably lead to higher costs in the publicly-funded sector[109].

New Zealand's primary and community care markets[110] may be much more competitive than our secondary care markets[111]. For example, in most urban centres there is a choice of GP for diagnostic and primary treatment care. There are a number of pharmacists and laboratories in most larger centres. Women have a choice between midwives and GPs in many centres, although there is speculation that the choices are reducing in some parts of the country. There is increasing interest in up-skilling GPs to provide care for patients previously cared for in hospitals: the move to a certificate for GPs for mental health is an example.

However, many rural towns have little or no choice when it comes to even GP care. GPs in such towns are increasingly being asked to up-skill in order to stabilise patients before patients are transported to the larger centres; but a number of rural towns arguably have tremendous difficulty in recruiting and retaining GPs. Moves to allowing nurses to prescribe some medicines, for example, may improve access for some people to care, but with limits to be placed on prescribing, service gaps in some towns are likely to remain. Telemedicine may improve access to some specialist care in the future, but the effects are still uncertain.

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109 Unless the supply of specialists increases dramatically.

110 Care which is delivered in a community setting as opposed to a hospital.

111 In some areas, however, there are workforce training issues to be considered before we can be confident that good quality services are delivered in the community. Community mental health and Mâori providers are good examples.

APPENDIX E
STANDARDISATION OF BENEFIT PACKAGES

Additional reasons for standardising benefit packages include:

- to facilitate value-for-money comparisons and to focus comparison on price and quality (Enthoven 1993);

- to combat market segmentation – the division of the market into groups of subscribers who make choices based on what each plan covers (such as mental health or vision care) rather than on price (Enthoven 1993) – such segmentation would minimise those who change plans because of price;

- to reassure people that it is financially safe to switch plans for a lower price with the knowledge that the lower-priced plans did not realize savings by creating hidden gaps in coverage (Enthoven 1993);

- to remove the potential for biased risk selection to reduce the demand elasticity for health plans that enrol a favorable mix of risks (Enthoven 1993);

- to ensure all individuals have adequate and comprehensive coverage, to reduce free-riding by those who may feel they will get care even if they have not purchased insurance and to reduce the risks of people delaying care when they need it (Pauly, Danzon et al. 1992);

- to encourage the use of care that individuals would not choose on their own but that will benefit others with altruistic concerns (Pauly, Danzon et al. 1992);

- to facilitate movement between health care plans – a move to an alternative plan will not lead to dramatic changes in coverage; and

- to help contain health care costs by carefully considering the services to be covered (Ellwood, Enthoven et al. 1992).

APPENDIX F
SERVICE SPECIFICATION IN THE NETHERLANDS

The Netherlands health care system – a mix of a social insurance and private insurance – makes a distinction between normal medical expenses and exceptional expenses associated with long-term care or high-cost treatment. The latter is governed by a compulsory national insurance scheme (the Exceptional Medical Expenses Act), which covers all those living in the Netherlands. The former involves a variety of arrangements governed by the Health Insurance Act. Up to age 65, all those earning below a certain income (in 1995, around $NZ60,000) and those on social security benefits are compulsorily insured; those over 65 are also compulsorily insured provided they earn less than around $NZ31,000 (in 1995).

In 1995, around 63% of the population is covered by the Health Insurance Act; schemes for civil servants cover around 5% of the population. Around 32% of the population has private health insurance. All schemes include occupational injury and disease.

Source: (Ministry of Health 1995) (including an update as at 1 January 1996).

Exceptional Medical Expenses Act – Entitlement to care

- Admission and stay in hospital (nursing care in other than psychiatric hospitals and wards, in the lowest class of accommodation, after the first 365 days; similarly, admissions to an 'ordinary' hospital from a psychiatric hospital or ward or teaching hospital or sanatorium for TB patients. Also covers medical and obstetric examinations and treatment by a specialist; may include transplantation and organs and tissues. 'Admission is authorised wherever in-patient treatment and care are reasonably indicated by the patient's medical condition'.

- Nursing-home care and care in a home for the physically disabled (including accommodation, nursing care including 24 hour care, medical treatment under the supervision of a nursing home doctor, associated rehabilitation, physiotherapy, occupational therapy. 'Admission requires an authorisation from the insurer and must be accompanied by a statement of grounds from the attending physician'.

