HEALTH CARE: TRUST, MISTRUST, VOICE OR CHOICE?

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Ways to deliver a health service

Four models:

- Trust
- Mistrust
- Voice
- Choice

  Most health service reforms involve shifting the balance towards/away from one or more models

Trust Models

- Government provided and funded. Sets budget. Salaried doctors, nurses have freedom over how budget is spent (Old British health service, pre-1980s China?).

- Privately provided and funded. Fee-for-service (United States, post-1980s China). Doctors, hospitals trusted to prescribe and treat only as necessary, and to submit honest bills to funders (insurers, patients).

Trust: Advantages

- Professionals like it. High morale (especially fee-for- service or unmonitored salary).
- No monitoring costs.
- Trust is intrinsically desirable. A trusting society is a good society.

But:

- Makes crucial assumption about the motivation of medical professionals. Assumes they are perfectly altruistic and are not in any way self-interested.
- But what if medical professionals are (partly or wholly) motivated by self-interest? Model offers perverse incentives.

Incentives in Trust Models

- In publicly provided systems, incentives for under-treatment: providing too little or too unresponsive care.
- In privately provided systems, incentives for over-treatment: too many drugs and high-tech services. Supplier-induced demand. In China, 30% of drug spending estimated as unnecessary.

Mistrust Models

Price/Quantity Controls

- Government controls prices (China: not-for-profits, pharmaceuticals. UK: treatments, pharmaceuticals)
- Government only funds approved treatments. Essential medicines list (China). NICE (UK)
- Government restricts quantity available. Rationing.

Command and Control

- Soviet system
- Targets and performance management.

UK: NICE

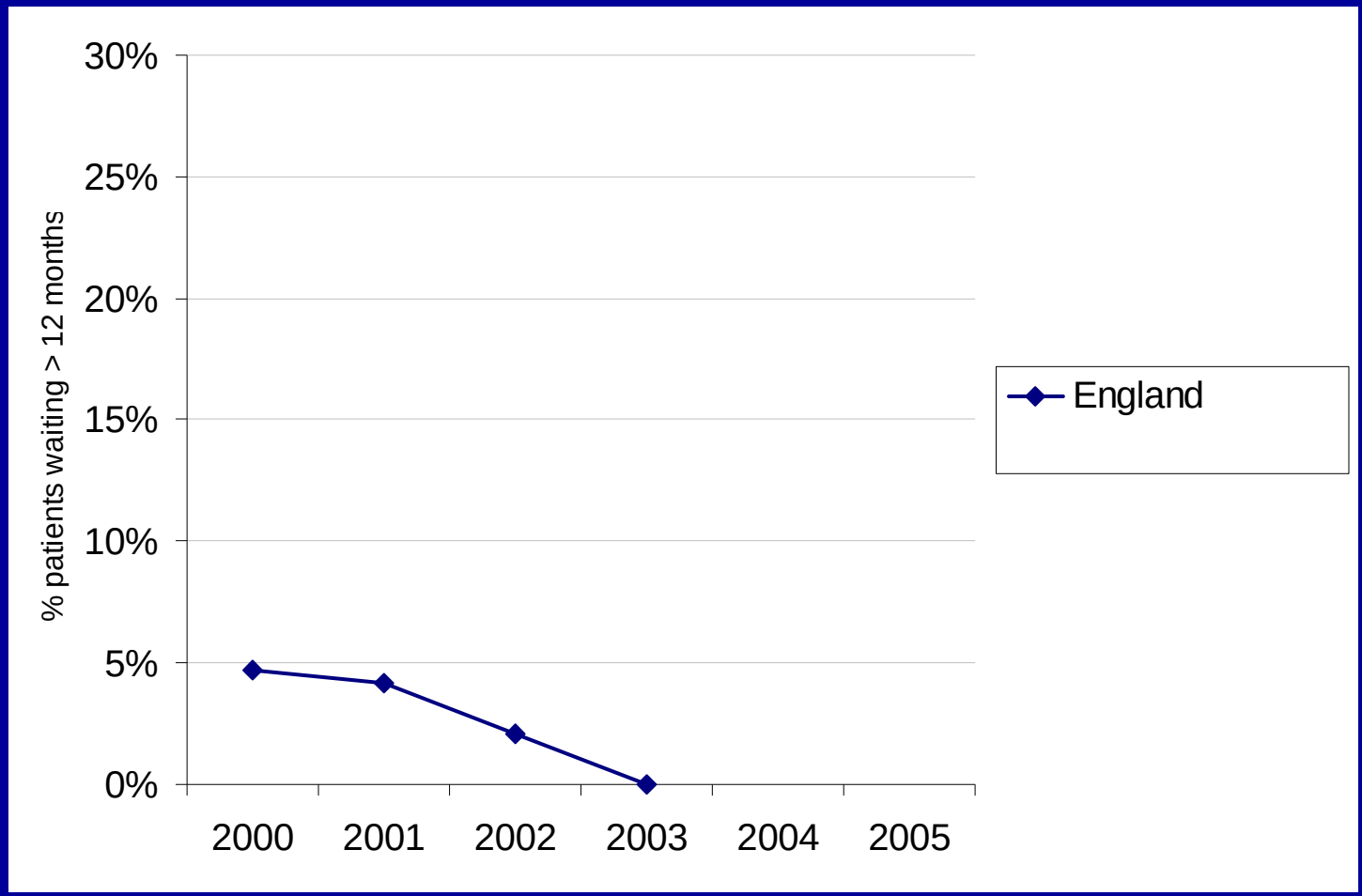
- NICE – National Institute of Clinical Effectiveness
- Only approves treatments that pass a test of cost-effectiveness (£30,000 per Quality-Adjusted Life Year).
- Also known as NASTY – Not Available So Treat Yourself

