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RESTRUCTURING PRIMARY HEALTHCARE MARKETS IN NZ:

Efficiency and Equity Implications of Provider-Insurers

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OVERVIEW

Theoretical framework

- ‘two-sided markets’ for health care
- contractual risk allocation
- application to centrally-planned health care systems

Application of framework to New Zealand

- Pre-NZPHCS
- NZPHCS
  - “insurance market side” implications
  - “health care service delivery side” implications

Summary and Conclusions

THEORETICAL FRAMEWORK

Arrow (1963)

1. "the special structural characteristics of the medical care market are largely attempts to overcome the lack of optimality due to the non-marketability of the bearing of suitable risks and the imperfect marketability of information"

   ⇒ necessity of 'two-sided' insurance markets

2. compensatory institutional changes emerge in response to the non-marketability of bearing suitable risks and imperfect marketability of information, but these changes may themselves interfere with optimality

   ⇒ "the social adjustment towards optimality puts obstacles in its own path" during contractual/institutional evolution

‘TWO-SIDED MARKETS’ FOR HEALTH CARE

Extrapolation from work of Rochet and Tirole

Two-sided markets

platforms that help parties “get together in many ways and thereby create value for these parties that they could not readily obtain without the co-ordination of the platform”
(Evans and Schmalansee, 2005)