- Care of the disabled in Het Dorp in Arnhem (a special village for the disabled in Arnhem).

- Placement in a hostel for the physically disabled.

- Placement in a day centre for the physically disabled.

- Day care in a nursing home.

- Services of a home nursing organisation.

- Rehabilitation (over a year).

- Admission and stay in a psychiatric hospital or the psychiatric ward of a general or teaching hospital (tests, treatment including observation and counseling, associated and other care in a therapeutic environment.

- Services provided by a Regional Institute for Out-patient mental health care.

- Services provided by a regional organisation for sheltered accommodation.

- Non-clinical psychiatric care (a maximum of 90 sessions of individual psychotherapy lasting up to 45 minutes each).

- Psychiatric out-patient services (for up to two hours a day).

- Part-time psychiatric treatment (day or night centre for up to at least four consecutive hours).

- Care of the blind and partially sighted (tests, treatment, counseling and full-time or out-patient admission to an institution with the aim of fostering and sustaining self-reliance).
- Care of the deaf and partially hearing. (In an establishment).
- Care of the mentally handicapped.
- Placement in a day centre for the mentally handicapped.
- Admission and stay in a hostel for the mentally handicapped.
- Testing for the hepatitis B virus in pregnant women.
- Testing for congenital metabolic disorders (PKU).
- Vaccinations (diphtheria, whooping cough, tetanus, polio, mumps, rubella, HiB, measles.)

Health Insurance Act – Treatments and services

(Generally free at point of use, with some charges for dental treatment, maternity care at home or in hospital, transport other than by ambulance.)

- Services of a genetic testing centre (including tests for hereditary defects, genetic counseling).
- Pharmaceutical services (medicines, serums, vaccines, blood and blood products, special dietary products and dressings).
- Aids and appliances (medical aids such as prostheses, spectacles etc).
- Rehabilitation (up to a year.)
- Medical and surgical treatment (by general practitioners, specialists, physiotherapy (including Mensendieck and Cesar physiotherapy, limited to a maximum of 9 treatments per complaint per calendar year with the exception of certain chronic conditions) and speech therapy).
- Obstetric care (normally provided by a midwife, may be provided by a general practitioner or specialist, if necessary in a clinic or hospital, when no midwife is available, or when medically indicated).
- Dental care (Since 1 January 1995, limited to children, preventive care for adults, plus specialist surgical treatment and in certain cases, the fitting of dental implants and related X-rays).
- Admission to and stay in a hospital (other than psychiatric hospital or ward). (Includes all medical, surgical and obstetric treatment required by the patient. Must be authorised by the health insurance fund with which the patient is registered, and is given wherever in-patient care is reasonably indicated by the individual's medical condition or where there is no choice but to remain in hospital (e.g., pending admission to a nursing home). Covered for up to 365 days, thereafter under the Exceptional Medical Expenses Act. Also includes certain types of tissue and organ transplantation, and reimbursement of the costs of obtaining suitable transplant material.)
- Transport.
- Maternity care. (Post-natal care and help given to mother and baby. For as long as the maternity centre considers necessary for up to a maximum of ten days.)
- Haemodialysis.
- Services for patients with chronic recurring respiratory problems.

- Services of a thrombosis prevention unit.
- Care of the deaf and partially hearing. (Except when in an establishment.)

APPENDIX G
SERVICE SPECIFICATION IN UNITED STATES
FEDERAL AND CALIFORNIA HMO LEGISLATION

Federal HMO legislation

Health Maintenance Organisations in the United States are governed by both federal and state legislation. Federal legislation requires HMOs to provide 'without limitation as to time or cost other than those prescribed by or under this subchapter, basic and supplemental services to its members' (Section 330e (b)).

Basic health services means:

- physician services (including consultant and referral services by a physician);
- inpatient and outpatient hospital services;
- medically necessary emergency hospital services;
- short-term (not to exceed twenty visits), outpatient evaluative and crisis intervention mental health services;
- medical treatment and referral services (including referral services to appropriate ancillary services) for the abuse of or addiction to alcohol and drugs;
- diagnostic laboratory and diagnostic and therapeutic radiologic services;
- home health services; and
- preventive health services (including (i) immunizations, (ii) well-child care from birth, (iii) periodic health evaluations for adults, (iv) voluntary family planning services, (v) infertility services, and (vi) children's eye and ear examinations conducted to determine the need for vision and hearing correction).

