COMPARING MODELS OF HEALTH CARE REFORM:
INTERNAL MARKETS AND MANAGED COMPETITION

by

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Comparing Models of Health Care Reform: Internal Markets and Managed Competition

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Abstract
This dissertation compares managed competition and internal market reform as proposed to be applied in the U.K., New Zealand, the Netherlands, and the U.S. The goal is to determine which model is likely to most efficiently ensure access for all citizens to a comprehensive range of health services.

I conclude that the managed competition model is to be preferred as it harnesses both market and regulatory mechanisms to create conditions for optimal decision-making. The model also promises greater flexibility in responding to different and dynamic health service markets. The problems with the managed competition model are the difficulty of ensuring that private insurers compete on price and quality dimensions rather than on risk avoidance ("cream skimming") and the existence of multiple purchasers within a system which may increase transactions costs.

An internal market relies on monopsony government-appointed purchasers so as to avoid problems of cream skimming and transactions costs; however, these equally become problems in an internal market as government purchasers move to contract on a capitation basis with small groups of providers offering managed care. Internal market reform focuses on a "purchaser-provider split" requiring public and private providers to compete for supply contracts with government-appointed authorities. The key concern with the internal market
model is the lack of attention paid to the incentives operating upon these authorities. Moreover, in mandating contracting-out the model makes no allowances for the different characteristics of health service markets.

In all health care systems it is essential to design governance mechanisms so that decision-makers have the incentives, skills, and resources necessary to make decisions that, over time, strikes the right balance between patients' needs and societal interest and between equity and efficiency. Neither model addresses governance issues sufficiently. However, the managed competition model offers the promise of tailoring market (exit), political (voice) and regulatory mechanisms to create the optimal mix of incentives.

Although preferable in theory, the managed competition model has never been fully implemented in practice. Its complexity means there is a danger of piece-meal implementation which may result in an inferior alternative institutional arrangement to the status quo in any particular health care system.
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1.1 Problems Justifying Reform Proposals

Over the course of the last decade, nearly every major OECD country has proposed and/or implemented health care reform.\(^1\) There have been a number of factors which alone or in combination have precipitated reform initiatives including increased total spending on health, increases in government expenditures, access concerns and growing rationing through waiting times, and concerns over the cost-effectiveness of many health services supplied.

Looking first at the growth in the percentage of GDP devoted to health, between 1972 and 1982 there was a 36% increase in the percentage of GDP devoted to health in the U.S., a 25% increase in the Netherlands, a 30% increase in New Zealand and a 26% increase in the United Kingdom.\(^2\) In the 1980s most countries managed to reign in cost increases; however, between 1982 and 1992 there was still a 36% increase in the percentage of GDP devoted to health in the U.S. and a 20% increase in the U.K.\(^3\) In New Zealand, there was a 12% increase and in the Netherlands a 2% increase over the same period.\(^4\) There is a concern that the ageing of the population in most western industrialized countries and the demand for new technologies will continue to put upward pressure on overall health care expenditures.

As in most OECD countries the majority of health expenditures are paid for by government there was also concern over the continued growth of government expenditures on health in an era of concern over rising deficits.\(^5\) The drive to reform health-delivery systems along pro-competition models is also part of a wider phenomenon whereby the role of government is under review in all areas.\(^6\)

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\(^2\)Ibid. at 37, Table 4.1.

\(^3\)Idem.

\(^4\)Idem.


\(^6\)Over the last two decades, the neo-classical paradigm had become the means by which to evaluate government programs in most Western capitalist states and it seems no longer sufficient to argue that public delivery systems ensure universal access and social justice — the pre-eminent criterion seems to have become whether or not institutional arrangements are efficient — R. V. Saltman and C. Von Otter, *Planned Markets and Public Competition: Strategic Reform in Northern European Health Systems* (Buckingham: Open University Press, 1992) at 5–7.
In predominantly government-funded systems that sought to reduce growth in health care expenditures throughout the 1980s by capping government expenditure and closing hospitals, there was widespread public concern over the resultant growing waiting lists and times and a sense that health providers were not responsive to patient and societal needs.\textsuperscript{7} In systems that relied to a greater degree on private insurers there were concerns over access to coverage for high-risk individuals who were facing increasingly higher premiums or excluded altogether from private insurance markets.

Reform has also been driven by the work of health economists who have emphasized that there is no evidence that many health care services supplied are cost-effective or even effective.\textsuperscript{8} This problem was seen as resulting from leaving allocation decisions in the hands of physicians who have been resistant to outside scrutiny of their decision-making processes and who have had little or no incentive to be sensitive to the costs and benefits of the services they supply or recommend. Thus the concern has arisen that the present allocation of resources across health needs and between health services used in response to those needs reflects what is optimal from the medical professions’ perspective rather than what is optimal from society’s perspective.

Allocation decisions have been left to physicians as historically both public and private insurers have been passive “indemnity insurers”, reimbursing providers for the costs of all services supplied on a fee-for-service basis. As discussed in Chapter 3, in the U.S., private insurers have not historically been proactive purchasers of health services as they have been readily able to pass on rising costs to employers who, in turn, have transmitted these costs to taxpayers through the receipt of tax subsidies and to employees through reductions in real wage growth.\textsuperscript{9} Workers have been under the misunderstanding that the rising costs of health care were being borne by employers.\textsuperscript{10} In the absence of any incentive to be cost-effective,

\textsuperscript{7}Saltman and Otter identify public resistance to continued rationing by queue of certain elective surgical procedures, particularly for the elderly, as a force that has contributed to health reform initiatives -- ibid. at 13.
\textsuperscript{8}R. G. Evans, “Going for the Gold: The Redistributive Agenda Behind Market-Based Health Care Reform” (1997) 22: 2 Jnl. of Health Politics, Policy, and Law 427 at 460 notes that students of health care system believe that there is a great deal of “inappropriate, unnecessary, and sometimes downright harmful care being paid for in all modern health care systems.” He goes on to note that the key question becomes one of moving closer to production frontiers.
\textsuperscript{10}One study that suggest 80–100% of reductions in health care spending will be translated into higher wages -- J. Gruber and A. Krueger. “The Incidence of Mandated Employer-Provided Insurance: Lessons from Workers'
U.S. health care providers have competed for patient allegiance on surrogate indicators of quality, such as the level of technology employed, perversely resulting in increasing competition contributing to cost-escalation as opposed to cost-reduction. In the Netherlands, the government has sought to constrain total expenditures on health care by regulating capital investment, labour costs, and prices but has not sought to substantially influence the decision-making of physicians. In the U.K. and New Zealand, where health services are financed predominantly from general taxation revenues, government has effectively capped the total amount of resources devoted to health but how these resources have been expended has still largely been left to the discretion of health care providers within government budget constraints. Thus, historically, in all countries under discussion, there has been relatively little pressure on the demand side to ensure the optimal allocation of resources between different health needs (balancing societal and patient interests) or to ensure the supply of the most cost-effective service in response to a particular need.

1.2 Thesis Outline

The purpose of this thesis is to analyze recent attempts to reform health care allocation systems by means of competition-oriented reforms. The competition-oriented reform models, managed competition reform and internal market reform, combine elements of both government planning and market approaches to health services allocation. Managed care is another concept that is often referred to in the context of health care reform and is the mechanism through which managed competition proposals seek to obtain cost-savings. These concepts are discussed further below.

The key concern in the internal market model is the lack of attention paid by the model to the accountability of and incentives that act upon government-appointed monopsony purchasers. In the absence of such incentives it is contended that an internal market system may result in the worst of both the government and the market approaches to reform -- the inertia and


inefficiencies of the government-interventionist approach with the cost and inequities of the competition approach. The key concern in the managed competition model is the notion that private insurers will compete on avoiding risk rather than on price and quality dimensions and that the existence of multiple purchasers within a system will increase transactions costs. However, these latter problems also become problems within an internal market as government purchasers move to contract with many small providers offering managed care plans on a capitation basis which results in a devolution of purchasing authority to private providers that must bear the risk of utilization by patients. Thus this dissertation finds that despite the different rationales of the internal market model and the managed competition model, in practice there is a convergence because of the reliance in both types of systems upon managed care.

The optimization problem that all health care systems must struggle with is how to strike a balance between individual needs and societal interests and more generally between equity and efficiency. Reform models should be assessed on their ability to solve this optimization problem. All of the competition-oriented reform models for health care allocation systems eschew direct government intervention in the supply of health services and advocate a regulated form of competition between insurers/purchasers (managed competition) and/or providers (internal markets) as the best means to solve the optimization problem. Both managed competition and internal market models of health care reform require active purchasers of cost-effective services. These models challenge the traditional assumption that the amount of resources to be spent on health will be capped at an efficient level as health care providers will only supply what is medically necessary and the assumption that within a hard budget that health providers will allocate resources optimally. In light of the shift to active purchasing in internal market and managed competition systems, is there a need for continued regulation of the supply side or can it be largely left to evolve on its own? To use the rowboat analogy of Osborne and Gabler, does the government have sufficient steering power in either an internal market model or a managed competition model that it can leave the private sector to row?13 Although the row boat metaphor has the power of simplicity, in the real world,

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things are often murkier and less clear-cut than policy-makers, economists and other rationalists would like to be able to assume. I argue that in fact the nature of governance and regulation required in the competition-oriented models is of a very sophisticated nature and there is great scope for inefficiencies within such regulation.

1.3 The Reform Models
The language of health care reform can often be confusing and there seems to be a small cottage industry in inventing phrases and acronyms for the various new arrangements between insurers, purchasers, providers and patients that are emerging. For political reasons, dissimilar reform initiatives may be labelled by the same name. For example, Marmor quotes one speaker at a January 1993 retreat for congressional staff members in the U.S. where they pondered the prospects for health reform as saying, "I don’t know what we’re going to do, but whatever it is, we’ll call it managed competition." Thus it is important to clarify at the outset what I mean by the terms “internal market reform”, “managed competition reform” and “managed care”.

1.3.1 Internal Market Reform and the Purchaser/Provider Split
Recent reforms in the U.K. and New Zealand have sought to create what is known as an “internal market” in health services and the reforms implemented in both countries are very similar. Proposals for reform of the U.K.’s National Health Service (“the NHS”) were first announced in 1989. Subsequently, the reforms were implemented through the National Health Service and Community Care Act 1990. In New Zealand, the then Minister of Health released his proposals for internal market reform in 1991. Subsequently, many of the reforms were implemented pursuant to the Health and Disability Services Act 1993. In the reformed systems, the purchaser and provider roles of regional public authorities, formerly responsible for purchasing secondary and community services and for managing public hospitals, have been split. The goal of the reforms is to eliminate what was seen as a conflict of interest in the old health authorities in both jurisdictions. Prior to reform, health authorities were both purchasers (as they bought all publicly funded hospital and secondary services) and

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17(N.Z.), 1993, No. 22 [hereinafter NZ Health 1993 Act]
providers (as they managed the government-owned hospitals that supplied most of the services). The perception was that the old public hospitals were not performing as efficiently as they could as they were under little pressure to do so. In the new internal market, government-appointed monopsony purchasers (100 Health Authorities in the U.K. and 4 Regional Health Authorities in New Zealand) must now bargain with competing public and private health service providers and contract for the supply of a full range of publicly-funded health services for the people of their regions. They are not permitted to provide health services directly. On the other side of the "split", public hospitals are now managed in the U.K. and New Zealand by, respectively, "NHS Trusts" and, "Crown Health Enterprises." In both systems these new enterprises are meant to act much more like private firms and compete with each other and private providers for supply contracts with purchasers.\(^\text{18}\)

An exception to the purchaser/provider split in the U.K.'s internal market are "GP Fundholders", of which there are now over 3500. Fundholders receive public funding, in the form of capitated budgets, with which to buy drugs, diagnostic tests and x-rays, outpatient services and approximately 20% of hospital and community services, on behalf of the patients enrolled with them. The purchaser and provider roles are combined in one enterprise to the extent that a physician can substitute the supply of his/her own services instead of buying services from other providers. Similarly, in New Zealand "Independent Practice Associations" ("IPAs") are exceptions to the purchaser/provider split. These associations are groups of physicians of varying size that receive budgets from Regional Health Authorities to fund their own services and other specified services such as drugs, diagnostic tests, x-rays etc. on behalf of their patients. Fundholding and IPAs are examples of "managed care" which is described further below. A key distinction between Fundholding and IPAs is that Fundholding is a central government initiative whereas IPAs have sprung up as a response by physicians to the new internal market reforms.\(^\text{19}\)

Diagrams 1 and 2 in Appendix 2 show the structures of the NHS internal market and the New Zealand internal market.

\(^{18}\)Thus the term "internal market" is something of a misnomer as the market created is not intended to be limited to the public sector although in reality it continues to be largely so.

\(^{19}\)See L. Malcolm & M. Powell, "The Development of Independent Practice Associations and Related Groups in New Zealand" (1996) 109: 1022 N.Z. Med. Jnl. 184 at 186 noting that "IPAs were viewed as vehicles for protecting the status of general practice in the face of considerable uncertainty."
1.3.2 Managed Competition Reform

Within the public sector, U.K. and New Zealand citizens have no choice but to rely upon a government-appointed purchaser to purchase on their behalf publicly-financed health services and cannot exit or shift with a share of public funding to another purchaser. This is in contrast to managed competition reform. Managed competition requires private insurers to compete for customer allegiance (who bring with them a risk-adjusted share of public funding) within a government regulated system. Alain Enthoven is often considered to be the creator of the managed competition model and his writing on this subject commenced in the late 1970s. In the Netherlands, what became known as the Dekker Committee (named after its chair Dr. W. Dekker), produced a report in March 1987 which proposed managed competition reform of the Dutch health care system. The reform plan has been changed several times since 1987 and implementation has been incremental and is still on-going. There are similarities between the Dutch reforms and proposals for reform in Russia, Israel and Germany. A version of managed competition was also unsuccessfully proposed by President Clinton in 1993 as a means of reform of the U.S. system.

Managed competition might be perceived as U.S.-style reform but it would in fact result in a system very different from that currently seen in the U.S. Most managed competition models, unlike the present U.S. system, seek to ensure universal coverage of citizens for a basic or core range of health services on the basis of their need as opposed to their ability or willingness to

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21Adview Van De Commissie Structuur en Financiering Gezondheidszorg (Commission on the Structure and Financing of Health Care), Bereidhedi tot Veranderende (Willingsness To Change), (’s Gravenhage: Distributiecentrum Overheidspublicaties, 1987) [hereinafter Dekker Report]


pay. A managed competition system is designed to ensure that competition occurs between insurers on the basis of price and quality rather than risk avoidance. Insurers would have a different function (they would be more purchasers than traditional insurers) and behave quite differently from present private insurers. Thus, throughout this dissertation when referring to private insurers in the context of managed competition reform, I shall label them “insurers/purchasers” as this phrase captures both their purchasing and risk bearing functions.

In a managed competition system, insurers/purchasers would not receive premiums directly. Instead, “sponsors” (who would probably be government-appointed bodies) would receive moneys either direct from central government or income-adjusted premium payments from individual citizens. In any event, a managed competition system may be financed largely progressively with there being little or no connection between individual contributions and entitlements to health insurance and/or services. Premiums paid on an income-related basis or moneys received from central government are pooled through the auspices of the sponsor. Each individual in the system would periodically (probably annually or biannually) choose their particular insurer and the sponsor would facilitate this process, making sure that insurers/purchasers compete on price and quality dimensions. The sponsor would then pay, on behalf of that individual, a risk-adjusted share of the pooled funding to that individual’s chosen insurer/purchaser. The amount paid should reflect the risk-profile of the particular individual so that insurers/purchasers are fairly compensated for the risks they cover. It is predicted that, as a consequence, insurers/purchasers will thus have incentives to compete on the cost and quality of services ultimately provided to their enrollees and in turn will enter into various forms of managed care relationships with health care providers. In fact, Enthoven has said that he now refers to his model for managed competition as “managed care-managed competition” to emphasize that what are meant to compete are integrated delivery systems supplying comprehensive care.

Diagram 3 in Appendix 2 depicts the structure of a managed competition system. Appendix 3 provides a more detailed description of Enthoven’s model of managed competition.

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25 For a critique of the present U.S. health care system, its inequities, and its seeming inability to change see R. G. Evans, supra note 8 at 427.
26 In which case the system would financed through general taxation.
1.3.3 Managed Care

A managed care arrangement is any contractual or organizational arrangements whereby an insurer/purchaser (who may be the government or a private insurer or an employer or a consortium of hospitals and/or physicians) attempts to influence the price, volume, and quality of health services supplied.\(^{28}\) Rather than insurers/purchasers passively reimbursing providers for every service performed or reimbursing policy-holders for all medical expenses incurred, managed care may involve insurers/purchasers monitoring and reviewing physicians’ recommendations and/or selecting physicians and other health providers whose practices accord with the purchaser’s perceptions of how best to service health needs. Managed care may involve purchasers (whether public or private insurers) paying a fixed sum per enrollee for a fixed time period (generally per month or per annum) to a group of providers who agree in return to provide a stipulated range of health care services to the defined group of enrollees.\(^{29}\) This method of reimbursement is known as capitation. Unlike internal market reform, that requires a compulsory “purchaser/provider split”, in managed care plans insurers/purchasers may choose to be vertically-integrated with health care providers (i.e. the insurers/purchasers actually own the hospitals and practices) as opposed to simply contracting with them on an arm’s length basis. In managed care, a patient’s choice of providers is generally limited to the health care providers his or her chosen insurer/purchaser has elected to contract with or is integrated with or a surcharge is imposed on patients who choose providers outside of those listed.\(^ {30}\)

In the wake of the failure of President Clinton’s proposals for national health reform in the U.S., managed care has grown rapidly as private insurers and employers are seeking to shift market power from health care providers to themselves and this phenomenon is likely to have far-reaching implications for the future of the U.S. health care system. Enthoven notes that


managed care arrangements (which now, it seems are often referred to by the new buzz words of “integrated financing and delivery systems”) come in a variety of types. Some own their own hospitals, some have preferred providers or close relationships with particular hospitals, and others enter into arm’s length contracts. It would not serve the purposes of this introduction to describe in detail the nature of these various arrangements. However, Appendix 1 briefly describes Health Maintenance Organizations, Preferred Provider Organizations and Point of Service Networks as these are the three main types of managed care organizations in the U.S.

In the U.S., managed care developments are ad hoc and are not part of a planned or co-ordinated or integrated health system. The U.S. does not seek to provide a comprehensive system ensuring access to everyone to health services on the basis of need as opposed to ability to pay. In 1993, 40.9 million people (18.1% of the non-elderly population) were uninsured, an increase of 1.1 million over the previous year. In 1995, 40.6 million people were uninsured, more than 10.5 million of whom were under the age of 19. There is no specific government regulation at the federal level to ensure competition between managed care plans on the basis of price and quality. In fact, as a result of competition between insurers on the ability to avoid risk the number of managed care plans who community-rate (i.e. cross-subsidize premiums from low-risk to high-risk individuals) has declined. Present developments in the U.S. can be distinguished from a managed competition system, for in the latter there would be comprehensive coverage for all citizens, it would be largely progressively funded, and mechanisms would be in place to stimulate competition on price and quality dimensions rather than risk avoidance.

1.4 The Chosen Health Care Allocation Systems

Many countries are seeking to reform their health systems by either introducing more competition into what were publicly operated delivery systems or reconfiguring public and

31Enthoven, supra note 12 at 1414.
34J. Gable, “Ten Ways HMOs Have Changed During the 1990s” (1997) 16: 3 Health Affairs 134.
private roles in pluralist, insurance based systems.\textsuperscript{35} Examples include Finland, Sweden, countries comprising the former U.S.S.R, Germany, and Israel. I have limited the focus of this thesis to health care reform in the U.S., the Netherlands, the U.K., and New Zealand. It is of particular value to compare and contrast reforms in the four countries I have chosen for four reasons. First, the four countries have either proposed or implemented internal market and managed competition models and all are seeing shifts towards managed care either by government design or as a market response. Second, there is the radical nature of the reforms proposed in all four countries. The Netherlands, the U.K., and New Zealand were some of the first countries in the world to implement managed competition and internal market reform and thus there is scope to analyze to what extent initial radical reform proposals were implemented and the progress of the reformed health allocation systems to date. Third, these countries all are shifting towards the use of managed care, although in the U.K. (particularly) this is a planned response whereas in the U.S. managed care is a market response to escalating health costs. I wish to compare the rationale of the purchaser/provider split with the rationale of managed care and argue that there are two distinct approaches. Finally, an analysis of managed competition, internal markets, and managed care reform as proposed or as effected in New Zealand, the Netherlands, the U.K., and the U.S., should provide valuable lessons to a country like Canada (which has a relatively similar socio-economic and legal structure to the countries under review) as it contemplates the sustainability of its present health care allocation system into the next century.

1.5 An Interdisciplinary Approach
An analysis of institutional design necessitates an interdisciplinary approach and the disciplines of law, economics, and political science all provide valuable tools for analysis. A traditional legal scholar might initially ask what legal analysis can offer in the area of health care reform but in fact the law is integral to the success or otherwise of an institutional arrangement.\textsuperscript{36} Both international and domestic law may prescribe individual entitlements to health care services and affect what is perceived as being the range and quality of health services necessary to satisfy the demands of distributive justice. Legislation is passed to create


new institutional arrangements and prescribes the power and responsibilities of health care providers, purchasers, patients, interest groups and citizens. In addition to the reforming legislation, legal liability imposed through other legislation and through the common law (particularly tort law) on health care providers, purchasers, and patients will affect their behaviour and impact on both the costs and distribution of health services in society. Supply contracts are a vital element of competition-oriented reform models and an examination is required as to whether existing contractual norms and laws are effective from the perspective of ensuring the efficient supply of an adequate range of health care services of adequate quality. Competition or anti-trust law is important as competition-oriented reform often requires the consolidation of market power on the demand side of the market but the response of providers may be to attempt to consolidate market power on the supply side. From an economist's perspective, one must inquire as to which reform proposals will result in institutional arrangements that are more allocatively efficient,\textsuperscript{37} technically efficient,\textsuperscript{38} and dynamically efficient\textsuperscript{39} than alternatives. Political science is important for it assists in understanding what weight governments will give to the (sometimes) competing considerations of efficiency, equity, and government cost control. The discipline also aids in understanding what incentives are needed to ensure that purchasers (or insurers) and health service providers are accountable for their decisions to the patients and/or policy-holders and/or citizens they represent. It also assists in estimating the difficulties with implementation of any particular theoretical model.

1.6 Organization of the Thesis

In Chapter 2, I consider from first principles the rationale for government intervention in health care systems on economic and distributive justice grounds. From this I articulate and clarify the rationale underlying various forms and degrees of government intervention in health insurance and health care service markets.

\textsuperscript{37} Allocative efficiency essentially describes the overall efficiency and allocation of resources within a particular economy.

\textsuperscript{38} Technical or productive efficiency occurs when the instruments in place achieve the realization of any given policy objective at the lowest possible cost in terms of the economic resources deployed — see Trebilcock. \textit{supra} note 13 at 23.

\textsuperscript{39} Dynamic efficiency looks at the long term cost and benefits of a particular institutional arrangement and in particular whether there is impetus within the system for ongoing and increasing innovation and efficiency.
In Chapter 3, I describe the systems that existed in the U.S., the U.K., New Zealand and the Netherlands prior to managed competition or internal market reform proposals in the late 1980s and early 1990s. I describe the implementation of government-mandated reform proposals in the U.K., the Netherlands and New Zealand. In the case of the U.S., I discuss the failure of President Clinton's managed competition reform proposal and the subsequent system wide managed care reform that has occurred as a market response to escalating costs.

In Chapter 4, I discuss the accountability of government-appointed monopsony purchasers in internal markets and compare this with the accountability of competing private insurers/purchasers in a managed competition system. I utilize Hirschman's concepts of "voice", "exit" and "loyalty" to classify different sorts of political and market incentives that may be deployed and compare the costs and benefits of internal market reform with managed competition reform.

In Chapter 5, I consider the validity of the purchaser/provider split as the underlying rationale of the internal market model and compare this with the more flexible managed competition model which allows insurers/purchasers to be either vertically integrated or to contract out.

In Chapter 6, I consider the problem of monopoly on the supply side. An impediment to consumer choice of competing insurers/purchasers in a managed competition system is where, due to economies of scale or historic government policy, there is a monopoly provider in a particular market. I discuss the need for regulation of natural monopolies in order that competing insurers/purchasers are able to offer their plans to all residents of a particular area. One must also consider the likely response of providers to reform, namely to consolidate to increase market power. Neither the managed competition nor internal market models specifically deals with this problem. Financial integration of providers into systems may in fact be a preferred policy option as it would allow co-ordination in service delivery. As Ham notes, the lack of integration between institutions servicing health needs (in the broadest sense) is one problem that all healthcare systems in the developed world have to deal with.40 I discuss how competition law must be in place that will allow health providers to form

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financially integrated “mini” systems but yet prohibit arrangements where health providers are simply seeking to improve their negotiating power with insurers/purchasers.

In Chapter 7, I discuss the continued need for government intervention to ensure the quality of health care services supplied. The goal of both internal market and managed competition reform is that purchasers will be proactive in negotiations with providers. I discuss incentives within various payment methods including salaries, fee-for-service, and capitation and argue that there is no ideal payment mechanism and everything will turn on the particular market in question. Rather than seeking the magic combination of payment mechanisms, the key is to ensure that purchasers have incentives to compete on price and quality dimensions and then to leave purchasers to determine their own arrangements with providers. I discuss the need for residual regulation to counteract excessive devolution of financial risk through capitation payments to providers. I also discuss to what extent ethical codes, professional self-regulation, and the threat of malpractice actions will inhibit providers from cutting the quality of health services supplied in the face of strong financial incentives to do so. The competition approach requires that competing purchasers and providers be rewarded for efficient performance: however, measuring performance in the delivery of health care is more complicated than in many other markets and not all needed care can be assessed in terms of outcomes. Thus, I explore the need for government regulation to ensure that citizens have information about care that is not readily measurable. I also explore the need for government to protect services supplied to vulnerable populations that may not be readily measurable in terms of outcome nor maintained by the use of “exit” as an accountability mechanism as this may only protect only what the majority value.

It has been said that the key issue in considering alternative forms of health care reform are what kinds of decisions are best made by whom?41 This thesis goes a step further and questions how to ensure that decision-makers are exercising their discretion in the best interests of both patients and society at large. This thesis draws on the work of Coase to the extent that it responds to his plea to study how alternative economic arrangements actually work in practice — the comparative institutional approach.42

Chapter 2: The Case For Government Intervention in Health Insurance and Health Service Markets from Economic and Justice Perspectives

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2.1. Introduction

In this chapter I examine the possible causes of market failure in both health insurance markets and health service supply markets so as to be clear as to when and where government intervention is necessary from the perspective of efficiency and equity. This analysis will assist in considering reform proposals in subsequent chapters. Incidentally I will explain some of the economic terminology that appear extensively throughout health reform literature. Evans questions the wisdom of exploring the issue whether or not government has to intervene directly to structure and regulate a health system given the accumulation of international experience that this is necessary; however, international experience has not yet revealed the optimal combination in terms of public and private roles. Thus examining market failure may help provide a better understanding of which roles and decisions are best performed and made by whom.

2.2. Market Failure in the Insurance and Supply Markets for Health Services

Sources of market failure in insurance and supply markets for health services are discussed below under the headings of externalities, adverse selection, minimization of administration and transaction costs, moral hazard, information asymmetry, and economies of scale.

2.2.1 Externalities

Externalities are a source of failure in health care markets as they represent unsatisfied demand. For example, externalities arise where a society wishes to have the benefits of medical research that private enterprise is unwilling to undertake given the public goods nature of much research and development. Government may intervene to meet this unsatisfied demand by directly subsidizing research and/or developing trade-mark or patent law to encourage private investment in research. Externalities also arise where as a society we are prepared to pay for the consumption of health services by others living in our community. For example, it is of benefit that the whole community be immunized against contagious disease as this reduces the individual risk of acquiring such disease. Each member of a community should therefore be

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43 A neo-classical economist will likely question whether the nature (as opposed to the extent) of government intervention in the U.S. (particularly the tax subsidy for employer contributions to health insurance premiums for employees) is not causing serious distortions to the market and ponder whether if these distortions were removed the market would not operate efficiently, at least relative to other systems with more government intervention — i.e. see M. V. Pauly, “Taxation, Health Insurance, and Market Failure in the Medical Economy” (1986) XXIV Jnl. of Economic Literature 629.

44 R. G. Evans, supra note 8 at 448.

45 OECD 1994 Review of Seventeen Countries, supra note 1 at 49–50.
prepared to contribute towards the cost of such immunizations. There are, however, impossibly high costs and "free-rider" problems associated with each citizen attempting to identify and contract with those individuals who either cannot afford, or are reluctant, to be immunized. Government may intervene to correct this market failure and to fulfil unsatisfied demand. The intervention required is not extensive in a developed country relative to the health care expenditures as a whole as the risk of contagious disease has substantially declined in this century and, in fact, spending on public health is a relatively small percentage of total health expenditures.47

Although demand for public health services may relate to a desire to protect and maximize our own standard of health, many individuals in society are also prepared to pay for the consumption of general health services by others who cannot afford them for moral reasons. Culyer has advanced the theory of a "caring" externality in health care justifying government intervention.48 The concept of a caring externality relates to the notion of social or distributive justice (discussed below).49 Evans notes that health care services are what are known as "merit goods" as society in general considers that individuals in particular circumstances should consume them.50 He notes that society's attitude is paternalistic, rather than altruistic, as collectively society is not prepared to pay for frivolous or unnecessary services but only what is perceived as being effective and essential care.

Refusing to supply basic care to a patient who cannot afford it may well result in significant extra costs subsequently being incurred if the patient's condition seriously deteriorates. This will not be a problem if a society is prepared to allow those in need of care to suffer or die without medical assistance. The existence of a caring externality suggests this will not be the case. Professional codes of ethics and moral values mean that most physicians would find it difficult to refuse to treat the impuissant when faced directly with an individual in need of treatment but

46A free-rider problem is where individuals abstain from acting or contributing resources to obtain a certain goal in the expectation that others in society will act or contribute to obtain that goal.
47It is nonetheless vitally important, as evidenced by the recent threats of Acquired Immune Deficiency Syndrome and Creuzfeldt-Jakob Disease, that there are adequately funded institutions with sufficient regulatory power to deal with public health problems as and when they emerge.
49The concepts are distinguishable, however, as the former originates in the economics discipline and speaks more of collective demand rather than the right of any particular individual to assistance.
50R. G. Evans, Strained Mercy — The Economics of Canadian Health Care (Toronto: Butterworths & Co. (Canada), 1984) at 63 [hereinafter Strained Mercy].
rather than bearing the costs of treatment themselves may seek to pass these on to other insured patients. Thus even those in society not prepared to pay for health care services for those in need may have these costs imposed upon them by others as a component of their own cost of health care.51

The idea that some level of subsidy should be made available to the poor to allow them to participate in health insurance markets (and thereby health service markets) seems to be universally accepted.52 What is much less clear is who should be defined as poor, what range and quality of health services the poor should receive a subsidy for, and, given the problems of adverse selection, moral hazard and information asymmetry in health insurance and service markets (all discussed below), whether it is effective to simply provide the poor with a subsidy or a voucher to purchase health insurance.

2.2.2 Adverse Selection

Health insurance markets are closely related to and impact on demand and supply in health service markets. The analysis which follows demonstrates that the demand for and existence of health insurance in an unregulated market contributes to and compounds market failures in health service markets. Apart from preventive health care services, an individual's demand for health services is frequently contingent on that person developing an illness or suffering an injury and that occurrence is to some extent stochastic.53 Consequently, we are often unable accurately to predict our own future demand for health services and cannot always save for the cost of health services needed in the future.54 This uncertainty coupled with the high cost of treating some diseases and afflictions means that in the absence of insurance even the most prudent individual could face financial ruin in the event of serious illness or injury.55 Consequently, all other things being equal, there will be a demand for insurance to cover the risk of needing to utilize health services particularly for high cost events. It is often assumed that coverage for hospitalization is more likely to be bought than coverage for general practitioner

51Enthoven, "The History And Principles of Managed Competition", supra note 20 at 41 implies that such cost-shifting currently occurs in the U.S. OECD 1994 Review of Seventeen Countries, supra note 1 at 317 notes those without insurance in the U.S. sometimes receive care and this is financed by charity and by shifting costs to other payers.
52Pauly, supra note 43 at 632.
53Ibid. at 630.
54C. Donaldson and K. Gerard, Economics of Health Care Financing: the Visible Hand (London: Macmillan, 1992) at 26. However, in the future as we acquire more information from genetic science regarding our propensity for ill-health than general support for publicly-funded systems may conceivably dissipate.
55Serious illness or injury can be a financial disaster not only because of the cost of care but because an individual's income-earning stream is interrupted or eroded permanently.
care and drugs as the need for hospitalization is a low-probability event which if it does occur can be very costly. However, it seems arguable that there will not be significantly less demand for insurance for high probability, low-loss events like general practitioner services and drugs for if someone develops a chronic illness the cumulative cost of this type of care could equal the magnitude of hospitalization costs. As an example, the cost of the cocktail of drugs required to impede HIV from developing into AIDS is beyond the range of most uninsured individuals.

Frank describes the process of adverse selection as being "the process by which 'undesirable' members of a population of buyers or sellers are more likely to participate in a voluntary exchange." In the case of the private insurance market this process occurs when high-risk individuals choose to buy the most comprehensive insurance policy available. While this seems a rational choice, the problem is that insurers are unable to distinguish between high-risk individuals (to whom they should charge higher premiums) and those individuals that are simply risk-averse and want to purchase comprehensive coverage. This problem is rooted, as are many problems in the health insurance and health service markets, in asymmetry of information as between buyers and sellers.

If a private insurance company assesses premiums on the basis of the average risk for a whole community ("community rating"), then individuals who are at a higher risk will be subsidized by lower risk individuals. Those individuals who assess themselves as low risk may elect to bear the risk of ill health or injury individually and stop purchasing insurance (self-insure) because the premium charged does not reflect their actuarial risk. The departure of these low risk individuals from the insurance pool will raise the average cost of premiums for the remaining policy holders and cause further departures by low risk individuals. If an insurer responds to the demand of low risk individuals for premiums which reflect their actuarial risk ("risk rating"), then additional administration costs will be incurred in assessing risk. An insurer may use categories of employment, age, gender, historical utilization of services, and other risk proxies to

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56 Pauly, supra note 43 at 639.
59 Strained Mercy, supra note 50 at 41.
60 See generally Akerlof, supra note 57.
assess individual or group risk. As Reisman notes, probabilities are easier to estimate for groups than for individuals. Consequently there may be individuals within groups classified by insurance companies as high risk who, because of a variety of factors peculiar to that person, are not high risk. This results in adverse selection as these individuals would contract with an insurance company for full cover in exchange for a premium reflecting their actuarial risk, but are unable to do so because insurance companies do not have sufficient information with which to distinguish these individuals from truly high risk individuals.

It is very difficult to estimate how pervasive the problem of adverse selection is likely to be. That it is likely a serious problem in unregulated insurance markets is best demonstrated by the fact that prior to the introduction of Medicare for the aged in 1965–66, 50% of Americans over the age of 65 were completely uninsured against the cost of illness and only half of those with health insurance had adequate coverage for hospitalization expenses. It is possible that a percentage of these uninsured elderly would have been prepared to pay the real risk-rated cost of insurance coverage but they were unable to obtain coverage for insurers could not or would not distinguish very high-risk elderly people from others. That there would be differences in risk as between the individuals who were not covered is demonstrated by the fact that it is estimated that 5% of all the aged entitled to the government’s Medicare program account for over 50% of the total costs of the program and 36% of those covered do not make any claims.

One must distinguish the problem of adverse selection from the distributive justice problem of high premiums for high risk individuals. The operation of an unregulated private insurance market, where insurers compete on the basis of risk selection, will result in very high premiums or, perhaps, no coverage at all for the chronically sick and aged. A relatively small fraction of the population requires most of the health services. Health expenditures for the disabled are five times more than those on the non-disabled, the old use far more medical services than the young, and medical costs rise very sharply shortly before death. In the U.S., about 72% of annual

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62 *Strained Mercy*, supra note 50 at 41.
64 Akerlof, *supra* note 57 at 492–494.
65 S. S. Wallack et al., “A Plan For Rewarding Efficient HMOs” (1988) 7: 3 Health Affairs 80 at 84.
national health expenditures are spent on 10% of the population.\textsuperscript{67} If an insurer can eliminate individuals who are likely to frequently utilize expensive services from its insurance plan then it can significantly reduce its operating costs. Thus, as Enthoven and Singer note, unlike sellers of most other goods and services, sellers of insurance have good reason to be concerned about who buys their services.\textsuperscript{68} The irony is that the unregulated operation of a health insurance market will result in those who objectively are in the most need of health care services being unable to obtain them because of the high cost of insurance or because of exclusionary policies. However, failure to provide affordable health insurance to those who most need it is not a source of market failure. Neo-classical economic theory is rooted in utilitarianism and the goal of an efficient market is to maximize overall benefits to a society given available resources.\textsuperscript{69} The efficiency of the market is not undermined, in economic theory, by distributional inequities. This view seems particularly impoverished with respect to health care for it ignores the reality that unless a society is prepared to allow individuals in need of medical care to die then there will be a cost to society in supplying health services to prevent such a morally unacceptable scenario. This issue will be discussed further below under distributive justice.

### 2.2.3. Minimization of Administration and Transactions Costs

Administration or loading costs increase as insurance companies seek to compete by assessing the risks of certain groups or individuals and these costs have to be included in the cost of health insurance premiums. Generally it is assumed that the total amount of health insurance demanded in an economy will diminish as administration or loading costs increase.\textsuperscript{70} However, Fuchs and Vladeck argue that demand for health insurance does not taper off substantially as premiums rise.\textsuperscript{71} As they explain, this is because demand for health insurance is relatively inelastic (or relatively unresponsive to changes in price) as people are risk averse and gain utility from freeing themselves from cost considerations in the period of emotional strain associated with illness, disease or injury.


Possibly there are some economies of scale associated with the supply of health insurance as some administration costs are likely to be partly in the nature of fixed costs. Those who argue this proposition point to the low administrative costs in single-payer systems like Canada, the U.K., and New Zealand compared with systems that are financed by many different private insurers, like the U.S. In 1993 the U.S. government paid for 43.9% of all health expenditures.\textsuperscript{72} Statistics compiled by the OECD show administration costs in 1991 totalling 5.84% of total U.S. health expenditures and 8.49% of expenditures once public expenditures are deducted.\textsuperscript{73} By comparison, in Canada, the government paid for over 72% of total health expenditures in 1990 and 1991.\textsuperscript{74} Administration costs in 1990 comprised just 1.28% of total public and private health expenditures.\textsuperscript{75} In the U.S. there are over 1500 private insurers offering a variety of health insurance policies.\textsuperscript{76} The sheer number of different insurance policies raise the operating costs for health care providers as they must deal with numerous insurance firms and comply with their various requirements before obtaining reimbursement.\textsuperscript{77} These latter costs are usually over and above the official administration costs recorded in a health system. Himmelstein et al. note that a single payer approach in the U.S. would sharply cut the U.S. $50 billion spent annually on insurance overheads by eliminating “marketing costs, efforts at selective enrolment, shareholder profits, executives’ exorbitant salaries and lobbying expenses.”\textsuperscript{78} Differential administration costs also contribute to access problems in the U.S. Higher administrative costs are incorporated

\textsuperscript{72}17.8% was paid for directly by patients and 4.8% from other sources — calculated from figures given by K. R. Levit et al., “National Health Spending Trends, 1960–1993” (1994) 13: 5 Health Affairs 14 at 22 (Exhibit 6).


\textsuperscript{75}OECD Health Systems: Facts and Trends, idem. does not provide any 1991 figures for Canada, but records that Canada spent a total of $62706 million (Canadian) on health care in 1990, $803 million of which was spent on health administration costs.


\textsuperscript{77}Strained Mercy, supra note 50 at 39.

in individual premiums than in premiums for employee groups and thus individuals who are not part of a group plan are less likely to be able to afford the price of insurance.\textsuperscript{79}

While it is clear that administrative costs are reduced in single-payer systems this is, in fact, not mostly due to true economies of scale involved in the supply of insurance but due to the fact that a single-payer system does not engage in risk-selection and risk-rating of premiums. Administration costs are thus lower as the government does not devote its energies to the avoidance of high risk individuals. It is important to bear in mind, however, that simply because a system has higher administrative or transactions cost does not mean that it is less efficient overall. One would have to weigh these additional costs against any additional benefits of such a system, say in terms of better health outcomes, a more responsive system, etc. For example, the Netherlands incurred administrative costs of 5.12% of total health expenditures in 1991 which is significantly higher than that incurred in Canada yet the Netherlands still spent less on a health as a percentage of GDP than Canada.\textsuperscript{80} Moreover, although incurring higher administrative costs and higher costs overall, the Netherlands performs better on most health outcome indicators than either the U.K. and New Zealand and does not have a problem with waiting list and times for general medical services.\textsuperscript{81}

\subsection*{2.2.4 Moral Hazard}

Moral hazard as a source of market failure in health markets has been the focus of much academic attention and is often portrayed as the primary cause of cost escalation in health insurance and service markets. As Pauly describes it, generally moral hazard arises "whenever an individual's behaviour that affects the expected loss is altered by the quantity of insurance he obtains."\textsuperscript{82} There are two forms of moral hazard. First, the insured may take fewer preventive steps than they otherwise would take to lessen their own risk of requiring health services in the future e.g. engaging in known high-risk activities like smoking (ex \textit{ante} moral hazard).\textsuperscript{83}

\textsuperscript{79}It is estimated that 53.9\% of the premium paid to private for-profit insurance companies for individual coverage and 23.4\% of the premiums paid for group coverage are absorbed by administrative costs and 9.8\% and 8.5\% of the premiums paid respectively to the non-profit Blue Cross and Blue Shield plans are absorbed by administrative costs. These are 1986 figures from the Division of National Cost Estimates, Office of Actuary, "HCFA: National Health Expenditures, 1986-2000" (1987) 8: 4 Health Care Financing Review as cited by M. W. Raffel and N. K. Raffel, \textit{The U.S. Health System: Origins and Functions}, 4th ed., (New York: Delmar Publishers, 1994) at 218.

\textsuperscript{80}Calculated from figures provided in \textit{OECD Health Systems: Facts and Trends}, supra note 73 at 108--9 and at 112--113.

\textsuperscript{81}See the discussion \textit{infra} in Chapter 3.

\textsuperscript{82}M. V. Pauly, "The Economics of Moral Hazard: Comment" (1968) 58: 3 Amer. Econ. Rev. 531.

\textsuperscript{83}Donaldson and Gerard, \textit{supra} note 54 at 31.
Secondly, moral hazard is said to arise when patients demand more (or more expensive) health services (*ex post* moral hazard). The second form of moral hazard seems to have generated the most concern in the economic literature and it is this form of moral hazard that this chapter will largely focus on.

It is important to note that recently, as health care systems have faced ever-increasing financial pressures, there has been a move to question or attribute blame to “those whose life style choices puts their health or lives at risk” (*ex ante* moral hazard) and to ration access on the basis of moral fault.\(^8^4\) Schwartz points out that it is difficult to categorically say that someone has “voluntarily” put their health at risk — behaviour may be a function, at least in part, of “genetics, family environment, social environment, gender, life trauma, ethnicity, community, education (and, especially, health education) and probably, most significantly, wealth.”\(^8^5\) He notes that limiting access to health services through charges is unlikely to have much of a deterrent effect.\(^8^6\) He also argues that imposing the costs of health care on people who engage in risky behaviour will not result in an equitable distribution of resources. He points to studies that demonstrate that reducing smoking would actually lead to more downstream costs for an economy overall in terms of the increase in the number of elderly patients and their delayed illnesses and increased pension payments.\(^8^7\)

The *ex post* moral hazard problem focuses on the patient who, at the point of consumption, is consuming more resources than they ought. Pauly argues that moral hazard losses “represent the consumption of units of medical care whose value to the consumer is less than their cost, because the insurance coverage reduces the user price below cost.”\(^8^8\) The problem with how the moral hazard problem is depicted in this statement is that it assumes that patients in general want to consume more health services just as they may want to consume more ice-cream cones or cars, which given the often unpleasant nature of tests, procedures, operations, and medicines, is a highly debatable assumption. This is not to say that there are not some medical services that patients might happily consume more of i.e. massage therapy, but in general this does not seem

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\(^8^5\)Ibid. at 204.

\(^8^6\)Ibid. at 209.


\(^8^8\)Pauly, *supra* note 43 at 640.
to be true particularly in the case of those types of hospital services we consider essential and that absorb the greatest proportion of health care expenditures.\textsuperscript{89}

In my opinion, it is indifference to the price of services that patients need as opposed to the utilization of additional services that they do not really need that is the key moral hazard problem. The point of purchasing health insurance is that policy-holders want to ensure that they have enough resources to purchase health services they need (or believe they might need) in the future. Therefore it is hardly surprising that at the point of consumption patients are consuming more resources than they may if they had to pay the full cost thereof at that point in time given that in the absence of insurance they would not have been able to afford the care that they need.

Thus, the moral hazard problem is better described not as the problem of patients utilizing more services than they need but of patients lacking any incentive because of third-party insurance to discriminate between health providers or health services on the basis of price. This is well demonstrated by the fact that compared to other OECD countries the U.S. has low per capita utilization rates of health services.\textsuperscript{90} What distinguishes the U.S. from other countries is not high per capita utilization of health services but the high prices charged for those health services.\textsuperscript{91}

The traditional market response to the problem of ex post moral hazard is for insurance companies to impose user charges at point of service so that patients become more price-sensitive.\textsuperscript{92} However, as Stoddart et al. note, patients in most health care systems (the U.S. being the notable exception till the recent managed care revolution) cannot initiate access to many

\textsuperscript{89}\textsuperscript{89} There may of course be a number of patients who are fearful or paranoid and want more tests and procedures than are effective; however, these people presumably constitute a small minority.

\textsuperscript{90}\textsuperscript{90} In 1991, the admission rate to U.S. hospitals as a percentage of population was 13.7 compared to 10.9 in the Netherlands, 13.9 in New Zealand, 19.3 in the U.K. and an OECD average of 16.2. The average length of stay in a U.S. hospital was 9.1 days compared to 33.8 in the Netherlands, 11.7 in New Zealand, 14 in the U.K. and an OECD average of 14.4 days. The number of physician contacts per capita in the U.S. were 5.6 times per annum compared to 5.4 in the Netherlands, 3.8 in New Zealand, 5.7 in the U.K. and an OECD average of 6.1 — Data from G. J. Schieber et al., "Health System Performance In OECD Countries, 1980–1992" (1994) Fall: 4 Health Affairs 100 at 106, Exhibit 4, from OECD data and their own estimates.

\textsuperscript{91}\textsuperscript{91} Despite the fact that throughout the 1980s efforts at cost control were mainly directed at hospitals, expenditures on hospitals rose from U.S. $154 billion (in 1989$) to U.S. $233 billion in the period 1980–1989. This growth was due to a 64% increase in real spending per admission between 1980–1989 which more than offset the 13% drop in admissions — see K. M. Langwell and T. Menke, "Controlling Costs of the US Health Care System: Trends and Prospects" in Arnauld, Rich, & White, supra note 28. W. P. Welch, D. Verrilli, S. J. Katz, & E. Latimer. "A Detailed Comparison of Physician Services for the Elderly in the United States and Canada" (1996) 275, 18 JAMA 1410 found that that Canadian elderly receive a higher volume of physician services than the U.S. elderly; however, Canada records overall lower expenditures per elderly person than in the U.S. because the average price for physician services is much lower.

health services without the referral of a general practitioner who is the gatekeeper to the consumption of more expensive services.\textsuperscript{93} The primary problem with a user charge as a corrective mechanism to the inefficiencies of the market is that it seeks to shift part of the risk of ill-health back to patients but patients have purchased insurance often for the very reason that they are risk-averse. The imposition of user charges tends to increase the risk of unforeseen health services expenditures and, in response, many individuals may demand further insurance to cover the cost thereof (known as “gap” or “supplementary” insurance).\textsuperscript{94} The existence of gap insurance mutes the degree to which user charges are likely to succeed in enhancing the price-sensitivity of patients and in controlling overall health expenditures. User charges will potentially only have their intended effect on the demand of those individuals who cannot afford gap insurance. Government could possibly intervene in health markets by limiting or prohibiting the purchase of gap insurance to make patients at all income levels more price sensitive.\textsuperscript{95} It could also require that user charges only be applied to those services and in those areas where it is indeed feasible for patients to “shop-around” for health services.

Imposing user charges may discourage poorer patients from purchasing needed and important health services.\textsuperscript{96} Stoddart et al. also note that in the face of user charges individuals are just as likely to forego those services from which they would gain the most utility as any others.\textsuperscript{97} In other words because patients do not have good information about the health services they will most benefit from and those that they can possibly forego, if user charges are imposed they may well forego essential treatment leading to more downstream costs for themselves and for the health care system overall. On the other hand, a large experiment conducted by the RAND corporation on the effect of patient copayments in the U.S. found cost sharing reduced utilization without adversely affecting health status, except for low-income individuals with hypertension.


\textsuperscript{94} For example, in the U.S., only 23\% of Medicare enrollees do not have at least some supplemental insurance coverage to that provided under Medicare -- Prospective Payment Assessment Commission, \textit{Medicare Prospective Payment and the American Health Care System} (Washington, DC: 1990) at 99 as cited by W. Greenberg, \textit{Competition, Regulation and Rationing in Health Care} (Ann Arbor, Michigan: Health Administration Press, 1991) at 76.

\textsuperscript{95} Donaldson and Gerard, \textit{supra} note 54 at 46 note that in Australia, the government sets its own fee schedule and reimburses only 75\% of this schedule for hospital care and 85\% for general practitioner care. Doctors are free to charge patients fees higher than the government’s fee schedule, but this extra amount cannot be privately insured.

\textsuperscript{96} Stoddart et al., \textit{supra} note 93 note that there is no reason to suppose that poorer patients have any more of a propensity to engage in moral hazard than wealthier patients.

\textsuperscript{97} For a discussion see \textit{ibid.} at 5–7. See also J. Hurley and N. Johnson, “The Effects of Co-payments Within Drug Reimbursement Programs” (1991) XVIII: 34 Canadian Public Policy 473.
vision or dental problems. However, the results of this study must be read with caution. The first point to note is that the problem of cost in the U.S. does not appear to stem from relative over-utilization of health services but due to high and rising prices for health services. Thus the fact that user charges result in declining utilization is not necessarily a positive feature, for what it should be intended to do is to make patients shop around for cheaper health services rather than forego services altogether. The results of the RAND experiment study must also be viewed with extreme caution as the study excluded the elderly and the chronically ill -- two sectors of the population that consume a significant proportion of health services. It also should be noted that despite the RAND experiment's findings that ultimate health outcomes were not adversely affected by user charges, the experiment did find that patients would be equally deterred from using services that were considered necessary and unnecessary. Whether the rationing of necessary services will have an adverse effect on ultimate health outcomes is something that, if it is able to be measured at all, may only be able to be measured in the long term. In this regard it is of note that some of the services that were found to be more sensitive to price were preventative services and mental health services. It also appears clear from the RAND experiment that if user-charges were not targeted at the income of the patient in question than user charges would disproportionately affect lower income patients.

User charges could be targeted at various income-levels so as not to discourage the purchase of health services by poorer patients; however the administrative costs of targeting and collecting user charges may outweigh any resulting efficiency gains.

There are other options apart from user charges available to counter moral hazard, each with its advantages and disadvantages and these are discussed in subsequent chapters. These include price regulation, nationalization of health insurance and the use of monopsony bargaining power.

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99 For a full discussion of the negative effects of patient copayments see Rasell, supra note 92.

100 K. N. Lohr, et al., “Use of Medical Care in the RAND Health Insurance Experiment: Diagnosis- and Service-specific Analyses of a Randomized Controlled Trial” (1986) 25 (Supp.) Medical Care 531.


102 For example, the New Zealand government abandoned its $50 a night patient user charge for public hospitals partly because of a public outcry but also partly because of the high administrative costs involved with collection. By the end of the first quarter (May 1992), after introduction of user charges for public hospital services, outstanding debts fell in the range of 30-60% of total revenue from charges — “Hospital Fees Unpaid Up To 63%”, June 18, 1992, New Zealand Herald, as cited by T. Ashton, “Charging for Health Services — Some Anecdotes from the Antipodes” in M. Malek et al., eds., *Strategic Issues in Health Care Management*, (Great Britain: John Wiley & Sons, 1993) 9 at 16.
to control health expenditures, and changing the method of reimbursement for health providers from fee-for-service to some form of per case basis\textsuperscript{103} or even to a capitation basis where providers receive a lump-sum in return for which the providers agree to supply a wide range of health services to all enrolled individuals.

Moral hazard can also occur in private insurance markets when insurers take excessive risks with policy-holders' premiums which are paid at the beginning of a coverage period.\textsuperscript{104} Government may regulate insurers on this basis and require the establishment of a guarantee fund.\textsuperscript{105}

2.2.5 Information Asymmetry

There are two equally important components to a patient's contract with a physician. First, a physician makes a diagnosis and essentially determines what a patients' medical needs are and then the physician determines what resources should be devoted to responding to those needs. In advising what services a patient needs, a physician may advise a patient to consume services provided by the physician herself or an associated provider.\textsuperscript{106} Where physicians and other health providers are paid on a fee-for-service basis, they will have a \textit{prima facie} financial incentive to recommend that their patients consume more of their own services than is cost-effective.\textsuperscript{107}

An information asymmetry problem arises between a physician and patient as many patients will not be well-informed as to the reasons for deterioration in their health or the costs and benefits of particular treatments. Given the cost and difficulties of acquiring information regarding the quality and appropriateness of services, patients are encouraged to rely on the professional skill of their physician to advise them of what their health needs are. A patient's physical or emotional distress and/or haste at the time of consulting his or her physician or other health provider may contribute to a patient's unquestioning reliance thereon.\textsuperscript{108}

\textsuperscript{103} \textit{Strained Mercy, supra} note 50 at 378 notes that per-case of episode-based reimbursement is calculated by treating each particular illness as requiring a "package" of treatment and a level of reimbursement is determined for that "package." See also Pauly, \textit{supra} note 43 at 642.


\textsuperscript{105} F. A. Sloan, \textit{idem}.

\textsuperscript{106} F. Rutten, "Introduction" in Mooney and McGuire, \textit{supra} note 69 at 1.

\textsuperscript{107} \textit{Strained Mercy, supra} note 50 at 71.

\textsuperscript{108} F. A. Sloan, \textit{ibid.} at 260.
Mooney and McGuire note, it is often not only difficult for a patient to judge the quality of services before consumption (ex ante) but after as well (ex post).109 Except in very obvious cases of poor quality service when things go radically wrong we often accept our physician’s own assessment of her performance and of the short and long term consequences for our health.110 The moral hazard problem associated with third-party insurance means that patients are unlikely to question the cost-effectiveness of a physician’s recommendations for treatment. As there is the potential for physicians to influence demand for their own services,111 they may respond to price caps or a fall in demand by some patients as a result of the imposition of user charges by recommending increased utilization by patients whose demand for health services is inelastic because of the fact they have gap insurance or are wealthy.112

To what extent is it likely that health providers will take advantage of the information imbalance existing between themselves and most patients? Arrow notes that the ethical indoctrination of physicians becomes important so that “the control exercised ordinarily by informed buyers is replaced by internalized values.”113 The medical profession self-governs its own behaviour to minimize opportunities for individual physicians to undermine patients’ confidence in the medical profession in general. Entry into the profession is restricted and members are required to operate according to ethical codes that are determined by the profession.114 Thus physicians’ moral and ethical codes will mean they are highly unlikely to knowingly recommend treatments without any clinical benefit. Physicians will also wish to ensure their continued reputation in order to ensure patients make return visits to them,115 and to avoid medical malpractice actions (although relatively few cases of negligence result in suits for medical malpractice).116

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109 Mooney and McGuire, supra note 69 at 14.
110 Reisman, supra note 61 at 8.
112 Donaldson and Gerard, supra note 54 at 56.
114 Governments in most jurisdictions have facilitated this development by legislating for the licensing of physicians, hospitals, and other health care providers. Licensing results in curtailment in the number of providers and therefore, all other things being equal, raises prices for their services. Higher prices may be viewed as an appropriate trade-off in return for higher quality services because of the potentially serious and irreversible effects on a patient who is the recipient of inadequate services.
115 Reisman, supra note 61 at 26.
116 Ibid. at 8 notes that patients will often not sue for medical malpractice. Apart from obvious cases, the patient is unlikely to have sufficient information to know whether or not a service was negligently provided and is thus far less likely to become aware of the negligence. Moreover, because of the high costs of litigation, it is only cost-effective to bring an action for negligent treatment where the harm suffered is significant. See also R. V. Bovberg, “Malpractice: Assessing the Health Security Act” (1994) 19: 1 Jnl. of Health, Politics, Policy and Law 207 at 210 and the
However, even within these parameters, physicians have a wide discretion to advocate the consumption of services that are not necessarily cost-effective i.e. they can advocate the consumption of services that while not harmful are of small marginal benefit or more costly services than is necessary to satisfy a particular health need. This problem of provider-induced demand is undoubtedly aggravated by the moral hazard problem as neither patients nor physicians are sensitive to the cost of services. It is also arguably aggravated by the desire of patients to have something "done" when they visit a doctor, the desire of patients to shift the risk of vitally important decisions to skilled professionals, and a reluctance to accept the limits of medical knowledge.

Although one can intuitively appreciate the potential for providers being able to influence demand for their own services, the empirical evidence for this is not clear-cut. There are studies which conclude that physicians and health service providers are influencing demand for their own services. On the other hand, there are commentators that argue the proposition that fee-for-service reimbursement leads to practitioners supplying more health services than is cost-effective is unproven. Clearly, there are variations in the ways that providers respond to financial incentives and that the reasons for provider behaviour are multi-factoral. Factors influencing behaviour will include education and training, the practice of colleagues and peers,


117Mooney and McGuire, supra note 69 at 14.

118Reisman, supra note 69 at 161.

119Increases in the volume of physicians' services in the U.S. during the Medicare physician fee freeze over the period 1984 to 1986 were associated with a continuing rate of increase in per enrollee physician expenditures of 10% or more during each of the years that fees were frozen - J. Mitchell, G. Wedig, and J. Cromwell. Impact of the Medicare Fee Freeze on Physician Expenditures and Volume: Final Report, Baltimore MD: Health Care Financing Administration. 1988 as cited by Langwell and Menke, supra note 91 at 38; in the U.S., Fuchs has found that a 10% higher surgeon per capita ratio in any particular area will result in a 3% increase in the number of operations and an overall increase in prices indicating that surgeons may be influencing demand for their own services -- V. R. Fuchs, "The Supply of Surgeons and the Demand for Operations" in V. R. Fuchs, ed., The Health Economy (Cambridge, Mass.: Harvard University Press, 1986) at 147; Evans argues that despite the historical increase in the number of physicians per capita in Canada and the U.S., physicians' average income and workload have not fallen as market theory would normally predict indicating that providers are able to influence demand for their own services -- Strained Mercy, supra note 50 at 87. For further examples of studies suggesting that physicians respond to financial incentives see: D. Hemenway et al., "Physicians' Responses To Financial Incentives: Evidence From A For-Profit Ambulatory Care Center" (1990) 322 New Eng. J. Med 1059; B. J. Hillman et al., "Physicians' Utilization And Charges For Outpatient Diagnostic Imaging In A Medicare Population" (1992) 268 JAMA 2050; J. M. Mitchell & E. Scott, "Physician Ownership Of Physical Therapy Services: Effects On Charges, Utilization, Profits, and Service Characteristics" (1992) 268 JAMA 2055; J. M. Mitchell & J. H. Sunshine, "Consequences Of Physicians' Ownership Of Health Care Facilities -- Joint Ventures In Radiation Therapy (1992) 327 New Eng. J. Med. 1497; and A. Swedlow et al., "Increased Costs And Rates Of Use In The California Workers' Compensation System As A Result Of Self-referral By Physicians" (1992) 327 New Eng. J. Med. 1502.

and absorption of ethical norms and trade-offs may be made by physicians between working longer hours and generating a higher income by providing more services.

The argument over whether or not in a fee-for-service system physicians influence demand for their own services cloud what is the more important issue, namely that physicians are insensitive to the cost of all services that they recommend. Physicians prescribe drugs, diagnostic tests, the use of various technologies and admissions into hospitals yet have no incentive to be sensitive to the cost-effectiveness of the various services they recommend. Stoddart et al. note the estimates of the cost of physician-generated inappropriate use vary but are sometimes as large as 30-40% of all services including hospital services and drugs. Chappel notes that in Canada, inappropriate use of technology varies between 25% and 60%. Maynard notes: “it is remarkable in all health care systems how policy formation reflects fashion and beliefs rather than knowledge base. The majority (perhaps 90%) of health care interventions are not based on evidence of their cost effectiveness but on tradition and judgements with all too brief reference to an incomplete and often biased knowledge base.”

The information asymmetry problem can also aggravate costs if providers seek to compete with each other on the basis of perceived quality (by physicians who admit patients to hospitals and by patients themselves) rather than price. The moral hazard problem of third-party insurance in an unregulated fee-for-service system means that hospitals often do not have to compete for custom on the basis of price, but will seek to attract patients with the promise of high quality care. Quality of health care is, however, very difficult to measure because of information problems. Hospitals will therefore tend to compete with each other on the basis of what Donabedian describes as “structural” measures as surrogate indicators of quality, i.e. the actual buildings and beds, technology, and skilled labor employed. Hospitals will attract the allegiance of physicians (who refer or admit patients to the hospital) by providing the type of technology demanded by them in that region and amenities such as adjacent offices. Thomson

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122 Hurley and Labelle, supra note 120.
123 See Stoddart et al., supra note 93 at 6.
notes that this type of competition increases hospitals' costs as physicians like hospitals to have spare capacity to suit their needs and prefer the latest technological equipment and highly-trained support staff.\(^{127}\) A hospital that displays a high number of qualitative indicators does not, however, necessarily supply higher quality care or result in better patient outcomes. Therefore in areas where there are many competitors, contrary to what neo-classical economic theory would predict, prices may increase rather than fall in an unregulated fee-for-service market.\(^{128}\)

To remedy market failure occurring from the information asymmetry problem a government may intervene to control costs by restricting the number of inputs into the health system i.e. the numbers of physicians, hospitals, other health providers, and technology thereby restricting the total volume of health services able to be produced. A government may attempt to change the financial incentives that health service providers have to exploit their market power deriving from information asymmetries. This might include the use of annual prospective global budgets for hospitals, utilization review and capitation payments for physicians and these changes may be achieved by direct regulation and/or through contracts (as per the internal market model). Alternatively, government could delegate this responsibility for micro-managing the supply side to private institutions and require these institutions to compete on price and quality dimensions (as per the managed competition model). All potential solutions have costs and benefits and are discussed in subsequent chapters.

### 2.2.6. Economies of Scale

Depending on the particular health service market in question there may be problems associated with economies of scale on the supply side. For example, because of the high capital costs involved in operating a hospital it is likely that in rural areas, hospitals may be natural monopolists i.e. it would be inefficient to have more than one hospital as this would result in a duplication of resources needed to service the local population. Competition for the market itself (a contestable market) may ensure on-going efficient performance on the part of the monopoly provider;\(^{129}\) but the high sunk costs often attributed to establishing a hospital may render the

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\(^{127}\) R. B. Thomson, "Review: Competition Among Hospitals In The United States" (1994) 27: 3 Health Policy 205.


threat of new entry less viable. This problem may be alleviated to some degree in the future as advances in technology enable more outpatient and day-surgery and accordingly providers of secondary care can compete in markets without requiring as significant an infrastructure investment.

In the face of monopoly provision in a relatively non-contestable market, a government could regulate the price a monopolist charges to eliminate supra-normal (excessive) profits, and regulate and monitor the quality of services produced by the monopoly. Given the cost and difficulty of specifying and monitoring the price and quality of health services a government may choose, as in the U.K. and New Zealand, to nationalize (i.e. own and operate) the hospitals themselves. In these latter countries, government finances, owns, and operates the majority of hospitals, and not just those that would, in the absence of government intervention, hold a monopoly position. Strictly all that is required to ameliorate market failure due to imperfect competition is to regulate and/or control the operation of monopolies and to prohibit collusion in oligopolistic markets (i.e. markets where there are a few major providers supplying most of the output in the particular market). In a situation of competing insurers/purchasers, as envisaged by managed competition, arguably the problem of monopoly supply is aggravated as insurers/purchasers will have less market leverage vis a vis large hospitals than one large government purchaser. The problem of monopoly supply and possible solutions to it are discussed further in Chapter 6.

2.3. Distributive Justice

Most agree that the fundamental basis for government intervention in the allocation of health care rests in distributive justice and that everyone should have access to some level of health care services on the basis of need as opposed to the ability to pay. Even in the U.S., which relies to a significant degree on private markets to allocate health services, government still plays a significant role in financing services for the very poor and the aged, paying for 43.9% of all health expenditures in 1993.

Dworkin describes a concept of “insulation” which he believes a majority of people instinctively accept with respect to the allocation of health care services. As he describes it the insulation

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130 Frank, supra note 57 at 444.
131 Calculated from figures given by Levit et al. supra note 72 at 22 (Exhibit 6).
concept has three features or underlying intuitions: the first is the primacy of health as a good, the second is that health services should be distributed in an egalitarian way, and the third is that it is intolerable to allow people to die when their lives could have been saved but resources were withheld for economic reasons. Dworkin argues that the insulation concept is now irrelevant for it offers no principles for rationing in times of rapid technological advances that offer questionable or low benefits in terms of outcomes or health gains. However, if these three intuitions truly underlie the general public’s attitude to health care allocation then they must be taken seriously or else distortions will undoubtedly occur in the allocation system (for example, physicians will provide care to patients who cannot afford it by raising the prices for other patients who have insurance or are wealthy). I will attempt in the following discussion to examine the three intuitions underlying the insulation principle in order to clarify more clearly what the demands of distributive justice are with respect to health care allocation.

First, with respect to the primacy of health as a good, the argument runs that health care is pre-eminent among all goods and that the most important thing is life and health for therein lies hope. Health has been described as one of Rawls’ “primary goods”, being something that a rational person would want irrespective of what else she would want, all other things being equal.\textsuperscript{133} Competition between private insurers will result in those who are in most in need of health care often being priced out of the market. Thus, because of the importance of health care to life itself, there are grounds for government to intervene in the market to ensure a fairer distribution of health services. However, endless utilization of health services by an individual will not necessarily result in a better health outcomes. There are at least four other determinants of health status besides the performance of the health care system: biological factors, physical environment, lifestyle, and social environment.\textsuperscript{134} Access to other social welfare services, economic, and political factors may have as significant (although perhaps more indirect) impact on “health” as the consumption of health services.\textsuperscript{135} As a result, equity in the context of health is generally characterized as achieving a fair distribution of health care services rather than


achieving a fair distribution of health, for the latter goal is viewed as too problematic.\textsuperscript{136} Thus this may explain why even in countries that attempt to provide universal access to a very broad range of health services the poor and otherwise vulnerable populations are in significantly poorer health relative to other people within the country in question.\textsuperscript{137}

The second intuition underlying the insulation concept is that of equal access for equal need. A survey of nine European countries by Wagstaff \textit{et al.} show policy-makers therein to be in broad agreement as to what constitutes equity in the allocation of health care: that financial contributions to the health care system should be related to ability to pay rather than utilization of health services; all citizens should have access to health care; and that access to and receipt of health care should depend on need rather than ability to pay.\textsuperscript{138} Wagstaff \textit{et al.} find that in countries such as the U.S., where a majority of the population rely on private insurance to finance health expenditures, the financing system is highly regressive.\textsuperscript{139} In fact, to the extent that private insurance premiums are risk assessed then contributions may be negatively related to income, since the worse-off tend to be in relatively poorer health.\textsuperscript{140} Wagstaff \textit{et al.} also find that systems that rely extensively on user charges like the U.S. and New Zealand (for general practitioner care) are also regressive. Thus, the means by which a health care system is financed is crucial from the perspective of satisfying the demands of social or distributive justice.

Communitarians argue strongly in favour of the concept of equal access for equal need. The argument is that inequities in access to health services are unacceptable due to the special nature of health, even though we might accept inequities in many other spheres. Dougherty argues: "...there is something more repugnant about unequal treatment in matters as intimate as life, death, and the quality of life than in the general arena of consumer goods and services."\textsuperscript{141} He uses the example of the contrast between our general acceptance of first-class seating on airlines with our general reluctance to accept that a poor father must pass through a first-class neo-natal unit to visit his own new-born child who is not receiving the same standard of care even though


\textsuperscript{138}A. Wagstaff and E. van Doorslaer, "Equity In The Finance Of Health Care: Some International Comparisons" (1992) 11 Journal of Health Economics 361 at 363 and see also J. W. Hurst, \textit{supra} note 5.

\textsuperscript{139}\textit{Ibid.} at 384.

\textsuperscript{140}\textit{Ibid.} at 384.

the care provided might be thought clinically adequate.° Walzer argues that the provision of medicine constitutes a separate sphere of justice within which sphere decency, community, solidarity, and equality must reign.° Communitarians believe that equality of access to health care services provides a link between individuals in community as everyone shares a common bond at some of the most important junctures in a human life through the consumption of health services relating to birth, pregnancy, sickness, dying, and death. As Dougherty notes, the provision of health services: "...draws people together in relationships of caring and response to the needs of others. This sense of sharing the burdens of illness and the general limits of the human condition is linked to notions of equal membership in a community."°

Notwithstanding the appeal of the arguments in favour of equal access for equal need, there are some who find the concept illogical.° The problem is that it seems absurd to allow an individual access to the latest medical technology such as heart and liver transplants yet, on the other hand, to deny her assistance to shelter, adequate nutrition, adequate income, and education, particularly as these factors are as likely to influence one's health in the long run more than access to health services. However, it is somewhat nihilistic to argue that unfairness in the distribution of most resources can be used to justify unfairness in the area of health care allocation. There is surely an argument that individuals that are restored to or are maintained in as good health as is possible through the utilization of health services have much better prospects for providing for themselves with respect to shelter, income, education, and nutrition.° Nonetheless it is true that given limited resources choices need to be made regarding the circumstances in which we are prepared to provide medical services to individuals and what these services will include, given that these resources could also be deployed to some other use that might be equally as important to any particular individual. As Callahan notes, what is essential or adequate in terms of health care services cannot be defined independently of resources.° Thus, providing access to hip replacement operations in a country with severe food shortages is obviously inappropriate but may not be inappropriate in wealthier countries.

142 Ibid. at 84.
143 M. Walzer, Spheres of Justice (New York: Basic Books, 1983) at 89.
144 Dougherty supra note 141 at 85.
146 See Daniels, supra note 133 at 26–28 arguing that health care should be provided to allow individuals to achieve "species-typical normal functioning."
147 D. Callahan, "What is a Reasonable Demand on Health Care Resources: Designing A Basic Package of Benefit" (1992) 8 Jnl. of Contemporary Health Law and Policy 5.
Consequently, what will satisfy the demands of distributive justice with regard to health care in any particular country must depend on its particular social and economic circumstances and will often be determined by political processes.\footnote{148}{idem.}

The concept of equal access for equal need implies that everyone will be entitled to access to the same level of care. Enthoven argues in the U.S. that there is in fact no general consensus on equal access for equal need, and that Americans accept the prospect of a two-tier system where people are able to use their own money to buy "higher system medical care (e.g. more convenience, amenities, attention from the doctor)."\footnote{149}{A. C. Enthoven, "On The Ideal Market Structure For Third-Party Purchasing Of Health Care" (1994) 39: 10 Soc. Sci. Med. 1413 at 1420.} Even in those countries that ostensibly aspire to a one-tier system there are limits (either explicitly or implicitly) on the number and quality of health services provided to all citizens and from which providers these services must be purchased. In some countries, such as the U.K., the number of health services not covered by a publicly-mandated system are relatively few and of little clinical importance while in others, such as New Zealand, general practitioner care is not covered for a majority of the population and government subsidies where available generally only cover 50% of the actual cost. In both countries people without supplementary private insurance must wait in queues for elective surgery. In Canada, which prides itself on a single-tier system, there is significant private financing of drugs used outside the hospital, ambulance services, and for home care services.

The limit on what health services are included in a publicly-mandated system can either be fixed by government specifying exactly what services should be available to all or by limiting the resources made available to health care providers who will then undertake implicit rationing between their various patients. This latter method of rationing has been the historical approach taken in many countries as there has been a reluctance to accept or acknowledge at a central level that medical resources have to be rationed. However, this approach may result in its own inequities as health providers may not allocate resources in a manner that satisfies distributive justice and if required to operate under a fixed budget may attempt to shift costs. As countries are reforming their health care systems to be more competition-oriented, the process of determining total expenditures on health services is shifting from an implicit to an explicit form of rationing. Whereas previously governments may have simply allocated a global budget for total expenditures on health and health providers determined what services to provide to what
patients on the basis of clinical need, now in order to enable competition between groups of purchasers and/or providers, government-appointed bodies, such as New Zealand’s Core Health Services Committee, struggle to determine what services to include in a package to be made available to everyone. Competition-oriented reform requires that explicit decisions be made about the range and minimum quality of services to be publicly-funded and this process is described in greater detail in Chapter 4.

Dworkin does not consider that issues of rationing are political alone and argues that principles of justice allows the development of mechanisms for determining or rationing the health care services that should be available to everyone but which will not preclude wealthier individuals from buying more health services if they so desire. Essentially he envisages a Rawlsian veil of ignorance being drawn down over the members of a society in which there is fair equality in the distribution of resources and in which the members of society have no knowledge or expectation about what their likely need for health care services will be over the course of their lives. Assuming that it is possible to know the costs and benefits of any particular medical treatment, then Dworkin argues the resultant allocation decisions made by this notional society will, by necessary implication, be just. He goes on to argue that such a society would not elect to buy life-sustaining treatment once they had fallen into a vegetable state or life-saving treatments if they were in the later stages of some irreversible form of dementia nor would they agree to expensive treatments that are likely to extend their lives by very small amounts. These principles for allocation seem reasonable but for the fact that they do not deal adequately with the third intuition underlying the insulation concept, namely that it is intolerable to allow people to die when their lives could have been saved but resources were withheld for economic reasons. Arguably the life-saving principle is both irrational and unduly sentimental but, as a matter of course, we expect our medical providers and caregivers to respect life and it seems an impossible burden to impose upon them to respect it in once instance, when the individual in question or her relatives are prepared to pay for the treatment in question, and not in others where our societal sense of justice means we are under no obligation to the individual in question or her family. The ethical principle of beneficence requires physicians to promote the welfare of patients and not merely to avoid harm. Williams and Beresford notes “[t]he physicians’ role as advocate

150 Dworkin, supra note 132.
of the best interests of their patients, regardless of cost, conflicts with another role that they are often expected to fulfil, that of gatekeeper of society’s scarce health care resources.\textsuperscript{152}

This discussion brings into focus the problem of balancing individual patient needs or wants with societal interests. A patient may value very highly an expensive life-saving operation with a 5% chance of success yet from society’s perspective that operation may not be valued nearly as highly as these resources could be more productively used in other places from the perspective of the health of society overall. If as a society we reject treating people differently in life-threatening situations but acknowledge that principles of justice would dictate rationing of particular health services, then the only answer seems to be to require that everyone in society, or the vast majority thereof, receives essentially the same rationed health care services so that everyone is treated equally when it comes to life-sustaining or life-saving treatments and providers are not forced into unacceptable ethical dilemmas. On the other hand, a truly single-tier approach may be politically unsustainable as there is an increasing demand for health resources due to the ageing of the population and those on higher-incomes strenuously resist government-imposed rationing on their own individual consumption.

If there were no other failures in health insurance markets aside from the caring externality and distributive justice, an economist might consider the appropriate government response to be to subsidize the cost of private health insurance premiums (by a voucher) for those who could not otherwise afford these premiums for a package of benefits that meets the demands of the caring externality.\textsuperscript{153} What should be included in this package is, as already mentioned, a vexed question and although explored in a preliminary fashion in Chapter 4 is deserving of much greater attention then can be accorded it in this dissertation. Assuming for present purposes it is possible to determine a package of health services that should be available to all and ignoring for the moment the problems of adverse selection, moral hazard, administration costs and information asymmetries, government subsidization of those unable to afford health insurance is still unlikely to be sufficient as problems immediately arise as individuals have an incentive to free-ride on the safety net designed for the poor.\textsuperscript{154} For example, in the U.S., there is evidence of significant numbers of middle-class elderly people transferring their assets to their children in

\textsuperscript{152} J. R. Williams & E. B. Beresford, "Physicians, Ethics and the Allocation of Health Care Resources" in Bayliss et al., supra note 93 at 121.
\textsuperscript{153} Strained Mercy, supra note 50 at 65.
\textsuperscript{154} Reisman, supra note 61 at 62 notes that a rational individual will evade the cost of private insurance to ride free on the public system where possible.
order to become eligible for Medicaid-covered nursing home care.\textsuperscript{155} One can also envisage instances of people taking a risk they will not need health services and, in the event that they do, seeking treatment as a charity case. Thus, arguable it is necessary to mandate that everyone purchase private insurance to cover the same benefits provided to the poor. There is also a problem that the services provided to the poor will be of low quality as the best providers may prefer the higher rates of reimbursement offered by private insurers.\textsuperscript{156} As Weale notes "[t]he principle that services for poor people are poor services is about as well attested an observation as we are likely to find in social affairs".\textsuperscript{157} If a majority of the population do not have a vested interest in a publicly financed health system then it may well deteriorate and eventually collapse through lack of voter support thus jeopardizing access by the most vulnerable in society to needed health services.

2.4 Conclusion
The unregulated operation of a health insurance market will perversely result in those who are most in need of health services being priced out of or directly excluded from the market. Due to the importance of health to every individual’s existence and dignity, distributive justice seems to require of a society (and a government as a representative thereof) that it intervene to ensure a fairer distribution of resources. Distributive justice cannot be discounted as a goal for a health allocation system and if ignored will result in costs to the system in any event. For example, the uninsured in the U.S. may receive care if health providers feel unable to ignore their plight and the costs of this care will be borne to some degree by insured individuals. So either explicitly or implicitly a system has to absorb the costs of distributive justice goals. Thus, the crucial task is not to design an efficient health allocation system \textit{per se} but to design and implement a system that results in the optimal allocation of resources to the health sector and efficiently achieves the goal of satisfying distributive justice concerns using these resources.