UK: Targets and Performance Management

- Government sets targets and monitors performance
- Rewards or penalties to staff for achieving or failing to achieve the target. Promotion /demotion/sacking.

Advantage: can work, at least in short-term.

% patients waiting for hospital admission > 12 months



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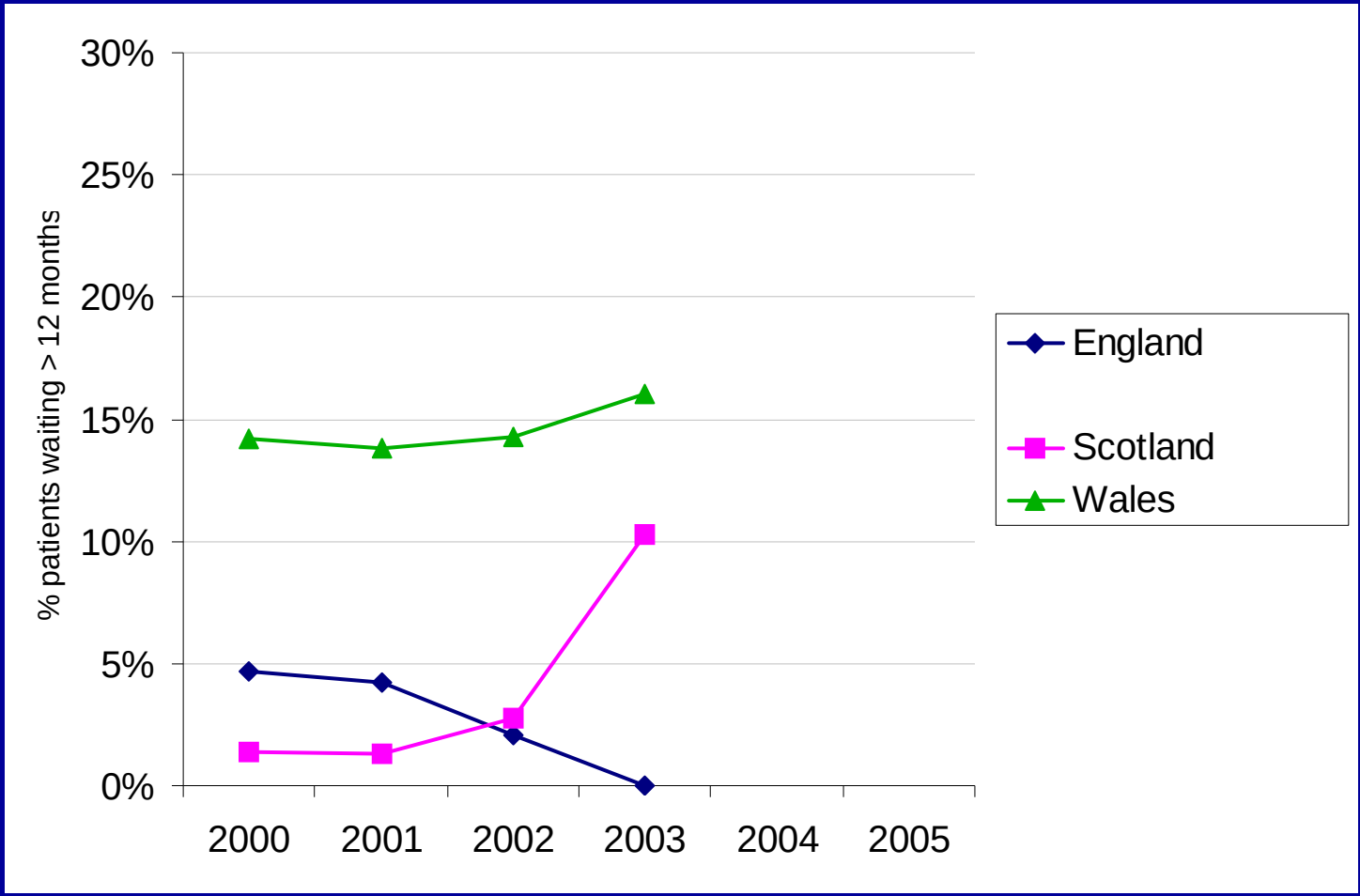

