NEW ZEALAND INSTITUTE FOR THE STUDY OF COMPETITION AND REGULATION INC.

FROM PROVIDERS TO PHOs: an institutional analysis of nonprofit primary health care governance in New Zealand

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CORPORATE MEMBERS

Contact Energy

Fonterra Co-Operative Dairy Group Limited

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Westpac Institutional Bank

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http://www.iscr.org.nz/f650,18412/18412_Health_nonprofit_governancce_in_NZ_May_24.pdf

CONTEXT

Escalating health care costs worldwide

Drive for more efficient resource allocation processes

Questions:

- which providers should receive funds?
- do institutional (ownership and governance) arrangements of firms matter?

NONPROFIT FIRMS AND HEALTHCARE

Absent contractual provisions, generally co-exist with shareholder-owned firms

- no clear evidence of superior performance of either status

A response to ‘missing market’ for ‘third sector’ goods? (Weisbrod, 1975, 1988)

Facilitating ‘trust’ as means of addressing information asymmetries between purchasers and providers? (Arrow, 1963; Newhouse, 1973; Rose-Ackerman, 1996)

Eschewing profits as a ‘strategic tool’? (Glaeser & Shleifer, 2001)

Personal altruistic motivations? (Besley & Ghatak, 2005; Lakdawallah & Philipson, 2006)

POLICY

Favoured by some government funders (e.g. NZ)

- Primary Health Care Policy (2001) limited government funding to nonprofit firms with governance shared between consumer and service provider interests
- "to guard against public funds being diverted from health gain and health services to shareholder dividends" (Minister of Health, 2001:14)

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THE NONDISTRIBUTION CONSTRAINT

Speaks only to the matter of allocating operating surpluses (profits)

- no owners with a claim on residuals

Is silent on the matter of control exercised over firm assets (governance) used to generate income streams

- allocation of decision-making control likely at least as important to achievement of efficiency objectives than presence or absence of shareholding interests
  - e.g. allocating profits as high salaries to those who would otherwise receive same proceeds as dividends

OUR PAPER

Develops framework based on competition for ownership of firms

Addresses

- economic rationale for firm having owners or not
- the optimal stakeholding identity (consumer or producer) of those owners
- competition for governance control in absence of owners

Applies the framework

- to primary health care firms generally
- the New Zealand case before and after policy change

THE FRAMEWORK

Hansmann's theories of ownership (1996) - endogenous

Market for ownership (inspired by Coase, 1937; Williamson, 1986)

- firm will be owned by stakeholding group whose ownership minimises costs of
  - ownership – co-ordinating, motivating (e.g. incentives, agency)
  - and market contracting (transaction costs, market power imbalances, contractual incompleteness, bounded rationality, holdup)

Stakeholders either

- suppliers (including labour, materials, capital – equity and debt)
- or customers

'Optimal' owners can change as environmental factors alter

‘NON-OWNED’ FIRMS

Will emerge endogenously when costs of maintaining a defined ownership stake outweigh the benefits

- control by defined ownership interests replaced by a set of fiduciary obligations
- fiduciary duties should favour the stakeholding group that, but for higher costs, would have been the defined owners

APPLICATION TO PRIMARY HEALTH CARE

Arguments for consumer ownership

- costs of market contracting – exerting information asymmetry
  - patients ameliorate risk by owning firm, hiring doctors
  - but how to monitor more-informed employees?
- costs of ownership
  - if costs of ownership are too high for alternative owners (i.e. doctors)
  - e.g. demand too low, or uncertain
  - consumers assume ownership risks – e.g. fundraising, philanthropic donations, tax benefits

But which patient-owners?

- a subset?
  - risks of exploiting those with poor health states
- all jointly – consumer co-operative
  - benefits in proportion to custom

ARGUMENTS FOR PRACTITIONER OWNERSHIP

Practitioners own and supply costly-to-contract human capital

- few other capital requirements
- relatively low observability, risk of reputational damage from financial partnership militates against equity-sharing
- observed mostly in practice - rare exceptions when other factors increase financial risk (e.g. capitation contracting)

Is supplier-controlled ‘non-ownership’ plausible?

- costs of ownership costs rarely prohibitive
- but observed historically – community-based care by missionaries, religious charities
    - ‘livings’
    - beneficiaries powerless

WHAT ABOUT 'MIXED' GOVERNANCE?

The NZ policy prescription

Joint ownership typical when

- substantial exogenous uncertainty leads to risks unable to be anticipated or contractually allocated (e.g. exploration, R&D)
- mutual holdup of resources not amenable to contractual resolution

Not clear where this could occur

- monopoly supply/monopsony purchase?
- but is mixed governance superior?
  - contracting difficulties anyway
  - tensions between practitioner and consumer interests likely costly => extreme conflict of interest w.r.t. practitioner salaries
  - and mixed governance forfeits ability to use contestability to resolve holdup

APPLICATION TO NEW ZEALAND

Pre 2002

- dominance of sole practice general practitioners (over 90% market share)
- linked professionally via Independent Practitioner Associations
  - practitioner-controlled co-operatives supplying support services to GPs as consumer-members
  - but grew into service-providing entities (complementary services to classic GP services)
- a small number of homogeneous consumer co-operatives
  - trade and student unions, Iwi (Maori) providers)
- plus a limited number of consumer-controlled nonprofit 'trusts'
  - predominantly rural areas eschewed by private providers

POST 2002 ARRANGEMENTS

Consumer co-operatives and community nonprofits

- few barriers to becoming PHOs

General Practitioners

- could utilise existing IPA structures to form new nonprofit entities
- effective control remaining with practitioners, despite ‘mixed governance’ mandate

The evidence

- 77 PHOs by 2004
    - 30 community-origin, 47 practitioner-led
    - community origin m/share by patient numbers 8.3%; practitioner-led 91.7%

PHO CASE STUDIES

Howell (2005)

- large urban PHO
- effective practitioner control (2003-4 year)
  - 11 trustees – 6 GPs (all IPA Directors), 2 more appointed by the IPA (practice nurses)
  - IPA chairman is PHO chairman

Cordery (2008)

- PHO operating as wholly-owned subsidiary of IPA
- GPs contracted with the IPA which operated the PHO contract through a charitable trust

CONCLUSION

‘Nonprofit’ requirement offers no guarantee that ‘trust’ can be relied upon to minimise diversion of funds away from health care

Markets for control of nonprofits will follow the balance of interests determined by the combined costs of ownership and market contracting

Policy implications

- better outcomes more likely to be achieved by recognising these pressures and altering contracts according to the different risks invoked by different controlling stakeholder interests in different circumstances