Distributive justice arguments, however, only seem to require of a government that it intervene to satisfy society’s demand for health care services for those people who cannot otherwise afford them. However, having accepted the need to insure access for people to health services who otherwise would not be able to afford them then a nationalized health insurance system covering


\textsuperscript{156}A. Weale, "Equality, Social Solidarity and the Welfare State" (1992) 100 Ethics 473 at 474.

\textsuperscript{157}A. Weale, \textit{idem}.
all citizens or at least a majority of citizens for services comprising a "decent minimum" or a "basic core" or a "comprehensive range" becomes justifiable on a mixture of political, economic, and social justice reasons:

1. to ensure that the quality of health services supplied to those covered by the public system does not fall;
2. to sustain continued political support for the public health system by capturing the middle-class and wealthy who are likely to have a greater influence on politicians;
3. because the particular society in question rejects treating individuals in need differently depending on their ability to pay (this is not, however, a conviction held by all societies);
4. in order to reduce administrative or transactions costs;
5. to avoid free-riding on a safety-net designed for the poor, that is relatively wealthy people not buying insurance coverage in the expectation they will be able to play the system to receive coverage should it eventuate they do need health services;
6. to minimize opportunities for cost-shifting so that providers are not subsidizing the costs of care for people without health insurance from the prices charged to those with health insurance;
7. to ensure comprehensiveness so as to minimize the ability or incentive of insurers and/or providers to shift costs to each other or on to society; and
8. to increase bargaining power on the demand side in order to deal with the problems of information asymmetry, moral hazard and monopoly supply.

Moving from the question of who to cover to what to cover, the vexed question in all health care allocation systems, whether they simply provide vouchers for the poor or guarantee universal access, is what range and quality of health services should be publicly funded. In other words, what should comprise the "decent minimum", the "basic core" or "a comprehensive range"? This question will depend on the overall resources available to society and an appropriate balance must be struck between expenditures on health services and other goods and services. If this determination is left to an unregulated market then the inefficiencies caused by moral hazard and information asymmetry will likely result in more resources being devoted to health care than is optimal and for a disproportionate share of resources being spent on services that physicians and well-insured patients value as opposed to those services society values.

There are no obvious solutions as to what is the most appropriate form of government intervention in the financing and supply of health services. That there is a role for government in
determining the allocation of health care services is undisputed. That extensive government intervention can lead to problems of its own as exemplified in the command-and-control systems of New Zealand and the U.K. is also without doubt. Although there is support for nationalization of health insurance, there would not seem to be any justification for nationalization of hospitals and other health providers after reviewing the causes of market failure in health insurance and supply markets. The important question that this thesis addresses is how to achieve a balance between the benefits of competition (technical efficiency, dynamic efficiency, and responsiveness) and the benefits of government planning (equity and cost control) and to identify concepts that appear to be working or are likely to work to assist other countries considering health care reform. That there are a range of possible solutions is amply demonstrated by the range of different health allocation systems in the world even amongst those countries that aspire to and provide national health insurance to all their citizens. The health systems of New Zealand, the U.K., the Netherlands, and the U.S. reflect the continuum amongst affluent OECD countries in terms of expenditures on health care as a percentage of GDP and in terms of their commitment to providing for a national health insurance system. These four countries also represent the continuum of health allocation systems in terms of the public/private mix in financing health insurance and in the supply of health care services. Moreover, all these countries have, in recent times, proposed to reform their health care systems using generally what can be described as competition-oriented reform proposals.

This thesis will now turn in Chapter 3 to examine more closely the incentives operating in the different health allocation systems in New Zealand, the U.K., the U.S., and the Netherlands: their respective historical developments; problems that have arisen and the magnitude of these problems in the various jurisdictions; proposals for either managed competition, managed care or internal market reform that have been advanced in these respective countries; and a description of reforms actually implemented. Chapter 3 thus provides the material for analysis in Chapters 4-7 of this thesis.
Chapter 3: The Reform of Health Care Allocation Systems in the U.S., the Netherlands, New Zealand, and the U.K.

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3.1 Introduction

In this chapter, I provide an overview of the U.S., Netherlands, New Zealand, and U.K. health care systems and the respective problems therein which prompted internal market reform and managed competition reform proposals in the late 1980s and early 1990s. The reason for discussing the four countries in the order in which I do is that this sequence reflects the continuum amongst the four systems in terms of levels of private funding and private delivery. At one end of the spectrum, the U.S. relies to the greatest degree on private funding and private supply whereas at the other end, the U.K. relies to the greatest degree on public funding and provision. The Netherlands falls within this continuum closer towards the U.S., but there is a fundamental and crucial distinction, namely that through government regulation the Netherlands seeks to ensure access for the poorer 60% of the population and coverage for the entire population for “exceptional” medical expenses. New Zealand falls closer on the continuum towards the U.K. but what distinguishes New Zealand is its relatively high reliance on private financing (by patients themselves and by private insurance) for primary care services.

In the conclusion to this chapter, on the basis of this overview, I begin to identify the factors which characterize a system that will efficiently achieve the objective of ensuring universal access to a comprehensive range of health services on the basis of need as opposed to ability to pay.

3.2 The U.S. Health Care System and the 1993 Reform Proposals

3.2.1 Introduction

In this section I discuss the history of the U.S. health care allocation system. Prior to President Clinton’s reform proposals in 1993, the U.S. system was characterized by rising costs and reduced access. The nature and extent of these problems prior to 1993 will be outlined first and I will then proceed to discuss how the plural financing of the system has contributed to cost and access problems. In particular, I focus on the growth in private insurance (which has been stimulated by tax subsidies) and the absence of comprehensive regulation prohibiting competition on risk avoidance. I outline the organizational arrangements for the supply of health care services and the financial incentives impacting on health care providers noting how historically providers have been paid on a fee-for-service basis and have had significant control over resource allocation decisions. I then outline President Clinton’s (now defunct) proposals for managed competition reform. Finally, I discuss the recent managed care
revolution which, in the absence of government-initiated reform, has caused radical reform of the system.

3.2.2 Problems in the System Prior to Reform Proposals
The problems in the U.S. system manifest themselves in cost-escalation and lack of access to health services for a significant portion of the population.

a. Cost
There is a strong correlation between what OECD nations spend on health and their wealth.\textsuperscript{158} The U.S. has remained an outlier over the last thirty years compared to other OECD countries, for it has devoted a one-third higher percentage of Gross Domestic Product ("GDP") to health than would be predicted from its real level of GDP.\textsuperscript{159} In 1992, the year prior to President Clinton's reform proposals, the U.S. spent 66% more on health services as a percentage of GDP than the OECD average of 8.1% and 30% more than that spent in Canada, the country with the second highest level of expenditures.\textsuperscript{160} The percentage of GDP devoted to health expenditures rose from 5.3% in 1960 to 13.9% in 1993,\textsuperscript{161} and in the early 1990s was predicted to reach 18.1% of GDP by the year 2000.\textsuperscript{162} Most OECD countries record a rising percentage of GDP being devoted to their respective health sectors over the last thirty years, but the U.S. has experienced higher rates of growth than most countries.\textsuperscript{163}

As discussed in Chapter 2, two distinguishing features of U.S. health expenditures is the relatively high component spent on administrative costs and the relatively small percentage of total health expenditures paid for by the public sector.\textsuperscript{164}

Cited sources of pressure on U.S. costs are the relatively high cost of malpractice premiums and "defensive medicine."\textsuperscript{165} An examination of some of the figures available suggests that in reality these sources comprise a relatively small component of total costs. Malpractice

\textsuperscript{158}OECD Health Systems: Facts and Trends, supra note 73 at 14.
\textsuperscript{159}Idem. and OECD, U.S. Health Care at the Crossroads, supra note 66 at 18 and 24.
\textsuperscript{160}Schieber et al., supra note 90 at 101–102.
\textsuperscript{161}Figures from Levit et al. supra note 72 at 15, Exhibit 1.
\textsuperscript{163}Schieber et al., supra note 90.
\textsuperscript{164}See the discussion at Chapter 2 under "Minimization of Administration & Loading Costs."
\textsuperscript{165}T. H. Boyd, "Cost Containment and the Physician’s Fiduciary Duty to the Patient" (1989) 39 DePaul L.R. 131 notes, defensive medicine "refers to a practice in which physicians utilize exhaustive diagnostic and treatment methods of minimum value to ensure the best quality of health care while at the same time erecting an undefeatable defense against liability."
insurance premiums average 6% of physicians’ practice costs.\textsuperscript{166} In 1990, the American Medical Association estimated that the cost of defensive medicine amounted to 3% of total health spending.\textsuperscript{167} Within different specialties, there may be greater incentives to practice defensive medicine. For example, Kessler and McCellan in a study of elderly Medicare beneficiaries treated for serious heart disease in 1984, 1987, and 1990 found that reforms that directly limit liability such as “caps on damage awards, abolition of punitive damages, abolition of mandatory prejudgment interest, and collateral-source-rule reforms -- reduce hospital expenditures by 5 to 9 percent within three to five years of adoption, with the full effects of reforms requiring several years to appear.”\textsuperscript{168}

As Table 3 in Appendix 4 illustrates, the higher costs incurred in the U.S. system are not explained by higher utilization rates in terms of days spent in hospital or numbers of patients admitted. Instead, higher costs appear attributable to the intensity of care provided per episode of illness and higher payment rates for providers.\textsuperscript{169} By intensity of care I refer to the number of tests, procedures, drugs, scans, and number of professionals involved in servicing a particular health need. Prices for health services in the U.S. are the highest of all OECD countries being 58% above the average.\textsuperscript{170} Higher prices not only reflect higher profit margins for providers but also the use of greater technology and the provision of more intensive care per episode of illness.\textsuperscript{171} One study comparing treatment of patients with uncomplicated hypertension in the U.S. and the U.K., found that physicians in the U.S. ordered 40 times more electrocardiograms, 7 times more chest films, 5 times more blood counts, and 4 times more

\textsuperscript{166}There are, however, wide variations between specialties with obstetricians and neurologists facing significantly higher premiums -- De Lew, Greenberg, & Kinchen, \textit{supra} note 155 at 159.
\textsuperscript{168}D. Kessler and M. McCellan, “Do Doctors Practice Defensive Medicine?” (1996) Quarterly Jnl. of Econ. 353 at 386.
\textsuperscript{170}OECD, \textit{U.S. Health Care at the Crossroads}, \textit{supra} note 66 at 24 -- using OECD purchasing-power-parity
\textsuperscript{171}Welch \textit{et al.}, \textit{supra} note 91 found when comparing the supply of physician services for the elderly in Canada and the United States that Canadians received more simple services but 25% less surgical procedures such as cataract extractions and knee replacements.
urinalyses than their British counterparts. From an economic perspective we are not generally concerned with the level of expenditures provided that the benefit (whether measured in dollars, or effectiveness, or utility or by some other means) is worth the expenditure and would not be better spent elsewhere. Evidence in this regard is by nature speculative because of the difficulty of measuring the quality of services supplied. Looking solely at health outcomes is not particularly helpful as there is no direct causal relationship with the efficiency of the health care insurance or service system. Notwithstanding the difficulties with assessing performance using crude mortality and life expectancy indicators, it is hard to overlook infant mortality rates which are generally assumed to be sensitive to the quality of medical and health services available to the whole population. As Table 4 in Appendix 4 shows, on the indicators of infant mortality rates and low birth weights as a percentage of births, the U.S. performs comparatively poorly. On the other hand, the U.S. records the highest life expectancy at aged eighty and over for men and the second highest for women amongst OECD countries. This suggests that the U.S. is allocating more resources to prolonging the life of the elderly as opposed to preventive and primary services that enables a basic standard of health care for the population as a whole. Although the U.S. population as whole may not be in better health as a result of higher national expenditures than the citizens of other OECD countries, there is anecdotal evidence that the well-insured receive very high quality care.

b. Access

Despite the government sponsored programs of Medicaid (for the very poor) and Medicare (for the elderly), there are significant access problems. In 1993, the year of President Clinton's proposals, 25% of the population would lose health insurance coverage for some period during the following two years, 37 million Americans had no insurance, and a further 22 million lacked adequate coverage. More recently Thorpe calculated from the March

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174 See generally R. G. Evans, M. L. Barer, & T. R. Marmor, eds., Why Are Some People Healthy and Others Not? The Determinants of Health of Populations (New York: Aldine De Gruyter, 1994). For example, social problems in the U.S. are manifested in a homicide rate four times that of Canada and ten times that of the U.K., and child poverty rates that are significantly higher than other developed OECD countries — De Lew, Greenberg, and Kinchen, supra note 155 at 157.
176 Schieber et al., supra note 90 at 105.
177 OECD, U.S. Health Care at the Crossroads, supra note 66.
178 Clinton Blueprint, supra note 24 at 3.
1996 Current Population Survey that 40.6 million people were uninsured throughout 1995, more than 10.5 million of whom were under the age of 19.\textsuperscript{179} Although most of the elderly (over 65) are covered by Medicare, less than half of those below the federal poverty line are covered by Medicaid.\textsuperscript{180} Some of the uninsured may be able to avail themselves of emergency hospital care supplied altruistically by providers, but there are wide variations in access to charity care across the country.\textsuperscript{181}

Health outcomes for some sectors of the U.S. population are significantly worse than the average. The infant mortality rate for Native Americans is 1.5 times the rate for Whites and the rate for Blacks is 2.1 times the rate for Whites.\textsuperscript{182} On average, Black men in Harlem are less likely to reach their sixty-fifth birthday than men in Bangladesh.\textsuperscript{183} Violence, poverty, and racism contribute to these outcomes; however, lack of access to primary and preventative health services is presumably a contributing factor although there has been remarkably little empirical research done with regard to demonstrating this.

Given the reliance of the U.S. health system on employment-based insurance it may be assumed that the uninsured will usually be unemployed. In fact, 87% of families \textit{without} health insurance have the head of the family engaged in part or full time work.\textsuperscript{184} A disproportionate share of the uninsured work for small businesses and there is a probably a correlation with the fact that small businesses face premiums 10–40% higher than those paid by large firms (because of the higher administration costs incurred for insuring a smaller population and the fact that risk cannot be pooled over a larger employee base.)\textsuperscript{185} Apart from the problem of being able to afford health insurance, continuity of coverage is also of concern. Employees are unwilling to change jobs for fear of losing their existing entitlements as most insurers will not agree to insure pre-existing conditions.\textsuperscript{186} In 1996 the Federal government

\begin{itemize}
\item \textsuperscript{179}K. E. Thorpe, “Incremental Approaches to Covering Uninsured Children: Design and Policy Issue” (1997) 16: 4 Health Affairs 64 at 65.
\item \textsuperscript{180}OECD, \textit{U.S. Health Care at the Crossroads}, supra note 66 at 63.
\item \textsuperscript{183}R. L. Braithwaite & S. E. Taylor, eds., \textit{Health Issues In the Black Community} (San Francisco, CA: Jossey-Bass, 1992).
\item \textsuperscript{184}C. G. McLaughlin & W. K. Zellers, \textit{Small Business and Health Care Reform: Understanding the Barriers to Employee Coverage and Implications for Workable Solutions} (Ann Arbor, Michigan: Regents of the University of Michigan, School of Public Health, 1994) at 2.
\item \textsuperscript{185}Ibid. at 4
\item \textsuperscript{186}A. M. Rivlin, et al., “Financing, Estimation, and Economic Effects” (1994) 1 Health Affairs 30 at 31 and 44. The authors also refer to one study which estimates that the mobility rate for married men would increase by one-third in the absence of pre-existing condition exclusions.
\end{itemize}
passed legislation directed at addressing this problem and this is discussed at the end of the section on the Managed Care Revolution (below). The high cost of health insurance also means that those who receive government income assistance and government subsidized health insurance are reluctant to take up employment because of the cost of buying health insurance.\textsuperscript{187}

Even amongst the insured, there may be difficulty in accessing needed services because of high deductibles or copayments. Such a method of financing services is regressive as it imposes the greatest burdens on the poor and the ill. In the U.S. both private insurers and government insurers (Medicaid and Medicare) impose patient copayments and deductibles, thus rationing access to these services on the basis of price for those people unable to afford or obtain additional insurance to cover these charges. The poor entitled to Medicaid saw the proportion of their after-tax income devoted to copayments and deductibles increase from an average of 7.8% in 1972/73 to 11.5% in 1989 whereas the general population devoted, on average, below 5% of their after-tax income to copayments and deductibles.\textsuperscript{188}

Having discussed the problems of cost and access, I will now turn to provide a brief overview of the financing of the U.S. health allocation system in order to better understand the underlying factors contributing to the problems of cost and access.

3.2.3 Financing of Health Care Services

a. Private Health Insurance

Private health insurance plans such as Blue Cross and Blue Shield were generally instigated by physicians and private hospitals in the earlier part of this century. Thus, until relatively recently, the boards of insurance companies were dominated by physicians. According to Enthoven, as a result, the health insurance subsequently supplied furthered professional self-interest by institutionalizing the "guild" principles of health care financing -- fee-for-service billing, free choice of providers, no patient copayments, solo practice, free choice of drugs by physicians, and the fiscal and clinical independence of physicians.\textsuperscript{189}

\textsuperscript{187}It is estimated that one-quarter of the approximately four million welfare recipients would enter the labour force if health insurance were available continuously -- \textit{ibid.} at 31 and 45.

\textsuperscript{188}Laingwell & Menke, \textit{supra} note 91 at 38 at 20.

\textsuperscript{189}See Enthoven, "The History and Principles of Managed Competition" \textit{supra} note 20 at 25 and Bovbjerg \textit{et al.}, \textit{supra} note 169 at 143.
In the first part of this century, most States encouraged the proliferation of the non-profit physician-dominated Blue Cross and Blue Shield plans by granting these health insurers exemptions from financial requirements imposed on other commercial insurance companies and exemptions from property and income tax.\textsuperscript{190} The percentage of the population with private health insurance grew from 9.1% in 1940\textsuperscript{191} to 61.6% by 1991.\textsuperscript{192} However, in the early 1990s private insurance still only accounted for 33.5% of all health expenditures.\textsuperscript{193} Thus clearly the burden of the costs of the highest users of care are borne by the government and patients themselves. The earliest non-profit Blue Cross and Blue Shield plans did not engage in risk-selection and calculated premiums on a community-wide basis. As competition between insurers grew, non-profit plans began to experience and risk-rate in order to remain competitive.\textsuperscript{194} This, however, resulted in increased problems in terms of access as high-risk individuals, who are often poor, faced increasing premiums.

The growth of private health insurance was encouraged from the 1940s by tax exemptions.\textsuperscript{195} As tax levels rose through the years this tax advantage became of increasingly greater value. Most commentators seem agreed that the historic tax treatment of health insurance premiums paid by employers for employees is both unfair and inefficient.\textsuperscript{196} The tax subsidy is unfair as it is a regressive means of financing health care as everyone, regardless of income, receives the same tax benefit and in a progressive tax system this disproportionately favours higher income families.\textsuperscript{197} It is also unfair as the self-employed and those buying their own health insurance (i.e. not through their employer) have not been granted similar tax benefits (although in 1996 the Federal government enacted legislation to correct this unfairness).\textsuperscript{198} It is inefficient as it results in employers and employees being less concerned about the price of


\textsuperscript{191}Bovbjerg et al., supra note 169 at 143.


\textsuperscript{193}Levit et al., supra note 72.

\textsuperscript{194}Bovbjerg et al., supra note 169 at 146.

\textsuperscript{195}The tax treatment of health insurance premiums resulted in monies paid for health insurance not being taxed in either the hands of the employer or employee -- ibid. at 145.

\textsuperscript{196}For a full appraisal of the economic impact of the tax subsidy on health insurance and health service markets in the U.S. see Pauly, supra note 43. He notes at 636–638 that health insurance premiums receive special tax treatment in two ways. First, employer paid health insurance provided as a fringe benefit is a tax-deductible business expense for the firm and second, consumer payments for health insurance are tax deductible for those taxpayers who itemize where their total medical expenses exceeded a certain proportion of income. Enthoven and Singer, supra note 68 note that in 1995, the Congressional Budget Office estimated that excluding employer-paid health insurance premiums from federal income and payroll taxes cost the government U.S. $90 billion.


\textsuperscript{198}Idem. See the *Health Insurance Portability and Accountability Act 1996*, PL 104-191 August 21, 1996, 110 Stat 1936 (HR 3103) §301.
insurance than they otherwise would be if they had to pay for the insurance with after-tax dollars. One study suggests that 80-100 percent of each dollar reduction in health care spending will translate into higher wages for employees. Nonetheless, reportedly employees operate under the misapprehension that health premiums are a cost incurred by employers.

Employers have historically had a limited interest in controlling the cost of health insurance premiums to the extent they have been able to pass on rising costs in the form of reductions in the growth of the wages and salaries of employees and to the extent that premiums paid are treated as tax-deductible items of expenditure. Rising costs and growing foreign competition during the 1980s compelled employers to lower labour costs, and it was at this time that many employers began to examine ways by which to reduce health insurance costs. One such measure was a move on the part of larger employers to self-insure rather than buying cover for their employees from private insurers. Private health insurance companies are regulated to differing degrees by states that may stipulate the degree of coverage to be provided. The 1974 Employee Retirement Income and Security Act (ERISA) has had a profound effect on the rate of self-insurance by employers. The ERISA legislation pre-empts state regulation of self-insuring employee benefit plans. As states have sought to regulate minimum benefit packages this has encouraged the growth of self-insurance amongst larger employers anxious to avoid the cost of compliance with such regulation. Another measure adopted by employers as a means to control costs was the purchase of health services from managed care plans, and this phenomenon is discussed further below.

b. The Role of the Government

Over the years U.S. governments (both federal and state) have played an increasing role in financing the health system. In 1960, only 25% of all health expenditures were paid for by government expenditures but by 1993 this had increased to 43.9% of all health

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199See W. A. Zelman, "The Rationale Behind the Clinton Health Care Reform Plan" (1994) 1 Health Affairs 9 at 27 and see R. Kronick, "A Helping Hand for the Invisible Hand" (1994) 1 Health Affairs 96.


201Reinhardt, supra note 197 at 181.

202Bovbjerg et al., supra note 169 at 153.


expenditures. Legislative jurisdiction over health care in the U.S. rests with individual state governments and, as a consequence, the details of the health care allocation system vary considerably between states. The discussion here is general in nature and refers primarily to the role of the federal government rather than the various state initiatives.

The U.S. failed to implement a national health insurance scheme in the 1930s and 40s, the period in which countries like the U.K. and New Zealand implemented their respective national health systems. There was strong opposition by the medical profession represented by the American Medical Association. However, such opposition was not unique to the U.S. and was overcome, albeit with difficulty, in the U.K. and New Zealand. Rothman argues that national insurance was not implemented as the physician-dominated Blues insurance plans were ensuring access by the middle-class to affordable coverage as a tactic to undermine political support for a national health insurance scheme which was not seen to be in the best interests of either private insurers or health providers. In this endeavour the Blues plans largely succeeded, and the impetus for reform largely dissipated as it was widely considered that employment group insurance would grow to cover the entire population without government intervention. This prediction, however, proved false.

By 1962 the need for some form of reform had become clear as 50% of Americans over the age of 65 were completely uninsured and only half of those with health insurance had adequate coverage for hospitalization expenses. Important reform was able to be effected after the Democratic landslide of 1964. Federally funded Medicare was intended to provide health insurance coverage similar to that provided by the Blues plans for those aged over 65. Despite the strong opposition of the American Medical Association there was significant public support for the Medicare proposals. Medicare became the single largest health

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205 Levit et al. supra note 72 at 21.
211 Enacted by that part of the Social Security Act Amendments of 1965 (P.L. 89-97) which created a new Title XVIII.
212 For a comprehensive account of the enactment of Medicare and Medicaid and description of both programs see Shonick, supra note 204, Chapter 10.
213 Blumenthal, supra note 210 at 466.
Medicare is financed partly by premiums paid by those enrolled in the scheme but is topped up by social insurance taxes and general revenues. Under the Medicare plan, coverage is automatically provided for hospital care and related benefits under Part A. Medicare does not, however, provide for long term care and only provides for very limited nursing home services (long term care). Additional premiums are required to be paid for enrolment in Part B of the Medicare plan that covers physician and other ambulatory services, durable medical equipment, and certain other services. Medicare beneficiaries must pay deductibles and patient copayments for services under both Parts A and B. In fact the Medicare program pays for less than half of the medical expenses of its beneficiaries and consequently 70% of those enrolled in Medicare purchase private gap insurance.

In 1965, the Medicaid program was implemented. This enabled federal subsidies to be paid to those states that provided coverage for the very poor as defined by federal guidelines. Medicaid provides coverage for preventive, acute, and long-term care services for over 10% of the population. Notwithstanding, about half of those below the federal poverty line are not covered by Medicaid. Despite the existence of federal subsidies, few states opt to provide the maximum available coverage to Medicaid recipients allowed under federal regulation.

Growing government expenditures on Medicare and Medicaid programs have caused concern. Medicaid expenditures have more than doubled since 1989 to an estimated U.S. $140 billion in 1993. Medicare’s board of trustees project that its hospital insurance trust fund (Part A) will be bankrupt by 2001. In 1982, in an effort to control expenditures, Congress changed the structure of Medicare payments from a retrospective cost-reimbursement method to a prospective payment method with the goal of encouraging Health Maintenance Organizations to cover Medicare beneficiaries. There have also been more recent initiatives to introduce managed care into Medicaid and Medicare plans.

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214De Lew, Greenberg, & Kinchen, supra note 155 at 152.
217Bovbjerg et al., supra note 169 at 148.
218Inglehart, supra note 216.
221J. White, “Which ‘Managed Care’ For Medicare?” (1997) 16: 5 Health Affairs 73.
3.2.4 The Supply of Health Care Services

a. Physicians

Unlike most other developed countries, the U.S. has not historically relied on general practitioners as the gatekeepers to the consumption of specialists’ services and hospital care. Insured patients in the U.S. have in the past been able to access the system at any level, and can initiate visits to specialists without being referred by a general practitioner. Thus, the prospects for moral hazard problems are accentuated as patients can enter the health system at any point i.e. a patient could see a specialist and be treated for a common cold.\(^\text{222}\) Perhaps as a reflection of this the ratio of specialists to general practitioners is higher in the U.S. than in other OECD countries.\(^\text{223}\)

The average rate of compensation per U.S. physician is much higher than in all other OECD countries\(^\text{224}\) -- around 50% more than Canadian physicians and 300% more than U.K. physicians.\(^\text{225}\) Physicians’ incomes in the U.S. have remained fairly stable over the last thirty years even although the number of physicians per capita has risen substantially.\(^\text{226}\) Between 1980 and 1989 there was a 80% increase in real spending per person on physician services despite the greater use of utilization controls.\(^\text{227}\) This provides some support for the contention, discussed in Chapter 2, that physicians influence demand for their own services in order to maintain their incomes.\(^\text{228}\) This seems to be particularly so in the case of specialists. The net incomes of radiologists, surgeons and anaesthesiologists has risen 286, 307, and 359 percent respectively from 1973 to 1991 compared with a net income increase of 166 and 190 percent respectively for family physicians and paediatricians over the same period.\(^\text{229}\)


\(^{224}\) OECD. U.S. Health Care at the Crossroads. supra note 66 at 25.

\(^{225}\) Langwell & Menke. supra note 91 at 25. See also Welch et al., supra note 91 discussing the price of services for elderly patients.

\(^{226}\) A 1992 OECD report suggests that the resilience of physicians' incomes in this regard must be due to an even stronger increase in the demand for services -- OECD, U.S. Health Care at the Crossroads. supra note 66 at 14.

\(^{227}\) Langwell & Menke, supra note 91 at 22–24. During the late 1980s, price increases accounted for more than half the increases in real expenditures on physician services -- OECD, U.S. Health Care at the Crossroads, supra note 66 at 14.


A 1992 OECD report notes that U.S. physicians have an indirect but significant influence on health care expenditures through their role as advocates for the consumption of new technology. Unlike hospital-based physicians in most other OECD countries who are salaried, U.S. hospital-based physicians have historically been paid on a fee-for-service basis and thus have had a financial incentive to recommend more profitable procedures to maintain or increase their incomes. Moreover, there appears to have been few restrictions on practitioners having a proprietary interest in the technology they advocate to their patients. A 1990 study of six imaging procedures found that physicians who self-referred (i.e. performed the procedure in their offices) ordered more than four times as many of these procedures per patient compared to physicians who referred patients to a radiologist, and also charged more per procedure. Adding cost and extra utilization, total expenditures on imaging ranged from 4.4 to 7.5 times higher for self-referring than referring physicians. In more recent times, however, both federal and state legislation has been passed prohibiting referrals to services where the referring physician or a member of his family has a financial interest in the enterprise producing the service.

Although most efforts to contain expenditures have been directed by the government at hospital expenditures, in 1989, Medicare adopted “Resource Based Relative Value Scales” to reform the payment of physicians which involved the setting of prices based on the input resources required to produce each physician service. However, rather than calculating the real costs of production for individual physicians, the Medicare fee schedule estimates practice costs on the basis of historical charges. According to some critics this simply entrenched past inefficiencies and inequities, with specialists continuing to be over-compensated and generalists being under-compensated.

b. Hospitals
The three different types of hospitals in the U.S. are public, private not-for-profit, and private for-profit hospitals. The majority of hospitals are acute care hospitals and are private not-for-
profit organizations. There has been an historical distinction in the behaviour of the three different types of hospitals particularly with respect to the treatment of the poor and the raising of revenues. However, Hollingsworth and Hollingsworth note that competitive pressures and the changing nature of financing are reducing these distinctions. Public and voluntary hospitals are becoming increasingly dependent upon private insurers for revenues and proprietary hospitals receive about half of their income from Medicaid and Medicare.

As Table 2 in Appendix 4 indicates, hospital expenditures comprised 46.2% of total expenditures in 1990 which is a smaller proportion than that spent by other countries on hospital care. However, Langwell and Menke note that over the period 1980–1989 there was a 64% increase in real spending per admission which more than offset the 13% drop in admissions. I have already discussed in Chapter 2 how a system of indemnity insurers coupled with unregulated fee-for-service payments results in competition between hospitals, paradoxically increasing rather than decreasing costs. Prior to the managed care revolution this appears to have been the case in the U.S.

Although expenditures on medical technologies are growing in most countries, by international standards the population-adjusted supply of certain large scale technologies in the U.S. is extraordinarily high. In other sectors such as telecommunications, technological advances have resulted in lower costs. Why has this not been the case in the health sector? An OECD report speculates that unlike other sectors, where consumers will tend to buy the least expensive product all else being equal, comprehensive insurance for health care means practically every non-experimental procedure is covered that provides some benefit, regardless of its cost-effectiveness. Thus there is an incentive to produce and sell high-cost technology. Another reason advanced for the investment in high-cost technology is that a hostile tort system has discouraged the development of medical advances such as vaccines that

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236 De Lew, Greenberg, & Kinchen, supra note 155 at 155 note that there are approximately 6,700 hospitals in the U.S. including 5,480 community acute care hospital, 880 specialty hospitals (i.e. psychiatric, long-term care etc.), and 340 federal hospitals open only to military personnel, veterans, or native Americans. 59% of community acute care hospitals are private not-for-profit hospitals, 27% are public hospitals, and 14% are private for-profit hospitals.
237 Hollingsworth & Hollingsworth, supra note 190 at 86.
238 Idem.
239 Langwell & Menke, supra note 91 at 20–21.
240 Thomson, supra note 127.
242 OECD, U.S. Health Care at the Crossroads, supra note 66 at 32
have the potential to have an enormous beneficial effect on health outcomes at relatively little cost.\textsuperscript{243}

Unlike most health care systems in developed countries, the U.S. does not regulate the supply of physical capital.\textsuperscript{244} However, in the 1980s the Federal government did take steps to control Medicare and Medicaid expenditures on hospital services. Prior to the Omnibus Budget Reconciliation Act of 1981, states were required to pay hospitals for treatment of Medicaid and Medicare patients according to a reasonable cost methodology. The 1981 Act allowed states to pay hospitals for Medicaid patients an amount that would cover only the costs of economically and efficiently operated hospitals. Consequently, the typical Medicaid hospital and physician payment is significantly lower than Medicare rates, resulting in 25\% of physicians refusing to treat Medicaid patients.\textsuperscript{245}

In 1983, the federal government implemented the Prospective Payment System (PPS) for inpatient hospital services under Medicare.\textsuperscript{246} In place of retrospective fee-for-service reimbursement, hospitals were to be paid according to a schedule of rates based on the average costs of producing services nation-wide for product lines defined by five hundred Diagnosis Related Groups ("DRGs").\textsuperscript{247} This was intended to provide an incentive for hospitals to operate more efficiently, as they are able to keep as profit any difference between their actual costs and the DRG payment. Some states took similar initiatives with respect to Medicaid payments. Under PPS the risk of the cost of treatment is shifted to hospitals and there is thus a strong incentive to contain costs. However, because the PPS regime was not applied by all payers to hospitals, the effect on total expenditure is unclear as there is the ability to shift costs to other payers. Despite the introduction of PPS for Medicare payments overall hospital expenditures continued to rise through the 1980s. There was an increased volume of more expensive diagnoses and technological innovation allowed more surgery to be conducted in an


\textsuperscript{244}In 1974 the Federal government introduced the Health Planning and Resource Development Act that required all states receiving federal aid to enact Certificate of Need ("CON") laws regulating capital investment in health care institutions. This legislation was criticized by Pauly and others on the basis that the CON program was captured and dominated by those hospitals that were the subject of regulation and used by them to exclude efficient competition — M. V. Pauly, "A Primer on Competition in Medical Markets" in H. E. Frech III, ed., Health Care In America: The Political Economy of Hospitals and Health Insurance (San Francisco: Pacific Research Institute For Public Policy, 1988) at 39. Subsequently the CON laws were repealed.

\textsuperscript{245}Langwell & Menke, supra note 91 at 38. M. L. Lassey W. R. Lassey & M. J. Jinks, Health Care Systems Around the World (Upper Saddle River, NJ: Prentice Hall, 1997) at 59 notes the federal Prospective Payment Commission estimated that Medicare pays only 91\% of costs and Medicaid pays only 74\%.

\textsuperscript{246}OECD 1994 Review of Seventeen Countries, supra note 1 at 330.

out-patient setting which is not subjected to the same cost controls as in-patient care.\textsuperscript{248} It is also possible that hospitals simply shifted charges they would have otherwise charged to Medicare to other insurers.

During the 1970s and 1980s, Maryland, New Jersey, New York and Massachusetts moved to impose global annual budgets on all hospitals and/or to regulate the prices that hospitals could charge all payers (and not just Medicare and Medicaid).\textsuperscript{249} This eliminates the ability of hospitals to cost-shift. Studies suggest that this regulation has been successful in containing costs,\textsuperscript{250} but despite its relative success this type of regulation has not been adopted by other states.

3.2.5 The Clinton Managed Competition Reform Proposals

An American economist, Alain Enthoven, is most often credited with designing the managed competition model and his work was first reported in two articles in 1978.\textsuperscript{251} The model formed the basis for President Clinton's proposals,\textsuperscript{252} although with such modifications that Enthoven did not support the Clinton initiatives.\textsuperscript{253} Appendix 3 provides the details of Enthoven's model.

President Clinton's 1993 proposals for reform by managed competition were motivated by a desire to provide universal access and reduce costs without fundamentally changing the system of private insurance and private delivery. Subsequent to the release of the President’s plan, several other proposals were introduced in to Congress but I will limit myself at this juncture to discussing the President's plan.\textsuperscript{254} The seven key points of the plan were as follows: 1. universal access achieved largely by employer mandates; 2. the creation of sponsors called “Regional Alliances" to consolidate market power on the demand side and reduce the information asymmetry problem; 3. the stimulation of price competition between private insurance plans and the growth of managed care; 4. global budgets to control overall expenditures; 5. regulation of quality; 6. shifting resources from the training of specialists to the training of generalists; and 7. reforming medical malpractice law and anti-trust law.

\textsuperscript{248}De Lew, Greenberg, & Kinchen. supra note 155 at 162.
\textsuperscript{249}\textit{Ibid.} at 163.
\textsuperscript{251}See Enthoven (1978) supra note 20.
\textsuperscript{252}The managed competition concept was subsequently further developed by Enthoven and Paul Ellwood and become known as the Jackson Hole Plan.
a. Universal Access

Clearly the desire for universal access stimulated the Clinton reforms and this goal was professed to be non-negotiable in terms of what reform measures President Clinton would agree to. The most important reform proposed was a requirement that all employers provide health insurance for all their employees and families covering a comprehensive list of services including mental health services, substance-abuse treatment, some dental services, and clinical preventative services. The reform proposal also provides that employers pay 80% of the average cost of that core package in their area, calculated per worker, the balance being paid by the insured individual. The proposals provided for government subsidies to be paid to low-wage firms and low-income individuals in order to assist in the purchase of health insurance. The proposals also provided for expenditures incurred by employers to be capped at between 3.5% and 7.9% of payroll depending on the size of the firm and the level of salaries paid. The contribution of low-income individuals was also capped at 3.9% of their income. The reform proposals also provided for the creation of a Medicare prescription drug benefit and a long-term home-care program for the severely disabled as opposed to nursing home services.

Under the Clinton plan, health insurers could offer either low, high or combination cost sharing arrangements. Under the high cost sharing arrangements, deductibles for individuals could be up to $200 per episode of illness and for families, up to $400 per episode. The high cost-sharing plans could also impose user charges or co-payments of up to 20% of the cost of the service in question; however, the reform proposal provided for an annual cap on out-of-pocket expenditures of $1500 for individuals and $3000 for families.

b. Regional Alliances

Clinton’s plan required government-appointed sponsors (referred to in the reform proposal as “Health Insurance Purchasing Co-operatives” and subsequently as “Regional Alliances”), to act as intermediaries between consumers and insurers. It was proposed that funding from government, employers, and from consumers themselves would be funnelled through the

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255 President Clinton said in response to concerns over his own reform proposals: “I have no special brief for any specific approach, even in our own bill, except this: if you send me legislation that does not guarantee every American private health insurance that can never be taken away, you will force me to take this pen, veto the legislation, and we’ll come right back here and start all over again” as cited by J. K. Iglehart, “Health Care Reform: The Role of Physicians” (1994) 330: 10 New Eng. Jnl. of Medicine 728.

256 Clinton Blueprint, supra note 24 at 21.
257 Rivlin, et al., supra note 186 at 31.
258 Ibid. at 42, Exhibit 4.
259 Zelman, supra note 199 at 13.
260 Clinton Blueprint, supra note 24 at 37.
Alliances and this would help consolidate the purchasing power of individual consumers and smaller employers. It was proposed that the Regional Alliances negotiate on behalf of everyone (except those on Medicare and employees in firms with over 5000 employees) within a region for the purchase of health care insurance from private insurers. States would be responsible for establishing Regional Alliances but would only be allowed to establish one Alliance in any particular region and would be required to ensure that each region encompasses a population large enough to ensure the Alliance controls adequate market share to negotiate effectively with insurers. If they so desired, states could have one single Regional Alliance to serve its entire population.

Enthoven's original managed competition model provided that sponsors would be able to select the health insurers that would be offered to consumers at enrolment time. This was not provided for in Clinton's reform plan for fear that Alliances could interfere with rather than enhance competition between plans. The Clinton reforms provided that Regional Alliances must offer a contract to each qualified health insurer seeking to provide services in the relevant region unless: 1) the premium offered exceeds the average by 20%; 2) the insurer discriminates on the basis of race, ethnicity, gender, income or health status; 3) the quality of care offered is determined by the state (as opposed to the Regional Alliance) to be unsatisfactory; 4) the insurer fails to comply with contract requirements; or 5) if the insurer offers a fee-for-service reimbursement of providers and the alliance already has contracts with three such insurers in the region.

c. Price Competition Between Competing Health Insurance Plans
The Clinton reform plan envisaged that private insurers would contract with various providers and offer consumers (through the Regional Alliances) insurance covering a comprehensive package of health goods and services. It was thus envisaged that there would be growth in the number of individuals enrolled in Health Maintenance Organizations and other forms of managed care. Insurers would generally be expected to limit the choice of providers available to consumers, thereby, it is hoped, reaping savings from selective contracting and by paying providers other than on a fee-for-service basis. However, under the Clinton proposals, Regional Alliances would have been required to ensure that a limited number of insurers continued to offer coverage entitling enrollees to an unrestricted choice of providers and which paid providers on a

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261 The reason given in the Clinton proposals for the exclusion of Medicare beneficiaries was essentially that the logistical difficulties of including Medicare recipients were too great in the short term; however, states would eventually be permitted to integrate Medicare beneficiaries into health alliances under specified conditions - Clinton Blueprint, supra note 24 at 216. These conditions are that beneficiaries have the same or better coverage as standard Medicare benefits and that federal financial liability is not increased.

262 Zelman, supra note 199 at 20.

263 Clinton Blueprint, supra note 24 at 66.
fee-for-service basis. It was proposed that annually, each Regional Alliance would facilitate individual choice of insurers and individuals, at this time, could switch insurers if they so desired. Information would be provided on each insurer’s enrollee satisfaction levels, how each insurer has rated on nationally approved quality indicators, and any restrictions within the insurance policy on choice of and access to providers. Under the Clinton plan, insurers would be prohibited from setting premiums on the basis of the risk of utilization of the insured individual except as expressly permitted by the Regional Alliance. Insurers would be required to accept anybody who sought to purchase insurance cover from them and would be prohibited from offering supplemental insurance covering the standard package of benefits required to be offered to everyone. The reform plan provided that insurers would not be able to impose pre-existing condition exclusions or waiting periods on prospective enrollees. Except for those individuals moving from or to a large firm (over 5000 employees) that elected to co-ordinate its own insurance coverage, the Clinton proposals eliminated the need for anyone to have to change their insurance plan or lose cover at the time of changing jobs.

The Clinton reform plan did not eliminate the tax deductibility of health insurance premiums which, as discussed earlier, aggravates the problem of the insensitivity of providers to the costs of services. The plan did, however, extend to the self-employed the benefit of being able to claim health insurance premiums as a tax deductible item.

With respect to price competition, the Clinton plan provided that government subsidies to smaller employers and poor individuals and taxation benefits would be targeted at the average cost of all insurance premiums. It was proposed that if anyone wanted to buy a plan that cost more than the average, then he or she (or their employer) must pay for this with after-tax dollars. Enthoven’s model of managed competition required that government subsidies be targeted at the lowest priced insurance plan to stimulate price competition. The Clinton Administration thought that targeting government subsidies at the lowest-cost plan would cause inequities, forcing the poor and near-poor individuals into the lowest priced plan. Clinton was severely criticized by Enthoven and others for this proposal.

d. Global Budgets
The Clinton reform proposals provide for a global budget to cap national expenditures on the comprehensive benefit package. It was proposed that caps be imposed on the average weighted

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264 Zelman, supra note 199 at 18.
265 Idem.
premium for each Alliance so that the total of weighted averages for all Regional Alliances equals the national per capita baseline target. The inflation factor allowed per annum was to be the increase in the Consumer Price Index; however, the National Health Board would be able to adjust the inflation factor for each alliance to reflect unusual changes in demographic and socio-economic characteristics.

Economists in the Clinton Administration calculated that the costs of universal coverage and start-up costs would be offset by planned savings in Medicare, Medicaid, and other federal programs, and new revenues, such as an increase in tobacco taxes. They estimated the new revenue plus savings would exceed the new costs over the period 1995-2000 by about $58 billion. Other commentators argued that the Clinton plan would result in a cost explosion and some estimated that the Clinton Administration underestimated the cost of premiums in the reformed system by 30%. One study calculated that the price of premiums in a system reformed along the Clinton plan would be 15.4% above that estimated by the Clinton Administration; however, Sheils and Lewin calculate that even if premiums were 15.4% above the Clinton estimate there would still be a cost saving of $25 billion through implementation of the Clinton plan.

e. Regulation of Quality
The Clinton reform plan provided for the creation of a National Health Board, consisting of seven members appointed by the President, to oversee the Regional Alliances, monitor quality standards, review the standard package of benefits to be made available to everyone, and set a figure for a national global budget (i.e. covering all public and private expenditures on health care) and ensure that it is met.

f. The Training of Generalists vs. Specialists
The Clinton health reform plan provided for an increase in the proportion of general practitioners to specialists in the health workforce by shifting the balance in the graduate training of physicians from specialties to primary care, investing more in the training of nurse practitioners and

267 Clinton Blueprint, supra note 24 at 102 – 110.
268 Ibid. at 103 – 104.
269 Rivlin, et al., supra note 186 at 32.
271 However, the $44 billion reserve cushion provided for by the Clinton administration for unanticipated increases in spending would be wiped out — ibid. at 51.
physician assistants, and adjusting Medicare payment formulas to increase reimbursement for primary care.272

g. Reform of Medical Malpractice Law
The Clinton Administration proposed the reform of medical malpractice law by requiring that patients with a malpractice claim attempt to resolve the claim through alternative dispute resolution. If a patient were not satisfied with the outcome of such a procedure, then the patient could pursue the complaint in court. To reduce the costs of litigation a number of other reforms were proposed: all lawsuits include an affidavit from a specialist practising in the relevant field attesting that malpractice has occurred, attorneys’ fees for malpractice cases be limited to a maximum of 33.3% of the award, that a pilot program be developed whereby national practice guidelines are developed and any defendant showing that his or her conduct complies with these guidelines be found to have met the required standard of care, rules be established reducing the amount of the malpractice award by the level of compensation received from other sources, that provision be made for either the defendant or plaintiff to request that an award be made in instalments to reflect the need for medical and other services, and that pilot projects be established to see whether malpractice liability would not be better shifted from individual doctors to the insurers or Health Maintenance Organizations that employ them.273

h. Reform of Competition Law
The Clinton reform plan provided for the following proposals to reform anti-trust or competition law:
1. the publications of guidelines giving greater certainty to smaller hospitals as to what constitutes a legal merger and specifying what joint ventures and arrangements are acceptable for both hospitals and physicians;
2. that health providers who share risk be able to establish and negotiate together the prices they will offer their services to insurers;
3. exemption of hospitals and physicians from competition law provisions in those states which choose to regulate rather than foster competition;
4. enabling health care providers to collectively negotiate fee schedules with regional health Alliances; and
5. repealing the current exemption from antitrust laws enjoyed by health insurers.

272Clinton Blueprint, supra note 24 at 139.
273Ibid. at 189 — 191.
3.2.6 The Failure of Reform Proposals

The need for reform of the health system in the U.S. was (and still is) manifest, and yet despite commitment on the part of the Clinton Administration, its attempts at effecting reform to ensure universal access proved unsuccessful.

The reasons for failure of the most recent attempt at establishing a national health insurance scheme in the U.S. are many, but some are rooted in the political process and the power of interest groups. Provider groups feared that government intervention could curtail their incomes and restrict their clinical autonomy, insurance companies feared government intervention would restrict their incomes, employers, particularly small employers, were concerned about the extra costs that would be imposed on them to provide health insurance for employees and often are ideologically committed to the concept of self-help, and Americans with adequate health insurance feared that their choice of providers would be restricted, quality would fall, costs would spiral in the effort to provide universal access for all and, in general, disapproved of “big government” reform. Many could not be persuaded, despite the evidence available to this effect from nearly every other OECD country, that ensuring universal access was possible without costs significantly increasing. Perhaps it is true that the American middle class can theoretically see the unfairness of a system that leaves over 14% of the population uninsured; however, there may not be prepared to sacrifice personally any measure of the quality of health services they receive, particularly when it is unclear to what degree entitlements to quality must decline in order to finance a level of health care for all. There also emerged a perception in 1994 that health care costs were largely coming under control through private managed care initiatives. The Clinton Administration also failed to galvanize public support for health reform evident at the time of his election by quickly bringing forward a reform proposal. Another factor is likely that the Clinton proposals were seen as very technical, incomprehensible, and thus likely to result in a bloated bureaucracy and cost increases. In retrospect the Clinton Administration should have kept its initial proposals

274 K. R. Wing, “American Health Policy in the 1980s” (1985-86) 36: 4 Case Western Reserve Law Review 608 at 610 notes health reform in the U.S. is a “divisive political struggle among interest groups [in which] defining the nature of the problem is as much in controversy as is fashioning a remedy; and [in which] the reform or remedy sought for one problem would only exacerbate the problems of the others.”
275 Glaser, supra note 209 at 697.
276 A Democratic poll showed that of the 54% of voters canvassed who said they were disappointed by Clinton, half cited the fact that he offered a health care reform plan that favoured big government — J. K. Iglehart, “Editorial” (1994) 13: 5 Health Affairs 5 at 6.
277 See T. R. Marmor, supra note 14 at 29 noting that a majority of Americans are in favour of a national health insurance scheme.
279 Blumenthal, supra note 210 at 466.
very simple and focused on selling the concept to the general public before fleshing out the technical details.

3.2.7 The Managed Care Revolution

In the U.S. it was historically thought that “medical need” would place an upper limit on total health expenditures. Thus it was considered unnecessary to put in place financial incentives to curb the supply of health services. However, as Bovbjerg et al. note, “need” is a subjective concept and almost any level of additional care will confer some benefit on a patient. In a system of passive payers (whether public or private) where health providers are paid on a fee-for-service basis then providers have an incentive (even if they do not always act upon it) to provide that combination of health services most likely to maximize their incomes.

Although historically in the U.S. most health providers were paid on a fee-for-service basis, there has been some experimentation with alternative means of reimbursement. Bovbjerg et al. note that Ikl City, Oklahoma initiated the first prepaid community-based health services plan in 1929 and similar organizations developed elsewhere through the 1930s. These organizations were the precursors of what have come to be known as Health Maintenance Organizations (“HMOs”) that provide managed care. Enrollees in a HMO are entitled, in return for a fixed annual or monthly payment, to a comprehensive benefit package from health providers stipulated by the HMO. Thus, rather than providing insurance, HMOs provide a guarantee of access to health care services. Different versions of managed care in the U.S. include “Preferred Provider Organizations” and “Point of Service Networks” and these are more fully described in Appendix 1. Of all the variants of managed care, HMOs limit patient choice to the greatest extent. HMOs generally require their enrollees to use only the providers affiliated with them except in the case of an emergency. HMOs do, however, impose relatively lower or no user charges on patients. The traditional emphasis of HMOs has been on primary and preventive care and the ethos that it is more effective to prevent people getting sick than to devote most resources to curing them when they are sick. There are, in fact, several types of HMOs and Inglehart notes that they can be categorized according to whether they employ physicians directly or whether they contract work out to groups of practitioners and other providers. Preferred Provider Organizations do not actually enrol people with particular health providers. Instead insured individuals are given a list of preferred providers

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280 Bovbjerg et al., supra note 169 at 150.
281 Idem.
282 Ibid. at 143.
and if a patient elects not to use one of these listed providers when seeking treatment then he/she must pay a higher user-charge. While historically patients (with sufficient insurance or financial resources) have been able to access the U.S. health system at any level, Point of Service plans require enrollees to select a general practitioner who acts as a gatekeeper and co-ordinator of the delivery of care from a limited list of other providers. However, patients can elect to pay an a higher user charge and obtain care from a provider who is not participating in the plan.

In general terms, managed care covers a variety of techniques whereby insurers/purchasers (be they public or private) seek to make health care providers sensitive to the costs and benefits of the services they are supplying or recommending to their patients. The goal of managed care, as Mechanic describes it, is “to limit expensive care that is unnecessary without interfering with appropriate treatment.” This is on the basis that in an indemnity insurance fee-for-service system, physicians will supply any mix and type of health services in response to a particular need that they consider beneficial without being sensitive to the costs thereof. Managed care involves an insurer/purchaser, through a variety of techniques, seeking to influence health care providers’ clinical decision-making. It may involve an insurer/purchaser requiring its authorization prior to hospitalization or before a particular course of treatment is adopted. An insurer/purchaser may monitor in-patient service utilization rates and may actively manage the care of patients in need of potentially expensive care. It may involve an insurer employing a high ratio of general practitioners to specialists in an attempt to create a culture within the organization directed more towards prevention than to acute care. Managed care may also involve the use of financial incentives such as bonus payments for the realization of annual targets and paying providers on a capitation basis. This latter initiative has caused particular concern for, depending on how the payment is structured, it may result in strong financial incentives on individual physicians to cut the quality of care.

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285 D. Mechanic, supra note 28 at 125.

286 Kane notes that managed care boils down to any attempt on the part of the insurers to directly manage the delivery of health services by providers to a defined group of enrollees — N. M. Kane, “Costs, Productivity and Financial Outcomes Of Managed Care” in R. B. Saltman & C. Von Otter, eds., Implementing Planned Markets In Health Care: Balancing Social And Economic Responsibility (Buckingham: Open University Press, 1995) 113 at 114.

287 De Lew, Greenberg, & Kinchen, supra note 155 at 157.
supplied to patients. This issue and general concerns that managed care will result in deterioration in the quality of health services supplied are discussed in Chapter 7.

In an ad hoc fashion managed care has dramatically reformed the U.S. health care system. Managed care has been growing in the U.S. since federal initiatives in the 1970s resulted in the growth of HMOs. An increased rate of proliferation of managed care plans throughout the 1990s was sparked by the prospect of implementation of President Clinton’s proposals and increased employer resistance to growing premium costs. As mentioned earlier, exemption under ERISA from state regulation of employee insurance plans encouraged larger firms to self insure. Thus, increasingly employers purchased coverage on behalf of their employees from managed care plans. As a consequence there has been a tremendous growth in the number of people enrolled in managed care plans. A 1993 survey found that 51% of full time employees were enrolled in managed care plans, compared with 29% in 1988. By 1995, 73% of all American who received their health insurance through an employer were enrolled in managed care plans.

The advantage of managed care is often claimed to be that managed care plans will save costs and will put more emphasis on primary and preventive health care services as it is more cost-effective for the insurer/purchaser to keep their enrollee population healthy than to pay for acute-institutional care when people fall seriously ill. As discussed in Chapter 7 this is a problematic assumption; nonetheless a feature of managed care plans is the emphasis placed upon delivery of services by generalists as opposed to specialists. As managed care grows in the U.S., specialists are finding it increasingly difficult to enter solo fee-for-service practice or even to negotiate a contract with a managed care plan. Health plans are beginning to offer generalists higher salaries than historically has been the case. Weiner estimates that by the year 2000, there will be a surplus of approximately 165,000 practising doctors, mainly specialists.

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289These initiatives were sparked by the work of P. Ellwood, W. McClure and colleagues who, in 1970, proposed a national “health maintenance industry that is largely self-regulatory” that would deal with the crisis in health care cost and distribution — P. M. Ellwood et al., “Health Maintenance Strategy” (May, 1971) Medical Care 250.
290Bovbjerg et al., supra note 169 at 153.
291Iglehart, supra note 283 at 1168.
293Iglehart, supra note 283.
Some studies suggest that Health Maintenance Organizations can save about 20–30% compared with traditional indemnity insurance. Each version of managed care results in a different mix of incentives for health providers and Mechanic notes that it should be no surprise in the U.S. that there are large variations in practice, levels of performance, and physician and patient satisfaction. One effect of the upsurge in managed care plans has been to put competitive pressure on the traditional fee-for-service plans. These latter organizations are now taking steps to contain costs and the cost advantage of HMOs over fee-for-service insurers may eventually disappear. Premium prices for traditional insurers are lower in regions where HMOs are highly concentrated.

Managed care appears to have contributed to an unprecedented reduction in the growth in health care costs in the period 1990–1995. Slower price growth was the main reason for the deceleration in nominal health expenditures -- insurers were securing contracts with health providers at discounted rates. Thus, the relatively recent embrace of managed care together with fears of imminent and significant government intervention in the form of President Clinton’s reform proposals may have helped to curb expenditure increases.

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295 For example, Group Health Co-operative of Puget Sound cared for its randomly assigned patients at a cost 28% below that for comparable patients assigned to an insurer which reimbursed providers on a fee-for-service basis (even where up to a 25% user charge was levied on patients up to an annual out-of-pocket limit of $1000) -- W. G. Manning et al., “A Controlled Trial Of The Effect Of A Prepaid Group Practice On Use Of Services” (1984) 310: 23 New Eng. Jnl. of Med. 1505.

296 For example, D. P. Goldman et al., “The Effects Of Benefit Design And Managed Care On Health Care Costs” (1995) 14 Jnl. of Health Econ. 401 found that costs increased when the Department of Defence replaced its traditional insurance plan for military health care beneficiaries with a HMO/PPO hybrid. The latter was a plan which relied on aggressive utilization review and restricted patient referral to contain costs. As it continued to reimburse providers on a fee-for-service basis there was little financial incentive for providers to contain costs.

297 For example, D. W. Hoy et al., “Change and Growth in Managed Care” (1991) Health Affairs 18 notes that in 1987 only 43.8% of private insurance plans used some form of utilization review whereas in 1991, 91.9% of plans undertook reviews. De Lew, Greenberg, & Kinchen, supra note 155 at 157, note that some of the other measures include prior approval of hospital admission, direct management of high-cost patient care, control of referral to specialists through primary care physicians, selective contracting with hospitals and other providers, and required second opinions for surgical procedures.


300 Ibid. at 18.

301 Ibid. at 30 note that this achievement must be put in context. The U.S. still spent 13.9% of GDP on health care in 1993, compared with 13.6% in 1992. This 0.3 percentage point increase equalled the average rate of increase recorded since 1960. Moreover, it is difficult to predict the implications of recent deceleration in expenditure growth. Levit et al. note three possible scenarios: recent deceleration could be evidence of a long-term trend to controls on expenditures; it could be a transitional response to the introduction of managed care plans and
data, however, suggests that the downward trend in the rate of increase in health care costs has levelled out but it seems unlikely that the system will return to rapid rates of growth. Consumers, however, are not benefiting from these cost savings as premiums continue to increase. Moreover, managed care has not resolved the access problem as the number of uninsured have continued to grow.

As mentioned in Chapter 1, ad hoc development in managed care in the U.S. will not result in a system that ensures universal access to a comprehensive range of health services allocated on the basis of need as opposed to price. By comparison, managed competition reform promises such a system. Rheindhart notes that “the ‘managed care revolution’ in American health care will gain real momentum only if and when the government starts to rely on the power of genuine ‘managed competition’ that would force insurance companies and their rivals, provider-sponsored networks, to compete for enrollees openly and fairly on the basis of premiums and the quality of their products.” Managed competition seeks to promote competition between insurers/purchasers on price and quality dimensions so that insurers aspire to purchase the most cost-efficient services on behalf of the people they represent. In doing so, it is assumed that insurers/purchasers will generally rely upon managed care techniques. Thus managed competition and managed care are complementary pieces to the puzzle of what constitutes a viable model for health care allocation.

In 1996 the U.S. federal government enacted the Health Insurance Portability and Accountability Act in an effort to ameliorate some of the worse effects of risk-avoidance techniques on the part of insurers and to improve the portability of health insurance. Although not directly tackling the problem of the uninsured in the system the Act addresses public concerns over profit-driven insurers, employers, and managed care plans dropping coverage for people once they become in need of expensive health services. The Act amends subsequently expenditures will once again increase at a higher rate; or it could be simply an ephemeral reaction resulting from the threat of structural reform by the Clinton administration. In this latter regard, it should be noted that growth in health care expenditures similarly decelerated under the American Hospital Association Voluntary Effort program in the period 1977–1980 when Congress was debating President Carter’s proposals for hospital cost control and awaiting his proposed health care financing plan — Aaron, supra note 278 at 11.

303See Ginsburg & Pickreign, supra note 300 at 155.
304Idem.
307Enthoven has said that he now refers to his model for managed competition as "managed care-managed competition" to emphasize that what are meant to compete are integrated delivery systems supplying comprehensive care — as quoted by P. Newman, “Interview With Alain Enthoven: Is There Convergence Between Britain And The United States In The Organization Of Health Services” (1995) 310 Brit. Med. Jnl. 1652.
the Employee Retirement Income Security Act of 1974 which now prohibits health insurers (including self-insuring employers and managed care plans) from limiting or denying coverage for pre-existing conditions for more than twelve months. After this waiting period of a year coverage is portable to the extent that no new waiting period is allowed to be imposed if an employer switches insurers or if an employee changes jobs provided that the employee in question maintains coverage with a gap no longer than 63 days. Employers are now prohibited from denying coverage to an employee or dropping an employee from coverage or charging a higher premium because of that person’s or a dependant’s health status or medical history. Other provisions of the Act prevent insurers and managed care plans denying coverage to small employee groups or to those individuals who at some point have had group insurance coverage for 18 months or more and are ineligible for coverage from any other source, and also requires insurers to renew coverage for employee group plans in the absence of fraud or misrepresentation provided that premiums are paid.

Having discussed the U.S. health care system, the next section of this Chapter will examine the Netherlands’ health care system.

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309 Employee Retirement Income Security Act of 1974 (ERISA) U.S.C.A. § 701 as inserted by ibid. § 101. A pre-existing condition restriction can in any event only relate to a medical condition diagnosed or treated some time during the 6 months preceding the 12 month waiting period and cannot be imposed on new-borns, newly adopted children less than 18 years old, or pregnant women.


3.3 The Netherlands’ Health Care System and the 1987 Reform Proposals

3.3.1 Introduction
Although the Netherlands’ health care system relies to a significant extent on private insurers, through government regulation it ensures nearly universal access to health insurance. The Dutch health care system merits close attention from an international perspective for its innovative managed competition reform proposals which were first proposed in 1987 and implemented on a piece-meal basis since 1992. Given the preference for private financing and supply in the U.S., the Dutch proposals system merits particular consideration from the perspective of implementing a national health care system in the U.S. that achieves universal access.

3.3.2 Problems in the System Prior to Reform Proposals
Problems in the Dutch system prior to the 1987 proposals for managed competition reform can generally be characterized as cost and access problems.

a. Costs
It was recognized by the Dutch government in the 1970s that the fragmentation of funding between government, Sickness Funds, and private insurers was accelerating health expenditures. Between the period 1970 and 1980, health expenditures as a percentage of GDP increased from 6.0% to 8.2%. Growth in expenditures was, however, successfully restrained through the 1980s due to a variety of government initiatives, and health expenditures as a percentage of GDP increased only from 8.2% in 1980 to 8.3% in 1989. The Netherlands’ success in this regard suggests that it is not necessary to have a single-payer system in order to be able to successfully contain costs. Nonetheless, throughout the 1980s, health expenditures were still above the level that would be predicted from the Netherlands’ GDP relative to other OECD countries. There was also concern that in the longer term

312B. L. Kirkman-Liff, “Health Insurance Values And Implementation In The Netherlands And The Federal Republic Of Germany: An Alternative Path To Universal Coverage” (1991) 265: 19 JAMA 2496 notes that values are relevant to a discussion of health reform proposals as a lack of value congruence between proposed reform and overarching social and cultural values will lead to failure.
314See J. W. Hurst, “Reforming Health Care In Seven European Nations” (1991) Health Affairs 7 at 13, Exhibit 1.
315OECD Health Systems: Facts and Trends, supra note 73 at 19, Chart 3.
expenditures would significantly increase because of the increasing percentage of individuals aged over 75.\(^{316}\)

b. Access

Although there is no compulsory health insurance scheme covering all citizens for general health services, the Netherlands still manages to achieve nearly universal access to a comprehensive range of health services. There are three important government-mandated insurance schemes. The first covers all citizens for exceptional medical expenses. The second covers the poorer 60% of the population for general medical expenses. The third requires all civil servants and their families (about 6% of the population) to purchase private insurance for a comprehensive range of health services. All these schemes are discussed further below. The government also regulates private insurers to prevent them risk rating premiums which would result in unaffordable premiums or no coverage at all for high-risk individuals.

As Table 4 in Appendix 4 demonstrates, the Netherlands performs better than the U.S., the U.K. and New Zealand on measures of health outcomes such as infant mortality and life expectancy. The reason for the better than average performance of the Netherlands cannot be attributed \textit{prima facie} to lower rates of smoking or alcohol consumption or unemployment.\(^{317}\) Notwithstanding a good performance with respect to health status indicators, there are inequalities apparent in the recorded levels of health outcomes achieved by different groups within the Dutch population. In 1991, over 6% of the Dutch population either had foreign nationality or originated from one of the former Dutch colonies.\(^{318}\) Mortality rates for Surinamese and Antilleans are 20% higher than for the indigenous population.\(^{319}\) Mortality rates among Turkish and Moroccan children aged between 1 and 5 years is 2.5--3 times higher than that of the total population of the same age.\(^{320}\)

I could not find any literature suggesting that waiting times/lists in the Netherlands for general medical services are of concern. There are, however, waiting lists for institutions caring for

\(^{316}\)M. Bos, "Health Care Technology In The Netherlands" (1994) 30 Health Policy 207 at 211 notes that the percentage of the population aged over 75 increased from 2.8% in 1960 to 5.3% in 1990.

\(^{317}\)Schieber et al., \textit{supra} note 90 at 108, Exhibit 5.


\(^{319}\)\textit{Ibid.} at 811.

\(^{320}\)See the various Dutch studies referred to \textit{ibid.} and P. J. Van Der Maas, "Health Of Migrants And Migrant Health Policy. The Netherlands As An Example" (1995) 41: 6 Soc. Sci. Med. 809 at 815. The authors note, however, that qualitative and quantitative studies show that Turks, Moroccans, and Surinamese are able with little impediment to access needed care.
patients with chronic conditions such as psychiatric hospitals, nursing homes, and homes for the mentally handicapped.321

3.3.3 Financing of Health Care Services

The Dutch health care system has historically been financed from a number of public and private sources. In 1988, prior to managed competition reform proposals, compulsory health insurance premiums accounted for approximately 60%, general taxation for 14%, voluntary health insurance premiums for 16%, and patient user charges for approximately 11% of total health expenditures.322 Plurality in financing has contributed to co-ordination problems and problems of cost-shifting.323 For example, it has proved difficult for the government to transfer resources from secondary care to preventive and primary care as the former is heavily financed by the private sector while the latter is not.324 Although the Dutch government cannot control overall expenditures on health care in the way that is possible in single-payer systems like New Zealand and the U.K., the publication of the government’s annual health expenditure plan in practice acted as an overall budget for both the public and private sector.325 The government was also involved in regulating the three compulsory insurance schemes and has increasingly begun to regulate private insurers and is heavily involved in the setting of prices charged by health care providers.

Unlike New Zealand and the U.K. where locally elected authorities have acted as both the purchaser and provider of hospital services, responsibility for the financing and delivery of all health care in the Netherlands has, historically, been split.326 Responsibility for financing the system has rested largely with private insurers and with Sickness Funds which are private non-profit entities who are responsible for administering the compulsory social insurance system. Historically, Sickness Funds have contracted with private health care providers to supply care to their enrollees whereas other private insurers have historically reimbursed their policyholders for all medical expenses incurred and have not engaged in direct contractual negotiations with health providers.327

322 OECD; Health Policy Studies No. 2, supra note 22 at 89.
324 Rutten & Van Der Werf; supra note 313 at 198.
325 OECD; Health Policy Studies No. 2, supra note 22 at 92.
327 Idem.
a. The Role of the Government

Since the early part of this century, the Netherlands has been governed by successive coalition governments. Historically, the Dutch political spectrum has been comprised of a social democratic party on the left, a conservative liberal party on the right, and a Christian democratic party in the centre. This latter party has had a considerable influence on implementation of government policy given its strategic position in the political centre and, as Schut notes, has resulted in government policy being characterized by incremental rather than radical change.328

Prior to proposals for managed competition reform in 1987, there were two important pieces of government legislation in place with respect to financing health care services. These were the Sickness Funds Insurance Act 1964329 which replaced the Sickness Funds Decree of 1941 (imposed during the German occupation), and the Exception Medical Expenses Act 1967.330

The Sickness Funds Insurance Act 1964 covers about 60% of the population by compulsory insurance of all non-government employees, pensioners, and social security beneficiaries earning below a certain income level (56000 guilders in 1994).331 The self-employed can acquire membership in a Sickness Fund on a voluntary basis. As in all countries, there was strong resistance on the part of the medical profession to the role of the Sickness Funds as physicians considered them a risk to their incomes and autonomy.332 All public employees of provincial and municipal governmental bodies and their dependants (around 6% of the population) are covered by a separate mandatory insurance scheme administered by twelve special private insurance arrangements. The premiums for these funds are adjusted for age and sex, and half of the cost is paid for by the government.333 The rest of the population earning over 56000 guilders (about 40% of the population) may voluntarily purchase private insurance.

328 Idem.
333B. L. Kirkman-Liff, "Health Care Reform in the Netherlands, Germany, and the United Kingdom" in A. Blomqvist & D. M. Brown, Limits to Care: Reforming Canada's Health System in an Age of Restraint (Toronto: C.D. Howe Institute, 1994) 167 at 191.
This general compulsory health insurance scheme is administered by about 40 independent non-profit Sickness Funds. All of the Sickness Funds are members of the Society of Dutch Sick Funds. The Society plays an important role in shaping health care policy in the Netherlands and is overseen by the Sick Funds Council. This Council is comprised of representatives from employers, labour unions, patient advocacy groups, hospitals, physicians, the Sickness Funds themselves, and the government.

The Sickness Funds have private origins in the guild tradition. They are organized on a geographic basis and Lassey, Lassey and Jinks note vary considerably in size, ranging from 4,000 to 250,000 members. Sickness Funds are independent of government; however, they rely on government financial support and are regulated in their activities. The Sickness Funds have historically not competed with each other and generally have held a monopoly in their respective geographic regions. However, until recent reform, they had relatively limited ability to use their market power to encourage competition between health care providers as they were required to contract with all providers in their region.

The Sickness Funds receive their revenues from the General Fund which is administered by a council made up of representatives of the Sickness Funds, hospitals, physician and specialist associations, employer associations, labour unions, and the government. The premiums paid to the General Fund are set each year by regulation at a fixed percentage of employees' wages with a maximum upper limit. Dependants are covered at no extra charge. The cost of these premiums are met jointly by the employer and the employee. In 1988, Schut notes that employee and employer contributions were 5.1 percent of employees' gross wage. The percentage of their own health premiums paid for directly by a Dutch employee is significantly higher than that paid by U.S. employees; however, the level of user charges at point-of-service is much lower for Dutch patients than American patients. Elderly people below a certain income level have their premium reduced below that which would be otherwise be charged by the Sickness Funds. The cost of subsidizing insurance premiums for the elderly is borne by the General Fund and by the government.

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334 Bos, supra note 316 at 213.
335 Lassey, Lassey, & Jinks, supra note 245 at 186.
337 Kirkman-Liff, supra note 333 at 189.
338 Schut, supra note 326 at 618.
339 Rutten & Van Der Werff, supra note 313 at 173.
340 Schut, supra note 326 at 618.
341 Kirkman-Liff, supra note 312 at 2497.
342 Rutten & Van Der Werff, supra note 313 at 174.
The general compulsory insurance plan administered by the Sickness Funds covers most non-catastrophic health risks and ensures access to primary and secondary acute care, drugs, and transportation. The criterion used to judge whether a particular service is included in the basic benefit package has historically been whether or not the new service is generally accepted by the medical profession.

Insurance for "exceptional expenses", including long-stay patients of more than one year, the physically and/or medically handicapped, and maternal and child health services, are covered by the Exceptional Medical Expenses Act 1967. The whole population has been compulsorily covered under this latter Act since 1968 and the premium is set at a percentage of employees' wages (4.55% with a real dollar ceiling) and is paid by the employer. Administration of this compulsory insurance scheme is partly delegated to Sickness Funds and private insurers. During the 1980s coverage under the Exceptional Medical Expenses Act was extended to other medical and social services such as outpatient psychiatric care, home health care, and home assistance.

Neither the Sickness Funds nor private insurers provide public health services and this has, historically, been left to elected local authorities. These local authorities have been responsible for communicable disease control, environmental health, and preventative programs such as vaccination and immunization. There has been little co-ordination between these elected authorities and Sickness Funds and private insurers.

b. Private Health Insurance

Approximately 40% of the population were (and still are) free to purchase their own private insurance plan for all health services except those covered under the Exceptional Medical Expenses Act. There were 46 competing private insurers operating in the Netherlands just prior to the 1987 reform proposals. Despite the fact that the purchase of private insurance is

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343 Bos, supra note 316 at 213.
345 Algemene Wet Bijzondere Ziektekosten, AWBZ, (Exceptional Medical Expenses Act) of December 14, 1967, Staatsblad (Official Journal of the State) 617.
346 OECD; Health Policy Studies No. 2, supra note 22 at 89.
347 Schut, supra note 326 at 619.
348 Idem.
349 C. Ham & M. Brommels, "Health Care Reform In The Netherlands, Sweden, And The United Kingdom" (1994) 13: 5 Health Affairs 106 at 115.
not compulsory, in 1992 only 0.7% of the population did not hold insurance. Historically, private insurance premiums were community-rated; however, throughout the 1970s, competition in the private insurance market resulted in market segmentation as insurers started to charge higher premiums to the elderly. Unlike the U.S., where most private insurance is purchased through employers, historically two-thirds of all private health insurance policies in the Netherlands has been purchased by individuals. In recent years the trend has been toward group rather than individual insurance.

In 1975, concerns over access to health insurance by high risk groups resulted in a government proposal for a public insurance system to cover the entire population but concerns over the level of public expenditures required to finance such a scheme resulted in the demise of this proposal. Instead the government decided to simplify the existing public insurance system and to tightly regulate the private insurance market to reduce the disparities in premiums and to constrain market segmentation. In 1986, the Health Insurance Access Act was passed that required private insurers to offer high-risk, lower-income persons who were self-employed a standard package of benefits for a maximum premium set pursuant to the Act. In 1989, the government began to require private insurers to provide this package of benefits to all people over 65, who had previously been covered by private insurance, at a premium which was not reflective of the risk of utilization by people aged over 65. A system was designed to spread the cost of subsidizing premiums for the elderly in this way amongst all the privately insured. Private insurers could charge a levy to all their policy holders to pay the cost of subsidizing the real cost of premiums for high-risk policy-holders and the deficits and levies were then mandatorily pooled with other private insurers. Schut notes that while this initiative achieved the government’s goal of improving access, it also resulted in private insurers losing what small incentive they did have to control utilization rates by policy-holders as the additional costs of insuring high-risk patients was pooled with other private insurers.

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352 Schut, ibid. at 619.
353 Kirkman-Liff, supra note 333 at 190.
354 There was also evidence that private insurers were more efficient than public insurers. A study in 1977 showed that privately insured patients required 56% less hospital-days than the publicly insured, a figure that Rutten & Van Deer Werff claim cannot be fully explained by the higher morbidity rates of the publicly insured – Rutten & Van Der Werff, supra note 313 at 191–2.
355 Idem.
356 Schut, supra note 326 at 633.
357 OECD; Health Policy Studies No. 2, supra note 22 at 91.
358 Schut, supra note 326 at 633.
c. Patient Charges
The Netherlands has resisted pressure from private insurers to introduce user charges as a means of cost-control on the basis that such charges would interfere with the rights of patients to free care at point of service. However, since 1991 patients incur user charges if the pharmaceuticals they purchase are above the indicative price set by government regulation (which will cover the cost of the cheapest drug that is clinically effective). Also, benefits for the privately insured may now not always cover treatment by dentists or pharmaceuticals for home use and cheaper private insurance plans may not cover general practitioner services. In addition, the compulsory Exceptional Medical Expenses Act imposes some user charges e.g. residents of a nursing home must contribute the sum they would have had to pay to for ordinary living expenses in their own home.

3.3.4 The Supply of Health Care Services
Prior to proposals for managed competition reform in 1987, the Dutch system had been criticized as lacking both horizontal and vertical co-ordination between the suppliers of various health and welfare services. The Health Care Prices Act and the Health Care Facilities Act, both passed in 1982, provided for a greater role for government than previously but still left much of the responsibility for determining price and capacity to negotiation between representatives of the Sickness Funds and private insurers with private health care providers, none of which have historically had any real incentive to be sensitive to the relative costs and benefits of services supplied.

a. Hospitals
In 1980, 90% of short-term hospitals, 30% of long-term care hospitals, 90% of psychiatric hospitals, and nearly all of the hospitals for the mentally handicapped were privately owned and managed. Historically, private hospitals have been affiliated with either Protestant, Catholic or non-denominational religious orders and all are non-profit.

There had historically been a concern that expenditures on hospital care have grown faster than expenditures on primary and preventative care and efforts have been made to reduce the proportion of all health expenditures on hospital care. Table 3 in Appendix 4 shows that relative to other OECD countries the Netherlands spent a high proportion of total expenditures

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359 Rutten & Van Der Werff, supra note 313 at 189.
360 Schrijvers, supra note 321 at 2216.
361 Rutten & Van Der Werff, supra note 313 at 182.
362 Schut, supra note 326 at 626–627.
363 Rutten & Van Der Werff, supra note 313 at 178.
on hospital care but that this ratio has fallen significantly over the period 1980–1990. The Netherlands has, relatively, a very high number of hospital beds per thousand of population. In 1991, the Netherlands had 11.4 hospital beds per thousand of population compared with 7.6 beds per thousand in New Zealand, 5.9 bed per thousand in the U.K., 4.7 beds per thousand in the U.S., and an OECD average of 8.4 beds per thousand of population.\(^{364}\)

*The Hospital Provisions Act 1971 and 1979* attempted unsuccessfUly to reduce the bed capacity of hospitals as an indirect means of controlling health expenditures.\(^{365}\) *The Hospitals Tariffs Act 1965* provided for price regulation of hospital costs. Hospital boards had to demonstrate that their charges reflected their actual costs before the published tariffs were approved by the Hospital Tariffs Agency. This reform did not, however, go to the root of the problem, namely the reimbursement of hospitals for services performed on a fixed price per bed per day. This reimbursement mechanism provided incentives for hospitals to keep patients in hospitals for longer periods than may be strictly necessary and deterred the development of out-patient clinics and day-care units.\(^{366}\) The *Health Care Prices Act* was enacted on 1 January 1982 and prescribes a process of regulated negotiations through which prices to be charged by hospitals and other institutions and health care professionals are set for the forthcoming year.\(^{367}\) Since 1983, Dutch hospitals have had to operate under prospective annual global budgets negotiated with representatives of private insurers and the Sickness Funds. These budgets cover both public and private patients and cover nearly all costs incurred by a hospital apart from specialists' fees.\(^{368}\) However, because the global budgets were fixed on the basis of historical expenditures, this resulted in a disincentive for hospitals to operate more efficiently for there was no financial reward for improved performance and, perversely, should the hospital reduce expenditures through cost savings then in years to come its future budget may be reduced. Thus, since 1988, a formula has been used to determine hospital budgets that attempts to estimate target costs for each hospital and allows money to follow the patient to the extent that the budgets allocated to hospital now recognize changes in the population served by the hospitals and in the volume of operations performed.\(^{369}\)

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\(^{364}\) Schieber *et al.*, *supra* note 90 at 106, Exhibit 4.

