The effect of increased part-charges on the health-seeking behaviours of Group 3 workers and their families

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Abstract

This thesis is about health, change and user charges. In 1991 New Zealand embarked in a new direction for the funding of health services, including extensive use of a targeting regime in which 'those that can afford' social services were paying more so that those who could not were paying less. For the 'high-income' families classified as Group 3, this meant that part charges at point of service were increased at all levels of health services. Concerns immediately arose that the income levels had been set too low and would create financial barriers for some 'high-income' families, particularly those on the margin.

This thesis explores the demand response of 129 families in Group 3 to the new charges imposed by the Interim Targeting Regime. The survey population is characterised by high incomes and insurance coverage across income levels. Through a nonrandom survey methodology based on the opinions and perceptions of the user community (Group 3 workers and their families), over one-quarter of the survey families reported health services demand being diverted from allopathic medical services. However, even though 25% reported demand diversion, only 11% of families reporting lowered health status.

The study also looked at diversion from conventional medicine to alternatives including self-treatment, seeking advice from a chemist, complementary therapies or changing lifestyle habits. The data did not suggest diversion to alternatives equal to the reduction of conventional medical services.

Through the use of nonparametric statistical techniques, characteristics of the survey population were analysed in an attempt to begin untangling a complex web of factors affecting the survey population's health services demand when faced with increases in price. Factors included in this study were income level, insurance coverage, health status, gender, family size and composition .

Various subsamples of the survey population reported different effects and different magnitudes of demand diversion. The differences between insured and uninsured families were particularly marked. Evidence provided by the user community implicates a high degree of moral hazard within the insured subsample. The study suggests further research on the influence on moral hazard in meeting the stated goals of the reforms.

Because the study is nonrandom and exploratory, any claim of representativeness would be unwarranted. However, the study suggests that the attributes of high incomes and insurance coverage may be inherent to Group 3. To more accurately assess the representativeness of any research on the effects of the increase in part charges on Group 3, the study proposes a further clarification of the specific attributes of the families belonging in the Group 3 category is necessary.

Finally, the study questions the adequacy of the targeting regime and the increase in part charges for meeting the objectives set out by the health reformers, particularly in respect to the objectives of cost containment and individuals becoming more responsible for their own health.

Preface and acknowledgments

Before I began this thesis I was warned that the business of life is often enough to thwart the best efforts to complete a masters degree. These academic soothsayers were correct. At some point, your research must dominate your life in order to 'master' it. It has taken slightly over two years to bring this thesis to closure. For me, the long illness and death of a beloved parent and a move from a small town to a large city away from friends, my University and supervisors caused long periods during which my work was temporarily abandoned.

The fact that I am writing this means that I am nearly at the end. For me, acknowledgments go beyond gratefully saying 'thank you'. The people who follow are actually part of my efforts and share the credit of the work I have done. To all of you, not only 'thank you' but 'we did a good job'.

I must first acknowledge the contribution of the families who took the time to share their experiences in the new user pays environment. I appreciate you letting me take your knowledge to a larger audience.

I also wish to acknowledge the confidence and suggestions of Stuart Birks and Nicola North, my supervisors. I appreciate your assistance in keeping me focussed on what was really important. Michael Belgrave was also particularly helpful in reviewing the final draft.

I have many friends who share my interest in health policy. The women of the Palmerston North Women's Health Collective were collectively and individually responsible for helping me crystallise my ideas on the responsibilities of the welfare state. I particularly acknowledge Jessie Hosie for her coffee breaks, comfortable lodging and advice regarding survey methodology.

As a mother of a small boy, there were times I was short on time and long on commitments. I thank Ann van Brunt for her support as my friend and acknowledge her loving care of my son especially during the pilot and pretest periods of my field research. Judith Morris, thanks for sharing your

time and experiences, particularly during the 'home stretch'. To my friend and fellow graduate student Kate McKegg, thanks for many, many things. I'll show you my diploma if you'll show me yours.

My partner Dennis Viehland and my son Daniel not only contributed but sacrificed to help me complete my master's work in general. In addition to giving me needed time away from duties as mother and wife to work on my thesis, Dennis provided innumerable and valuable suggestions and referrals when I became stuck. I really couldn't have done it without you.

Most of all, I wish to acknowledge my father who raised me to think anything is possible if you commit yourself to making it happen. From him I learned we are all connected in some grand way and the pain of one person is shared by us all. I wish he were alive to see my degree and this work completed. He would enjoy showing it, freshly printed and bound, to all his neighbours and friends.