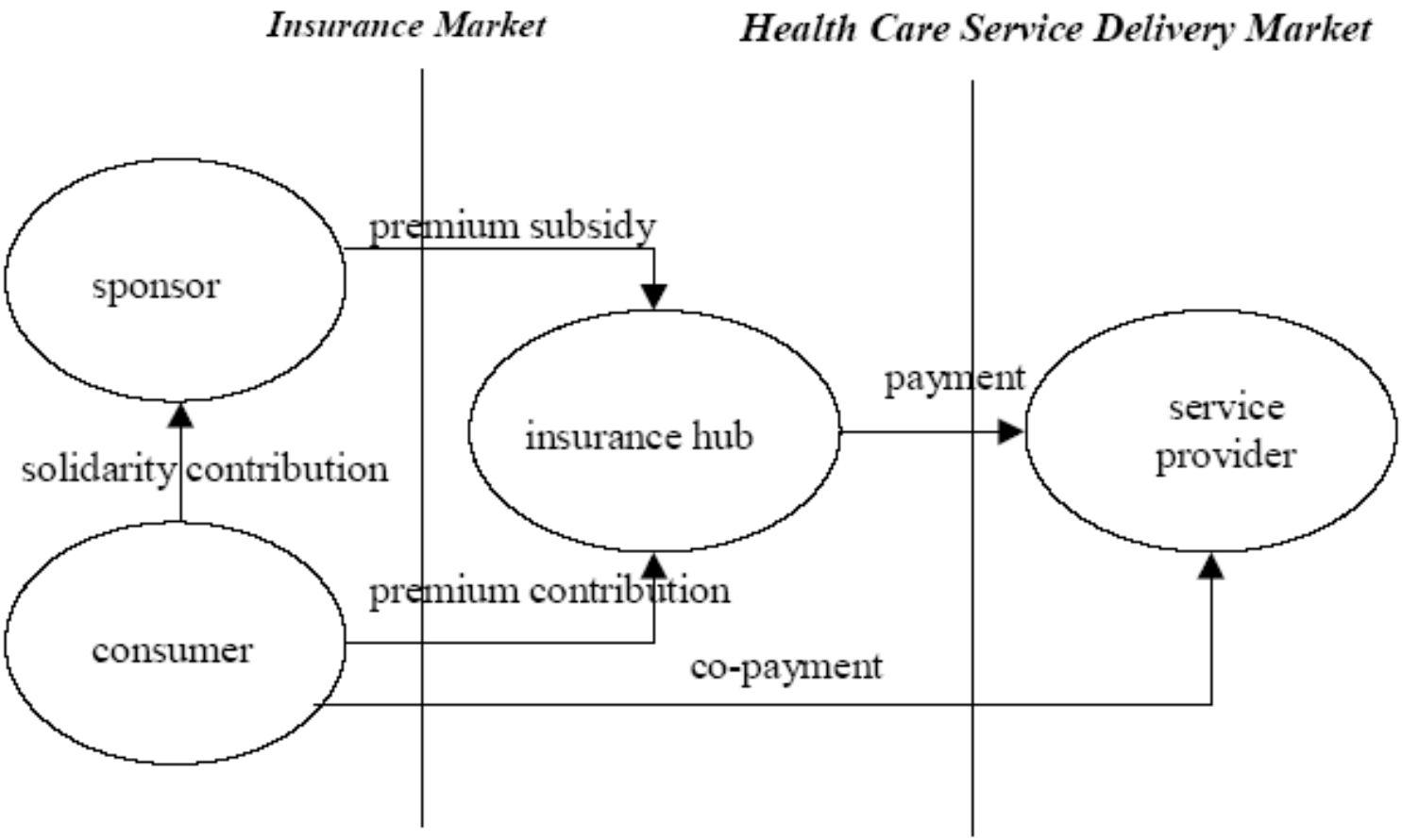
Application to health care

Insurance provider at the ‘hub’

risk-bearing (insurance) markets on one side (inputs)

health care service delivery markets on the other side (outputs)

TWO-SIDED HEALTHCARE MARKET



Adapted from Van der Ven and Ellis (2000:761) and Rochet and Tirole (2002:552)

GOVERNMENT AND TWO-SIDED MARKETS

Government as sponsor

structuring coverage,regulating plans, managing enrolment

reallocating premium burden across consumers

‘solidarity contributions’ to effect wealth transfers

Government as insurance hub provider

distinction between of solidarity payments, premium subsidies

Government as health care service provider

distinction between purchasing and provision (the ‘purchaser-provider split’)

CONTRACTUAL RISK ALLOCATION

Contracts as mechanism to allocate risk

Insurance contracts

specify premium paid and patient co-payments (input side)

specify service provider remuneration terms (output side)

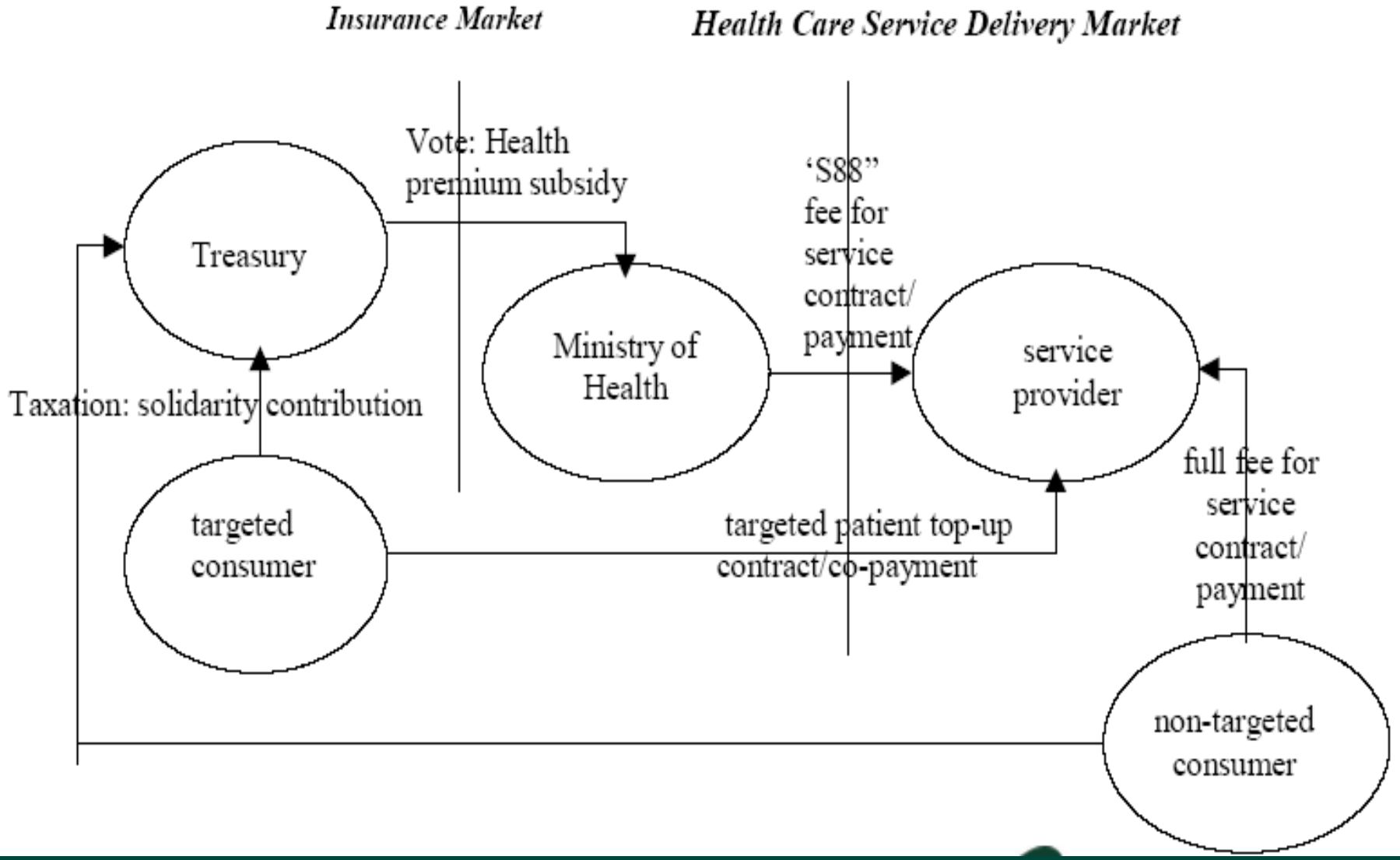
Competition in each of insurance markets, service provision markets when insurers can set the degree of consumer cost-sharing optimally can result in a second-best efficient outcome