'Such term does not include a health service which the Secretary, upon application of a health maintenance organization, determines is unusual and infrequently provided and not necessary for the protection of individual health. The Secretary shall publish in the Federal Register each determination made by him under the preceding sentence.'

(Section 300e-1.Definitions (1).)

Supplemental health services means: 'any health service which is not included as a basic health service' (Section 300e-1. Definitions (2).)

California HMO legislation

California's Health and Safety Code, Chapter 2.2 deals with health care service plans. (Known as the Knox-Keene Health Care Service Plan Act of 1975.) A health care service plan is 'any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or reimburse any part of the cost for such services, in return for a prepaid or periodic charge paid by or on behalf of such subscribers or enrollees'. (Section 1345. Definitions (f).)

Basic health services means:

- physician services, including consultation and referral;
- hospital inpatient services and ambulatory care services;
- diagnostic laboratory and diagnostic and therapeutic radiologic services;
- home health services;
- preventive health services; and
- emergency health care services, including ambulance services and out-of-area coverage.

(Section 1345. Definitions (b).)

Each plan must provide to subscribers and enrollees all of the basic health care services (although some plans may be exempt). In addition, a series of additional services are also specified. For example, Section 1367.2. relating to Alcoholism, chemical dependency or nicotine use states:

'On or after January 1, 1990, every health care service plan that covers hospital, medical, or surgical expenses on a group basis shall offer coverage for the treatment of alcoholism under such terms and conditions as may be agreed upon between the group subscriber and the health care service plan'.

Similar statements apply for:

- comprehensive preventive care of children;
- insurance coverage for those who are blind or partially blind;
- diabetic daycare self-management education programs;
- mastectomy coverage – including prosthetic devices or reconstructive surgery;
- mammography (if the policy covers mastectomy and reconstructive surgery);

- prenatal diagnosis of genetic disorders of the fetus (if the policy covers maternity services);

- insurance coverage for those who have physical or mental illnesses;
- diethylstilbestrol; and

- direct reimbursement of medical transport providers.

Note that Section 1373. (h) (1) allows plans to exclude professional mental health services, but if they are covered coverage should include care offered by a psychiatric health facility and that reasonable efforts should be made to offer members the services of licensed psychologists, but failure to do so shall not constitute a misdemeanor (Section 1373. (h) (5)).

Section 1374.4. Maternity benefits also notes that no plan providing maternity benefits can contain exclusions, reduction or other limitations to coverage, deductible or coinsurance for involuntary complications of pregnancy, unless such provisions apply generally to all benefits paid under the plan.

Sections 1373.14, 1374.7, 1374.10 also have provisions for coverage including long-term care facility services or home-based care, to not exclude those with significant destruction of brain tissue (including Alzheimer's disease) and those with genetic disability traits. (Note: other similar requirements apply to plans other than HMOs.)

APPENDIX H

SERVICE SPECIFICATION IN UNITED STATES

FEDERAL MEDIGAP LEGISLATION

Medicare Supplement Contracts (California Health and Safety Code, S 1358.18, pp. 126-129)

(All contracts relate to Medicare-eligible coverage Parts A and B, and are in addition to the core package not in lieu of the core package.)

Plan A ('core' package)

Hospitalization from 61st to 90th day (Medicare Part A)
Medicare lifetime inpatient reserve day expenses (Medicare Part A)
Upon exhaustion of the Medicare Part A inpatient coverage including lifetime reserve days, expenses up to a lifetime maximum of an additional 365 days
Reasonable cost of the first three pints of blood (Medicare Parts A and B)
Coinsurance (Medicare Part B), subject to Part B deductible