\(^{365}\) Rutten & Van Der Werff, *supra* note 313 at 183.


\(^{367}\) Akved & Hermans, *supra* note 332 at 25 (§§37).

\(^{368}\) OECD; *Health Policy Studies No. 2, supra* note 22 at 92.

\(^{369}\) *Idem.* and Akved & Hermans, *supra* note 332 at 26 (§§38). J. A. M. Maarse, “Hospital Budgeting in Holland: Aspects, Trends and Effects” (1989) 11 Health Policy 257 notes that about 35% of the budget is determined by the number of beds and the specialists in the hospital, 25% relates to the size of the population in the hospital’s catchment area, and the balance is calculated by costing the number of admissions, patient days, out-patient surgeries, and specialist visits that have agreed to have been provided by the institution in question.
hospital's budget is exceeded in any particular year then the budget is reduced by that amount in the following year.\footnote{Kirkman-Liff, supra note 333 at 189.}

Notwithstanding all the foregoing initiatives, the Dutch health care system records, relative to other OECD countries, a significantly higher average length of stay per patient in hospitals.\footnote{OECD Health Systems: Facts and Trends, supra note 73 at 30, Chart 7.} The average length of stay in hospital in the Netherlands in 1991 was 33.8 days compared with 11.7 days in New Zealand, 14 days in the U.K., 9.1 days in the U.S., and an OECD average of 14.4 days.\footnote{Schieber et al., supra note 90 at 106. Exhibit 4 notes that despite the relatively high number of hospital beds, the percentage of the population actually admitted to hospital is lower in the Netherlands than in other countries. In 1991, 10.9% of the Dutch population was admitted to hospital compared to 13.9% in New Zealand, 19.3% in the U.K., 13.7% in the U.S., and an OECD average of 16.2%.} The magnitude of this difference leads one to speculate that it is as a result of the Dutch commitment to financing long-term care and its Exceptional Medical Expenses program rather than an excessive propensity to keep hospitalized general patients.

Even though hospitals, as private institutions, borrow in the private market, most of their loans are government guaranteed.\footnote{Schieber et al., supra note 90 at 106, Exhibit 4 notes that despite the relatively high number of hospital beds, the percentage of the population actually admitted to hospital is lower in the Netherlands than in other countries. In 1991, 10.9% of the Dutch population was admitted to hospital compared to 13.9% in New Zealand, 19.3% in the U.K., 13.7% in the U.S., and an OECD average of 16.2%.} Other forms of government intervention in the secondary health market included the prohibition on building new facilities without government authorization and the existence of plans for different regions within the Netherlands providing for the distribution of medical specialties amongst various hospitals.\footnote{OECD; Health Policy Studies No. 2, supra note 22 at 92.} The government has promoted the mergers of hospitals in the belief that this will lead to benefits from economies of scale. From 1967 to 1984, 93 hospitals were involved in 43 mergers.\footnote{F. Schut, W. Greenberg, & W. P. M. M. Van De Ven, “Antitrust Policy In The Dutch Health Care System And The Relevance Of EEC Competition Policy And U.S. Antitrust Practice” (1991) 17 Health Policy 257 at 262, Table 1.} \textit{The Hospital Facilities Act 1982} required a new general hospital to have a minimum size of 175 beds, in order to qualify for two full-time medical specialists in each of the six 'core specialties.'\footnote{Schut, supra note 336 at 1452.} Between 1984 and 1988, the average market share of the two largest hospitals in each legally defined health region increased by more than 10% to 60% of the market.\footnote{Ibid. at 1451.}

\textbf{b. Physicians}

As Table 3 in Appendix 4 shows in 1990, there were 2.5 physicians per thousand people in the Netherlands compared to 1.9 in New Zealand, 1.4 in the U.K., 2.2 in the U.S., and an OECD average of 2.2.\footnote{F. T. Schut, "Prospects for Workable Competition In Health Care: Dutch Design and American Experience", Paper for the Second World Congress on Health Economics, Zurich (September 10–14, 1990), Erasmus University, Rotterdam, as cited by Schut, Greenberg, & Van De Ven, supra note 374 at 266.}
average of 2.5 physicians per thousand of population. With 5.4 visits per capita to a physician recorded in 1991, the Netherlands is below the OECD average of 6.2 and the respective averages of 5.7 in the U.K. and 5.6 in the U.S. but above the 3.8 visits per capita to a physician recorded in New Zealand.

Remuneration of practitioners varies depending on whether they are providing services to Sickness Fund patients or patients covered by private insurance. General practitioners are paid through a capitation system by Sickness Funds, the fee being uniformly set for the whole of the Netherlands by regulated negotiations between representatives of practitioners and insurers. Each Sickness Fund patient must choose a general practitioner to register with from the list of those that the Fund has contracted with. Pursuant to the Sickness Funds Decree of 1941, each Sickness Fund has to contract with all the physicians in their region on nationally determined conditions. The Decree was a source of market power for health care providers as it eliminated the need for physicians to compete for contracts with their local Sickness Fund. In the private sector, physicians charge on a fee-for-service basis. Prior to managed competition reform, there were statutory guidelines in place prescribing the negotiation of uniform tariffs for physicians which were binding on all physicians once approved.

Approximately, 33% of physicians are generalists in the Netherlands compared to 37.5% in England, 38.3% in New Zealand, and less than 30% in the U.S. Historically, general practitioners in the Netherlands have acted as gate-keepers to the supply of services by

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378 Schieber et al., supra note 90 at 107. Exhibit 4.
379 idem. The U.K. figure is from 1989.
380 Rutten & Van Der Werff, supra note 313 at 175.
381 Schut, supra note 336 at 1450.
382 Schut, Greenberg, & Van De Ven, supra note 374 at 262, Table I.
383 OECD: Health Policy Studies No. 2, supra note 22 at 91.
384 Ten Have & Keesberry, supra note 323.
385 There are 27,000 general practitioners in England compared to 45,000 hospital doctors — P. Day & R. Klein, "Britain's Health Care Experiment" (1991) 10: 3 Health Affairs 39 at 47.
386 In 1990, there were 6339 medical practitioners of which 2428 were general practitioners — Department of Health, The New Zealand Health Workforce 1990 as cited by The Strategic Information Service, Guide to Key Personnel in the Public Health Sector, (March 1993) p. xi.
specialists and hospitals and to the consumption of pharmaceuticals. In general, health insurers will only reimburse the cost of specialist care, paramedical services, and outpatient psychiatric care if patients are referred by their general practitioner. Once a patient has obtained a referral from their general practitioner, they are free to choose their specialist or hospital although Sickness Fund patients must select a specialist who has a contract with their Sickness Fund. The use of general practitioners as the gatekeepers to the consumption of more expensive secondary services is generally portrayed as an important means by which the Dutch are able to keep total health expenditures relatively under control while obtaining favourable health outcomes. However, the increasing cost of pharmaceuticals has become an issue of major concern as historically, general practitioners have had a large degree of flexibility with respect to prescribing. Increasingly the prescribing of pharmaceuticals is being controlled so that, for example, only certain specialties are able to prescribe certain drugs and for some drugs, permission to prescribe must be obtained from the Sickness Fund in advance. In 1991, the concept of reference prices for pharmaceuticals were introduced. Each class of medicine with the same therapeutic effectiveness was allocated a “reference price” beyond which the insured would have to pay from his or her own pocket. This was intended to make physicians and patients more aware of the cost-effectiveness of different medicines.

More than 90% of general practitioners in the Netherlands belong to the National General Practitioners’ Association (a division of the Dutch Medical Association) which negotiates on behalf of general practitioners with Sickness Funds and private insurers. Over 95% of specialists belong to the National Specialists Association, another division of the Dutch Medical Association. Historically, the government has regulated the number of specialists in the system. Almost all specialists, apart from ophthalmologists, dermatologists, and psychiatrists, conduct their practices from hospitals and do not maintain independent practices. Sickness Funds reimburse specialists for out-patient consultations by way of a fee that entitles the patient in question to one full month of treatment for the particular complaint or condition and if continuation of treatment is required beyond a month, then the specialist receives an additional fee. If the amount of billing by a specialist who contracts

388 Schut, supra note 326 at 619.
390 Rutten & Van Der Linden, supra note 344 at 1612.
391 Idem.
392 Kirkman-Liff, supra note 389 at 471.
393 Idem.
394 Rutten & Van Der Werff, supra note 313 at 175.
with a Sickness Fund is greater than the average agreed to by representatives of the Funds and the National Specialists Association then an adjustment is made, and the specialist must repay one-third of the first 30,000 guilders that she earns above the agreed average and two-thirds of all income earned beyond that.\textsuperscript{395} Private insurers reimburse specialists on a pure fee-for-service basis and only specialists who are employed by university hospitals and by psychiatric institutions are compensated on a salary basis.\textsuperscript{396} The Dutch Minister of Health, Welfare and Sport, Els Borst Eilers, announced in January of 1995 that the government intends to change the basis of reimbursement for specialists in hospitals from a fee-for-service to a fixed income arrangement (either salary, capitation or some combination thereof) within two years.\textsuperscript{397}

Pursuant to the \textit{Health Care Prices Act}, rounds of regulated negotiations characterize the Dutch health market.\textsuperscript{398} The negotiation of fees for general practitioners and specialists involved complex rounds of negotiations with private insurers and Sickness Funds that were, prior to reform, closely regulated and prescribed by government. There are two elements to the reimbursement package: the professional fee and an amount calculated for the costs of practice operation. Kirkman-Liff describes the negotiation process as follows.\textsuperscript{399} First, the Ministry of Social Affairs and the National General Practitioners’ Association and the National Specialists’ Association negotiate an acceptable income for physicians by considering the salaries of public sector employees in what are considered to be comparable professions and also negotiate an acceptable figure for the number of patients a physician would be expected to care for.\textsuperscript{400} Next, the Ministry of Welfare, Health Care, and Culture, after considering macro-level forecast of health care costs, develops directions for the Central Body for Health Care Tariffs. The Central Body then considers representations by various interested groups on the guidelines that should be used in negotiation and subsequently issues guidelines. Negotiations between insurers and providers may then proceed; however, the negotiations are limited by the guidelines and all final agreements are reviewed by the Central Body. One final step is that the service component of agreements negotiated between the Dutch Sickness Funds and the General Practitioners Association are subject to the approval of the Sickness Fund Council. Although the negotiations have been criticized as having a

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{395} Kirkman-Liff, supra note 389 at 473.
\item \textsuperscript{396} Schrijvers, supra note 321.
\item \textsuperscript{397} M. Spanjer, “Changes In Dutch Health-Care” (7 January 1995) 345 The Lancet 50.
\item \textsuperscript{399} Kirkman-Liff, supra note 389 at 472–3.
\item \textsuperscript{400} Public sector salaries are not below that of the private sector as they have been indexed to the private sector as part of the trade-off for a prohibition on industrial action by public employees — \textit{ibid}. at 472.
\end{itemize}
\end{footnotesize}
ritualistic character because of the pervasive influence of government, the process has been relatively successful in containing the growth rate in physicians’ fees.  

3.3.5 The Dekker and Simons Reform Proposals

Prior to the 1987 proposals for reform, the Dutch health care system was characterized by the OECD as a system where “tight and detailed central regulation of prices, volume, and capacity has been superimposed on an essentially private system of provision and a mixed system of finance.” The Committee on the Structure and Financing of Health Care (the Dekker Committee, so named after its chair Dr. W. Dekker) produced a report in March 1987 proposing managed competition reform of the Dutch health care system. The Committee identified five problems in the system:

1. fragmentation of funding resulting in inefficient cost-shifting;
2. lack of choice for citizens between the various insurers;
3. continuing problems with the growing disparities in premiums paid for private insurance by high and low risk patients and a tendency for private insurers to compete by avoiding enrolment of high-risk individuals;
4. few financial incentives for the Sickness Funds to act efficiently and to contract with the most efficient providers as they were reimbursed from the Central Fund for all expenses and were required to enter into contracts with any local provider that wished to supply services to an individual enrolled with a Sickness Fund;
5. government regulation was perceived as being costly, complex and inflexible and central planning seemed incompatible with the fragmentation of financing between the different insurers and purchasers of services.

The Dekker Committee’s recommendations for reform rested on the concepts of regulated competition between private insurance plans and compulsory national health insurance. The report eschewed direct government regulation of the volume and price of health services in favour of regulated competition in the health insurance market with the distinction between private insurers and Sickness Funds being eliminated. It also proposed a universal scheme of national health insurance covering general services for all citizens and for the integration of health care and other related social services. Compulsory basic insurance would cover approximately 85% of the cost of expenditures on general health services for all citizens and

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401 Ibid. at 478.  
402 OECD; Health Policy Studies No. 2, supra note 22 at 87.  
403 Dekker Report, supra note 21.  
404 OECD; Health Policy Studies No. 2, supra note 22 at 94.  
405 Ibid. at 87.
could be obtained either from Sickness Funds or private insurers who would compete with each other for enrollees. The Dekker Committee advocated optional private gap insurance to cover the remaining 15% of costs including such goods and services as drugs, dental care for adults, cosmetic surgery, and abortion.

The Dekker reform proposals were inspired by Enthoven's managed competition proposals. Enthoven's proposals required that the government's risk-rated contribution be set at the lowest priced insurance package with individuals having to pay all additional costs if they choose a more expensive plan. The Dekker proposals, however, required individuals to pay a two-part premium. About 75% of the premium would be set by government at a fixed percentage rate of the individual's income and would be paid to the Central Fund. Thus the vast majority of expenditures would be financed on a progressive basis. The Central Fund would pool all premiums collected and then pay a capitated risk-related premium to the particular insurer chosen by the individual in question. The amount paid on behalf of each citizen would thus have no correlation to the amount paid in by that person to the Central fund and would reflect their risk of needing health care services as opposed to their ability to pay. The balance of the premium would, however, be paid directly by citizens to their chosen insurer. Requiring all enrollees to pay a small share of the total premium directly to their chosen insurer would result in a small measure of price competition. Insurers (both Sickness Funds and private insurers) would have to charge all individuals the same flat-rate premium and thus could not charge high-risk individuals higher premiums; however, between insurers the rate could be different thus providing an incentive for insurers to compete for enrollees on the basis of price. To ameliorate any incentive for insurers to engage in cream-skimming of low-risk individuals, the Dekker report proposed that insurers must accept all individuals that wished to enrol with them.

Under the reform proposals, Sickness Funds and other insurers would not have to contract with every provider who wished to supply services i.e. they would be able to engage in selective contracting. It was, however, proposed to leave in place the price-setting negotiations between insurers and providers that fixed physicians' fees and hospital budgets, but with a proviso that these negotiations would set the upper limit for prices and discounts would be allowed. Insurers (both Sickness Funds and private insurers) would have to charge all individuals the same flat-rate premium and thus could not charge high-risk individuals higher premiums; however, between insurers the rate could be different thus providing an incentive for insurers to compete for enrollees on the basis of price. To ameliorate any incentive for insurers to engage in cream-skimming of low-risk individuals, the Dekker report proposed that insurers must accept all individuals that wished to enrol with them.

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\[406\text{Kirkman-Liff, supra note } 333 \text{ at } 195.]
guarantees of hospital borrowing. It was proposed that government eventually move away from regulating prices in health services markets but that government would still, when necessary, intervene to prevent monopolistic and collusive behaviour. It was also proposed that there would be considerable deregulation of the hospital industry and the Hospital Facilities Act would be confined to the planning of large hospital facilities and that negotiations between hospitals and insurers would no longer be subject to detailed government guidelines.407

Unlike New Zealand and the U.K., the Netherlands has not been able to implement its reform proposals within the time-frame initially set down. As Schut describes it, the system of coalition government means that the implementation of any government policy is open at various stages to attack or delay tactics initiated by interest groups.408 This is particularly so in the health sector where historically representatives of insurers and providers, as bilateral monopolies, have negotiated issues such as price and capacity. However, the initial prospects for the Dekker proposal seemed good for, as Schut puts it, the proposal “offered not only a theoretically elegant blueprint of an equitable and efficient health care system but also an ingenious political compromise.”409 The political compromise rested in the fact that the Dekker proposals had aspects which appealed to all major interest groups and while each of these groups opposed some part of the proposal, opposition was not united against any particular part.410

The Dekker proposals were first put forward in 1987. In November 1989 there was a change of government. The new centre-left government decided to continue with the implementation of the Dekker reforms, but some elements of the proposal were altered particularly with respect to putting greater emphasis on access or what the Dutch refer to as “social solidarity.” The plan subsequently became known as the Simons Plan after the former Secretary of State for Health.411 It was decided that coverage under the compulsory basic insurance should be extended from 85% of all regular health care costs to 96% of total costs. It was also decided that the proportion of the amount paid by each and every individual to the Central Fund that was fixed as a percentage of the particular individual’s income would be increased from 75% to 85%.412 This would have the effect of reducing the total real amount paid by those on lower

407 Schut, supra note 336 at 1450 at 1448.
408 Schut, supra note 326 at 638.
409 Idem.
410 Idem.
412 Schut, Greenberg & Van De Ven, supra note 374 at 259, fn 2.
incomes. The new government also stipulated that only non-profit insurers would be able to provide coverage under the compulsory basic benefit package and gave permission for small discounts in the case of group insurance.413 It was also decided that the reform proposals would be phased in gradually and would not be fully implemented until 1995.

In 1992, the Dunning Committee (Government Committee on Choices in Health Care 1992) argued for a more careful evaluation of what would and would not be included in the basic package of services covered by the proposed compulsory basic insurance plan for all citizens.414 The Dunning Committee proposed that four criteria be used to effectively sift out those services that should not be included in the basic package of care. These criteria were: first, that the community in general consider the care to be necessary; second, that the services are effective; third, that the services are efficient using cost-effectiveness analyses and cost-utility analyses; and, finally, that it is not appropriate for patients themselves to pay for the health service in question. It was assumed by the Committee that individuals would be free to purchase health services that were not included in the core package and to buy private insurance to cover the cost thereof. Unlike New Zealand, where the Core Health Services Committee has an on-going role in defining what services should be publicly provided, the Dunning Committee was disbanded after the preparation of its report.

Van De Ven and Schut noted in 1994 that the Dekker reforms had been implemented to the following extent.415 From 1992, Sickness Funds were free to negotiate their own rates of reimbursement with providers. Prior to this time, it had been illegal to pay higher or lower fees than those set through the Central Tariff Agency. Sickness Funds were also able to extend their working area to encroach into the areas traditionally served by other Funds; several private insurance companies obtained permission to establish themselves as Sickness Funds; and individuals are now free to change Funds or insurers once every two years during an open enrolment period. Also from 1992, general practitioners were no longer restricted as to where they could locate themselves. From 1993, Sickness Funds ceased being reimbursed for all medical expenses they paid for on behalf of the individuals enrolled with them and began, instead, to receive a partially risk adjusted per capita payment from the Central Fund. In addition to this payment, Sickness Funds also received a flat-rate premium from all their enrollees for an amount determined by the various Sickness Funds.416 From 1994, Sickness

413OECD; Health Policy Studies No. 2, supra note 22 at 97.
415Van De Ven & Schut, supra note 350.
416Idem.
Funds were no longer obliged to contract with every willing provider in an area. The reforms appear to have resulted in some cost-savings as the Sickness Funds have broken the price cartel of some medical providers and insurers in general are seeking more cost-effective ways to deliver needed services such as the use of mail-order firms as an alternative means of drug supply.\footnote{Idem.}

### 3.3.6 The 1995 Health Care Reform Plan


The Dekker proposals provided for the integration of acute and long-term care. The new proposals result in the retention of a separate \textit{Exceptional Medical Expenses} scheme, although it was decided that this would be restricted to only long-term care and mental health care and all other benefits currently covered such as drugs, medical devices and rehabilitation would become the responsibility of private insurers. Although there would have been benefits from the integration of acute and long-term care, there was a concern about how to assess accurately the risk of the need for long-term care services as it requires a projection many years into the future.\footnote{OECD; \textit{Health Policy Studies No. 2}, supra note 22 at 99.} It may be better for these sorts of services to be provided independently of a competition-oriented scheme.\footnote{Van De Ven & Schut, `supra note 350 at 1468.}

With respect to services considered “curative basic care” the government is proceeding with the Dekker/Simons proposals.\footnote{Schut & Hermans, `supra note 411.} Schut and Hermans noted that the government plans to increase the level of risk taken on by Sickness Funds from 3% to 65% within 3 years. They also note that in 1997 the Sickness Funds bore 27% of the risk of utilization. In 1996 and 1997, the payments made to Sickness Funds were adjusted to include not only age and sex but also region of residence and disability status. Even although not fully accountable for the services they purchase, Schut and Hermans report that the increase in risk bearing has resulted in premium competition with “the cheapest sickness fund charging a 40 percent lower flat-rate premium that the most expensive one whereas in 1996 this margin was only 10 percent. In addition, an increasing number of sickness funds are considering, or have already started, managed care activities.”\footnote{Schut & Hermans, supra note 411.} Schut and Hermans also report that in 1997 the \textit{Sickness Fund Act} was modified to introduce a system of user charges but note that concern over access resulted
in a complicated array of targeted user charges such that any potential cost savings may well be outweighed by administrative costs.\textsuperscript{422} It is proposed that the government will eventually stop price and capital regulation and allow managed competition to run its course. Although the government is planning to reform the private insurance sector as well through managed competition, so far it has failed to accomplish this so there is as yet no open enrolment period and no risk equalization payment to cross-subsidize those insurers that serve relatively high risk populations.\textsuperscript{423}

Pursuant to the 1995 announcements there is now a third sector of health services which are described as amenity and/or inexpensive care. Using the criteria of the Dunning Committee, any health service that does not pass through the four sieve test of necessity, effectiveness, efficiency and personal responsibility is to be placed in this sector and government will leave the provision of these services entirely in the hands of the private sector.\textsuperscript{424} For example, the government shifted dental care for adults into this sector on the rationale that the costs thereof were low enough that such services should be left to personal responsibility; however, subsequently there was concern about access for people in need of dental prostheses and thus coverage for dental prostheses was transferred back to the social insurance basket of services.\textsuperscript{425}

Having discussed managed competition reform proposals and reform in the Netherlands health care system, I will now turn to examine internal market reform of New Zealand's command and control system.

\textsuperscript{422}ibid. at 15--16 of final draft.
\textsuperscript{423}ibid. at 16 of final draft.
\textsuperscript{424}ibid. at 17 of final draft.
\textsuperscript{425}Idem.
3.4 The New Zealand Health Care System and the 1991 Reform Proposals

3.4.1. Introduction

This section provides an historical overview of the financing and supply of health care in New Zealand. First, I outline the problems in the New Zealand system that ostensibly inspired internal market reform in 1991, namely concern over rising costs and access problems, particularly long and growing waiting lists. I then examine the various factors that created these problems by examining the financing of the system and the delivery or supply of health care services. I then describe the 1991 proposals for internal market reform and the reforms as subsequently implemented by the Health and Disability Services Act 1993 and as modified since that time.

3.4.2 Problems in the System Prior to Reform Proposals

As with many health care system, problems in the New Zealand system have manifested themselves generally as cost and access issues.

a. Cost

In 1980, New Zealand spent 7.2% of its GDP on health care and in 1992, 7.7%.

While obviously this represents an increase in expenditures, these figures are to be compared with an OECD average of 7.0% in 1980 and 8.1% in 1992. Looking more closely at the period 1980--1992, New Zealand's health care expenditures as a percentage of GDP fell between 1980 and 1985, but increased steadily between 1985 and 1991 at a compound annual rate of growth in the latter period of 2.6% compared with an average growth rate of 1.6% in the OECD.

However, this growth rate may reflect falling real GDP rather than growing health care costs due to the New Zealand share market crash in October of 1987 which saw the market falling eventually to one-third of its pre-crash level. By mid-1992, the market was still not back to half its pre-crash level. During this period of recession relatively fixed expenditures on health services comprised a larger percentage of real GDP. The compound annual rate of growth in terms of per capita health spending in U.S. dollars in New Zealand was only 5.8% for the

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426 Figures in this paragraph are taken from Schieber et al., supra note 90 at 101, 102. Exhibits 1 and 2, from OECD data and their own estimates.

427 G. J. Schieber et al., "Health Spending, Delivery, and Outcomes in OECD Countries" (1993) 12: 2 Health Affairs 120 at 121, Exhibit 1.

period 1985--1991 compared with 6.5% in the Netherlands, 7.3% in the U.K., 9.0% in the U.S., and an OECD average of 7.6%. Muthumula and McKendry note that a major cause of significant increases in nominal expenditures on health care in the period 1985--1988 was the removal of the wage-price freeze in 1985.429

Although New Zealand's relative expenditures would suggest that cost-containment would not be a significant factor motivating reform, nonetheless the government of the day portrayed health care costs as exploding. The National Government stated in its Green and White paper that in real terms, between 1980 and 1991, the Department of Health's budget increased from NZ$1.1 billion to NZ$3.8 billion, an increase of some 27% more than the increase in consumer prices over the same period.430 These figures have been contested and appear to be significantly inflated.431

b. Access

With regard to available indicators of health status, New Zealand generally performs at or around the average for OECD countries. New Zealand does have, however, high mortality rates compared to other OECD countries for ischaemic heart disease, respiratory diseases, breast and bowel cancer, motor vehicle crashes and suicide.432 Infant mortality rates are often taken as more reflective of the access to and quality of a health system. As Table 4 in Appendix 4 illustrates New Zealand performs relatively poorly on infant mortality rates.433 However, neonatal and perinatal (age up to 28 days) mortality rates are low suggesting that post neonatal infant mortality and SIDS (Sudden Infant Death Syndrome) are the most common causes of infant mortality,434 the latter being related to primary and preventive care

430 Upton, supra note 16 at 7--8.
431 R. D. Bowie, "Health Expenditures and the Health Reforms -- a Comment" (1992) 105: 945 New Zealand Med. Jnl. 458 argues that the government's figures are in fact incorrect, and calculates that the increase of health costs above the consumer price index was not 27%, as alleged, but rather 7.7%. Using what Bowie describes as the conventional measure (339.6/315.1 - 1) x 100 = 7.7%. In fact the percentage increase (rounded up) is 7.8% calculated as follows:

\[
\left\{ \frac{3.807 \times 357/1125}{1} \right\} \times 100 = 7.8\%
\]

Moreover, he notes that the population increased by 8.4% from 3.138 million to 3.401 million over the same period. Therefore, in fact, the per capita consumer price index-adjusted expenditure fell by 0.7%.
433 In 1991, New Zealand recorded 8.3 deaths per thousand live births compared with 6.5 in the Netherlands, 7.4 in the U.K., and 8.9 in the U.S. The OECD average is 9.4 deaths per thousand live births, but it is increased by the enormous death toll of 56.5 deaths per thousand in Turkey. If Turkey's statistics are removed from the calculations then the OECD average is 7.5 deaths per thousand live births, significantly below that recorded in New Zealand. These figures are taken from Schieber et al., supra note 90 at 108, Exhibit 5.
434 Ministry of Health, supra note 432 at 13.
rather than hospital care. In a recent study, Grant et al. found that user charges act as a barrier to access for primary health care services for some sectors of New Zealand’s population.\textsuperscript{435} Their cross-national comparison suggested that primary care is not as accessible in New Zealand as it is in the United Kingdom, Canada and Australia and that these latter countries perform better on health indicators of mean life expectancy, years of potential life lost, and infant mortality rate than New Zealand does.\textsuperscript{436}

Despite overall improvements in New Zealand’s mortality rates over the course of the last century there have been different rates of change between social groups. As in other countries, there is a correlation between low income and poor health.\textsuperscript{437} The mortality rate of those in the lowest socio-economic group is about twice that of the highest socio-economic group.\textsuperscript{438} Durie and others have pointed out discrepancies between Maori and European health status in New Zealand.\textsuperscript{439} Notwithstanding that socio-economic factors may explain why the health status of Maori people is, on average, poor, there is evidence that even allowing for these factors the health system does not serve Maori well.\textsuperscript{440} A 1993 study, comparing the period from 1975–77 to 1985–87 found that some progress had been achieved in reducing ethnic differences in mortality in New Zealand men but substantial differences remained for diseases that were amenable to medical intervention. The authors of this study conclude that these differences reflect poor access to appropriate health care services for Maori people.\textsuperscript{441} Part of the problem may lie with user charges for general practitioner care and part with a reluctance on the part of some Maori to embrace European methods of treatment and delivery of services.

\textsuperscript{435}C. C. Grant, C. B. Forrest, & B. Starfield, “Primary Care and Health Reform in New Zealand” (1997) 110 New Zealand Med. Jnl. 35.

\textsuperscript{436}Ibid. at 38.

\textsuperscript{437}Ministry of Health, supra note 432 at 13 notes “In the 1992/93 Household Health Survey, people with a family income of $20,000 or less were more than three times as likely as people with an income of over $30,000 to report their health as ‘not so good’ or ‘poor’.”


\textsuperscript{439}M. H. Durie, “Implications of Policy and Management Decisions on Maori Health: Contemporary Issues and Responses”, in M. W. & N. K. Raffel, eds., Perspectives On Health Policy: Australia, New Zealand And The United States (Great Britain: John Wiley & Sons, 1987) at 201 notes “Maori women appear particularly disadvantaged with a rate of lung cancer three times higher than the non-Maori rate, ten times greater for cancer of the cervix, four times higher for coronary artery disease, and three times higher for diabetes. Maori children are eight times more likely to develop rheumatic fever, eight times more likely to die from accidents, and nine times more likely to suffer from ear infection and death. Maori deaths from asthma, obesity, cancer (except bowel), renal disease, and diabetes are all well in excess of the non-Maori population. Mental hospital admission rates are three times as high and broad mental health problems are indicated in other statistics.”

\textsuperscript{440}E. Pomare and G. de Boer, Hauora: Maori Standards of Health, (Wellington: Department of Health, 1988) found Maori people to be grossly disadvantaged economically and culturally and concluded that the most substantial benefits to the health and well-being of Maori people would come about by improving their status in society.

Many within Maoridom believe that Maori require autonomy in the delivery of health in order to provide the services Maori need in an acceptable manner.\footnote{E. Murchie, 	extit{Rapuora: Health and Maori Women} (Wellington: The Maori Women’s Welfare League Inc., 1984) argues that Maori should be able to choose health provision arrangements appropriate for their needs. See also S. Milroy & A. Mikaere, “Maori And The Health Reforms: Promises, Promises” (1994) 16: 2 New Zealand Universities Law Review 175.}

An aspect of access which has been the focus of much recent concern is the growth of and the length of time spent on waiting lists for elective surgical services. According to the government that initiated internal market reform, waiting lists reportedly increased from 38,501 people in 1981 to 62,000 people in 1991.\footnote{I. Hay, 	extit{The Caring Commodity – The Provision Of Health Care In New Zealand} (Auckland: Oxford University Press, 1989) at 151.} No nation-wide information on the actual length of waiting lists was collected until 1967. The nation’s 1967 figure of 31,928 people awaiting surgery gives some indication that waiting lists were already a problem by this date.\footnote{Upton, supra note 16 at 28.} Time spent on waiting lists is also of concern. On average in 1988, 45% of those on waiting lists had to wait less than six months for treatment, while 15% reportedly had to wait longer than two years.\footnote{A. Gibbs, J. Scott, & D. Fraser, 	extit{Unshackling the Hospitals – Report of the Hospital and Related Services Taskforce} (Wellington: Government Printer, 1988) made the following comment on the inequities evident in the management of waiting lists: “Waiting lists are not queues in the conventional sense of queuing for a bus, where the order of priority remains the same.....Hospitals have great difficulty in determining patients’ priorities. They tend to respond to plaintive pressure from patients, general practitioners, politicians or the media.”} There was also reports of inequities in how waiting lists were managed.\footnote{R. M. Burdon, 	extit{The New Dominion: A Social and Political History of New Zealand 1918-1939} (Wellington: A. H. & A. W. Reed, 1965) at 249 cited by Hay, supra note 444 at 110.}

The figures on waiting times were used by the Government as evidence of how inefficient and inequitable the system was prior to the 1991 proposals for reform.

### 3.4.3 Financing of Health Care Services

#### a. The Role of Government

On 2 April 1938, Labour Prime Minister Michael Savage announced his government's proposals for a national health insurance scheme. Although the scheme was supported by the public, the medical profession of the day, represented by the British Medical Association (“the BMA”), opposed it.\footnote{Upton, supra note 16 at 28.} Nonetheless, on 1 April 1939 the 	extit{Social Security Act 1938} came into effect. However, general practitioners refused to cooperate with the government with respect to the implementation of maternity benefits and primary care that were to be free at point of
service for patients. Eventually, agreement was reached with general practitioners on the provision of maternity benefits; however, the BMA held out with respect to the provision of general practitioner services as it opposed the government concept of payment on a capitation basis. As discussed in subsequent chapters, payment by capitation would result in practitioners having to bear the risk of abnormal or excessive utilization by individual patients. In 1941, the government capitulated and general practitioners retained the right to charge patients what they wished for their services. The government instead made available a subsidy that could be claimed either by the patient or the doctor, and that almost covered practitioners' consultation fee at that time. The Social Security Amendment Act 1941 effected these changes. It is in 1941 that a fundamental dichotomy emerges between the provision of secondary and of primary care. Since 1938, secondary care has largely been funded by, and provided by, government. Since 1941, primary care has been privately provided with government subsidies failing to keep pace with the charges fixed by individual practitioners.

Through the 1980s and prior to the 1991 proposals for reform, the government's contribution of funds to total health care expenditures was progressively reduced. In 1980, expenditure by central government on health was 80.5% of total health care expenditures but by 1991 it had fallen to 72.1%. In 1980, health comprised 15.8% of total government spending and 12.8% in 1990. Prior to the reforms, the New Zealand government still contributed the largest share to the health system, funding almost 100% of public hospital expenditures, 72.3% of pharmaceutical expenditures, 52.1% of private hospital treatment, as well as 76% of public health expenditure. It is important to note, however, that government only paid for 51.5% of primary services which included targeted subsidies for regular visits to the general practitioner, full subsidies for maternity care, mental patients, and laboratory tests. There was (and remains) inconsistencies in the subsidies provided for primary care. For example, some primary services such as laboratory tests were virtually 100% subsidized so that an individual patient paid nothing. Other services, like visits to a general practitioner and x-rays, attracted a far lower level of subsidization.

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448 Ibid. at 245.
449 Hay, supra note 444 at 121.
452 Upton, supra note 16 at 44.
453 Idem.
454 Ibid. at 14.
Although the proportion of expenditures paid by government would seem to provide scope for the effective exercise of monopsony power and for co-ordination there has, historically, been a fragmentation of funding amongst various government sources that has led to confusion and inconsistency. For example, funding and co-ordination of continuing care for the intellectually, physically and psychologically disabled, and the frail elderly has historically been distributed among Department of Social Welfare, Area Health Boards, the Department of Health and other agencies.

b. Funding By The Accident Rehabilitation And Compensation Insurance Corporation

The Corporation was formed on 1 April 1974 to administer a major public accident insurance fund designed to remove the risk of personal liability due to accident.\(^{455}\) It is a no-fault scheme that compensates for the full medical costs of accident victims and 80% of lost earnings and, until recent reforms, lump-sum compensation for permanent disability.\(^{456}\) The 1974 scheme abolished the right to sue for personal injury caused by accidents. Physicians in New Zealand are thus protected from civil claims for damages that arise directly or indirectly from medical misadventure.\(^{457}\)

Prior to internal market reform, the Accident and Rehabilitation Compensation Insurance Corporation ("the Corporation") funded 12% of primary services and 9.9% of private hospital treatments.\(^{458}\) Over the period 1980 to 1990 the Corporation's share of total health care expenditure increased from 0.7 to 4.2%.\(^{459}\) The growing waiting times for public surgery, and the high cost of reimbursing lost earnings while accident victims were waiting for treatment resulted in the Corporation increasingly buying services from private hospitals in order to treat accident victims more quickly so as to get them back to work. This resulted in patients


\(^{456}\)Since 1 July 1992 a "disability allowance" is paid in lieu of lump sum payments. Payments for pain and suffering and loss of enjoyment of life are no longer made.

\(^{457}\)The Accident Compensation Amendment Act 1974 amended the term "personal injury by accident" to include "medical, surgical, dental or first aid misadventure". Patients suffering medical misadventure are still able to initiate common law claims for exemplary damages -- Donnelaar v. Donnelaar, [1982] N.Z.L.R. 97. The 1992 changes to the scheme have revived some private tort actions, such as the tort of emotional shock.

\(^{458}\)Upton, supra note 16 at 44.

receiving prompter treatment if he or she had suffered the misfortune of an accident rather than an illness. Also, until 1992, the Corporation covered the full cost of consultation by an accident patient’s general practitioner, which would otherwise be a cost borne to a large degree by the patient. The proportion of practitioner visits classified as “accident related” rose from 15% in 1981/82 to 22% in 1989/90.\textsuperscript{460} This indicates that either the number of accidents in New Zealand had increased, or (more likely) that doctors and patients were seeking to have injuries classified as “accidents” rather than as illness or sickness in order to jump queues in public hospitals and to avoid user charges. In 1990, patients were required to sign a declaration affirming they had suffered an accident.\textsuperscript{461} The Consumer reports that by 1993 accident claims had dropped by 570,000 compared with the 1990 figure.\textsuperscript{462}

The National Government effected reform of the accident compensation system in 1992 by limiting the coverage and benefits available.\textsuperscript{463} The most recent reforms mean that accident victims can no longer receive free general practitioner care and must now pay between N.Z. $10.00 and N.Z. $15.00 per visit. This still does not provide parity with visits to a general practitioner for illness (which for an adult, without a community services card which entitles the holder thereof to a government subsidy, is approximately N.Z. $35.00--$40.00 per visit) and thus both patients and doctors still have an incentive to expand the ordinary meaning of accident in order to obtain a higher government subsidy.

c. Funding By Private Insurers

The proportion of the population with private insurance increased from 18% in 1975 to 45% in 1994.\textsuperscript{464} By virtue of a 1967 amendment to the \textit{Land and Income Tax Act}, medical insurance premiums began to be treated as a tax-deductible item of personal expenditure;\textsuperscript{465} however, these tax benefits were eliminated on December 17th, 1987.\textsuperscript{466} New Zealanders purchase private insurance in order to avoid long queues for elective surgery in the public hospitals and

\textsuperscript{460} Upton, supra note 16 at 15.
\textsuperscript{462} Idem.
\textsuperscript{464} H. Glennie, "Private Insurance And Public Hospital Care", The New Zealand Herald, 14.7.1994, Section 1: 8.
\textsuperscript{465} Hay, supra note 444 at 157.
\textsuperscript{466} Section 59(6) of the \textit{Income Tax Act} 1986 provides that premiums paid in respect of any policy of personal accident or sickness insurance are not deductible after 17 December 1987. Section 59(6) was added by s.4(3) of the \textit{Income Tax Amendment Act (No. 2)} 1988.
to cover the cost of growing user charges for visits to general practitioners and other primary care services. However, although half of households with incomes in the top quarter have private insurance, fewer than 20% of those in the bottom quarter have private insurance.\textsuperscript{467} Those on lower incomes, with less effective political voice, have been left on the waiting lists in the public sector and must bear the full brunt of user charges at point of service, while those with higher incomes have had elective surgery performed in the private sector.

The proportion of total expenditures paid for by private insurers increased from 1.1% in 1980 to 3.5% in 1991.\textsuperscript{468} Although overall still a small proportion, private insurance is much more important in the funding of \textit{particular} health services namely elective surgical services, specialist services, and general practitioner charges. The reason why private insurance comprises only a small percentage of total expenditures, despite the fact that 45% of the population have private insurance, is that private insurance does not generally cover acute and emergency care which is provided predominantly by the public hospitals. However, prior to the 1991 reform proposals, private insurance funded 10% of general practitioner services, 6.1% of diagnostics, 15.4% of miscellaneous specialist services, 2.8% of pharmaceuticals, 16.2% of private hospital treatments, and 24.5% of private hospital treatments excluding psychiatric and geriatric hospitals.\textsuperscript{469}

\textbf{f. Funding By Patients}

Prior to the reforms, patients directly funded 26.5% of the total cost of general practitioner care, 24.7% of pharmaceutical expenditures, 21.1% of private hospital treatment, 76.5% of miscellaneous specialist service charges, 49.5% of diagnostics, and 82.2% of dental costs.\textsuperscript{470} In the period 1980 to 1991, the percentage of total health expenditures financed directly by patients increased from 10.4% to 14.5%.\textsuperscript{471} A study that compared household expenditures on health care between 1987 and 1991 found spending on health care to be unequally distributed across income groups. In particular, the highest income household spent six times as much on dental care as the lowest income household. This is partly explained by the absence of government subsidies for the majority of dental services and the absence of widespread

\textsuperscript{467}{N. K. Raffel. "New Zealand's Health System -- A Brief Description" in Raffel & Raffel, eds., \textit{supra} note 439 at 135.}
\textsuperscript{468}{Muthumala & McKendy, (1991) \textit{supra} note 429 at 11.}
\textsuperscript{469}{\textit{Ibid.} at 32 and 55, Appendix 4J}
\textsuperscript{470}{\textit{Ibid.} at 32 and at Appendix 5J.}
\textsuperscript{471}{Bowie, \textit{supra} note 431.
comprehensive dental care insurance plans.\textsuperscript{472} The same study concluded that in 1991 high income households spent 3.6 times as much on health services as low income households, compared with 3 times as much in 1987.\textsuperscript{473}

3.4.4 The Supply of Health Care Services

a. Hospitals
Historically, New Zealand has devoted a relatively high proportion of total health expenditures to hospital services. For example, in 1990 New Zealand spent 56.3\% of all expenditures on inpatient care compared with an OECD average of 46.1\%.\textsuperscript{474} In particular, government spends a very high proportion of total expenditures on hospital services. In 1991, funding for hospitals and other institutions comprised nearly 73\% of central government health expenditures compared to only 7.9\% for general practitioner services and 24.3\% on community care in general.\textsuperscript{475}

(i) Private Hospitals
After the enactment of the Social Security Act 1938, the importance of private hospitals sharply declined.\textsuperscript{476} However, their importance was re-established pursuant to the Hospitals Act 1957 which required the Minister of Health to encourage the development of private hospitals on the assumption that the growth of private hospitals would ease increasing strains on the public sector. The actual number of private hospitals in existence rose from 152 in 1958 to 200 in 1992, but the number of private beds available more than doubled, rising from 2565 in 1958 to 7149 in 1992 (compared with 18,823 beds in the public sector).\textsuperscript{477} Private hospitals do not generally provide acute and emergency care, leaving this responsibility to the public hospitals.

Hay notes that the scale and nature of private hospital facilities and the size of financial rewards for various types of surgery meant that doctors in private hospitals tended to

\textsuperscript{472}N. J. Devlin, "The Distribution of Household Expenditure on Health Care" (1993) 106: 953 New Zealand Med. Jnl. 126–127, although dental care is provided free for school children up to 16 years and some dental repairs may be funded under the Accident Compensation Scheme.
\textsuperscript{473}These figures appear to include expenditure on dental care.
\textsuperscript{474}Figures taken from OECD Health Systems: Facts and Trends, supra note 73 at 28, Table 4.
\textsuperscript{475}Muthumala & McKendy, (1991) supra note 429 at 55, Appendix 4l.
\textsuperscript{476}In 1939, 22\% of the nation's hospital beds were privately provided. This figure had dropped to less than 15\% in 1949 — Appendices to the Journal of the House of Representatives 1950: 38-9.
concentrate most heavily on "-ectomies" -- hysterectomies, tonsillectomies, appendectomies, adenoidectomies, colectomies, rather than on the broad spectrum of surgical procedures. As in the U.K., most specialists in New Zealand work in both the public and private sectors, and since working in the private sector is more profitable, specialists have little incentive to reduce public sector waiting lists. Consequently, doctors spend less time engaged in major surgery in public hospitals, which results in lengthening waiting lists in the public sector.

(ii) Public Hospitals
Throughout the 1980s the 27 locally elected hospital boards were reorganized into 14 Area Health Boards. Prior to the 1991 reform proposals, Area Health Boards both supplied secondary care through public hospitals which they managed on behalf of the government and received government funding for the purchasing of most hospital and other secondary services for their respective catchment populations. Thus, the provider and purchaser functions were combined in one entity for each of the 14 regions. Although Area Health Boards had more responsibility than the old hospital boards with respect to public health promotion, they were still not generally responsible either for the purchase or provision of primary care, which was delivered through the private sector on a fee-for-service basis with general practitioners collecting subsidies from the government. In contrast to the hospital boards (which the Area Health Boards replaced) whose members were all locally elected, the Minister of Health could appoint three extra members to serve on the Area Health Boards to provide expertise that was seen to be lacking amongst the elected members or so as to make the Board more representative of the community in which it operated. Under the Area Health Board Act 1983 a Board was required to appoint community committees in those areas formerly serviced by a hospital board in order to consult with these various communities.

In 1989 the restructuring of 27 hospital boards into 14 Area Health Boards responsible for public health, hospitals, and some primary services, in their respective regions was completed. Towards the end of 1989 the New Zealand Health Charter was introduced. This required each Board to sign a performance-oriented accountability agreement with the Minister of Health. The purchasing and provider roles of the Area Health Boards were more clearly defined and the agreements provided the Boards with a clearer understanding of their obligations and the funds within which they had to achieve those obligations on a yearly basis.  

478 Hay, supra note 444 at 152.
480 Ashton reports that the 1989 initiatives resulted in prima facie productivity improvements. For example, the average length of stay in hospital fell from 15.55 days in 1987 to 13.31 days in 1989, and the throughput of surgical
(iii) Physicians

Since 1941, government subsidies have failed to keep pace with the increased fees charged by general practitioners. In 1992, Ashton noted that the real value of the “General Medical Services Benefit” (paid by government to general practitioners to subsidize the prices patients are charged) has fallen from around 75% of the total fee when it was first introduced to less than 20%.481 User charges for general practitioner care in New Zealand are higher than in many other countries.482 The inconsistency that results from only partial state funding of general practitioner care and full funding of hospital care had resulted in some people turning to hospitals for “free” (but, in terms of real costs, much more expensive483) care, rather than visiting their general practitioner.484 Changes in the provision of primary care were made throughout the 1980s. The General Medical Services Benefit was increased in October 1988 and again in September 1990 for children, the elderly, and the chronically ill in an effort to selectively improve access to primary care. From 1 September 1990, practitioners were given the option of joining a contract scheme which offered an inflation-adjusted subsidy for all consultations in return for limits on user charges and the provision of patient information for a national database. This scheme was abandoned by the National Government upon its election in 1990.

3.4.5 Internal Market Reform and the Health and Disability Services Act 1993

a. Background to Proposals for Reform

The proposals for reform of New Zealand’s health system have to be understood in the context of the radical restructuring of New Zealand’s economic and political landscape throughout the period 1984—1990. By the time the present National Government was elected in October 1990, most state services that conceivably had commercial potential had been restructured in an attempt to mimic private firm behaviour. This process was known as “corporatization.” It was argued that accountability as well as efficiency would be improved if the management

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481 Ibid. at 149.

482 Ashton et al., supra note 479 at 18.

483 The price per visit to a general practitioner in Auckland is approximately for most patients (with those with a community services card paying approximately NZ $22.00). The real cost of a day in hospital is on average is NZ $600.00 per patient although patients are charged nothing.

484 Ashton, supra note 480 at 149.
function could be placed at arm's length from the political responsibility of Ministers.485 Many of these corporatized entities were subsequently sold to the private sector.

Upon its election in December 1990 the National Government announced the establishment of (yet another) task force to report on the health care system. This signalled the National Government's intention to implement further reforms, even though the 14 Area Health Boards had been in full operation for less than two years. The terms of reference of the task force reflected a preference for the sort of reform that had already been undertaken in other sectors, i.e. the need for targeting of government subsidies and greater competition in the purchase and provision of health services.486

In 1991 the Minister of Health produced a "Green and White Paper" which identified the following problems in the health system:487

1. Public hospital waiting times were too long.
2. There was conflict in the dual roles of the Area Health Boards as purchasers and providers of secondary (hospital) health care.
3. Legislative and operational constraints on the Area Health Boards made it difficult for them to operate efficiently.
4. Funding of the system was fragmented.
5. People on higher incomes and in particular geographic locations had better access to services than others.
6. There were few incentives in the existing system to induce both general practitioners and patients to make efficient choices as to health care services.
7. There was a lack of consumer control — too little consultation and too little opportunity for local involvement in the delivery of health services.

The government said that underlying all the problems in the health system was the issue of fairness, and that there were inconsistencies in the existing system. However, the government

486 Ashton, supra note 480 at 152 that there was an implicit acceptance within the National Government of the ability of competition to improve efficiency within the health sector, and of the general applicability of competitive market forces to the funding and provision of health care.
487 Upton, supra note 16 at 11-19. It was titled "Green and White" as it contained matters upon which public submissions were invited before policy was formulated and notification of formulated government policy.
seemed particularly concerned about increases in government costs and were committed to a system that would provide greater consumer choice and flexibility.\(^{488}\)

b. The 1991 Reform Proposals

The 1991 reform proposals were as follows:

1. A regime of targeted user fees for primary and secondary care that included introducing, for the first time since 1938, partial user fees for public hospital care. Those who qualify for government subsidies for treatment must now carry a "community services card" before they are entitled to obtain health care at a reduced price that reflects a government subsidy. To be entitled to a card, a person must be on a "low income."\(^{489}\)

2. The disbandment of the members of the 14 Area Health Boards (the majority of which had been elected by people in the area). The Boards had previously been responsible for the purchase of most hospital care and had also managed the major public hospitals. The proposals provided for the separation of the Boards' purchaser and provider roles.

3. The establishment of four Regional Health Authorities ("RHAs") to act as purchasing agents with available government funds. The Northern RHA is responsible for a population of 1,078,878, the Midland RHA, 683,499, the Central RHA, 855,879, and the Southern RHA, 746,046. The Minister of Health is required each year to enter into a funding agreement with the RHAs and to monitor the performance of those agreements. It was envisaged that RHAs would be responsible for purchasing all general practitioner and other primary care services and secondary care for illness, accident, and disability on behalf of individuals residing within their respective geographically defined regions. One of the problems identified in the system prior to 1991 was the fragmentation of funding leading to difficulties in co-ordinating care and perverse incentives being created for providers and patients. Thus the consolidation of funding for illness, accident and disability in one body is geared towards ensuring better co-ordination in the purchasing of health services and reducing the potential for cost-shifting.

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\(^{488}\) Hon. S. Upton as reported in Hansard. *Health and Disability Services Bill — Introduction*, 20 August 1992, 10773 at 10776 noted in introducing the *Health and Disability Services Bill* into parliament: "There is also a widespread conviction that something as vital and as personal as our health cannot be serviced by a monolithic system. People want choice and flexibility. A standard, pre-packaged approach is not acceptable, either."

\(^{489}\) Ministry of Health, *supra* note 432 at 21 notes "low income is defined by a number of thresholds, ranging from $17,134 and below for a single person to $45,692 and below for a family of six."
4. Provision for the eventual establishment of private health care plans as alternatives to the services offered by the RHAs to which individuals could shift their allotted portion of government funding, which would otherwise be spent by an RHA.

5. Public consultation by a government-appointed committee to define a list of "core health services" that must be available to all New Zealanders without charge or at "affordable" prices. RHAs and private plans must purchase core health services as a matter of priority for those individuals residing within their respective geographic regions.

6. The separation of responsibility for the purchasing of public health services from other types of health services, and the establishment of a government appointed Public Health Commission to purchase public health services from public and private providers.

7. The restructuring of public hospitals (approximately 100) into 23 special government-owned companies known as Crown Health Enterprises ("CHEs"). CHEs compete with each other and private providers for supply contracts with the four RHAs. Unlike the old Area Health Boards, the new CHEs do not operate under global budgets and are not necessarily responsible for ensuring the health of their local population; this latter responsibility falls on the four RHAs. The CHEs are required, in effect, to mimic the behaviour of private firms. While they are required to exhibit a sense of social responsibility, this is not to limit their requirement to act as a successful and efficient business that supplies health services.

8. Subject to economic viability and government approval, small hospitals would be run as community trusts to compete with CHEs and other private providers.

c. The Reforms as Implemented
Some of the 1991 proposals were never implemented and some were implemented but subsequently dropped or significantly modified.

Patient copayments for hospital care, introduced in 1991, were abandoned in 1993 although higher user charges for the majority of the population for primary services remain in place as does the requirement for those receiving subsidies to carry an entitlement card named the "Community Services Card." The government did subsequently expand upon its original definition of lower income groups entitled to government subsidies for primary services and

\[\text{NZ Health 1993 Act, supra note 17, s.11.}\]
this resulted in an extra 100,000 people being covered.491 In 1996, the Ministry of Health reported that approximately 60% of the population are in fact entitled to Community Services Card but that only 40% of the population have one.492 A community services card does not entitle the holder thereof to free service but a partial government subsidy which generally for adults only covers half the cost of a general practitioner’s fees.493

Since 1993, the Core Health Services Committee has abandoned its task of attempting to define a list of prioritized core health services although, as will be discussed in subsequent chapters, it has continued to attempt to prioritize different classes of health need.

The Public Health Commission was disbanded in July 1995, and responsibility for purchasing public services was assumed by the RHAs and a special monitoring unit was created within the Ministry of Health.494

In 1996, responsibility for purchasing elective surgical services for accident victims was transferred back from the RHAs to the Accident Rehabilitation Corporation.495 A report by a government-appointed committee on the 1993/94 performance of the Accident Rehabilitation and Compensation Insurance Corporation noted that the Corporation cannot influence hospital surgery schedules or transfer procedures and consequently rehabilitation of accident victims is impeded.496 While prima facie the integration of purchasing for illness and accident removed the apparent unfairness of different standards of treatment for illness and accident victims, the Corporation found itself having to absorb rocketing income maintenance costs as accident victims languished in queues for treatment in the public sector.497 As a consequence, purchasing responsibility was eventually transferred back to the Corporation.

New Zealand’s original 1991 proposals for reform envisaged the development of competition between Regional Health Authorities and private plans and were in fact a version of Enthoven’s managed competition model. This policy has been abandoned for the foreseeable future because of strong public opposition to what was perceived as a step towards the “Americanization” of the public health service and because of concerns over “cream

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492 Ministry of Health, supra note 432.
494 See generally the Health and Disability Services Amendment Act 1995 (N.Z.) No. 84.
495 See the Accident Rehabilitation and Compensation Insurance Amendment Act (No. 2) (N.Z.) (1996) No. 106, s.6.
496 Noted in 18 The Capital Letter 17 (817) at 2
497 It was noted idem. that the Corporation reportedly estimates that there are between 13,000 and 20,000 accident claimants on waiting-lists, with an average waiting-time of six months, at a cost of between $70 and $100 million in earnings-related compensation.
skimming” (discussed further below). The dropping of the proposal for private plans has a profound impact on the viability of the managed competition theory underlying and supporting the reform process. Instead of competition between insurance plans indirectly stimulating efficient competition between health care providers, the emphasis is now only on competition between health care providers which the Regional Health Authorities is expected to micro-manage through the contracting process. Consequently, governance issues become very important and, in particular, the incentives the Regional Health Authorities will have to negotiate efficient contracts with providers. Issues of accountability and governance are dealt with in Chapter 4.

In addition to governance, other issues of importance include flexibility and transactions costs. With respect to flexibility the mandatory purchaser-provider split means that the Regional Health Authorities do not have the option of vertically integrating with providers; they can only contract out even where this option is inefficient. The costs and benefits of an inflexible purchaser/provider split are discussed in Chapter 5. With regard to transactions costs, undoubtedly there are additional transaction and administrative costs in internal markets which were not incurred in the previous system. Where there once was 14 Area Health Boards there are now 4 Regional Health Authorities (“RHAs”) and 23 Crown Health Enterprises contracting with each other, with private for-profit and charitable providers, and with the government. As an example of some of the costs of contracting, it is reported that one Crown Health Enterprise, Canterbury Health, spent some $93,000 in an unsuccessful bid to run a cardio-thoracic unit in Christchurch which subsequently the local RHA decided not to proceed with. Charitable providers that provide national services, such as Plunket (maternal and baby care) and the IHC (Intellectually Handicapped) Society, have complained about the costs incurred in having to negotiate four separate contracts with the four RHAs. The President of the IHC, Dr. Roderick Deane, has described the ensuing paper war as “bureaucracy gone mad”. Issues of transactions costs, particularly from the perspective of comparing transactions costs in internal markets with those incurred in a managed competition system, are dealt with in both Chapters 4 and 5.

A spontaneous initiative on the part of physicians subsequent to implementation of the internal market reforms has been the formation of general practitioners into groups in order to better negotiate with the RHAs. These entities have become known as Independent Practice
Associations (IPAs). By 1996, 50% of general practitioners had joined IPAs.\footnote{Ministry of Health, supra note 432 at 20.} If IPAs achieve savings on historical consumption patterns, then this is shared between the IPA and the RHA. IPAs do not (yet) carry any significant financial burden for when budgets are exceeded these extra costs are nonetheless paid by the relevant RHA.\footnote{See Malcolm & Powell, supra note 19.} This type of arrangement is similar to the concept of GP Fundholders in the U.K (discussed in the next section) with the difference being that Fundholding was a government-orchestrated initiative whereas IPAs sprung up in New Zealand as a response to the consolidation of power on the purchasing side.

With respect to the cost of the system, it is as yet unclear what impact the reforms have had on the total amount spent on health and it appears that New Zealand is devoting a similar amount to health as a percentage of GDP as it has in past years although data is only yet available for 1994.\footnote{Ministry of Health, supra note 432 at 65.} The real growth in public sector health expenditures (1994 dollars) in the year ending June 1994 was 3% compared to -1.3% in the previous year but this increase may be attributable to a one-time cost of transition to the new internal market system.\footnote{Muthumala & McKendy, (1991) supra note 429 at 43, Table 4.} What is clear, however, is that the rate of private sector spending has continued to increase significantly.\footnote{Privately funded real expenditures increased by 6.6% per annum over the period 1980–1995 whereas publicly funded expenditures increased by 1.2% — Ministry of Health, supra note 432 at 66.}

With respect to access, clearly one of the problems in the former system had been the reliance on user charges to finance a number of important primary care services and the lack of integration between secondary and primary care so as to allow substitution between different types of services. The reforms were also meant to result in the integration of primary and secondary care as Regional Health Authorities were responsible for purchasing both levels of care with government funds. The difficulty is that the government only partially subsidizes general practitioner care for some patients and thus the Regional Health Authorities may not have sufficient bargaining leverage with practitioners, particularly those in more affluent areas where most patients are covered by private insurance. There is, however, some indication that some RHAs are recognizing the benefits of primary and preventive care and fully subsidizing this type of care for some groups.\footnote{Ibid. at 21 notes “Some RHAs have been able to contract with IPAs for free GMS consultations for children under five years. One RHA has also contracted, on a pilot basis, for free mental health consultations with GPs”} The most visible problem of New Zealand’s former command-and-control system was implicit rationing through long and growing waiting lists.
Despite several cash injections by the government specifically designated to help reduce waiting lists,\footnote{F. Barber, "Cash Help To Slash Waiting Lists For Surgery", The New Zealand Herald, 14.10.94.} waiting lists have increased by over 50% from 62,000 in 1991 to a reported 93,930 people waiting as of March 1996.\footnote{Over 18,000 people had been waiting for over two years as at 30 June 1996 compared with 14,901 as at 30 June 1995.} Over 18,000 people had been waiting for over two years as at 30 June 1996 compared with 14,901 as at 30 June 1995.\footnote{S. Upton, supra note 16 at 28 (1991 figure); Purchasing for Your Health: A Performance Report on the First Year of the Regional Health Authorities and Public Health Commission, (Ministry of Health: Wellington, 1995), Table 17 at 85 (1993 and 1994 figures); L. Dalziel, Opposition health spokeswomen as cited by the New Zealand Herald, 17 April 1996, Section 1: 1 (1996 figures).}

In mid-1997, the New Zealand government announced further reforms of the internal market in an effect to control what was perceived as rising and excessive transactions costs and in response to widespread public dissatisfaction with the reforms. The main thrust of the new reforms is that rather than 4 Regional Health Authorities there will be one central purchasing authority. However, given that the four regional offices will be maintained as “branches” of this central authority, it is difficult to ascertain to what extent this will result in any real as opposed to simply cosmetic change to the existing internal market.

The performance of New Zealand’s new internal market is discussed in more detail in subsequent chapters. I will now turn to examine internal market reform of the U.K. system which prior to reform most typified the command-and-control model of the four countries under review.
3.5 The U.K. Health Care System and the 1989 Reform Proposals

3.5.1. Introduction
Prior to internal market reform the U.K. exemplified the "command-and-control" approach to health care allocation. A command-and-control system is one in which government not only finances the vast majority of services but is also heavily involved in the delivery of services. The command-and-control system in the U.K. has historically relied upon rationing resources by physicians between different people and different medical services within a fixed government budget.

The command-and-control approach is often associated in the literature with the ability to contain total health expenditures. However, the creation of a command-and-control system as a response to market failure in health insurance and supply markets creates its own set of problems. Problems with the U.K. health system have manifested themselves in rationing through waiting lists that are perceived as being both too long and unequitably managed, in the growth of the private sector as those dissatisfied with waiting lists and who are wealthy enough to afford private insurance and/or private care exit from the public sector, and in the decline of capital and infrastructure. In response to these problems, the U.K. has undertaken radical internal market reform in an effort to improve the technical or productive efficiency of the system. Both the advantages and disadvantages of the pre-reform system will be outlined below and the proposals for internal market reform will be described.

In the U.K. there are in fact four slightly different health systems in England, Scotland, Wales and Northern Ireland. England is the most advanced in terms of implementing internal market reform and unless otherwise stated, the discussion will refer to the historical development of and reforms within the National Health Service ("the NHS") in England.

3.5.2 Problems in the System Prior to Reform
Problems in the NHS have primarily manifested themselves around access and in particular fairness in access. It is also important to discuss issues of cost in terms of a debate between those who argue that the U.K. is not receiving value for money for its health expenditures and those who argue that the system is underfunded.
a. Cost
Throughout the 1980s the government expressed concern at the increases in public real expenditures on health services. In the period 1978/79 to 1991/2 there was a 22% increase in expenditures in real terms, without any perceptible impact on the length of waiting lists for surgery and time spent thereon by patients. In the longer term there was concern that the ageing population would exert continued pressure for increased health care expenditures. In contrast to the government’s concern over rising costs, there has been a strong outcry, on the part of providers and others, that the NHS is underfunded. Discontent had grown amongst providers as growth in public expenditures, historically set at 2% per annum in real terms, was curbed over the 1980s. Comparing expenditures on health with other OECD countries shows that, relatively, the U.K. had, up until the 1989 reform proposals, consistently spent less on health care than would be predicted from its real level of GDP. In 1980, the U.K. spent 5.8% of GDP on health services compared to an OECD average of 7.0%. In 1990, the U.K. spent 6.2% of GDP on health services compared with an OECD average of 7.6%.

b. Access and Waiting Times
As Table 4 in Appendix 4 indicates, with respect to average performance on health outcomes, the U.K. performs better than would be expected from its relatively low level of health expenditures. The infant mortality rate is just below the OECD average of 7.5 deaths although the percentage of babies with low birth weights is relatively high. The U.K.’s life expectancy rates of 73.2 years for males and 78.8 years for females are both close to the OECD averages.

Despite an adequate performance with respect to average measures of health outcomes, Spiby notes that the U.K. does not perform well on specific health indicators compared to its European neighbours. For example, it has significantly higher death rates for ischemic health disease than West Germany or France. It also, together with the Netherlands, has high death rate for males from malignant tracheal, bronchial, and lung cancer and high death rate for

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512 Schieber et al., supra note 90 at 101, 102, Exhibits 1 and 2, from OECD data and the authors’ own estimates.
513 Idem.
514 This average of OECD countries excludes the outlier figures of Turkey and is calculated using the 1991 figures provided in ibid. at 109, Exhibit 5, from OECD data and the authors’ own estimates.
515 “Ischemic” is a condition where there is an inadequate amount of blood reaching the heart resulting in inadequate oxygen supply. J. Spiby, “Health Care Technology In The United Kingdom” (1994) 30: 1–3 Health Policy 295 at 296.
women from the same cause, even though the percentage of the population that smokes and the amount of tobacco consumed, while high, is not the highest of OECD countries.516

Another issue of concern has been the growth and management of waiting lists, particularly for elective surgery. Waiting lists grew through the 1980s from a reported 700,000 to 900,000 in 1990.517 The median waiting time was five weeks but 23% of patients had to wait 12 months or more for services.518 As in New Zealand, waiting lists in the U.K. have been for elective surgery and not for emergency services. Waiting lists, like user charges, are a means of rationing access to health services, but unlike user charges one would assume that priority on waiting lists would be assigned to those who, objectively, are in the greatest clinical need; however, it appears that this is not always the case. Specialists are influenced by factors other than the objective clinical need of the patient in front of them relative to all other patients. According to Aaron and Schwart these factors include age, the visibility of and the way the particular nature of the illness is perceived by society, and the cost of treatment.519 Aaron and Shwartz note those patients unwilling to accept the consequences of resource limits in the U.K. have found ways to “work the system” — for example, by jumping the queue in order to obtain elective surgery faster.520

It is possible that health care providers have an incentive to exaggerate the real extent of waiting lists as leverage to argue for more funding. It is also possible that specialists that are employed in the public sector on a salary basis but work part-time in the private sector on a fee-for-service basis have an incentive to maintain long waiting lists in the public sector as their existence may enhance demand for their services in the more lucrative private sector.

3.5.3 Financing Health Care Services

a. The Role of the Government

After a battle with the medical profession the National Health Service Act 1946 was eventually passed and it provided for universal free access to primary and hospital services, subject only to the express provisions of the Act.521 Section 1 of the National Health Service Act 1977

516See Schieber et al., supra note 90 at 109, Exhibits 6, from OECD data and the authors’ own estimates and OECD Health Systems: Facts and Trends, supra note 73, Table 3.3.14 and 3.3.15 at 94–95.
517Day & Klein, supra note 385.
518OECD, Health Policy Studies No. 2, supra note 22 at 120.
520Ibid. at 9.
521The National Health Service Act (U.K.) 1946 9 & 10 Geo. 6, CH. 81 enacted 6 November 1946 subsequently repealed and replaced by the National Health Service Act (U.K.) 1977 c. 49.
requires the Secretary of State for Health to promote the establishment in England and Wales of a comprehensive health service in order to secure improvement in the physical and mental health of the people of those areas and in the prevention, diagnosis, and treatment of illness.522 Section 3 of the Act provides that the Secretary of State, to such extent as she considers necessary to meet all reasonable requirements, has a duty to provide hospital and other like accommodation, medical, dental, nursing and ambulance services, maternity and young child care, preventative, acute and convalescent care, and services required for the diagnosis and treatment of illness.

With respect to the financing of services, since 1946 the government has remained by far the largest financier of the health system. Of the four countries under consideration in this thesis, the U.K. has the highest percentage of health services paid for by the public sector at 89.6% in 1980 and 83.5% in 1990.523 By contrast, the OECD reports that in 1990, the percentage of health services paid for by the public sector was 81.7% in New Zealand, 71.3% in the Netherlands524 and 42.4% in the U.S.525

The budget for the NHS is determined by the British Treasury generally on the basis of previous years' outlays and anticipated inflation and this budget is then approved by the House of Commons. Prior to the 1989 proposals, the Department of Health allocated the government budget to the fourteen Regional Health Authorities who in turn funded the various District Health Authorities (that purchased hospital services and managed all the public hospitals) and Family Practitioner Committees (that reimbursed the work of general practitioners).

b. Private Health Insurance

The proportion of the population with private health insurance has, since 1945, been small but has steadily grown in recent years.526 In 1980, total expenditures on private health premiums comprised just 1.2% of all health expenditures but by 1990 it had grown to 3.2%.527 By comparison, in New Zealand, the Netherlands, and the U.S., expenditures on private health premiums as a percentage of total expenditures on health in 1990 comprised respectively

522 The National Health Service Act (U.K.) 1977 c. 49, s.1.
523 OECD Health Systems: Facts and Trends, supra note 73 at 252, Table 7.1.1.
524 This figure misrepresents the fact that only a small percentage of the Netherlands budget is financed from general taxation revenues and the majority is financed by payroll taxes and employee contributions as a percentage of their wages.
525 OECD Health Systems: Facts and Trends, supra note 73 at 252, Table 7.1.1.
526 OECD, Health Policy Studies No. 2, supra note 22 at 116.
527 Calculated by the author using figures from OECD Health Systems: Facts and Trends, supra note 73, Table 4.1.1 at 108 and Table 7.1.9 at 260.
3.5%, 13.3%, and 32.9%.\textsuperscript{528} In 1988, it was estimated that 10.5% of the U.K. population were covered by private insurance.\textsuperscript{529}

The private health insurance market is highly specialized comprising private insurers who finance mostly elective surgery and private hospitals who specialize in these services.\textsuperscript{530} The private sector in the U.K. plays a far larger role than the economic measures of its respective size would indicate as it allows those on higher incomes to buy private insurance to avoid rationing by waiting in the public sector.\textsuperscript{531} The private sector also provides an additional source of revenue for specialists employed in the public sector and the fee-for-service basis on which reimbursement occurs in the private sector provides a financial incentive for specialists to provide more services in the private sector than in the public sector.\textsuperscript{532}

c. Patient Charges

Unlike New Zealand, there are no user charges for general practitioner services in the U.K. Since 1952, there have been user charges for pharmaceuticals. In 1989, user charges were introduced for eye and dental care.\textsuperscript{533} By 1993, user charges had risen to an undifferentiated rate of £4.25 per prescription item.\textsuperscript{534} 60% of the population are exempt from these charges,\textsuperscript{535} and over 80% of prescriptions are in fact dispensed to those who are exempt.\textsuperscript{536} User charges account for approximately 4% of total expenditures on health services.\textsuperscript{537}

\textsuperscript{528}Calculated by the author using figures from OECD Health Systems: Facts and Trends, supra note 73, Table 4.1.1 at 108 and Table 7.1.9 at 260.


\textsuperscript{530}C. Propper & A. Maynard, "Whither the Private Health Care Sector?" in Culyer et al., supra note 511 at 48.

\textsuperscript{531}Aaron & Schwartz, supra note 519 at 22.


\textsuperscript{533}The National Health Service Act (U.K.) 1977 c. 49, ss. 78, 79, 79A and regulation enacted pursuant thereto.


\textsuperscript{535}National Health Service Act (U.K.) 1977 c. 49, s. 83A(2) allows regulation to be made exempting individuals from user charges due to their age, the nature of their medical condition, the circumstances in which they acquired the condition, on the basis of their own or some other person's entitlement to statutory benefits, or on the basis of their level of resources relative to their requirements. Schedule 12 of the same Act provides, amongst other exceptions, that no user charges shall be made for drugs, medicines and appliances for patients resident in hospital.

\textsuperscript{536}Ryan & Yule, supra note 534 at 31.

\textsuperscript{537}Maynard, supra note 510 at 1434.
3.5.4 The Supply of Health Care Services
The Secretary of State for Health has historically been accountable to Parliament for the supply of health services in England. It was the responsibility of the Secretary of State to appoint Regional Health Authorities who were responsible for financing government authorities further down the hierarchy, controlling capital investment, and employing senior specialists working in public hospitals. Regional Health Authorities could delegate duties imposed on them by the Secretary of State to District Health Authorities and Family Practitioner Committees, both organizations being established by the Secretary of State. District Health Authorities historically were responsible, within their respective districts, for the supply of public hospital services, and Family Practitioner Committees were responsible for the purchase of general medical, dental, ophthalmic, and pharmaceutical services.

a. Hospitals
Section 6 of the National Health Services Act 1946 provided for the nationalization of the hospital service market by providing for the vesting of all private not-for-profit hospitals and all municipal hospitals in the Minister of Health. Prior to the 1989 reform proposals, responsibility for the management and operation of public hospitals had been largely delegated to the District Health Authorities of which there were about 145, each serving a catchment area of approximately 250,000 people.

Since the mid-1980s, District Health Authorities have been required to solicit tenders for the supply of catering and ancillary services but otherwise there was no requirement or incentive to contract out for services to other public or private institutions. Due to the means by which hospitals were funded, improving efficiency may have actually proved disadvantageous as it might result in a reduction in the level of government funding in the next financial year and/or might result in more referrals but with no more resources to deal with these new patients. Hospital budgets were capped by the funding received from District Health Authorities. This may have resulted in incentives for cost-shifting as specialists based in public hospitals referred patients back to their general practitioners who were not subject to the same budget limitations for either the cost of their own services or for the pharmaceuticals.

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538 Loveridge & Starkey, eds., supra note 5 at 3.
539 OECD, Health Policy Studies No. 2, supra note 22 at 113.
540 See the National Health Service Act (U.K.) 1977 c. 49, ss 13, 14 & 15.
541 The National Health Service Act 1946 9 & 10 Geo. 6, CH. 81 enacted 6 November 1946.
542 OECD, Health Policy Studies No. 2, supra note 22 at 118.
they prescribed.544 Long and growing waiting lists for elective surgery can also be viewed as a form of cost-shifting on to patients.

Historically, there have reportedly been problems with over-centralization of the hospital sector and lack of autonomy for hospitals, resulting in an inability to make cost-efficient decisions.545 The direct line of hierarchy between the government and Regional and District Authorities has resulted in government being held accountable at the highest level for small difficulties within the system and has politicized decisions such as the rationalization of the hospital sector.546 The U.K. system also has generated little useable information about the cost and benefits of different types of services provided by hospitals.547

Prior to the 1990 reforms there were 200 private acute hospital providing about 10,500 beds in the U.K.548 As in New Zealand, private hospitals only provide elective surgery leaving acute and emergency care within the domain of public hospitals. In 1986, it was estimated that 16.7% of residents in England and Wales undergoing elective surgery (excluding abortion) were treated in the private sector.549 The Health Services Act 1976 provided for the creation of a Health Services Board to control the establishment of private hospitals in order to safeguard the NHS from what was feared to be too much competition from the private sector. This Board was subsequently dissolved pursuant to s. 9 of the Health Services Act 1980.550

b. Physicians

In 1991, 37.5% of physicians were generalists.551 Prior to the 1989 reform proposals, the supply of general practitioner services was managed by the government through local Family Practitioner Committees (the members of which were government-appointed) who were responsible for the funding and delivery of primary health care services.552 These Committees contracted with general practitioners and prepared a list of NHS practitioners.553 The Committees were also responsible for making arrangements with dentists for the supply of

545 Enthoven, supra note 543 at 63.
546 Ibid. at 60.
547 Ibid. at 63.
548 Culley & Meads, supra note 532 at 675.
551 Day & Klein, supra note 385 at 47 note that there were 27,000 general practitioners in England compared to 45,000 hospital doctors.
552 Culley & Meads, supra note 532 at 674.
553 The National Health Service Act (U.K.) 1977 c. 49. ss 29–34
dental services, with practitioners and opticians for ophthalmic services for certain groups, and for the supply of pharmaceutical services.  

Every individual in the U.K. is enrolled with a general practitioner. General practitioners are treated as independent private contractors. Patients are free to select a general practitioner from the NHS list subject to the consent of the practitioner concerned. Where the patient has no particular preference than her Family Practitioner Committee will assign her to a practitioner. The average list size in England was reported in 1991 to be 1900 patients. Over 90% of all episodes of ill health in the U.K. are treated in general practice, which likely contributes to the NHS’s relative success in restraining health expenditures as general practitioners act as filters or gatekeepers to the consumption of more expensive secondary health care services. The opportunities open to patients to access the system at more expensive entry-points are limited as patients can only otherwise be admitted to hospital through the Accident and Emergency Departments, by the ambulance service, or by self-referral to very specialized clinics.

At the time of the creation of the NHS there was a long battle as organized medicine resisted government attempts to reimburse general practitioners on a salary basis for the supply of general services to the public. However, by 1966 this resistance had faded and practitioners agreed to adopt a basic salary proposal (described as a ‘practice allowance’) and in subsequent years, practitioners have been among the strongest defenders of salaried reimbursement under the NHS. Prior to the 1989 proposals for reform, general practitioners were in fact reimbursed by three methods by the Family Practitioner Committees: a basic practice allowance or salary (which was larger for practitioners locating in those areas viewed as being under-serviced); a capitation payment per registered patient (with three levels of payment depending on the age of the patient); and specific fee-for-service payments for particular preventative services. Fee-for-service payments and payments of costs were pegged to the total average costs for all practitioners, with practitioners being able to keep any moneys they saved below the average. Maynard and Walker note that, historically, the prices fixed by the government for the price of labour have reflected to only a very limited degree the relative

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554 Ibid. ss. 35, 37 and 38-40.
555 Day & Klein, supra note 385 at 47.
557 P. Bryden, “The Future of Primary Care” in Loveridge & Starkey, eds., supra note 5 at 65.
559 Ibid. at 153.
560 Culyer & Meads, supra note 532 at 674.
561 OECD, Health Policy Studies No. 2, supra note 22 at 113.
The system of capitation payments was eroded over the years until by the mid 1980s only 46% of general practitioners’ incomes were derived from capitation. Specialists in the public sector are reimbursed by salaries and “distinction awards.” Until recent reforms, specialists were paid by and were accountable to the relevant Regional Health Authority rather than to the District Health Authority that managed the hospital. Specialists may work part-time in private hospitals although their primary employer remains the NHS. In the mid 1980s, a specialist who worked in the private sector in addition to their salaried employment in the public system could expect, on average, his or her income to increase by £17,000.

3.5.5 Internal Market Reform and the NHS and Community Care Act of 1990
The presidents of three leading Royal Colleges representing specialists issued a public statement on 7 December 1987 warning that the NHS was in crisis and called for an immediate independent review. This statement was in response to the reduced growth in government expenditures on health services over the preceding decade and the pressure being brought to bear on health care providers to produce the same standard of care for the population with fewer funds. According to Day and Klein, this statement on the part of the Royal Colleges so angered the then prime minister that she announced a review of the NHS in January 1988 without consulting her ministerial colleagues.

