ECONOMIC INCENTIVES AND CLINICAL DECISIONS

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Abstract

In the face of escalating health care expenditure, OECD countries are turning to a variety of cost-containment strategies. This thesis analyses three such mechanisms.

In Part I, I consider the use of coinsurance to limit the demand for health care. Because coinsurance reduces the elasticity of demand with respect to the price of health care, consumers facing low coinsurance rates may be charged a higher price by doctors. Such discriminatory pricing enables the doctor to extract surplus created in the insurance market, and therefore reduces the effectiveness of coinsurance. I show that in equilibrium, some consumers remain uninsured. I also show how this problem is solved if the doctor and insurer enter into managed care style arrangements. Such arrangements improve insurer and doctor profitability, and restore complete insurance market coverage.

In Part II, I consider the design of fundholding schemes which encourage doctors to restrict expensive treatment to severely ill patients. I show that such schemes may be undermined by a patient-doctor side contract. In the face of such patient-doctor collusion, the fundholding scheme may be made collusion-proof by increasing its "power". I show that the optimal collusion-proof scheme may pay the doctor more than his reservation wage. An alternative solution to patient-doctor collusion is to use a partial fundholding scheme that requires some additional co-payment from the patient.

Part III analyses New Zealand's internal market reforms. Introduced in 1993, the reforms involved the separation of funding and provision of health care, and

were intended to simulate a competitive market environment, thereby improving the incentives of government owned health care providers to be efficient. On the supply side, I look at the internal restructuring of hospitals into private-sector clones. I argue that this commercialisation failed to take account of informational issues within the hospital. On the demand-side, I examine the suitability of internal markets for eliciting optimal innovation from the hospital sector. Again, I find that a standard argument, namely that increased competition leads to innovation, is questionable in the context of the internal market.

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