(Gaynor, Haas-Wilson and Vogt, 2000)

Evolution: implications for two-sided health care markets

Managed Care as example

PRE-NZPHCS PRIMARY HEALTH CARE



PRE-NZPHCS: KEY FEATURES

Government as sponsor and insurer (risk manager)

Private sector service provision

- practitioner charging autonomy (1938 f.f.s. ‘S88’ payments)
- no risk bearing associated with patient demand uncertainty

Tightly-targeted insurance market

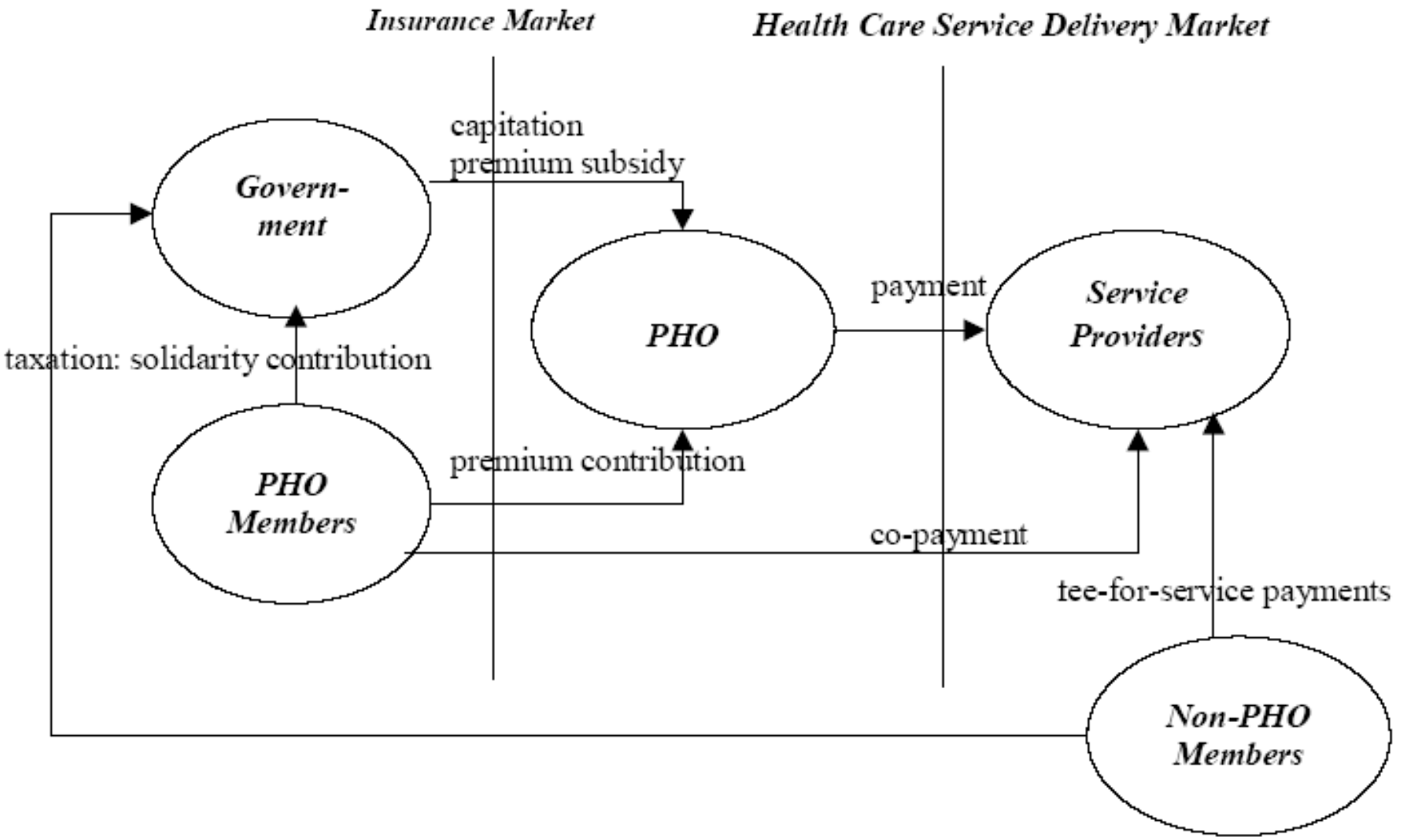
- majority self-insuring
- limited risk-sharing (government = residual risk bearer)
- taxation ‘solidarity payments’ as principal wealth redistribution method (ex ante equity adjustments; cost to all taxpayers)
- ‘S88’ payments = welfare benefit outputs from social insurance