Proposals for internal market reform of the NHS were first announced at the beginning of 1989 and encapsulated in a White Paper entitled Working for Patients. Subsequently, the reforms were implemented in the National Health Service and Community Care Act 1990. The stated goal of the reforms was to improve the efficiency of resource allocation by creating competition on the supply side of the market between public and private institutions. It is important to note that government remains the predominant funder of health services and the

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563 Day & Klein, supra note 385 at 49.  
564 For a criticism of these awards see K. Bloor. A. Maynard, Rewarding Excellence?: Consultants’ Distinction Awards and the Need for Reform, (Discussion Paper 100) (York: Centre for Health Economics, University of York, 1992.)  
565 Kirkman-Liff, supra note 333 at 206.  
567 Day & Klein, supra note 385 at 45.  
569 NHS 1990 Act, supra note 15.  
570 Maynard, supra note 510.
reforms go to the organization of delivery of services and not to the funding thereof. There were eight important reforms:

1. the splitting of responsibilities for the purchasing and the provision of hospital health services, both functions having formerly been performed by the District Health Authorities. The District Health Authorities were to become purchasers of health services and to contract with competing public and private providers;

2. the establishment of public hospitals as self-governing "NHS trusts" with the power to vary salary packages for employees and to borrow capital within annual financing limits.

3. the establishment of groups of general practitioners as "Fund-holders" with their own budgets to purchase some diagnostic and elective procedures from hospitals and other providers;

4. the creation of indicative prescribing budgets for those general practitioners not electing to become Fund-holders;

5. the creation of 100 new specialist positions within public hospitals to help reduce waiting times;

6. the creation of a tax exemption for the purchase of private insurance for those over 60;

7. the membership, remuneration, and staffing of District and Regional Health Authorities and Family Health Services Authorities would be reorganized on "business lines;"

8. rigorous audits would be introduced throughout the NHS.

The key element of internal market reform in the U.K., as in New Zealand, is the notion of splitting the purchaser and provider roles of the District Health Authorities which had formerly been responsible for purchasing all secondary health services in their respective regions and which had been responsible for managing all the public hospitals in the same region. In the reformed system District Health Authorities are expected to be transformed into active purchasers and engage in hard-bargaining for the supply of cost-effective hospital and other secondary services for their catchment populations. The health service providers from whom they may choose to contract with include independent public hospitals ("NHS trusts") and private hospitals or other organizations. Thus the term "internal market" is somewhat misleading as it is intended that both public and private health care providers will compete in the new market. Under the original internal market proposals Regional Health Authorities were to continue to perform their role of overseeing and financing the District Health Authorities. More recent reforms (1 April 1996) have, however, resulted in the abolition of the Regional Health Authorities and the merging of District Health Authorities and Family Practitioner Committees into 100 Health Authorities which are responsible for purchasing
hospital, primary and community health services for varying populations ranging from roughly 125,000 up to just over a million. The operations of these Health Authorities are now overseen by 8 branches or outposts of the NHS Executive (an agency within the Department of Health).\footnote{News Release by the Department of Health, 96/106, 1 April 1996, “Changes To Health Service Structure Release £139 Million For Patient Care”.}

With respect to funding, prior to the 1989 proposals for reform the Regional Health Authorities had been financed by what was known as the Resource Allocation Working Party (“RAWP”) formula. This formula was intended to result in the reallocation of government funding to the various regions on the basis of need as opposed to historical payment arrangements. In order to do this, allocations were based on regional differences in standardized mortality ratios.\footnote{R. Carr-Hill. “RAWP Is Dead: Long Live RAWP” in Culyer \textit{et al.}, \textit{supra} note 511 at 192.} The RAWP forum has subsequently been reviewed and refined and is meant to determine the funding received by Health Authorities, although just prior to the most recent elections the Department of Health was only allocating 76% of the total budget according to this formula.\footnote{See the discussion by K. Bloor & A. Maynard, “Health Care Reform in the UK National Health Service”, Paper prepared for the First Meeting of the International Health Economics Association, May 1996, British Columbia at 4.} Bloor and Maynard note that the RAWP formula does not apply to primary care which is still largely “demand determined and not case limited: it is a function of the number of general practitioners and their prescribing behaviour.”\footnote{\textit{Ibid.} at 5.}

Unlike New Zealand, the U.K. Health Authorities are not responsible for funding disability services. A new regime was introduced in the U.K. for the purchase of community care for the elderly, the mentally ill, and the mentally and physically handicapped but the budget for purchasing these services is managed by local authority social services managers.

Section 3 of the \textit{National Health Service and Community Care Act} (“the Act”) allows Health Authorities to enter into “NHS contracts” for the provision of health goods and services.\footnote{\textit{NHS 1990 Act}, \textit{supra} note 15, s.3} Publicly and privately owned health care providers must compete for supply contracts with Health Authorities which will contract with the most cost-efficient health care provider. Section 4 of the Act does, however, provide that an “NHS contract” is not in fact a contract in the traditional legal sense, but an arrangement, and any dispute arising in relation thereto is to be referred to the Secretary of State for her determination. The nature of contracting in the U.K. internal market is discussed in Chapter 5.
The public hospitals are now managed by “NHS Trusts.” These institutions are not trusts in the usual legal sense but body corporates, the composition of which is determined by the Secretary of State.\(^{576}\) NHS Trusts must comply with directions received from, and are directly accountable to, the Secretary of State.\(^{577}\) There is no mandatory legislation in the U.K. requiring that all public hospitals become independent NHS Trusts;\(^ {578}\) however, at the time of writing nearly all public hospitals had in fact been transformed into NHS Trusts pursuant to government policy. An NHS Trust assumes responsibility for the management of a public hospital or hospitals and other establishments or facilities previously managed or provided by a Health Authority. A NHS Trust has the freedom to negotiate its own terms of service for its employees instead of being bound by national agreements. Specialists employed by an NHS Trust are employed by and accountable to the Trust itself rather than to the relevant Health Authority as has historically been the case.\(^ {579}\) An NHS trust is required to carry out its functions “effectively, efficiently and economically.”\(^ {580}\)

Section 10 of the Act requires that all NHS Trusts ensure that their revenues will meet their outgoings in any financial year. NHS Trusts must set prices to equal (normally) short run average costs plus a 6% rate of return on capital assets.\(^ {581}\) Trusts can only set prices equal to marginal cost when they have unplanned excess capacity.\(^ {582}\) Anand and McGuire note that efficient prices would be set at marginal cost and that short-run average cost would in fact equal marginal cost if there were constant returns to scale but that the relationship between average cost and marginal cost is unknown in the health care sector.\(^ {583}\)

Trusts have an advantage over GP Fundholders (discussed below) and other private providers in that they are exempt from income tax and corporation tax. On the other hand, NHS Trusts are not allowed to run a loss from one financial year to another, making them vulnerable to short term fluctuations.\(^ {584}\) This puts Trusts at a competitive disadvantage \textit{vis-à-vis} GP

\(^{576}\) Ibid. s. 5.
\(^{577}\) Ibid., Schedule 2, s. 6—8.
\(^{578}\) The Secretary of State, pursuant to the \textit{NHS 1990 Act}, supra note 15, s.5 and Schedule 2 has the power to establish public hospitals as independent trust.
\(^{579}\) Kirkman-Liff, supra note 333 at 206.
\(^{580}\) \textit{NHS 1990 Act}, supra note 15, Schedule 2, s.6.
\(^{582}\) Maynard, \textit{supra} note 510 at 1434.
\(^{583}\) McGuire & Anand, \textit{supra} note 581 at 5.
\(^{584}\) Maynard, \textit{supra} note 510 at 1440.
Fundholders who are able to run losses from year to year and makes it more likely that Trusts will stay with the status quo and resist innovation.585

Section 14 of the Act provides for the recognition of “GP Fund-holders.” General practices with more than 5000 patients (originally, the requirement was 11,000 patients) can apply to a Health Authority to become a Fund-holder. A Fundholder receives a capitated budget with which to buy drugs and approximately 20% of hospital and community services for the patients that are enrolled with them.586 Consequently, the existence of GP Fundholders provides some competition for Health Authorities in their role as purchasers. The 1989 White Paper claimed that Fund-holders would have an incentive to minimize costs in order to retain a surplus from the budget allocated to them but this would not be at the expense of the range, number, or quality of services provided as Fundholders would need to maintain standards in order to be able to attract patients onto their respective lists.587 There are now 3,500 Fundholders, involving around 15,000 general practitioners, who act as purchasers for approximately 50% of the population for a limited range of health services.588 The Fundholding initiative was originally seen as a “bolt-on” to the main reforms (being the purchaser/provider split) but has assumed increasing importance.589

There are now three types of Fundholders:
a. practices with 5,000 or more patients enrolled on their lists may apply to central government to be a “Standard Fundholding Practice” (by far the most common form of Fundholding) and, if successful, receive an annual budget with which they must pay their own staff and purchase general practitioner, diagnostic, community, outpatient, and elective surgical services and drugs, medicines, and listed appliances for all the patients enrolled with them;590

585 Idem.
b. practices with 3000 or more patients enrolled on their lists may now apply to be a “Community Fundholding Practice” and, if successful, receive an annual budget to pay their own staff, and purchase diagnostic tests, some community health services, and drugs, medicines, and listed appliances for all the patients enrolled with them;
c. 70 practices, each with over 30,000 patients, are in a pilot project for their potential to be “Total Fundholders” and are required to purchase the full range of publicly health services.591

GP Fundholders are not allowed to keep any surpluses as pure profit. Regulation requires GP Fundholders to invest savings back into their respective practices thus, it is hoped, ultimately benefiting patients.592 However, there are some anecdotal reports of Fundholders investing heavily in the physical capital of their practices only to then sell their practices to other physicians, accruing personally a significant capital gain.593

Problems have arisen as to how to determine the GP Fundholders’ budgets. One issue is whether their budgets should reflect historical use patterns (which would ease transition and cause less disruption but do little to improve efficiency) or whether some formula can be worked out to fund the purchasers on a per capita risk adjusted basis (which would likely improve efficiency). The government has decided upon the route of reimbursing on historic patterns, moving over time to adjust budgets along a formula basis.594 Thus, section 15 of the Act provides for payment by the relevant Health Authority to the Fund-holder to be determined by such factors as the Secretary of State may direct. In order to enable a Fundholder to manage the actuarial risk of the patients enrolled with the practice, Fundholders financial liability is capped at £6000 per annum for any patient and any costs incurred beyond this sum are paid for by the Health Authority.595 The accountability of Fundholders is discussed in Chapter 4. Day and Klein note that Fundholding and the purchaser/provider split are in fact two contradictory models of contracting.596 This is because Health Authorities are government agencies and are required to contract out for the supply of all health services whereas GP Fundholders are private entities and are allowed to provide health services directly. The differences between GP Fundholding and the mandatory purchaser/provider split enforced in the balance of the internal market reforms is discussed further in Chapter 5.

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592Fundholding Regulations 1996, supra note 590.
593See Maynard, supra note 510 at 1438.
595Fundholding Regulations 1996, supra 590, s.21.
596Day & Klein, supra note 385.
A new standard contract for general practitioners was introduced on 1 April 1990 which placed greater emphasis on costs and performance than had been historically the case.  Financial incentives were provided to encourage practitioners to perform minor surgery; to practice in deprived or isolated areas; to undertake child health screening and to encourage health promotion centres; and once a year to make home visits to patients over 75 to assess their health. The importance of capitation was emphasized with the proportion of fees paid through this means increased from 46% to 60% of general practitioners’ incomes. Some of the requirements regarding the supply of health promotion services were dropped on 1 April 1993.

The reforms have not attempted to deal with the reimbursement regime for specialists. Maynard and Walker note that specialists continue to receive a salary, may earn a Distinction Award and may earn a significant portion of their income from private practice. The fragmentation of income sources in this manner adversely affects management’s ability in both Trusts and Directly Managed Units to hold specialists accountable for their performance in the public sector.

With respect to the issues of cost and access outlined at the outset of this section, internal market reform in the U.K. has come at a price. Compared to previous years, the 12.2% and 13% annual percentage increase in total health expenditures recorded in the years 1990/91 and 1991/2 is high. Total health expenditures as a percentage of GDP also significantly increased in these years; a 7.6% increase in the 1991-2 year compared with an average rate of growth of 1.7% over the whole period 1980–1992. Moreover, the growth rate in per capita health spending in U.S. dollars of 11.4% in 1991–2 was significantly higher than any other OECD country. The 1992/3 figure of 9.6% for the annual percentage increase in total health expenditures, while high, is more comparable to pre-reform growth figures; however,

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597 P. Bryden, “The Future of Primary Care” in Loveridge & Starkey, eds., supra note 5 at 69 notes that for the first time, performance-related payments were offered for cervical cytology and childhood immunizations. See also J. Cairns & C. Donaldson, “Introduction to Economics In The New NHS” (1993) 25 Health Policy 1 at 4.
600 For a criticism of these awards see K. Bloor. A. Maynard, Rewarding Excellence?: Consultants’ Distinction Awards and the Need for Reform, (Discussion Paper 100) (York: Centre for Health Economics, University of York, 1992.)
602 Public Expenditure Analyses to 1995-96, Treasury 1993 cited by Maynard, supra note 510 at 1434, Table 1.
603 Schieber et al., supra note 90 at 101. Exhibit 1 from OECD data and the authors’ own estimates.
604 Ibid. at 102, Exhibit 1 from OECD data and the authors’ own estimates.
more recent statistics show that spending on government funded health care has continued to increase in real terms by 3% per annum over the reform period and that efficiency has fallen.  

With respect to access and long waiting lists, unlike New Zealand, the U.K. internal market had some early success in addressing this problem. The number of individuals waiting for elective procedures fell by 2.9% in the period December 1994 to March 1995, at which point there was 1,040,161 people on waiting lists and approximately the same number of people were on waiting lists at 30 September 1995. The number of people waiting for more than 12 months for elective procedures on 30 September 1995 was 27,900 -- a reduction of 55% since September 1994, when there were 62,300. How much of this improvement is due to the improved efficiency of the system as opposed to additional government expenditures is unclear. More recently, however, it appears that waiting lists have started to increase again with 1,207,500 waiting at the end of September 1997 (an increase of 1.5% over the previous quarter) and with the number of people waiting for more than 12 months increasing by 24%.

On the 8th of December 1997, the new Labour government in the U.K. released a White paper detailing further reforms in the U.K. It is beyond the scope of this dissertation to consider in depth the content of these latest raft of reforms. For completeness, however, I note that the reforms provide for the abolishment of GP Fundholders and for the creation of “Primary Care Trusts” which are to be large groups of general practitioners and community nurses who will commission services from NHS Trusts. The NHS Trusts will remain independent organizations, although there is the possibility that Primary Care Trusts will vertically integrate with NHS Trusts and share management functions.

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606 Health Care UK 1994/95, supra note 588 at 38, Table 13. There were 1,040,152 people on waiting lists at 30 September 1995 -- 9 less than at March 1995 -- News Release by the Department of Health, 96/1. 1 January 1996, “Hospital Waiting List Statistics Published".

607 News Release by the Department of Health, ibid. T. Besley, J. Hall and I. Preston, Private Health Insurance and the State of the NHS, (Commentary No. 52) (London: The Institute for Fiscal Studies, 1996) at Figure 3 similarly show a significant decline in the percentage of the population on long term waiting lists after 1990.

608 J. Snell, “Action Team Appointed to Tackle Rising Waiting Lists” (20.11.97) Health Services Journal 4 as quoted by W. Bartlett supra note 605.
3.6 Synthesis and Conclusion

In this section, I synthesize the information in the earlier sections of this chapter regarding how the four systems under study have been structured in terms of finance and delivery, the problems that have arisen, and proposed reforms. The goal here is to begin to ascertain the factors which either alone or in combination are likely to result in a system that efficiently achieves the objective of ensuring universal access to a comprehensive range of health services on the basis of need as opposed to ability to pay. In 1995 White identified what he viewed as international standards for health systems: universal coverage; comprehensiveness of principal benefits; progressive financing (contributions linked to ability to pay rather than utilization); and cost control through administrative mechanisms including global budgets, limitations on system capacity, and binding fee schedules. I discuss these characteristics, arguing that although important they are insufficient alone from the perspective of addressing the need to allocate resources between different health needs (balancing societal and patient interests), of ensuring that the most cost-effective service is supplied in response to a particular health need, and of ensuring the technically efficient production of services.

Financing

Looking first at financing, I discuss the issues that arise under the headings of private insurers and progressive/regressive financing, single-payer systems, and comprehensiveness and integration.

Private Insurers and Progressive/Regressive Financing

The fact that many countries have proposed more market-oriented reforms of their respective health allocation systems seems at first blush surprising given the high cost and inequities within the U.S. system. The U.S. system has been described as a “parody of excess and deprivation” as 18% of the non-elderly population are not insured yet the well-insured in the U.S. receive some of the highest quality health care in the world (although it is argued that many services provided are not cost-effective or even effective). The poor performance of the U.S. system highlights the inefficiencies and inequities of a system largely financed by

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610 Korea is an example of the cost and inefficiency of an unregulated private market for health services. The implementation of universal access through competing private insurers and private health providers paid on a fee-for-service basis has resulted in an explosion in health care expenditures relative to GDP — see J. W. Peabody, S. Lee and S. R. Bicke, “Health For All In the Republic of Korea: One Country’s Experience With Implementing Universal Health Care” (1995) 31: 1 Health Policy 29.
private insurance that is subject only to piecemeal regulation and the problem of a system that is not comprehensive and, as a consequence, allows a great deal of cost-shifting.

Difficulties within the U.S. are often used as evidence against any form of market or competition-oriented reforms and particularly any role for private insurers. This argument is unsound as there is a clear distinction to be made between using market reforms as a means to achieve a broader public goal -- namely universal access to a comprehensive range of health services and adopting a U.S. style system of piecemeal access that is regessively financed. This is readily apparent when one considers the Netherlands which accords a relatively large role to private insurers. There is a strong commitment in the Netherlands to what is described as the principle of “solidarity” which in essence is the goal of ensuring universal access on the basis of need as opposed to ability to pay. The Dutch achieve this goal despite the fact that the wealthier 40% of the population voluntarily purchase private insurance for general medical services and the poorer 60% must purchase insurance (contributions are progressively financed as a fixed percentage of incomes) from non-profit insurers (Sickness Funds). The whole population is compulsorily insured for exceptional medical expenses. As far as one is able to measure the success of a system by health outcomes such as mortality rates and incidences of disease, the Netherlands has outperformed all the other countries under study. The Netherlands does spend a slightly higher amount on health as a percentage of GDP than would be expected from its level of GDP relative to other OECD countries but significantly less than the U.S. and less than the single-payer system of Canada. A 1990 publication reported that the Dutch were generally satisfied with their health care system and certainly are more satisfied than the citizens in the U.S., the U.K., and (one would strongly suspect although there is only anecdotal evidence) New Zealand.\footnote{R. J. Blendon \textit{et al.}, “Satisfaction With Health Systems In Ten Nations” (1990) Health Affairs 185 looked at the level of public satisfaction within ten different countries’ health care systems found that between 41% and 47% of the Dutch population were satisfied with their health care system. This result was below the 56% of the Canadian population who, of all nations, were the most satisfied with their health system, but significantly above the 27% of the U.K. population, and the 10% of the U.S. population reporting themselves to be satisfied. This 1990 publication did not report on the New Zealand health system but the barrage of negative media reports coming from that country would suggest that New Zealanders are not happy with their health care system.} A 1996 study of the European Union found that 14.2% of the Dutch population were very satisfied and 58.6% were fairly satisfied with “the way health care runs in the Netherlands.” By comparison, 7.6% of U.K. citizens were very satisfied and 40.5% were fairly satisfied with “the way health care runs in the U.K.”\footnote{E. Mossialos, “Citizens’ Views on Health Care Systems in the 15 Member States of the European Union” (1997) 6 Health Economics 109 at 111, Table 1.} It is also notable the Netherlands ensures access to a comprehensive range of health care services including prescription medication, home care, and long term care which may not be covered in
those countries with a greater degree of public funding. The Dutch system is of course not without its problems and one of the problems has been reductions in access as a result of risk-rating on the part of private insurers which has resulted in the need for government regulation and which in part inspired the Dekker managed competition proposals.

There are some who bring to bear fire and brimstone rhetoric against market or competition oriented reforms. One must, however, be careful to identify demons correctly. From the perspective of distributive justice what is important is that the system is financed largely progressively with contributions being based on ability to pay rather than need for the health services and it is true this is usually achieved through public rather than private financing. The problem is not directly private insurance or the existence of private insurers but more particularly the fact that private insurers compete for profits by seeking to identify high-risk people and either excluding them completely or charging them higher premiums than they can afford. The managed competition model seeks to change the paradigm for competition by ensuring first that the system is largely progressively funded and then fostering competition between private insurers on price and quality dimensions and regulating and monitoring to prevent competition on risk identification and risk exclusion.

Single-Payer Systems

The U.K. and New Zealand systems are often described as "single-payer" systems as the majority of health expenditures are paid for by the government. This term is somewhat misleading for even in systems like the U.K. and New Zealand there is a mixture of public and private financing with different proportions being apparent in different health service markets. New Zealand does not perform particularly well with respect to access and health outcomes because of its high reliance on private financing of primary care services and, in particular, patient financing of those services. Those entitled to government subsidies have only approximately half of the cost paid whereas those who are able to afford top-up private insurance generally have between 80–100% of these costs paid. The fact that the actual amount paid for by the private sector as a percentage of total expenditures is small (as the "big ticket" items are all publicly funded) means that commentators often overlook the significance of private spending in New Zealand. Thus New Zealand is typically portrayed as a system ensuring universal access but the question glossed over is universal access to what? In reality, even though as a system the Netherlands relies to a greater degree on private insurance than New Zealand it ensures better access to health services to the people who need them the most.

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615 See for example, R. G. Evans, supra note 8.
by not imposing user charges for general practitioner services on the poorer 60% of the population compulsorily insured. Thus, from the perspective of distributive justice, the Netherlands’ system is a better system than the New Zealand system despite its overall greater reliance on private insurance and private financing. The importance of private insurance financing has been growing steadily in both New Zealand and the U.K. People buy private insurance as a means of avoiding the effects of growing waiting lists and times for elective surgery that are characteristic of a tightly-controlled public system.

It is often argued that single payer systems are better able to contain costs. From an examination of the four countries under study this would seem to be true as New Zealand and the U.K. each spend less on health as a percentage of GDP than the Netherlands and the U.S.616 However, not all single-payer systems spend less than pluraly financed systems. Health expenditures as a percentage of GDP in the single payer system of Canada have been consistently high. Notwithstanding, it seems fairly clear that a government in a single payer system has monopsony purchasing power with which it may choose (if it wishes and is able to suppress opposed interest groups) to control total health expenditures in a way that is not possible in a system that relies to a significant degree on unregulated private finance. However, the costs of rationing by waiting lists and long waiting times are not factored into aggregate figures for health expenditures and thus simply comparing reported percentages of GDP spent on health services may result in an exaggerated perception of the ability of systems like the U.K. and New Zealand systems to control costs. As evidence for this, for a short period post internal market reform in New Zealand, responsibility for purchasing health services on behalf of accident patients was transferred from the no-fault accident compensation authority to Health Authorities. Subsequently, accident patients were forced to queue with sickness and disability patients in the public sector rather than having private services brought for them. As a result, the income maintenance costs incurred by the no-fault compensation system sky-rocketed as accident victims languished on waiting lists for months. Eventually, purchasing responsibility was transferred back to the accident compensation authority so that they could purchase more timely services in the private sector. Thus when a public body has to incur some of the lost earnings resulting from lengthy waiting lists and times then they will not be tolerated.

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616See the statistics provided by Schieber et al., supra note 427 at 121, Exhibit 1 and Saltman & Von Otter, supra note 6 at 5 who note that Northern European countries (which have top-down planning model) have required fewer financial resources than countries with mixed public/private or pluraly financed health systems (such as Germany, France, the Netherlands or the U.S.) despite (with the exception of the U.K.) an equivalent growth in per capita income and national wealth.
The fact that one health care system spends less on health care than another cannot mean that it is necessarily a better system or a more efficient system. Taking to its extreme this would mean that Turkey, which has the lowest level of expenditures amongst OECD countries, is the most efficient system in the OECD. However, it seems almost impossible to determine, whether a country's particular level of health expenditures is close to a point of allocative efficiency in terms of the amount spent on health relative to, say, education or defence or telecommunications as many value and political judgements are involved in the absence of price signals regarding what public services people value highly. There is also great difficulty in measuring whether any particular system is providing value for money in terms of the health services supplied or health outcomes achieved. As McGuire and Anand note, "the choice of health care systems should be guided by empirical data but this is rarely the case because of the lack of empirical data and the difficulties of testing one system against the other given that each system is a product of its own historical and cultural setting."

**Comprehensiveness and Integration**

Comprehensiveness and integration have been recognized as the key features of an efficient health care system. The problems of a lack of comprehensiveness in financing are clearly apparent in the U.S. system which has historically been a merry-go-round of shifting costs as health providers pass on costs to insurers who pass on costs to employers who pass on costs to the government (through the tax subsidy) and to their employees (through lower wages) who in turn believe that the costs are being fully borne by employers. Health providers who provide charity care or who receive lower prices for caring for Medicaid patients pass on part or all of the cost of these services on to other privately insured patients.

With respect to comprehensiveness in terms of financing, all systems under study have had different financing regimes for different health services, often making a distinction between sickness and disability services and between general practitioner services, specialist services, and hospital services. This has proved problematic as it enabled cost-shifting from sector to sector and meant that there was little ability to make effective substitution decisions between different types of care. Looking across a number of health systems, irrespective of the

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617 It has been argued in the U.K. that the health sector has been underfunded for many years — see generally A. Towse, *Financing Health Care In The UK: A Discussion Of NERA’s Prototype Model To Replace The NHS* (London: Office Of Health Economics, 1995) and J. Dixon, A. Harrison, & B. New. "Is the NHS Underfunded?" (1997) 314 BMJ 58.


619 The Health Care Study Group notes that a genuine universal system is an invitation to strategic thinking about the needs and institutions of an entire society and such a system is better able to control costs as it limits cost shifting — see the Health Care Study Group Report, *supra* note 41 at 501.
proportion of public and private financing, the rule of thumb would seem to be that where costs can be shifted, be it from payer to payer or from payer to provider or to patients or to society at large, then they will be. In order to foster cost-effective decision-making, financing of health care should cover an comprehensive range of health services to allow effective substitution by decision-makers.

As part of internal market reform the new purchasing authorities in the U.K. and New Zealand are responsible for funding a comprehensive range of health services including hospital and physician services and in New Zealand they are also responsible for funding disability services. These initiatives are clearly a positive step. The Dutch Sickness Funds (the non-profit insurers that cover the poorer 60% of the population) have always been responsible for funding hospital and physician services. As part of managed competition reform proposals it was proposed to make Sickness Funds and private insurers not only responsible for coverage for all general medical services but also the services covered under the compulsory Exceptional Medical Expenses scheme (long term care); however this proposal was dropped because of concern of how to fairly finance insurers for providing this coverage.

Cost-Containment Initiatives

Throughout the 1980s many OECD countries sought to control total health expenditures by regulating the number of "inputs" into the system, i.e., the numbers of physicians and other health providers, the number of hospital beds, and the distribution of technology. For example, despite the push to more competitive arrangements, the Dutch government has continued to encourage the cutback of training capacity of physicians and the consolidation of hospitals. The policy of reducing the resources invested in a health system is based upon the assumption that the more hospitals, health care providers, and technology in a system of full insurance, the greater the increase in cost, irrespective of needs or outcomes. Such measures, coupled with prospective budgets for hospitals and/or physicians and capped government expenditures, proved successful at containing the percentage of GDP spent on

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621 See the OECD 1994 Review of Seventeen Countries, supra note 1 at 27.
622 Schut, Greenberg, & Van De Ven, supra note 374 at 263.
623 It is believed that in the absence of supply side controls, the combination of full insurance and information asymmetry between health providers and patients will result in increasing health expenditures with diminishing marginal returns in terms of health outcomes. In other words, health providers can (and sometimes will) influence demand for their own services and may recommend to patients they receive health services that are not cost-effective. Patients have neither the financial incentive nor the knowledge to prevent this. This hypothesis is not without controversy -- see R. Labelle, G. Stoddart, & T. Rice, "A Re-examination of the Meaning and Importance of Supplier-Induced Demand" (1994) 13 Jnl. of Health Economics 347 and the discussion in Chapter 1.
health services in a number of jurisdictions\textsuperscript{624} but has not necessarily improved cost-
effectiveness.

A popular initiative in many countries has been to close and/or consolidate hospitals with a 
view to reaping efficiencies from economies of scale and specialization and with a view to 
shifting resources from expensive acute care to primary and preventive care and home care. It 
is of interest to note, however, that countries such as the U.S. and Canada, who expend the 
highest level of GDP on health care, do not have a high ratio of acute beds relative to other 
OECD countries. Moreover, it is unclear whether or not a shift to primary and preventive care 
and home care will be in fact cost-effective and, as Klein notes, such policy appears to be 
driven largely by faith rather than evidence.\textsuperscript{625} The U.K. and New Zealand systems are what 
are known as “command-and-control systems” as the government is not only heavily involved 
in financing health care but also in the delivery of hospital services. Having direct control of 
hospitals in these countries may have made it easier for government to decommission hospitals 
and reduce funding than in a system composed of private hospitals.

Evidence of Cost-Effectiveness
There is growing awareness that there is little evidence for the clinical cost-effectiveness of 
many health care services. Culyer notes that the greatest source of inefficiency in all health 
systems is the production of health services that are inappropriate, ineffective or not cost-
effective.\textsuperscript{626} Why has this been the case? Historically, in the health care systems of most 
developed countries, public and private insurers have not actively purchased services but have 
either passively reimbursed providers on an unrestricted fee-for-service basis or indemnified 
patients for their health care costs.\textsuperscript{627} Patients have had no incentive to consider the cost of 
health services their physician recommends due to the moral hazard associated with third-party 
financing (be it from public or private insurance). Even when patients did have an incentive to 
consider costs through the imposition of user charges or deductibles, they likely did not have 
the information or expertise to ration effectively their own utilization. This would suggest, 
perhaps, that health expenditures in most countries could be significantly cut without

\textsuperscript{624}See OECD 1994 Review of Seventeen Countries, supra note 1 at 37–39. Of 24 OECD countries, only Canada, 
Finland, Greece, Iceland, Italy and Norway had more rapid rates of growth in the 1980s than in the 1970s.
\textsuperscript{626}A. J. Culyer, “Chisels Or Screwdrivers? A Critique Of The NERA Proposals For The Reform Of The NHS” in 
Towse, ed., supra note 617 at 28.
\textsuperscript{627}J. C. Dechene, “Preferred Provider Organization Structures and Agreements” (1995) 4 Annals Of Health Law 35 
notes that the fundamental flaw in traditional indemnity insurance is the absence of an agreement between the 
entities responsible for payment and the providers of services, with the goal of limiting costs.
compromising health care. However, a lack of sensitivity on the part of physicians to the costs and benefits of health services supplied or recommended seems to be a general problem in all systems even those which have tightly controlled the resources available to the system. The experience of the U.K. and New Zealand suggests that simply restricting the flow of resources into the system and leaving allocation decisions to health providers operating on hard budgets will result in growing waiting lists and times and in growing dissatisfaction with the health system and also in costs being shifted to where budgets are softer. In other words, simply tightening budgets may not result in better allocation decision but more adroitness in cost-shifting to other payers or on to patients or society at large. Capping health care expenditures can only be a short-term answer. In the longer term, a system must focus (at the meso level) on the decision-making process whereby health needs are prioritized so as to balance societal interest with patients' interests and (at the micro level) selection of the most cost-effective service to satisfy a particular health need and the technically efficient production of services.

An important caveat that I will note at this point and discuss again in subsequent chapters, is that there is a danger in relying too heavily on the fact that there is not significant evidence of the cost-effectiveness of many health services. This is because the effectiveness of many important health services may be very difficult to measure. As a society we value very highly the supply of particular health care services that cannot be readily measured in terms of outcomes such as the supply of palliative care and the care of vulnerable populations such as the mentally and physically handicapped. Thus only focusing on the easily measurable will not result in a health system that a society wants. Moreover, it may be difficult to establish the cost-effectiveness of some primary and preventive services which common sense dictates will be of benefit to society. The benefits of primary and preventive care may not be realized for many years and it may be difficult because of the time-frame involved to identify a causal link between a resulting health benefit and the primary and preventive care provided.

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628 R. G. Evans, supra note 8 at 460 notes that students of health care system believe that there is "a great deal of inappropriate, unnecessary, and sometimes downright harmful care being paid for in all modern health care systems." He goes on to note that the key question becomes one of moving closer to production frontiers.

629 So, for example, resulting in growth in expenditures in areas that are more heavily privately financed such as drug coverage.

630 For a similar view see Klein, supra note 625.
The Shift to Proactive Purchasing

The problem of passive third-party payers (public or private insurers) has been a problem in all countries under discussion. There has been insufficient pressure on the demand side to ensure optimal decision-making on the part of health providers. Recent years have seen the growth of managed care plans in the U.S. stimulated by both government and private initiatives. Managed care plans seek to reverse the historical arrangements of passive payers reimbursing on a fee-for-service basis. Rather, insurers become proactive purchasers. As managed care plans have grown as a competitive force, traditional insurers have taken steps to contain their own costs, thus reducing the ability of providers to cost shift. Whether or not managed care can, in the long term, control escalating expenditure, is a matter for debate. It is important to note that managed care developments in the U.S. are ad hoc and are not part of a comprehensive, integrated, and progressively financed health system.

Internal market reform and managed competition reform both seek to provide a comprehensive progressively financed health system that seeks to achieve efficiency gains through proactive purchasing, the theory being that this will provoke an efficient supply side response. The concept of a proactive purchaser is a significant development from the historical role of government and private purchasers as passive “indemnity insurers”, reimbursing either provider or patient for all costs incurred on the assumption that no care is supplied or consumed that is not “needed.” The transition from passive indemnity insurer to prospective block budgets for hospitals to proactive purchasing of all health services is depicted in the table in Appendix 5.

In subsequent chapters, I will analyze and compare the managed competition model and the internal market model. Both of these models meet the general requirements that White described of being progressively financed, ensuring universal coverage and covering a comprehensive range of benefits. The test is the degree to which these models over time ensure optimal decision-making from the perspective of prioritizing needs in health care, choosing the most cost-effective service to address a particular need, and ensuring the technically efficient production of services.

It has proven insufficient in the U.K. and New Zealand to accrue market power on the demand side and to reduce the inputs into their respective systems. Purchasers need incentives in order to be proactive purchasers of health services and to make optimal decisions. Thus general issues of governance have long been overlooked in health systems as the focus has historically
been on third-party payers passively financing the supplier of health care services and there was no purchasing or demand side tension. Once we determine there is a need for a purchasing role, then governance issues become critical. These issues are addressed in the context of the accountability and responsiveness of purchasers in Chapter 4. The purchaser/provider split is key to internal market reforms effected both in the United Kingdom and New Zealand and this results in the elimination of vertical integration between purchasers and providers. However, managed competition reform, as proposed in the Netherlands and the United States, relies on managed care plans to achieve cost-savings and these plans allow vertical integration between insurers/ purchasers and providers as the goal is to actively influence providers’ decision-making. Thus, while at one level all four countries are embracing competition-oriented reforms, the nature of reforms effected reveals a key divergence in approach. The implications of these different approaches are dealt with in Chapter 5. In Chapter 6, I address the issue of monopoly on the supply side and how this problem can be ameliorated from the perspective of proactive purchasers. Finally, in Chapter 7, I address issues of quality, both from a societal perspective and from patients’ perspectives, and mechanisms that can be used to ensure that an appropriate balance is achieved between equity and efficiency.
Chapter 4: Accountability Of Health Service Purchasers: Comparing Internal Markets And Managed Competition

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4.1 Introduction

In this chapter I analyze and compare internal market and managed competition reform from the perspective of the accountability of purchasers (be they government-appointed monopolies or competing private insurers) to the citizens they ultimately represent.

Enhancing accountability was cited as a goal of internal market reform of the former command-and-control systems of the U.K. and New Zealand. Specifically, Kirkman-Liff notes that the philosophical intent of the internal market reforms seems to have been to increase the accountability of the various public institutions responsible for the health allocation system.

Improving accountability should improve the quality of decision-making by reducing agency costs between decision-makers and the public she/he represents. Donahue argues that concerns with efficiency are, at their base, merely part of concern for the more fundamental quality of accountability. What is the scope of "accountability"? In the health sector it is possible to identify at least three spheres of accountability: political, market, and professional. This thesis is primarily concerned with ensuring accountability through political and market mechanisms although reference is made to professional accountability and this is further developed in Chapter 7 in the context of ensuring the quality of health services supplied. In this chapter I will:

1. argue that a series of difficult agency questions and public choice problems arises with respect to the accountability of government-appointed purchasers in the U.K. and New Zealand and there are not the incentives in place necessary to ensure that government-appointed purchasers are responsive to the citizens they represent;
2. evaluate the prospects for the use of political "voice" by citizens as a means of reducing agency costs between citizens and the government-appointed purchasers that represent them; and
3. canvass the advantages and disadvantages of some of the possible means of enhancing voice and the limits of voice as an accountability and efficiency enhancing mechanism.

In addition to political voice, I examine "exit", a market mechanism, as a means of improving accountability. In managed competition proposals in the Netherlands and the U.S., consumer choice of insurers in a regulated market is viewed as the means through which to ensure

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631 The White Paper outlining internal market reform of the U.K.'s health system said the two objectives of reform were to give patients better health care and to provide greater rewards for those working in the National Health Service ("NHS") who "successfully respond to local needs and preferences" (Department of Health, Working for Patients, Cm855 (London: HMSO, 1989). Similarly, in introducing his health reform proposals in 1993, New Zealand's then Minister of Health declared that there were three reasons to support the Bill, the first being that it would greatly improve upon the accountability of the public health system (Hansard Reports, 20 August 1993, 10773).
632 Kirkman-Liff, supra note 333 at 207.
accountability and efficiency. Citizens must choose an insurer/purchaser offering a managed care plan that best suits their needs and, should they become dissatisfied, may “exit” to another insurer/purchaser with a risk-adjusted share of public funding. I will discuss the relative costs and benefits of exit as a means of reducing agency costs and ensuring accountability.

As I will discuss, although managed competition and internal market models are prima facie different there is a convergence as internal market systems move towards managed care arrangements. Government appointed purchasers and private insurers in all systems may wish to shift financial risk to groups of health providers offering managed care plans. They shift risk by paying groups of providers on a capitated basis.635 In such a case, the managed care plan takes on the insurance function as it bears the costs and risk of utilization of services by patients, the purchaser function as it largely determines what range and mix of health services to supply to any individual it covers, and (at its discretion) the provider function if it actually owns the hospitals or employs the providers who provide services to patients. Consequently, the roles of the public and private sectors and of insurers, purchasers, and providers in all systems are shifting, changing, and becoming less compartmentalized.636

4.2 Accountability, Agency, and Public Choice
Improving accountability is often cited as a goal of health care reform yet it is often unclear what exactly is meant by accountability in terms of to whom and for what a decision-maker is accountable for.

In the political sphere, Donahue defines accountability as being where “government action accords with the will of the people the government represents -- not the will of individuals who happen to work in the government and not what those individuals think the citizens should want but what the people, by their own criteria, count desirable.”637 Thus, accountability may also be described as the level of responsiveness by public institutions to their citizenry. The question that arises is the level of agency costs existing between citizens and their elected representatives. Donahue argues that the question of agency engages the root social challenge of accountability and devices such as the law, ethics, and the market may all be utilized with a view to ameliorating the problem.638

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635 A lump sum per person to cover all health services needed by that person regardless of how many services in reality that person needs.
637 Donahue, supra note 633 at 23.
638 ibid. at 10.
Trebilcock notes that agency costs are said to occur when one person or organization (the principal) contracts with another person or organization (the agent) for performance of a service and the performance requires the delegation of some decision-making authority from the principal to the agent, but the agent’s interests do not perfectly coincide with those of the principal’s.639 Factors reducing agency costs between shareholders and managers in publicly-traded companies are not generally present in the public sector.640 Consequently, agency problems are a great deal more complicated in the public sector than within private firms. In particular, citizens have little incentive to band together into more powerful lobby groups because their own personal share of the public sector’s inefficiency is very small and individuals may decline to take any initiatives to lobby for improvement in the expectation that they can free ride upon the efforts of others.641 In contrast, members of interest groups who personally have much to gain from a particular government decision will have a greater incentive to lobby the government but any resultant policy change may not reflect the more diffused interest of the public at large.

Agency cost problems are closely related to public choice analysis.642 Proponents of public choice analysis are sceptical of the benefits of government and public administration. McAuslan argues they are, in fact, contemptuous of democracy as it has developed in the twentieth century.643 Buchanan notes that public choice is “a perspective that emerges from an extensive application of the tools and methods of the economist to collective or non-market decision making.”644 The theory extends the assumption, made by neo-classical economists, that actors in the private market are principally motivated by self-interest to the actions of politicians, public servants, and interest groups in the public sphere. Although many examples of behaviour

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639 Trebilcock, supra note 13 at 8.
640 In publicly traded firms Fama identifies three factors that help reduce agency costs as between shareholders and managers: competition in the market for managers including a preference for hiring managers from firms that have performed well in the stock market; tying managers’ salaries to stock performance; and competition between firms in their output markets resulting in managers striving towards efficient performance to reduce the chance of their firm’s insolvency or of being vulnerable to takeover and consequential job loss (the market for corporate control) — E. Fama, “Agency Problems and the Theory of the Firm” (1980) 88 Journal of Political Economy 288 at 291–293.
641 Donahue, supra note 633 at 49–51.
supporting public choice theory can be found in the literature, examples of governments and public servants not acting out of self-interest (or at least appearing not to) may also be found. This suggests that public decision-makers cannot always be simply assumed to be acting out of self-interest or that what decision-makers perceive as being in their own self-interest may be much more than responding to financial incentives or maintaining or building political power. A sense of public spirit, the law, ethics, culture, moral and social conventions, a desire to embrace good ideas and policy, and ideology likely impact on public servants' psyches to a greater or lesser degree, just as they do for everyone else.

Pragmatically, widespread disenchantment on the part of those on the left and the right of the political spectrum with government’s performance suggests that public choice problems cannot be ignored when considering the design of a health allocation system. Balancing the views of both the proponents and critics of public choice, it seems important that there should be, wherever possible, clear financial and political incentives for politicians and public servants to act in the larger public interest. This does not mean that public provision or regulation of markets will be an inferior alternative to an unregulated market (it will depend on the market) nor that a sense of public spirit on the part of public servants should not be fostered. Whether or not they will do so naturally, politicians and public servants must pursue the greater public good and therefore incentives and checks need to be built into the system to ensure that this occurs and to integrate the interests of the general public (the principal) with that of politicians and public servants (the agents). Where discretion is granted (as inevitably it must be), decision-making should be as transparent and open as possible to negate any propensity to log-roll, vote-buy, and to build empires.

How do we operationalize these general observations in a health allocation system? On the demand side, what combination of incentives will solve the difficult agency problem of ensuring that purchasers balance society’s interests with that of individual patients? Let us begin by looking at the question of to whom and for what the government-appointed purchasers in the

645In the health sector, McAuslan gives the example of senior consultants in the U.K.'s National Health Service awarding themselves publicly-funded merit awards – McAuslan, supra note 643 at 689.
646For example, the notion that politicians are only interested in expanding their own political empires does not rest well with the phenomenon in all industrialized countries where governments across the political spectrum have actively tried to either down-size or privatize public organizations. Clearly, ideas (or at least ideology) have some currency here.
647G. Brennan & J. M. Buchanan, “Is Public Choice Immoral? The Case For The ‘Noble’ Lie” (1988) 74 Virginia Law Review 179 at 187–88 argue that public choice theory becomes problematic when it is used in the positive sense as a predictive model of behaviour in political roles. They argue that the proper role of public choice theory should be in the normative sense of institutional reform, meaning improvements in the rules under which political processes operate.
U.K.'s and New Zealand's reformed health systems are accountable to. Several agency questions arise in these jurisdictions: the question of agency costs between citizens and the government-appointed purchasers; between citizens and the government; and between the government and its own appointed purchasers. A dual agency problem arises in this latter case as, ultimately, the principal in this agency relationship is still the general public, with central government acting on behalf of the public in regulating and monitoring the relevant purchaser's performance.

4.3 The Lines Of Accountability
The important areas of responsibility in health service allocation would seem to be as follows:

a. determining the most allocatively efficient level of resources to be devoted to health services which requires balancing expenditures on health services against other areas and requires recognition that, e.g., improved housing, nutrition, and increased employment opportunities may have an important effect on health outcomes as the consumption of health services;\(^{648}\)

b. satisfying equity or justice in terms of access to health services but otherwise determining priorities for treatment of health needs on the basis of cost-effectiveness;

c. choosing the most cost-effective services or treatments to serve patients' needs;

d. ensuring the technically efficient production of services;

e. ensuring that the quality of services provided is adequate and meets society's expectations;

f. ensuring that providers are sensitive to patients' concerns and that patients' circumstances, values, and attitudes to risk are factored into the decision-making processes at the point of supply.

To an extent these accountability requirements will conflict and thus a balance must be struck between what is in society's interests and patients' interests and more broadly between equity and efficiency. As discussed below, the lines of accountability drawn in the U.K.'s and New Zealand's reformed systems are too often blurred and there is confusion as to who among central government, purchasers, and providers is ultimately responsible for realization of these goals. Where goals are clearly specified there are often not matching incentives to ensure the realization of those goals.

As the U.K. and New Zealand systems are both financed primarily through general taxation revenues it is effectively central government's responsibility to determine the allocatively efficient level of resources to devote to health services i.e. they must decide on behalf of the public at large how much to spend on health service relative to, for example, education, defence,

\(^{648}\)See generally Evans, Barer, & Marmor (eds.), supra note 174.
and tax breaks. There is no obvious reason to suppose that the government will be able to
determine what is an efficient level to spend on health services although, of course, there is the
prospect that resources will be distributed more fairly than in an unregulated private market.
Managed competition proposals provide more promise for determining an allocatively efficient
level of resources by restructuring and regulating the market for private health insurance and
allowing competition between private insurers to determine the total level of resources to be
spent on health. However, in those countries that have proposed or implemented managed
competition, priority has been given to containing total costs rather than letting the workings of a
managed market determine the most efficient amount in total to spend on health care.649
President Clinton’s (now defunct) proposal for reform did not leave cost-control to the workings
of a regulated market and instead stipulated that managed competition take place under a global
budget.650 In the Netherlands, despite the partial implementation of managed competition, there
has been a marked reluctance to dismantle complex price and capital regulation designed to keep
a check on total health care expenditures.651 It is unclear whether this reluctance to dismantle
price and total budget caps is because the administration of these respective countries do not
really believe that managed competition will work as theoretically envisaged or whether because
the overriding concern is to control increases in government expenditures even although such
increases may be (possibly) allocatively efficient.

Once central government has determined its annual health budget then in the U.K. and New
Zealand these funds are paid to the various government-appointed purchasers. Upon payment
from central government, the onus is then essentially upon the purchaser to purchase primary and
secondary health care services to benefit the people they represent within the budget allocated to
them.652 In contracting for health services, these government-appointed purchasers are expected
to fulfil a complex matrix of responsibilities within a fixed budget. How do we ensure that
purchasers perform their functions efficiently and exercise their discretion in the interests of the
people they represent?

In the U.K., the Audit Commission is required to audit the activities of Health Authorities.653
Longley notes, however, that there are no constitutional mechanisms for ensuring that the

649 For a discussion see W. P. M. M. van de Ven, “Regulated Competition In Health Care: With Or Without A Global
650 Clinton Blueprint, supra note 24 at 102-110.
652 It should be noted that in New Zealand significant user charges apply for general practitioner, drugs, and outpatient
services and in the U.K. user charges apply to drugs.
653 NHS 1990 Act, supra note 15, s.20.
deliberations of the Commission and similar bodies are taken into account and acted upon by government.\textsuperscript{654} In New Zealand, the Audit Office audits annually the Regional Health Authorities which must comply with the requirements of the \textit{Public Finance Act}.\textsuperscript{655} These sorts of measures ensure a degree of accountability by reducing opportunities for fraudulent use of public moneys, but further incentives are required to ensure that purchasers are accountable in the fullest sense to the people they represent.

An initial step towards improving accountability is to clearly specify the goals and objectives of purchasers, both in governing legislation and in transparent management contracts. This should facilitate monitoring by central government of purchasers’ performance relative to those objectives. Moreover, if purchasers’ objectives are clearly and publicly articulated then it is difficult for the purchasers and for central government (as their political masters) to recant from the goals underlying these responsibilities in pursuit of their own self-interest due to the potential for adverse publicity. The difficult question is what objectives and responsibilities should be specified and what weight should be accorded to each.

In the U.K., the Health Authorities are required to implement directions received from the Secretary of State with respect to the exercise of their functions under the \textit{National Health Service and Community Care Act} and with respect to the application of government moneys.\textsuperscript{656} Apart from directions with respect to special hospitals and the establishment of Community Health Councils (which must be incorporated in regulations), there does not appear to be a legislative requirement that these directions be publicized.\textsuperscript{657} A “Code of Accountability” is intended to serve as an informal contract between central government and the Health Authorities, but the Code does not create any statutory duties.\textsuperscript{658} New Zealand’s Regional Health Authorities’ statutory objectives are couched in general terms, but they are specifically required to meet the Crown’s objectives as notified to them.\textsuperscript{659} Every such notification is required to be published in the Gazette and tabled in the House of Representatives.\textsuperscript{660}

Both in New Zealand and the U.K. central government publishes annual guidelines setting out the purchasers’ objectives in general terms. The U.K. government issues in June of each year a

\textsuperscript{655}(N.Z.), 1989, No. 142.
\textsuperscript{656}\textit{NHS 1990 Act, supra} note 15, s.17 & s. 97 (7) (as amended by the \textit{Health Authorities Act, supra} note 705, s. 47.)
\textsuperscript{657}\textit{Ibid.}, s.18.
\textsuperscript{659}\textit{NZ Health 1993 Act, supra} note 17. s.10.
\textsuperscript{660}\textit{Ibid.}, s.8(5).
policy document informing the Health Authorities of their purchasing intentions for the following year. For the 1997/98 year there are three sets of objectives: long term objectives and policies; medium term priorities and objectives for the 1997/98 year; and baseline requirements and objectives for 1997/98 year. In the longer term, performance will be assessed under three headings: equity, efficiency, and responsiveness. The New Zealand government publishes in November of each year a policy document that specifies the government's goals and objectives for the health system. These guidelines are used by the Regional Health Authorities to help them formulate their annual plans and to negotiate funding agreements with central government. In the 1996/97 policy document government set out six principles to provide a framework for purchasing decisions: equity, effectiveness, efficiency, safety, acceptability, and risk management. Somewhat more detailed objectives were specified within those general principles. For example, in terms of acceptability, purchasers are required to (amongst other things) improve people's choice and satisfaction and preserve personal dignity and privacy, involve, inform, and consult people and communities, and improve the responsiveness of services to people's diverse needs, preferences and cultural values.

It is not, however, sufficient to simply fix goals and objectives -- the attainment thereof must be monitored. Propper notes that monitoring efforts in the U.K. are concentrated on a small set of dimensions of output: annual growth in activity, waiting times, and targets for improvements in the health of certain groups of the population. Thus, Propper argues, the Health Authorities will focus their efforts on those aspects of performance being monitored and not others. The New Zealand government is attempting to develop performance indicators to gauge how well

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662 Six medium term priorities were set for the 1997/98 year: working towards developing a primary care led system; to review and maintain progress on the effective purchasing and provision of comprehensive mental health services; improving the clinical and cost effectiveness of services; giving greater voice and influence to users; ensuring that integrated services are in place to meet the continuing health care needs of the elderly, disabled, vulnerable people, and children; and encouraging public organizations to be good employers. Baseline requirements and objectives set include: the attainment of specific goals relating to the reduction of the incidence of coronary heart disease, stroke, cancers, suicide, gonorrhoea, and accidents and the attainment of specific targets for waiting times for health services. - ibid. at 11–21
664 As an example, in terms of equity, the Regional Health Authorities are required to "improve access...to health and disability services in terms of waiting times, geographical accessibility, and affordability" and give "relatively greater weighting to health gain for those people with lower health status in all population groups, and ... greater weighting to Maori and child health gain": In terms of efficiency, Regional Health Authorities are required (amongst other things), where a choice of effective services for addressing a given health problem exists, to choose the most cost-effective service — ibid. at 11.
665 Idem.
Regional Health Authorities are meeting their objectives. To date, however, the monitoring unit of central government has only been able to describe current utilization patterns and there has yet to be any comprehensive evaluation nor attempted comparison of purchasers' performances. It is significantly easier to focus on and pursue those goals and objectives that are easily measurable, such as increased turnover or reduced waiting lists, rather than those that are defined in a more abstract or general way such as enhancing people's satisfaction with the health system or maintaining and improving the quality of services delivered. Although a balance must be struck between the benefits of monitoring and the transactions costs associated with monitoring, it would seem important that in monitoring performance central government should give weight to a broad range of performance indices and not simply focus its efforts on those that are the easiest to measure.

In addition to setting goals and monitoring the attainment thereof, it is also important to ensure that there are incentives built into management contracts. Allen concludes that the present structure of the U.K. internal market provides no penalties for purchasers that arrange "bad" contracts for supply yet such arrangements will deny patients care in the same way as the alleged inefficiencies of the old command-and-control system. Similarly, in New Zealand, although financial incentives are reportedly included in contracts for managers of the Crown Health Enterprises (government-owned corporations that run the public hospitals), there are no incentives built into contracts for managers of Regional Health Authorities, apart from the prospect of dismissal. The lack of attention to the incentives that influence purchasers is contradictory given that the purchaser's role is crucial to internal market theory, which hinges on astute bargaining by purchasers with competing providers for a variety of health care services. There is also a question of the amount of resources devoted to the purchasing authorities. Due to insufficient investment (in terms of human and capital resources) one manager suggested that the best that can be hoped for on the part of New Zealand Regional Health Authorities is that they will act as a form of passive insurer. This statement is particularly illuminating given that it was intended the Authorities would be anything but passive payers. There is also a question of the skill level of the people who comprise purchasing authorities. Decision-makers need the

667 These objectives include: securing better health; ensuring the acceptability of services; obtaining better and fairer access to services; ensuring that services are better targeted to needs; obtaining more services for money ("efficiency") and minimizing financial risk — see Purchasing For Your Health: A Performance Report On The First Year Of The Regional Health Authorities And Public Health Commission (Ministry of Health: Wellington, 1995) [hereinafter Performance Report] at 10–11.
668 ibid. at 142.
671 Dr. R. Naden, "Contracting To Purchase Health And Disability Services: An RHA Perspective" in Contracting In the Health Sector (Auckland: Legal Research Foundation, 1994) 64 at 66.
incentives, skills and the resources necessary to make decisions over time that strikes the right balance between patients’ needs and societal interest and between equity and efficiency.

Unlike private firm managers, managers within a government-appointed purchaser do not bear the risk of job loss associated with insolvency or takeover of a private firm. Central government could, however, negotiate management contracts that tie salaries of managers to a comprehensive range of performance measures. A further possibility might be for government to request tenders for management contracts.672

The greatest difficulty with all measures designed to enhance management’s performance lies in objectively measuring and comparing performance with respect to purchasing activities. Smith notes, in reality any system of ensuring performance in health care delivery will be incomplete and imprecise and may encourage providers to “concentrate on the quantifiable at the expense of the unquantifiable.”673 As discussed above, the tendency is for central government (and thus purchasers and providers) to focus on those aspects of performance that are easiest to measure. One conceivable means around this problem is to tag graduated bonus payments for each and every element of performance with management being paid more or less depending on how they are perceived as having performed by a monitoring unit within central government. This should help encourage purchasers to compete on those aspects of performance that are more abstract as well as those that are easy to measure.

Despite the most well-crafted of agency arrangements, central government’s propensity to monitor an agency’s performance will be limited as it is itself an agent at this level for the general public and public choice problems arise. Thus, it is important to consider what incentives purchasers have to be directly accountable to the people of the region they represent. Two broad types of incentives, “voice” (political accountability) and “exit” (market accountability) are described further below. Another broad type of incentive is professional accountability. Professional accountability is where self-regulating professions monitor and regulate the behaviour and standards of individuals within the profession to ensure the quality and standards of health services for patients. Professional accountability is undoubtedly an important mechanism and arguably may have protected patients from the worst effects of severe

672Propper, supra note 666 at 1688 speculates about the possibility of introducing franchises for the purchasing role. The problem with this idea is that long-term contracts would likely be required in order for management to develop the skills and knowledge required to manage the purchasing agency effectively, and it may subsequently prove very difficult to replace existing management with incumbency advantages.

and quickly implemented cost cutting initiatives in many jurisdictions. The invisible web of collegiality may be what in fact holds many health care systems together. On the other hand, professional bodies and collegiality within and between health professions may also serve to protect vested interests and maintain the status quo in terms of the distribution of income generated from the supply of health services and the status quo in terms of the range and quality of health services supplied. Some issues of professional accountability are addressed in Chapter 7 of this thesis.

4.4 Hirschman’s Voice and Exit

Albert Hirschman in his celebrated book, *Exit, Voice and Loyalty*, describes how market and political forces can act in tandem as efficiency-enhancing mechanisms in both the public and private sectors. The first concept he describes is that of “exit” which is a means of ensuring the accountability of decision-makers through a competitive market. When a dissatisfied customer shifts custom from one firm to another (exits), the customer not only improves her/his own personal welfare but if there are sufficient other dissatisfied customers then this action in aggregate sends a clear signal to the firm from which customers are exiting that it must remedy inefficiencies or risk insolvency or (if a publicly listed company) a takeover. Exit requires no direct communication between the dissatisfied customer and the firm and may thus be a relatively cheap means for an individual to improve her/his own welfare and, indirectly, overall welfare. Exit cannot work, however, as a mechanism in monopoly markets (apart from consumers electing to abstain from consuming the product or service altogether) and may work less well in oligopolistic markets where there is the risk of collusion. The success of exit as a mechanism also depends upon the assumption that consumers have all the information they need to make efficient choices.

The second concept that Hirschman describes is that of “voice” which is generally associated with ensuring accountability through political processes. Voice is any attempt to change a firm or organization from within rather than trying to avoid the problem by exit. By comparison with exit, voice is “messy”, costly, and its effectiveness is dependent upon “the influence and bargaining power that customers and members can bring to bear within the firm from which they

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674 Evans has made the point for many years that all money that is spent on health services in one form or another results in income for health service providers — *Strained Mercy*, *supra* note 50 at 281 and 17 years later see Evans, *supra* note 8 at 440.


buy or the organizations to which they belong. Unfortunately, those individuals who are most concerned about the quality of an organization's performance and would be most likely to have the political influence necessary to achieve improvement are prima facie also those most likely to exit to another organization when deterioration in quality begins to occur.

It is important to underscore Hirschman's view that there is no prescription for the combination of exit and voice that will be the most efficiency-enhancing. Moreover, over time, as markets and institutions evolve and circumstances change, the appropriate levels of exit and voice will also change. Hirschman also notes that if exit is too easy an option then a crucial number of customers may depart before the firm has had an opportunity to correct its performance, thus resulting in its insolvency and, in some instances, welfare losses. Thus, in some firms and organizations it is important to foster "loyalty" so that individuals will use voice and lobby for improvement and give the organization or firm time to make any necessary adjustments before resorting to exit.

As I will discuss, in internal market systems like New Zealand and the U.K., citizens have no choice as to who acts as their purchaser of publicly-funded health services and thus they rely upon voice to ensure the performance of government-appointed purchasers. The mechanism of voice is, however, diluted by the fact that in both New Zealand and the U.K. there are supplementary private health insurance schemes covering services that are also provided by the public system. There is some opportunity for exit to work as an efficiency enhancing mechanism in the context of the U.K.'s GP Fundholders as, in theory at least, citizens should be able to shift from Fundholder to Fundholder taking with them a risk-adjusted share of public-funding. In managed competition proposals and reforms in the U.S. and Netherlands, exit (in theory) is the primary means by which to ensure the performance of insurers/purchasers offering managed care plans.

678 Ibid. at 40.
679 Ibid. at 51.
680 Ibid. at 124 notes: "[i]t is very unlikely that one could specify a most efficient mix (of exit and voice) that would be stable over time. The reason is simple: each recovery mechanism is itself subject to the forces of decay which have been invoked here all along."
681 Ibid. at 24.
4.5 Voice And Political Accountability

How may voice work to improve the accountability of government-appointed purchasers in the U.K. and New Zealand? Here I will examine five mechanisms to improve voice: devolution, election, consultation, charters of rights and Ombudspersons, and capture of the politically influential.

4.5.1 Devolution

The first question to consider is what opportunities citizens have to influence their purchaser's decision-making processes. In New Zealand there are four Regional Health Authorities, each responsible for populations of between approximately 680,000 and 1 million people. From 1 July 1997 there will be one National purchasing agency responsible for the whole population of 3.6 million. The extent to which purchasing power will actually be consolidated as a result of this most recent reform is perhaps overstated given that four regional offices will remain in place. In the U.K. there are (since 1 April 1996) 100 Health Authorities which are responsible for varying populations ranging from roughly 125,000 up to just over a million, the operations of which are overseen by 8 branches or outposts of the NHS Executive (an agency within the Department of Health).

The large size of New Zealand's Regional Health Authorities and the U.K.'s new Health Authorities will be conducive to rationalizing and co-ordinating the purchase of health services; however, this benefit must be weighed against the difficulty people may experience in having their voice heard by a large and distant administrative body. Conceivably, responsibility for purchasing services could be further devolved in order to improve opportunities for the use of voice. The difficulty is that devolution will result in additional transactions costs and in a diminution of monopsony purchasing power. The degree to which diminution of market power on the demand side will be a problem will depend on the structure of the supply side of the health service market in question. This is likely to be particular problem in areas which are not densely populated in which case the prospects for competition on the supply side either within or for many health markets in many areas seems remote. If the large size of purchasers

683 The 1991 census night population was 3.435 million and the 1996 census population was 3.681 million — Statistics New Zealand, http://www.stats.govt.nz/statsweb.nsf/cc
684 News Release by the Department of Health, 96/106, 1 April 1996. "Changes To Health Service Structure Release £139 Million For Patient Care".
685 In the U.S., several studies have shown that large insurers are able to extract discounts from providers. See, for example, F. A. Sloan & E. R. Becker, "Cross-subsidies And Payment For Hospital Care" (1984) 8 J. Health Politics, Policy, and Law. 660. In those countries where government expenditures accounts for the great majority of total health expenditures, government has been able to use its monopsony purchasing power to control costs — see the Health Care Study Group Report supra note 41.
renders voice ineffective as an accountability-enhancing mechanism yet further devolution is unacceptable because of increased transactions costs and diminution of monopsony power, then nothing would seem to be lost from the further centralization of purchasing power.

The agency problem is complicated by the devolution of responsibility for the purchasing of health services from central government to various regional agencies. The public's attention is fragmented between central government, purchasers, and public and private providers. It thus may be difficult to know to whom complaints and concerns should be addressed and voice is rendered less effective as a mechanism for improving the quality of decision-making. This fragmentation problem is potentially very serious as important areas of responsibility could successfully be avoided by all parties. Thus, somewhat counter-intuitively, voice as a mechanism for enhancing accountability may be aided by the centralization of responsibility for purchasing health services. Possibly it was hoped that delegating responsibility for health allocation decisions to government-appointed purchasers in the U.K. and New Zealand would dilute the political ramifications for central government of hard decisions.686 If this was in fact a goal, it has not been realized for a clear result of the reform process in both countries has been the continued politicization of health allocation issues at the central government level.687 This politicization of the health system is reinforced by central government's seeming inability not to interfere in the operation of both purchasers and providers in both New Zealand and the U.K.688

In the U.K., in addition to the 100 Health Authorities, there are over 3,500 Fundholders, involving around 15,000 general practitioners, who act as purchasers for approximately 50% of the population for a limited range of health services.689 Fundholding is a form of managed care and Fundholders receive a capitated budget with which to buy drugs and approximately 20% of hospital and community services.690 Paying by means of capitation and transferring financial risk to health providers is essentially a way of devolving purchasing responsibility to a local level.

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686 K. Hawkins (ed.), The Uses of Discretion. (Oxford: Clarendon Press, 1992) at 12 notes that "[s]ometimes, of course, law-makers want to remain as silent as possible on controversial or complex matters of public policy; in these circumstances, awards of discretion to legal bureaucracies allow legislatures to duck or fudge hard issues."
687 For example, Culyer & Meads, supra note 532 at 684 note that the absence of locally elected Health Authorities, rather than eliminating politics from the decision-making process, simply transmits the problem to higher levels of government. Similarly, G. Wilson notes that the reformed New Zealand system has not managed to depoliticize decisions in primary or secondary care — G. Wilson "Health Purchasing: A Regional Health Authority Perspective" (1995) 18:1 Public Sector 11. See also Longley, supra note 654 at 123.
688 For examples in New Zealand see Flood supra note 493 at 105, fn 72.
690 See What the Doctor Ordered, supra note 586 at 6. Standard Fundholders do not purchase the following sorts of hospital care: emergency admissions, inpatient mental health, costs above £6000 per annum for any patient, accident and emergency, maternity, and medical inpatients.
Fundholding can be viewed as separate from the purchaser/provider split characteristic of the balance of internal market reforms in the U.K. Fundholders are both purchasers and providers and can substitute, subject to licensing and other speciality regulation, their own services for services they may otherwise purchase from other health providers. By comparison Health Authorities must contract out for the supply of all services.

Given a fixed capitated budget with which to buy services on behalf of patients, the physicians who comprise a Fundholder have a *prima facie* incentive to purchase the most cost-effective mix of services on the part of their patients. One of the positive features of GP Fundholding, as with other forms of managed care, is that it may provide an incentive to provide primary and preventive care so as to keep the Fundholders' enrollees healthy and thus in less need of more expensive acute and institutional services.\textsuperscript{691} The attraction of the Fundholding concept is, in theory, that a patient has a close relationship with his or her physician and thus a physician, acting as a purchaser, is more likely to be responsive to a patients' expressed preferences (voice) within the limitations of the physician's budget. Of course, the larger the number of physicians making up the Fundholding consortium the greater the likelihood that any individual physician will be distanced from management decisions. In theory, if a Fundholder is unresponsive to voice then a patient may exit to another Fundholder or exit to a non-Fundholding general practitioner (in which case the relevant Health Authority would purchase all services). In both cases there would be a consequent loss of income for the Fundholder.

The critical question is whether improvements in the quality of services from a patient's perspective (i.e. shortened waiting times, improved facilities, and greater choice) and from a societal perspective (i.e. better health outcomes in terms of lower incidences of disease, faster recovery and return to work etc.) results in the benefits of Fundholding outweighing the costs. It is of course, very difficult to quantify in monetary terms the value of improvements in service quality in a publicly-financed system. Initially it did appear that Fundholders were achieving improvements in both the quality and range of services purchased for patients. This result may have been, however, only a function of the character of those who initially elected to become Fundholders at the commencement of the reforms. Indeed, increasingly, as the number of Fundholders have grown, the reports on Fundholders' performances are far more mixed.\textsuperscript{692}

\textsuperscript{691}The validity of this proposition is discussed in more detail in Chapter 7.
\textsuperscript{692}See in general *What The Doctor Ordered*, supra note 586.
There is a concern that the rapid growth of Fundholding will diminish the Health Authorities' power to plan and co-ordinate the delivery of services to a large population. Concern has also been raised regarding a perceived lack of accountability of GP Fundholders. Unlike Health Authorities or NHS Trusts, Fundholders are not subject to an annual audit by the Audit Commission. The Audit Commission's 1996 report criticized the lack of monitoring of Fundholders by Health Authorities.

The U.K. government has attempted to respond to these criticisms, however, the difficulty remains that Health Authorities are themselves purchasers and requiring them to regulate Fundholders creates a conflict of interest and blurs the responsibilities of Health Authorities. It would seem more appropriate for the NHS Executive (central government) to directly regulate the activities of both Health Authorities and Fundholders.

Concerns about Fundholders' accountability might be thought to be addressed by the prospect of exit by patients (with a share of public funding) to other Fundholders and to Health Authorities. However, it seems that is it not part of the U.K. patient culture for patients (yet) to readily switch. There is no evidence that patients are moving between Fundholders or from non-Fundholding physicians to Fundholders for reasons other than changing address. The advantages and disadvantages of exit as an accountability-enhancing mechanism are more fully explored in the next section of this chapter. It should be noted, however, that in terms of competition between purchasers, Fundholders have a competitive advantage over Health Authorities for the following reasons:

a. Fundholders do not have to compete (yet) with respect to a full range of services;
b. the budget allocation received by Fundholders is higher than that received by Health Authorities for non-Fundholding patients. The initial enthusiasm that general practitioners have shown for Fundholding may wane if their "generous" cash allowances disappear and they are reimbursed on a risk-rated capitation formula.

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694 See Health Care UK 1994/95, supra note 588 at 4 which notes "GPs are independent contractors: their contracts are broadly drawn, giving them massive scope for exercising discretion in the way they use the resources at their disposal, a discretion which they are currently able to use without being called to account."
695 What The Doctor Ordered, supra note 586 at 63 and generally 64--79.
696 See An Accountability Framework For GP Fundholders (March 1995) as quoted by Longley supra note 654 at 132.
697 Fundholders are accountable to the NHS Executive (through its regional offices) but day-to-day management is normally through the Health Authorities.
c. individuals can only “exit” with their share of public funding to the Health Authority if they can find a general practitioner to enrol with that is not a Fundholder. A bias is created in favour of GP Fundholders as it is impossible for Health Authorities to lure patients back from a Fundholder. Thus competition for patient allegiance can only really exist between Fundholders:

d. Health Authorities often have no alternative but to contract with NHS Trusts for the provisions of most services. NHS Trusts can thus afford to save their best deals for GP Fundholders so as to obtain extra marginal revenue.

4.5.2 Election

One means of improving voice as an accountability mechanism would be for the public to elect the members of the purchasing institutions. Voice is enhanced for the members know that if they are not responsive to their constituents they may well be voted out of power at the next election. The reason often offered for eschewing the possibility of citizens electing the boards of their own purchasers is that government-appointed purchasers will be more independent and this will help to reduce public choice costs. In fact, it is far from clear that devolving responsibility to government-appointed purchasers will reduce public choice problems given that the members thereof rely on the continued support of the government who appointed them to their positions.

Locally-elected purchasers may be more responsive to the exercise by voice of people within the communities they represent and the members thereof may be more representative of the communities they serve. Longley notes that members of the business community are disproportionately over-represented on the U.K.’s government-appointed Health Authorities and that in no sense can it be said that the Authorities are representative of the communities they serve. If Authorities were locally elected, then central government would not have a conflict of interest in regulating and monitoring their performance as they may have with their own appointees. On the other hand, if purchasers were elected, it seems less feasible that central government would be able to impose the types of management contracts described earlier and, consequently, it may be substantially more difficult to build in incentives and disincentives for those elements of performance that are both difficult to monitor and measure. Arguably, the prospect of being voted out of office every few years may be a sufficient incentive for performance, but the problem arises again that the elected officials may endeavour to vindicate

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700 Propper, supra note 666 at 1686 notes that “[t]he nature of competition between the District Health Authorities and GP Fundholders is also one-sided; a good District Health Authority cannot win back patients from a poor GP Fundholder unless the Fundholder chooses to relinquish its purchasing role.”

701 See generally Morone, supra note 305 at 207.

702 Longley, supra note 654 at 116 and 122.
themselves to voters by concentrating on easy-to-measure performance indicators such as turnover and waiting lists. Moreover, the election every few years of members of a purchasing body will still mean that many if not most people will have to rely on members that they may not have voted for and with whose policies they do not agree with as well as the additional problem of citizens being trapped until the next election juncture with a purchasing body that is clearly performing poorly. Thus, simply allowing the election every few years of purchasers could arguably prove too crude a means of ensuring the optimal performance of purchasers.

4.5.3 Consultation

Problems of access by citizens to large government-appointed purchasers may conceivably be overcome by imposing a duty on those purchasers to consult widely with the people they represent.

In the U.K., regulations require Health Authorities to consult with “Community Health Councils” on any proposals which the Authority may have under consideration for any “substantial development” or “substantial variation” in the provision of health services in a particular area. At least half of the members of a Community Health Council are appointed by local government and each relevant local government has one representative thereon. At least one-third of the Council members are appointed by voluntary organizations. Purchaser or provider interests are not permitted to be represented on the Councils. However, each Health Authority must make arrangements to ensure that it receives advice appropriate for enabling it effectively to exercise its statutory functions from “medical practitioners, registered nurses and registered midwives” and “other persons with professional expertise in and experience of health care.”

In New Zealand, each Regional Health Authority is required, in accordance with its statement of intent, to consult “on a regular basis” with “regard to its intentions relating to the purchase of services” with such of the following as the authority considers appropriate: “(a) Individuals and organizations from the communities served by it who receive or provide health services or

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703 There appear to be 207 Community Health Councils in the U.K. — see http://www.ukpc.org/pub/chclist.htm
704 See generally the Community Health Councils Regulations (U.K.) 1996, S. I. 1996/640, s.18. Section 18(3) provides there is no duty to consult where the Authority is satisfied that “in the interest of the health service” a decision has to be taken without allowing time for consultation.
705 However, prior to 1 April 1996, U.K. purchasing agencies were under a wide duty to recognize local advisory committees representing different health professions in the relevant district or region and to consult with these committees — see the Health Authorities Act (U.K.) 1995, c.17, s.4, s.5, & Sch. 6.
706 The National Health Service Act (U.K.), 1977, c.49, s.12(1) as amended by ibid.
disability services: (b) Other persons including voluntary agencies, private agencies, departments of State, and territorial authorities.\footnote{7\textsuperscript{07}}

Currently, legislation in New Zealand and in the U.K. places a similar emphasis on consultation with citizens as it does with health professionals and providers. The policy reason for this is likely the assumption that in a publicly-funded system it is important to obtain the co-operation of health providers, perhaps so that they will be less resistant to foregoing the financial rewards of an unregulated private sector. However, placing the same weight on consulting providers as on consulting the people that the purchasers are meant to represent undermines the role of purchasers as agents for those people. Moreover, as purchasers may be captured by provider groups during the consultation process, the latter obviously having financial stakes in the purchasers' decisions it may be inappropriate to require purchasers to consult providers. This does not mean that purchasers should not consult health providers but rather that greater weight or emphasis should be given to consulting citizens.

Given an unequivocal statutory obligation to consult, a purchaser will be vulnerable to an action for breach of statutory duty if it should then fail to do so.\footnote{7\textsuperscript{08}} There is also the prospect of a judicial review action for breach of a legitimate expectation should a purchaser fail to consult if it has a history of so doing or has otherwise held out that it would.\footnote{7\textsuperscript{09}} In New Zealand it has been stated, \textit{obiter dicta}, that in the absence of fraud, corruption, or bad faith, judicial review actions alleging a failure to consult are unlikely to be successful in reviewing a decision by a Regional Health Authority to enter into a contract for the supply of services.\footnote{7\textsuperscript{10}} Nonetheless, such litigation would be one means by which individuals and organization in the region would be able to exercise voice. It should be noted that, even if successful, judicial review actions are likely to be brought by specific groups or individuals with specific grievances and will not redress (except indirectly) a failure by a purchasing agency to undertake consultative initiatives within the wider community.\footnote{7\textsuperscript{11}} Also, as a mechanism for voice, such actions are a very costly means of ensuring

\footnote{7\textsuperscript{07}} \textit{NZ Health} 1993 Act, supra note 17, s.34.

\footnote{7\textsuperscript{08}} See Flood, supra note 493 at 104.

\footnote{7\textsuperscript{09}} Legitimate or reasonable expectation may arise \textit{(inter alia)} from an express promise or assurance or from the existence of a regular practice which the claimant can expect to continue: \textit{Council of Civil Service Unions v Minister for the Civil Service} [1985] AC 374; \textit{Attorney-General for the State of New South Wales v Quin} (1990) 170 CLR 1.


\footnote{7\textsuperscript{11}} For example, in \textit{New Zealand Private Hospitals}, \textit{ibid.}, the plaintiffs (being representative of the private hospital continuing care industry within the region) successfully challenged the Regional Health Authority's tendering process for contracts for the supply of long-term care on the grounds that the Authority did not adequately consult with the plaintiffs in accordance with Section 34.
accountability. On the other hand, arguably, the prospect of the costs and adverse publicity of a judicial review action and/or a few successful cases brought against purchasers may be enough to induce agencies to take seriously their general duty to consult widely.

4.5.4 Charters of Rights and Ombudspersons

Another means of enhancing voice is to stipulate at a central level what people can expect of their purchasers and increase the amount of information that patients and public receive regarding purchasers’ and providers’ performances. Establishment of an independent Ombudsperson also provides a forum for people to voice their concerns.

In the U.K., the Patients’ Charter sets out the national standards regarding what patients can expect in terms of access and treatment from the publicly-financed system. At the regional level, Health Authorities and NHS Trusts (which manage the public hospitals) are encouraged to negotiate even higher standards and every year Health Authorities publish an annual report on each hospital’s performance on Charter standards. The Patients’ Charter, introduced on 1 April 1995, expressly states (amongst other things) how long patients should expect to have to wait for various services.\(^\text{712}\) The Charter also sets out patients’ rights and expectations with respect to general practitioner, community, ambulance, dental, optical, and pharmaceutical services.

The U.K.’s Health Services Commissioner may investigate a complaint from a person who “has sustained injustice or hardship” as a consequence of “a failure in a service provided by a health service body, a failure of such a body to provide a service which it was a function of the body to provide, or maladministration in connection with any other action taken by or on behalf of such a body.”\(^\text{713}\) The scope of the Commissioner’s authority was recently extended to allow her or him to hear complaints regarding all aspects of publicly funded health services and to hear complaints regarding the clinical judgements of doctors, nurses, and other clinical professionals.\(^\text{714}\) The list of bodies subject to investigation has also been extended to include private providers. However, the Act continues to expressly provide that the Commissioner is unable to question the merits of a decision taken by a body in the course of exercising any discretion vested in that body except in the case of maladministration.\(^\text{715}\) This provision is

\(^{712}\)The Charter notes that patients can expect to be seen immediately in Accident and Emergency Department, to be seen within 18 months for inpatient or day case services, within 12 months for coronary revascularisations and associated procedures, and within 26 weeks for a first consultant outpatient appointment with 90% of patients being seen within 13 weeks — *NHS Waiting Times Good Practice Guide, January 1996*, (Leeds: NHS Executive, May 1996) at 2.

