The Impact of Parallel Public and Private Finance on Equity and Access: What does the Evidence Say?

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Health System Policy Debate

- Long-standing, perpetual calls for greater role for parallel private finance in Canada
- Court challenges to provincial regulation of private health insurance, physician fees, and physician practice options

Private Finance vs. Private Delivery

- My focus is solely on parallel (or duplicative) private financing. This is distinct from issues relating to private delivery.
Question and Objective

**Question**: Compared to a system of public-insurance only, how will the introduction of parallel private finance, dual practice, and deregulated private fees affect access to the publicly financed system?

**Objective**: review analytics and evidence, with a focus on health system equity and access in the public system

- The impact is an empirical question
- It’s complicated: insurance markets, health care service markets
- Good quality, consistent evidence on some aspects; lower-quality, contested evidence on others

**Punchline**

- Parallel private financing reduces health system equity
- On balance, it likely reduces access in the public system
Conditions for Parallel Private Finance to Thrive

- Privately financed sector must offer something publicly financed system does not
  - amenities
  - choice
  - shorter wait
- Providers: Incentive for providers to deliver privately financed care
- Insurance: Private insurance to defray high costs of care
Parallel Finance and Equity in Health Care System

1. Equity of Use/Access
   - Distributional equity: allocation according to need
     - horizontal equity: those in equal need receive equal treatment
     - vertical equity: those with differing needs receive appropriately different treatment

2. Equity in Finance
   - Distributional equity: contribution according to ability to pay
     - horizontal equity: those with equal ability contribute equal amounts
     - vertical equity: those with differing abilities contribute appropriately different amounts

3. Net Incidence
   - difference between value of services received and contributions made
Impacts on Equity

1. Equity in Use
   - unequivocally reduces distributional equity in use/access
Reduces Distributional Equity of Access and Use

Disproportionately increases access/use for those of high SES
- Greater ability to self-insure and pay for care privately
- Greater ability to obtain private insurance

Providers prioritize those seeking care privately

Private insurance strives to exclude certain users
- concentrates on a small number of uncomplicated elective procedures
- often excludes coverage for pre-existing conditions and for chronic conditions
- often excludes coverage for seniors

⇒ Overall, it compromises allocation according to need
Impacts on Equity

1. Equity in Use
   • unequivocally reduces distributional equity in use/access

2. Equity in Finance
   • may increase distributional equity in contributions (if no tax subsidies or related measures)

3. Net Incidence
   • reduces distributional equity with respect to net benefit (net benefit increases for high-SES)

⇒ Overall, reduces distributional equity in health care system
Parallel Private Finance and Access to Public System

1. Demand-side: What will be the impact on the demand for health care in the public system, the private system, and in total?
2. Supply-side: What will be the impact on the supply of health care to the public system, the private system, and in total?

⇒ Determining factor with respect to access will be the relative sizes of these demand-side and supply-side effects.
Case 1: Equal Demand and Supply-side Responses

**Demand:** Total demand (across both sectors) stays constant but A units of demand shifts from public system to privately financed care

**Supply:** Total supply (across both sectors) stays constant but A units of supply shifts from the public system to privately financed care

⇒ Everyone gets treated, but access (as measured by wait times) has worsened for public patients.

- Why?: differential prioritization
Case 2: Differential Demand and Supply Responses

**Demand**: Total demand stays constant but $A$ units of demand shifts from public system to privately financed care

**Supply**: Total supply grows by $1$ (new unit of supply goes to private sector) and $(A - 1)$ supply shifts from the public system to privately financed care

$\implies$ **Everyone gets treated, additional patient treated in public sector; ambiguous impact on wait times in public sector.**
Case 3: Differential Demand and Supply Responses

**Demand**: Total demand grows: A units of demand shifts from public system to privately financed care, B units new demand

**Supply**: Total supply constant and (A+B) units of supply shifts from the public system to privately financed care

⇒ Those who rely on the public system are unambiguously worse off (fewer treated, wait times increase.)
General Demand-side Effects

<table>
<thead>
<tr>
<th></th>
<th>Public</th>
<th>Private</th>
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</thead>
<tbody>
<tr>
<td><strong>Existing Demand</strong></td>
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<tr>
<td>1. Continue to use the public system</td>
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<td>2. Substitute private for public</td>
<td>decrease</td>
<td>increase</td>
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<tr>
<td><strong>New Demand</strong></td>
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<tr>
<td>1. Complementary Public Demand</td>
<td></td>
<td>increase</td>
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<td>2. Stimulated Private Demand</td>
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<td>increase</td>
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Most probable scenario:

- Private demand increase
- Public demand decrease (but less than shift from public to private)
- Total demand increase
Supply-side Effects

Issue: What will happen to the supply of health care services?

- Depends critically on work decisions of health care professionals, and physicians in particular
  - total work effort (work vs “leisure”)
  - allocation of work effort among:
    - clinical care in public sector
    - clinical care in private sector
    - non-clinical professional activities
Supply-side Effects

1. **Total Work Effort (Labour Supply)**
   - Income Effect: work less
   - Price Effect: work more

Evidence: Little or no impact of total hours work (general studies on physician labour supply in response to fee changes; in the context of dual practice in Norway, Australia)

2. **Allocation of Work Effort Across Professional Activities**
   - Re-allocate from non-clinical activities to clinical care in private sector
   - Within clinical care: reallocate from clinical care in public sector to clinical care in private sector

Evidence: Re-allocate hours of work to private clinical care (Australia)

→ Net result is reduced supply to public sector
Supply-side: Cost Pressure and the Real Public Budget

**Increases wages for health care professionals**

- Competition between public and private sectors for limited time and effort of health care professionals (MDs, nurses, technicians, etc.) will drive up wages
- This reduces real value of public budget, reducing the volume of services that can be provided through public system

**Evidence**

- Norway
- UK
- BC
Can these detrimental effects be mitigated?

Partially: limit size of the parallel financed sector

- tax policy
  - remove tax subsidy to private insurance
  - tax the purchase of parallel private insurance
- regulate the insurance products that can be offered (benefit packages)
- regulate ability to restrict access (e.g., seniors, pre-existing conditions)
- prohibit public facilities from providing privately financed care