Moral hazard: low

- patient ‘co-payments’ cannot be efficient insurance contracts
- but limited in application (subsidies = 30% of practitioner income)

Adverse selection: non-existent

NZPHCS: STATED DESIGN (King, 2001)



NZPHCS: KEY DESIGN FEATURES

Substantial increase in government expenditure share

Universal capitation funding

- mandatory risk-sharing for registered population

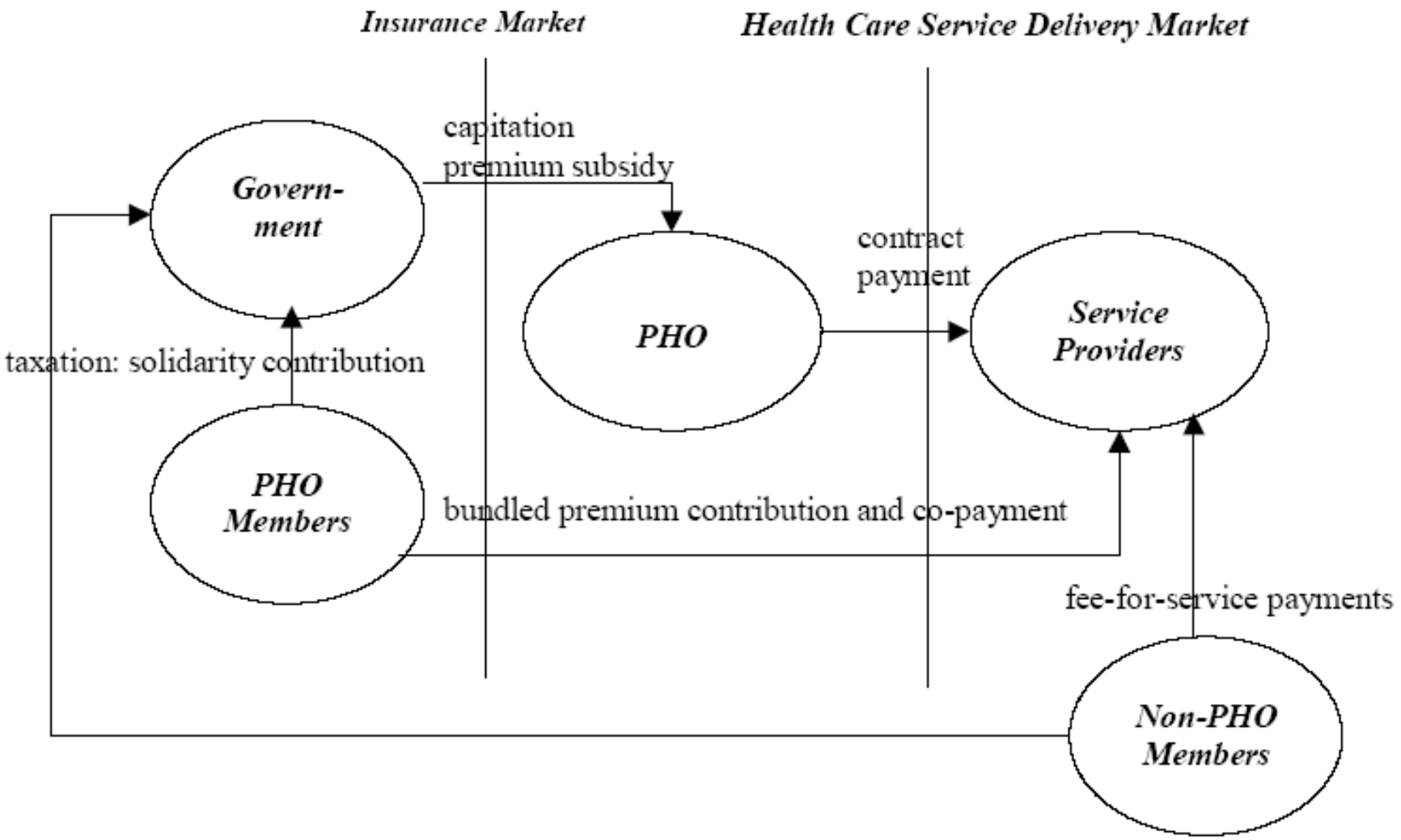
Subsidy becomes premium contribution to private sector competing insurers (PHOs)