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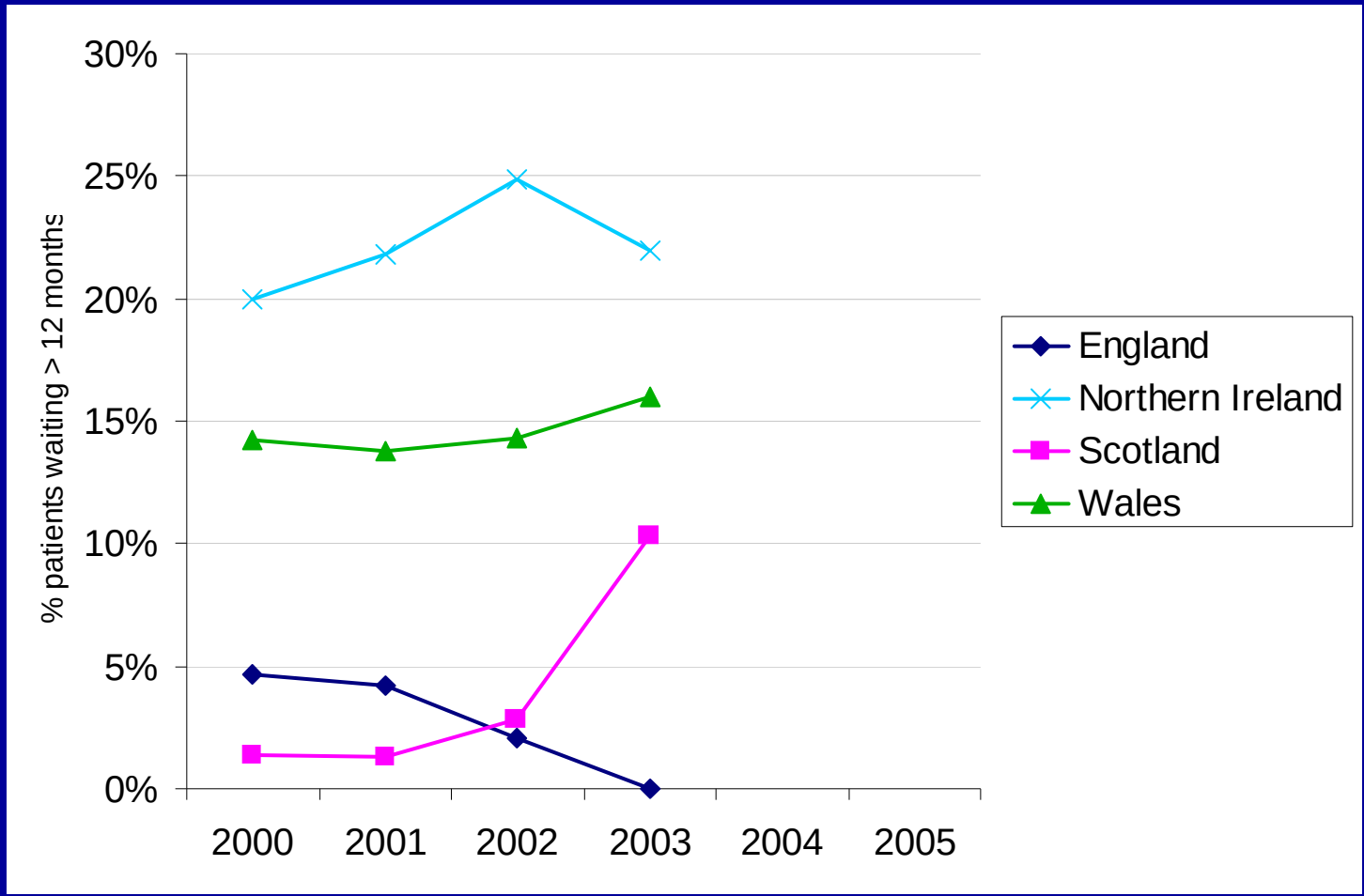

