

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

Jeremiah Hurley^{1,2}

¹Department of Economics, McMaster University

²Centre for Health Economics and Policy Analysis, McMaster University

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Context

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

⇒ **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

	Public	Private
Existing Demand		
1. Continue to use the public system		
2. Substitute private for public	decrease	increase
New Demand		
1. Complementary Public Demand	increase	
2. Stimulated Private Demand		increase

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 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**
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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