- Government 'risk-free'; private sector become risk managers

PHOs as managed care providers

- contracts with insured individuals
  - no apparent barriers to optimal ex ante contracts, ex post co-payments
- contracts with service providers
  - as agents of insured individuals
  - ability to design optimal incentive contracts

NZPHCS: IN PRACTICE



TRANSITION IMPLICATIONS

Retention of provider charging autonomy

- negates ability to design optimal provider incentive contracts
- leads to bundling of ex ante premium contributions and ex post co-payments into a single ex post payment

Price 'regulation' expectations

- ex post 'bundled payments used to effect social/political wealth transfers
- increased government subsidies must lead to compensatory decreases in ex post payments for government subsidy categories

Conflict: insurance wealth transfer objectives and social/political wealth transfer objectives

- neither achieved, or one 'crowds out' other
- implications for efficiency, equity

INSURANCE CONSEQUENCES (I)

Selective increase in subsidies

increase in moral hazard in subsidised group only

Insurance response

increase ex post premiums only to the newly-subsidised

Regulatory response

ex post payments for newly-subsidised must directly reflect increases in subsidies

Insurance response to regulatory response

spread additional moral hazard costs across all individuals

ex post premiums rise, even for those not receiving increased subsidies

INSURANCE CONSEQUENCES (II)

Efficiency outcome

- prices rise for low-subsidised
- consumption falls below optimum => lower welfare
- prices to higher-subsidised less than optimal given increase in moral hazard risk => lower welfare

Equity outcome

- extra costs arising from lower welfare collected only from ill
- ex post collection becomes a consumption 'tax on falling sick'
  - perfectly risk-rated ex post premium contribution
- wealth transfer from the low-subsidised sick to the high-subsidised sick
- wealth transfer from the sick to the well

Contrary to efficiency raising objectives of insurance instruments

EVIDENCE

Prices rising for all categories of patients

higher charges in practices receiving lower subsidies, even for patients of same subsidy class (Consumer, 2005 Survey)

Patient charges not reflecting increases in subsidies (King, 2004: Cabinet paper)

Introduction of Care Plus after less than 2 years

targeted at the chronically ill

acknowledgement that the burden of the system design outcomes falls most heavily on the frequently ill?

SERVICE DELIVERY CONSEQUENCES

Retention of practitioner charging right

- removes ability for PHOs to strike efficient incentive contracts with service providers

"If you can't manage the risk, don't bear it"