\(^{713}\)The *Health Service Commissioners Act* (U.K.), 1993, c.46, s.3.

\(^{714}\)See the *Health Services Commissioners (Amendment) Act* (U.K.), 1996, c.5.

\(^{715}\)The *Health Service Commissioners Act* (U.K.), 1993, c.46, s.3(4) & s.3(5).
consistent with case-law reflecting a general reluctance on the part of the courts to intervene in the rationing and allocation decisions made by government authorities and providers within the U.K.'s National Health Service.  

In New Zealand, a code of rights for health and disability service consumers was brought into force on 1 July 1996. The ten rights provided for in the code are couched in very general terms. Unlike the U.K. Patients' Charter, there are no specific statements of rights and expectations with respect to waiting lists and waiting times. The code frames rights in the context of the consumers' relationships with health care providers and not in the context of consumers' relationships with purchasers. Moreover, the Act states that providers will not be found in breach of the code if they have taken "reasonable actions in the circumstances to give effect to the rights, and comply with the duties" in the code, although the onus is on the provider to prove that it took reasonable actions. Consumers have recourse to a Health and Disability Services Commissioner in the event of a failure to implement these rights. The powers of the Commissioner are relatively limited. She may, however, refer a matter to the "Director of Proceedings" who in turn may institute disciplinary proceedings before the "Complaints Review Tribunal" who has power to award damages, makes declarations and order and grant such other relief to the complainant as the Tribunal thinks fit.

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716 For a discussion of these cases see J. H. Tingle, "The Allocation Of Healthcare Resources In The National Health Service In England: Professional And Legal Issues" (1993) 2 Annals Of Health Law 195. More recently see R. v. Cambridge Health Authority, ex p B., [1995] 2 All ER 129 (CA) at 130 where it was noted "[the judiciary]. . .was not in a position to decide on the correctness of the difficult and agonizing judgements which had to be made by health authorities as to how a limited budget was best allocated to the maximum advantage of the maximum number of patients."

717 See the Health and Disability Commissioner (Code Of Health And Disability Services Consumers' Rights) Regulations (N.Z.), 1996/78.

718 The ten rights are: to be treated with respect; to freedom from discrimination, coercion, harassment, and exploitation; to dignity and independence; to services of an appropriate standard; to effective communication; to be fully informed; to make an informed choice and give informed consent; to support; to make a complaint about the provision of health or disability services; and for the code of rights to apply when a consumer is participating or it is proposed that the consumer participate in teaching or research.


720 She has the power to investigate a complaint that there has been a breach of the code. She may refer the matter to an "advocate" to resolve the complaint. If after an investigation the Commissioner resolves there has been a complaint then she may, amongst other things report her opinion and recommendations to a health professional body and/or make a complaint to that body. If after a reasonable time no action is taken the Commission may make public comment thereon and/or report the matter to the Minister of Health — ibid., ss. 36, 42, 45, & 46(2).

721 Ibid. s.49 and s.52.
The use of charters and codes of rights is, as Ferguson notes, one way of providing information to patients. However, in New Zealand and to a lesser extent in the U.K., the rights described are couched in terms of the provider-patient relationship and do not set out what expectations patients and the public should have of their purchasers. Conceivably this may detract from individuals focusing their voice to ensure maximum performance on the part of purchasers in negotiations with providers. At a minimum, given the agency relationship between purchasers and the people they represent, it would seem appropriate to clearly articulate the role of purchasers as agents for people in charters and codes of rights and to include purchasers in any complaint procedures. This may be as limited as providing purchasers with notices of complaints made and the results of complaint procedures so they can take account of this information in their future purchasing decisions or as extensive as requiring purchasers to provide advocates for individuals in complaint procedures.

### 4.5.5 Capturing the Voice of the Politically Influential

In both the U.K. and New Zealand, citizens may purchase private insurance to cover the cost of private services and user charges imposed in the public sector. The existence of private insurance covering services that are meant to be available to all in the publicly-funded system may dilute the use of voice on the part of those holding private insurance who, as a consequence, have less of a vested interest in the public system.

As discussed in Chapter 3, one of the strongest criticisms made of the U.K. and New Zealand’s former command-and-control health systems was the growth of waiting lists, particularly for elective surgery. Although reducing waiting times and waiting lists was a goal of the reforms, New Zealand’s new system has not solved this problem. Waiting lists have increased by over 50% from 62,000 in 1991 to a reported 93,930 people waiting as of March 1996. Waiting lists are overwhelmingly for elective as opposed to acute surgery. The New Zealand administration has reversed its position from arguing that waiting lists were reflective of the inefficiencies of the old command-and-control system to arguing that waiting lists are not reflective of an

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724This argument has been made before in earlier writing see C. M. Flood & M. J. Trebilcock, “Voice And Exit In New Zealand’s Health Care Sector” in Contracting In The Health Sector (Auckland: Legal Research Foundation, 1994) at 37; Flood supra note 682; and Flood, supra note 493 at 101.

72572,647 people were on waiting lists in 1993 and 77,558 people in 1994 — S. Upton, supra note 16 at 28 (1991 figure); Performance Report supra note 667, Table 17 at 85 (1993 and 1994 figures); L. Dalziel, Opposition health spokeswomen as cited by the New Zealand Herald, 17 April 1996, Section 1: 1 (1996 figures).

726S. Upton, ibid. at 11 where the then Minister of Health states that on of the problems with the (pre-reform) system is that “public hospital waiting times are too long” and goes on to interchangeably refer to the problem of long waiting times and long waiting lists.
inefficient system and that waiting times are a more useful measure. However, it seems likely that there will generally be a strong correlation between the length of waiting lists and waiting times. Moreover, there are no comprehensive statistics available to enable a comparison of average waiting times pre and post reform. The current administration’s response to the problem of lengthening waiting lists is to simply abolish the present lists, and introduce a system of booking whereby patients will not be put on a waiting list unless the system can meet their needs within six months. \footnote{See “Extracts From An Address By The Former Minister For Crown Health Enterprises To The Auckland Divisional Conference Of The New Zealand National Party, 25 June 1995. Debunking The Myths And Restoring Reality” in (1996) 4 Health Care Analysis 130 at 131.} If the patient’s needs cannot be met in this time-frame then she/he will simply be referred back to their general practitioner for management of their condition. If successfully implemented, this booking system will artificially deflate waiting lists.

Concomitant with the increase in waiting lists for elective surgery in New Zealand has been an increase in the estimated proportion of the population with private insurance from 35% in 1985, to 45% in 1993, to 55% in 1995.\footnote{1996/97 N.Z. Policy Guidelines, supra note 663 at 24–25.} The percentage of total health expenditures paid for by private insurance has, unsurprisingly, more than doubled from 2.75% in 1990 to 6.18% in 1994.\footnote{Consumer Institute – July 1993 as cited by D. Muthumala & P. S. Howard, Health Expenditure Trends In New Zealand 1980–1994, (Wellington: Ministry of Health, 1995) at 35 and Consumer Institute – June 1995 as cited by Anon., “Public Health Service Wins Praise In Survey”. The New Zealand Herald, 15 June 1995.} Although this represents a significant increase, the percentage of total expenditures paid for by private insurance remains small in real terms as private hospitals still generally only provide elective surgery and not the full range of acute and emergency services, which are available with minimal waiting times in the public sector.

Using Hirschman’s model we can see that part of the problem in New Zealand may well lie in the fact that rather than using their voice to press for improvements in the performance of the public health system with regard to the supply of elective surgery, quality conscious individuals are simply seeking fulfilment of their elective surgery needs in the private system. The effects of this are even more pernicious than might be first envisaged because of what Hirschman describes as the “lazy monopoly” problem.\footnote{Muthumala & Howard, ibid. at 58, Appendix 4.} A lazy monopoly (which in general operates in a market where there is no competition for the market itself) may in fact have an incentive to encourage those that would otherwise be likely to use their voice to criticize the monopoly to move to another market. This phenomenon sounds like “exit” but in truth it is not because the decision-maker suffers no financial consequences as a result of the movement of the quality-conscious
and politically influential to another market. Hirschman's description of a lazy monopoly fits both New Zealand's Regional Health Authorities and the U.K. Health Authorities, in that they do not forego any part of their public funding as a result of the shift by disgruntled citizens into the private sector for elective surgery. Thus, there is more scope for productive inefficiency or slack as the purchasers have fewer demands placed upon their resources once quality-conscious individuals have exited to the private sector. There is also the question of distributive justice as those individuals who buy private insurance or private services may not be those who are, clinically, in the greatest need of (or would benefit most from) elective surgery.

As in New Zealand, most private insurance in the U.K. is used to cover the cost of elective surgery. In fact, Propper and Maynard estimate that less than two dozen procedures account for over 70% of all private operations. As discussed in Chapter 2, in contrast with New Zealand's striking failure to reduce waiting lists, the U.K. seems to have been relatively more successful (at least in the early stages of the reform process) in reducing both waiting lists and waiting times for elective surgery. The impetus to deal with waiting lists and times appears to have originated from central government, and through top-down control the goal of containing waiting lists and times has become a primary goal in the priorities set by central government for purchasers to follow and, consequentially, in agreements between purchasers and providers. Patients are now also clearly informed of what they can expect in terms of waiting times in the Patients' Charter. Clearly, while an undue fixation on waiting lists and times at the expense of other goals may reduce providers' flexibility in managing the supply of care, such a focus demonstrates that the system (at least compared to one where waiting lists are growing apace) is anchored in reality and not just in rhetoric to satisfying end-users.

Why has the U.K. system been more proactive than the New Zealand system in controlling waiting lists? There are two possible reasons. First, there is the possibility that the presence of GP Fundholders in the U.K. system is resulting in more aggressive bargaining for the supply of timely elective surgery. The evidence for this to date is mixed although arguably the mere prospect of competition between GP Fundholders and Health Authorities has helped to improve the performance of the system overall. Secondly, there is the possibility that, unlike New Zealand, as the vast majority of people in the U.K. rely on the public system for the delivery of all their services the political ramifications of not reducing or dealing with the waiting list problems have become too high and that voice is being used by a sufficient number of politically influential people to maintain and improve the quality of the public health system. The

percentage of the U.K.'s population with private insurance has indeed grown in recent times but is still only approximately 11.3%. This is a relatively small percentage in comparison with the estimated 55% of New Zealand's population with private insurance. Thus, given that nearly 89% of the U.K.'s population are totally dependent on the public system for fulfilment of their elective surgical needs, it could be assumed that much greater political pressure has been brought to bear to reduce waiting times for elective surgery than in New Zealand where only 45% of the population is totally dependent on the public system for elective surgery.

There has been empirical work conducted in the U.K. examining the linkage between length of waiting lists and uptake of private insurance. Besley, Hall and Preston found that there is a positive association between the purchase of private health insurance and length of local NHS waiting lists. They also found that individuals who express dissatisfaction with the NHS are more likely to purchase private insurance and that the privately insured tend to be "better off, better educated, middle-aged and more inclined to support the Conservative party." This provides some evidence for the thesis that those who are most sensitive to quality issues and are most likely to have the political connections with which to exercise voice are more likely to "exit" by buying private insurance. The authors of this study also did find that individuals with private insurance were less like than those without to support additional spending on the public system; however, this result must be treated with caution as still a significant majority of those with private insurance did support additional spending on the NHS. This may possibly be explained by the fact that those with private insurance still rely upon the public system for supply of acute health care services and the fact that relative to other OECD countries the U.K. has spent a smaller amount on health than would be predicted from its real level of GDP.

How could one change the incentives inducing quality-conscious and wealthier individuals to buy private insurance covering services available in the public sector and enhance the use of voice? One method would be to make exit more difficult. The first step is to remove all government subsidies of private insurance and private supply of services that are already provided in the public sector. On this basis one must question the effect of the 1990 U.K. reform whereby private insurance premiums became a tax-deductible item of expenditure for those aged over 60 and the U.K. government's announcement in March 1997 that it will subsidize private

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734 Besley, Hall & Preston, supra note 608.
735 Ibid. at 1.
736 Ibid. at 34.
insurance covering long-term care for the elderly." Taking matters a step further, government could seek to reduce the incentive to obtain private insurance for services that are provided in the public sector by imposing a surcharge on premiums that purport to provide coverage for those classes of services.

A more radical step would be to prohibit private insurance covering those services that are available in the public sector. This is what Canada does albeit on a province by province basis. Exit is made more difficult as only those individuals who can afford to pay directly for the cost of private care are able to exit the public sector. Evidence suggests that as a consequence voice is strongly used as a mechanism to enhance the quality of Canada’s health care system and to protect what are perceived as being core values. Certainly, waiting lists are less of a problem in Canada than in the U.K. and New Zealand. The Fraser Forum estimates the number of Canadians on waiting lists for surgical procedures in 1995 to be 165,472. As I have noted in an earlier publication, this equates to approximately 0.56% of the Canadian population, which is a significantly smaller proportion than the 1.78% of the U.K. population and the 2.62% of the New Zealand population on waiting lists. Some might wish to argue for supplementary private insurance on the basis that the U.S. system relies predominantly on private insurance and does not appear to have a problem with waiting lists. This is, however, comparing apples with oranges as the U.S. does not attempt to achieve a universal health insurance system ensuring access to health services on the basis of need as opposed to ability to pay as do most other OECD countries.

Some argue that advocating the reduction of private insurance is untenable as the existence of a private insurance market covering services provided in the public sector eases pressure on and demand for publicly-funded services and, thus, waiting lists will be reduced. Indeed, on the basis of this assumption governments often subsidize the purchase of private insurance and private care. However, Davis found that where there is a high percentage of surgical beds in the private sector, the length of waiting lists for public surgical beds proves to be at least twice as

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739 The National Forum, Canada Health Action: Building on the Legacy (National Forum on Health: Ottawa, 1997) at 5 concluded in 1997 "...the health system has always engendered strong support among Canadians. In recent years, however, its significance has broadened into symbolic terms as a defining national characteristic."
741 See Flood supra note 493.
long as is likely if no private surgical beds are provided.\textsuperscript{742} This is plausible when it is considered that only a portion of the population can or will utilize private care (in the absence of government subsidies) as only a portion of the population have health insurance or can afford to pay for private care themselves. Recent experience in New Zealand indicates that according a significant role to private insurance covering services that are meant to be provided in the public system is not associated with a reduction in waiting lists in the public system. Empirical analysis would be required to identify the independent effect of the take-up of private supplementary insurance on the length of waiting lists but it is possible that the former is in fact exacerbating the latter. Possibly the waiting list problem in New Zealand and the U.K. is caused by specialists who are employed both in the public sector (where they are generally paid on a salary basis) and in the private sector (where they are paid on a fee-for-service basis). This incentive combination may mean that specialists are well served by long-waiting lists in the public sector which will increase demand for their services in the private sector.

4.5.6 Conclusions on Voice and Political Accountability
In conclusion to this section on voice and accountability, I have tried to address the various mechanisms through which to enhance voice and thus political accountability to render purchasers in internal markets more accountable to the citizens they ultimately represent. As Hirschman predicted the use of voice is "messy" and there are no easy or clear-cut solutions. Devolution of purchasing responsibility is one means of improving voice and accountability but the benefits thereof have to be weighed against the extra transactions costs and diminution in monopsony purchasing power associated with increasing the number of purchasers. Consultation is another means of improving accountability but there are difficulties with ensuring that purchasers are not captured by vested interested groups and there is a need for incentives to make sure that purchasers give more than lip-service to a requirement to consult. Election of members of purchasing boards is, in a democracy, the most obvious way of ensuring accountability. There are problems, however, as more complex measures of performance such as the quality of services supplied may be lost in the political process. Moreover, although the majority of the population may be satisfied with the members of the purchasing board they have elected there will still be a significant portion of the population who will not be satisfied. The existence of Ombudspersons and charters of rights are important mechanisms through which to improve accountability but presently they seem to be geared towards the patient/provider relationship rather than the patient/purchaser relationship. A key means by which to improve voice in a publicly-financed system is to capture the quality-conscious and politically influential

individuals therein. In New Zealand, the fact that 55% of the population hold supplementary private insurance allowing them to jump long queues for elective surgery in the public sector diminishes political pressure brought to bear on government-appointed purchasers to remedy the problem.

It is possible that the many different mechanisms for voice could be combined into an internal market system that would ensure the accountability of government-appointed purchasers to the citizens they ultimately represent. What has been seen to date in the U.K.’s and New Zealand’s internal markets is a significant level of rhetoric but insufficient attention to the goal of improving the accountability of purchasers except in terms of cost-containment.

4.6 Exit And Market Accountability
In addition to political accountability, purchasers’ accountability to the people they ultimately represent may be enhanced through a competitive market for purchasers. If individuals were (to use Hirschman’s terminology) entitled to “exit” from purchaser to purchaser taking with them a risk-adjusted share of government funding then, prima facie, there would result unambiguous financial incentives encouraging the performance of purchasers. Distributive justice concerns would be satisfied as the system would be largely progressively financed. This is the premise of managed competition reform proposals.

Offering consumers the choice of competing private purchasers is the mechanism through which both efficiency and accountability are claimed to be enhanced in Enthoven’s model of managed competition reform, in the partially-implemented Dutch reforms, and in President Clinton’s defunct reform proposals in the U.S. Limited competition between public and private purchasers is being encouraged in the U.K. and New Zealand. In the U.K., GP Fundholders (in theory) compete with each other and Health Authorities with regard to the purchase of a limited range of services. In New Zealand, there have been some initiatives, similar to Fundholding in the U.K., through Independent Practice Associations. 743 Thus limited competition between purchasers in the U.K.’s and New Zealand’s internal market is being incrementally introduced albeit from the bottom up as opposed to the top down in managed competition models.

The concept of exit as an accountability and efficiency enhancing mechanism is very appealing because of its apparent simplicity particularly when compared with the messy and varied

743 See Malcolm & Powell, supra note 19. Unlike GP Fundholders, however, it appears that IPAs do not carry any significant financial burden with any shortfall being picked by the relevant Regional Health Authority. This will surely have to change, however, as IPAs extend into purchasing a full range of health services.
mechanisms needed to improve voice. Its elegance is that of the spontaneous order of competitive markets envisaged by neo-classical economists. However, in managed competition proposals distribution inequities have been corrected by every individual receiving a fair share of public funding which they may shift between competing purchasers so as to send a clear signal to purchasers when they are and are not performing well. The theoretical appeal is obvious but, as will become clear, the goal of redistribution means that government must regulate and manage competition and consequently issues of political accountability cannot be avoided.

In all proposals for managed competition, the process of competition between purchasers is managed or regulated by what Enthoven terms sponsors. Enthoven notes that managed competition reform requires “intelligent, active, collective purchasing agents contracting with health care plans on behalf of a large group of subscribers and continuously structuring and adjusting the market to overcome attempts to avoid price competition.” In Enthoven’s model, a sponsor may be either a governmental agency, an employer, or a purchasing co-operative. Clinton’s proposals for reform required government-appointed Regional Health Alliances to collectively oversee health coverage for over 80% of the population under the age of 65. In the Netherlands, the Central Fund (a government agency) is required to act as a sponsor. In the U.K., the Health Authorities are responsible for monitoring Fundholders’ activities, resulting in a conflict of interest because theoretically Fundholders are in competition with Health Authorities for patients’ allegiance. Similarly, in New Zealand, it is the Regional Health Authorities’ responsibility to administer managed care initiatives.

The apparent simplicity of the exit mechanism belies many of the problems that have to be surmounted before it can be effectively operationalized. These problems include:

i) the incentive for competing purchasers to “cream skim” healthy enrollees and avoid enrollees with high health costs or with a high risk of such costs in the future;

ii) the need to solve the basis upon which price competition will occur between purchasers;

iii) the need to define “core” services i.e. the range and quality of services purchasers will compete to provide (or, from the other side of the coin, the need to define consumer entitlements);

iv) the question of whether consumers have or will have sufficient information to choose wisely between competing purchasers;

v) the problem of transactions costs; and

vi) the problem of supply side monopoly.

\footnote{Enthoven, (1993), supra note 20 at 29.}

\footnote{See the American Health Security Act of 1993, H.R. 3600, 103d Cong., S. 1757, 1st Sess., (1993).}
These problems are discussed more fully below.

4.6.1 Cream Skimming
When a consumer exits from one insurer/purchaser to another there is a risk that she/he is moving as a result of cream skimming. This would be inefficient as it would be rewarding insurers/purchasers who compete on the ability to avoid risk as opposed to the ability to compete on price and quality. The technical difficulties, importance, and need for effective resolution of this problem are generally underestimated in managed competition proposals.

In an unregulated competitive private health insurance market, high risk individuals may be either priced out of, or simply excluded, from the insurance market. For example, Fuchs notes that in the U.S. the competitive revolution in health care has caused Blue Cross and Blue Shield, who have historically fulfilled a de facto social insurance function, to cease community rating and engage in risk rating. As a consequence, a growing proportion of the population are left without health insurance. Similarly, in the Netherlands, prior to managed competition reform, there was increasing concerns that risk-rating by private insurers was making insurance unaffordable for elderly and/or unhealthy people and that some high-risk groups were being denied coverage altogether.

Managed competition reform proposals seek to satisfy equity concerns by providing for mandatory universal coverage for a comprehensive range of health services. Premiums are collected on an income-related basis by a sponsor which is often a government agency. Citizens’ contributions do not depend upon their health cost and/or risk profile. The sponsor pays on behalf of every individual a fixed annual premium to that individual’s chosen purchaser in return for which the purchaser undertakes to cover all of that individual’s health care needs for a comprehensive range of services (as defined by regulation) in that year. This is in effect a sophisticated voucher scheme. However, if competing purchasers receive the same premium for each insured individual then they have an incentive in a managed competition model to cream skim those enrollees with low health costs and avoid those enrollees with high health costs and/or a high risk of incurring such costs in the future.

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In order to minimize cream skimming, managed competition models require purchasers to accept all who seek to enrol in their plan; however, cream skimming behaviour may be more subtle. Tactics may include contracting with certain types of providers in certain locations and not with others (i.e., electing not to contract with the local facility specializing in oncology services) or locating the only benefits office on the top floor of a building with no wheelchair access in an affluent white suburb. Such tactics will usually (at least eventually) be detectable. Managed competition models require sponsors to oversee and regulate purchaser behaviour and require that consumers exercise their right to change purchasers through the agency of their sponsor (i.e., the sponsor acts as an individual’s agent in effecting the switch). This arrangement reduces opportunities for purchasers to use subtle cream skimming tactics. A sponsor may also monitor movement by individuals between purchasers to ensure that such movement is not the result of cream skimming behaviour. Another measure would be to license health purchasers on the condition that they undertake not to engage in cream skimming behaviour with penalties being enforced for violation of this condition. A related idea would be for the government to define cream skimming tactics as per se in breach in of competition law on the basis that allowing firms to cream skim may result in the demise of other firms that are better able to compete on price and quality. All of the preceding suggestions for curbing cream skimming are open to the criticism that purchasers will simply invent more sophisticated and undetectable methods of cream skimming. Thus sponsor must be continually monitoring competition and putting in place new measures to reduce cream-skimming incentives.

Aside from regulations and sanctions, a potentially less intrusive means of reducing cream-skimming is to correct the financial incentives encouraging purchasers to cream skim. This requires the sponsor to risk-adjust the premiums paid so that competing purchasers are compensated for the risk they bear as a result of the risk profiles of the people that have chosen


749 See for example Enthoven, (1993), supra note 20 at 33.

750 Fielding & Rice, supra note 228 at 222 suggest “...[o]ne thing that might help is for plans to report the use and cost experience of disenrollees; this could be made public, alerting consumers that certain plans have a tendency to ‘dump’ sick patients.”
to enrol in their particular plan. An adjustment in this regard must be effected in any event to allow those purchasers with whom a disproportionate share of enrollees with high health costs have enrolled to remain viable. Appropriately risk-adjusting premiums is essential to ensure fair competition. If this is not done then those purchasers that are adept at cream skimming may receive greater income than competitors who perform better on price and quality dimensions. The premiums must be adjusted so that each purchaser receives a premium per enrollee that reflects purchasers' perceptions of the particular individual enrollee's risk of utilization of health services. It is purchasers' perceptions of risk which is important as opposed to what the risk is in truth may be for this is, given the current state of knowledge, unascertainable.

In the Netherlands, managed competition reform requires the Central Fund to collect income-related sums and from this pay 85–90% of a risk-adjusted premium on behalf of each and every individual to that individual's chosen purchaser/insurer. The difficulty is that, to date, the Central Fund has not appropriately risk adjusted the premiums paid. In 1993 and 1994 premium payments were differentiated on the basis of age and gender alone and did not include risk factors that could be readily ascertained by competing purchasers such as an individual's chronic health status or medical history. Van de Vliet and van de Ven found that if age and gender are the only factors used for risk adjustment then there is a strong financial incentive to cream skim. They note that it is easy for purchasers to identify those individuals with the greatest non-catastrophic health expenditures in any year, and 10% of these individuals can be predicted to have per capita expenditures four years later that are on average nearly double the per capita expenditures within their age-gender group. The inequity of inadequately risk-adjusted premiums has been acknowledged in the Netherlands. In 1993 and 1994, the government only required that Sickness Funds (non-profit organizations that have historically acted as monopoly insurers for the poorer 66% of the Dutch population and thus may be assumed to provide for most high-risk patients) be financially responsible for just 3% of the difference between their actual expenditures on health services for their enrollees and the total premiums received from the Central Fund. This percentage was subsequently increased to 14% in 1996 and 27% in 1997.

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751 van Barneveld, van Vliet & van de Ven, supra note 748.
752 van Vliet & van de Ven, "Towards a Capitation Formula For Competing Health Insurers" supra note 748.
753 van de Ven et al., "Risk-Adjusted Capitation: Recent Experiences in the Netherlands" supra note 748 at 123.
755 Personal correspondence with Dr. Frederick Schut, Erasmus University, Rotterdam 24 March 1997.
Van de Ven and Schut contend that three misunderstandings lie at the root of why the Netherlands has failed to date to implement a system of adequately risk-adjusted payments.\textsuperscript{756} The first misunderstanding is the assumption that age, gender, and region will explain a large proportion of the variance in health expenditures whereas, in reality, these factors only explain 10--20\% of the predictable variance in health expenditures for any individual.\textsuperscript{757} Similarly, in the U.S., it has been estimated that 5\% of all the aged entitled to the government's Medicare program account for over 50\% of the total costs of the program and 36\% of those covered do not make any claims.\textsuperscript{758} Thus, clearly, age is but one factor in ascertaining who are high-risk individuals. Adjustments for age, sex, and location may more satisfactorily explain variations between very large groups. but risk-adjustment must occur at the individual level for the purposes of managed competition reform as it is through the individual's decision to exit that competing purchasers are held to account.

The second misunderstanding noted by Van de Ven and Schut has been the assumption that the incentive to cream skim would be minimized because of the ability of purchasers to reinsure risks; however, reinsurance companies will themselves generally charge risk-adjusted premiums to purchasers, thus leaving in place the original incentive to cream skim.\textsuperscript{759}

The third misunderstanding that Van de Ven and Schut note is the assumption that if perfectly risk-adjusted premiums were paid then purchasers would have no incentive to operate as efficiently as possible.\textsuperscript{760} Van de Ven and Schut believe that this argument is also flawed for two reasons. First, given the current knowledge base, it is only possible for purchasers to \textit{partially} predict the risk of any individual's future needs. The cream skimming incentive only arises where there is a \textit{discrepancy} between what risk factors are considered by purchasers and what risk factors are incorporated into premiums paid by sponsors. If all known risk factors were incorporated into premium payments then purchasers would still have to manage the unpredictable risk of utilization, the latter being much more significant than the former in determining future patterns of use. Van de Ven and Schut also argue that adequately risk-adjusted premiums will not act as a disincentive for efficiency as any savings are captured by purchasers (at least in the private sector) as profit. This latter argument is more tenuous as given risk-adjusted premiums, private purchasers have an incentive to compete to improve the quality of services provided so as to attract enrollees but no incentive to compete on the level of

\begin{footnotesize}
\textsuperscript{756} van de Ven & Schut, \textit{supra} note 754 at 110-111.
\textsuperscript{757} \textit{Ibid.} at 110.
\textsuperscript{758} S. S. Wallack \textit{et al.}, "A Plan For Rewarding Efficient HMOs" (1988) 7: 3 Health Affairs 80 at 84.
\textsuperscript{759} van de Ven & Schut, \textit{supra} note 754 at 110-111.
\textsuperscript{760} \textit{Ibid.} at 111.
\end{footnotesize}
premiums as the price is effectively determined by the sponsor. This issue is discussed further below under the problem of facilitating price competition.

Another type of financial incentive that may deter cream skimming is the use of "risk corridors" where the risk of high utilization is shared between the sponsor and purchasers. This is currently the situation for the U.K.'s G.P. Fundholders who each only bear financial liability for up to £6000 per annum for any patient and any costs incurred beyond this sum are paid for by the Health Authority (i.e. the sponsor). Such a measure caps the risk incurred by a Fundholder, thus diminishing (but not eliminating) the incentive to cream skim but also removes any incentive Fundholders have to be sensitive to the cost of the services they buy past the figure of £6000. There does not appear to be any empirical evidence (as yet) that cream skimming is a serious problem in Fundholding practices; however, the Audit Commission did find an inverse relationship between the proportion of Fundholding practices in an area and the average degree of social deprivation to be highly significant statistically. In other words, through a process of self-selection, physicians are only electing to become Fundholders in areas where on average their patients are likely to be healthy. Also a survey by the National Association of Health Authorities and Trusts of the 1996/97 contracting round shows that there has been a rise of between 3% and 13% in accident and emergency admissions. One could speculate that GP Fundholders may have contributed to the phenomenon by encouraging emergency admissions because Fundholders have a financial incentive to do so as their patients are then treated without any deductions from their budgets. Even if cream skimming is not a problem in the U.K. it is difficult to know whether this is attributable to the use of risk-corridors or to the fact that the ethical norms of physicians deter them from cream skimming or to the fact that, to date, there has been little real competition between Fundholders.

Reform advocates must recognize that adequately dealing with the issue of cream skimming is the key to managed competition reform and absolutely necessary in terms of protecting vulnerable populations. The role of sponsors is crucial in this regard. Will government-appointed sponsors be up to the task and how will they be kept accountable? Will they have the information needed to calculate risk-adjusted payments? In the former command-and-control health systems of the U.K. and New Zealand, which have historically produced little accessible data on service usage, the initial costs of setting up information gathering systems will be

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562 What The Doctor Ordered, supra note 586 at 10.
significantly higher and the transition more disruptive than in countries like the Netherlands and the U.S. which have historically relied to a greater degree on private insurers and private providers. Before reform proceeds there should be a high level of confidence that the transition will generate sufficient benefits to offset the cost.

4.6.2 Price Competition
If the sponsor determines the payment or premium to be received by competing purchasers, then will there be any scope for price competition?

The Netherlands' reform proposal attempts to stimulate price competition by requiring that a fixed percentage of the premium (currently 10%) be paid by each enrollee directly to his or her chosen purchaser.\textsuperscript{764} The purchaser may set this fixed annual fee at any level but it must be the same fee for all enrollees (i.e. it cannot be risk rated). Enthoven's proposal for managed competition reform requires that the premium paid by the sponsor be pegged to the premium of the lowest priced purchaser, with individuals having to bear the full cost of a decision to select a purchaser with a higher priced plan.\textsuperscript{765} By contrast, Clinton's managed competition plan required that the sponsor's contribution be pegged to the average price of all plans for fear that to tie contributions to the lowest priced plan would result in lower-priced plans being "ghettoized" i.e. low quality plans for poor people.

In order to foster price competition, it appears that one has to sacrifice a total commitment to progressive financing of the system. The greater the percentage of the premium directly paid by any individual to his or her purchaser, the greater the incentive for the purchaser to compete on the basis of price but, as a result, the financing of the health system becomes more regressive (as the poor will have to divert a greater percentage of their income than the rich to paying a fixed fee). The purchaser will, in this case, have a greater incentive to cream skim as this fixed payment will not be risk-rated as it would be the same fee for all enrollees. Thus allowing a margin for price competition brings with it the risk of increasing the potential for cream-skimming and adversely affecting distributive justice. Thus, the margin allowed for price competition must be restricted to a relatively small component of total costs. This problem again has to be put in context and one will recall from Chapter 3 that presently most systems have some proportion of their system regressively financed. A comprehensive managed competition system requiring a small premium payment every year on the part of each citizen is arguably as

\textsuperscript{764}In 1994 this averaged to approximately 200 guilders (U.S.$120) per person per annum — van de Ven & Schut, supra note 754 at 102.
\textsuperscript{765}Enthoven, (1993), supra note 20 at 32.
fair if not fairer than a command-and-control system imposing user charges on basic care such as prescription drugs, general practitioner care, ambulance services etc.

4.6.3 Defining Core Services/Defining Entitlements

Defining what range and quality of health services will be made available by competing purchasers and what consumers should be able to expect to be entitled to is important to managed competition reform. Ideally, consumers should be free to move between purchasers in search of the best premium price and/or quality of services knowing that an adequate range and minimum quality will always be provided.766

There have been various attempts in the Netherlands, New Zealand, and in the state of Oregon, U.S., to define the range of “core” services to be universally available. Acknowledging that resources are limited, there have been attempts to prioritize services in terms of importance to assist in allocation decisions. This task has proved to be quite elusive in practice.

The original Dekker proposals for reform in the Netherlands required the legal definition of a standard package of benefits to be available to all as part of the reformers’ goals to improve access and solidarity (equity).767 It was proposed that insurance contracts would be different forms of the legally defined standard package and would vary only with respect to the list of providers able to be visited and the conditions that must be fulfilled in order for costs to be covered (such as a referral slip from a general practitioner).768 In 1991, the Dutch cabinet essentially skirted the hard issues of what should and should not be included in the basic package by deciding that 95% of current health services currently provided should be included in the standard package. In 1992, the Dutch government’s “Committee On Choice In Health Care” produced a report (which subsequently became known as the Dunning report), dealing with the rationing of services.769 The Committee did not produce a prioritized list of services to be included in the standard package but recommended that all services satisfy four criteria before being included in the standard package. These criteria were described using the metaphor of a funnel with four sieves with only those services that managed to pass through the four sieves (or tests) to be included.770 The sieve approach provides guidance on what services should be

767Factsheet, supra note 747 at 3.
768Van de Ven & Schut, supra note 754 at 101.
770The Committee notes “[t]he first sieve retains care that is unnecessary, based on a community-oriented approach. The second sieve selects on effectiveness, allowing only care confirmed and documented as effective. The third sieve selects on efficiency, which can be measured by such methods as cost-effectiveness analysis. The fourth sieve retains...
universally provided but applying these principles in practice is an enormously difficult task requiring information on cost-effectiveness and consideration of community values. After producing its report the Dunning Committee was dissolved and no other institution appears to have explicit responsibility for determining what services should and should not be included in the basic package using the sieve principles.

The Oregon Basic Health Services Act, passed in 1989, was designed to extend coverage of the Medicaid package in Oregon to include all those at or below the poverty line primarily by means of explicitly rationing the services provided. In determining what priorities should be given to different health services in the standard package, the Oregon Health Service Commission solicited public input through consultation. The priorities accorded to services as a result of this process were the subject of much criticism, particularly from health care providers, for ranking low cost services such as correction of crooked teeth, thumb sucking, lower back pain, toothaches, migraine headaches, and salmonella poisoning over possible life-saving treatments such as liver and bone marrow transplants. As a result of this criticism the Commission recompiled the list of priorities using a methodology that largely eliminated cost considerations and diluted the influence of public input and re-ranked services based on the treatment's perceived value to the individual patient, its value to society, and the medical necessity of the treatment. This reordering resulted in life-saving treatments being accorded a much greater priority, which reflected health providers' concerns that the earlier list violated the ethical "rule of rescue" that requires physicians to act in the case of a life-threatening situation.

The Oregon experience highlights a number of important issues. If one assumes that providers were not acting solely out of self-interest in advocating high-cost life-saving procedures but were driven predominantly by a moral imperative, then this suggests there must be rights to health services that should trump more utilitarian concerns. Arguably individuals should have certain care that can be left to individual responsibility. The Committee feels that any care that is retained in one of the four sieves does not need to be in the basic benefit package — ibid. at 19.

771 The Oregon Basic Health Services Act, Or. Rev. Stat. §§414.705-414.750 (1993). Prior to implementation of this Act only those individuals who satisfied family status requirements and had incomes equal to or less than 51% of the poverty line were eligible — Oregon Health Services Commission, Prioritization Of Health Services: A Report To The Governor And Legislature (1991) xvi as cited by C. J. Halligan, "Just What The Doctor Ordered": Oregon's Medicaid Rationing Process and Public Participation In Risk Regulation" (1995) 83 Georgetown Law Journal 2697.

772 For a fuller description of the processes see Halligan, ibid. at 2708–11.

773 See ibid. at 2711-12.

774 Support for this view comes from Sweden where the notion of deploying resources to help many people with mild disorders instead of a few with severe injuries and the notion of giving priority to those patients who are considered to provide important contributions to society, were both firmly rejected by a body constituted to consider priorities in health care — Swedish Parliamentary Priorities Commission, Priorities In Health Care, (Stockholm: Ministry of Health and Social Affairs, 1995).
basic rights such as a right to life and a right to freedom from incapacity, pain, and suffering that should trump more utilitarian cost-benefit considerations that might give greater societal priority to fixing crooked teeth. The great difficulty is that all such rights must be limited to some degree (otherwise millions of dollars could be spent on potentially life-saving treatments that have only a remote chance of success). The conundrum is how to define these limited rights. The Oregon process is interesting for the degree of community participation that it entailed but one must question whether the results would have been the same if the community had actually been determining the priorities for health services for consumption by themselves as opposed to those below the poverty line. This re-engages the earlier discussion of voice and the argument that if the great majority of the population are dependent on a system for the supply of health services, then there likely will be the political will to ensure ready access to the supply of a comprehensive range of services of high quality to everyone on the basis of need as opposed to the ability to pay.

New Zealand’s National Advisory Committee on Health And Disability was initially constituted with the intention of defining a list of prioritized core services to enable better comparison of competing purchasers. Notwithstanding that the proposal for managed competition between Regional Health Authorities and private purchasers has been put to one side, the Committee has continued with its work. It is contributing to the debate as to what are cost-effective services, what sorts of general health services should be given priority, and what services should be excluded from the publicly-funded sector. The Committee has, however, found it impossible to develop a specific list of priorities in treatment. Significant discretion is thus left in the hands of the Regional Health Authorities and they may find it easier to revert to the default option of largely maintaining the service patterns that have historically existed in their regions.

In the U.K., there is no equivalent body to that which existed in the Netherlands and Oregon and currently operates in New Zealand. Increasingly there are calls in the U.K. to develop explicit rationing criteria. If competition between Fundholders for patients is sufficiently developed there will be a greater need to define the range of publicly financed services to provide a benchmark for performance.

775 NZ Health 1993 Act, supra note 17, s. 6.
776 Core Services For 1995/96: Third Report Of The National Advisory Committee On Core Health And Disability Support Services (Wellington: The National Advisory Committee On Core Health And Disability Support Services, 1994).
777 See the (1996) 312 BMJ edition which is devoted to moving the debate forward on the rationing of health care in the U.K.
The difficulties that have arisen should not deter continued attempts in all jurisdictions at defining and prioritizing a core package of services to be universally available. The complexity of rationing issues must be dealt with by all types of health systems whether reformed along competition-lines or not, unless it is proposed, as has historically happened, to leave these kinds of determinations to the value judgements of individual health care providers. These issues must begin to be addressed by communities as the growth of costly technology coupled with ageing populations and increasing expectations will stretch the ability of systems to meet demands for health services.\textsuperscript{778} Some may argue that determining core services is a misguided endeavour that will stymie innovation and result in inflexibility in the system.\textsuperscript{779} From this perspective, the approach taken in New Zealand where priorities are set in terms of general health needs (i.e. Maori health, primary care etc.) may be a more fruitful one. However, as all systems move towards managed care systems there would seem to be a need to more specifically define entitlements and standards and it is difficult to see how to avoid this. Clearly, at least, it is important that the process be an on-going one with continual adjustment being made at the margins to the services to be covered publicly. Due to the value judgements involved in determining the relative priorities for purchasing services, it is crucial that the public at large be consulted and that the decision-maker in question be receptive to their opinions.\textsuperscript{780}

\subsection*{4.6.4 Consumer Choice and Information}

One must consider the key question of whether consumers can make effective choices between competing purchasers in a managed competition system. The argument is sometimes made by opponents of the concept of competing purchasers that consumers are not capable of distinguishing between the merits of competing purchasers offering managed care plans. Certainly it appears that in the present U.S. system, that many Americans do not understand the differences between health plans and thus may not be making effective choices although, reportedly, the vast majority (70\%) are satisfied with the choices they have made in the past.\textsuperscript{781} In any event, the U.S. experience is not necessarily translatable to a managed competition system as there a sponsor would be required to facilitate consumer choice. There would still be, of

course, potential for purchasers to confuse consumers with fine-print in their policies limiting and restricting access to and the quality of services. As the action of individual exit is the primary means of ensuring accountability in managed competition systems it is vital that sponsors vigilantly monitor the policies offered by purchasers to consumers.\textsuperscript{782} There should be an insistence on plain-wording and a requirement that any limitations on coverage be clearly spelt out on the front page of the policy. Consumers should be entitled to expect, in the absence of express limitations, that the coverage they have historically enjoyed will be available to the same degree. Purchasers may offer to provide a greater range of services in order to distinguish themselves from competitors, but this may make it difficult for consumers to compare purchasers.\textsuperscript{783} To help ameliorate this problem sponsors could require that any additional benefits to the basic package be listed on a separate page of the policy.

The issue of choosing an insurer/purchaser in a managed competition system must be put in context. In internal market systems it is assumed that government agents can be sufficiently astute and have the necessary information to act as the purchasers of care. Surely it can also be assumed then that they are capable of disseminating this information to consumers? Individuals make difficult decisions about when to visit their doctor, which doctor to visit, and which treatment option is preferable. In reality these sorts of choices are arguably more vexed in terms of a lack of information and making decisions at a difficult time, than choosing between health plans once a year. There is a great deal of anecdotal evidence that unacceptable restrictions of choice are occurring the U.S. as a result of managed care.\textsuperscript{784} Again this problem has to be put in context. The U.S. system has been described as a "parody of excess and deprivation"\textsuperscript{785} with historically well-insured patients being able to access the system at any point i.e. through specialists, hospitals, etc. The concern expressed in the U.S. regarding the diminution of choice might in fact be reflective of a gearing down of expectations to accord more with other developed countries rather than imposing any real threat to the quality of health care supplied. In any event, a managed competition system does not in and of itself dictate the degree of restriction placed on patients' choice of providers. Thus this is a matter that could be regulated

\textsuperscript{782} E. W. Hoy, E. K. Wicks, & R. A. Forland, "A Guide to Facilitating Consumer Choice" (1996) 15: 4 Health Affairs 9 conclude that consumer choice of plans can be facilitated if sponsors "(1) create a level field for comparison through standardized benefits and structured enrolment processes; (2) offer a limited number of plans that meet appropriate selection criteria; (3) provide comprehensive, objective and reliable consumer information; (4) support this process with education; and (5) hold plans accountable through uniform reporting of performance data."

\textsuperscript{784} Fielding & Rice, supra note 228 at 222.

\textsuperscript{785} See generally G. Anders, Health Against Wealth: HMOs and the Breakdown of Medical Trust (Houghton Mifflin, 1997).

\textsuperscript{785} Enthoven & Kronick, supra note 611.
by sponsors if it was considered that insurers/purchasers were unduly restricting patients' choice of providers.

Sponsors will also have to monitor and disseminate information to consumers on the quality of various plans offered. This is a task fraught with pitfalls as the quality of services offered is a difficult matter to measure given that the relationship between the consumption of health services and ultimate health outcomes is often ambiguous. Problems arise, for example, in comparing the different mortality rates of hospitals as high mortality rates may not be a function of the quality of the service provided but indicative of the characteristics of the patients admitted. Without seeking to understate the burden that will be placed on sponsors in managed competition reform, it is important to note that monitoring quality will be a problem in all systems reformed along competition-oriented lines. Thus, for example, New Zealand's monopsony Regional Health Authorities must monitor the quality of competing health care providers. Consequently, the difficulties associated with monitoring quality cannot be used as a justification for not developing competition between purchasers if the alternative is for a government-appointed monopsony purchaser to stimulate competition between health providers as in internal market reform. Consideration must be given to providing for the needs for individuals who are physically and mentally handicapped or who are chronically or terminally ill. These individuals may be particularly vulnerable to reductions in the quality of health services,\footnote{See the comments of M. Schlesinger & D. Mechanic, "Perspective, Challenges For Managed Competition From Chronic Illness" (1993) 12 Health Affairs 123 at 130-131.} as it is particularly difficult to measure and monitor performance in terms of providing services that are primarily of a caring rather than a curative nature. This is a critical issue in any system that seeks to foster competition whether it be between purchasers (as in managed competition models) or directly between providers (as in internal market models). Issues of how to maintain the quality of health services supplied are discussed in Chapter 7.

4.6.5 Transactions Costs and the Problem of Monopoly on the Supply Side

One must consider the transactions costs inherent in offering a choice of competing purchasers. The trade-off is that the greater the number of purchasers the greater the choice for consumers and the greater the competitive vigour (provided that sponsors are able to prevent cream skimming), but a large number of purchasers in a system brings with it the prospect of higher transactions costs and a diminution of purchasing power \textit{vis a vis} health care providers.

In order to be able to manage the risks associated with providing a comprehensive range of health services, competing purchasers will find it necessary to provide coverage for a relatively
large population. Very small groups carry a significantly greater percentage of utilization risk as, generally, a relatively small number of individuals in any particular group account for the lion’s share of health expenditures.\textsuperscript{787} Also, purchasers will wish to be of a relatively large size to enhance their market power \textit{vis a vis} health providers.\textsuperscript{788} For example, in response to the prospects of competition between purchasers there has been an integration of sickness funds and private insurers in the Netherlands. Amongst Sickness Funds, from 1987 to 1991, thirteen mergers took place involving 33 Sickness Funds, so that the number of independent Sickness Funds was reduced from 46 to 26.\textsuperscript{789} Industry observers predict that as a result of there will eventually only be 10 to 15 national chains of health insurers serving the Dutch population of 15 million.\textsuperscript{790} Thus, transactions costs in the Dutch reformed health allocation system may eventually be significantly less than they have historically been. The problem may, in fact, prove the opposite one with competition law having to be invoked to ensure that there is real competition between large purchasers in all regions and to prevent the maintenance or creation of cartels.\textsuperscript{791} As purchasers transform into more aggressive buyers of health services, creating a tension on the demand side never felt before, then the response on the supply side may be to consolidate to create matching or greater market power. Consequently, effective anti-trust legislation will be required to maintain workable competition on the supply side.

The issue of transactions costs must be put in perspective as these costs seem unlikely to be greater in a managed competition system that requires competition between purchasers for the supply of all publicly-financed services than, for example, in the present internal market system in the U.K. which allows 3500 GP Fundholders to act as smaller purchasers in addition to the 100 Health Authorities. There are so many Fundholders because they do not have to purchase the full range of publicly-funded health services but only a very limited range of relatively low-cost services. In New Zealand, in addition to the 4 Regional Health Authorities and 1 ACC purchaser there are 61 Independent Practice Associations, all acting as purchasers.\textsuperscript{792} Thus as managed care flourishes in these internal markets (or for that matter in any system) the effective number of purchasers increases and consequently transactions costs will increase. Moreover, the

\textsuperscript{787}For example Wallack \textit{et al.}, supra note 758 at 84 note “[m]edicare claims data suggest that for a random sample of 20,000 aged beneficiaries, the 95 percent confidence interval is plus or minus about 4% ($100 in 1987) of the \textit{per capita} cost for a year. Groups comprising only one hundred enrollees would result in a 95 percent confidence interval of plus or minus 66 percent ($1300 in 1987).”

\textsuperscript{788}See \textit{OECD Health Policy Studies No. 2}, supra note 22 at 99.

\textsuperscript{789}Schut, Greenberg, & Van De Ven, supra note 374 at 266.

\textsuperscript{790}As noted by van de Ven & Schut, supra note 754 at 97–98 and 105–106.


\textsuperscript{792}See “Report on Ministry of Health, Managed Care Conference, 2-4 May 1996, Managed Care Applied” at http://www.enigma.co.nz/hcroy9607/9607/s07.htm
present number of government-appointed purchasers in the U.K. and New Zealand has been centrally determined and there does not appear to be any particular economic or planning reasons for the present number of purchasers in either jurisdiction. Currently, both the U.K. and New Zealand have been reassessing the number of government-appointed purchasers. It may well be that economies of scale would dictate that there be fewer competing purchasers in a managed competition system.

Undoubtedly, the problem of monopoly supply is a serious one and an increase in the number of purchasers in a market may exacerbate the problem. The problem and mechanisms with which to address this problem such as regulation, competition law, public ownership of monopolies, and joint bargaining on the part of purchasers with monopolies are the focus of discussion in Chapter 6. It is sufficient to note for present purposes that the problem of monopoly supply will also be a problem in internal market systems or any other form of system seeking to encourage managed care where purchasing responsibility and financial risk is devolved to integrated groups of health service providers.

4.6.6 The Residual Role of Voice
One can see from the preceding analysis that the role of the sponsor is crucial in managed competition models. Sponsors are often government appointed. Where the sponsor is not government appointed but is, as in the Clinton plan, a large employer, the government still has to monitor and ensure that the sponsor is performing its difficult, yet vital, regulatory role. Thus, one can see that the role of government in managed competition reforms while different is no less crucial than in any other health allocation systems that seek to ensure access to health services on the basis of need as opposed to ability to pay.

There is also a need for voice or political accountability as a means of enhancing accountability of competing purchasers in a managed system because patients may be trapped with a particular insurer/purchaser and/or provider affiliated with that insurer/purchaser that they are dissatisfied with until the next point in time when they are able to change their insurer/purchaser (that point in time which be set by regulation). This may have serious implications if patients are demanding a service or quality of service that their particular purchaser is resisting providing. Time may clearly be of the essence in these types of disputes, particularly where the patient does

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793 In the U.K., a “NHS Confederation” came into being on 20 March 1997 which is meant to be a representative voice for not only the 100 Health Authorities but also the 500 NHS Trusts — see http://www.nahat.net/contact.htm. In New Zealand, the 4 Regional Health Authorities are scheduled to be amalgamated into one national purchasing authority by 1 July 1997 — see T. Ashton, “Contracting the Kiwi Way: Costly or Constructive?” (Paper presented at the CHEPA 10th Annual Health Policy Conference, Hamilton, Ontario, May 21-23, 1997).
not have the resources to pay for the services him or herself whilst trying to obtain satisfaction from their insurer/purchaser. Thus, charters of rights, access to a Health Commissioner or Ombudsperson, and associated remedies remain relevant. These administrative processes are all means by which enrollees are able to exercise their voice to protect the quality of services received.

4.7 Conclusion
Where government-appointed purchasers do not face competition, the system relies on political accountability or voice to render purchasers accountable. Significant and complex agency questions arise in this respect. The theory of internal market reform requires purchasers to be accountable to the citizens that they ultimately represent in purchasing services but in practice this is given little weight in either New Zealand or the U.K. A great deal of rhetoric emphasizes improving consumer choice and enhancing public participation, but neither the regulatory framework nor the allocation of resources reflects this. There is potential for management contracts between government and purchasers to be designed to reward efficient performance; the great difficulty is how to measure performance and to resist focusing only on those performance indicators that are the easiest to measure. The present lack of incentives for management of government-appointed purchasers to perform seems to indicate a lack of commitment in both the U.K. and New Zealand to the role of government-appointed purchasers. However, the purchaser’s role is crucial to internal market theory, which hinges on astute bargaining between government-appointed purchasers and competing public and private providers.

This chapter has canvassed a range of possibilities for strengthening the use of voice on the part of the public as a means to ensure the accountability of both purchasers and government in internal market systems. Arguably, although not straightforward, mechanisms for voice could be sufficiently refined to ensure the accountability and efficiency of purchasers. As Longley notes an institutional framework is required to ensure that efforts in this regard are more than mere tokens and that the public interest is properly taken into account. Possibilities include further devolution of purchasing power, mandatory consultation, local elections of purchasers, and providing consumers with more information regarding the level of service they can expect and demand as a matter of course. Ultimately, I argue that for voice to operate effectively it is

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794 For example, E. D. Kinney, “Protecting Consumers And Providers Under Health Reform: An Overview Of The Major Administrative Law Issues” (1995) 5 Health Matrix 83 at 126 notes that of all the proposals for health reform that abounded in the U.S. between 1993/1994, President Clinton’s proposal provided the most detailed framework for adjudicating disputes between purchasers and enrollees.

795 Longley supra note 654 at 155.
crucial to ensure that those with political influence have a vested interest in the performance of government-appointed purchasers. The growth of private insurance covering some of the services that are also supplied in the public sector reduces the incentives of the politically influential to protect the quality of publicly-financed services. The movement of dissatisfied individuals into the private insurance market looks like "exit" but in reality it is not for there are no financial consequences for the government-appointed purchasers. As a result, voice is diminished as an efficiency-enhancing tool and inequities are increased.

Ensuring accountability through voice seems messy by comparison with the *prima facie* simplicity of the exit or market mechanism. Managed competition reform is essentially a sophisticated form of voucher scheme. It is appealing in theory as it offers the spontaneous order of competitive markets but with distribution inequities corrected. Each and every individual receives a share of public funding (based on their need as opposed to their ability to pay) and their chosen insurer/purchaser benefits from this revenue. If an individual is dissatisfied with their current insurer/purchaser they may "exit" to another taking with them a risk-weighted share of public funding. However, "exit" is not as appealing as it first appears because of the continued need for government intervention to facilitate competition on price and quality dimensions.

A managed competition system seems to have some advantages over an internal market system for the following reasons:

a. there is no conflict of interest in government regulating and monitoring purchasers as they are not government-appointed;
b. incentives do not need to be designed and included in management contracts in an attempt to induce performance on the part of government-appointed purchasers;
c. there are arguably clearer lines of accountability with a direct line of accountability between purchasers and their enrollees and with sponsors and purchasers having more clearly defined roles the former being largely a regulator and leaving purchasers to enter into a variety of arrangements with health providers;
d. individual preferences are given expression through the individual action of exit whereas ensuring accountability only through voice satisfies the preferences of the majority or those with political clout;
e. managed competition reform provides scope for the use of both exit and voice as efficiency-enhancing mechanisms on the part of citizens whereas a pure internal market system relies solely
on voice. Hirschman notes that the use of voice as an efficiency-enhancing mechanism is diminished if the public are not able to threaten, at the limit, to exit.\footnote{Hirschman, supra note 675 at 82-83.}

f. managed competition provides roles for the private sector and harnesses private sector creativity but not in the diminished way, as in New Zealand and the U.K., in terms of creaming off the wealthy (and relatively healthy) and supplying them with top-up insurance to cover the failings of the public system (such as long waiting lists for elective surgery); and
g. there is a potential for greater innovation in contracting with purchasers and the option of vertical integration with providers should this prove more efficient. In other words, the exact forms of managed care arrangements are not dictated centrally but are left to evolve in the face of incentives to compete on price and quality dimensions.

The Achilles' heel of managed competition reform is whether or not sponsors have the ability to adequately deal with the cream skimming problem so as to encourage price and quality competition. Sponsors are required to risk-adjust the premiums paid so that competing purchasers are compensated for the risk they bear as a result of the characteristics of the people that have chosen to enrol in their particular plan. In the absence of purchasers receiving a premium on behalf of each enrollee that reflects that enrollee's risk of subsequent utilization of health services (as is able to be assessed by purchasers), the incentive is for purchasers to engage in cream skimming tactics. The technical difficulties, importance, and need for effective resolution of this problem are generally underestimated in managed competition proposals. Solving this problem is crucial in order to protect vulnerable populations in managed competition systems. Without seeking to understate the problem, it is important to note that cream skimming is not solely a problem for managed competition systems as increasingly internal market systems and other systems (like Canada) are encouraging managed care where integrated groups of providers carry the financial risk of utilization by patients, thus resulting in an incentive for health service providers to cream skim.\footnote{See M. Matsaganis & H. Glennster. "The Threat Of 'Cream Skimming' In The Post-reform NHS" (1994) 12 J. of Health Economics 31.} Similarly, the need to determine how to ration health services and to assess what services are cost-effective is not solely a problem for managed competition systems. although sponsors will have to monitor policies offered by competing purchasers so that consumer choice is facilitated.

The most significant advantage offered by an internal market system with government-appointed monopsony purchasers over a managed competition system is potentially that of lower transactions costs and increased market power on the demand side. First it must be noted that
extra transactions costs are only a problem if they are not set-off by concomitant efficiency gains. It is difficult to know what the efficiency gains are of a managed competition system but it is certainly arguable on a qualitative basis that any extra transactions costs will be offset by efficiency gains. It must also be recognized in the context of comparing the managed competition model with an internal market model that the problems of transactions costs and diminution in monopsony purchasing power will become an increasing problem in internal markets as government-appointed purchasers increasingly contract with small groups of providers offering managed care. In the U.K.'s internal market, a limited form of competition between purchasers is being encouraged from the bottom up by way of GP Fundholding. The transactions costs of Fundholding are potentially higher than that associated with a managed competition system. Currently, there are 3500 Fundholders acting as purchasers in the U.K. in addition to the 100 Health Authorities, whereas potentially in the Netherlands (where managed competition is slowly being implemented) mergers between insurance companies will likely result in only 10-15 national chains of insurers. One must surely question the wisdom of the U.K.'s push towards further expanding the Fundholding initiative given the resultant increase in transactions costs that will result. One must also question a reliance upon competing Fundholders as opposed to competing purchasers on the grounds that the ethical norms of Fundholders as health service providers may be severely tested as they are put under increasing financial pressure. In order to protect the role of physician as that of patient advocate and to ensure the quality of health services (particularly for vulnerable patients) it may be better to encourage competition between large purchasers and regulate the degree to which purchasers can shift financial risk through capitation payment mechanisms down to small groups of health providers.

A managed competition system offers the prospect of a mix of regulatory, political (voice) and market (exit) mechanisms that can be tailored to ensure the accountability of purchasers. Dranove argues in favour of competition or exit for “[a] regulated approach will lock in existing institutional arrangements, with all future changes dictated by the whims of the political process, rather than by the demands of consumers.”798 But a politics-free health allocation system is an impossible goal unless one is willing to sacrifice the goal of redistribution. In managed competition models, government must manage or regulate competition between purchasers to: ensure universal coverage; to eliminate cream skimming; to stimulates competition on price and quality dimensions: to facilitate choice by consumers among competing purchasers; and to

ensure that the quality of services provided is of an adequate quality. It is a serious mistake to assume that the government's role is not as critical where there are competing purchasers as it is in one where governmental agencies act as the sole purchasers of services. Political accountability and voice continue to have a large and important role to play.

In the next chapter of this dissertation I will move to more closely scrutinize internal market reform as implemented in the U.K. and New Zealand and in particular the rationale for the "purchaser/provider split." This requirement for a purchaser/providers split will be compared with the managed competition model that allows competing insurers/purchasers to determine their own arrangements with providers be it contracting out or vertical integration or some other sort of arrangement on the continuum between those two polar options.

Chapter 5: The Interface Between Health Service Purchasers and Providers: Contracting-out vs. Integrated Production

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5.1 Introduction

Internal market reform and managed competition reform seek to achieve efficiency gains through proactive purchasing. The concept of a proactive purchaser is a significant development from the historical role of government and private insurers as “indemnity insurers”, reimbursing either provider or patient for all costs incurred on the assumption that no care is supplied or consumed that is not “needed.” In managed competition models, competition between insurers is managed or regulated to provide financial incentives for insurers to compete along price and quality dimensions in purchasing and/or providing health services. Managed competition models generally assume that private insurers will put in place “managed care arrangements” which are essentially a variety of techniques whereby insurers seek to influence the clinical decision-making of health care providers. In these models, insurers are left free to choose the most efficient supply arrangement and, subject to anti-trust laws, may or may not be vertically integrated with health providers. For example, as part of managed competition reform in the Netherlands, prohibitions on insurers/purchasers being involved in the supply of health services and on the vertical integration between insurers/purchasers and providers have been removed. By contrast, government-appointed purchasers in internal market models are regional monopsonies and are precluded from supplying health services themselves and must contract out for the supply thereof. The goal of internal market reform is to stimulate competition directly between health service providers rather than, as in the managed competition model, between health service purchasers. This chapter will consider and contrast the implications of these two distinct approaches from the perspective of the costs and benefits of mandatory contracting out required by internal market reform relative to the more flexible approach of managed competition. This chapter will draw upon the theory of the firm to evaluate the configuration of purchasers and providers in internal market and managed competition models. The chapter will then move on to consider contracting in the U.K. and New Zealand internal markets and whether or not the reforms have resulted in a more efficient system than what was previously in place.

5.2 The Purchaser/Provider Split

In the U.K. and New Zealand, a key structural feature of the new internal markets is a rigid split in the purchaser and provider functions in all health service markets. The details of these reforms were described in Chapter 3. Prior to internal market reform in both the U.K. and New Zealand, the purchaser and provider roles were integrated rigidly for all publicly-funded

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800 Schut, Greenberg, & Van De Ven, supra note 374 at 262, Table 1.
secondary health services. The concern that this arrangement evoked was that decision-makers had incentives to purchase services from the public hospitals they managed rather than from (possibly) more efficient public or private hospitals or providers. Thus, it was assumed that the public hospitals were not performing as technically efficiently as possible.

In New Zealand, as a result of internal market reform, there are now 4 Regional Health Authorities which are only permitted to purchase health services and cannot provide health services or vertically integrate with health service providers. In early 1997 it was announced that from 1 July 1997 there would be one National Purchasing Authority with 4 regional offices. The extent to which this change is more than cosmetic is as yet unknown; however, in any event this dissertation focuses on the period between 1993 and 1997. As a result of internal market reform there has been consolidation of purchasing responsibilities and Regional Health Authorities are now responsible for purchasing all publicly-funded health and disability services and public health services. Responsibility for managing the public hospitals has been assumed by 23 government-owned corporations, known as Crown Health Enterprises, which must compete with each other and private providers for supply contracts with Regional Health Authorities. Thus, rather than being completely integrated, the purchaser and provider roles for all health services have now been rigidly split.

In the U.K., as a result of internal market reform there are 100 Health Authorities which are responsible for purchasing health services. On the other side of the split, the public hospitals are now managed by independent 450 NHS Trusts which are statutory corporations reportable to the Secretary of State. In addition to the Health Authorities there are 3500 GP Fundholders that act as small purchasers. Fundholders must purchase on behalf of their enrolled patients all primary, diagnostic, community, outpatient, and elective surgical services and drugs, medicines, and listed appliances. Fundholding is a form of managed care as the Fundholders seek to influence the cost and quality of the health services supplied by the

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801 Except with the Ministers of Health's permission — see the Minister of Health's Policy Guidelines For Regional Health Authorities 1996/97 (publication details not given in the document but presumably published in Wellington by the Ministry of Health in November 1995) at 18, where it is stated that "[i]f RHAs wish to engage in activities related to their purchase role which might technically be considered as a form of service provision, they must seek the approval of the Minister of Health. The Minister would only approve activities that provide a net benefit to RHAs' populations in terms of the quality and/or quantity of services or the price the RHA pays, which cannot be achieved in other ways. RHAs may not own providers."

802 Recently, however, responsibility for purchasing health services for accident victims has been transferred back to the Accident and Rehabilitation Compensation Insurance Corporation — See the Accident Rehabilitation and Compensation Insurance Amendment Act (No 2) (N.Z.) 1996, No. 106, s.6.

803 See the Health Authorities Act (U.K.) 1995, c.17.
providers they contract with. In contrast to Health Authorities, Fundholders are both purchasers and providers and are able to choose whether to contract out for supply or produce the service themselves. The existence of Fundholders runs counter to the thesis of the efficacy of splitting the purchaser and provider function. Thus, comparing the reasoning behind, and development of, Fundholding with the balance of the internal market reforms will help in understanding the costs and benefits of both types of reform.

The mandatory rigid purchaser provider split in New Zealand and the United Kingdom is primarily justified as a device to reduce managerial conflicts of interest in the old vertically integrated health authorities. The new government-appointed purchasers in both jurisdictions are, through proactive purchasing pressure, meant to ensure efficient performance on the part of public and private providers. The purchaser/provider split is, however, at odds with the international trend towards managed care and/or integrated delivery systems wherein the purchaser and provider roles may be combined. As discussed in chapter 3, the term managed care covers a variety of techniques whereby insurers/purchasers (be they public or private) seek to make health care providers sensitive to the costs and benefits of the services they are supplying or recommending to their patients.

It is important to note that there is nothing inherent in a managed care arrangement or, for that matter, in a managed competition system, which dictates whether insurers/purchasers will choose to be vertically integrated with or contract out with health providers. All other things being equal, insurers/purchasers are free to negotiate the most efficient supply arrangement with health care providers. In some instances, depending on market conditions and the nature of the health services in question, it may be easier for insurers/purchaser to influence providers’ decision-making when they are in a close relationship. Managed care plans link the financing and supply of medical care. This may be through contracts between insurers and hospitals and physicians or by insurers owning hospitals or employing physicians. When an insurer is vertically integrated with (i.e. owns) hospitals and employs physicians on a salary basis, cost controls are achieved within the firm. When an insurer/purchaser contracts out to health care providers then contracts must incorporate the ability for insurers to monitor providers’ treatment recommendations and contain incentives for providers to make cost-efficient treatment decisions. The current emphasis in health care policy is, however, upon “integrated delivery systems.”804 The appeal of an integrated delivery system is the concept

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that different health providers work together in order to co-ordinate the application of their varying skills and the care supplied to any patient. The goal is that the patient receives the most cost-effective care and costs are not shifted from provider to provider or on to patients or to society at large. The key to this integration is essentially risk sharing as it is only then that different health care providers have an incentive to co-ordinate their different skills. Thus this suggests that vertically integrated institutions may be generally preferable to looser contractual arrangements.

5.3 Theories of the Firm And Reasons For and Against Vertical Integration

Internal market reform assumes that the process of government-appointed purchasers contracting out to competing health providers will be more efficient than the rigid vertical integration of the old system. It is helpful to return to first principles at this point and consider the reasons that private firms contract out or vertically integrate. As Williamson noted in 1975, attention to the internal organizations of private firms will likely prove fruitful in attempting to study the conduct and performance of quasi-market and nonmarket organizations.

Most discussions of the theory of the firm begin with Coase’s observation in the mid 1930s that some economic activities are organized in markets and some internally within a firm. A firm may buy goods or services as inputs for production in a market (contracting out) or it may extend its boundaries to include production of the inputs (in-house or in-firm production). For example, a pharmaceutical company may choose to contract out for the supply of chemicals it needs to manufacture drugs from other firms or it may choose to source the chemical(s) in-house. In the latter case it may buy the firm/s necessary to supply it with the chemicals it needs for production or buy the assets needed for controlling the factors of production in which case it would be “vertically integrated.” A vertically integrated firm has one managerial hierarchy.

As Demsetz describes, given the existence of markets, Coase addressed the question of why firms exist at all and concluded that profit-maximizing behaviour requires “the substitution of firms for markets when the cost of using markets becomes large relative to the cost of

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managing." Coase identified different costs with respect to the process of in-house production and with respect to the process of contracting out for the supply of products or services to other firms. The three costs he identified as associated with contracting out were: the costs of discovering what the true price is for the required good or service in the market; the costs of negotiating and concluding a separate contract for each good or service required; and the costs associated with writing a long-term contract where one party is unsure and/or unable to specify what will be required of the other in the future. These types of costs are generally referred to as "transactions costs." Coase identified the costs of in-house production by firms in (rather vague) terms of the rising costs "of organizing additional transactions within the firm," the entrepreneur's failure "to make the best use of the factors of production", and the increase in the price of supplies because "the 'other advantages' of a small firm were greater than those of a large firm." He described the first two types of in-house costs as correlating with the economists' phrase of 'diminishing returns to management.'

Williamson is most generally associated with developing Coase's theory that transactions costs determine whether production is sourced within a firm or contracted out to other firms and in seeking to predict when the costs of contracting in the market will be greater than the costs of in-firm production. Williamson makes two behavioral assumptions. The first is that individuals have "bounded rationality": the second is that individuals may act opportunistically in transactions.

With respect to the assumption of "bounded rationality," Simon, an organizational psychologist, is credited with first having observed that "[t]he capacity of the human mind for formulating and solving complex problems is very small compared with the size of the problems whose solution is required for objectively rational behavior in the real world." Consequently, whilst individuals generally intend to be rational, their actions may not accord with their intentions. In the relevant literature this problem is often (unclearly) tied to the problem of identifying future contingencies and the ability to specify in contracts appropriate responses thereto. Depending on the degree of uncertainty involved in any particular

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808 Coase, supra note 806 at 395.
809 Idem.
transaction it may be very difficult for parties to foresee all contingencies. Even if complete information was available on all future contingencies, parties to a contract may not rationally solve the puzzle of what provisions to incorporate in the contract to address these contingencies or it might cost too much to solve the puzzle relative to the discounted risk of waiting to see what events unfold. If complete contracting was viable or efficient in all circumstances there would be no need for the existence of firms.812

The second assumption Williamson makes is that individuals may act opportunistically in transactions i.e. with a lack of candor or honesty or with guile in pursuing their own self-interest. Generally, Williamson considers this behavioral tendency to be of little consequence as long as there is a competitive market for the particular good or service required. However, when a party to a contract has made specific investments in assets or skills to produce the goods or services required and these specific assets are not readily acquirable elsewhere then this party has significant incumbency advantages at the contract renewal juncture. Williamson refers to this problem as a case of “asset specificity.”813 The market, at the point in time at which the contract is open for renewal, is significantly less competitive than it was at the outset and the incumbent may effectively have been transformed into a monopoly. By the same token, the incumbent may also be vulnerable to exploitation by the purchaser as it may be very difficult or impossible for the incumbent to use the specialized assets for other purposes. A bilateral monopoly situation may thus arise. The outcome of negotiations between the parties will depend on the relative susceptibility of each party to hold-out tactics. In such a case, vertical integration may be a more efficient choice for one or both parties than short-term or long-term contracting. The key to understanding this, as Flannigan notes, is to realize that, by vertically integrating, the firm(s) avoid the opportunism problem by moving the contracting interface to a competitive (large-numbers) market.814 Thus, rather than contracting with a supplier who controls specialized assets, an integrated firm (which now controls the specialized assets) can contract in competitive markets for the factors required for production using those specialized assets. Vertical integration reduces opportunism problems as then neither firm has a pre-emptive claim on profits and the integrated firm’s internal control mechanisms can be more extensive and refined than that which was feasible through

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contracting.\textsuperscript{815} Williamson also notes that the decision to vertically integrate can reduce any information asymmetry problems i.e. where one party opportunistically relies on information that the other party does not have regarding costs, quality or other underlying conditions germane to the trade.\textsuperscript{816}

Williamson argues that unlimited integration will not occur due to the costs associated with increasing firm size. These costs include: loss of information regarding the real value and scarcity of production factors that is signaled through market prices;\textsuperscript{817} the creation of incentives within the firm for non-pecuniary form of opportunism (such as slacking on the job) on the part of employees; loss of management control because of the scale of the enterprise: the deadlines and delays of hierarchies; and other bureaucratic costs associated with internal firm management.\textsuperscript{818} The unresolved issue remains of how to move beyond abstract generalizations of the costs of increasing firm size (or, conversely, the costs of contracting-out) to make predictions in a particular market of what is likely to be the most efficient firm configuration.

Thus far the discussion has been limited to consideration of the private sector. Does the theory of the firm have relevance where one or more of the parties to the contract is the government or are government agents as in the U.K.’s and New Zealand’s internal markets?

Some scholars argue that due to inherent inefficiencies of government operation, government should always contract out for the supply of services or goods.\textsuperscript{819} The theory of contestable markets suggests that even in the case of monopoly it is more efficient to contract out to the private sector. It is argued that if there is competitive bidding for the supply of public utilities for a fixed period this process will drive prices down from the monopoly to the competitive level.\textsuperscript{820} Thus, while competition within the market may result in wasteful duplication of resources, competition for the market results in the necessary competitive rigour to ensure efficiency without costly regulation. The theory of contestable markets has been criticized by

\textsuperscript{815}See Williamson, \textit{supra} note 805 at 10.
\textsuperscript{816}Ibid. at 14.
\textsuperscript{818}Williamson, \textit{supra} note 810 at 133–135.
\textsuperscript{820}Idem.
Williamson notes that, just as in the private sector, future contingencies are never able to be fully predicted ex ante in a long term contract, resulting in the need for on-going negotiation and agreement between the parties with scope for opportunistic behavior by both parties. Moreover, Williamson argues that long-term contracts often require the deployment of specialized assets which cannot be readily utilized for other purposes or obtained elsewhere. As a consequence, incumbent suppliers have an advantage at contract renewal junctures as new entrants will not be easily able to acquire the assets they need and contracting with a new entrant may result in a lag time in the production process.

Trebilcock concludes from the literature of the theory of the firm that governments will find it more efficient to contract out for the supply of services or goods rather than produce the good or service itself when: (1) the desired product or service is easily described and its volume and quality can be specified in advance; (2) the costs of negotiating contracts is relatively inexpensive (and, one might add, the cost of monitoring and enforcement of contractual performance is relatively low); and (3) production involves few economies of scale or scope but large returns to specialization.

Using Trebilcock’s general criteria, one may conclude given information asymmetry and contestability problems that appear to be apparent in many health service markets that any form of competition-oriented reform will be inefficient, be it internal market or managed care reform. This is not, however, necessarily the case. We may use some of the general theories regarding contracting-out to consider the cost and benefits of the rigid purchaser/provider split in internal markets. These criteria are of less relevance when it comes to consider the role of government as sponsor in the managed competition model, where the role of the sponsor is to pool funding, calculate risk-adjusted payments, and regulate competition between competing insurers/purchasers to ensure competition on price and quality dimensions. None of these regulatory tasks will be easy but there is a significant difference between the role of government as regulator (even where the regulation required is sophisticated and complex) and

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821 Williamson, supra note 810, ch. 13.
824 Trebilcock, supra note 13 at 13. Another way of stating this would be that government will find it more efficient to contract out than to produce the service itself where (1) information asymmetries between the parties are small and there is adequate information available on costs, prices, and quality thus reducing the scope for opportunistic behavior and (2) there is competition within or for the market (which depends to a large measure on the degree of investment in specific assets and substitutability thereof).
the role of government as purchaser of health services. In the latter case, government is expected to engage in micro-managing of individual health service markets and of individual health providers. Essentially one must determine what is the most appropriate role for government, and a factor influencing this decision is that if government is left as a purchaser then there are potential efficiency losses from enforcing a rigid purchaser/provider split in order to avoid conflicts of interest.

Turning back to the particular question at hand, namely the efficiency of the internal market model's requirement that government-appointed authorities contract out for the supply of health services, there needs to be some analysis of the degree of information asymmetry and/or the degree of asset specificity required to trigger a decision to produce the product in-house as opposed to contracting out. The next section will examine the degree of asset specificity and information asymmetry in health service markets with a view to determining what, if any, generalizations can be made when choosing between in-house production and contracting out.

5.4 The Varying Characteristics of Health Service Markets

Whether or not government or a private firm should contract out for the supply of a good or service or produce that good or service itself depends on the nature and conditions of the market in question both in the short and (in the foreseeable) long run. Consequently, it is important to consider the characteristics of different health service markets. In particular, we must consider the scope for opportunism arising in health markets due to investment in specialized assets and due to information asymmetry.

Where a provider invests in resources for which there are no ready substitutes in order to secure a contract then, at the point of contract renewal, the incumbent provider will have significant advantages over other potential competitors. These advantages will accrue from the fact that switching providers might subject the purchaser to an unacceptable lag in supply and the fact that if there is a monopsony, a new entrant to the supply market is unlikely to make the necessary capital investments without the guarantee of a long-term contract. From the incumbent supplier's perspective, it is now dependent on the purchaser as it is unable to readily transfer its specialized investments to other uses. The market is no longer competitive and there is potential for opportunistic behaviour on the part of both contracting parties.
Crocker and Masten note that investment by providers in assets can take at least four general forms. These are physical-asset specificity, site or location specificity, human-capital specificity, and dedicated assets (which are investments made to support a particular contract which are not specific to the purchaser but which would result in substantial excess capacity if the contract was not renewed.) In addition, Crocker and Masten note that the need for timeliness in supply may result in the threat of delay being an effective strategy for achieving bargaining concessions. As I will seek to demonstrate, the threat of hold-out and the relative abilities of contracting parties to withstand hold-out is key to understanding how bargaining between bilateral monopolies in internal markets is likely to occur.

All types of asset specificity noted by Crocker and Masten may be present in certain health service markets. However, broad generalizations about health service markets are impossible as there are distinct markets for different services. Let us take three general types of health services to illustrate this point -- emergency services, general practitioner services, and mental health services.

In the case of emergency services, a hospital and the technology employed therein may not be readily able to be deployed for other purposes, which makes the owner of the hospital dependent on the purchaser. On the other hand, it may be absolutely critical to the purchaser to have an ongoing relationship with the hospital in order to ensure timely access for patients. The purchaser’s vulnerability in this regard will depend on surplus capacity within the hospital and the number of other hospitals located nearby. The purchaser may consider that it is compromising the safety of local patients should it contract with a hospital that is more, for example, than 30 minutes drive from the population it serves. In terms of negotiations between a purchaser and the incumbent provider, arguably it will be the purchaser who will be most vulnerable to threats of hold-out by the provider and this problem will be exacerbated by the provider having significantly better information than the purchaser about the costs of production. A purchaser’s vulnerability to opportunistic hold-out tactics will not be as critical for elective (i.e. non-urgent) surgical services as presumably the criteria of proximity to the population will not be marked and thus more hospitals may be able to compete. In terms of human-capital specificity, a hospital employs specifically skilled staff and the degree


826 Possibly this problem of hold-out could be mitigated by locally based clinics with staff capable of triage with ambulance and helicopter providing transport to larger centres with a number of hospitals. The viability of this option will depend on the cost and the impact on patients’ safety and cost.
to which the skill of the staff will make it difficult or impossible to switch to a substitute provider or service will depend on the elasticity of the labour market (which is related not only to the numbers trained in a particular specialty but to the substitutability of one set of skills for another and relevant licensing requirements). Should a hospital hold a monopoly in the supply of a particular service, then this may provide it with scope for opportunism in concluding contracts for the supply of other contestable services by cross-subsidizing its operations in contestable markets with profits made in monopoly markets.