This thesis has been typed in Helvetica and uses the publishing style of the University of Chicago Press.

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Health and health policy in New Zealand

Health is a precious condition of our lives. We need good health to work, to raise our children, to live productive and enriching lives. Good health is so important that even in good health we act preventively to maintain health. We seek diagnostic procedures which might give us an early indication of illness. We may watch our diet, exercise and generally live our lives in ways to promote good health.

On the other hand, ill health disrupts the routine of our lives. It can incapacitate us physically and mentally. Serious ill health can lead to long-term disability or unemployment. It is no wonder when we are ill we often take immediate steps to regain our good health. These actions may include accessing conventional medical services which carry costs some of us cannot afford.

This thesis is about health, health-seeking behaviours and public policy. In February 1992 New Zealand embarked in a new direction for health services moving to a 'more market' philosophy which included a greater reliance on user pays as part of its cost-containment strategy. Part-charges were increased with the idea that people would think more carefully about accessing health services resulting in an overall reduction in utilisation of health services and the state's financial commitment.

The National Government divided the population of New Zealand into three groups Rather than 'need' being classified by those often requiring a higher than average number of services, entitlement to subsidies became defined by the total household income of the 'family unit'. Group 1 was defined as beneficiaries and their families, pensioners with little other income, families entitled to full Family Support and other low income individuals. Group 2 was a very small group made up of families entitled to partially abated Family Support. Group 3 was the 'all other' category - if a family was excluded from Group 1 or Group 2 entitlement, that family belonged to Group 3. Group 3, the high-income families, were to pay more for their

health care while generous subsidies would be granted to the low-income and middle-income families.

By moving away from more universally applied health services and subsidies to a targeting regime, concerns arose over the question of thresholds. How high do incomes need to be in order for families to be able to 'afford' health care? Eligibility for Group 3 status did not automatically mean families who were not entitled to more generous substitutes could 'afford' the new pricing schemes. How would Group 3 families react if they found their access to health services compromised by the increases in part-charges? Would they forego or delay treatment, even if it meant prolonged or greater ill health? Would the demand for health services be diverted to other forms of care?

As an American with first-hand experience in one of the most market-oriented health delivery systems in the world, I found not only the history of New Zealand's health services but also its struggle to push delivery in 'more market' directions to be quite absorbing. My experiences purchasing health services through the market led me to question not only the efficacy but the ideological foundations of National's strategies. Particularly, I wondered if targeted cost sharing offered the benefits National believed it had. Personal experience with many years of cost sharing led me to be very cautious in embracing cost sharing (or 'user pays' as it is called in New Zealand) as an effective tool for ensuring a healthier New Zealand.

I became further interested in the differences between market-oriented private and public health service delivery systems. I came to understand that cost sharing, a strategy used in many welfare states to ration its health resources, has definite implications for not only clinical medicine and health economics but political science, social policy, ethics and philosophy as well. Questions regarding Group 3's reactions to increased part-charges could only be answered through studying possible changes in the health-seeking behaviours of Group 3 workers and their families. Understanding how and why people make their health-seeking and care-seeking choices when faced with considerations of affordability became the underlying motivation for this thesis. New Zealand's reforms to its medical services subsidies provided a 'natural experiment' to study the effects of changes in price relative to demand for services.

Regardless of the shift from universal to targeted health services, the policies established by the National Government did not entirely abdicate the welfare state's responsibility for the health of its citizens. In this introductory chapter, the welfare state's commitment to health care provision in general is discussed. Then National's health reforms are briefly summarised before turning to look more specifically at its strategies of targeting and user pays[1]. User pays as a strategy of health care reform is reviewed, specifically at the level of primary care. The aims of this study and outline of the thesis will conclude this chapter.

Health policy and the Welfare State

Because we not only value our own health but the health of others, the welfare state has assumed in varying degrees some responsibility for the health of its constituents. Unfortunately, unlike other social services provided in various forms, 'health' is not a commodity that can be traded like housing or food. It cannot be measured in units or kilograms. One difficulty faced by the welfare state is the definition of 'good health' which Blank (1993:4) maintains is varied by and intrinsically bound to racial, ethnic and cultural factors. Although the meaning of 'health' remains elusive, 'health services' can be defined and measured. To say that *health* has become a responsibility of the welfare state is somewhat inaccurate. What the welfare state can and does provide is *access* to *health services*.