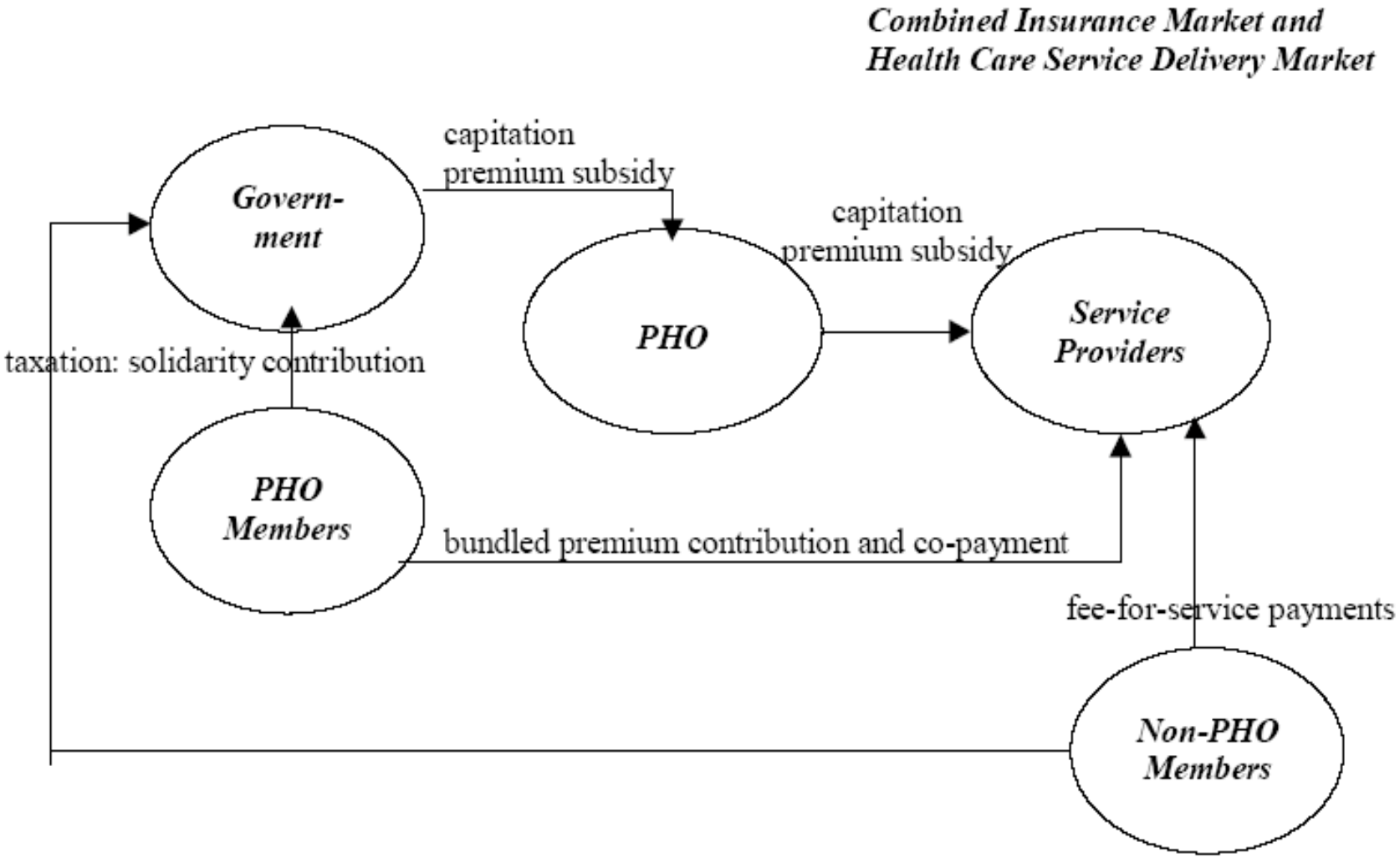
- 'passing on' capitation contracts to service providers

Service providers become insurers

- inefficiently small – 1200-2000 patients
- risk management costs rise
- first recourse to manage => pass on to consumers in higher prices (replicating pre NZPHCS risk-free provider status)
- incentives for adverse selection (screening) increase

Welfare reduces further (relative to pre-NZPHCS, efficient insurance market)

PROVIDERS AS INSURERS



COMPETITIVE RESTRICTIONS

Unlikely to see evolution to more efficient model

Provider-governors mandatory in PHOs

- formed around existing provider groups
- conflict of interest – on both sides of the 'passing on' contracts
- unlikely to be party to contracts to restrict their practitioner charging autonomy

Patients 'locked in'

- Government subsidies non-transferrable; payable only to PHOs
- patients don't face full cost of service delivery => less competition from unsubsidised providers

Providers may also be 'locked in' to PHOs

- local geographic monopolies; strong network effects

CONCLUSIONS

- NZPHCS does not appear to be a centrally-planned iteration towards a more efficient system
- Rather, appears to be a consequence of an attempt to use health care system institutional design to 'fix' a perceived problem on the health care service delivery side
- With disastrous consequences for the efficiency of the entire system
- Restructuring of the primary health care sector in NZ "has put obstacles in its own path"