With respect to general practitioner services, investments in physical capital are presumably relatively small and easily diverted to other production purposes, for example the office lease. Moreover, while in some rural or remote areas a general practitioner may hold a monopoly, one would predict that patients will generally have a choice of practitioner within a reasonable traveling distance and/or that the market is contestable. In many jurisdictions there is a problem with attracting general practitioners into rural areas because of a variety of professional and life-style factors. Where physicians are paid on a fee-for-service basis this allows them to locate in an urban areas with high numbers of physicians and still earn an sustainable income as they can influence demand for their own services. If physicians are paid on a capitation basis they may find themselves forced to relocate from areas with high numbers of physicians in order to attract a sufficient number of enrollees as they will not be able to top up their incomes by simply seeing the same people more often. General practitioners who have a continuous relationship with a patient may, in a sense, develop specialized human assets through acquiring information about the history and preferences of the patient; however, one would envisage that practitioners could be prevented from monopolizing this information if adequate medical records were required to be kept and were required to follow the patient upon their exit to another general practitioner.

With respect to mental health services, one sees in practice significant investments in specifically designed institutions which could not be readily deployed to other uses although rehabilitative and continuing care services may not require such specialized investment.

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827 By this I mean that a new general practitioner (having satisfied all relevant licensing requirements) could readily enter the market as a supplier.


829 Although the sale in the latter part of 1996 by South Auckland Health (one of the 23 Crown Health Enterprises) of the Kingsheat psychiatric hospital for $6.8 million suggests that it is indeed possible to actually dispose of specifically designed institutions. The relevant question is the value realized in the sale relative to the original investment discounted by the number of years in service.
The proximity of the provider of mental health services to the population it serves may not be as crucial as for emergency services; however, proximity to local communities might be viewed as an important element of the quality of the service supplied in terms of integration of the patient into local communities. The supply of some mental health services may require investment in specialized knowledge in terms of a provider's familiarity with a patient's case-history. It may also require that there be continuity in the supply of services to patients if relationship-building and trust are considered key components of quality.

In some health markets, the paucity of information available regarding future contingencies hinders both long-term planning and the ability to conclude long-term contracts. Problems of information paucity are exacerbated in former command-and-control systems, like the U.K. and New Zealand, as historically there been no systematic emphasis on the collection and dissemination of information on the cost and quality of services. In these countries, the administration and transactions costs incurred have been low but perhaps at the cost of information regarding performance.

In many health markets, providers will have information regarding production costs and quality that a purchaser (be it a public or private insurer or individual patient) will not have. This problem is possibly a function of the fact that in many health systems allocation decisions have been left in the hands of health providers so there has been little need to elicit this information. Nonetheless, for some services of a caring nature it will be difficult if not impossible to gauge performance by way of measurable health outcomes. However, the degree of these problems will vary significantly depending on the health service markets in question. Stipulating, measuring and monitoring quality in contracts, for example, for some mental health services, palliative care services and disability health services, may be difficult due to the lack of any readily measurable criteria for performance. By comparison, assessing the quality of an appendectomy seems relatively straightforward in terms of removal of the offending appendix, the lack of complications or readmission required thereafter, and the patient's recovery time.

S. R. Smith & M. Lipsky, "Privatization In Health And Human Services: A Critique" (1992) 17: 2 Jnl. of Health, Politics, Policy, and Law 233 at 237 — "...most services cannot be judged on the basis of decisive client outcomes. They cannot be standardized in their treatment approaches, nor can auditors effectively intrude into the interactions between workers and clients to determine whether decisions were made appropriately and consistently with existing policy."
The clear lesson from these examples is that to assume homogenous health service markets is erroneous. A recent survey by Ashton in New Zealand (consisting of interviews with management of purchasers and providers) suggests that there are significant variations in transactions costs depending on the health service market in question. In particular, the transactions costs associated with contracting out of acute mental health services are perceived as being much higher than for other services. By comparison, transactions costs for rest home services were perceived as being low. She contends that consequently it appears transaction costs do increase as asset specificity, frequency of transactions, uncertainty, and problems of measurement increase. This work generally supports the argument that different markets warrant different treatment.

Health service markets vary in their characteristics such that there are some services where contracting out might be the more appropriate option and others where in-house production would be more appropriate. One cannot even make general predictions about service areas, such as mental health services or general practitioner services, as much will depend upon the particular conditions of smaller markets within those general categories. For example, the market for mental health services can be broken down into at least three discrete markets: forensic mental health services (for criminals and/or those who are a danger to themselves or the community), acute/intensive mental health services, and rehabilitation and continuing care mental health services. Each of these markets will exhibit different levels of asset specificity, information problems, and scope for opportunistic behaviour. Moreover, the characteristics of these markets are dynamic and are liable to change over time. For example, developments in technology may reduce the fixed costs of operation and thus the monopoly characteristics of hospitals. Key-hole surgery allows significantly faster patient recovery time and overall reduces the average number of beds and staff required in hospitals by negating the need for many patients to stay overnight thus reducing the number of beds needed and the overall fixed costs of operation. This highlights the need for a flexible system that responds to changes in technology and the production process on the supply-side.

832 Ashton, “Contracting For Health Services In New Zealand: Early Experiences”, ibid.
833 See the New Zealand’s Commerce Commission Decision No. 275, ISSN No. 0114-2720, 1 August 1995 (Application by the Midland Regional Health Authority and Health Waikato Limited for authorization under the Commerce Act (N.Z.) 1986, No. 5, s.58, at 32.
Williamson noted that opportunism problems arising from asset specificity and information asymmetry are not of significant concern provided there is a competitive market. Miller notes from his study of fifteen U.S. communities that insurers initiated only a limited amount of integration with hospitals. He advances the thesis that in a period of excess hospital bed supply, "it can be cheaper for insurers to “buy” rather than to “make” hospital services." Thus, the extent to which rigid contracting out will be efficient will depend on the level of competition on the supply side.

The theory of the firm seeks to explain the size and structure of firms. The size and structure of purchasers and publicly-owned providers in internal markets have been fixed by government fiat and have not evolved as responses to market forces. In many government-controlled systems, such as the U.K., New Zealand and Canada, recent emphasis has been upon consolidating hospitals generally on the assumption that there are economies of scale efficiencies to be reaped from such consolidation. However, Schut concludes that empirical research does not support the belief that the larger the hospital the better and moderate-sized hospitals are characterized by constant returns to scale. As an example of how government has fixed the size and scope of hospital operation, in New Zealand the Auckland Crown Health Enterprise ("CHE") (one of 23 CHEs) manages six hospitals on six separate sites with a total of 1420 beds. By comparison, the Health Waikato CHE, is responsible for 14 hospitals on 14 sites with a total of 1501 beds and the Lakeland Health Ltd. CHE is responsible for 1 hospital with 260 beds. The Auckland CHE’s six hospitals cover a wide range of specialties: Auckland Central (specializing in neurosurgery, ophtalmology, oncology); Starship (for children’s medicine); Greenlane (specializing in cardiothoracic surgery and respiratory medicine); National Women’s (specializing in gynecology and obstetrics); and the Mason Clinic (for secure psychiatric patients). It is difficult to ascertain whether the size and structure of the CHEs is optimal in terms of the number and types of hospitals they are respectively responsible for. However, much does seem to turn on hospitals’ geographic proximity to each other and does not appear to be related to the manageability of the institutions or co-ordination between health service needs. The result is that although neighbouring hospitals may in fact be potential competitors in a number of health service

834Miller, supra note 804 at 100.
markets when they are under the administrative and managerial umbrella of one CHE any potential for competition is negated. As government determines the size of purchasers and providers in both the U.K. and New Zealand, potential competition is artificially suppressed in both jurisdictions. As a result a bilateral monopoly situation often arises, with monopsony on the demand side and monopoly on the supply side. The results of negotiations in a bilateral monopoly situation is difficult to determine. The risk is that there will be no efficiency gains from the new arrangements but that there will be increased transactions or administrative costs arising from mandatory contracting out.

5.5 Contracting in Internal Markets
The contract appears to be, as Allen notes, the fulcrum of the internal market model for it performs the function of formalizing the agreement between purchasers and providers as to the range and quality of health services to be delivered and at what price. A contract is the only linkage allowed between government-appointed purchasers and health care providers in the U.K.’s and New Zealand’s internal markets and proprietary or vertically integrated relationships are precluded. This is in contrast to the managed competition model and, indeed, to the general ethos of managed care where, all other things being equal, there are a variety of relationships, contractual and proprietary, that may exist between insurers/purchasers and health care providers.

The rationale underlying the purchaser/provider split in the U.K. and New Zealand is that prior to internal market reform it was easier for the management of the old integrated institutions to purchase services from the public hospitals they managed even when there were other more efficient private providers. The propensity for slack management to prefer inefficient in-house production over more efficient contracting does not seem an important issue in the theory of the firm. Presumably this is because it is assumed that, although there might be some initial inertia, a private firm in a competitive market will have no option but to divest itself of production functions if this is the most efficient option. The problem in both the U.K.’s and New Zealand’s former command-and-control systems was that there were no incentives for management within these integrated institutions to choose the most cost-efficient range of services and to purchase from the most efficient provider supplying services of an adequate quality. Rather than directly tackling the problem of the lack of incentives

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838 In the New Zealand context see Upton, supra note 16 at 11-19.
839 See the discussion in Chapter 4.
for purchasers, reformers in both New Zealand the U.K. have focused their energies on minimizing the discretion decision-makers are accorded by indiscriminately splitting the purchaser and provider roles and requiring purchasers to contract out for the supply of services. The contract is used in internal markets as a managerial device to minimize discretion.840

The primacy in internal markets of “contracting” as opposed to hierarchical or administrative arrangements would seem to reflect the preference of neo-classical economists for allocation through the market as opposed to by government. This preference is based on the assumption that contracts are voluntarily entered into and the parties thereto are fully informed. Thus the welfare of the parties thereto must be improved or else they would not have entered into the contract.841 However, as discussed in the following section, these assumptions cannot be made with respect to the contracts concluded in the U.K.’s and New Zealand’s internal markets.

5.5.1 Contracts in the U.K.’s Internal Market
Contracts in the U.K.’s internal market violate the assumptions that economists usually make about contracts in the private sector in a number of important respects to the point that, I would argue, it is positively misleading to describe the process as “contracting.”

The government-appointed Health Authorities have no choice but to contract out for the supply of health services and thus as they do not enter contracts voluntarily, the resultant contracts cannot be assumed to be welfare-enhancing. Notwithstanding the existence of GP Fundholders (discussed later in this chapter), Health Authorities still purchase the vast majority of health services and thus many providers will have no choice but to contract with Health Authorities. Moreover, in the absence of contractual or constitutional restraints, there is the possibility that the Health Authorities will use their monopsony power to engage in opportunistic behavior at the expense of health care providers and, ultimately, patients.842

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841Pareto efficiency (after Vilfredo Pareto) is a state where no reallocation can make any individual better off without making someone worse off in terms of maximizing value from resource use. In government decision-making there is a constant trade-off of interests and the concept of Pareto efficiency becomes redundant. Kaldor-Hicks efficiency test says that an action is acceptable if the resulting efficiency gains in theory would be enough to compensate the other party even if in reality that compensation does not occur. Clearly, however, this type of measure may result in unacceptable distributional results.
As Health Authorities are government-appointed, there may be both direct and indirect pressure not to disrupt established entitlements and to maintain the status quo in contracting arrangements. In private markets, managers have incentives to conduct their business efficiently otherwise there is the risk of insolvency and consequent job loss. Both purchasers and providers may know that in the U.K.'s internal market the government may well be unwilling to sack the management of inefficient Health Authorities or NHS Trusts because of political repercussions particularly where the inefficiency relates to cost-cutting or savings which may not be politically popular. As one example, the U.K. government allocated extra funding to the Thames regions to mitigate the effects of a fall in funding as a result of the new contracting process and it prevented some purchasers from switching to cheaper providers to protect incumbents. If the government continually intervenes to blunt the effect of competition then, as Ham and Maynard note, the result may be the worst of the command-and-control system and the free market system; bureaucratic controls coupled with high transaction costs.

Rather than being free to make any bargain they choose, a prospective party to an “NHS contract” (which is generally a contract between a Health Authority and a NHS Trust or a GP Fundholder) who considers that they other party is taking advantage of an unequal bargaining position may refer the matter to the Secretary of State for Health who may specify the terms to be included in any proposed arrangement and direct the parties to proceed with it. Moreover, unlike ordinary commercial contracts, “NHS contracts” are not enforceable at law and any dispute arising in relation thereto is not to be referred to the regular courts but to the Secretary of State (or her or his appointee) for determination. The Secretary of State is permitted to vary the terms of the arrangement in dispute or terminate the arrangement, powers which Allen argues are beyond the regular courts in the U.K. in the resolution of ordinary commercial contracts. Maynard argues that this absence of legal redress in the U.K.'s internal market may be of little significance as many private sector commercial agreements are settled out of court. However, this argument overlooks the fact that in the private sector it

846 Ibid. at 846.
847 See the National Health Service and Community Care Act (U.K.) 1990, c. 19, s.4.
848 Ibid., s.4 (3).
850 Maynard, supra note 510 at 1438.
may be the threat of litigation that provides an incentive for the parties to negotiate a compromise. Also the determination of disputes through the courts creates a line of precedent that parties in dispute may turn to for guidance in reaching settlements (although U.K. regulations do require that the reasons for a particular decision be given and thus a line of administrative precedent could emerge).  

The U.K. government regulates the prices negotiated between the Health Authorities and the NHS Trusts by requiring that the prices charged by NHS Trusts be based on their respective average costs. Marginal costing may only be used where there is surplus capacity above and beyond that predicted to be needed to fulfill the volumes of services required by purchasers in that year and can only be applied during the actual financial year that the spare capacity arises.  

NHS Trusts cannot negotiate differential rates notwithstanding the fact that there may be significant differences in the volumes of services demanded by different purchasers. As McGuire and Anand note, unless there are constant returns to scale, average costs do not equal marginal costs and consequently insisting on prices being fixed at average costs will be inefficient in some markets. This reiterates the point that there are many different health service markets and they cannot all be treated the same.

NHS Trusts are expressly prohibited from cross subsidizing one contract, procedure, or specialty from another and are only allowed to make a return of 6% per annum on their net assets. NHS Trusts are not able to carry forward surpluses into the next financial year. and the government regulates and prescribes the amount of private capital able to be borrowed. Moreover, progress has been slow in enabling NHS Trusts to negotiate employee contracts. These sort of restrictions leaves the NHS Trusts at a competitive disadvantage compared to private providers who are under no such restrictions but are understandable given the monopoly held by NHS Trusts in many health service markets.

Regulation of competition in the U.K. internal market is not the responsibility of the usual institutions of competition policy (such as the Office of Fair Trading and the Monopolies and

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849 See the National Health Service Contracts (Dispute Resolution) Regulations (U.K.), 1991, S.I. 1991/725.
850 Allen, supra note 837 at 6.
851 Idem.
852 McGuire & Anand, supra note 581 at 5.
854 Health Care UK 1994/95, supra note 588 at 6 notes that although the intention was that NHS Trusts should set their own arrangements for pay at a local level, the government accepted in February 1994 the Pay Review Bodies’ recommendations for clinical staff of across the board rises of 3%.
Mergers Commission) but is left to the government in the form of the NHS Management Executive. On 12 December 1994 the Department of Health published guidelines intended to inform participants in the U.K.’s internal market of current government policy with respect to mergers and anti-competitive behaviour. Allen notes that the government’s guidelines go to the competitive structure of the market and thus do not affect the form, content or interpretation of ‘contracts’ directly, although they may well affect which providers and purchasers become the contracting parties in any particular transaction.

Given that “contracts” in the U.K.’s internal market are not legally enforceable and the government controls both purchasers and most hospital providers, the rhetoric of “contracts” may disguise the real fact that the result is simply new hierarchical arrangements within the old U.K. bureaucracy. As Checkland puts it “[t]he reality of contracting has been that the word is shorthand for a complex social process which has been evolving steadily since the reforms were introduced.” This leads to the insight that there is not necessarily a clear choice between contracting out and vertical integration. In truth there is a continuum of options in the context of public/private relationships. The case of the U.K.’s internal market falls closer towards the pole of vertical integration than towards the pole of contracting out as normally understood in the private sector. Even within the internal market, government-appointed purchasers and providers may vary in the extent to which they treat relationships between them as hierarchical or administrative or as arms length market transactions to be formally codified in contracts.

Some commentators argue that rather than fostering increased devolution of power and “less” government, internal market reform in the U.K. has in fact resulted in increased centralization. Harrison notes in the King’s Fund Policy Institute report Health Care in the UK 1994/95:

“[i]f we look at actions rather than words, it would be easier to regard the new NHS not as a competitive structure, but rather one in which providers are increasingly having to respond to central targets set for the reduction of waiting lists and other requirements of the Patient’s Charter, for the introduction of higher rates of day case surgery and for the reduction in costs.

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856 Allen, supra note 837 at 7.
or cash releasing efficiency savings. Targets are set nationally in the best traditions of Soviet-style planning and are then faithfully passed on by purchasers to their main providers, often unamended in the light of local circumstances or to the scope of savings in particular forms of care.\textsuperscript{859}

However, Harden argues that it would be a mistake to think that the contractual approach offers nothing new. He argues that

"...[t]he new element is not 'consumer sovereignty', however, nor greater rights for individuals. Rather, it is the fact that the parties to the contract have separate interests. In this sense 'competition' is inherent in the contractual approach; not competition between different purchasers, or different providers of services, but in the contractual relationship itself. The public interest -- i.e. the overall functioning of the public service in question -- is not the responsibility of a single unitary organization, but instead emerges from the process of agreement between separate organizations, none of which has responsibility for the public interest as a whole...[it] is this which is essential to the creation of a structural bias towards minimizing discretion and a focus on performance/outputs rather than process/inputs."\textsuperscript{860}

I find Harden's arguments unconvincing and cannot see how competition \textit{within} the contractual relationship will result in a net improvement in the public good. Surely there is a significant risk that this sort of "competition" will be nothing but a contest to avoid accountability and responsibility and maintain the status quo in order to ensure political longevity? As Maynard (blisteringly), describes it "[t]here is a risk that the (internal market) reform process has created a quasi-centralized bureaucratic confusion dressed up in the rhetoric of market competition."\textsuperscript{861} Is the minimization of discretion necessarily a good thing? The theory of the firm suggests that having the discretion to be vertically integrated would, in some health service markets, be efficient. Another way to view "minimization of discretion" is as fragmentation of accountability as central government, government-appointed purchasers, and providers all point to each other as being responsible for any failures in performance.\textsuperscript{862} Minimizing discretion also fails to acknowledge that purchasers themselves need incentives to in turn ensure the most efficient performance on the part of providers.\textsuperscript{863} If purchasers do have incentives to ensure the efficient supply of health services then mandating a rigid purchaser/provider split reduces the potential for innovation and change.

\textsuperscript{859}Health Care UK 1994/95, supra note 588 at 7.
\textsuperscript{860}I. Harden, The Contracting State (Buckingham: Open University Press, 1992) at 33.
\textsuperscript{861}Maynard, supra note 510 at 1437.
\textsuperscript{862}See Flood & Trebilcock, supra note 724.
\textsuperscript{863}See Chapter 4.
5.5.2 Contracts in New Zealand's Internal Market

The purchaser/provider split in New Zealand has been more rigorous and real than in the U.K. There has been a concerted attempt to reform public hospitals into government owned corporations (Crown Health Enterprises) that seek to mimic private firm behavior. Unlike the U.K., in New Zealand's internal market there is no explicit government regulation of pricing, there is no prohibition on cross-subsidization by providers, there is no explicit regulation of private borrowing by the Crown Health Enterprises.\(^{864}\) Regulation of competition is left to the general competition authorities,\(^ {865}\) and all contracts are enforceable through the regular courts in the usual manner.

Nevertheless, contracts between Regional Health Authorities and the Crown Health Enterprises contradict the assumptions that neo-classical economists generally make about contracts in the private sector. In New Zealand's internal market, Regional Health Authorities must purchase through contracts a comprehensive range of services for the population of their respective regions. Thus, the contracts that result cannot be assumed to be welfare enhancing as some may not have been entered into or would have resulted in significantly different terms if the Regional Health Authority in question was able to supply or threaten to supply its own health services rather than being forced to contract out. As Regional Health Authorities are monopsony purchasers in their respective regions, most health care providers have no real choice but to contract with them. In addition, the Minister of Health may compel Crown Health Enterprises to supply health services.\(^ {866}\) A Regional Health Authority is also entitled by statute to give notice of the terms and conditions upon which it will make payments to public and private health providers and acceptance of such payment is deemed to constitute acceptance of those terms and conditions.\(^ {867}\) The gap between prices paid and Crown Health Enterprises' actual costs is acknowledged by management within the Regional Health Authorities who in turn blame central government for not funding them to a sufficient degree so that they are able to pay prices that cover the costs of providers.\(^ {868}\)

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\(^{864}\) Although they have only recently been able to supply services to private purchasers and there are government guidelines in place which effectively regulate this source of income.

\(^{865}\) There was a transition period of nearly two years where key players were exempt from these requirements. The Minister of Commerce issued a statement under the Commerce Act (N.Z.) 1986, No.5, s.26 in June 1993 stating that, when considering competition issues in the health sector, the Commission should take into consideration the major changes underway and give the industry time to work through the transitional arrangements in place. The notice was withdrawn in May 1995.

\(^{866}\) The Health and Disability Services Act (N.Z) 1993, No. 22, s.40.

\(^{867}\) Ibid., s.51.

\(^{868}\) See e-mail letter from J. Webster, Manager, Central Regional Health Authority, 4 April 1997 -- on file with author.
In the private sector, management face the risk of insolvency if their firm is not competitive and concomitant job-loss and damage to credibility in the management job market. These sorts of incentives do not act upon management in the Crown Health Enterprises. To date, Crown Health Enterprises that are failing have been propped up through deficit funding i.e. the government injects funds and that sum is then treated as debt to be repaid over the longer term (perhaps past the horizon point where current managers envisage themselves staying in their positions). Part of the problem has been is that the Crown Health Enterprises were saddled with unrealistic debt burdens at their inception. The debt accrued historically by the old Area Health Boards was simply transferred to the new Crown Health Enterprises. This has reportedly caused serious motivational problems for staff as any savings made through efficiency gains are diverted to debt repayment as opposed to service enhancement. This deficit funding also means that the Regional Health Authorities need not be unduly concerned that opportunistic behaviour on their part will result in the insolvency of a Crown Health Enterprise. Possibly, a Regional Health Authority could use its monopsony power to negotiate prices with Crown Health Enterprises that are insufficient to cover their long-run average costs. There is some anecdotal evidence that this is presently occurring in New Zealand.

Despite the rhetoric of contracts and competition, implying as it does “less” rather than “more” government intervention, there has been significant political interference in New Zealand’s internal market. According to management within Crown Health Enterprises, this places them between a rock and a hard place with, on the one hand, the expectation that they will conduct the Enterprises along private firm lines and yet, on the other, the difficulty of so

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869 In 1994 it was reported that the Crown Health Enterprises had debts totally $1256 million and operating deficits of $180 million -- A. Stone, “Health Budget Boost ‘Inadequate’” The New Zealand Herald, 24.2.94, Section 1: 5.

870 The Auckland Healthcare (a CHE) board chairman, Graeme Hawkins is quoted as saying that the money paid to it often fell well short of its actual costs. Examples include: one young heart disease patient cost just under $80,000 to treat but the CHE received $1868 in payment; a child with acute bronchitis cost just under $40,000 to treat but the CHE received $1561, and a child with pneumonia stayed in the CHE for 32 days costing nearly $30,000 but the hospital was paid only $17,928 – see A. Young, “Health Chiefs Hit Back” NZ Herald, 4.12.96, A19. Of course, what really needs to be shown is that the CHE’s costs do not reflect inefficiencies in production and that the CHE’s average cost falls below the average price paid by the Regional Health Authority.

871 Example that I have previously noted elsewhere (Flood, supra note 493 at 105, fn 72.) – “the government allegedly prevented one case-strapped CHE from bidding for a tender to supply hospital services in Saudi Arabia: has intervened on various occasions to prevent the closure of surgical wards and hospitals; put in place guidelines regarding access to secondary services in face of criticism of the RHAs and CHEs closing small rural hospitals; abandoned the policy of targeted user charges for in-patient hospital services; set up a $20 million fund for general practitioners and communities to use to provide alternative services if CHEs choose to cut services or close hospitals; and set up a $130 million fund to be administered by the government (as opposed to the RHAs) to encourage CHEs to introduce a new system of booking patients for surgery.”
Managers for Crown Health Enterprises were actively head-hunted from the private sector with a strong emphasis being placed on hiring those with general management skills as opposed to a particular knowledge or experience in the health sector. Since the commencement of the reforms 12 of the 23 Crown Health Enterprises have had their chief executive officers resign.\(^{873}\)

5.5.3 Benefits of Internal Markets

What have been the benefits of introducing the purchaser/provider split and mandatory contracting out in the U.K. and New Zealand systems?

Firstly, it is important to note that as a result of the reforms in both the U.K. and New Zealand there is no evidence of any significant change in the priorities given to health needs, the sorts of health services supplied in response to a particular health need, nor the providers who are supplying these services.\(^{874}\) This should not be that surprising giving the structure of the internal market is essentially that of bilateral monopoly. Generally in both the U.K. and New Zealand, contracting continues to consist of “block contracts” (a fixed sum for an unspecified number of services) with a CHE or an NHS Trust.\(^{875}\) Acute and emergency care, mental health services, primary care providers, are generally provided pursuant to block contracts.\(^{876}\) The use of a prospective capped payment is no different from the payment regime under the old command-and-control system. Cost and volume contracts are used for elective surgery so that essentially providers receive a fee for each service provided but the total amount they can receive in a particular period is capped. In New Zealand there was much consternation when this method of payment resulted in CHEs providing all contracted elective surgery in a relative short-time period and then closing down surgical theaters for the rest of the year.\(^{877}\) Due to the adverse media publicity, clauses were subsequently included in contracts requiring CHEs to pace the delivery of their services over the course of the year. Cost per case or fee for service...


\(^{873}\) Interview with L. Mckenzie, Manager Medical & Surgical Services, Central RHA on 22 November 1996. Wellington, New Zealand.

\(^{874}\) In the U.K. see D. Hughes, S. McClelland, & L. Griffiths, “‘Cinderella’ Services in the NHS Internal Market: Does Contracting Make a Difference?”, Forthcoming Dalhousie Law Journal, 1998 (p. 7 of draft) who note in particular “although the nature of developments varies widely from Health Authority to Health Authority, there is no evidence of any general movement of resources away from the acute sector.”

\(^{875}\) McGuire & Anand, supra note 581 at 4 note that block contracts dominate in the U.K.

\(^{876}\) In New Zealand, see Ashton, supra note 813 at 9. See also the 1994/95 contract between the Southern Regional Health Authority and Canterbury Health Limited signed respectively by the parties on 17 October 1994 and 19 October 1994 — on file with the author [hereinafter *Canterbury Health 1994/95 Contract*].

\(^{877}\) See B. Orsman, “Bolger Shares Dim View of Hospitals: Closing Doors for Surgery Undermines Confidence” (17 April 1996) New Zealand Herald at 5.
contracts are used for a small number of services. For example, in one contract between a Regional Health Authority and a CHE fee-for-service applied to maternity services, termination of pregnancy, post-natal primary care and school dental services. Soderlund found in the U.K. that the change in a hospital's status from being a Directly Managed Unit (being managed by the Health Authority that is also responsible for purchasing services from it) to being a NHS Trust (independent of the Health Authority and expected to act more like a private firm) was associated with efficiency gains including lower hotel costs per episode and significantly lower direct treatment and diagnostics costs. This is in contrast to New Zealand where it has been acknowledged that internal market reform has not resulted in public hospitals achieving anywhere near the 30% efficiency gains envisaged prior to reform and that performance may, if anything, have weakened. Sonderlund, however, notes that it is impossible to say whether the hospitals that became NHS Trusts would have become more efficient anyway (i.e. the more efficient hospitals sought to become NHS Trusts first). Since initially NHS Trusts were a self-selected group, Sonderlund considers this hypothesis plausible. He also notes that it is impossible to know whether the transition is a real “one-off” efficiency gain or a permanent and persistent change in organizational functioning. Moreover, the fact that the NHS Trusts operate more efficiently than Directly Managed Units does not mean that the system as a whole is more efficient. The total costs for the system may still be greater where providers are NHS Trusts as opposed to Directly Managed Units. For example, empirical work conducted in South Africa suggests that private for-profit hospitals are able to produce more outputs at lower cost than directly managed public hospitals. However, when the total costs faced by the government in contracting out are included in the analysis (such as the extra administrative costs in negotiating contracts), costs per episode of care are more costly for the private for-profit hospitals than for directly managed hospitals. In any event, the argument developed here is not that contracting-out to independent institutions will never be an efficient choice in any particular market. The point is that purchasers should in general have the incentives to choose the most efficient configuration both initially and as market conditions evolve. As Williamson notes: “[w]hichever way the

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878 See for example, Canterbury Health 1994/95 Contract, supra note 876, cl. D04.
assignment of transactions to firm or market is made initially, the choice ought not to be regarded as fixed. Both firms and markets change over time in ways that may render inappropriate an initial assignment of transactions to firm or market."882

Setting aside for the moment GP Fundholding in the U.K. (which is not a purchaser/provider split as Fundholders are able to provide health services), the benefits have been primarily that of generating information about the cost and benefits of services. Ashton notes that improved information systems assists purchasers in monitoring the performance of providers and thus in improving provider accountability and assists management in quality improvement.883 The costs of generating this information have been high and there is no evidence as yet that the cost of information generation is outweighed by the benefits of use of this information to improve service purchase and production. However, an efficient system will require information about the costs and benefits. Consequently, an internal market system might be viewed as a transitional system where information gathering systems are put in place and the system as a whole reorients itself to considering costs and benefits. One manager in a Regional Health Authority described the benefits of internal market reform as follows:

"-it has made CHEs focus on what they are doing in terms of services, volumes and costs - in the past their information on each has been poor and there have been failures to link costs to services and volumes
- it has created a currency for service debates, we now have some way of doing trade-offs between services
-the purchaser now has a currency to use in its resource allocation work across services
- the contracts have quality requirements which encourage CHEs to monitor the quality of their services."884

A recent report prepared for the incoming New Zealand government in 1996 noted internal market reform had "enabled greater focus on evidence-based practice, increased service integration, increased accountability for primary care and the development of better information within the health system."885 One should note that "increased service integration"
and "increased accountability for primary care" can be attributable to integration of financing for secondary and primary services and could have been achieved independently of the "purchaser/provider split."

5.5.4 Costs of Internal Markets
Many commentators have expressed concern over the increased transactions costs associated with enforced contracting out in New Zealand and in the U.K. Although the magnitude of transactions costs are often assumed to be indicative of inefficiency this is not necessarily true. The important question, often overlooked in some commentators' zeal to rid a system of every last transaction cost, is whether the efficiency gains hoped to be realized from the reformed system outweigh the extra transactions costs. A system could have high transactions costs but still be more efficient than an alternative configuration with lower transactions costs but higher internal management costs. The crucial questions are: 1) whether the internal market system, with its enforced purchaser/provider split, is relatively more efficient than the old vertically-integrated hierarchies and; 2) whether there is a better institutional arrangement for the allocation of health services? The problem is that comparison is difficult given the lack of information regarding costs and benefits in the old command-and-control systems and apparent government resistance until recently to seriously analyzing the effects of internal market reform in both the U.K. and New Zealand.

Ashton argues that given the concern over the increased transactions costs in New Zealand's internal market, the development of long term, informal, and co-operative relationships between purchasers and providers in New Zealand's internal market will be the most appropriate development in cases where contestability on the supply side is limited. This is known as "relational contracting." Macneil developed the idea that the relationship between parties to a "relational contract" would result in "a mini-society with a vast array of norms beyond the norms centering on exchange and its immediate processes." Thus the argument runs that contracts in internal markets should be not be viewed through the lens of spot or discrete private sector contracts. As Allen points out, long-term contracts in the private sector

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886See Ashton, supra note 883.
887T. Ashton, "Voice And Exit In New Zealand's Health Care Sector -- Commentary" in Contracting In The Health Sector (Auckland: Legal Research Foundation, 1994) at 42 and see also Ashton, supra note 813 who discusses MacNeil's description of relational contracts based upon long-term trust relationships
888The distinction between classical, neo-classical and relational contracts was first advanced by I. R. Macneil, "Contracts: Adjustment of Long-Term Economic Relations Under Classical, Neo-classical and Relational Contract Law" (1978) 72 Northwestern University Law Review 854.
889Ibid. at 901.
often vitiate economists' usual assumptions about contracts but their continued existence likely means that they are efficient.\textsuperscript{890} In such a case, as Llewellyn notes, the contract only provides an adjustable framework, "..which almost never accurately indicates real working relations, but which affords a rough indication around which such relations vary, an occasional guide in case of doubt, and a norm of ultimate appeal when the relations cease in fact to work."\textsuperscript{891}

However, the idea of developing closer relations between purchasers and providers as a means of reducing the transactions costs of the purchaser/provider split while still seeking to preserve the benefits of contracting out in contestable markets is problematic. One of the primary reasons motivating the purchaser/provider split was so that public authorities would not prefer to procure health services from the institutions they themselves managed as opposed to other potentially more efficient providers. Developing the close relationships needed to sustain long-term contracts between purchasers and providers increases the likelihood that purchasers will be "captured" by providers.\textsuperscript{892} The development of close relationships between purchasers and providers undermines the rationale for a rigorous purchaser/provider split and in particular the goal of reducing any managerial conflict of interest. Moreover, although longer-term co-operative relationships may well be efficient for some services, as mentioned earlier, different health service markets exhibit different characteristics. Large government-appointed providers in the U.K. and New Zealand supply many different sorts of services, some of which may be more efficiently supplied pursuant to long-term relational contracts and others of which may be more efficiently supplied by contestable spot-markets. However, it is unlikely that a purchaser will be able to compartmentalize those services in which they will develop a close relationship with a provider from other services i.e. the need to develop a close relationship to ensure the effective provision of one service may well spillover and affect other contestable service markets.

Williamson notes that business people may adapt to institutional problems and develop norms of behaviour which reduce the transactions costs associated with uncertainty, opportunism, and small-numbers contracting without the need for vertical integration.\textsuperscript{893} He discusses the need

\textsuperscript{890}Allen, supra 670 at 332-335 notes that long-term contracts do not proscribe in detail the parties' rights and obligations and often parties accept the unwritten laws of the particular trade. Even when problems do arise between the parties they rarely resort to the courts.


\textsuperscript{892}Capture" refers to a process where incumbent providers are preferred over other potentially more efficient providers because of personal relationships that have sprung up between the regulator or purchaser and provider.

\textsuperscript{893}Williamson, supra note 805 at 106.
for business-people to maintain their reputation as one incentive which counteracts the incentive to act opportunistically at contract renewal junctures. Thus this explains why long-term contracting persists over time in the private sector and presumably is efficient. However, it is important to note that the need for business-people to maintain their reputation is a key factor absent from internal market contracting. For this reason, I am doubtful that there is any real prospect of relational contracting in internal markets. This is because government-appointed purchasers and government-owned/controlled health care providers have few incentives to be concerned about the reputational effects of their own opportunistic behaviour in the market-place as they know that the other party (whether due to the lack of competition in the market or due to government fiat) has no choice but to contract with them. As both purchasers and providers are government-owned, there is also no threat that either party could take the other over. For example, the contract for the year 1 July 1994 to 30 June 1995, for the total sum of NZ$150,357,714 between the Southern Regional Health Authority and Canterbury Health Limited (one of the 23 CHEs in New Zealand responsible for 8 hospitals totaling 953 beds) was not signed until 27 October 1994. The following year, the parties signed a two page heads of agreement but still had not signed a formal contract by the end of the 1995/1996 year. My prediction that long-term contracts are unlikely to develop under present conditions in the U.K. and New Zealand, has been borne out in practice to date with the observation that generally the contract term is not more than one year. Longer term contracts are not evolving in the U.K., despite the fact that the nature of the contractual arrangements are more hierarchical or administrative in nature than in New Zealand.

Clearly, it is a mistake to consider the merits and costs of contracting in the U.K.'s and New Zealand's health sector independently of the political milieu in which contracting is occurring. The motivations of both purchasers and providers cannot be assumed to be, as they are in the private sector, that of survival in a competitive market. Rather the motivations of purchasers and providers are more clearly linked to the political incentives in play given that they are funded by government monies and are government appointed or government owned. For

895 See Canterbury Health 1994/95 Contract.
896 Luhrs, supra note 872.
897 See Canterbury Health 1994/95 Contract. See also the Brent and Harrow Health Authority contract with West Middlesex Hospital NHS Trusts dated 8 April 1997 for the contract year running from 1 April 1997 on file with author. This contract is only worth £36,000 but the solicitor to Brent and Harrow Health Authority notes that their contracts with their two main acute providers for about £25,000,000 is on similar terms and has not yet been agreed for the financial year — letter from P. Allen, 1.8.1997, on file with author.
example, CHEs and NHS Trusts might be able to opportunistically politicize the negotiating process by arguing that the purchaser is underfunding the provider. The political nature of the system may also result in resistance to change as it is much safer, politically, for management with the government appointed purchasers and government owned health providers to maintain the status quo than to take risks that may jeopardize one’s political life. This results in a stickiness in the system, as historical utilization patterns are simply rolled over.

Bloor and Maynard concluded that political considerations influenced the UK government’s decision to reallocate 76% (rather than 100%) of health funds on the basis of a needs indices that had been reviewed and refined over some time. This decision resulted in benefits to South and Home Counties and, as Bloor and Maynard record, became known as the “mid-Surrey effect”. It seems to be the case in both New Zealand and the U.K. that the tendency is to use the year prior to internal market reform as a benchmark for price, volume, and quality standards, resulting in entrenchment of historical inefficiencies. In the first year of operation of the U.K.’s internal market (1991/92), pre-existing arrangements for supply were rolled over. From April 1992, the U.K. Health Authorities were free to selectively contract with providers; however, Hughes concludes “although the nature of developments varies from Health Authority to Health Authority, there is no evidence of any general movement of resources away from the acute sector.” Similarly, in New Zealand, for the first year of operation (1993/94), pre-existing arrangements for supply were rolled over. As a more specific example, in the 1994/95 contract between the Southern Regional Health Authority and the Canterbury Health Limited CHE, the contract specifically states that “[w]e (the RHA) acknowledge that the quality standards outlined in this section are intended to describe and quantify quality levels equivalent to which you provided in 1993/94 and at no additional cost.” The inertia problem is compounded by the fact that budgets set for the U.K. Health...

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898 This seems to be the case in New Zealand with daily newspaper reports by providers accusing purchasers and the government of underfunding the health sector. In the U.K. similar complaints of underfunding are made by providers — see S. Lyall, “For British Health System Bleak Prognosis” 30.1.1997 N.Y. Times News Service. I do not mean to suggest that there may not be some truth to the claims of underfunding, but that this issue becomes a political one with providers portraying the problem of a simple one of “government underfunding” and government portraying it as another simple problem — “greedy doctors”.


900 ibid. at 4.

901 Hughes, McClelland & Griffiths, supra note 874 at 7.

902 Canterbury Health 1994/95 Contract, Section G, p. 112.
Authorities and New Zealand’s Regional Health Authorities were based on historical consumption patterns, although there are efforts underway in both countries to distribute funds on a per-capita weighted basis. In essence, although there appears to be some movement at the margins, the historical configuration of providers and service patterns have largely remained intact in both New Zealand and the United Kingdom.

5.6 Managed Care in Internal Markets
The GP Fundholding scheme has resulted in some of the most significant changes to the U.K.’s previous allocation system. Similarly, in New Zealand, although still in infancy, it has been argued that Independent Practice Association are the key to effecting real change. Glennerster concludes that GP Fundholders were better contractors as they had better information and more motivation to improve service standards and because they could switch their contracts without resulting in the financial and political implications for providers that a decision on the part of a Health Authority to switch contracts would entail. There are over 3,500 Fundholders, involving around 15,000 general practitioners. Fundholding is a form of managed care. In the Fundholding scheme groups of general practitioners receive a capitated budget with which to buy drugs and approximately 20% of hospital and community services. Paying by means of capitation and transferring financial risk to health providers is essentially a way of devolving purchasing responsibility to a local level. The Fundholding initiative was originally seen as a “bolt-on” to the main reforms (being the purchaser/provider split) but has assumed increasing importance.

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908 See What The Doctor Ordered, supra note 586 at 6. Standard Fundholders do not purchase the following sorts of hospital care: emergency admissions, inpatient mental health, costs above £6000 per annum for any patient, accident and emergency, maternity, and medical inpatients.
As a result of the Fundholding scheme, there has been a shift in the balance of power from hospitals and specialists to general practitioners. If Fundholders are effective advocates for their patients, this change must be considered a positive one, although it raises the question of the inequities of treatment depending on whether one is registered with a Fundholder or not. The interesting point, from the perspective of contracting out versus in-house production, is that the Health Authorities and GP Fundholders do not compete on a level playing field. Health Authorities incur relatively greater transactions costs as they must contract out for the supply of all health services. GP Fundholding is a form of managed care as each Fundholder receives a fixed annual fee to care for all its enrollees. A practitioner who is a Fundholder member can, subject to other regulations and licensing requirements, decide whether to attend to the patient’s needs in-house or to contract-out for the supply of services from specialists, hospitals, and other providers. The Health Authority, rather than an active purchaser of services, serves only as a conduit of funds from the government to the Fundholder (although there are increasing calls for Health Authorities to take more of a supervisory and planning role vis a vis Fundholders).

The evidence suggests that the entire Fundholding initiative is not efficient given that to date the transactions costs involved outweigh efficiency gains.910 For the year ending 1994/95, the Audit Commission calculated that Fundholders received a total of £232 million of public monies to cover the costs of staff, equipment, and computers needed for managing Fundholding. On the other side of the ledger, the Audit commission reports that Fundholders made efficiency savings of £206 million over the 1994/95.911 Once this is deducted from the total costs, there is a shortfall of £26 million. The actual shortfall may be even greater, however, because the Commission was not able to calculate the management and transaction costs incurred by Health Authorities and health providers in dealing with Fundholders. The Commission did note that the average direct cost incurred by NHS Trusts (which are responsible for managing public hospitals) in dealing with GP Fundholders was £5,900 a year per Fundholder. The Commission also referred to the estimate of one NHS Trust that it costs four times as much to negotiate contracts with 13 Fundholders, accounting for 4% of the trust’s incomes, as it does with the Health Authority, accounting for 91% of its income.912

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910 See generally See What The Doctor Ordered, supra note 586.
911 Ibid. at 7.
912 Ibid. at 66, Exhibit 26, & at 82.
This should not necessarily be taken as evidence that all managed care arrangements will be inefficient. Part of the reason for the high transactions costs associated with Fundholding is that there are so many small Fundholders that the various Health Authorities and NHS Trusts must do business with. One would predict that if larger integrated delivery systems (really) competed with each other, the transactions costs would not be of the same magnitude as these systems would have an incentive to minimize internal transactions costs. It is also to be noted the incentives that the Fundholders respond to are more complex than a simple for-profit motive, as the disposal of surplus is regulated and must be used to further patient amenities.913

The strongest criticism of the managed competition model is that it would result in higher transactions costs than an internal market model because it involves competing insurers/purchasers. The issue of transactions costs must be put in perspective as these costs seem unlikely to be greater in a managed competition system that requires competition between purchasers for the supply of all publicly-financed services than, for example, in the present internal market system in the U.K. which allows 3500 GP Fundholders to act as smaller purchasers in addition to the 100 Health Authorities. There are so many Fundholders because they do not have to purchase the full range of publicly-funded health services but only a very limited range of relatively low-cost services. In New Zealand, in addition to the 4 Regional Health Authorities and 1 purchaser who purchases all services for accidents victims pursuant to New Zealand no-faulty accident compensation scheme, there are 61 Independent Practice Associations, all acting as purchasers.914 Thus, as managed care flourishes in these internal markets (or for that matter in any system), the effective number of purchasers increases and consequently transactions costs will rise. Moreover, the present number of government-appointed purchasers in the U.K. and New Zealand has been centrally determined and there does not appear to be any particular economic or planning reasons for the present number of purchasers in either jurisdiction. Currently, both the U.K. and New Zealand have been reassessing the number of government-appointed purchasers.915 It may well be that economics of scale would dictate that there be fewer competing purchasers in a managed competition system.

915 In the U.K., a "NHS Confederation" came into being on 20 March 1997 which is meant to be a representative voice for not only the 100 Health Authorities but also the 500 NHS Trusts — see http://www.nahat.net/contact.htm. In New Zealand, the 4 Regional Health Authorities are scheduled to be amalgamated into one national purchasing authority by 1 July 1997 — see Ashton, supra note 883.
5.7 Conclusion: A Flexible Approach

The purchaser/provider split in the U.K. and New Zealand was adopted in order to prevent government-appointed purchasers from purchasing services from the public hospitals they managed at the expense of other (perhaps) more efficient public and private providers. It also sought to restructure public hospitals into institutions that were, to varying degrees, more like private firms. The goal of internal market reform was thus to minimize the discretion of decision-makers and to encourage them to enter into contracts for supply with efficient health care providers. However, this focus does not tackle the real problem, namely a lack of incentives for purchasers to enter into the most efficient supply-side arrangements. The problem in the previous rigidly integrated health authorities of the U.K. and New Zealand was not that they were integrated with hospitals but that they did not have incentives to purchase well. Thus attacking the potential conflict of interest in being both the purchaser of government funded health services and being a significant provider attacked the symptom but not the root of the problem. Moreover, it is likely that in some health service markets the most efficient arrangement may be or could evolve to be that of vertical integration. Flexibility is key.

One might argue that a purchaser/provider split in internal markets is acceptable as reducing scope for opportunistic behaviour is one of the key reasons why firms tend to vertically integrate in the private sector. The tendency towards opportunism in internal markets on the part of purchasers and providers is tempered by the political milieu in which they must operate.916 Government-appointed purchasers and providers in the U.K. and New Zealand know that threats of hold-out and overt opportunistic behaviour will not be tolerated. However, in the absence of specifically designed managerial incentives, the political incentives to which government-appointed purchasers and providers respond has led to maintenance of the status quo and perpetuation of inefficient historical patterns of supply. Thus, the risk of opportunism is not one of private firms seeking monopoly rents, but of government-appointed decision-makers not performing their role of purchasers as well as they could or should.

Some commentators advocate long-term relational contracting between purchasers and providers as a means of reducing transactions costs in internal markets. The development of such a relationship raises the specter of purchasers being “captured” by providers, which is in

916Williamson, supra note 805 considers the twin problems of institutional design as being how to limit opportunism and how to economize on bounded rationality.
large part what motivated the indiscriminate split between purchasers and providers in the first place. By prohibiting purchasers in internal markets from providing health services, the discretion and power of government-appointed monopsonies is checked. However, I argue that it was not the level of discretion accorded in the first place that was the key problem, but rather the lack of incentives, institutional support, and information needed for purchasers to actively purchase a range of cost-efficient services from health care providers.

The rationale behind the purchaser/provider split runs counter to the international trend towards managed care arrangements and the benefits of integrated delivery systems. Government appointed purchasers in internal markets could seek to purchase managed care plans from competing groups of providers. This is in fact what is happening in the U.K. with GP Fundholders. However, Fundholding is a central government initiative and Fundholders have been lured into participation with relatively generous budgets. Independent Practice Associations in New Zealand evolved as supply-side response to what was seen as the potential for aggressive purchasing behaviour on the part of Regional Health Authorities. However, neither the U.K.'s Health Authorities nor New Zealand's Regional Health Authorities have incentives to encourage managed care arrangements. Moreover, as they cannot provide services or integrate with other providers, they must wait for providers to initiate managed care plans. The large health care providers with the resources to implement large scale managed care plans, are largely government-owned institutions who have strong incentives to maintain the status quo.

Simon's assertion that individuals operate under bounded rationality most surely apply to anyone concerned with institutional design. As soon as one feels that she or he has discovered an important piece to the puzzle of what constitutes the best institutional design, one finds that it does not quite interconnect with the other pieces located. So, the evaluation of alternative institutional arrangements becomes more of an art than a science and it is difficult to move past abstract generalizations about likely incentive effects in the absence of rigorous empirical data. One point is clear in the health sector: the configuration of any health system will have to constantly evolve to respond to changing needs. The need for continual change has been

917 For example, a recent survey by the World Bank and World Health Organisation predicts that depression, heart disease, and road accidents would replace respiratory infections, diarrhea diseases and complications of child-bearing as the world's leading causes of death and disability. It also predicts that there will be an extraordinary epidemic of tobacco-related mortality and disability which will claim more than 8 million lives worldwide in 2020. Some would argue that the growth in technology is endogenous to the system in question, but the inescapable fact is that the system itself provides incentives for the growth of certain technologies which in turn place strain on the...
historically shown in all systems. Even the command-and-control systems of the U.K. and New Zealand have undergone successive reform after reform. Maynard refers to the successive “redisorganizations” of the National Health Service and the same can be said of New Zealand. No sooner has one set of reforms been implemented than another is introduced. These periodic government-imposed upheavals dampen the morale of people working within the health sector. Moreover, little effort is expended on evaluating past reforms or fully evaluating the likely effects of new proposals. There is no perfect or easy solution to what constitutes the best institutional design. However, a paradigm shift is needed so that the health system in question is constantly and incrementally evolving. The managed competition model offers more promise in this regard than the internal market model.

system itself in terms of increased costs — see the latest Science journal as quoted by L. Dayton, “Plagues For The New Millennium”, NZ Herald, Wednesday, December 4, 1996, A19.

Maynard, supra note 510 at 1435.

For example, as a reaction to the public’s dissatisfaction with internal market reform in New Zealand, it has now been proposed by the new coalition government (the National Party and New Zealand First) to abolish the Regional Health Authorities. This proposal is a response to what the public see as the infestation of the public health system by management and bureaucracy. Unfortunately, it fails to address the real problem in most health systems, i.e. a lack of incentives on the demand side to realize the supply of a cost-efficient range of service from efficient suppliers.
Chapter 6: The Problem of Monopoly Supply

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6.1. Introduction

In light of the shift to active purchasing in internal market and managed competition systems, does there need to be continued regulation of the supply side or can it be largely left to evolve on its own? A managed competition system offers the prospect of a new paradigm for competition between insurers/purchasers and injects demand-side pressures into health service markets where there once was none. If a framework for managed competition was implemented whereby insurers/purchasers were forced to compete on price and quality dimensions, could market forces be left to operate within that framework? To use the rowboat analogy of Osborne and Gaebler, does the government have sufficient steering power in a managed competition model that it can leave the private sector to row?920 Although the row boat metaphor has the power of simplicity, in the real world, things are often murkier and less clear-cut than policy-makers, economists and other rationalists would like to be able to assume.

First, it is important to note that governments may wish to continue to regulate inputs on the supply side in order to contain total public expenditures, irrespective of efficiency considerations. Although an internal market system or a managed competition system may achieve a level of spending on health that is allocatively efficient, this efficient level may be above that which a government is prepared to fund from public moneys. As Schut and Hermans note in the Netherlands, "...the government faces the dilemma that managed competition may improve efficiency and reduce unit costs, but this may not guarantee the realization of macro-economic cost containment goals. This is because managed competition may not only lead to lower production costs but also to higher productivity and a higher responsiveness to consumer preferences or patient needs."921 The difficulty is that although distributive justice considerations support financing of health expenditures from general taxation collected progressively,922 historical overruns in public sector borrowing mean that expenditures have to be curbed now to compensate for past excesses. If and when governments have public sector deficits under control then the quest for cost containment of government expenditures as a goal in and of itself should abate.

In Chapter 4, I discussed the need for regulation of insurers/purchasers in a managed competition system in order to ensure that they compete on price and quality dimensions. However, even if the right mix of incentives were in place for purchasers there is still a problem if there is

920Osborne & Gaebler, supra note 13 advocate that government intervention be directed towards steering rather than rowing. However, as Trebilcock notes, supra note 13 at 4, Osborne & Gaebler "leave to others the task of developing the rigorous theoretical frameworks and detailed empirical investigations that would enable hard policy choices to be made among alternative governing instruments in particular sectors of government activity."
921Schut & Hermans, supra note 411 at 19.
922See the discussion in Chapter 1.
monopoly on the supply side. As discussed in Chapter 4, there may be monopoly on the supply side due to economies of scale in production but, particularly in the former command and control U.K. and New Zealand systems, monopoly may be due to government policy geared to consolidating hospitals and reducing hospital beds. The problem of monopoly on the supply side might be aggravated with competing insurers/purchasers as proposed in managed competition as a monopoly provider will be in a better negotiating position vis a vis a number of competing insurers/purchasers as opposed to a government monopsony. There is thus the opportunity for the monopoly provider to engage in cost-shifting tactics. Moreover, if a monopoly provider will not deal with a particular insurer/purchaser then the latter will not be able to offer its plan to local residents. Managed competition requires that insurers/purchasers offer their services to all individuals within a defined region. Practically, consumer choice of insurers/purchasers may be a mirage if the reality is that a consumer must pick a particular insurer/purchaser as it is the only one which has a contract with the local monopoly hospital. One must also recognize that health systems are dynamic and there will be a supply side response to proactive purchasing behaviour with health care providers merging and/or collaborating in order to gain market power.

From the preceding discussion, one can see that an important supply side issue that require resolution in any system that seeks to promote competition between health care providers is the problem of monopoly supply in health care service markets. This chapter will explore the problem of monopoly supply and analyze various possible solutions.

6.2. Competing Purchasers and the Problem of Monopoly Supply

6.2.1 The Problem of Monopoly Supply
The problem of monopoly supply is that a monopoly provider (being a single seller or group of sellers behaving like a single seller in any particular market) will prefer to produce fewer services and at a higher price than otherwise would be charged in a competitive market. From a socio-political perspective, monopoly may viewed as objectionable as it results in the transfer of resources from the ultimate consumers to the owners of the monopoly. From a purely economic perspective monopoly are objectionable as it results in a “dead-weight loss” to society (a misapplication of society’s limited resources). This occurs because consumers have an

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923 R. Posner, *Antitrust Law: An Economic Perspective* (Chicago: University of Chicago Press, 1976), Chap. 2, at 8–22. It is interesting to note that the usual textbook description of monopoly does not describe what effect a monopolist’s behaviour will have on the quality of the goods or services supplied.

924 Consumers are generally portrayed as having less power and wealth than owners of monopoly. This stereotype may be true in the case of some products but may not be the case in others where consumers themselves are large corporations.
incentive to purchase alternative services at a cheaper price but these alternative services are actually more costly to produce than those produced by the monopoly. Economists will, however, point out that the cost to society of regulation to prevent this inefficiency may be greater than the cost of the inefficiency. 925

6.2.2 How Monopoly Arises

Monopoly may arise as a result of a concerted effort on the part of a firm to exclude competitors and/or because of the fact that it is the most efficient competitor. In the latter case, where the monopoly situation is persistent over time there may be what is known as a “natural monopoly”. In essence, a natural monopoly is said to occur where as the volume of production of the service or good increases long-run average costs tend to decrease. 926 In other words, there are relatively high fixed costs associated with production of even a small number of services or goods and consequently efficiencies arise as a higher volume of services or goods are produced reducing overhead costs as a cost per unit of production. It would be inefficient to encourage competition within the market as this would result in an inefficient duplication of resources. One must consider the cost-effectiveness of regulation or other incentives that would ensure that the natural monopoly operates as if it were in a competitive market. It is important to note that unlike, for example, a telecommunications network or the electricity grid, hospitals may be natural monopolies in some health service markets and not in others. Thus, for example, a hospital may be a natural monopoly in the supply of heart transplant surgery but face competition in the supply of outpatient services.

Another means by which monopoly may arise, particularly in health care systems, is as a result of government policy. As mentioned in the introduction to this chapter, governments in many OECD countries have sought to control costs by controlling the number of inputs on the supply side, in particular, by controlling the number of hospitals and other health providers. Monopoly may have also arisen as a result of government policy to purchase or procure health services from only publicly owned institutions, thus precluding the potential entry of private competitors. Prior to internal market reform, this was the situation in both the U.K. and New Zealand.

925 See for example Demsetz, supra note 129.

6.2.3 Cross-Subsidy From Monopoly to Competitive Markets
In an internal market system, as government-appointed purchasers are monopsonies (the only buyer in a market), then if there is monopoly on the supply side a bilateral monopoly emerges and it is difficult to predict what will be the result of negotiations. In the U.K. and New Zealand, the size of (respectively) NHS Trusts and Crown Health Enterprises and the number of hospitals they are responsible for has been centrally determined. Consequently, although individual hospitals may not be monopolies they are controlled by government-mandated organizations that generally hold monopolies in one or more health service markets. Thus, there is the risk that NHS Trusts and Crown Health Enterprises will cross-subsidize their operations in health service markets where they face competition from others where they hold a monopoly. This is also a risk in managed competition systems where organizations that are providers in a number of health service markets cross-subsidize from the market in which they hold a monopoly to those markets where they face competition, thus potentially eliminating more efficient competitors in those latter markets.

6.2.4 Control of Bottleneck or Essential Facilities
Due to the presence of a number of competing insurers/providers in a managed competition system, the monopoly supply problem may be greater than in an internal market system where purchasers are monopsonies (i.e. the only buyer in a market). In such a system, the only hospital in a region will have a significant advantage in negotiations as it will know that competing insurers/purchasers will have to contract with it in order to provide a full service plan to local residents. In a managed competition system, if one insurer/purchaser owns the only hospital in a region then it may refuse to supply competing insurers/purchasers. The effect of this is to prevent competitors in the insurance/purchasing market from enrolling individuals into their plans who, if they needed, for example, emergency services, would have to use the hospital’s facilities. This is known as market leverage -- the use of power in one market (the hospital service market) to gain or maintain power in another related one (the health care insurance/purchase market).\(^\text{927}\) In a managed competition model, the goal of the insurer/purchaser who is integrated with a monopoly health care provider would be to force people dependent on that provider to exit from their preferred insurer/purchaser to it.\(^\text{928}\) The


\(^{928}\)In terms of consumer choice the effects are even more egregious as individuals would have neither choice of purchaser nor of provider.
societal costs of monopoly are arguably greater when the monopolist controls bottleneck or essential facilities as it has spill-over effects into other related markets.

On the other hand, as discussed in the last chapter, there may be significant efficiency gains that accrue from vertical integration between insurers/purchasers and health care providers. Such integration may improve the ability of insurers/purchasers to control the clinical decision-making of health care providers and to render them more cost-sensitive. Proponents of the managed competition model envisage a system whereby several large insurers/purchasers offering managed care plans would compete on price and quality dimensions. This amounts essentially to the idea of competing “integrated delivery systems” -- the new catch-phrase in health policy.929 Enthoven has said that he now refers to his model for managed competition as “managed care-managed competition” to emphasize that what are meant to compete are integrated delivery systems supplying comprehensive care.930 In an integrated delivery system a number of different health service providers (hospitals, general practitioners, specialists, nurses, etc.) work within an organizational or contractual arrangement to provide co-ordinated and seamless care to a particular population. As Miller notes, several types of integration activities “offer the prospect of reduced administration costs; lower medical care prices; utilization, and expenditures; and higher quality of care.”931 Integration and co-ordination of care is important as it recognized that where there are a variety of ways in which the needs of patients can be met, some may be more cost-effective than others. For example, a cardiologist could take a patient’s blood pressure every month or a nurse-aid could do so without any reduction in the quality of the procedure. As Fuchs notes “..physicians’ decisions are the major determinant of the cost of care. Only in an integrated system, however, do physicians have the incentive, the information, and the infrastructure needed to make these decisions in a cost-effective way. Integrated systems also have an advantage in avoiding excess capacity of high-cost equipment and personnel.”932 Some might consider these claims to be somewhat exaggerated, nonetheless, an integrated system clearly has many potential benefits.

From a policy perspective, the ideal system may be one in which there is regulated competition between managed care plans. These plans can be thought of as smaller, financially, integrated sub-systems that combine the insurance, purchasing and most provider functions into one firm.

930 As quoted by Newman, supra note 27.
931 Miller, supra note 929.
932 Fuchs, supra note 746 at 17.
What is offered is not insurance *per se* but the supply and co-ordination of health services as and when they are needed. However, where there is monopoly on the supply side the benefits of allowing integration have to be balanced against the cost of decreased competition between insurers/purchasers offering managed care plans. As competition between insurers/purchasers is the key to ensuring the accountability and efficiency of a managed competition system this may have to trump the achievement of efficiency gains from vertical integration where the two are not compatible.

Is there sufficient depth in health service markets so that each insurer/purchaser is able to offer its own integrated delivery system i.e. its own independent panel of health care providers? Yao *et al.* point out that barriers to entry are the key to competition between insurers/purchasers offering managed care plans. A new health plan must establish a large complex network of providers, either by acquiring or contracting with incumbent providers, or by introducing new providers into the market. Without the threat of entry, there is no real competition either in or for the market. In some health service markets, however, it may be inefficient to duplicate hospitals and technological equipment as they are natural monopolies.

The extent of the problem of a lack of competition on the supply side due to natural monopoly will vary from country to country and within any particular country and between health service markets. In terms of population density, the Netherlands is very densely populated country with 449 people per square kilometre. The U.K. is less densely populated with 235 people per square kilometre. By comparison, the U.S. and New Zealand have very low population densities with respectively, 28 people per square kilometre and 13 people per square kilometre. In both the U.S. and New Zealand, however, there are discrete urban areas which are much more densely populated than outlying areas. For example, one-third of New Zealand’s population live in the greater Auckland region. In more densely populated regions there would likely be greater scope for competition between insurers/purchasers offering managed care plans. These sorts of generalizations do not, however, take us very far in terms of considering the design of a system.

Looking more particularly at the U.S. and the prospects for a competition between large managed care plans, Kronick, Goodman and Wennberg estimate that 42% of the U.S. population

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live in areas capable of supporting managed competition with three efficient full-service provider networks and 29% of the population live in areas that could not support more than one efficient full-service provider network. The rest of the population lives in areas that can support limited competition with some sharing of hospital services.\textsuperscript{935}

In the Netherlands the problem of monopoly on the supply side is diminished because of the uniformly high population density. A natural monopoly is a rare phenomenon in the Dutch hospital market.\textsuperscript{936} Nine out of ten hospitals in the urbanized Dutch Randstad area, accounting for about 45% of the population, have more than ten potential competitors within a 24 kilometre radius.\textsuperscript{937} The managed competition model may thus be more viable in the Netherlands than in many other countries due to the fact that one may more safely generalize across the whole system to say that most health service markets are competitive or contestable.

In the present U.K. and New Zealand internal markets it is clear that the hospital market is highly concentrated.\textsuperscript{938} However, if the present NHS Trusts and Crown Health Enterprises were unbundled then the degree of monopoly on the supply side would be significantly reduced. Propper argues that there is indeed scope for competition between health care providers in the U.K. and estimates that only 8% of a large sample of all acute health service providers have no competitors within a 30 minute travel distance in the four specialities of general surgery, orthopaedics, ENT, and gynaecology.\textsuperscript{939} New Zealand’s population is so dispersed that although competition between managed care plans in the Auckland region may be viable, in most other areas it seems likely that the problem of monopoly supply may be severe.

As I argued in the last chapter, it is not possible to reach a generalized conclusion as to the potential for competition in a health care system and, for the purposes of this thesis, it is not necessary to do so. It is sufficient to conclude generally that health service markets differ within any particular system and the nature of those markets vary in turn depending on their location. Also health service markets are dynamic and advances in technology will alter the mix of capital


\textsuperscript{937}Although, according to the U.S. Department of Justice 1984 merger guidelines, markets with a Herfindahl-Hirschman Index of more than 1800 (about six equally sized firms) are regarded as highly concentrated and more than 70% of the Dutch hospital markets still exceed this figure. The Herfindahl-Hirschman Index is the sum of the squared market shares of all firms in the same relevant product and geographic market and varies from 0 to 10,000 with a score of 10,000 being indicative of a pure monopoly — Schut, supra note 336 at 1451.

\textsuperscript{938}See Ashton & Press, supra note 813.

\textsuperscript{939}C. Propper, “Market Structure And Prices: The Response Of NHS Hospitals To Costs And Competition” (Mimeo. Dept. of Economics, University of Bristol, 1994).
and other resources required for production. Moreover, in response to proactive purchasing health care providers will seek to accrue market power. The important conclusion is that one size does not fit all. Consequently, a model that rigidly assumes competitive or contestable markets system wide and across many different health service markets is likely to lead to inefficiencies because of its inflexibility. The fact that there is not sufficient depth across all health service markets to create integrated delivery systems capable of independently satisfying the needs of enrollees of competing insurers/purchasers does not mean the managed competition model is fundamentally flawed. The important question is what degree of regulation or combination of other incentives is required to allow competing insurers/providers to purchase services from natural monopoly providers?

6.2.5 The Supply Side Response to Proactive Purchasing

In addition to the problem of competing insurers/purchasers seeking to exclude potential competition through ownership of essential facilities, there is also the problem of initiatives taken by health care providers. If proactive insurers/purchasers seek to extract the best bargains from health providers then it is naive to assume that there will be no supply-side response to these efforts. Providers may attempt to enhance their own bargaining power vis a vis insurers/purchasers by merger or by collusion.\footnote{This is a problem in both managed competition and internal market systems.} Thus one must consider not only the issue of monopoly supply in current markets but also how supply markets will respond to pressure on the demand side. For example, Morrisey \textit{et al.} note in the U.S. that providers are forming into (so-called) integrated delivery systems in order to have one institutional voice with the goal being to increase their market power in contract negotiations with insurers/purchasers.\footnote{Morrisey \textit{et al.}, supra note 929 at 64.} Schut notes in the Netherlands that general practitioners, pharmacists, specialists, and hospitals are independently seeking ways to strengthen their market power by forming into strong regional organizations or cooperations.\footnote{See Schut, supra note 791 at 227-8.} Similarly, in New Zealand, an important motivation for general practitioners in forming “Independent Practice Associations” was to improve their negotiating power with the Regional Health Authorities.\footnote{Malcolm \& Powell, supra note 19 at 186. A similar type or response was not seen in the U.K. as the government itself sought the consolidation of general practitioners into “Fundholders” thus preempting market-power enhancing initiatives on the part of practitioners.}

There would seem to be no policy objection to health care providers forming alliances so as to offer their own integrated delivery systems/managed care plans \textit{provided} they assume the insurance/purchasing role. This will happen when a group of health care providers bear the
financial risk of misapplication of resources. In this case the group of health care providers effectively becomes the insurer/purchaser as they are managing the financial risk and deciding on the mix of health services to supply. Effectively they are integrating back into the health insurance/purchasing role. In the U.S. there has been growth in the number of integrated provider organizations which are essentially groups of health providers that offer managed care arrangements to private insurers.\textsuperscript{944} These arrangements are often referred to as “integrated delivery systems” even although they are distinguishable from a situation where an insurer vertically integrates forward to incorporate hospitals and physicians into the firm’s operations. Not all arrangements that call themselves “integrated delivery systems” are necessarily desirable in terms of health policy. The appeal of an integrated health system is the concept that different health providers work together in order to co-ordinate the application of their varying skills and the care supplied to a patient. The goal is that the patient receives the most cost-effective care and costs are not shifted from provider to provider or on to patients or to society at large. The key to this integration is essentially risk sharing as it is only then that different health care providers have an incentive to co-ordinate their different skills. Arrangements describing themselves as “integrated delivery systems” that do not exhibit these qualities are not truly “integrated” and may in fact be examples of collusion.

To summarize, there are essentially four component problems when examining monopoly on the supply side:

i. how to prevent a health care provider cross-subsidizing from health service markets where they are a monopoly to health service markets where they face competition;

ii. how to prevent insurers/purchasers who are vertically integrated with monopoly providers from suppressing competition between insurers/purchasers by refusing to sell the health care services in which they hold a monopoly and/or causing insurers/purchasers to inefficiently duplicate facilities that are natural monopolies;

iii. how to prevent monopoly health care providers from charging prices above long run average cost and producing fewer services than is optimal from society’s perspective; and

iv. how to prevent the formation of monopoly (except where it is a natural monopoly) on the supply side as an attempt to build market power where there are no off-setting efficiency gains.

\textsuperscript{944}Morrisey et al., supra note 929 at 65–66 note, however, that the hype surrounding integration does not accord with the reality. By the last quarter of 1993, they found 23.3% of U.S. community hospitals participated in at least one form of physician organizational arrangement. The authors note, however, that the impetus for integration may be shifting from hospital-sponsored systems to physician-sponsored systems, physician-centred systems financed by private investors, and insurer-led efforts.
6.3. Solutions to the Problem of Monopoly Supply

There are at least six possible solutions to the problem of monopoly on the supply side. These are collective bargaining on the part of insurers/purchasers with monopoly health service providers, an enforced purchaser/provider split in natural monopoly markets, nationalization of monopoly health providers, employment of the essential facility doctrine, employment of general competition law, and industry specific regulation of monopolies. In this next section I will discuss the costs and benefits of all six solutions with a view to assessing their ability to solve the four component problems of monopoly supply summarized in the preceding paragraph.

6.3.1 Collective Bargaining

Insurers/purchasers in a managed competition system could come together as one voice when negotiating with monopoly health care providers. Collective bargaining is nothing new in many jurisdictions. For example, in the Netherlands there were statutory guidelines in place prescribing the negotiation of uniform tariffs for physicians which were binding on all physicians once approved.945 This negotiation occurred between representatives of the physicians, the private insurers, and Sickness Funds and was monitored and regulated by government through the Central Agency on Health Care Tariffs.946 Although this regulated negotiation was criticized as ritualistic and bureaucratic, it was also credited with having suppressed the growth of physicians’ fees.947

Collective bargaining on the part of insurers/purchasers may occur in a managed competition system irrespective of government initiatives to facilitate it. By way of analogy, J. C. Robinson reports in the U.S. that employers are forming into alliances to bargain with managed care plans.948 He uses the example of the Pacific Business Group on Health, an alliance of 27 large firms with 2.5 million employees and dependants and $3 billion in annual health expenditures, that is effectively regulating competition between private managed care plans. Robinson reports that the Pacific alliance is standardizing the benefit package offered across firms and health plans, analyzing risk selection factors, requiring health plans to disclose information, putting in place mandates for improvements in quality, and negotiating premiums on behalf of its members.949 Robinson does not mention this, but such activity would seem to be open to challenge under general competition laws. Collective bargaining on the part of

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945 Schut, Greenberg, & Van De Ven, supra note 374 at 262, Table 1.
946 OECD; Health Policy Studies No. 2, supra note 22 at 91. For a description of the complicated negotiation process see Kirkman-Liff, supra note 389 at 472–3.
947 Kirkman-Liff, ibid. at 478.
949 The thus are essentially performing the role of sponsors as envisaged by Enthoven in his managed care model.
insurers/purchasers would need to be expressly exempted from general competition laws as such activity would *prima facie* constitute collusion. Such an exemption would have to make a clear distinction between situations where collective bargaining is necessary to deal with the problem of a monopoly provider and where it is simply a device to extract extra concessions from health care providers.

The problem with collective bargaining is that such a mechanism may provide opportunities for collusion in other areas. Although it may be satisfactory to have insurers/purchasers forming an alliance to negotiate with monopoly health care providers it is not satisfactory when it comes to a few large insurers/purchasers competing on price and quality determinants for citizens' custom. By standardizing benefits and reducing price competition to a single premium bid, managed competition looks to simplify consumer choice; however, it also provides many ripe opportunities for collusive behaviour on the part of large insurers/purchasers.\(^{950}\) Thus, as a matter of policy, to reduce opportunities for collusive behaviour generally collective bargaining should be discouraged even where insurers/purchasers could point to off-setting efficiency gains in any particular transaction.

Collective bargaining will not correct the problem where an insurer/purchaser is vertically integrated with a natural monopoly provider -- the bottleneck situation. There will still need to be some other means by which to compel the vertically integrated monopoly to supply services to competitors in the upstream market. In a system of managed competition with several large insurers/purchasers competing nation-wide one could argue that they will have to co-operate. Although in some areas an insurer/purchaser may have the advantage of being vertically integrated with a monopoly hospital in other areas a competitor will hold the upper-hand in terms of controlling the monopoly hospital. Again, however, there would seem to be a high risk of explicit or implicit collusion where insurers/purchasers agree to divide up the health insurance/purchasing market so effectively avoiding competition.

6.3.2 Selective Application of the Purchaser/Provider Split

In the previous Chapter, I was critical of the rigid purchaser/provider split imposed in internal market system because of its indiscriminate application to all health service markets in a system regardless of the particular structure of the market. In some markets, an enforced purchaser/provider split may result in additional transactions costs without any prospect of offsetting efficiency gains. The appeal of a managed competition system is that having put in

\(^{950}\)Yao, Rorordan & Dahdouh, *supra* note 933 at 317.
place the framework and necessary regulation to ensure competition between insurers/purchasers on price and quality dimensions, then insurers/purchasers are left to determine what is the most efficient supply side arrangement. However, where there is a natural monopoly on the supply side (i.e. there is no prospect of efficient entry by other competitors), one may wish to preclude vertical integration between insurers/purchasers and health providers so as to allow insurers/purchasers to complete on a level playing field when it comes to negotiation with the natural monopoly. One should be clear here that this is not a suggestion of a system-wide purchaser/provider split as in internal markets, but a purchaser/provider split only in those markets that are natural monopolies. This argument is similar to arguments for unbundling the network components of the telecommunications and electricity sectors (the natural monopoly elements) from the other competitive or contestable elements of the respective sectors.\textsuperscript{951} The difficulty is that a hospital may be a natural monopoly in some markets but not in others and pragmatically it would be difficult to effect a split in only those segments of a hospital’s operations in which it held a natural monopoly.

The need for an enforced purchaser/provider split in natural monopoly markets will require monitoring as the nature of health service markets may change, eliminating natural monopolies in some markets and creating new ones in others (in which case if an insurer/purchaser controls the natural monopoly it may be required to divest it). Unbundling or a split between insurers/purchasers and natural monopoly providers will reduce the problem of competing insurers/purchasers using market leverage through their control of natural monopoly providers to exclude competitors. It will not, however, eliminate it as there may be collusive behaviour between an insurer/purchaser and a monopoly health care provider. An enforced split where the provider is a natural monopoly will also not eliminate the problem of monopoly cross-subsidizing from monopoly to competitive markets or of a monopoly producing fewer services at a higher price than is efficient.

6.3.3 Public Ownership of Monopoly

One possible means of solving the problem of natural monopoly is to nationalize (or leave nationalized) health providers that are natural monopolies. Presently, most hospitals in the U.K. and New Zealand are government-owned through (respectively) the larger umbrella organizations of the NHS Trusts and the Crown Health Enterprises. If these countries introduced

a managed competition system of competing insurers/purchasers then these administrative organizations would have to be unbundled and hospitals privatized in order to allow insurers/purchasers to form their own relationships with health care providers. Insurers/purchasers may then enter into whatever arrangements with health providers they consider efficient i.e. vertical integration, joint ventures, short or long term contracts, etc. Arguably those hospitals that are natural monopolies should remain government-owned thus precluding the option of vertical integration. Government could then direct the natural monopoly hospitals to supply competing insurers/purchasers on reasonable terms. Is public ownership the best means to deal with the incidence of natural monopoly or is there some other means by which to remedy the problem at less cost?

With respect to the costs of public ownership, it is often alleged that there are internal slackness problems within government organizations and efficiencies are gained from privatization; however, there is little empirical data to support the general contention that private hospitals are more efficient than public hospitals particularly once case-mix is taken into account. In other words public hospitals look after sicker people so it is flawed to compare their “performance” to private hospitals. On the other hand, privatization of government organizations in many sectors and in many countries seem to have resulted generally in greater efficiencies.952 When considering the efficiencies of privatization, analysts are not comparing private firms with government enterprises where performance incentives have been carefully crafted but rather with government enterprises where it was just assumed that public ownership would translate to management working to maximize the public interest. Arguably, a government owned corporation with a sufficiently refined internal incentive structure could be as efficient as a privatized firm. Of course, in a natural monopoly situation we would not want a public firm to act just as a private firm would as we would still have the problem of production at too low a level for too high a price. The goal would be to design incentives so that the nationalized hospital is technically efficiently but does not seek monopoly rents or to reduce production or lower quality.

Smith and Lipsky note that what are perceived as efficiencies arising from privatization are often only cheaper labour costs.953 Cheaper labour costs may result only in a transfer of wealth from labour to management and not in real efficiency gains. Moreover, even if cheaper labour costs do actually translate into longer-term efficiency gains, it does not appear that labour costs are

953 Smith & Lipsky, supra note 830 at 241–142.
actually cheaper in private hospitals. In systems like the U.K. and New Zealand where government has paid for the vast majority of health costs, governments have been able to tightly control wage increases for labour in the publicly funded sector. Of course, in these latter systems private hospitals have had no incentive to be efficient due to financing by private insurers on an indemnity basis for the supply of services "supplemental" to those provided publicly. Arguably in a managed competition system privately run hospitals would have incentives to operate efficiently. The same is also true, however, for publicly owned hospitals. A managed competition system offers the prospect of a market (albeit a regulated and somewhat contrived market) where competing private insurers/purchasers can be expected to bring pressure to bear on both privately and publicly owned providers to perform efficiently.