Whether those health services are meeting the needs of the welfare state's constituents are often determined by measures of health status. Since it is extremely difficult to define what 'health' *is*, in order to provide services, the welfare state has come to define health by what it *is not*. Indicators of health status have focused on the 'absence of disease' instead of the prevalence

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1 The terms cost sharing, co-payment, user pays and part-charges for the purpose of this thesis are similar but not interchangeable. 'Cost sharing' will be used to broadly describe any strategy, public or private, to charge the user a fee at the point of service and encompasses 'co-payments', 'deductibles' and 'user pays'. 'Co-payment' refers specifically to the charge required by insurance companies which is paid by users of health services at point of service. 'Deductible' refers to the amount paid by the consumer at point of service not reimbursed by private insurance. 'User pays' generally refers to a strategy of charging all or part of the costs of providing a publicly-funded service to the users rather than paying all costs through taxes or general revenue. The term 'part-charges' is more specific referring to the actual amount patients might expect to pay at point of service.

of health. Mortality and morbidity statistics have become the accepted substitute for measures of health status and have often driven health policy.

Because the complexity, capriciousness and undifferentiated nature of illness and disease precludes the welfare state from guaranteeing good health, the welfare state has focused on guaranteeing access to health services as a substitute. Some welfare states have elevated access to health services to the status of a public good, leading to universal schemes. Even the most reluctant welfare states have declared health to be a key ingredient for productivity and integral to the ability and right to fully participate in society.

While there is no controversy that health policy is a high priority for welfare states, there is ample divergence of opinion on how an individual state's health policy can best achieve a healthy society. The continuum for the Western world runs from fully integrated public health systems paid for by general taxes as in the Netherlands to a subsidised but predominantly market-oriented health care system in the United States (see Blank 1994:57 for a convenient typology).

New Zealand's health system

Hewitt (1992) argues ideology has played a formal role in the development and conception of welfare states and their strategies and institutions. Since its Social Security Act of 1938, New Zealand's health policies could be said to reflect an ideology in which access to health services is viewed as a positive right of citizenship. For New Zealand, this has meant not only economic but geographic access to health cares services for all New Zealanders. After expanding the 1938 provisions of the Social Security Act to general practice in 1941, New Zealand incrementally began to provide universal access to many health services and heavily subsidised those that were not universally provided such as primary care.

At the time of my arrival from the United States to New Zealand in 1991, New Zealanders still benefited from a health delivery system with a strong universal flavour. Public hospital care and most laboratory work were substantially free, pharmaceuticals were heavily subsidised and the General Medical Services (GMS) benefit paid a portion (but increasingly smaller portion) of the charge for visits to general practitioners. Although a

private health system was increasingly available and insurance was a growth industry, for most New Zealanders I met, the delivery system either owned, administered or subsidised by the government continued to be their first choice for medical services.

However, this was changing. Although the budget for health services increased substantially throughout the 70s and 80s, demand in the public sector was not met with an adequate supply. This resulted in long queues for everything from operations to specialist services. As a response, more and more New Zealanders were beginning to look to the private delivery system for care. Increasingly, New Zealanders began to purchase health insurance to insure a choice between long queues in the public sector and the unsubsidised significantly higher costs of the private sector. By 1992, forty-five percent of the population had private health insurance, making up 3.5% of the total expenditures on health (New Zealand 1992 Yearbook, 124).

Recognising the need for reform and wishing to abate its accelerating financial commitment to health services, New Zealand governments began designing ways to decrease dependence on its public delivery system and reduce total costs. Although reform had begun by earlier regimes, the ideology reflected by the reforms of the National government elected in 1990 were decidedly 'more market' than any previous. National Government's initiatives have included major cuts in social assistance, changes in targeting methods and a redesign of the manner in which the State provides its services (Boston 1992a:1).

National's reforms for the health sector included both supply-side and demand-side changes. On the supply side, the National Government proposed an 'internal market' model, severing the purchasing and providing roles of public health services with the goal of increasing competition and accountability while decreasing the difficulty in determining actual costs of delivery. On the demand side, a scheme of targeted user pays by income grouping was introduced in order to reduce the government's total dollars spent on health care and to reduce demand for 'unnecessary' services.

As established in the Minister of Health's (1991a) *Your Health and the Public Health*, the official policy goals were couched in such consumerist

terms as improving access, reducing waiting times and widening choice. These official policy goals did not specifically identify the need to reduce government spending on health, but the message contained in the 1991 Budget was clear. National sought to slow the steady increase of health spending as part of New Zealand's national budget.