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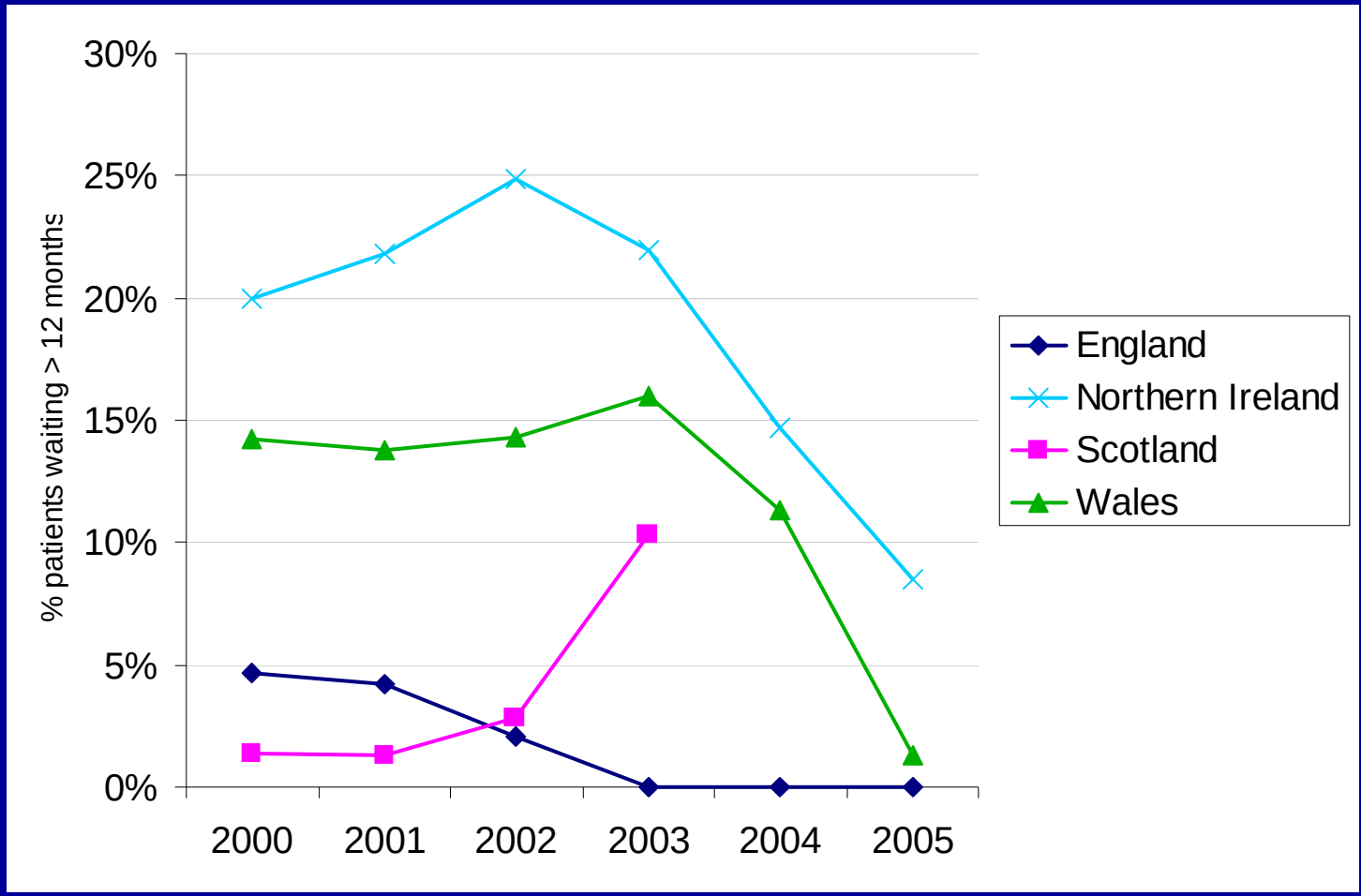