Plan B

Hospitalization from 61st to 90th day (Medicare Part A)
Medicare lifetime inpatient reserve day expenses (Medicare Part A)
Upon exhaustion of the Medicare Part A inpatient coverage including lifetime reserve days, expenses up to a lifetime maximum of an additional 365 days
Reasonable cost of the first three pints of blood (Medicare Parts A and B)
Coinsurance (Medicare Part B), subject to Part B deductible

plus

Medicare part A inpatient deductible

Plan C

Hospitalization from 61st to 90th day (Medicare Part A)
Medicare lifetime inpatient reserve day expenses (Medicare Part A)
Upon exhaustion of the Medicare Part A inpatient coverage including lifetime reserve days, expenses up to a lifetime maximum of an additional 365 days
Reasonable cost of the first three pints of blood (Medicare Parts A and B)
Coinsurance (Medicare Part B), subject to Part B deductible

plus

Medicare part A inpatient deductible

plus

Skilled nursing facility care (actual billed charges up to coinsurance amount from the 21st through to 100th day)
Medicare Part B deductible
Specified medically necessary emergency care in a foreign country (80% of Medicare-eligible expenses, within first 60 days of each trip outside the United States ($250), subject to a deductible and lifetime maximum benefit of $50,000)

Plan D

Hospitalization from 61st to 90th day (Medicare Part A)
Medicare lifetime inpatient reserve day expenses (Medicare Part A)
Upon exhaustion of the Medicare Part A inpatient coverage including lifetime reserve days, expenses up to a lifetime maximum of an additional 365 days
Reasonable cost of the first three pints of blood (Medicare Parts A and B)
Coinsurance (Medicare Part B), subject to Part B deductible

plus

Medicare part A inpatient deductible

plus

Skilled nursing facility care (actual billed charges up to coinsurance amount from the 21st through to 100th day)
Specified medically necessary emergency care in a foreign country (80% of Medicare-eligible expenses, within first 60 days of each trip outside the United States ($250), subject to a deductible and lifetime maximum benefit of $50,000)

plus

Specified at-home recovery benefit (at-home short-term assistance with activities of daily living for those recovering from an illness, injury or surgery)

Plan E

Hospitalization from 61st to 90th day (Medicare Part A)
Medicare lifetime inpatient reserve day expenses (Medicare Part A)
Upon exhaustion of the Medicare Part A inpatient coverage including lifetime reserve days, expenses up to a lifetime maximum of an additional 365 days
Reasonable cost of the first three pints of blood (Medicare Parts A and B)
Coinsurance (Medicare Part B), subject to Part B deductible

plus

Medicare part A inpatient deductible

plus

Skilled nursing facility care (actual billed charges up to coinsurance amount from the 21st through to 100th day)
Specified medically necessary emergency care in a foreign country (80% of Medicare-eligible expenses, within first 60 days of each trip outside the United States ($250), subject to a deductible and lifetime maximum benefit of $50,000)

plus

Specified preventive medical care (an annual clinical preventive medical history and physical examination and patient education; fecal occult blood test or digital rectal examination or both; mammogram; dipstick urinalysis for hematuria, baceriuria and proteinuria; pure tone, air only, hearing screening test, administered or ordered by a physician; serum cholesterol screening every five years; thyroid function test; diabetes screening; influenza vaccine administered at any appropriate time during the year and tetanus and diphtheria booster every to years; any other tests or preventive measures determined appropriate by the attending physician; actual charges up to 100% of Medicare-approved amount for each service up to a maximum of $120 annually)

Plan F

Hospitalization from 61st to 90th day (Medicare Part A)
Medicare lifetime inpatient reserve day expenses (Medicare Part A)
Upon exhaustion of the Medicare Part A inpatient coverage including lifetime reserve days, expenses up to a lifetime maximum of an additional 365 days
Reasonable cost of the first three pints of blood (Medicare Parts A and B)
Coinsurance (Medicare Part B), subject to Part B deductible

plus

Medicare part A inpatient deductible

plus

Skilled nursing facility care (actual billed charges up to coinsurance amount from the 21st through to 100th day)
Medicare Part B deductible
Specified medically necessary emergency care in a foreign country (80% of Medicare-eligible expenses, within first 60 days of each trip outside the United States ($250), subject to a deductible and lifetime maximum benefit of $50,000)

plus

100% of Medicare Part B Excess charges

Plan G

Hospitalization from 61st to 90th day (Medicare Part A)
Medicare lifetime inpatient reserve day expenses (Medicare Part A)
Upon exhaustion of the Medicare Part A inpatient coverage including lifetime reserve days, expenses up to a lifetime maximum of an additional 365 days
Reasonable cost of the first three pints of blood (Medicare Parts A and B)
Coinsurance (Medicare Part B), subject to Part B deductible

plus

Medicare part A inpatient deductible

plus
Skilled nursing facility care (actual billed charges up to coinsurance amount from the 21st through to 100th day)
80% of Medicare Part B Excess charges
Specified medically necessary emergency care in a foreign country (80% of Medicare-eligible expenses, within first 60 days of each trip outside the United States ($250), subject to a deductible and lifetime maximum benefit of $50,000)
Specified at-home recovery benefit (at-home short-term assistance with activities of daily living for those recovering from an illness, injury or surgery)