The role of targeted user pays in the reforms

The move to a targeted system which included significantly increasing the part-charges for 'high-income' families was a significant change from the previous system in which family practice subsidies were awarded because of an individual's affiliation with a group defined by their general health status as needing extra help in accessing health services (e.g. children and the elderly). Under the new regime, only the chronically ill were given special status, a status that had to be 'proved' for entitlement by utilising services until a certain number of services and pharmaceuticals had been reached.

Reforms to cost sharing were across the board and included hospital stays, outpatient services, primary health care and pharmaceuticals. Initially, laboratory services were intended to be included but were never fully integrated into the cost-sharing arrangements.

From 1941 through 1972 the subsidy level of the GMS saw very little amendment From 1972 to the present, subsidy levels have been the target of a great deal of revision. One might validly ask why there has been such a long period of quiescence over the issue of subsidy levels. Fougere (quoted in Hay, 1989:162) believes that many of those same people who might have the "time, money and political influence" effectively to pressure for greater subsidy have been absorbed into third-party payment systems, primarily private medical insurance.

The preponderance of private medical insurance may not only be a factor in how people have responded politically to GMS levels, but also to how they might react to National's reforms. With nearly one half of all New Zealanders benefiting from insurance coverage at the time of the changes to cost sharing (Southern Cross Health Care Group, 1990), reimbursals from insurance claims could cushion the effect of increased user pays producing decreases in utilisation that might be lower than desirable to

meet policy goals. On the other hand, as government subsidies decrease, insurance companies experienced an increase in costs, resulting in increased premiums. Indeed, one of the findings of this study was that certain individuals chose to discontinue coverage due to increase premiums (see Chapter 6, "Changes in Insurance").

Table 1.1 presents the value of primary care and pharmaceutical subsidies for Group 3, before and after the initial round of reforms to user pays as well as the average patient charge from 1 February 1992. Keeping in mind many Group 3 members would have insurance cover, even though adults of this group received no subsidy from the government, insurance reimbursals would have returned as much as 90% of the part-charges for primary care services to those with coverage. Certainly, with the moral hazards of insurance coverage factored in, as will be discussed in Chapter 3, no clear cut price/demand relationship could be expected.

It was perhaps inevitable with the fundamental shift from health-related need to income-related need that persons utilising health services came to be described as 'winners' or 'losers' (see O'Dea, et al. 1993; Davis, et al. 1994, 117). Generally, 'winners' were declared to be Group 1 and 2 adults and Group 1 pensioners whose subsidy under the new regime increased. Children of Group 3 families were declared 'losers' as were Group 3 adults and pensioners. Without the less than obvious effects of insurance as a factor, such distinctions could be clearly drawn.

Olliver (1988:3) reasons "because there need to be losers if there are to be winners, some attention is paid to those at whose cost social policy goals were achieved." In the case of National's reforms, Group 3 seemed at first glance to be clearly the losers. But with a large number of Group 3 members having insurance compounding the effects of racial, ethnic and cultural factors on utilisation, could such a distinction be made with certainty? Or, as insurance premiums increased, would more Group 3 families drop their insurance coverage? This study concentrates on those at whose cost the social policy goals of National's health reforms seemed to be achieved.

Table 1.1
Primary Care Subsidies to 1 February 1992

General Medical Services benefit	Before 1/9/90	1/9/90-1/2/91	1/2/91-1/2/92	After 1/2/92	1/2/92 Patient Charge
Children 0-4	$16	$29	$25	$15	$16
Children 5+	$16	$24	$20	$15	$16
Adults	$4	$4	0	0	$31
Beneficiaries	$12	$12	$12	0	$31
Elderly	$12	$17	$12	0	$31
Chronically ill (child 0-4)	$16	$29	$25	$25	$6
Chronically ill (Child 5+)	$16	$24	$20	$20	$11
Chronically ill (Adult)	$12	$17	$17	$17	$14
Prescription charges					
Children 0-4		$2	$5	$20	
Children 5+		$2	$5	$20	
Adults		$5	$15	$20	
Beneficiaries		$2	$5	$20	
Elderly		$2	$5	$20	
Chronically ill		$2	$5	$5	

Table adapted from Ashton 1992b, 151 and 159

Primary care and user pays

Utilisation studies investigating the effect of cost sharing on various levels of health services have repeatedly indicated that the inverse relationship between price and health care services utilisation may be the strongest at a primary care level (Lohr, et al. 1986; Manning, et al. 1987; Keeler and Rolph 1988). In other words, increasing cost sharing for primary care consultation resulted in greater percentages of reduced utilisation than for other ambulatory services and secondary care.