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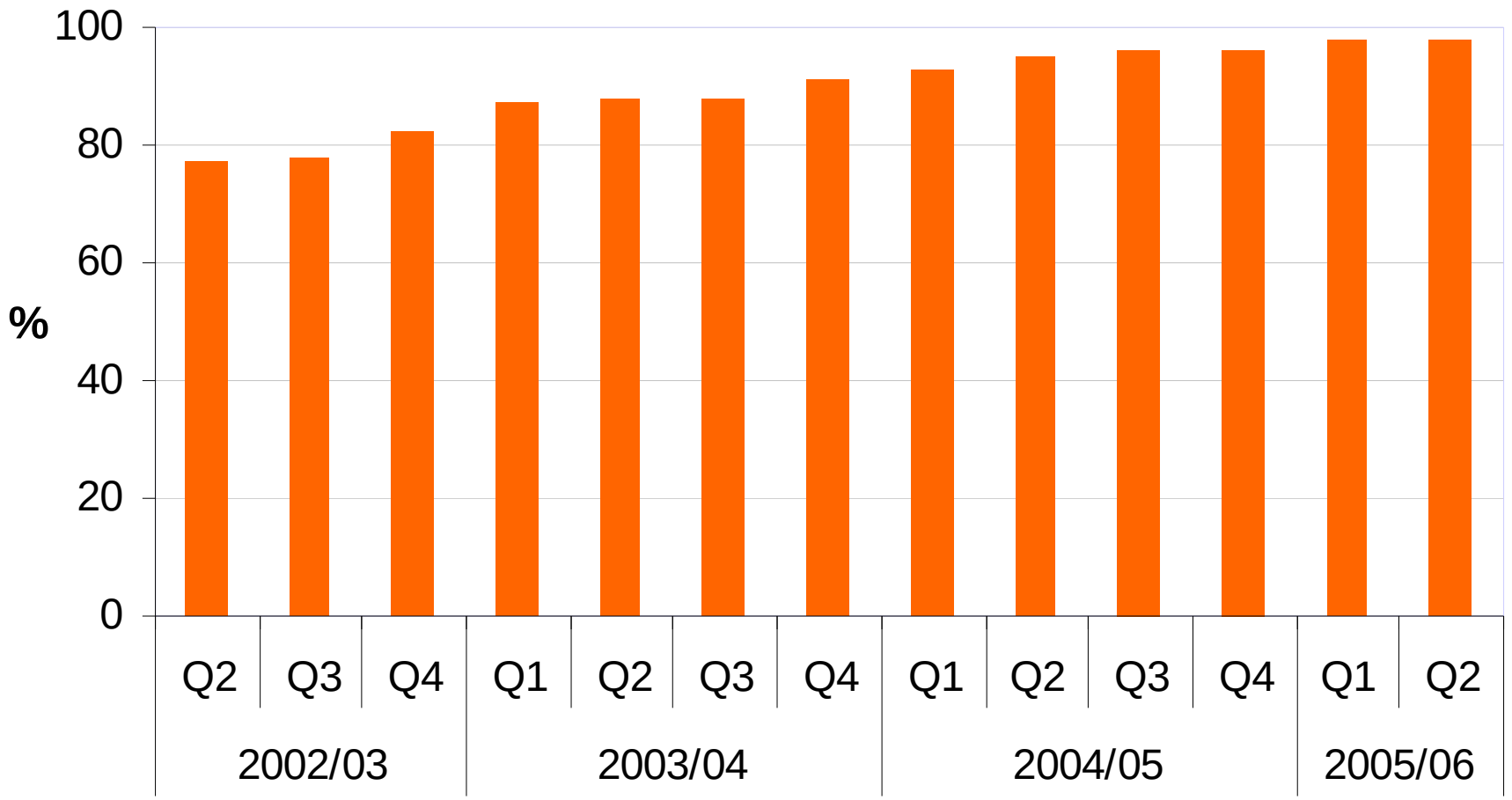
% Patients spending less than 4 hours in major A+E Departments