What of the benefits of government-owned natural monopoly? The most viable alternative to nationalization of natural monopolies is regulation and thus the costs of regulation (discussed below) may be avoided by nationalization. However, if management of public hospitals are given incentives to operate like private firms then some sort of regulation would also be required as presumably if a nationalized hospital perfectly mimicked a private firm it would charge a monopoly price and produce at too low a level. For example, although general competition laws do not apply to the health sector in the U.K., it is interesting to note that in other sectors the Secretary of State may refer to the Monopolies and Mergers Commission "any question relating to the efficiency and cost of the service provided by or the possible abuse of a monopoly situation by a nationalized corporation which supplies goods or services." One benefit of public ownership is that possibly government may be able to prevent the hospital in question from cross-subsidizing from natural monopoly markets to other competitive or contestable markets. Thus, in the U.K., the NHS Trusts are specifically prohibited from cross-subsidizing. There is little empirical evidence as to whether this prohibition is effective and one must wonder the degree to which it is possible to monitor and detect cross-subsidization. Moreover, a government may choose not to deal with the cross-subsidization problem. In New Zealand, there is no prohibition on the Crown Health Enterprises cross-subsidizing from one market to another. Another possible benefit of nationalized hospitals is that presumably they will not be as driven by the profit motive as private for-profit hospitals (and, for that matter, "non-profit" hospitals) and thus the quality of services is less likely to be compromised in the competitive process. On the other hand, prior to internal market reform, publicly owned hospitals in the U.K. and New

\[954\] For example, specialists in the U.K. and New Zealand receive higher rates of pay per unit of service in the supplementary private system than they do in the public sector.

\[955\] Competition Act 1980 (U.K.) s. 11 (1), (3)(a), (f) (as amended).

\[956\] NHS 1990 Act, supra note 15 and Allen, supra note 670.
Zealand appeared to suffer from internal slackness problems as evidenced by long and growing waiting lists and public hospitals were perceived as being unresponsive to patients’ concerns. Thus, the pursuit of profits may not undermine quality goals in publicly-owned institutions but problems with internal slackness may have a detrimental effect on quality.

Gorringe argues, following Coase, that it is important to base efficiency assessments on actual preferences and not on “objective” measures such as health outcomes. It may be that individuals prefer to have their services delivered by a public hospital notwithstanding the fact they may be more efficiently delivered by a private hospital. Anecdotal evidence suggests there is strong opposition to the idea of privatization of public hospitals in the U.K. and New Zealand. On the other hand, Blendon et al. found that people in countries where health care services were publicly funded but privately delivered were generally more satisfied with their systems than in systems that were both publicly funded and publicly delivered or privately funded and privately delivered. It seems likely that people in the U.K. and New Zealand are erroneously associating privatization of hospitals with a U.S. style health care system that rations access on the basis of price and not need. If people were assured that this would not be the result of privatization and this was demonstrated (perhaps by way of incremental privatization in certain parts of the country and monitoring the performance of the privatized entity relative to a nationalized hospital) then preferences may change.

Nationalization of hospitals may be seen in terms of using a sledge-hammer to crack a nut. A hospital is unlikely to be a natural monopoly in all the health service markets it operates in. For example, a hospital may hold a monopoly in the supply of accident and emergency services but there is viable competition from the nearest hospital for the supply of elective surgery. Nationalizing the hospital to cure the natural monopoly problem may thus lead to other problems. Again we return to the problem of applying an inflexible and indiscriminate solution to markets that are very different. The ideal solution must be something that is more targeted, selective, and flexible.

958 Blendon et al., supra note 612.
959 I should note here, however, that with increased cut-backs to nursing staff in many jurisdictions family-members are increasingly called upon to supply nursing care in hospitals, and thus patients will be disadvantaged if there are longer travelling times to hospitals.
960 For example, the design of incentives to ensure performance on the part of management in all these competitive markets.
6.3.4 Essential Facilities Doctrine

Another potential means by which to alleviate the problem of monopoly on the supply side is by employment of the "essential facility doctrine". This doctrine has been applied primarily in the U.S. pursuant to sections 1 and 2 of the Sherman Act where a firm denies another firm reasonable access to an "essential facility" that the latter firm must obtain in order to compete in a particular market with the former firm. As Makar describes it the doctrine "requires the owner of an "essential facility" to provide its business rivals with equal or non-discriminatory use of, or access to, the facility on fair terms."

One must be careful in applying this doctrine to jurisdictions other than that of the U.S. It does not appear to be a doctrine of general application in the Netherlands, the U.K. or New Zealand. In those jurisdictions the problem that the doctrine attempts to correct is dealt with through general competition laws (refusal to deal and/or abuse of a dominant position provisions). Even within the U.S. doubt has been raised about the application of the doctrine beyond instances of collusive behaviour to single firm conduct. Nonetheless, prima facie, the essential facility doctrine seems particularly apt in the context of the bottleneck problem in a managed competition system and thus is worth discussing.

There are four elements that need to be established in order to rely on the essential facility doctrine in the case of single-firm conduct:

1. the monopoly must control the essential facility in question;
2. it must be impracticable or unreasonable for a competitor to duplicate the essential facility;
3. the competitor must have been denied access to the facility; and
4. allowing access must not detrimentally compromise the monopoly's own use of the facility.

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When is a facility "essential" and what constitutes denial of access? A good or service is essential when it constitutes a factor of production that is crucial to the production of some other good or service.\textsuperscript{966} Thus in the case of a hospital that is a natural monopoly in one or more health services markets, in order to compete for the custom of local residents, all insurers/purchasers will need to buy services from that hospital in order to be able to offer comprehensive coverage. It would, however, be inefficient for all insurers/purchasers to attempt to build their own hospitals in the area as this would amount to an inefficient duplication of resources. The important question is on what terms to allow insurers/purchasers access to natural monopoly hospitals. The U.S. case-law with respect to what constitutes a denial of access is unclear and case-law does not "indicate to what extent the monopolist must exercise an affirmative duty to negotiate or propose reasonable terms, or in what ways and to what extent the terms of access must be unreasonable to constitute a violation".\textsuperscript{967}

Debate arises over how to calculate the price to be paid by competitors for the services offered by an essential facility. Should the price reflect the marginal cost of production, the average cost or production, or should the monopolist be able to include in the price charged to competitors in upstream or downstream markets the monopoly rents lost in those latter markets as a result of entry by competitors? In the U.S. in \textit{Laurel Sand \\& Gravel v. CSX Transportation, Inc.}\textsuperscript{968} the court found that the access arrangements did not have to ensure that the plaintiff was able to garner profits. In New Zealand, the Privy Council recently condoned a telecommunications monopoly's proposal to charge a new entrant a price for interconnection to essential infrastructure that reflected the loss of monopoly rents suffered by the monopolist in \textit{downstream markets} as a result of the new entry.\textsuperscript{969} There are various arguments as to why it is efficient to allow what appears to be \textit{prima facie} a perverse arrangement to occur;\textsuperscript{970} however it is important to note that the proposed pricing rule in the Telecom case was created on the assumption that the monopoly is regulated so monopoly rent is eliminated over time.\textsuperscript{971} The difficulty is, (and this was expressly recognized by the Privy Council) that the courts are in no position to perform this on-going regulatory role.\textsuperscript{972} Werden argues that "[i]f the essential facility is a bottleneck that


\textsuperscript{967}Werden, supra note 964 at 456.

\textsuperscript{968}[1991-1 Trade Cases, sec 69. 312] (4th Cir.).


\textsuperscript{972}Telecom Corp. of N.Z., Ltd., supra note 969.
prevents the delivery of the relevant product to certain customers, mandated access would enhance welfare, but only if the facility is subject to pre-existing regulation that can effectively control the price and other terms of access." He goes on to argue that the essential facility doctrine should be entirely abandoned in favour of industry specific regulation for three reasons: it would allow for a more consistent determination of what constitutes a natural monopoly and when is should be subject to mandatory access; unlike general anti-trust laws regulation can respond to the specific conditions of the industry; and a regulator rather than a court is likely to be in a better position to determine complex issues regarding the reasonableness of the terms of access.

Over the course of the last decade, physicians and other health care providers have attempted to employ the essential facility doctrine in the U.S. The doctrine is most often sought to be employed in the health care sector by physicians in order to gain admitting privileges to hospitals that are seeking to limit the number of physicians working at the hospital. These sorts of actions are not often successful as physicians have found it difficult to present a credible story that a hospital is an “essential facility” when they still have financially viable practices even when they are denied admitting privileges to the hospital. This sort of reasoning undermines the potential of the doctrine to remedy the problem of a vertically integrated insurers/purchaser foreclosing access by other competing insurers/purchasers to a natural monopoly. Competitors may remain solvent notwithstanding foreclosure as they are able to compete in other markets. However, in that particular market consumers would not have a choice of purchaser and there would be no incentive for the purchaser to be accountable to local consumers on price and quality dimensions.

In Blue Cross & Blue Shield United of Wisconsin, et al., v. Marshfield Clinic a managed care plan sought to establish access to a hospital owned by another. Posner found that the physician owned health care clinic was not an “essential facility” for purposes of antitrust doctrine that would require it to cooperate with a would-be competitor. He noted that the clinic did not control even 50% of any properly defined market, even if it operated the only Health

973 Werden, supra note 964 at 479.
974 Idem.
976 Makar attributes to this phenomenon an increasing number of physicians, fewer hospitals (as a result of consolidation) and hospitals being selective in employment of physicians in order to avoid medical malpractice liability on the grounds of granting admitting privileges to physicians whose qualifications or work was not of a sufficient standard — ibid. at 928.
977 See ibid. at 932–934.
978 65 F.3d 1406 (7th Cir.1995), cert. denied No. 95-1118.
Maintenance Organization (a form of managed care plan) in the area, and therefore could not be considered "essential". Posner noted that consumers are not better off if the natural monopolist is forced to share some of its profits with potential competitors as the monopolist will still charge fees reflecting their monopoly. This statement is a confusing, however, as surely this will depend upon what terms the monopolist is required to give access to competitors. In a managed competition system, the dynamic and ongoing nature of competition between insurers/purchasers is essential. Allowing a purchaser that is vertically integrated with a natural monopoly to foreclose access to other purchasers would not simply be a case of allowing a monopolist to collect its monopoly rents in a particular health service market. It would impede competition in the insurance/purchasing market that covers many health service markets and not just the market the natural monopoly operates in. As an example, if competing insurers/purchasers cannot buy emergency services from a hospital that is a natural monopoly, it cannot offer to local residents a comprehensive plan which would include not only emergency services, but elective surgery, primary care, outpatient care, nursing care, mental health services etc.

A monopolist can successfully defend a claim under the essential facility doctrine on the grounds that it had legitimate business reasons for its actions. Areeda notes, "denial of access is never per se unlawful; legitimate business purpose always saves the defendant." An insurer/purchaser may be able to demonstrate efficiencies accruing from vertical integration with a natural monopoly. A vertically integrated monopolist would have a viable argument that in order to run the hospital or other essential facility efficiently it is legitimate to deny competing insurers/purchaser access to it. The argument would be that in order to provide a coherent and comprehensive managed care plan it cannot allow physicians affiliated with other insurers/purchasers with different styles of practice and management of care to disrupt the hospital’s activities.

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979 Ibid. at 1413.
981 Areeda, supra note 962 at 847.
982 In Smith v. Northern Michigan Hospital Inc. 703 F.2d 942 at 953 (6th Cir. 1983), the court rejected a claim by a group of physicians that a hospital’s decision to award its affiliated clinic an exclusive contract for the provision of emergency services. The physicians argued, relying in part on the essential facilities doctrine, that the hospital and clinic joint were in a horizontal arrangement and it was an unreasonable restraint of trade to deny the physicians admitting privileges for emergency room services. The court concluded that as the hospitals was in a vertical relationship with the clinic and had to staff its one emergency room in the most “effective, efficient and medically prudent manner.”
983 Presumably, the monopolist’s physicians could perform the operations or services for other insurers’ patients but this may lead to continuity of care and management problems for competitors.
In summary, there are several potential obstacles to the employment of the essential facilities doctrine as a means to solve the bottleneck problem. The doctrine is of little assistance in correcting the other three monopoly supply side problems.

6.3.5 Competition Law

It is beyond the scope of this thesis to describe in detail the general competition laws in each of the four jurisdictions. Rather the point of this section is to consider, given the general goals of competition law, whether it is an appropriate method with which to deal with the four problems of monopoly supply (the bottleneck problem, the cross-subsidy problem, the problem of monopoly producing at too low an output and too high a price, and the creation of monopoly in the absence of off-setting efficiency gains).

a. Bottlenecks

General competition laws deal with access to bottlenecks and essential facilities through refusal to deal and abuse of dominance provisions. As I discussed above in the context of the essential facility doctrine, the key problem with respect to employment of competition law is the ability of competition authorities to set and monitor the terms of access. Issues arise such as whether the price charged by the monopolist should be based on marginal cost or average cost plus a fair rate of return on the owner's investment or even whether the price should reflect the loss of the monopolist's profits as a result of new entry by competitors in upstream or downstream markets. Arguably, competition authorities and the general courts are ill-equipped relative to an industry specific regulator to undertake the necessary analysis. Competition law may be relied on, however, to prevent anti-competitive arrangements between insurers/purchasers and natural monopolies as this may be caught under the collusion provisions. The general conspiracy or collusion provision will not, however, prevent a vertically integrated entity from foreclosing access to its own health providers. For example, in the U.S., section 1 of the Sherman Act requires that in order to establish a violation there be two or more parties participating in the conspiracy. A managed care plan and its wholly owned hospital subsidiary would not be capable of conspiring.

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984 J. F. Quinn and G. F. Leslie, "Essential Facilities and the Duty to Facilitate Competition" (Symposium on Competition Law and Deregulation in Network Industries, University of Toronto, Faculty of Law, June 14, 1996) at 29-30.
985 See Telecom Corp. of N.Z., Ltd., supra note 969. For a discussion see Flood, supra note 970 at 212-214.
986 Sherman Act, supra note 961.
987 This is known as the "Copperweld" doctrine — Copperweld Corp. v. Independence Tube Corp., 467 U.S. 752 (1984).
b. Cross-Subsidization from Monopoly to Competitive Markets

General competition laws do not specifically deal with the problem of cross-subsidization by a single firm from one market where it is a natural monopoly to another where it faces competition. General competition laws often contain a section prohibiting “predatory pricing”; however, predatory pricing is normally thought of in the context of a dominant firm in a particular market cutting its prices to below cost in order to drive out competitors. The competition authorities are thus required to analyze a single market. This analysis becomes much more complicated when a firm operates in a number of markets and is cross-subsidizing from its activities in one market to its activities in another. The firm may be able to successfully argue that it is not engaged in predatory pricing as its average costs for its total operation is not above the average price charged in all the markets it operates in. Usually predatory pricing can be detected where the costs of operation are above the price but clearly this is going to be more difficulty in an instance of cross-subsidization.

c. Preventing Monopoly Profits and Output

Can competition law prevent natural monopoly health care providers from charging prices above long run average cost and producing fewer services than is optimal from society’s perspective? General competition laws do not prohibit or prevent the extraction of monopoly rents per se. Competition laws are usually unconcerned with monopoly that has arisen as a result of a superior competitive performance. For example, the U.S. Supreme Court has said in the context of s. 2 of the Sherman Act\(^988\) that what is required is “wilful acquisition or maintenance of monopoly power as contrasted with monopoly achieved as a result of historical accident, business acumen, or the like.”\(^989\)

The general premise of competition law is that the existence of monopoly rents is part of the dynamic process of competition and will attract new entrants into the market and over time the monopoly rents will disappear. The difficulty is that in a natural monopoly market there is no possibility of a new entrant or, if there is a new entrant, this would result in an inefficient duplication of resources. Moreover, general competition laws do not usually empower competition authorities and courts to regulate prices on an on-going basis. An exception to this is New Zealand’s Commerce Act which enables goods and services to be placed under the direct price control of the Commerce Commission where the Minister determines there is limited

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\(^{988}\) *Sherman Act, supra* note 961.

competition in the market and it is necessary or desirable for prices to be controlled in the interests of users, consumers and suppliers.900

d. Preventing the Formation of Monopoly
It may seem a basic proposition to someone unfamiliar with the health care sector that competition or anti-trust law should be left to regulate the competitive or contestable segments of health care service markets. There are two reasons why this assumption cannot be readily made in the health sector. The first is empirical evidence showing that increased competition is associated with increased rather than decreased costs. The second is the policy goal of having competition between managed care plans offering an integrated and comprehensive health care system to each and every enrollee. These two reasons are discussed further below.

(i) Increasing Competition and Increasing Welfare
Competition law implicitly assumes that fostering competition will result in lower prices and improvements in overall welfare. The thrust of general competition laws seems antithetical to the regulatory environment in many health care systems that seeks to control the number of inputs (hospital beds, physicians, technology etc.) to the system.991 In fact, the empirical evidence in health services markets suggest that the stimulation of competition is associated with cost and price increases.992 However, it is key to recall that this data has been collected mostly in the U.S. (which is a fragmented system that relies on private financing and provision to a greater degree than most other countries) and in the context of passive indemnity insurers reimbursing health providers on a fee-for-service basis. Consequently, historically, where there has been competition between providers it has not been on the basis of price or real indicators of quality but rather upon what uninformed consumers who are insensitive to cost might regard as rough quality indicators such as the level of technology employed, the skill and numbers of hospital staff, and general amenities. By comparison, in a managed competition system, insurers/purchasers have incentives to compete on price and quality dimensions and thus one would predict that competition will be associated with cost reductions and/or improvements in quality. In fact, there is empirical evidence from the U.S. that competition between managed care plans has resulted in cost reductions,993 although one must be careful in interpreting of these results as the U.S. is not an example of a managed competition system. Within the U.S.'s present unplanned, uncoordinated and ad hoc health system there many opportunities for cost-

900 The Commerce Act (N.Z.), (1986) No. 5, Part IV.
991 Greenberg, supra note 94 at 112.
992 See Thomson, supra note 127.
shifting from plan to plan, from plans to patients and from plans to society at large. There also still remain the difficulty of determining indicators of improvements in quality so that competition is over real improvements in the quality of services as opposed to competition solely on technology and amenities. Some sort of entity is needed to help inform consumers about the quality of service offered by managed care plans (this is discussed in the next chapter).

(ii) Encouraging Competition Between Integrated Plans
With general competition law’s bias towards encouraging competition on the assumption that this will improve overall welfare it may not facilitate the development of integrated delivery systems. From a policy perspective what is important is competition between managed care plans offering an integrated and comprehensive service and not necessarily between individual physicians, hospitals, etc. Competition law must be flexible enough to accommodate this objective and not undermine its achievement by preventing the formation of such systems. Let us look here at the application of competition law in the four systems and the potential in each to allow competition between integrated delivery systems.

(iii) Application of Competition Law
The countries under study have taken a variety of different approaches to the applicability of competition law to health service markets.

It is of particular interest to consider the U.K. which has chosen not to employ general competition law to regulate its new internal market. Instead, it has chosen to leave regulation of monopoly and competitive markets alike to the Department of Health. The Department of Health published on 12 December 1994 the government’s guidelines with respect to mergers and anti-competitive behaviour.994 The Guidelines cover four areas: provider mergers and joint ventures; providers in difficulty; purchaser mergers and boundary adjustments; and collusion. Dawson notes that the policies outlined in these guidelines are drawn from traditional models of competition policy except that the Department of Health is intended to be the regulator of this policy, rather than the Monopolies and Mergers Commission. She suggests that there will be a conflict between the Department’s roles in rationalizing capacity in the NHS and in enforcement of competition policy.995 This is particularly so with respect to the Secretary of State’ power to intervene where providers are experiencing financial difficulties. The temptation will be, for political expediency, not to allow hospitals to fail yet if the rigor of competition is to improve

994 The Operation of the Internal Market: Local Freedoms, National Responsibilities, (London: Department of Health, 1994 (HSG (94) 55.))
995 Dawson, supra note 855.
technical efficiency, then providers must know that there is the prospect of failure with all its attendant draw-backs for management and staff alike. Thus, Dawson argues, if the government is serious about stimulating competition, investigations of possible breaches of competition law should be left to the independent Monopolies and Mergers Commission.\textsuperscript{996}

As in other jurisdictions, the decision whether or not to allow hospital providers to merge or form joint ventures is a difficult one, for although there may be resulting benefits from economies of scale, allowing monopolization of the market (where entry barriers are high) will result in higher prices. The guidelines propose that mergers will not be challenged by the NHS Executive providing that they do not require existing independent NHS Trusts to be dissolved and the resulting entity after merger provides less than half of the services in a particular market. The market is defined as the area around each provider in terms of travel time (14–19 minutes for accident and emergency services; 30 minutes for all other services). If these criteria are triggered, then the NHS executive will attempt to weigh the benefits of the merger against the costs of reduced competition. Le Grand points out that the wording of the guidelines tend to suggest that it would be the rare case where the NHS executive will allow a merger that falls within the guidelines.\textsuperscript{997}

The guidelines acknowledge the difficulty of determining when collusive behaviour is detrimental to the objectives of the NHS. Dawson notes that the guidelines adopt the approach common in U.K. competition law of prohibiting certain consequences of collusive behaviour rather than collusion \textit{per se} with the emphasis being on distinguishing acceptable contracts that protect patients from unacceptable contracts that protect health purchasers or health providers. There are numerous pitfalls in this approach as in the U.K. internal market government controls on returns to capital may mean that price/cost differences are difficult to isolate which in turn makes it difficult to determine whether standardized pricing is the result of collusion or competition.\textsuperscript{998}

In contrast to the U.K., New Zealand has elected to generally employ competition law to regulate its internal market. To date there have been very few cases. This likely reflects the nature of the relationships concluded between the formally split government purchasers and Crown Health Enterprises which, as discussed in the last chapter, are mainly one year contracts as opposed to longer term contracts, joint ventures, or other initiatives. As purchasers and providers are

\textsuperscript{996}Ibid. at 6.
\textsuperscript{997}J. Le Grand, "Internal Market Rules OK" (1994) 309 British Medical Journal 1596.
\textsuperscript{998}Dawson, \textit{supra} note 855 at 8.
formally prohibited from integrating, there are commentators who call for purchasers and providers to develop longer-term relational contracts in order to reduce transactions costs.\textsuperscript{999} The \textit{Commerce Act (N.Z.)} 1986, No.5, however, treats vertical integration with greater leniency than longer term contracts. In the former case the test is whether the acquisition will result in the acquiring or strengthening of dominance. New Zealand’s Court of Appeal has indicated that the dominance acquired has to be significant.\textsuperscript{1000} By contrast, a long-term contract falls within the ambit of s.27 of the Act and the lesser test is applied of whether or not the contract substantially lessens competition in the market. In a recent case, the Commerce Commission refused clearance for a 10 year build and operate contract between a Regional Health Authority and a mental health facility on the grounds that after five years the market may become contestable.\textsuperscript{1001} \textit{Prima facie}, this seems reasonable but the Commission failed to recognize some important health policy considerations relating to the overall efficiency of the proposed contract such as the benefit of continuity of supply of mental health services and the need for a relationship of trust between purchasers and providers in order to ensure the quality of mental health services supplied. Thus, although New Zealand’s \textit{Commerce Act} 1986, No. 5 (N.Z.) allows the competition authorities to consider efficiencies clearly there is a learning curve in understanding the factors contributing to short and long term efficiencies in various health service markets.\textsuperscript{1002}

Competition law has not historically been applied to the Dutch health sector for two reasons.\textsuperscript{1003} First, it was thought that the promotion of competition amongst health insurers would be detrimental rather than advantageous to the public interest, and, secondly, there has historically been an exemption for practitioners and other “learned professions” from the scope of anti-trust

\textsuperscript{999}Ashton, supra note 887.
\textsuperscript{1001}See the New Zealand’s Commerce Commission Decision No. 275. ISSN No. 0114-2720, 1 August 1995 (Application by the Midland Regional Health Authority and Health Waikato Limited for authorisation under the \textit{Commerce Act (N.Z.)}, (1986) No. 5, s.58, at 32.)
\textsuperscript{1002}The \textit{Commerce Act (N.Z.)}, (1986) No. 5, s. 61 states that the Commission shall not grant application approving (amongst other things) a contract that has the effect of substantially lessening competition unless the Commission is satisfied that the agreement “...will in all the circumstances result, or be likely to result, in a benefit to the public which would outweigh the lessening in competition that would result, or would be likely to result or is deemed to result therefrom.” Section 3A of the Act provides “[w]here the Commission is required under this Act to determine whether or not, or the extent to which, conduct will result, or will be likely to result, in a benefit to the public, the Commission shall have regard to any efficiencies that the Commission considers will result, or will be likely to result from that conduct.”
\textsuperscript{1003}In any event Dutch competition law has few teeth. Schut, Greenberg, & Van De Ven, supra note 374 consider that existing legislation is unlikely to be effective to remedy competition problems in the health sector. For example, while the Economic Competition Act provides for some measures to combat abuse of a dominant position, actual policy enforcement has been virtually non-existent and there is little prospect of this situation improving as there is no scope for the imposition of fines or opportunities for plaintiffs to seek damages. There is also no scope to seek injunctions to stop mergers or take-overs that are likely to breach the Act.
legislation. This latter exemption was removed in 1987 but as the government continued to regulate prices charged by the physicians and hospitals under the Health Care Tariffs Act, there has been little scope for the operation of competition law.

Of all the countries under study the U.S. has had the most experience with the application of competition law to the health sector. Since 1975, the health services market has largely been treated just as any other market would be for the purposes of anti-trust law. Anti-trust law has been used to prevent organized medicine’s attempts to thwart the development of managed care in the U.S. In a series of cases in the late 1970s regarding utilization review of dentists, the Supreme Court found that the dentists could not prevent cost-containment efforts on the part of insurers. In the Supreme Court’s decision of Federal Trade Commission v American Medical Association, the American Medical Association was required to change its code of ethics that precluded groups of physicians from contracting with managed care plans. In a 1984 case, it was also found that it was not anti-competitive for private insurers to preclude physicians from charging patients user charges in addition to the amount paid by the insurer to the physician. From the case law to date it seems that managed care plans are entitled to select surgeons and physicians with whom they believe they will best compete in the market-place with.

A distinction is made in U.S. law between insurer-sponsored managed care plans and physician run plans. An insurer-sponsored plan is a vertical arrangement between an insurer/purchaser and a group of suppliers. In contrast, a physician-sponsored plan is a horizontal arrangement among a group of competitors and is therefore subject to antitrust scrutiny. In U.S. Healthcare, Inc. v. Healthsource, Inc., the First Circuit notes “no one would think twice about a doctor agreeing to work full-time for a staff HMO, an extreme case of vertical exclusivity. Imagine, by contrast, the motives and effects of a horizontal agreement by all of the doctors in a town not to work at a hospital that serves a staff HMO which competes with the doctors.”

1004 Schut, Greenberg, & Van De Ven, supra note 374 at 271.
1006 FTC 701 (1979), aff’d 638 F.2d 443 (2d Cir. 1980), aff’d 452 US 960 (1982).
1007 See the discussion by Greenberg, supra note 94 at 91-13 who notes citing Patrick v. Burget, 486 US 94 (1988) that managed care plan cannot use this as a pretext to punish or eliminate from the market physicians who are also competitors.
As mentioned, health policy-maker may favour the establishment of integrated delivery systems. In a managed competition system this is often seen as occurring from the top down, i.e. insurers/purchasers entering into arrangements with providers. Integration may occur from the bottom up with groups of providers essentially integrating forward into the insurance/purchasing function. What is key to the determination of whether the group of providers has integrated forward is whether they bear the financial risk of utilization. If the group does not have to manage the financial risk associated with utilization of services then their motivation for formation into a group may be more readily assumed to be collusive in order to enhance market power vis a vis aggressive purchasers. Presently, in the U.S., physicians must share financial risk before horizontal arrangements pass the per se illegality test under the Sherman Act.1012 Not surprisingly, physicians in the U.S. feel that the present per se illegality rule applied to horizontal arrangements between physicians for the purpose of sharing information on prices should be eased.1013 They consider this necessary in order to be able to compete with the increasingly larger insurance companies and managed care plans.1014

The anti-collision provisions of the U.S. Sherman Act1015 are generally interpreted using a “rule of reason” test which requires the court to consider all relevant market factors and weigh the pro-competitive and anti-competitive effects to determine whether the arrangement or activity in question unreasonably hurts competition.1016 However, price fixing is perceived as so detrimental that the rule of reason test is not applied and it is considered per se illegal even if pro-competitive justifications are offered.1017 One may, however, envisage situations in managed care plans where price fixing should be allowed as part of the design of an integrated,

1012See Arizona v. Maricopa County Medical Society 457 U.S. 332 (1982) where agreements for maximum price setting between physicians were struck down as a per se violation of the Sherman Act. supra note 961. Maricopa Foundation for Medical Care is a “PPO” that represents approximately 70% of the physicians in the Phoenix, Arizona area. The foundation was formed for the purpose of promoting fee-for-service medicine. It has three objectives: (i) to establish a schedule of maximum fees for patients insured under the plans approved by the foundation; (ii) to review the medical necessity and appropriateness of treatment rendered by physicians; and (iii) to draw cheques on the insurance company accounts to pay the physicians. The case stands for the principle that financial integration and evidence of risk-sharing are important factors in determining whether a physician joint venture raises anti-competitive concerns.


1015Sherman Act, supra note 961.


comprehensive and co-ordinated system of care. Jacobs notes that collective price negotiation that comprises but one part of a “multifaceted integrative scheme designed to achieve some overall competitive benefit” such as a managed care plan, may be acceptable under U.S. antitrust law.\textsuperscript{1018}

From this discussion, one can see that the application of general competition law to competitive or contestable health service markets is far from clear-cut. There is an inherent tension between the desire to allow efficient integration and to prevent the accretion of market power without offsetting efficiency gains. In order to be flexible, the general competition laws of the system must allow for trade-offs to be made between the loss of competition and gains in efficiency. Competition laws that declare certain behaviour to be \textit{per se} illegal are not likely to be useful in the health care sector. If the competition authorities and regular courts are not empowered to make trade-offs between efficiencies of integration the development of integrated delivery systems may be impeded. Despite the problem of applying general competition law, it has proven in the U.S. to be flexible enough to allow the development of managed care plans. Moreover, as demonstrated in the U.K., allowing the government to fulfil the role that competition authorities would ordinarily undertake is unlikely to remedy the problems that arise in maintaining competition in competitive and contestable markets.

\textbf{6.3.6 Industry Specific Regulation}

Let us turn now to consider industry specific regulation. Having concluded that despite the difficulties it is likely appropriate to leave competition law to regulate the competitive or contestable segments of the markets there is still the outstanding problems of access to bottleneck or essential facilities, regulating the price charged by natural monopoly, and cross-subsidization from monopoly competitive markets. Is industry specific regulation the means by which to solve these problems?

The advantages of an industry specific regulator are as follows:

1. General competition authorities may lack the specialized institutional knowledge and capacity to deal with complex industries. Commentators have argued this in the context of telecommunications and electricity sectors and other public utilities. Such an argument would seem to be even more applicable to the health sector due to the severe information asymmetry problem and the associated problems of regulating quality (discussed below).

\textsuperscript{1018}\textsuperscript{}Jacobs, \textit{supra} note 1005 at 169.
2. The terms of access to a natural monopoly by down-stream or up-stream competitors will likely require on-going monitoring that the competition authorities and regular courts are ill-equipped to perform.

3. A regulator may be able to deal with access issues industry-wide in a more cost-effective manner than piece-meal competition law litigation.

4. A regulator may be able to pre-empt access difficulties by competitors in upstream or downstream markets thus precluding monopolists from collecting monopoly rents in those markets throughout protracted litigation proceedings.

5. There is no provision in general competition laws or pursuant to the essential facilities doctrine that would compel a monopolist to expand a hospital or other essential facility to cater to the needs of competitors.

The disadvantages of a specific regulator are:

1. A specific regulator is more likely to be concerned with outcomes rather than the process of competition and there is a natural tendency over time for the regulator to protect those who are subject to regulation rather than the process of competition itself -- in other words the regulator will be “captured” by the regulated;

2. In order to regulate, a specific regulator must obtain extensive information about the firm(s) being regulated and the cost and time involved with this may seriously impede rigorous competition in a market and may also provide opportunities for collusive behaviour;

3. An information asymmetry problem exists between the regulator and the monopoly with management of the monopoly having a much better understanding of the firm and its markets than the regulator does;1019

4. A monopolist will not passively give up their rents and will spend considerable resources attempting to manipulate the regulatory process;1020

5. The remedies available to the general competition authorities and courts pursuant to competition law (injunctions, private damages, criminal sanctions) would be lost and these remedies may prove more powerful than administrative law remedies.1021

Some of the disadvantages of regulation will be ameliorated or aggravated depending on the type of regulation undertaken. For example, a regulator faces an information asymmetry problem as a

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1020 Idem.
monopolist will have more information about its own costs of production than a regulator will. Where the regulator uses rate-of-return or cost-plus regulations the regulator "must become involved in micro management of the firm, second-guessing the decisions of management."1022 This clearly can be a costly and time-consuming process. By becoming involved in the micro-management of the firm, there is greater opportunity for the regulator to be "captured" by those being regulated, becoming more concerned with the welfare of the firm being regulated rather than societal welfare.1023 Cost-plus regulation also has the potential to entrench inefficiencies as there is no incentive to reduce costs and, moreover, may lead to over-investment in fixed costs.

In recognition of the problems associated with rate of return or cost-plus regulation there has been a general shift in public utility regulation to price-cap regulation.1024 The benefits of price-cap regulation is that the monopolist is able to keep as profit any cost-savings made below the fixed price thus producing internal incentives for efficiency.1025 One difficulty is how to ascertain the level at which to fix the price. A price-cap is a relatively crude form of regulation and may be insensitive to the differing underlying cost structures faced by monopolists in different areas. The greatest concern regarding using price-caps to regulate natural monopoly health providers is monopolists will have incentives to cut the quality of services supplied.1026 In fact, the incentive structure of price-cap regulation is very similar to that which underpins capitation payments. The problem of ensuring the quality of health services will, however, equally be a problem in competitive health service markets and thus, regardless, some independent mechanism or entity will be required to safeguard the quality of services supplied.

Regulation holds the promise of being more targeted and flexible than nationalization. It allows firms to achieve the benefits of vertical integration but intervenes to the degree needed to prevent insurers/purchasers that are vertically integrated with monopoly health providers from foreclosing competition in the insurance/purchasing markets. A regulator is likely to be better able to deal with a natural monopoly than competition law which is premised on the assumption that the more competition within a market the better.

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1022 Abbott & Crew, supra note 1019 at 17.
1023 One possible solution is to have the members of the regulatory body appointed on a short-term basis only.
1024 Abbott & Crew, supra note 1019 at 17.
1025 J. Vickers & G. Yarrow, Privatization — An Economic Analysis (Cambridge, Mass.: the MIT Press, 1988) at 116 conclude that in a case of asymmetric information where a principal (i.e. the government) has many agents under its control (i.e. hospitals that are natural monopolies), then the optimal incentive arrangement involves linking each agent's reward not only to its own performance but also to the performance of the other agents.
1026 Abbott & Crew, supra note 1019 at 19.
6.4 Conclusion

As one can see from the discussion in this chapter, all the problems of utility regulation are present in abundance in the regulation of health care delivery and are, in fact, further complicated by information asymmetry and moral hazard problems.\textsuperscript{1027}

The least intrusive solution to the problem of monopoly supply is to rely on co-operation. In a managed competition system, an insurer/purchaser may hold the advantage in some markets where it is vertically integrated with monopoly providers and not in others. Thus one can envisage a situation where vertically integrated insurers/purchasers would work out access arrangements for competitors as they know this will need to be reciprocated in other markets.\textsuperscript{1028}

In this scenario the only explicit supply-side regulation that would be required is competition law to prevent any collusion between insurers/purchasers where they explicitly or implicitly divide up the insurance/purchasing market between them. This scenario is, however, based on the assumption that insurers/purchasers are beginning from a level playing field and no one insurer/purchaser has a significant advantage in terms of control of monopoly health care providers.

The use of competition law to maintain and encourage competition in competitive and contestable health service markets is problematic because as a matter of policy we wish to encourage competition between integrated systems and not individual health providers. These problems support the contention that a specific regulator should regulate not only the natural monopoly but competitive segments as it would have a greater understanding of the complexities of the system. However, provided that competition law allows trade-offs to be made between the pursuit of competition and efficiency gains than the U.S. case-law suggests that competition law will generally facilitate rather than hinder the development of managed care plans. In an internal market system, where the government appoints the purchasers and owns most of the hospitals, leaving government to regulate competition can result in conflicts of interest. Private competitors may choose not to enter the market given the knowledge that publicly owned hospitals will not be allowed to fail and will be protected from the rigors of competition.

On balance, industry specific regulation seems the most appropriate means to deal with the problem of bottlenecks, cross-subsidy, and monopoly rents. Competition law should be left to regulate the competitive and contestable markets. A specialized regulator is more likely to have

\textsuperscript{1027} Ibid. at 13.
\textsuperscript{1028} This is on the assumption that there is regulation requiring insurers/purchasers to provide coverage to all residents in a particular location and setting limits on distances that residents may be expected to travel in order to access care.
the institutional capacity to effectively monitor a monopoly over time. It promises to be more flexible to different market conditions and to tailor remedies. No system of incentives will be perfect yet of the competing alternatives, specific regulation is more likely to deal with the problems effectively. Although in principle this sounds appealing one must be careful of regulatory ossification of the system. By this I mean that purchasers and providers may become so bogged in regulation that innovation, spontaneity, responsiveness -- the best qualities of a competitive market -- are lost. As I discussed in Chapter 3, there needs to be regulation in a managed competition system to stimulate competition between insurers on price and quality dimensions. To the greatest degree possible, once this regulation is in place, insurers/purchasers should be left to determine their own supply side arrangements. Thus government intervention to remedy monopoly supply side problems should be as discrete and selective as possible.
Chapter 7: Achieving Quality in a Competition-Oriented System

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7.1 Introduction

Health care services are not like other essential services, for example electricity or telecommunications, where the quality of the service supplied is relatively easy to measure by consumers. Quality is of significant concern in health service markets primarily because of the information asymmetry that exists between patients and health care providers. For some health services, patients may be ill-equipped to judge the quality of the diagnosis made or of the care their health provider is supplying or recommending.\textsuperscript{1029}

In indemnity insurance systems, quality has not historically been viewed as a significant problem for it is assumed that where providers are paid on a fee-for-service system, they have no incentive to cut the quality of services supplied. The achievement of quality has been historically left to self-regulation by the health professions and (to a greater or lesser degree depending on the jurisdiction) the deterrent effect of medical malpractice actions. In some jurisdictions, like New Zealand and the U.K., hospitals were nationalized with the implicit assumption that the management thereof would work to maximize the public interest. Increasingly, however, there has been growing concern over the conflicts of interest involved in allowing health professions to regulate themselves\textsuperscript{1030} and in the real deterrent effect of medical malpractice actions.\textsuperscript{1031} In systems with nationalized hospitals, concern grew that management was finding it easier to allow waiting lists to grow rather than to strive for improvements in efficiency -- in other words they were slacking on the job.\textsuperscript{1032}

In both internal markets and managed competition, it is envisaged that proactive purchasers will use a variety of techniques to influence the behaviour of health providers in supplying and recommending treatment. “Managed care” covers a number of different types of measures whereby purchasers of services seek to make health care providers more cost sensitive. Depending on the incentives influencing purchasers, they may seek to devolve financial risk on to health care providers. A form of managed care is where a purchaser pays providers by way of capitation -- a fixed sum per person for a particular period regardless of the actual cost of services needed by that person. As Kinney notes: “[the] theory of capitation is that providers,

\textsuperscript{1029}For a fuller discussion of the information asymmetry problem see Chapter 2.

\textsuperscript{1030}For example, T. Stolzefus Jost, “Oversight of the Quality of Medical Care: Regulation, Management, or the Market” (1995) 37 Arizona Law Review 823 at 835 refers to the “dramatic erosion in the public’s confidence in self-regulation.”


\textsuperscript{1032}Saltman & von Otter, supra note 6 at 13 identify public resistance to continued rationing by queue of certain elective surgical procedures, particularly for the elderly, as a force that has contributed to health reform initiatives.
by assuming risk, will have incentives to contain their costs. There is a fear that capitation will lead to unacceptable cuts in quality. This chapter explains how all payment systems have incentive effects be it fee-for-service, salary, capitation or some combination thereof and it will explore whether there is a holy grail in terms of the ideal incentive mix. I argue that if one achieves the right incentive mix at the purchasing level then one does not have to be unduly concerned about purchasers devolving excessive amounts of financial risk to health care providers as it will not be to their advantage to do so. In a managed competition system, one would envisage that if the quality of services fell individuals would "exit" to a competing insurer/purchaser and this would send a clear signal to the insurer/purchaser in question to improve the quality of its service or risk losing further revenue. However, the exit mechanism may not work as an accountability enhancing mechanism where patients cannot readily assess the quality of services they receive. Thus, there is an argument for explicit regulation to empower citizens with information to allow them to make choices between competing insurers/purchasers.

If incentives at the purchaser level (be the purchasers government-appointed health authorities or private insurers) are not working well then residual regulation prohibiting excessive devolution of financial risk to health care providers will be required. Other means by which to inhibit individual health care providers from cutting the quality of care delivered include the traditional methods of professional self-regulation, codes of ethics, and medical malpractice actions.

An important initial question to address is what is meant by the word "quality" and in this chapter I explain how patients, purchasers (whether government-appointed health authorities or private insurers), and society at large will have different perspectives on what constitutes quality. Balancing these perspective requires that a system must not only be concerned with technical quality but also quality in terms of selection of a service or treatment for a particular need, and quality in terms of prioritizing needs. What system of incentives or regulation is required either of purchasers or providers to ensure the efficient realization of these paradigms of quality? It is of primary importance to have a governance structure and a set of incentives in place that encourage purchasers to maintain the quality of health services and, in turn, enter into a variety of arrangements with health care providers that reflects this commitment to quality. What is key is that purchasers internalize or otherwise take into account the costs of reductions in quality in terms of resulting health expenditures in the longer term. In essence, what is needed is a combination of incentives so that purchasers seek to obtain a point close to what is optimal from

the perspective of balancing what is in the interest of society and of particular patients and in terms of trade-offs between cost and quality. If a combination of regulation and incentives is properly designed at the purchasing level then purchasers should be largely left to determine their own supply side arrangements with health care providers with there being a need to regulate individual health providers or practices only where the incentives at the purchasing level fail. Both the managed competition model and the internal market model have not addressed well governance issues at the purchasing level yet it is the motivation to shift allocation decisions from physicians and other health care providers to providers (government-appointed health authorities in the internal market model and regulated private insurers in the managed competition model) that is driving reform.

7.2. The Meaning of Quality
An important question is what do we mean by the word “quality”? As McGlynn points out, to a large extent quality is in the eye of the beholder and purchasers, providers, and patients will have different views on what constitutes quality. Thus, there are several dimensions to quality issues and trade-offs have to be made before patient welfare and societal welfare, the determination of which has often been historically left to health providers because of the information asymmetry problem. The concern has been that under the guise of protecting the quality of services, physicians and other health providers have in fact been maximizing their own self-interest and have been supplying a mix of services at a level of quality that best serves them as opposed to their patients or society.

Although quality is generally thought of in terms of skilful diagnosis and treatment, there are at least three separate quality paradigms that a system needs to address. The first is technical or production quality -- skill in providing a particular treatment or service. The second is quality in terms of choosing the most appropriate service for a particular need. The third paradigm is quality in terms of correctly prioritizing need.

Technical quality is directly linked to the skill in performing a particular task. The technical quality of services produced may depend on co-ordination between different health professionals. Joist notes that “[h]ealth care production processes are most clearly evident in complex health care institutions such as the hospital, in which patients are admitted, fed, cleaned, toileted, moved from place to place (for X-rays or surgery, for example), connected to and disconnected from various machines, medicated, observed and monitored, discharged and

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This feature of health care delivery reinforces the advantages of integrated delivery systems where providers with different skills work together to ensure the co-ordinated supply of services to patients. The formation of integrated systems also opens up the possibility of a move away from professional self-regulation and/or government regulation towards internal “total quality management.”

This management concept, which had a significant impact on Japanese production techniques and subsequently upon American production, relies upon a commitment to continual improvement of the quality of the system. The goal of management is not to punish or select out particular workers who are not performing well but to create an environment where workers feel able to discuss mistakes and learn from them, thus contributing to the quality of the production process or of the system as a whole. A move to total quality management would constitute a significant paradigm shift in the health sector which has historically in many countries relied upon punitive sanctions of individual health providers through medical malpractice actions or professional discipline as the means by which to assure quality.

Technical quality may be able to be assessed by outcomes, such as in the case of surgical services the need for readmission, infection rates, mortality rates etc. Unfortunately, for many services there will not be measurable outcomes by which we can assess technical quality. In 1966, Donabedian conceptualized three aspects of health care: structural elements (such as professional credentials and the years of experience of health providers, the amount of technology employed); process elements (what tests, procedures and services are performed); and outcomes of care, both short and long term. Despite the significant strides that have been made in outcome assessment since 1966, it is important to realize that the quality of many health care services is still not able to be assessed in terms of outcomes such as life expectancy, functionality, productivity etc. Consequently, in many cases one will still have to rely upon structural and process elements as indicators of quality.

In competition-oriented reforms, like managed competition or internal markets, the inclination is for purchasers to focus on “health outcomes” in terms of measuring the performance of individual health providers and of the system as a whole. This is reflective of an economic assessment of health systems which focuses on examining the “outputs” or “product” of the

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1035 Stoltzfus Jost, supra note 1030 at 841.
1037 See A. Donabedian, “Evaluating the Quality of Medical Care” (1966) 2 Milbank Memorial Fund Quarterly 166.
1038 McGlynn, *supra* note 1034 at 11.
health system as “health” or “healthiness.” Thus the tendency is to look to incidences of disease, mortality, life expectancy as measures of “health” and thus as a reflection of the performance of the health system overall. Where outcomes are difficult to measure, regulators and all purchasers (be they government-appointed or private insurers) find it easier to focus on easy-to-measure indicators of performance like turn-over (the number of operations performed and the number of patients treated) and on cost reductions rather than upon more subtle indicators of quality. Services of a caring as opposed to a curative nature, such as services for the terminally ill, the chronically ill, the elderly, the disabled, and the mentally ill are most at risk in terms of degradation of quality in a competitive system. Providing palliative care may not be a priority from the perspective of improving the overall “health” of the population yet most people, I believe, consider such services to be an integral and important component of the health system and as important, if not more important, than services that seek to promote health or prevent disease or illness. Similarly, providing health services to the mentally and physically handicapped may not to improve the overall “health” of society but is still valued by patients and society alike. Thus a preoccupation with measurable health outcomes whilst understandable is impoverished and will result in a skewering of the system towards producing services which are able to be readily measured. In evaluating technical quality, a system must allow for the fact that the satisfaction of some health needs will not be readily measurable in terms of outcomes and devote special attention to ensuring that an appropriate level of resources is devoted to those needs.

This leads one here to discuss a related quality issue that on a broad interpretation of technical or production quality would fall within the ambit thereof. Here I am referring to quality from patients’ perspective in terms of waiting times for surgical services and the trauma, anxiety or pain they undergo whilst receiving medical services or treatment. Depending on the particular problem, waiting times may cause unnecessary stress, loss of productivity and lost wages, and may aggravate the underlying condition. It can also result in direct patient costs. For example, in New Zealand, if a patient cannot be dealt with by the internal market system within 6 months then he/she is not put on a waiting list but is sent back to his/her general physician to “manage” his/her condition. This has direct financial implications for the patient, as in New Zealand there are user charges for physician and pharmaceutical services but not for hospital services. Other

\[1039\text{For example R. G. Evans & G. L. Stoddard “Producing Health, Consuming Health Care” in Evans, Barer, & Marmor, supra note 135 at 38 note “the growing field of health services research has accumulated extensive evidence inconsistent with the assumption that the provision of health care is connected in any systematic or scientifically grounded way with patient “needs” or demonstrable outcomes....Accordingly, the greatly increased flow of resources into health care is perceived as not having a commensurate, or in some cases any, impact on health status. Nor is there any demonstrable connection between international variations in health status and variations in health spending.”} \]
quality issues relate to the pain or anguish incidentally inflicted upon a patient receiving medical treatment. Even although the “outcome” of treatment may be satisfactory, the quality of the process of supplying care may be unacceptable if unnecessary levels of trauma, anxiety or pain are incidentally inflicted upon the patient. 1040 This may be, for example, if a nurse is ‘sloppy’ in administering an intravenous drip or, as another example, if a physician fails to tell a patient what is entailed in medical procedures about to be administered.

The second element of quality is deciding upon what services or treatment (if any) to supply in response to a particular health need. The ability to diagnose has in recent history been monopolized by licensed physicians who have sought to protect this privilege through the argument that the quality of care would suffer if unlicensed providers were allowed to diagnose and treat patients. 1041 However, information technology has developed and significant advances have been made in our ability to examine and compare physician’s prescribing practices so we are no longer limited to relying upon the formal acknowledgement of a physician’s skills by the profession. The results gained from empirical analysis of physicians’ prescribing practices are disturbing and in some instances suggest that some physicians will be more concerned with their own professional self-interest than with quality whether from a patient or societal perspective. 1042 Self-interest aside it has also become clear that physicians themselves lack good information about the cost and benefits of particular treatments. Studies show significant levels of variation in the treatment of medical needs that appear to be unjustifiable from a clinical perspective and that there are potential efficiency gains to be had from consistency in prescribing patterns without any apparent detriment to quality. 1043

From a patient’s perspective, quality of service will depend upon receiving the best possible service for a particular need in terms of immediate access, short recovery times, minimization of side-effects, and greater chance of survival or full recovery, irrespective of cost. Societal welfare may be enhanced, however, if some of these elements of quality were foregone and resources so freed up were devoted to other needs or wants i.e. other health needs, education,

1040 One example is where the “outcome” of a procedure is successful in that a woman had a successful caesarean birth and she and her child are healthy. However, the clumsy application of an epidural resulted in unnecessary pain and anxiety for the mother as it only worked on her left side. The epidural had to be administered again causing additional stress to the woman who was aware of the attendant risk of paralysis from injection into the spinal cord.

1041 Stoltzfus Jost, supra note 1030 at 828–829. One should note, however, that until the recent managed care revolution in the U.S., patients were able to “self-diagnose” to an extent as they could access specialists without having to visit a general practitioner first.

1042 See the discussion in Chapter 2 regarding the ability of physicians to influence demand for their own services.

1043 See the discussion by C. E. Phelps & C. Mooney, “Variations in Medical Practice Use: Causes and Consequences” in R. J. Arnould, R. F. Rich, & W. D. White, eds., Competitive Approaches To Health Care Reform (Washington, D.C.: The Urban Institute Press, 1993) at 171–172 who note that factors influencing behaviour will include factors such as education and training, the practice of colleagues and peers, and absorption of ethical norms.
infrastructure, tax reductions, etc. Assuming that the level of resources devoted to health is fixed, we have to decide whether it is worth providing, as an example, one service at a cost of $10,000 with a 100% success rate or a substitute service at a cost of $1000 per person with a 80% success rate, thus successfully servicing eight times as many people for the same cost. Thus here a trade-off must be made between a patient’s desire to have the best possible service and societal welfare.

I have already discussed some of the difficulties associated with the prioritization of health needs in Chapter 4. The problem of prioritization of health needs is complicated by the fact that purchasers, patients and society at large will have different priorities. As a general goal we should be striving towards a system that satisfies societal goals but this general utilitarian approach must be overridden in some instances such as in the case of services for vulnerable populations. As a matter of equity, I believe that these sorts of services, for example HIV/AIDS services, psychiatric services, services for the mentally or physically disabled, should be provided even though most of us in society (rightly or wrongly) consider the likelihood of us needing these services is almost zero. This prioritization process is complicated by the fact that society often demonstrates a strong preference towards satisfying what has become known as the “rule of rescue.” As a society we are prepared to expend significant resources on rescuing individuals from imminent life-threatening peril. Examples include a child trapped in the bottom of a well, a skier buried alive at the bottom of an avalanche, a yachtsman who has disappeared in the Pacific. In health, examples include a child who has a 5% chance of survival if they receive a heart and lung transplant that will cost $1 million. Society often demonstrates a strong preference when directly faced with such a poignant case to finance the child’s chance of survival. This preference crystallizes in a much stronger degree when the child is your child or you are the person in need of expensive but potentially life-saving technologies. Clearly, a balance has to be struck between society’s desire to satisfy the rule of rescue, individual needs (particular individuals may not strike a sympathetic chord with society but their need may just be as great as others, for example a convicted pedophile/murderer in need of a expensive life-saving operation) and society’s desire not to spend ever increasing amounts on health. These will never be easy issues to resolve and there must continue to be ongoing evaluation in a health care system of prioritization of health care needs through a body such as New Zealand’s Core Health Services Commission.

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1044 This may be justified in economic terms under the idea of a “caring externality” or on grounds of equity — see the discussion in Chapter 2.
1046 See the discussion in Chapter 4.
Issues of quality have historically been left to physicians who controlled production processes and the involvement of other health professionals, monopolized the diagnosis process, and strongly influenced what health needs would be given priority in terms of allocation of resources. The new wave of competition-oriented reforms seeks to change the balance of power between purchasers and physicians. Purchasers (be they government appointed monopsonies in internal markets or competing private insurers in managed competition markets) seek to strongly influence or “manage” physician decision-making.

7.3 Modes of Reimbursement for Health Providers

In this section, I examine three modes of reimbursement: fee-for-service, salary and capitation. Variants of these reimbursement mechanisms may be used by government to gear incentives towards competing purchasers or by purchasers towards competing health care providers. The goal of this section is to seek to understand what effect on quality will there be as a result of use of a particular reimbursement mechanism.

7.3.1 Fee-for-Service

Proponents of the theory of supplier-induced demand assume that in a fee-for-service system that health providers have an incentive to supply as many services as possible. If one focused on utility as a function of income, then in a fee-for-service system, prima facie, health providers have an incentive to provide as many services as possible to maximize income. In reality health providers wish to maximize their own utility which may be a combination of net incomes and other factors, such as prestige and professional status, work hours, promotional opportunities, etc. Consequently, if paid a higher fee, they may not necessarily produce more services but less as they can earn the same income but have more leisure hours. Therefore the link between a fee-for-service payment regime and production beyond an optimal point is not clear-cut. Clearly there is the potential, however, for a fee-for-service payment system to result in production beyond the optimal production frontier but the extent of this problem will depend on a multitude of factors.

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1047 Stoltzfus Jost, supra note 1030 at 832–833 notes that in the U.S., physicians and other providers have been subject to increasing government regulation with the goal of protecting quality.

1048 This was recognized by Shaw when he said “[t]hat any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair of political humanity.” -- The Doctor’s Dilemma, 1911 as cited by N. Barr, “Economic Theory and the Welfare State: A Survey and Reinterpretation” (1992) XXX: 2 Jnl. Econ. Lit 741 at 741.

1049 Hurley and Labelle, supra note 120 and P. C. Coyte, supra note 20.
As discussed in Chapter 2, the key problem with a fee-for-service payment mechanism is it does not offer any positive incentive to consider whether there are alternative treatments that provide the same benefits at lower costs to society and there is no financial incentive to weigh differing health needs. In particular, a fee-for-service system does not provide any incentive for providers to consider the cost-effectiveness of the various services that they recommend above and beyond those which they supply themselves. The information asymmetry existing between physicians and patients means that patients are unable to detect when physicians are recommending services that are not cost-effective (and vice versa as individual behaviour may mitigate the cost-effectiveness of providers' actions such as where a patient does not take a full course of antibiotics as instructed by a physician.) Moreover, in a system of full insurance (be it public or private) patients themselves have no financial incentive to question a provider's recommendations — the moral hazard problem. Due to information asymmetry, there is a plausible argument that to protect patients from reductions in quality it is preferable to have incentives to provide services beyond rather than below the optimal cost-effective point (assuming, of course, that such over provision results in simply extra costs and no actual harm to the health of the patient). On the other hand, all systems must be concerned with cost and over-provision of one instance of health need may necessarily lead to under-provision of another. The goal is to design a system that results in production at the optimum point in terms of trade-offs between quality and cost.

Historically, general practitioners in all of the countries being studied in this thesis were reimbursed on a fee-for-service system. In the Netherlands, general practitioners are paid on a fee-for-service basis by private insurers and on a capitation basis by sickness funds. Schut and Hermans note that maximum fee levels and capitation payments are set by negotiation between associations representing insurers and physicians and must be approved by the Central Board on Health Care Prices on the basis of the Health Care Prices Act. In New Zealand, physicians have historically been paid on a fee-for-service basis with no government regulation limiting either the fee or the volume of services supplied. Increasingly, however, Independent Practice Associations are being formed which may be paid on a capitated budget basis. In the U.S. physicians were historically paid on an unregulated fee-for-service basis; however, the recent shift on the part of insurers to managed care has resulted in approximately half of all American physicians having at least some patients whose insurers pay by means of capitation or use

1050 Schut and Hermans, supra note 411 at 8.
1051 Malcolm & Powell supra note 19. One Independent Practice Association, South Link Health, a joint venture of 260 physicians, reported a surplus of over $1 million at its annual meeting in October 1997. The Chair of South Link Health attributed this to the success of budget holding — New Zealand Doctor, 1 October 1997, "Frontpage", http://www.nzdoctor.co.nz/oct1FP97.html.
“withhold” payments. These arise where some portion of payment is held until the end of the financial year by the purchaser and only paid to the physicians if agreed utilization targets are met.\textsuperscript{1052} Prior to internal market reform in the U.K., general practitioners were paid on a mixture of a salary basis (which is larger for practitioners locating in those areas viewed as being underserved), a capitation payment per registered patient (with three levels of payment depending on the age of the patient), and specific fee-for-service payments for particular preventative services.\textsuperscript{1053} Fee-for-service payments and payments of costs are pegged to the total average costs for all practitioners, with practitioners being able to keep any moneys they save below the average.\textsuperscript{1054} The system of capitation payments had been eroded over the years until by the mid 1980s only 46\% of general practitioners’ incomes were derived from capitation.\textsuperscript{1055} Capitation was, however, effectively revived through the development of GP Fundholder which has been discussed extensively in earlier chapters. Specialists in the U.K. public sector are reimbursed by salaries and “distinction awards.”\textsuperscript{1056}

The problem of escalating costs is often generally tied to fee-for-service payments. In fact, it is not fee-for-service payments per se that contribute to escalating costs but fee-for-service in conjunction with what are known as the “guild” principles of health care allocation -- indemnity insurance, free choice of providers, solo practice, and no limits on what physicians may prescribe or recommend as treatment.\textsuperscript{1057} These guild principles have been actively promoted and protected by physicians in many countries as they are clearly of professional advantage in terms of maintenance of income and autonomy. If, however, proactive purchasers have incentives to monitor physicians’ decisions then the guild principles may be displaced. In such a case it cannot be assumed that the use of fee-for-service payments by proactive purchasers will result in an inefficient system. Both managed competition systems and internal market systems rely upon a proactive purchaser to ensure the most cost-effective services for any particular health need are chosen and health needs themselves are reprioritized in a manner that is closer to what is optimal from society’s perspective.

\textsuperscript{1053}Culyer \& Meads, \textit{supra} note 532 at 674.
\textsuperscript{1054}OECD, \textit{Health Policy Studies No. 2, supra} note 22 at 113.
\textsuperscript{1055}Day \& Klein, \textit{supra} note 385 at 49.
\textsuperscript{1056}For a criticism of these awards see K. Bloor \& A. Maynard, \textit{Rewarding Excellence??: Consultants’ Distinction Awards and the Need for Reform, (Discussion Paper 100)} (York: Center for Health Economics, University of York, 1992.).
\textsuperscript{1057}Enthoven. (1993). \textit{supra} note 20 at 25.
Proactive purchasers can use a myriad of techniques to control physicians’ behaviour in a fee-for-service system such as review of prescribing patterns and disseminating information to physicians regarding the cost-effectiveness of particular services. Some 87% of Health Maintenance Organizations in the U.S. (a form of managed care) say they use clinical practice guidelines as a technique for monitoring quality. Some physicians may chide this as “cookbook” medicine that undermines and discredits their skills as professionals to tailor treatment to each individual’s particular needs. Studies show, however, significant variations in the treatment of medical needs that appear to be unjustifiable from a clinical perspective. Thus, there are potentially significant efficiency gains to be had from greater consistency in prescribing patterns, although Schlesinger et al., found that only 14% of the U.S. managed care industry in 1993 were in fact adopting “standardizing” strategies. Another popular technique in the U.S., as mentioned above, is “withholds” where a Health Maintenance Organization holds back a portion of providers’ fee-for-service payments throughout the year. The amount withheld is paid out at year’s end if utilization goals are met. Such modifications to a fee-for-service payment may result in significantly different incentive structures than those associated with fee-for-service payments in a guild system.

A very important advantage of a fee-for-service payment is that a purchaser can influence the priorities that providers give to certain types of services. Thus, for example, if a proactive purchaser (a health authority or a private insurer) wishes providers to supply more preventive and primary services it can pay the provider for those services on a fee-for-service basis and more of those services will be supplied relative to other services that are not paid for on a fee-for-service basis. Similarly, at the purchaser level itself, government could reimburse purchasers on a fee-for-service basis for the provision of some services where there is a concern that not enough of these services would otherwise be brought, for example public health services.

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1059 See for example the description of one paediatrician’s response to managed care in G. Anders, Health Against Wealth: HMOs and the Breakdown of Medical Trust (Boston: Houghton Mifflin, 1996) at 75.


1061 Phelps & Mooney, supra note 1043.

1062 M. J. Schlesinger, B. H. Gray & K. M. Perreira, “Medical Professionalism Under Managed Care: The Pros and Cons of Utilization Review” (1997) 16: 1 Health Affairs 106 at 115. Interestingly, the authors note that those managed care organizations that adopt standardizing techniques are the ones in which “the medical director and medical staff have the most pronounced influence over organizational policies.”
or services for vulnerable populations. This important issues are discussed more fully below in the context of training incentives upon purchasers.

7.3.2 Salary
Payment by salary *prima facie* gives no incentives to under or over provide health care services.\(^{1063}\) Paying hospitals by way of fixed prospective payments budgets results in similar incentive effects as remuneration is not linked to production or performance.

Paying providers on a salary basis would appear to diminish many of the problems associated with cutting the quality of services in a competitive system. On the other hand, as salaries are not tied to production there is an incentive to slack on the job which may lead to reductions in quality particularly in terms of growing waiting lists or times for treatment. There is also no *positive* incentive to supply the most cost-effective service or even services of high quality. Thus what providers choose to provide may be the result of what is common practice among their peers in the locality in which they practice or what was commonplace at the time they were trained many years previously. One may argue that many other public servants, e.g. law professors, are paid on by salary and few suggest that their performance would be significantly improved by paying them on a fee per lecture basis or an amount per student that they attract into their classes per year. The difference is, however, that physicians do not only determine the nature and volume of their own services but make recommendations for other services such as diagnostic tests, x-rays, drugs, and specialist or hospital services. It is to this decision-making process that incentives must be geared in order to compensate for the fact that physicians will be otherwise insensitive to the cost of the services, good and treatments they recommend.

On the other hand, there are significant advantages to electing to pay providers by way of a salary. A purchaser in a managed competition could influence performance by, for example, choosing to hire those providers who prefer preventive and primary techniques over more intensive and invasive (and thus expensive) health care services. The purchaser could create an integrated firm within which the culture of operation is directed towards supplying and recommending services believed to be cost-effective. It may be easier to translate the plan’s management practices into physicians’ prescribing behaviour when physicians are employees within the firm rather than independent contractors. A purchaser may initiate peer review and

\(^{1063}\)See P. C. Coyte, “Current Trends and Future Directions for the Canadian Health Care System”, unpublished mimeo, Dept. of Health Admin., University of Toronto, December 18, 1996 at 14 “[s]alaried physicians neither face incentives to practice efficiently nor to restrain their propensity to refer patients for diagnostic services or specialty care.”
promotions as incentives for performance and may pay bonuses when utilization targets are met. Alternatively, it may find it easier to foster a team approach in the absence of crude financial incentives directed towards performance. Some of the earliest Health Maintenance Organizations in the U.S., generally non-profit organizations, operate on a “staff model” basis and continue to choose to pay their physicians on a salary basis.

7.3.3 Capitation

A capitation payment is where a provider or group of providers receives a fixed sum per person enrolled with them and for that sum has to provide all of a defined range of services that the person may require over a particular time period. Posner J. notes payment by capitation provides an incentive to minimize the procedures performed, since the marginal revenue derived from each procedure performed is zero.\textsuperscript{1064} Posner’s analysis, however, is static and fails to allow for the fact that over the longer term, the advantage of capitation is that providers will have an incentive to keep their enrollee population healthy through the use of preventative services for if they fall ill it will cost the health provider more to service them in the longer term. Admittedly (and as discussed further below), this advantage of capitation depends on providers not being able to shift the long term costs of their failure to provide preventive care on to others. Posner’s statement also does not acknowledge that in a competitive market there will be an incentive to provide services or risk losing patient loyalty and consequent revenue.

It is important to note that through a capitation payment a purchaser not only transfers risk to health providers but a measure of \textit{purchasing power} within a fixed budget. The goal is to render health providers sensitive to costs by requiring them to take a measure of responsibility for purchasing services and to bear the risk of utilization by patients. However, as discussed in Chapter 4, in a managed competition system there would be regulation in place guaranteeing everyone access to a comprehensive range of services. It is generally then up to the health provider to decide upon \textit{what} service or \textit{mix} of services from that range to buy/supply to any particular patient from their fixed budget. An advantage of capitation payments is that it allows a physician or other health provider to tailor the supply of health services towards the health needs of the people that he/she serves. This means that the provider can be more responsive to the particular needs of the individual he/she serves. For example, in New Zealand, there has been some success with devolving payments by way of capitation to Maori communities and/or Maori physicians within those communities which provides them with autonomy in decision-

\textsuperscript{1064}Per Posner J. in \textit{Blue Cross & Blue Shield United of Wisconsin, et al., v. Marshfield Clinic}, 65 F.3d 1406 (7th Cir.1995), cert. denied No. 95-1118.
Particular groups in society may have preferences for different sorts of health services than the majority of the population prefers and payment by capitation offers the promise of realization of those groups' needs.

In a fee-for-service system, the potential is for over-provision beyond the optimal point of trade-offs between cost and quality. With capitation, the potential is for under-provision below the optimal point where the entity being paid on a capitated basis is confident of being able to shift the costs of failing to provide services of an adequate quality on to others. Insurers/purchasers paid by way of capitation may prescribe fewer services than are needed, or less effective services, or services of a lower quality in order to maximize profits. Similarly, health providers paid by way of capitation may prescribe fewer services than are needed, or less effective services, or services of a lower quality in order to maximize profits. Thus, the problems of quality are similar in both managed competition systems and in internal market systems if, in the latter case, government-appointed health authorities seek to pay health care providers on a capitation basis. In a managed competition system, if insurers/purchasers do not ensure the supply of services of sufficient quality there is a risk that citizens will register their dissatisfaction by shifting their risk-adjusted share of funding to another insurer/purchaser.1066

There is a potential for such an accountability mechanism to operate in an internal market system if government-appointed purchasers ensure that the “money follows the patient”, in other words that the capititated sum is transferred to the citizen’s chosen health care provider(s).

Individual patients will be more concerned over the quality of service provided than they would be over the cost of additional beneficial (but not cost effective) services supplied in a system of full insurance. Consequently, patients have a much stronger incentive to hold providers paid by way of capitation to account for the quality of services supplied than they do to hold providers paid on an unlimited fee-for-service basis to account for supply of more services than are cost-effective. The difficulty is that patients may not have sufficient information to be able to detect instances where quality has fallen to unacceptable standards. The further difficulty is that a patient may have no real choice but to enrol with a particular purchaser as that purchaser controls access to (for example) local emergency services. Thus referring back to the previous chapter, where there is natural monopoly on the supply side, direct regulation is required in order to allow


1066 Whether or not exit can operate as an accountability enhancing mechanism in an internal market will depend on whether the government appointed purchaser ensures that money follows the citizen should the citizen seek to enrol in another managed care plan.
other purchasers to buy services from that monopoly. A further problem is that exit may not work well as an accountability enhancing mechanism for, as discussed in Chapter 4, purchasers will find it easier to compete on risk avoidance and cost shifting rather than on cost and quality dimensions. In such a case exit will work as an advantage to relatively inefficient competitors who will seek to encourage high risk and high cost patients to exit to other competitors. Thus, the key to success in ensuring the quality of services in a managed competition system is to ensure that competing insurers/purchasers have incentives to compete on quality dimensions and to prescribe their ability to shift costs and risk to others. Similarly, in an internal market system where providers or groups of providers are paid on a capitation basis, they need to have incentives to compete on quality dimensions and be prevented from shifting cost and risk to others of their decision-making.

There are increasing concerns over the quality of health services supplied by providers who are paid by capitation in the U.S.1067 The U.S. public appears to have grave concerns over the quality of care supplied by managed care plans and tragic stories proliferate in the media of managed care plans denying access to potentially life-saving services.1068 A study by Nelson et al. found in 1996 that one in four elderly Americans in a Medicare managed care plan would not recommend their plan to someone with a serious or chronic health problem.1069 One study of U.S managed care plans noted that 22% of sick non-elderly patients reported difficulties in obtaining treatment that they or their doctor thought necessary compared with 13% in traditional fee-for-service plans.1070

In response to wide concerns over the quality of services supplied by U.S. managed care plans, Zelman notes that hundreds of legislative bills have been introduced that prima facie seek to protect access to care, choice of care, quality of care, choice of providers, and basic consumer protections.1071 Gosfield reports that in the first half of 1996 some thirty-three U.S. states enacted laws to protect consumers of managed care plans from quality reductions.1072 Notwithstanding all this activity, there is no definite evidence that Health Maintenance Organizations (being an important form of managed care in the U.S.) supply lower quality

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1067See Gosfield, supra note 1058 at 27.
1068 See generally Anders, supra note 1059.
1072Gosfield, supra note 1058.
care. The limited data there is suggest that, at least in the aggregate, financial incentives to limit care have not significantly compromised that the quality of health services supplied in the U.S. However, the fact that there is no clear-cut evidence proving the quality of patient care suffers as a result of a shift to paying health providers by way of capitation in the U.S. may be due to the difficult of objectively measuring quality in the first place. Focusing solely on indicators of performance in terms of outcomes such as life expectancy, infant mortality rates, readmission rates, etc., is impoverished as it fails to pick up more subtle indicators of quality such as the level of unnecessary pain, discomfort, or distress suffered by patients. Even though in terms of health outcomes, the quality of care supplied to patients in managed care plans does not appear to have fallen, quality as more broadly defined in terms of process does appear to have fallen.

There are several factors to consider when analyzing the problem of quality reductions in U.S. managed care plans. First, reductions in quality may not necessarily be a bad thing if we accept the proposition that the previous indemnity insurance/fee-for-service system had resulted in supply beyond the optimum point in terms of cost and quality trade-offs. In other words, increasing resources were being spent on individual patients with relatively small benefit. Thus, the concern we are seeing manifested in the U.S. over the quality of care supplied may be symptomatic of difficulty regearing consumer expectations to a point closer to the optimal point in terms of cost/quality trade-offs. However, this argument does not provide much comfort in the face of the fact that the present U.S. system is a fragmented and ad hoc arrangement where managed care plans are not regulated to ensure that they bear the longer term costs of their failure to ensure services of an adequate quality. Moreover, unlike nearly every other OECD country, the U.S. does not ensure access to a basic level of health care coverage for all its citizens. Consequently, savings reaped by private managed care plans in the U.S. are not redistributed by way of pooling to ensure coverage to more people but are retained as profit.


1074 See M. A. Hall, “Rationing Health Care at the Bedside” (1994) 69 N. Y. U. L. Rev. 693 at 715–16 relying on the RAND Corporation’s Health Insurance Experiment which compared health outcomes of populations enrolled with traditional indemnity insurers, HMOs, and traditional insurers that imposed user charges.


1076 For a vivid example of cost-shifting to patients by way of quality reductions see the letter by S. S. Baker in (1996) 334: 16 New Eng. Jnl. of Med. 1062 describing how an HMO refused to authorize the provision of liver-transplantation services to a child at a local centre and required her to use a centre 1500 miles from the child’s home. The father of the child eventually lost his job due to absenteeism (he visited the child regularly) and with it his HMO coverage. The cost of the child’s care had to be paid for by Medicaid. Although the father eventually found another job, the HMO excluding pre-existing condition so the child’s care was not covered.
Secondly, the problems of quality associated with managed care plans in the present U.S. system may be thought by some to constitute evidence of the failure generally of market or competitive mechanisms in health systems. However, quality problems in the U.S. cannot be assumed to be evidence of quality problems that will arise in a managed competition system. The U.S. fails to ensure comprehensive care to all its citizens on the basis of their need as opposed to their ability to pay and managed care has developed on an ad hoc basis. Consequently, there are many leakages in the present U.S. system allowing managed care plans to compete on risk avoidance and cost shifting and the incentives are not in place for them to compete on price and quality dimensions. Initially it was thought that managed care plans could cut costs and improve quality but it now appears that early positive reports may have been due to U.S. managed care plans "cream-skimming" enrollees with the lowest risk. In other words, managed care plans look to be performing well but this is because they are successfully avoiding servicing those patients with the most expensive health care needs. There is evidence that the enrollees of Health Maintenance Organizations are generally healthier than their counterparts in fee-for-service plans, and if it were not for the imposition of user charges and deductibles in fee-for-service plans the health outcomes of patients might be significantly better than HMO type plans where generally no user charges or deductibles apply and thus patients may access primary and preventive services without financial impediment.

Finally, one should note that academic, media, and public concern over managed care plans is not necessarily evidence of problems with capitation. M. R. Gold et al., note from a sample of 108 U.S. managed care plans that 37% of managed care plans used capitation as the primary means of paying physicians. Morrisey et al found in a survey of 1495 U.S. hospitals in late 1993 that 82% of hospitals received 5% or less of their patient care revenue from capitated

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1078 See P. Braveman et al., "Insurance-related Differences In The Risk Of Ruptured Appendix" (1994) 331 New Eng. J. Med 444. This study surveyed patients with appendicitis and found that patients enrolled in an HMO type plan were significantly less likely than patients receiving fee-for-service care to suffer a ruptured appendix. The authors speculate that higher deductives and copayments in fee-for-service systems may have discouraged fee-for-service patients from seeking treatment as rapidly as enrollees in HMO type plans.

1079 M. R. Gold et al., "A National Survey Of The Arrangements Managed-Care Plans Make With Physicians" (1995) 333: 25 The New Eng. Jnl. of Med. 1678. Of the 108 plans, the authors found that 29 were group-model or staff-model health maintenance organizations (HMOs), 50 were network or independent-practice-association (IPA) HMOs and 29 were preferred-provider organizations (PPOs). The authors found that 56% of the network or IPA HMOs used capitation as the predominant method of paying primary care physicians as compared with 34% of the group or staff HMOs and 7% of the PPOs. From these figures, I calculate that 37% of all plans use capitation as the primary means of paying physicians.
plans. The authors of this study note that, in fact, the majority of HMOs and preferred provider organizations (PPOs) appear to enter into discounted fee-for-service arrangements and/or rely upon fee caps and per diems. Thus a significant proportion of managed care plans still rely upon fee-for-service (albeit modified through use of withholds and utilization review) as a means of reimbursing health care providers.

As mentioned above, the key to ensuring that capitation works efficiently is to prevent provider(s) shifting the costs of their decision-making onto others, whether other providers, or patients, or society at large. For example, where health providers paid on a capitation basis, such as the U.K. Fundholders, are only required to provided a limited range of health services they may have an incentive to recommend that their patients consume more expensive services than they really need but which the provider is not responsible for funding. On the hand, if one places too great a financial burden onto individual or small groups of health providers in terms of rendering them responsible for purchasing the whole gamut of health services, then problems will arise regarding cashflow and the ability to absorb fluctuations in expenditures caused by patients’ varying utilization rates. If a small number of health providers are paid on a capitated basis then if they enrol a disproportionate number of patients with chronic illnesses requiring expensive treatments (i.e. HIV patients needed the expensive cocktail of drugs needed to keep the virus in remission), they may quickly deplete the capitated sum received. This provides very strong incentives to avoid treating high-risk patients in the first place and/or to cut costs and quality towards the end of the financial year. Consequently, there are grounds to cap the financial risk or to place restrictions on the minimum size of risk-bearing entity paid on a capitation basis. In the U.S., the federal government has proposed new rules that will regulate compensation arrangements in Medicare and Medicaid managed care plans and some states have enacted laws limiting the extent to which financial risk can be transferred to health providers. The U.K. takes the approach of capping the liability of GP Fundholders at 5000 pounds per patient. This latter approach, of course, results in the side-effect that Fundholders, as purchasers, have no incentive to be sensitive to the costs of treatment for a patient beyond this

1080 M. A. Morrisey et al., “Managed Care And Physician/Hospital Integration” (1996) 15: 4 Health Affairs 62 at 68.
As discussed in Chapter 4, the problem of devolving financial risk to too low a level is also associated with the problem of increased transactions costs as in essence each provider who receives a capitated payment to buy a range of services becomes a small purchaser and must enter into arrangements and negotiations with other providers. In this respect, the movement towards managed care arrangements in internal markets is problematic as they are generally conceived of on a small scale and providers are only responsible for purchasing a limited range of health services resulting in incentives for providers to recommend that their patients consume those services that they are not responsible for funding.

7.3.4 Hybrid Payment Systems

As discussed above, all payment mechanisms have their advantages and disadvantages and much will depend on the configuration of payers, purchasers and other health providers. Ideally a payment system would not be linked to the production of health services per se (as fee-for-service is) or per person (as capitation is) but one that is tied to outcomes. Thus, purchasers or providers would be paid on the results they obtain. If it were possible to link a plan's financial incentives to patient outcomes then many agency problems would be significantly ameliorated. However, as discussed in the last chapter, it not feasible to focus on outcomes as some outcomes are more readily measured than others creating the risk that health care plans and providers will divert resources to those aspects of performance that are easily measurable and downplay those that are as important for patient care but harder to measure. Also many outcomes of treatment are observable only long after treatment. Imposing strong financial incentives on health care providers to achieve particular patient outcomes could lead risk-adverse health care providers to avoid complex cases.

Some commentators, such as Pauly and Coyte, advocate a mixed system of capitated and fee-for-service payments. Prima facie, a hybrid payment system may capture the best elements of both capitated and fee-for-service payments systems. On the other hand, if designed poorly, it may result in the worst of both types of payment systems, namely the production of some services at too low a quality and the production of too many of other sorts of services or at too

high a level of quality in terms of the cost of the quality improvements. The devil is, as usual, in the detail.