The strength of this apparent price/demand relationship is considered particularly important because (1) primary care physicians are often considered the 'gatekeepers' of other forms of both ambulatory and secondary care (Keeler and Rolph 1988), and (2) lack of access to primary and preventative care at an early stage is attributed to higher numbers of

'sicker' people being treated at later stages in illness or disease (Manning, et al. 1987).

In thinking about these two concerns in relation to reducing overall costs of care, it appears that they may be conflicting effects. Certainly, they may act as counterbalances in a study of primary care utilisation. Grants to all regional health authorities consumed the highest percentage of *Vote: Health* at 70% (Department of Statistics 1992). If reducing primary care has the potential to reduce the demand for these services, logically a reduction in expenditure for these services would ensue. However, if keeping people away from general practitioners results in people being admitted to the hospital when they could have been treated much more cheaply by services and treatments available through their general practitioner, expenditures could increase. If moral hazard is present in the population, increasing the likelihood of ineffective or unnecessary care, it is equally possible that demand for primary care could be reduced without an erosion of health status.

So in addition to the pure price/demand considerations of reducing primary care, less transparent, more long-term effects on secondary care should be explored. If all reduction in demand is the result of 'unnecessary' or 'inappropriate' care we can reach our policy goals of cost-containment. If, however, as the RAND study suggests (Lohr, et al. 1986) increasing cost sharing indiscriminately results in a reduction in the episodes of care, 'sicker' people may be showing up at their general practitioners or at the hospital, as many physicians and community service workers feared (Scott 1992; Delahunty and McCabe 1993:8). In the long run, increasing part-charges at a primary care level might place us further away from our policy goals of cost containment.

The aim of this study

A review of the pertinent studies, provided in Chapter 3, clearly indicates an inverse relationship between price (at time of service) and demand for primary care services. This policy study will focus not only on the fact or extent of this relationship but also on the *responses to and results of* decreased in utilisation.

This thesis specifically looks at the effect of increased part-charges on Group 3, particularly in the areas of general practice visits and the related downstream cost of pharmaceuticals. The empirical evidence from overseas suggests a decrease in utilisation but has that been the pattern for New Zealand's workers and their families? If families in Group 3 have reduced the number of general practice visits, has less medical care equated to lowered health status? If so, has there been any effect on wage-earners' health and, therefore, their ability to earn? Have these families made any other changes in their health-seeking behaviours? Have the effects of increased part-charges been uniform across income levels? Is there a difference in the way insured and uninsured families in Group 3 experienced the increases? From a policy perspective, are part-charges an effective tool for reducing utilisation of primary care services, thus useful for cost containment? Or, returning to the question of ideology, does this system of rationing reduce health status and increase inequity in New Zealand's health care system?

In order to explore the effects of increased part-charges on workers and their families, this study employs a survey design through which 129 families reported their experiences with the new cost-sharing arrangements in the first year of the changes. The results of their experiences form the basis of this thesis.

Outline of thesis

This chapter has introduced user pays as a tool for the 'more market' policies of the health reforms. User pays as a strategy for reform indicates an axiomatic belief in the price/demand relationship of neo-classical economics. This belief, and others prevalent in the neo-classical economics viewpoint, are inseparable from the political ideology of the framers of New Zealand's health reforms. Chapter 2 examines the interconnectedness of ideology, need and strategies for need fulfilment, reviewing the implications of ideology on policy design and specifically discussing the ideological bias of National's health reforms. Chapter 2 also summarises the economics of health, looking at health services as a 'commodity' and examining commonly cited failures of the market for health care services. Cost sharing as an economic instrument of policy is more thoroughly explored in the third chapter. Key results of studies pertinent to the issue of cost sharing at a primary care level are provided and discussed.

The ideological perspective influencing the structure of this study as well as the study's research question and design are reported in chapter 4. Chapter 5 includes an overview of the survey results, supplying the 'general statistical' information provided by the respondents to the survey. Armed with the general overview provided in chapter 5, chapter 6 looks at how different subgroups within the survey population, delimited by income, insurance coverage, health status, gender, family size and composition have reacted to the changes in part-charge arrangements. My conclusions and the implications of this research for future health policy research and reforms are provided in chapter 7.

Although cost sharing may encourage less dependence on others and more dependence on ourselves for our own health, there are also definite and unavoidable risks to this policy strategy. This thesis explores both the advantages and the disadvantages of user pays in the New Zealand context and reports the findings of 129 Group 3 working families as they experienced their first year under the reforms.