Plan H

Hospitalization from 61st to 90th day (Medicare Part A)
Medicare lifetime inpatient reserve day expenses (Medicare Part A)
Upon exhaustion of the Medicare Part A inpatient coverage including lifetime reserve days, expenses up to a lifetime maximum of an additional 365 days
Reasonable cost of the first three pints of blood (Medicare Parts A and B)
Coinsurance (Medicare Part B), subject to Part B deductible

plus

Medicare part A inpatient deductible

plus

Skilled nursing facility care (actual billed charges up to coinsurance amount from the 21st through to 100th day)
80% of Medicare Part B Excess charges
Specified medically necessary emergency care in a foreign country (80% of Medicare-eligible expenses, within first 60 days of each trip outside the United States ($250), subject to a deductible and lifetime maximum benefit of $50,000)

plus

Basic outpatient prescription drug benefit (50% of outpatient prescription drug charges after a $25 calendar year deductible to a maximum of $1250 per enrollee per year)

Plan I

Hospitalization from 61st to 90th day (Medicare Part A)
Medicare lifetime inpatient reserve day expenses (Medicare Part A)
Upon exhaustion of the Medicare Part A inpatient coverage including lifetime reserve days, expenses up to a lifetime maximum of an additional 365 days
Reasonable cost of the first three pints of blood (Medicare Parts A and B)
Coinsurance (Medicare Part B), subject to Part B deductible

plus

Medicare part A inpatient deductible

plus

Skilled nursing facility care (actual billed charges up to coinsurance amount from the 21st through to 100th day)
100% of Medicare Part B Excess charges
Specified medically necessary emergency care in a foreign country (80% of Medicare-eligible expenses, within first 60 days of each trip outside the United States ($250), subject to a deductible and lifetime maximum benefit of $50,000)

plus

Basic outpatient prescription drug benefit (50% of outpatient prescription drug charges after a $25 calendar year deductible to a maximum of $1250 per enrollee per year)
Specified at-home recovery benefit (at-home short-term assistance with activities of daily living for those recovering from an illness, injury or surgery)

Plan J

Hospitalization from 61st to 90th day (Medicare Part A)
Medicare lifetime inpatient reserve day expenses (Medicare Part A)
Upon exhaustion of the Medicare Part A inpatient coverage including lifetime reserve days, expenses up to a lifetime maximum of an additional 365 days
Reasonable cost of the first three pints of blood (Medicare Parts A and B)
Coinsurance (Medicare Part B), subject to Part B deductible

plus

Medicare part A inpatient deductible

plus

Skilled nursing facility care (actual billed charges up to coinsurance amount from the 21st through to 100th day)
100% of Medicare Part B Excess charges
Specified medically necessary emergency care in a foreign country (80% of Medicare-eligible expenses, within first 60 days of each trip outside the United States ($250), subject to a deductible and lifetime maximum benefit of $50,000)

plus

Extended prescription drug benefit (50% of outpatient prescription drug charges after a $250 deductible up to a maximum of $3000 per enrollee per year
Specified preventive medical care (an annual clinical preventive medical history and physical examination and patient education; fecal occult blood test or digital rectal examination or both; mammogram; dipstick urinalysis for hematuria, baceriuria and proteinuria; pure tone, air only, hearing screening test, administered or ordered by a physician; serum cholesterol screening every five years; thyroid function test; diabetes screening; influenza vaccine administered at any appropriate time during the year and tetanus and diphtheria booster every to years; any other tests or preventive measures determined appropriate by the attending physician; actual charges up to 100% of Medicare-approved amount for each service up to a maximum of $120 annually)

Specified at-home recovery benefit (at-home short-term assistance with activities of daily living for those recovering from an illness, injury or surgery).