+ 24% increase in A+E admittances

Source: Chief Executive's Report on the NHS - Statistical Supplement (December 2005)

Incentives in Mistrust Models

Price/Quantity Controls

- If only prices controlled, to sell as much as possible.
- If only quantity controlled, to raise prices
- If both controlled, to focus on uncontrolled areas to raise revenue.

Incentives in Mistrust Models

Targets and Performance Management

- To concentrate resources on targeted aspects of care and ignore non-targeted aspects
- To ‘game’ the system: to change behaviour in ways that formally meet the target but actually do little to benefit the patient
- To misrepresent the figures

Voice Models

- Informal face to face talks with professionals
- Board membership
- Complaints procedures
- Opinion polls
- Petitions
- Elected representatives

Incentives in Voice Models

- Wish to avoid unpleasantness
- But basically there is a lack of incentives – unless voice recipient (listener) is part of a managerial hierarchy, or has other incentives to respond (for instance, need for votes by elected representatives)
- Responds to those with loudest voices (usually the better off or more powerful in society).

Voice in UK National Health Service

- Unemployed, and individuals with low income and poor educational qualifications use health services less relative to need than the employed, the rich and the better educated
- Intervention rates of coronary artery bypass grafts or angiography following heart attack were 30% lower in lowest group than the highest.
- Hip replacements 20% lower among lower income groups despite 30% higher need.
- A one point move down a seven point deprivation scale resulted in GPs spending 3.4% less time per consultation

Quasi-markets and Choice of Provider

- Providers are independent. Non-profit or for-profit. Public/private partnerships. Compete in a quasi-market.

- Users choose provider. Public money follows the choice. So hospitals get more resources through the number of patients they attract; schools according to number of pupils.

Quasi-Markets

‘Quasi-markets’ differ from normal markets in three ways:

- Funds come from government (taxation or social insurance). Promotes equity of access
- Diverse providers: for-profit, non-profit, public.
- Agents advise or act on behalf of patients. This is to avoid supplier-induced demand.

Choice Models: Advantages

- Provides strong incentives for responsiveness and efficiency. Evidence (US, UK) suggests that fixed price systems lower costs and increase quality.
- Promotes equity through diminishing the power of voice.
- Can appeal to both the altruist and the self-interested.

Incentives in Choice Models: Cream-skimming

Cream-skimming: selecting easiest, least costly patients. Favours less needy and better off. Possible solutions:

- Stop-loss insurance
- No discretion over admissions
- Risk- adjustment Larger amounts of money associated with higher cost users.

Incentives in Choice Models: Supplier-Induced Demand

Supplier-induced demand: incentives to over-supply or over-treat. Possible solutions:

- Primary care referral system for secondary care. Family practitioners to act as gate-keepers.
- Primary care budget holders. Primary care clinics hold the budget for secondary care. Has worked in UK: GP fund-holders.

Overall

- All systems are bad.
- Looking for the ‘least-worst’.
- In many situations (but not in all) the one with the least worst structure of incentives is:
- Choice in a quasi-market. But design of relevant policies is very important.