APPENDIX I
HEALTH EMPLOYER DATA INFORMATION SET (HEDIS)

HEDIS® 1999 Reporting Set Measures by Domain

Domain	Description of changes
EFFECTIVENESS OF CARE	
Childhood Immunization Status*	Minor modifications
Adolescent Immunization Status*	Minor modifications
Advising Smokers to Quit *	Minor modifications
Flu Shots for Older Adults*	Minor modifications
Breast Cancer Screening*	No changes
Cervical Cancer Screening*	Minor modifications
Prenatal Care in the First Trimester*	Minor modifications
Low Birth-Weight Babies	No changes (not required)
Check-Ups After Delivery*	Minor modifications
Beta Blocker Treatment After a Heart Attack*	Minor modifications
Cholesterol Management After Acute Cardiovascular Events	**New measure**
Eye Exams for People with Diabetes*	Minor modifications
Comprehensive Diabetes Care	**New measure** (voluntary)
Follow-Up After Hospitalization for Mental Illness*	Minor modifications
Antidepressant Medication Management	**New measure**
The Health of Seniors	Specifications in HEDIS '99, Vol. 6
ACCESS/AVAILABILITY OF CARE	
Adults' Access to Preventive/Ambulatory Health Services	Minor modifications
Children's Access to Primary Care Practitioners	Minor modifications
Availability of Primary Care Providers	Measure retired
Availability of Behavioral Health Care Providers	Measure retired
Availability of Obstetrical and Prenatal Care Providers	Measure retired
Initiation of Prenatal Care	Minor modifications
Low Birth-Weight Deliveries at Facilities for High-Risk Deliveries & Neonates	No changes (not required)
Annual Dental Visit	No changes
Availability of Dentists	Measure retired
Availability of Language Interpretation Services	No changes

SATISFACTION WITH THE EXPERIENCE OF CARE	
HEDIS/CAHPS 2.0H* Survey(Adult Medicaid, Commercial)	New survey instrument
HEDIS/CAHPS 2.0H, Child (Medicaid, Commercial)	New survey instrument
HEDIS/CAHPS 2.0, Medicare	New survey instrument
HEALTH PLAN STABILITY	
Disenrollment	No changes
Practitioner Turnover	No changes
Years in Business/Total Membership	No changes
Indicators of Financial Stability	Minor modifications
USE OF SERVICES	
Frequency of Ongoing Prenatal Care	Language clarified
Well-Child Visits in the First 15 Months of Life	Minor modifications
Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life	Minor modifications
Adolescent Well-Care Visits	Minor modifications
Frequency of Selected Procedures	Minor modifications
Inpatient Utilization--General Hospital/Acute Care	Minor modifications
Ambulatory Care	Minor modifications
Inpatient Utilization--Non-Acute Care	No changes
Discharge and Average Length of Stay-Maternity Care	No changes
Cesarean Section Rate	No changes
Vaginal Birth After Cesarean Rate (VBAC-Rate)	Language clarified
Births and Average Length of Stay, Newborns	Minor modifications
Mental Health Utilization--Inpatient Discharges and Average Length of Stay	No changes
Mental Health Utilization--Percentage of Members Receiving Inpatient, Day/Night Care and Ambulatory Services	Minor modifications
Readmission For Specified Mental Health Disorders	Measure retired
Chemical Dependency Utilization--Inpatient Discharges and Average Length of Stay	No changes
Chemical Dependency Utilization--Percentage of Members Receiving Inpatient, Day/Night Care and Ambulatory Services	Minor modifications
Readmission for Chemical Dependency	Measure retired
Outpatient Drug Utilization	No changes

COST OF CARE	
Rate Trends	No changes
High-Occurrence/High-Cost DRGs	Language clarified
HEALTH PLAN DESCRIPTIVE INFORMATION	
Board Certification/Residency Completion	Minor modifications
Practitioner Compensation	Minor modifications
Arrangements with Public Health, Educational and Social Service Organizations	No changes
Total Enrollment	No changes
Enrollment by Payer (Member Years/Months)	No changes
Unduplicated Count of Medicaid Members.	No changes
Cultural Diversity of Medicaid Membership	No changes.
Weeks of Pregnancy at Time of Enrollment in the Health Plan	No changes.

* These measures and survey instruments are required for reporting in Accreditation '99. Where measures are not relevant for a given population, plans are not required to report that measure.

Source: http://www.ncqa.org/pages/communications/news/h99meas.htm
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