Managed care is often associated solely with capitation payments but in reality it covers a wide variety of techniques by which purchasers seek to influence providers' behaviour. There are also many permutations of fee-for-service, salary and capitation payments. Although one may make predictions of the incentive effects of various combination of payments, much will depend upon the particular health service market in question\textsuperscript{1089} and the responses of providers within those markets. For example, when the U.S. government started to require hospitals paid by the Medicare program to be paid on a per case basis according to a schedule of rates based on the average costs of producing services nation-wide for product lines defined by five hundred Diagnosis Related Groups ("DRGs"),\textsuperscript{1090} the system of payment became subject to what was known as "DRG creep" as physicians were able to categorize minor problems into more serious DRG groups. Competing purchasers in a managed competition system may be more quickly able to respond to providers' chiselling behaviour than a regulator or a government appointed purchaser in an internal market would be able to. Moreover, managing physicians has been compared to herding cats,\textsuperscript{1091} and it has been said that it is necessary to change the method of paying physicians periodically as they will have figured out some means to chisel on to the system to their professional advantage.\textsuperscript{1092} Thus, it is necessary to have a flexible approach both between health service markets and over time in a particular market. Mandating a particular payment system across all health service markets is too inflexible. If insurers/purchasers have incentives to compete on price and quality dimensions then one should begin with the assumption that they should be left to tailor a mix of payment regimes to balance quality and cost. \textit{Prima facie}, it seems to make sense for government not to be involved in micro-managing physicians, hospitals and other health providers but to devote its energies to getting the incentives right at the purchasing level. There are, however, some impediments to this idea as discussed below.

\textsuperscript{1089}As P. C. Coyte, "Current Trends and Future Directions for the Canadian Health Care System", mimeo, Department of Health Administration, University of Toronto, December 18, 1996 at 14 notes, "no payment scheme has all the answers."


\textsuperscript{1091}R. H. Miller, "Health System Integration: A Means to an End" (1996) 15: 2 Health Affairs 92 at 102–103.

\textsuperscript{1092}R. Evans as quoted by A. Maynard, "Health Care Reform: Don't Confuse Me With Facts Stupid!" in \textit{Four Country Conference on Health Care Reform and Health Care Policies in the United States, Canada, Germany and the Netherlands, Conference Report} (Amsterdam and Rotterdam: Ministry of Health, Welfare, and Sport, 1995) 47 at 49 — "the elaborate relative values system of remuneration introduced in the United States may affect pay relativity and hence incentives to specialize (e.g. in family practice) but seems to ignore experience which is neatly summarized by Evans who argues that the only way to pay "docs" is to change the payment system every two years because by then they have found their way around its constraints and are once again milking the health care system!"
7.4. Solutions to Quality Problems

From the earlier discussion in this chapter one can conclude that what is needed is a system of incentives that: render health providers as technically efficient as possible in the production of health care services; ensure that health providers select the most cost-effective mix of services to deal with a particular health need; and ensures that health providers give priority to services that reflects society’s priorities both in terms of cost-effectiveness but balanced by the need to cater for vulnerable populations and by society’s possibly irrational but distinctly human desire to satisfy the rule of rescue.

In the balance of this chapter I will discuss mechanisms that are available to protect the quality of services provided. In summary these are as follows: ensure that insurers/purchasers have incentives to compete on quality dimensions and leave them to conclude their own arrangements with health providers; empower citizens by supplying them with information regarding the quality of services and allow money to follow the consumer either from purchaser to purchaser or from provider to provider; ethics and professional self-regulation; medical malpractice actions; and the establishment of an Ombudsperson to deal with patients’ concerns and other mechanisms for patients to exercise “voice”;

7.5 Incentives for Insurers/Purchasers to Compete on Quality

If citizens are supplied with sufficient information to make decisions regarding quality and there is sufficient competition within the market to allow choice of insurers/purchasers, then the exit mechanism will serve as a quality enhancing mechanism. However, the exit or market mechanism may not work when the number of individuals affected by a drop in quality is too small to result in a change in behaviour on the part of the insurer/purchaser. Exit may also not work in the case of stigmatized health services, such as services for people with HIV or psychiatric diseases.1093 The rest of the population may believe that these sorts of diseases are never likely to afflict them or their family and thus will not be motivated to “exit” from an insurer/purchaser if incidents of low quality services being supplied to HIV or psychiatric patients come to light.

If one looks only at health outcomes as a an indicator of quality of care then a shift to managed care may not appear to have any significant effect on the quality of care provided at an aggregate level. However, as discussed in previous chapters, a very small percentage of the population

accounts for by far the largest share of health care costs. Therefore looking at averages for the whole population may mask the situation of those who are most in need. Donelan et al. note, drawing an analogy with fire insurance, “the true test of consumer satisfaction with insurance coverage comes not in occasional, routine contacts with the insurance company, but when the house is burning.” Extrapolating from this, it is possible to conclude that an important indicator of quality is how well a particular insurer/purchaser serves the most vulnerable when in need.

Specific regulation of competing insurers/purchasers is required to ensure that the quality of the services they are supplying to vulnerable populations is of a sufficient standard. The regulator could develop key performance indicators with special emphasis being given to services provided to vulnerable populations and to those elements of performance that are not readily measurable or are at risk of being overlooked. A regulator could, in disseminating information to citizens about the quality of different plans offered by competing insurers/purchasers, emphasize information regarding how plans treat vulnerable populations. This may, to some extent, help shape citizens’ preferences so that they select insurers/purchasers who ensure services of an adequate quality for vulnerable populations.

In terms of shifting costs from managed care plan to plan, the obvious way to avoid making trade-offs between cost and quality is to avoid high risk patients in the first instance. In the absence of a comprehensive system, there will be opportunities for cost-shifting with managed care plans seeking to cream-skim healthy enrollees and shift cost to other parts of the system. In such a case insurers/purchasers who are better competitors on cost and quality dimensions might be squeezed out by others more adept at risk avoidance and cost shifting. This harks back to the earlier discussion in Chapter 4, which discussed the crucial need to adequately risk-adjust patients to reward those plans that care for high-risk patients and to ameliorate the incentive for plans to compete on their ability to avoid risk rather than to compete on price and quality dimensions. Schlesinger speculates about the possibility of requiring insurers/purchasers in a managed competition system to continue to be responsible for the health care costs of a citizen who has shifted to another competitor. Depending on the degree of financial

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1094Donelan et al., supra note 1070 at 265.
1095The Health Care Study Group notes that a genuine universal system is an invitation to strategic thinking about the needs and institutions of an entire society and such a system is better able to control costs as it limits cost shifting — see the Health Care Study Group Report, supra note 41 at 501.
1096Lohr makes the important point that whether relying on process measures or outcome measures, that proper adjustments must be made for case-mix, severity of illness, and the presence of other conditions (comorbidity) — K. N. Lohr, “Perspective: How Do We Measure Quality?” (1997) 16: 3 Health Affairs 22 at 24.
1097Schlesinger, supra note 1045 at 63.
costs are devoted on purchasers competing on price and quality dimensions and not on the ability to avoid risk and shift costs.\textsuperscript{1098} Internal markets as implemented in the U.K. and New Zealand do not offer a comprehensive system. Managed care arrangements such as the U.K.'s GP Fundholders amount to piece-meal managed care reform, with enormous room for cost-shifting on the part of Fundholders to other purchasers (i.e. the government-appointed Health Authorities). To be a comprehensive system, all citizens in the U.K. would have to be enrolled in a GP Fundholder and Fundholders would have to be responsible for the purchase of the vast majority of all health services. In such a case, an internal market system would take on all the characteristics of a managed competition system.

Even in a comprehensive managed competition system, there is still the problem of competing insurers/purchasers shifting costs to society. Society will benefit if adequate resources are devoted to detection and early prevention of health problems as citizens will be healthier and in less need of health services in the long term.\textsuperscript{1099} There may not be sufficient incentives for competing insurers/purchasers to invest in preventive and primary care if they know that an individual is unlikely to stay for their entire life-time with their plan and thus the longer-term costs are likely to be born by another insurer/purchaser.\textsuperscript{1100} As McGlynn notes, "[i]t takes years for the preventable complications of many chronic diseases to develop...coronary artery disease may develop after many years of poor lifestyle habits or failure to control blood pressure."\textsuperscript{1101} All purchasers may potentially benefit from greater spending on primary and preventive care but

\textsuperscript{1098}Of course, purchasers would still try to maximize the system to their advantage through other tactics. These tactics would, however, certainly have to be significantly subtler than what is presently occurring in the U.S., and the likelihood of gaining significant benefits from risk-avoidance and quality-reduction tactics would be reduced because of the risk of detection by the regulator.

\textsuperscript{1099}This is a commonly held perception but it is not without its problems. In the context of a fixed government budget on health spending, there is a temporal problem that shifting resources from acute and hospital care now to preventive and primary care disadvantages those individuals who have not benefited from the latter services and are in need of hospital care now. Moreover, the fact that, for example, people live longer healthier lives mean that fewer hospital resources will be required as there will presumably more people living into old age and will need long-term nursing care and other health services -- see C. M. Flood, "Conflicts Between Professional Interests, the Public Interest, and Patients' Interest in an Era of Reform: Nova Scotia Registered Nurses" (1997) 5 Health Law Journal 27.

\textsuperscript{1100}Schlesinger, supra note 1045 at 61–63. See also Lohr, supra note 1096 at 24.

\textsuperscript{1101}McGlynn, supra note 1034 at 13.
because of fear of free-riding, no one purchaser is prepared to invest. This problem was recognized by policy-makers in New Zealand in the context of the government’s original plan for the internal market system to evolve into a managed competition system.\textsuperscript{102} In recognition of the fact that there would be underprovision of public health services by competing insurers/purchasers, the government appointed a “Public Health Commission” that had a separate budget with which to buy public health services. The Public Health Commission has since been dissolved once it was determined not to implement a managed competition scheme.\textsuperscript{103}

This concern of people exiting from competing insurers/purchasers thus diminishing the incentive to invest in the longer term health of their enrollees harks back to the discussion of exit, voice and loyalty in Chapter 4. Although we want exit at the margin to ensure the on-going efficient performance of insurers/purchasers this must be balanced against the need for most enrollees to remain “loyal” to their particular insurer/purchaser. Those who remain loyal will be more likely to use their “voice” over time to lobby for the improved performance of their particular insurer/purchaser with the ultimate threat of exit at the margin if performance does not improve.

Another means by which competing insurers/purchasers can shift the costs of their decisions to society is through externalities.\textsuperscript{104} Schlesinger refers to the externalities of the loss of productivity for society as a result of failing to detect disease at an early stage, the burden imposed upon unpaid family members as caregivers as a result of not preventing chronic illness, and the costs to unrelated persons of not preventing illness, such as the costs of crime as a result of untreated alcohol or drug addictions.\textsuperscript{105} As an insurer/purchaser does not have to internalize these costs it will spend fewer resources on these sorts of services than is optimal from society’s perceptive. One might consider this as evidence against competing insurers/purchasers as proposed by the managed competition model, but there is little evidence to suggest that government-appointed monopsony purchasers in internal markets will internalize these sorts of costs. For example, New Zealand’s Regional Health Authorities closed down many hospitals in rural areas but did not have to internalize the cost of individuals and their families enduring long

\textsuperscript{102}New Zealand’s original 1991 proposals for reform envisaged the development of competition between Regional Health Authorities and private plans. This policy has been abandoned for the foreseeable future because of strong public opposition to what was perceived as a step towards the “Americanization” of the public health service and because of concerns over “cream skimming” – See Hon. S. Upton in Hansard, Health and Disability Services Bill – Introduction, 20 August 1992, 10773 at 10776.


\textsuperscript{104}For a discussion of externalities in general see Chapter 2.

\textsuperscript{105}Schlesinger, supra note 1045 at 50–51.
travelling distances to hospital. The New Zealand government eventually intervened with guidelines as to the maximum distances an individual was expected to travel for different types of services. As another example, a trend in many countries is the closure of hospitals and reductions in the number of hospital beds and a concomitant greater reliance on “home care” where the latter is often provided by unpaid female family members. Thus, while it may be cost-effective from the perspective of government budgets to rely on homecare, this decision-making does not take into account the wider costs for society and the distribution of those costs.

Given that a managed care plan will not reflect society’s optimal allocation of health resources, government may seek to intervene to require that the plan produce certain services that are otherwise being under-provided from a societal perspective. Thus, government may choose to pay competing managed care plans on a fee-for-service basis for preventive services in order to ensure provision closer to a point that is optimal from society’s perspective. Similarly, government may want to pay for certain stigmatized services or where the quality of care is particularly difficult to measure services on a fee-for-service basis on the assumption that the “exit” mechanism may not be sufficient to ensure the provision of sufficient such services or of a sufficient standard.

One possible means to deter competing insurers/purchasers from making cuts in quality is to require that they operate on a non-profit basis. In the U.K., GP Fundholders receive a capitation payment to buy a range of services and surpluses are required to be reinvested back into their practices so (the reasoning goes) to benefit patients. Ostensibly, such a mechanism has the potential to enhance professional satisfaction and autonomy while allowing surpluses to be ploughed back into patient benefits. However, there have been suggestions that Fundholders are simply investing surpluses into capital such as nicer offices so enhancing the value of the practice for later resale. In the Netherlands, the Sickness Funds have historically been non-profit organizations. The early U.S. Health Maintenance Organizations were non-profit institutions. In recent times in the U.S. there has been a strong trend to transform not-for-profit

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106 Costs would include time off work and associated loss of productivity for the patient as well as family, the direct costs of travel, and the loss of support of family-members for the patient (which becomes particularly important in the light of cut-backs in nursing staff with family members being expected to fulfil these duties on many occasions). In an emergency and a patient was not able to reach emergency services in time there would also be the costs associated with the patient’s death.

107 For a taxonomy of the costs involved in relying on unpaid family members to provide home care services see J. E. Fast et al., Conceptualizing and Operationalizing the Costs of Informal Elder Care. Final Technical Report to the National Health Research Development Program (NHRDP) March 17, 1997 at 4–11.


109 See Maynard, supra note 510 at 1438.
to for-profit organizations. This has primarily been because of the desire to access capital markets in order to allow expansion and development. Sage notes that U.S. state regulators are attempting to protect public assets by examining the shift by insurers from charitable status for for-profit plans. He goes on to note that laws have been passed in some states that cap profits for managed care plans and that Massachusetts has gone even further and totally prohibited for-profit health care plans.

Requiring private insurers/purchasers to be non-profit operations may also make managed competition a far more palatable option politically in a number of countries. This is particularly so for the citizens of countries, such as the U.K. and New Zealand, who are nervous about allowing the profit motive to infiltrate their health care system seeing such an infiltration as the “Americanization” (and in essence the ruin) of their respective health care systems. Thus, I would not discount a policy initiative that required competing insurers/purchasers to operate on a non-profit basis with a requirement that surpluses be reinvest back into health services or amenities for patients. This may be a transitional phase and once non-profit plans were in place one could re-evaluate the costs and benefits of for-profit plans.

Not-for-profit organizations also offer the potential advantage of encouraging loyalty amongst enrollees so that these people will not exit to another plan in the face of declining performance but use their voice to lobby for improvement. If most enrollees are loyal to their plan over their respective lifetimes then plans have a greater incentive to invest in health services likely to preserve the health of their enrollees over the long term. A not-for-profit organization may also find it easier to create a culture amongst the health providers that it contracts with or employs that values and promotes primary and preventive health care services over more intensive and interventionist type of approaches. It may be more difficult to develop a public service ethos in a profit-driven enterprise where an emphasis on primary and preventive health care may be viewed by both providers and patients as the rhetoric cloaking a cost-cutting agenda regardless of the real welfare of patients or society.

7.6 Empowering Citizens with Information

If accountability for quality were ensured by citizen choice of plan, provision of valid and reliable information regarding the quality of services offered by plans is vital. Although the

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1110 See generally (1997) 16: 2 Health Affairs (a special issue on hospital and health plan conversions from nonprofit to for-profit.)
1112 Idem.
discussion of information asymmetry to date has been in the context of health providers and patients. An information asymmetry also exists between citizens and competing insurers/purchasers. In a system of full insurance, although patients will not be sensitive to the cost of the services they consume they will be concerned about the quality of the services they receive. Thus there are strong arguments in favour of government intervening to improve the flow of information regarding the quality of services offered and empowering citizens with this information. In particular, there is a need to provide evidence of the effectiveness of particular health services. This is so whether one is seeking to encourage competition between insurers/purchasers (in a managed competition system) or between health care providers (in an internal market system).

There is a limit to how much information to supply to patients to allow them to make informed determinations of the quality of service they are supplied. The supply of information is not costless, and one has to make trade-offs here as with the supply of other goods and services. Clearly, at the extreme, each patient would have to be trained as a physician to completely remove the information asymmetry problem. Some argue that even if citizens have good information regarding the quality of services they will be reluctant to use that information in considering the merits of different health providers. However, although there may be a few individuals for whom this remains true, in modern society there seems to be a growing resistance to the contention that “doctor knows best.” Moreover, with new information technologies, information is cheaper and more readily able to be accessed by a greater number of people. Information brings with it a sense of control, well-being, and enriches autonomy, all valued qualities in a time of ill-health where one feels as if one is losing control. Legal doctrine has fallen in with this societal development through the development of the doctrine of informed consent which requires the physician or health provider to disclose the risks of treatment that objectively a person in the shoes of the patient would have wanted to know.

Too much information may not only be costly but result in confusion. Thus the goal is not necessarily to increase the volume of information but to supply quality information, for as T. S.

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1113 Although clients’ perceptions of quality may not have a strong relationship with the effectiveness of services in terms of their final impact on their health.
Eliot asked, "[w]here is the knowledge we have lost in information?" Edgman-Levitan and Cleary suggest that little is known about the kinds of information that citizens need in order to be able to make the optimal choice of competing insurers/purchasers. Information that U.S. citizens said they would use in a study by Edgman Levitan and Cleary includes "information on how a plan works, what it costs, the covered benefits, the quality of care and overall satisfaction with care if it were available." The authors found consumers are most interested in "information about costs of coverage, technical competence, the information and communication provided by physicians, co-ordination of care, and access." The sorts of information identified by U.S. consumers as important may be reflective of the present system of unregulated and unmanaged and ad hoc competition between a multitude of insurers. By contrast, and as discussed in Chapter 4, a managed competition system would seek to level the playing field through regulation that would set out the terms of coverage every citizen can expect regardless of their choice of insurer/purchaser. Such regulation should ameliorate most of the concerns identified and provide citizens with the assurance that they may exit to another insurer/purchaser without compromising the basic coverage guaranteed to all.

When choosing an insurer/purchaser the question arises as to whether citizens need information about the quality of care supplied by all health care providers affiliated with a particular insurer/purchaser or information regarding the quality of services the citizen in question knows they are most likely to require or whether they just require general information regarding the general standards of care offered by competing insurers/purchasers. Sloan recommends that government disseminate information on "supplier characteristics, including price, diagnostic- and therapeutic-procedure-specific outcomes, and disciplinary actions taken against individual physicians". However, information supplied regarding the quality of individual health care providers may be misleading, as high mortality rates, infection rates, etc. may be reflective of the difficult case-mix dealt with by the particular hospital as opposed to the poor quality of services supplied. Also particular hospitals may specialize in serious high-risk cases. Zalkind and Eastaugh note that using overall death rates as an indicator of the quality of care offered by hospitals may lead to "substantial predictive error rates, even when adjustment for case mix is

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1119 Ibid. at 44.
1120 Idem.
excellent.”112 This speaks to a need for government to moderate the flow of information and, conceivably, prevent competing insurers/purchasers representing that they offer higher quality care on the basis of flawed measures such as mortality rates.

As mentioned earlier, in order to keep competing insurers/purchasers responsive to concerns over the quality of services supplied, citizens need information not just about the “outcomes” of care but also the process of care. In dismissing managed competition reform, Woolhandler and Himmelstein note “[e]mpathy, humanity, and imagination are neither profitable nor readily quantifiable...”1123 However, such attributes may be profitable for insurers/purchasers if citizens seek out purchasers that aspire to incorporate these attributes into the delivery of their services.

It should be noted that it is not necessary for the efficient working of the system that all citizens be informed, critical, purveyors of the quality offered by competing insurers/purchasers. So long as there is a critical margin of informed citizens willing to exit from plan to plan this will be sufficient to keep insurers/purchasers offering those plans responsive to quality concerns. It is important, however, that these citizens with a propensity to exit at a decline in quality are good risks in terms of their likely future utilization of health services. If they are poor risks, the insurer/purchaser will not be concerned about their departure and in fact will encourage it.

Competition-oriented reform represents, at least to some extent, a backlash against the historic monopolization by physicians of the health care allocation process. However, one must acknowledge that the information asymmetry problem will likely never fully be remedied by the supply of information. Thus there may continue to be a residual need to rely upon the ethics and professional behaviour of physicians and other health providers.

7.7 Ethics and Professional Self-Regulation
Although empirical evidence suggests that physicians do respond to financial incentives to a greater or lesser degree in a fee-for-service system and supply health services above that which is optimal in terms of cost-effectiveness, it is possible that under a capitation system physicians will not respond by way of cutting the quality of services offered below that which is optimal. Any financial incentive to cut quality standards may be suppressed to a greater or lesser degree by the ethical rule of *premum non nocere* (above all, do no harm). The same ethical standards do

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not inhibit physicians from supplying services above that which is optimal on a cost-effectiveness analysis as there will usually be some small benefit for the patient (or at least no harm) in supplying a more expensive service or additional services whereas failing to supply necessary health services or cutting the quality of services may cause physical harm to a patient. Consequently, a physician in good conscience is more likely to do the former and not the latter.\textsuperscript{1124}

When financial incentives are trained upon individual physician to contain costs then this acutely brings into focus the conflict between the physician’s personal financial interest and his or her fiduciary duty to his or her patient/s. The intensity of this conflict will depend upon the intensity of the incentive to contain costs. Arguably, where physicians are paid on a capitation basis or receive bonuses for meeting utilization targets then they have a legal duty to disclose this financial interest to patients. In \textit{Moore v. Regents of the University of California} the Supreme Court of California held that “a physician who is seeking a patient’s consent for a medical procedure must, in order to satisfy his fiduciary duty and to obtain the patient’s informed consent, disclose personal interest unrelated to the patient’s health, whether research or economic, that may affect his medical judgement.”\textsuperscript{1125} Where physicians operate under strong financial incentives to control the costs of the health services they recommend or provide, there is the potential that this will erode patients’ trust and confidence in their physicians.

As discussed earlier in this chapter, if purchasers are forced to compete on price and quality dimensions then it would seem unlikely that they will devolve risk-bearing down to small groups of health providers as they will be concerned over the possible detrimental effect on quality. However, if this prediction is not correct then residual regulation will be required to prevent excessive financial risk being devolved to small groups of health providers given that they will both have opportunity and strong incentives to cut the quality of care supplied.

An important source of information regarding the quality of services supplied will be the patient’s physician. It is alleged that U.S. managed care plans are imposing gag clauses upon physicians in an effort to prevent physicians making negative comments about plans and the quality of care offered to patients. It is also alleged that plans are trying to stop physicians advising patients of treatment options that their plan has chosen not to cover. Gag clauses may be explicitly provided for in written contracts or implicitly imposed — the latter being evidenced

\textsuperscript{1124}See the discussion by D. Orentlicher, “Health Care Reform And The Patient-Physician Relationship” (1995) 5 Health Matrix 141 at 160–161.
by termination of a physician’s employment contract soon after he or she has publicly criticized a plan.\textsuperscript{1126} Although managed care plans deny that gag causes are prevalent in the industry,\textsuperscript{1127} nonetheless some U.S. states have moved to legislate against managed care plans imposing or negotiating “gag clauses” in their contracts with physicians.\textsuperscript{1128} Gag clauses clearly intrude into the physician-patient relationship and erode the agency relationship. Essentially, gag clauses seek to make a health provider more responsive to managed care plan’s financial interests as opposed to a patient’s best interests. On the other hand, it is possible that physicians are manipulating patients’ concerns over the quality of services supplied to improve their own negotiating position with managed care plans. In that case, gag-clauses may be best viewed as a justifiable but probable over-reaction on the part of insurers/purchasers.

Experience from the U.S. does suggest that the medical profession will use a variety of tactics under cover of protecting their own financial self-interest in order to advance their own professional interests. For example, in \textit{Wilk v. American Medical Association}\textsuperscript{1129}, the court found the American Medical Association guilty of a conspiracy to contain and eliminate the profession of chiropractic. The Association argued that in establishing a code of ethics that made it unethical for medical physicians to associate professionally with chiropractic physicians it was simply setting standards to promote the quality of health care provided to patients.\textsuperscript{1130} The medical profession in the U.S. is not happy with the shifting of the balance of power that is occurring from themselves to insurers/purchasers. A Commonwealth Fund study released in early 1997 of 1700 U.S. physicians concluded that the majority of physicians were dissatisfied with medical practice in managed care plans and 60% had serious problems with external reviews and limitations placed on clinical decision-making.\textsuperscript{1131} The U.S. Federal Trade Commission has taken a strong stand against American Medical Association’s ethical restrictions that inhibit physicians from working for HMOs and against concerted action on the part of some health providers to resist new types of health care delivery organizations.\textsuperscript{1132} Consequently, although physicians clearly have the expertise to comment on the quality of care of services supplied, it may be difficult to sift out issues where they are furthering their own professional interest.

\begin{footnotes}
\footnote{Martin & Bjerknes, \textit{supra} note 1117 at 442.} \footnote{\textit{Ibid.} at 441–442.} \footnote{See generally \textit{Ibid.} See for example, in California, 1993 Ca. S.B. 1832, Stats. 1994 c. 614.} \footnote{\textit{Wilk v American Medical Association} 895 F.2d 352 (7th Cir.) cert. denied, 496 U.S. 927, and cert. denied, 498 U.S. 982 (1990).} \footnote{\textit{Ibid.} at 356.} \footnote{"Managed Care Docs Dissatisfied -- Survey" (10 March 1997) Modern Healthcare at 22.} \footnote{Yao, Rirordan & Dahdouh, \textit{supra} note 933 at 311.}
\end{footnotes}
Notwithstanding, as a safeguard, in any system that seeks to set financial incentives so that physicians may gain personal profit from reducing the quality of care or in other ways have incentives to be sensitive to the cost of services supplied, extra attention should be devoted to training physicians both at the tertiary level and as part of their continuing education to ensure the development and maintenance of ethical norms resulting in the subordination of their own personal interests to that of their patients. A further ethical norm which should be ingrained is the duty of the physician and provider to advise the patient of the range of treatment options and then to advise the patient of the reasons why the physician is recommending or prescribing a particular treatment. Of course, there will always be a tension and a physician, in reality, will strike a balance between her or his patients’ needs and resources available. However, the development and enrichment of strong ethical norms for physicians will provide a general assurance to patients that within the confines of the resources received physicians will do their utmost to satisfy all the needs of their patients in the fairest manner. Moreover, physicians should act as advocates on the part of their patients, ensuring that they receive a fair share of available resources in proportion to their relative health needs. The balance between this advocacy and the incentives to contain costs on the part of competing insurers/purchaser in a sense reflects the need of a system to balance individual patient needs against the larger needs of the population being served by the insurer/purchaser.

The need for the enrichment and strengthening of ethical norms is also in recognition of the fact that changing the financial incentives impacting on physicians may not necessarily change physicians’ behaviour or at least change their behaviour in a way one is able to predict. The reasons for behaviour are multi-factorial although I do believe that financial incentives are generally a strong motivation. As Morone notes: “[b]eware of incentives. Economists and other rationalists restlessly tinker with peoples’ incentives. This is a dangerous game. Although incentives are important for understanding problems and fashioning solutions, they are also tricky devils, always veering off in unanticipated ways...People are complicated, social system almost infinitely so. A great many uninvited incentives lurk in each policy change.”  

Ethical norms and the bonds of collegiality developed between health providers can undoubtedly help to protect the quality of health services developed particularly in times of change and transition within a health system. For example, in the context of New Zealand’s internal market reforms, Gorringe notes “[l]uckily, however, cooperation evolved before formal contracting. We can call on such things as commitment of people to professional goals, to caring and to

cooperation and loyalty within organizations to bridge the motivational gap left by the incompleteness of contracts and their associated incentive structure.\textsuperscript{1134} In sum, it would be unwise to underestimate the importance of physicians' and other health providers' altruistic concerns for patients and the importance of their relationships with each other.

7.8 Medical Malpractice Actions

One possible means by which to protect the quality of health services supplied is through the deterrent effects of medical malpractice suits.

In these times of constrained resources and moves to put in place financial incentives for physicians to cut costs there are calls to constrain and limit the ability to bring medical malpractice suits and even calls to introduce no-fault schemes (as presently in place in New Zealand.\textsuperscript{1135} Presumably, these calls at least in part originate from physicians and other providers. This is understandable given that providers are expected to juggle often conflicting obligations and incentives: their obligations to society as a whole to fairly allocate resources; their obligations to their own patients to distribute resources fairly between them; their obligation to provide the best possible treatment to any particular patient; and financial incentives to prescribe or produce beyond the optimal point (in a fee-for-service system) or below the optimal point (in a capitation system). As physicians are pressured to perform in all these dimensions they do not want to be at risk for legal actions in a system where standards and expectations are shifting.

There is also academic support for the abolition or reform of medical malpractice claims.\textsuperscript{1136} Due to high costs of litigation, evidentiary difficulties, information asymmetry between providers and patients (making it difficult for patients to detect instances of malpractice), reportedly only a small proportion of instances of malpractice are litigated upon.\textsuperscript{1137} This fact does not appear to be well-known by physicians who reportedly significantly over-estimate the

\textsuperscript{1134} Gorringe, \textit{supra} note 957 at 5.

\textsuperscript{1135} See for example, the no-fault system proposed in the United States discussed by A. Wencl & D. Strickland, "No-fault Med Mal: No Gain for the Injured" (May 1997) Trial: Jnl. of the Assoc. of Trial Lawyers of America 18. See also R. E. Astroff, "Show Me the Money!: Making the Case for No-Fault Medical Malpractice Insurance" (1997) 5: 3 Health Law Review 9.

\textsuperscript{1136} For example, in the U.S. it is estimated that less than 20% of malpractice victims actually file law-suits — \textit{The Report of the Harvard Medical Practice Study, supra} note 1031. See generally, P.C. Weiler, H. H. Hiatt, J. P. Newhouse et al., \textit{A Measure of Malpractice} (Cambridge MA: Harvard University Press, 1993) and Dewees, Trebilcock & Duff, \textit{supra} note 116.

likelihood of being sued and reportedly engage in “defensive medicine”\textsuperscript{1138} in an effort to protect themselves.

The fact that medical malpractice claims has not rid the system of malpractice is often used to support the contention that medical malpractice suits have little deterrent effect and in support of calls for a no-fault system. Equally, however, one could argue that the high level of malpractice going undetected and/or unpunished suggests that reforms are needed to improve detection of malpractice and to facilitate the bringing of claims. Without delving into the substantive merit of this debate, it is vital to realize that the empirical work done on the effect of medical malpractice claims has been in the context of indemnity-insurance fee-for-service systems, and a very different set of incentives present themselves for consideration in a system characterized by managed care arrangements. In a fee-for-service system of full insurance, the sorts of negligence sought to be deterred are more likely to be due to mistakes, accidents, or acts of incompetence. In a system of capitation payments characterized by managed care it is possible that negligence may arise from decisions to sacrifice quality for personal financial gain. Such occurrences should be treated very strictly, so sending a clear signal to other health care providers that such behaviour will not be tolerated. Thus, the value of medical malpractice suits as a deterrent mechanism should not be readily dismissed.

An interesting question that arises is the degree to which physicians can avoid medical malpractice actions by claiming a lack of resources — whether as a result of government-imposed limitations or as a result of restrictions imposed by insurers/purchasers supplying managed care. U.S. courts have treated the determination by managed care plans of coverage and the determination of medical decisions by physicians as two separate transactions. \textit{Wickline v. State of California} stands for the proposition that a physician’s ultimate responsibility is to his or her patient and this trumps any financial or other obligation to a managed care plan — “the physician who complies without protest to the limitation imposed by a third party payer, when his medical judgement dictates otherwise, cannot avoid his ultimate responsibility for his patient’s care.”\textsuperscript{1139} Hirshfeld and Thomason argue that the courts’ position on this matter fails to recognize that managed care plans will, through a variety of techniques, seek to influence health providers

\textsuperscript{1138}T. H. Boyd, “Cost Containment and the Physician’s Fiduciary Duty to the Patient” (1989) 39 DePaul L.R. 131 at 131 notes, defensive medicine “refers to a practice in which physicians utilize exhaustive diagnostic and treatment methods of minimum value to ensure the best quality of health care while at the same time erecting an undefeatable defense against liability

\textsuperscript{1139}192 Cal. App. 3d 1630, 1645 (Cal. Ct. App. 1986). (check citation, also at 239 Cal. Rptr. 810, 819 (Ct. App. 1986).)
clinical determinations. As mentioned earlier, however, as advocates for the patient physicians should not be silent in the face of constraints placed upon them by insurers/purchasers. The rationale for this advocacy is not however that each individual patient should be entitled to the very best that medical science has to offer irrespective of cost or likelihood of effectiveness, but that every patient is entitled to a fair share of resources that is proportionate to their health needs.

What of the liability of managed care plans themselves? In the U.S., the dynamic nature of the market where insurers are forming into managed care plans and performing both the role of the insurer and the role of the provider has resulted in confusion over where liability should fall. In a managed competition model, responsibility for the supply of quality care should fall equally upon the insurer/purchaser and the physician or other health provider.

Medical malpractice actions will certainly not be sufficient to ensure the quality of health services but should be considered part of a package to safeguard quality in a competition-oriented system. Malinowski notes, "[a]lthough legal liability may address some of the most egregious instances of inadequate care and instill incentives for providing quality care, it cannot be relied on to police more subtle and systematic lapses in care." He goes on to note "[t]o protect patients' interests and the discretion of physicians to treat them adequately, clearer ethical standards will have to be established and some regulatory safeguards imposed."

7.9 Ombudsperson and other Voice Mechanisms

Another mechanism through which to protect the quality of health services supplied from patients' perspective is to create an Ombudspersons' office. This mechanism has already been mentioned in Chapter 4 and I will not repeat what was stated there regarding the advantages of such a mechanism. In order to quickly resolve disputes that arise between insurers/purchasers and citizens, the Ombudsperson should be empowered to mandate dispute resolution and quick determination. If citizens must instigate lengthy and expensive litigation in order to determine matters that need to be resolved quickly -- such as the extent of coverage provided; then insurers/providers could use their size and financial power to make complaint resolution particularly difficult thus preventing complaints being made.

1142 M. J. Malinowski, "Capitation, Advances in Medical Technology, and the Advent of a New Era in Medical Ethics" (1996) 22 American Jnl. of Law & Medicine 331 at 338.
7.10 Conclusion
Managed competition implicitly assumes that insurers/purchasers will enter into a variety of managed care arrangements with health care providers. In this respect, there is a convergence with internal market models in the U.K. and New Zealand that are also moving towards forms of managed care. Proponents of internal markets argue that an internal market system avoids the problems of cream-skimming, transactions costs, and quality control associated with a managed competition system. However, in internal markets there is a drive to encourage managed care arrangements (for example, GP Fundholders in the U.K. and Independent Practice Associations in New Zealand). Competition between providers paid on a capitation basis in an internal market system will result in the same problems said to arise in managed competition systems and the problem of transactions costs may even be aggravated because of the small size of the managed care plans effected.

Any system that seeks to directly or indirectly foster competition on the supply side carries the inherent risk that competition will occur along the lines of avoiding risk and that quality may be cut. When financial incentives are trained upon individual or small groups of physicians, this acutely brings into focus the conflict between the physician's personal financial interest and his or her fiduciary duty to his or her patient/s. The intensity of this conflict will depend upon the intensity of the incentive to contain costs being trained upon the physician.

A system needs to contain a series of checks and balances with sufficient tension one way to ensure cost containment but sufficient tensions another way to maintain the quality of care. It will serve neither society nor patients nor providers to allow significant levels of financial risk to be devolved to small groups of health providers or individual physicians. It will not serve society as it will have to pick up the longer term costs of physicians electing to cut the quality of services supplied. It will not serve patients as they will bear the individual cost of under-treatment. It will not serve providers as they will find it increasingly difficult to resolve financial incentives with their ethical, legal and professional responsibilities.

The argument made in this dissertation is that the internal market model is flawed as it pays insufficient attention to incentives operating upon government-appointed monopsony purchasers or, in other words, governance issues. The goal of internal market reform is to shift some of the power of resource allocation decisions away from health physicians and other providers into the hands of government-appointed authorities; however, the model fails to ensure these authorities have incentives, the skill and the resources to make these allocation decisions, balancing
individual patients’ needs with society’s interests. By contrast, managed competition provides incentives for insurers/purchasers to compete on price and quality dimensions. I argue that if incentives can be sufficiently trained upon competing insurers/purchasers so that they truly compete on price and quality dimensions then insurers/purchasers will not enter into supply-side arrangements that may have the effect of resulting in a reduction of quality. In the absence of such incentives, there is a strong case for limitation on the degree to which insurers/purchasers (in managed competition systems) or government-appointed purchasers (in internal markets) can devolve financial risk on to health care providers. Complementary solutions would be the prohibition of gag clauses and protection of physicians from punitive actions should they speak out about the quality of care offered by particular plans. In addition, the traditional methods of professional self-regulation, codes of ethics, and medical malpractice actions could also be employed.

In a managed competition system, an important role for government would be to ensure the filtering of information to citizens regarding the quality of health services and to ensure the protection of the quality of services for vulnerable populations that the mechanism of “exit” may not otherwise protect. If sufficient individuals “exit” from a particular insurer/purchaser to another this provides a clear incentive to improve performance; however, where the exit is by a very small number of high-cost individuals (for example, HIV patients) then this mechanism may simply be too crude to protect the quality of services.

Government, in the role of sponsor, may be able to help to shape citizen preferences for insurers/purchasers that care for the most vulnerable in society by ensuring the publication of data and rankings on how well an insurer/purchaser cares for the most vulnerable. Although the process of exit ensures that an insurer/purchaser remains responsive to concerns about the quality of care from a patient’s perspective, exit may undermine quality in terms of what is optimal for society. It is in society’s interests to ensure that individuals do not fall sick in the first instance and thus to invest in primary and preventive care; however, give the propensity to exit, insurers/purchasers may feel they are unlikely to reap the full benefit of investments in primary and preventive care. If primary, preventive and public health services are perceived to be at risk of underprovision in a system of competing insurers/purchasers then government could buy these services on a fee-for-service basis ensuring greater production thereof. The other possibility is to require competing insurers/purchasers to be non-profit organizations that encourage a culture or ethos directed towards primary and preventive care. Such non-profit organizations may inspire amongst individuals enrolled with them a greater degree of loyalty than for-profit organizations.
resulting in quality-conscious individuals using voice in order to improve the performance of their insurer/purchaser before exiting to another.
Chapter 8. Conclusion

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8.1 Motivation for Health Reform

Health reform is ongoing in nearly every OECD country in response to concerns over growing health expenditures. As government is the primary payer in many countries there has been particular concern over the growth in government expenditures. This concern is aggravated by the prospect of an ageing population with high expectations as to the satisfaction of their health needs and wants. Access concerns have arisen in countries that rely to a greater degree on private finance, such as the U.S. and the Netherlands, as private insurers increasing refuse to provide coverage to high-risk people or charge them such high premiums that they are unable to afford coverage. In countries where governments have tightly controlled health expenditures, such as the U.K. and New Zealand, there have been access concerns over growing waiting lists and times and that the allocation of resources, left to physicians’ discretion, was not occurring in a fair or efficient way. Policy-makers in all jurisdictions have also become increasingly aware of a body of literature emphasizing that there is no evidence of the cost-effectiveness or even effectiveness of many health care services supplied. A general concern has arisen that prioritization of health needs and the supply of health services has unduly emphasized acute care and expensive technologies over primary and preventive care. This allocation pattern, it is argued, reflects what is optimal from the medical profession’s perspective as opposed to what is optimal for society.

8.2 The Macro Cost-Containment Approach.

Throughout the 1980s, many OECD countries sought to control increasing expenditures on health by limiting the total amount of resources available to their respective health systems. This was achieved in single-payer systems by capping government expenditures, by changing the method of payment to hospitals from reimbursing for all costs incurred to a prospective annual budget (thus devolving to hospitals a measure of budgetary responsibility), and by reducing the number of hospitals and hospital beds and the numbers of health providers. This macro cost-containment approach is grounded in the economic intuition that expenditures on health services equates with incomes for health providers. Health providers have an incentive to lobby for an ever-increasing amount of resources to be devoted to the health sector regardless of real need. This self-interested behaviour is often disguised in the rhetoric of increasing societal need for health services or the threat of declining quality of services. Thus, the theory runs, because of
the large inefficiencies within most health care systems, government can cap or cut the amount of resources devoted to the system without detrimentally affecting "health" and physicians and other providers will of necessity increasingly select the most cost-effective services.

Containing costs through the macro cost-containment approach has been effective in a number of countries from the perspective of controlling the percentage of GDP devoted to health services. However, in the U.K. and New Zealand systems the maxim; "If costs can be shifted rather than reduced then they will" has proven correct. Costs have been shifted on to the public at large and to patients in particular by long and growing waiting lists for elective surgery in public hospitals and longer travelling times to general practitioners, specialists, and hospitals. Similarly, in Canada, reducing the number of hospitals and hospital beds has resulted in significant costs (as yet unquantified) imposed on informal caregivers and increased waiting lists. Thus, although some so-called single-payer systems may prima facie appear less expensive their true costs may be hidden.

The macro cost-containment approach to health reform is also based upon some contradictory assumptions. The story its proponents tell of money hungry and scalpel happy physicians taking advantage of ignorant patients and members of the public does not rest well with their subsequent assumption that when faced with restricted resources physicians will select the most cost-effective service. Simply restricting the resources available to a system will not necessarily result in selection of the most cost effective services and movement towards the optimal production frontier. As an example, there is no evidence that the supply of services in the U.K. is any more cost-effective than in Canada despite the fact that a significantly lower level of resources is devoted to healthcare in the U.K. than in Canada. The common criticism of the present mix of health services supplied is that there is too great an emphasis on acute care and advanced technology at the expense of primary and preventive care but it does not appear that there is any less emphasis in a low-spending country like the U.K. than a high-spending country like Canada. Thus, it has not been demonstrated that the macro-containment approach will reorient the system so that health needs are appropriately prioritized as well as the most cost-effective services selected to respond to those needs. It also leaves open many opportunities for cost-shifting on the part of physicians and other health providers who find it much easier to
continue rather than to change their old patterns of practice and instead to shift costs on to other payers or patients in terms of longer waiting lists or times or otherwise less responsive service.

8.3 A New Paradigm - the Proactive Purchaser

In all four systems there has been relatively little pressure on the demand side to ensure the optimal allocation of resources between different health needs (balancing societal and patient interests) or to ensure the supply of the most cost-effective service in response to a particular need. In response to this problem, both managed competition and internal market reform models seek to introduce proactive purchasers that will actively influence the allocation of resources to different health needs and the selection of the most cost-effective service in response to a particular health need. Thus, often described as market or competition oriented reform, both types of reform may be more constructively thought of as reform models that seek to inject tension on the purchasing or demand side of health service markets. The new wave of competition-oriented reforms seeks to change the balance of power between purchasers and physicians. Purchasers (be they government appointed monopsonies in internal markets or competing private insurers in managed competition markets) seek to strongly influence or manage physician decision-making.

These types of models respond to social justice concerns by ensuring access to a comprehensive range of health services on the basis of need as opposed to ability to pay. Both managed competition and internal market systems should be largely progressively financed in order to satisfy distributive justice concerns. A managed competition system covering a comprehensive range of health services of an adequate quality may result in a more equitable system than a system like Canada which relies to a significant degree on private financing for important health services such as drugs consumed outside of hospitals and home-care services or the New Zealand system which has high user charges for general practitioner services. Covering a comprehensive range of services is not only important from an equity perspective but also to enhance the potential to substitute the most cost-effective service, whatever its nature, in response to a particular health need. Comprehensiveness is also important from the perspective of accountability. If payers/purchasers are only responsible for certain health needs or services then there is more scope to argue that particular problems or patients do not fall within their jurisdiction and budget.
In order to facilitate a measure of price competition, a managed competition model would require citizens pay either (as in the Netherlands’ model) a small fixed premium or (as in Enthoven’s model) the difference in premium price between the lowest price plan and their selected plan or (as in Clinton’s proposals) the difference in premium price between the average priced plan and their selected plan. There may be a concern that managed competition would consequently result in a two-tier system but this is not necessarily true or at least no more true than in many systems (even those described as “single-payer”) that rely on private financing for important services such as general practitioner services, drugs, home-care services, etc. or systems where physicians consciously or unconsciously prefer patients and health needs that they can most identify with (for example, treatment of heart disease rather than prevention of diabetes). In other words, in every country there is in reality a two-tier system although its presence is not always frankly acknowledged. In seeking to facilitate price competition there is the potential in managed competition regimes for the ghettoization of lower-priced plans. This may lead one to conclude that there needs to be regulatory control of premium prices to reduce the potential for wide differences between the quality and coverage offered by the lowest and highest priced plans. However, the spectre of an unacceptable two-tier system is significantly lessened provided a comprehensive range of health services is included in the publicly-funded basket and the sponsor ensures that the quality of services in even the cheapest plan is at a level acceptable to the majority of society.\textsuperscript{1140}

Setting an acceptable level of quality or, in other words, determining minimum entitlements is a difficult task. However, this is a problem that all systems must wrestle with unless governments intend to leave allocation and rationing issues within the “black-box” of clinical decision-making and rely on the macro cost-containment approach to limit the resources available to clinicians. It seems reasonable that a system needs to create the right combination of incentives so that the most cost-effective service is supplied in response to a health need. However, this belies the difficulties of measuring the relative importance of needs. For example, would a potentially life-saving operation that costs $25,000 to perform and have a 10% chance of success be “effective”? Limiting access to someone’s chance of life or full recovery does not fit well with the notion of

\textsuperscript{1140}So competition on quality dimensions would be those over and above sponsor-mandated minimum requirements. For example, a sponsor may require that all elective surgery be completed within 6 months but some health plans may offer to ensure provision of surgery within 3 months.
effectiveness because of the judgements that have to be made with regard to the value of the outcome sought to be obtained. Thus although this is a topic beyond the scope of this thesis, there needs to be an on-going process in place whereby the general public are involved in determining health spending priorities and the range and quality of health services to be supplied.

8.4 Internal Markets

Internal market reform has been implemented in systems previously described as "command-and-control" -- where government not only played a significant role in financing health services but in providing health services through the nationalization of most hospitals. Although this thesis has been critical of internal market reform in the U.K. and New Zealand, there have been some benefits. An important aspect of reform has been the integration of funding of a wide range of health services into regional government purchasers. Arbitrary partitioning of funding between different health services and health needs is characteristic of many health systems and lessens the ability of purchasers and/or providers to make cost-effective substitutions between different health services in response to health needs. Integration of funding is also important as a means of reducing cost-shifting for if other payers are responsible for different health needs or health services then the temptation is to simply shift costs. The other benefit of internal market reform has been the generation of information regarding the costs and benefits of different health services. In the previous command-and-control systems of both the U.K. and New Zealand there was little usable information generated regarding the costs and benefits of different health services. Information has had to be generated in the new internal markets as both purchasers and providers need to be able to measure their own and each others performance so as to provide a "currency for decision-making."

The primary problem with the internal market model is that although it recognizes the central need for proactive purchasing it does not address itself to the issue of how to ensure the government-appointed Health Authorities will in fact be proactive. To ensure optimal decision-making, these Authorities not only need resources and skills but sufficient incentives. As internal markets eschew competition between purchasers as a means of ensuring performance, one has to rely solely upon political mechanisms or "voice" to ensure the responsiveness of Health Authorities to the citizens and patients they are meant to represent in their purchasing decisions. Significant and complex agency questions arise in this respect. These issues have not
been sufficiently addressed and voice mechanisms are under-developed in both the U.K. and New Zealand.

Unsurprisingly, given the lack of attention to the incentives trained upon purchasers, internal market reform in the U.K. and New Zealand has resulted in little change in the range of health services supplied and the health providers who supply them. Internal market reform does not promote dynamic efficiency as Health Authorities are prevented from taking different responses in different health service markets — they must contract out even when vertical integration may be the more efficient option. Thus, flexibility and dynamic efficiency is forsaken in the quest for a *prima facie* simple administrative structure where “one size fits all.”

The configuration of the supply side, in particular the number and size of New Zealand’s Crown Health Enterprises and the U.K.’s NHS Trusts (which are the administrative organizations that manage hospitals) has been government-determined and is rigid. There appears to be a problem of monopoly supply in hospital services within internal markets but this is a product of years of the macro cost containment approach to health reform and, in particular, government consolidation and control of hospitals. Although now ostensibly independent of government, public hospitals that could be potentially in competition with each other are often under the same management umbrella. It is unclear to what degree there would be monopoly on the supply side if these administrative structures were unbundled and hospitals were privatized. The result of monopoly on the demand side and monopoly on the supply side, particularly since both are government controlled and threats of hold-out are politically unsustainable, is essentially stalemate with little real willingness to change or innovate on either side.

The contract has been described as the “fulcrum of internal market reform” symbolizing the new relationships between purchasers and providers. There is not, however, a stark choice between contracting-out and vertical integration in quasi-government markets. There is in fact a continuum of options in public/private relationships. The U.K. internal market, although dressed in the garb of contracting out, in reality falls closer on the continuum towards vertical integration. The U.K. internal market may be better understood as a new form of hierarchical arrangement within government. New Zealand has made a more serious attempt at contracting-out and relies on formal legally-enforceable contracts. Notwithstanding, in both the U.K. and
New Zealand, the most prevalent form of contracting has been "block contracts" resulting in little change from the previous system where hospitals were paid by prospective annual budgets. The rigidness and inflexibility of the U.K. and New Zealand systems both pre and post reform lends itself to periodic system reform or, as Maynard describes it, "redisorganizaton." This phenomenon has been recently demonstrated once again with the announcement in both New Zealand and the U.K. of further reforms that purport, in particular, to reduce the transactions costs of the internal market. The rigidity of the structures in places in these countries means that the whole system must periodically be reformed to catch up with changes in health markets caused by exogenous or endogenous factors. Periodically, the entire system must also be shaken up as one or more of the important players in the system (hospitals, physicians and other health providers, private insurers, government authorities, patients) have figured out how to maximize to their own particular benefit all the loopholes of the existing system configuration. By comparison a managed competition model promises greater dynamic efficiency as competing insurers/purchasers can more readily respond to different health service markets and changes within those markets over time.

The most dynamic innovation of internal market reform in the U.K. and New Zealand has been the development of managed care plans controlled by general practitioners. For example, the U.K. GP Fundholders have been active in negotiating quicker responses on the part of hospitals and other providers than Health Authorities and in reducing waiting lists and times. These managed care developments are, however, in sharp contrast to the balance of the internal market reforms for two reasons. First, they rely upon private purchasers (consortiums of general practitioners) as opposed to government-appointed purchasers. Second, other internal market reforms require a rigid purchaser/provider split but GP Fundholders (as with all managed care plans) can substitute the supply of their own services in place of buying services from other providers.

The belief is that Fundholders have an incentive to give greater emphasis to primary and preventive care in order to keep their enrollee population healthy. However, as with all managed

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Footnotes:

1142 Fundholders are, however, intended to operate on a non-profit basis with surpluses being reinvested back into their practices for the benefit of patients.
care plans this benefit will only accrue if Fundholders know that they must bear the long-term consequences of their decision-making and that there is at least a serious risk that failure to provide care to their enrollee population will have cost consequences for them. This problem is discussed further below in the context of managed competition as managed care is integral to the managed competition model. What is important to note at this point is that if GP Fundholders are only responsible for purchasing a limited as opposed to a comprehensive range of health services then this increases the potential for shifting costs on to other payers or purchasers and may mean that over the longer term Fundholders will not engage in optimal decision-making.

The empirical evidence available to date suggests that the efficiency gains achieved by the U.K. Fundholders has been outweighed by additional transactions and administrative costs. This may be a transitionary phenomenon but it also may be reflective of the fact that purchasing responsibility has been devolved to too low a level and that purchasers should generally serve a larger population than the 5000 minimum allowed in the U.K. Although internal markets are often lauded as resulting in lower transactions costs than a managed competition system it is by no means clear that this is a valid assertion given the move in internal markets to contracting with small managed care plans like the GP Fundholders in the U.K. and Independent Practice Associations in New Zealand. In the Netherlands (population 18 million), there are 26 Sickness Funds and 46 private insurers and it is predicted that private insurers will eventually merge into 14 or 15 insurers. By comparison, in the U.K. (population 58 million), there are currently 3500 GP Fundholders operating as mini-purchasers in the U.K. in addition to the 100 Health Authorities. In the absence of empirical evidence it is simply incorrect to assume that an advantage that internal market reform holds over managed competition reform is lower transactions costs. This stance reflects the common misunderstanding that managed competition is "U.S. style" reform and that as the U.S. system is well known for its high level of transactions costs then the managed competition model is similarly flawed. Moreover, the fixation with the level of transactions costs misses the point that we should be concerned with whether or not any resulting efficiency gains outweights any concomitant increase in transactions or administrative costs.

Questions may also be raised over the devolution of significant amounts of risk-bearing on to physicians. On the one hand, the Fundholding scheme should be extended to cover all publicly-
funded health services in order to mitigate against cost-shifting yet on the other hand it is by no means obvious that general practitioners have the managerial and administrative skills necessary to act essentially as small insurers. Devolving significant amounts of financial risk on to physicians would also seem to strike at the heart of and potentially undermine the trust often said to be required in the physician/patient relationship. Arguably the ethical norms of physicians will mean that it is less likely that physician-run managed care plans would make unacceptable cuts to the quality of health services or avoid high-risk patients. However, I would argue that on balance excessive devolution of risk on to physicians has the potential to undermine the idea of a physician as an agent and advocate on the part of the patient. Optimally, decision-making processes in a health system should balance societal interests with patients’ interests. Physicians are best positioned to be advocates on the part of their patients. Although it is recognized that this advocacy may be influenced by their own self-interest it is better to err on the side of caution here and let physicians’ self-interest be one that is advanced by recommending more services of a higher quality rather than one advanced by unacceptable quality cuts. If managed plans have sufficient incentives to compete on price and quality dimensions it seems unlikely that they would devolve excessive amounts of risk down to physicians without safeguards in place to ensure the standards of care provided. In a managed competition model it would be a sponsor’s explicit duty to monitor this process.

It is often argued that internal market reform (with its reliance on monopsony purchasers) is preferable to a managed competition system as it avoids the problem of “cream-skimming” -- where insurers/purchasers compete with each other by trying to avoid servicing high risk or high cost individuals. However, cream-skimming is equally a problem in internal markets as government purchasers seek to contract on a capitation basis with groups of providers offering managed care plans. Government appointed purchasers and private insurers in all systems may wish to shift financial risk to groups of health providers offering managed care plans. They shift risk by paying groups of providers on a capitated basis.1143 In such a case, the managed care plan takes on the insurance function as it bears the costs and risk of utilization of services by patients, the purchaser function as it largely determines what range and mix of health services to supply to any individual it covers, and (at its discretion) the provider function if it actually owns the hospitals or employs the providers who provide services to patients. The problems generally associated with managed competition systems, such as cream skimming and additional

1143 A lump sum per person to cover all health services needed by that person regardless or how many services in reality that person needs.
transactions costs, are in truth problems associated with any system that seeks to encourage competition between managed care plans. Policy-makers should not be lulled into thinking that these same problems will not exist simply because, as in the U.K. and New Zealand internal markets, managed care is being encouraged from the bottom up in terms of paying groups of physicians or integrated groups of health providers on a capitated basis rather than competing private insurers. In particular, the problem of cream-skimming is just as serious a problem in this context as it is in competition between large insurers/purchasers. There is a danger that internal markets are allowing the development of managed competition through the back-door without sufficient consideration of the important issues of the role of the sponsor, accountability mechanisms, and cream-skimming.

8.5 Managed Competition
The concept of a proactive purchaser is fundamental to a reorientation of a system by injecting tension into the demand side of health service markets. Whereas the internal market model relies upon voice as the mechanism through which to ensure the accountability of purchasers, the managed competition model also allows the operation of exit or consumer choice between competing insurers/purchasers. This process of competition is regulated by a government sponsor who requires through regulation and monitoring that insurers/purchasers compete on price and quality dimensions and not on their ability to avoid high-risk individuals. The managed competition model generally assumes that private insurers will put in place managed care arrangements which are essentially a variety of techniques whereby insurers seek to influence the clinical decision-making of providers.

The concept of exit or consumer choice of insurers/purchasers is often discounted on the grounds that citizens cannot make good decisions between competing insurers/purchasers offering managed care plans. There is a level of arrogance in some of the rhetoric discounting the ability of ordinary citizens to make judgements about the activities of purchasers and providers. The information asymmetry suggests that at a micro-level patients will not always be able to monitor providers’ performance. However, at macro and meso levels citizens’ judgements and preferences would seem to be as valid as any other area with respect to the level of resources to devote to health relative to other needs, which health needs to give priority too, how well providers respond to patients’ needs generally, and difficulties with access, waiting lists and times. Moreover, and as discussed further below, it is not necessary that all citizens shop around
from plan to plan. The overall quality of services should be set at a level that the vast majority of society are content with. Provided each plan has a significant number of quality-conscious individuals who will signal their dissatisfaction with a plan’s performance by exiting to another, exit should work as a mechanism to enhance the quality of services for all. A sponsor will have to provide citizens with information on the performance of insurers/purchasers, ensure that competition occurs on price and quality dimensions, and ensure that a minimum quality of services is maintained.

There has been a strong shift in many health systems towards an economic analysis of health service allocation that focuses on the impact (or lack thereof) of health services on health outcomes. However, too strong a focus on cost-effectiveness where effectiveness is measured by health outcomes will not result in a proper balance nor will such an approach receive the necessary public and political support needed to sustain it. An important component of any health system is caring health services such as care of the mentally and physically disabled, palliative care, the frail elderly and care pursuant to the process of healing. Social justice requires that these services be treated as importantly as any other health service that may have greater benefits from a purely utilitarian perspective of maximizing health. Consequently, richer conceptions of performance are needed. This has been apparent in internal markets where performance has been measured by “easy-to-measure” indicators such as turnover, increased day-surgery, number of readmissions, etc. Ensuring that insurers/purchasers are at least in some measure directly accountable to the people they represent ought to help ensure that the more difficult to measure indicators of quality that people value are nonetheless taken into account.

Some argue that there is no room for exit to work as an accountability enhancing mechanism as a very small percentage of the population accounts for the largest share of health expenditures. If insurers/purchasers can “cream-skim” healthy enrollees and avoid treating costly patients then they will not be operating efficiently nor achieving social justice goals. Where an insurer/purchaser cannot avoid treating a high-risk individual there is a concern that they may cut the quality of the health services they provide in order to save costs and/or to try to force a patient to shift to another insurer/purchaser.
One method of preventing cream-skimming is to risk-rate the per capita sum paid to competing insurers/purchasers. As the Netherlands experience demonstrates, however, policy-makers lack an understanding of the importance of this issue and incorrectly assume that adequately risk-rating payments will mean that there is nothing to compete on as insurers/purchasers are reimbursed for all costs. This of course is not correct as the percentage of risk that can be predicted is much smaller than what the risk is in reality. In addition there are also technical difficulties to actually risk-rating per capita sums paid so that they reflect the risk of each individual as perceived by insurers. This requires a sponsor to keep abreast of risk determinants used by insurers/purchasers. A sophisticated regulator is required. There is a certain amount of irony in this point, for the promotion of competition as a means of allocating health care is rooted in a sceptical view of government but, in fact, in order to succeed such competition requires sophisticated governance.144

Undoubtedly, cream-skimming is a potentially serious problem. However, it must be remembered that such behaviour on the part of insurers/purchasers sends a signal not only to those individuals whose risk has crystallized but to other individuals that this particular insurer/purchaser is untrustworthy at the time that it is needed the most. Thus, the need for managed care plans to maintain their reputation in the market place will inhibit cream-skimming behaviour. One can envisage that the need to maintain a good reputation will be more salient for those health services and patients that most people can identify with. Thus, cutting the quality of health services for the elderly or for patients with heart disease or cancer is likely to promote concern amongst most people able to identify with the fact that they too will grow old and there is a reasonable risk that they or their loved ones will be afflicted with heart disease or cancer. Services for small vulnerable populations or stigmatized health services (where people use the "head in the sand" approach believing that their own risk, for example, of psychiatric disease or of giving birth to a disabled child is much lower than what it really is) may be the services that are most at risk. Thus, there will be a need for the sponsor to emphasize in published data how well plans treat the most vulnerable groups in order to foster a sense of solidarity between the general populace and vulnerable groups within it. In such a case, low-risk individuals may signal their dissatisfaction by the use of either exit or voice with how a plan treats others who

are not similarly situated. There may, however, be a need for a sponsor to be particularly vigilant with regard to the quality of services supplied to small vulnerable groups with whom the rest of the populace has no developed affinity.

It is crucial that decision-makers bear the cost of their own decisions in the short and long term. The problem is that the use of “exit” and competition between insurers/purchasers may reduce the likelihood of having to bear the longer term costs. On the other hand, a monopoly (be it public or private) may well be unresponsive to concerns and resistant to change. Thus, what is required is a mixture of what Hirschman describes as exit, voice, and loyalty. Insurers/purchasers need to be large in order to pool and manage financial risk and in order to keep transactions and administrative costs down. Exit as an option should not be available at any time but perhaps annually or, as in the Netherlands, biannually, so that insurers/purchasers have an opportunity to improve their performance before many people shift their custom. It may be that insurers/purchasers should be required to be non-profit foundations or organizations in order to encourage loyalty on the part of enrollees and thus the use of voice rather than exit when performance deteriorates. Enrollees should have avenues through which to exercise voice in order to lobby for improvements in their chosen plan, such as the use of a patient ombudsperson or a patient charter of rights, with the ultimate threat of exit being available if performance does not improve.

In order for exit to operate there must be a choice of insurers/purchasers offering managed care plans. In some health service markets there may be natural monopolies or monopolies that have resulted from previous government policy. The fact that there is not sufficient depth across all health service markets to create integrated delivery systems capable of independently satisfying the needs of enrollees of competing insurers/purchasers does not mean the managed competition model is fundamentally flawed. The important question is what degree of regulation or combination of other incentives is required to allow competing insurers/providers to purchase services from natural monopoly providers? As discussed in this dissertation, all the problems of utility regulation are present in abundance in the regulation of health care delivery. On balance, industry specific regulation seems the most appropriate means to deal with the problems of bottlenecks, cross-subsidy, and monopoly rents. Competition law should be left to regulate the competitive and contestable markets.
There is no perfect or easy solution to what constitutes the optimal institutional design; however, a paradigm shift is needed so that the health system in question is constantly and incrementally evolving. The managed competition model offers more promise in this regard than the internal market model. However, the managed competition model has not been fully implemented in any jurisdiction and there is little empirical evidence as to how the model would actually work in practice. The model is being slowly implemented in the Netherlands. This slowness is in part due to the Dutch system of coalition government and is not necessarily indicative of the difficulty of implementing managed competition per se. Moreover, it is not necessarily clear that hasty implementation of reform is advantageous. The advantage of reform implemented quickly is often touted to be that vested interest groups have little opportunity to mobilize to resist change. However, change must often be by necessity incremental, responding to and/or building upon what often may be accidents of history or earlier policy decisions. More importantly, the health system is a service industry and service requires continuity and a meeting of expectations notwithstanding that some may consider these expectations ill-conceived. Expectations can be shaped over time, but the temporal element is key and people need time to redefine their expectations. As an example, it is unrealistic and unfair to shift quickly from a system revolving around acute cute to one with significantly greater emphasis on primary and preventive care particularly since there will presumably be individuals who have not benefited from such primary and preventive care measures and need acute hospital services now.

Managed competition reform is often criticized on the basis that it would result in a U.S. style system. This is an unwarranted criticism. There is a clear distinction to be made between using market reforms as a means to achieving a broader social goal -- namely universal access to a comprehensive range of health services and adopting a U.S. style system of piecemeal access that is regressively funded. Managed competition reform would result in a system significantly different from that presently or historically in operation in the U.S. It would result in a system that more efficiently achieves the distributive justice goal of ensuring access to a basic level of health services for all on the basis of need as opposed to ability to pay. The U.S. does not directly acknowledge this goal but nonetheless coverage for the uninsured or government insured is indirectly subsidized by a merry-go-round of cost-shifting. The U.S. system also has resulted in the health needs of the uninsured only being addressed, if at all, when acute and thus primary
and preventive care, which in the long-run may result in significant cost-savings for society, is discounted. The present managed care revolution in the U.S. is resulting in cost-savings but these surpluses are being transferred from physicians and other providers to managed care plans. In the absence of government co-ordination and regulation any cost-savings are thus accrued as corporate profit and are not pooled and redistributed to fund coverage for all. More importantly, scarce resources are still devoted to the mission of trying to avoid covering or treating high-risk individuals rather than trying to most efficiently deal with their needs. Clearly, although the devil is in the detail in terms of the specific design of a managed competition system, such a system would be a significant improvement upon the present U.S. system. The managed competition model is a relatively complicated model. This complexity may make it difficult to “sell” politically and the Clintons foundered badly in this regard in the face of fierce lobbying and criticisms on the part of insurance and physician groups resistant to any prospect of government control of their incomes or their professional autonomy. This is to be expected. Fierce resistance on the part of the medical profession is a phenomenon characteristic of all health care systems that have implemented or have tried to implement universal health insurance.

There are temptations to implement the managed competition model in a piece-meal fashion and this may create more problems than it solves. Internal market reform is itself piece-meal implementation of the managed competition model, pragmatically adapted for the command-and-control systems of the U.K. and New Zealand. However, without the driving force of competition between purchasers offering managed care plans, managed competition in a sense loses its engine. With internal market reform we are left with the worst of both worlds, the inflexibility and resistance to change of the old command-and-control system together with the additional transactions and administrative costs associated with the managed competition system.

Capitalist economies implicitly accept the presence of exogenous rules to facilitate transactions that drive the spontaneous order of markets. As discussed in Chapter 2, in health insurance and health service markets the “free market” as conducted pursuant to general contract, property, antitrust and other laws will not ensure the efficient realization of social justice goals in the allocation of health care services. The managed competition model’s intellectual appeal is its recognition of social justice goals coupled with its implicit assumption that government is better
at setting the exogenous rules for the efficient obtainment of these goals rather than being involved in the production process itself. Thus in managed competition, government sponsors lay down the framework for and regulates competition between private insurers/purchasers offering managed care plans. A key question in health reform and in all institutional design is what decisions are best made by whom? Comparing managed competition and internal market reform, government is less suited to the role of being a purchaser of health services and negotiating with a range of health providers in a range of health markets than it is to the role of sponsor where it is required to lay down the framework for competition and regulate or manage this process. This is a specific role that builds upon the strengths of government as a policy-maker and regulator. By contrast, the role of government as purchaser in internal markets involves micro-managing the supply of care on the part of a number of differing health providers in a number of differently structured and changing health service markets.

Advocating that government sets the exogenous rules for competition and production, however, belies the technical difficulties involved in performing this role well. The successful execution of the sponsor role is critical to the managed competition model. Managed competition is an example of the concept of "smaller but smarter government" but to put it crudely, can government be smart enough? To use the metaphor of Osborne and Gaebler, although ideally the government's role in health care should be "steering" rather than "rowing", in the sea of health care allocation the currents are very strong due to the strong social justice, economic, and political interests at stake.\footnote{See Osborne and Gaebler, supra note 13.} Evans has said that "the notion that some sort of automatic, self-regulating marketlike structure can be established that will substitute for public management and yet achieve public objectives is a fantasy: powdered unicorn horn."\footnote{R. G. Evans, supra note 8 at 462.} It is a serious mistake to assume that the government’s role is not as critical in a managed competition system where there are competing purchasers as it is in one where governmental agencies act as the sole purchasers of services. Political accountability and voice continue to have a large and important role to play in managed competition systems. However, while I agree that there is an indisputable role for government in restructuring and implementing a new paradigm for health service allocation, it is far from clear that it is preferable that government be selectively purchasing or managing discrete health service markets or managing hospitals. Thus while the nature and scope of
government's participation needs to change its importance is not undermined and its participation remains key.

8.6 Reflections on the Canadian System

The goal of this dissertation has been to compare internal market reform and managed competition reform in the Netherlands, the U.K., New Zealand, and the United States. It is, however, appropriate to conclude with some general comments on the relevance of this research to the Canadian system.

The Canadian approach to health reform has primarily been of the macro cost containment school. This approach has been tried in many countries over the course of the 1980s and has ultimately proved unsatisfactory from the perspective of truly controlling costs or reconfiguring the system towards the supply of cost-effective services. The macro cost containment approach may be thought of as akin to putting a lid on a fiercely boiling pot (the health system) but pressure periodically forces the lid up allowing boiling water (costs) to overflow. Canada and all health systems need more creative approaches. Although there are undoubtedly problems and pitfalls with the managed competition model it certainly bears closer scrutiny from a Canadian perspective than a simple dismissal of it as being in the land of "powdered rhino horn" or as "American style reform." The very strong resistance to any hint of Americanization of the Canadian health system, however, means that at least for the foreseeable future an explicit policy promoting managed competition reform is unlikely to be implemented. Moreover, it is true that if a government's goal in health reform is simple cost-containment as opposed to higher productivity and lower production costs than a managed competition model may be unacceptable as it could conceivably result in high overall expenditures due to higher responsiveness to citizen's preferences and needs. Accepting this, the question arises at to what other measures could be taken to reform the present Canadian system that would be more politically acceptable.

In some provinces there has been a shift to devolving budgets and health allocation responsibility to regional government-appointed authorities. Although this initiative is described as devolution there is also a significant amount of centralization as these regional government authorities assume management responsibilities for hospitals, a function formerly performed by hospital boards. Thus, these new regional government authorities are both purchasers and providers as
they are responsible for buying services and for managing hospitals. These new entities resemble the Area Health Boards and District Health Boards that were in existence in New Zealand and the U.K. prior to internal market reform. In the U.K. and New Zealand this vertical integration was viewed as problematic as there was no incentive for these regional entities to contract out to other potentially more efficient providers or to shift funding from acute and high technology care to primary and preventive care. Should Canada consider a move to an internal market system similar to that implemented in the U.K. and New Zealand? From the perspective of policymakers in other countries, such as Canada, there is much to be learnt from critically analyzing the experiences of the U.K. and New Zealand systems.

On the positive side, there have clearly been benefits that have accrued in internal markets from consolidating funding for a comprehensive range of health services in regional purchasing authorities. Presently, public funding for hospital and other secondary services is separate from physician services. There is also a significant amount of private financing of drugs consumed outside hospitals, medical equipment, and home care services. Integrating funding for secondary, primary and drug services in regional authorities would be a first step towards facilitating cost-effective substitution between services.

The New Zealand and U.K. systems have experienced enormous upheaval in implementing an internal market through a purchaser/provider split only to see the split incrementally unravelled through managed care arrangements and through developing close relationships between government-appointed purchasers and providers. Recent announcements in both New Zealand and the U.K. propose the abandonment of internal markets, although in both systems the change seems likely to be more cosmetic than real as the purchaser/provider split, apart from some name changes, is to be left in place. The clear lesson from the U.K. and New Zealand is that enforcing a rigid purchaser/provider split and mandatory contracting out is not the key or at least is insufficient alone. A rigid purchaser/provider split, just as rigid vertical integration, can be criticized as application of an inflexible and indiscriminate solution to health service markets that are very different. What is key is that purchasing or budget-holding entities have the

resources, the skills and, in particular, the incentives to purchase and/or provide the most cost-effective range of services and to be responsive to the people in the region they represent. Thus the concerns of accountability and governance that this dissertation has raised are key.

In some provinces there has been discussion with regard to changing the method of payment for physicians from fee-for-service to capitation or a hybrid payment and experimenting with managed care. All methods of reimbursement have their advantages and disadvantages. Once more what is key is that a proactive purchaser has the incentives to select the right payment mechanism in any particular health service market. Much greater attention needs to be given to ensuring tension on the demand or purchasing side or, in other words, ensuring good governance on the part of these regional government authorities. It is this issue that demands future research and consideration on the part of policymakers, lawyers, and economists.
Appendix 1

U.S. Managed Care Organizations

Health Maintenance Organizations ("HMOs"): Managed care has been growing in the U.S. since federal initiatives in the 1970s resulted in the growth of HMOs. HMOs employ physicians and own their own hospitals or instead contract with a limited number of independent institutions. Enrollees are entitled, in return for a fixed annual or monthly payment, to a comprehensive benefit package from health providers stipulated by the HMO. HMOs require their enrollees to use only the providers affiliated with them for all health services except in the case of an emergency. HMOs usually impose no or low user charges. There are, in fact, several types of HMOs and Inglehart notes that they can be categorized according to whether they employ physicians directly or whether they contract work out to groups of practitioners and other providers.

Preferred Provider Organizations ("PPOs"): In PPOs, insurers selectively contract with health providers who agree to provide health services on a discounted price schedule. PPOs do not actually enroll patients with health care providers but patients are given a list of preferred providers and if a patient elects not to use one of these listed providers when seeking treatment then he/she must pay a higher user-charge.

Point of Service Networks ("POS Networks"): POS Networks attempts to combine elements of HMO and PPO organizational arrangements. While historically patients (with sufficient insurance or financial resources) have been able to access the U.S. health system at any level, POS Networks require enrollees to select a general practitioner who acts as a gatekeeper and coordinator of the delivery of care from a limited list of other providers. However, patients can elect to pay a higher user charge and obtain care from a provider who is not participating in the network. POS Networks are distinguishable from PPOs for in the former there is the element of coordinated care associated with a collaboration or team of health providers.

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1148 These initiatives were sparked by the work of P. Ellwood, W. McClure and colleagues who, in 1970, proposed a national "health maintenance industry that is largely self-regulatory" that would deal with the crisis in health care cost and distribution in the U.S. — P. M. Ellwood et al., "Health Maintenance Strategy" (May, 1971) Medical Care 250.
1150 De Lew. Greenberg, and Kinchen, supra note 155 at 156.
1151 Idem.
Appendix 2

Diagram 1
Structure of the NHS Internal Market

Secretary of State

Department of Health

NHS Management Executive

8 Regional Offices

PURCHASERS

Health Authorities (100)

PROVIDERS

NHS Trusts (450)

General Practitioners

Patients

GP Fundholders (3500)

Other Private Providers

Funding

Contracts
Appendix 2

Diagram 2
The Structure of New Zealand’s Internal Market

Appendix 2

Diagram 3
Managed Competition Model

Government Sponsor
(Pools Funds & Regulates Competition Between Insurers/Purchasers)

Risk-rated payment on behalf of each consumer

Insurer/Purchaser Chosen by Citizens

Managed Care

Insurer/Purchaser

Private Providers

choice

contract
-capitation
-utilization reviews
-bonus payments
-etc.

choice

Insurer/Purchaser

vertically integrated with private provider(s)

Patients

service delivery

service delivery

choice

choice
Appendix 3

Enthoven's Model of Managed Competition

An American economist, Alain Enthoven, is most often credited with designing the managed competition model and his work was first reported in two articles in 1978. The model formed the basis for President Clinton's proposals, although with such modifications that Enthoven did not support the Clinton initiatives. Enthoven describes his model of managed competition as "a purchasing strategy to obtain maximum value for consumers and employers, using rules for competition derived from microeconomic principles." It is thus instructive to summarize Enthoven's managed competition model for comparison with President Clinton's proposals and the Dekker proposals in the Netherlands. The model operates according to three principles: universal coverage through efficiencies from competition; competition between health insurance plans; and the elimination of risk rating through management of competition between insurance plans by a sponsor.

a. Universal Coverage Through Efficiencies From Competition

Enthoven's model of managed competition accepts as a basic concept that a health system must ensure universal access to a core set of health care services of adequate quality. Enthoven argues, noting that the present U.S. system is a complex patchwork of institutions leading to cost-shifting, higher costs, and delayed care, "it would be more humane, economical, and rational simply to adopt a policy providing coverage to virtually everybody through an integrated financing and delivery organization that provides primary and preventive care as part of a comprehensive benefit package." He rejects, however, top down global budgets, historically used in countries such as the U.K. and New Zealand, to control the costs of providing universal access. Instead, Enthoven relies on price competition between competing insurers and providers to control costs. Enthoven argues that managed or regulated competition as opposed to government provision will enable continuing innovation and flexibility and will result in a system that allows consumer choice and is more "user friendly."

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1152 See Enthoven, supra note 20.
1153 The managed competition concept was subsequently further developed by Enthoven and Paul Ellwood and become known as the Jackson Hole Plan. The managed care concept can, however, be traced back to an earlier version of the idea presented by Herman M. Somers and Anne R. Somers to the Sun Valley Forum on National Health in June 1971 and published in the Milbank Memorial Fund Quarterly in April 1972 – U. E. Reinhardt, "III: Publications and Reports: Health Reform, Lineage of Managed Competition" (1994) Spring (II) Health Affairs 290.
1155 Enthoven, "The History and Principles of Managed Competition" supra note 20.
1156 Ibid. at 41.
b. Competition Between Health Insurance Plans
Managed competition recognizes that an unregulated market in health insurance will result in unacceptable inefficiencies and inequities and aspires to restructure the incentives in the market and efficiently combine competitive forces with government regulation. Members of the public are pooled into groups to strengthen market power on the demand side in the market for health insurance and to ameliorate the power accrued by health providers due to moral hazard and information asymmetry. The goal is to stimulate competition between private insurers on the basis of cost and quality, rather than on risk-selection. The model assumes that, as a result, private insurers will negotiate better performance on the part of health care providers and costs will be reduced. Insurers will negotiate contracts with providers for the supply of services and/or vertically integrate with providers. This flexibility to determine what is the most efficient arrangement, be it arm’s length contracting or vertical integration or something on the continuum between these two poles, distinguishes managed competition from internal markets where, in the latter, there is an enforced purchaser/provider split and government-appointed purchasers must contract out for the supply of services.

Although Enthoven has referred to his managed competition model as one promoting consumer-choice in fact choice may often be limited to an annual selection by citizens of an insurance plan offering managed care rather than an active and on-going selection of health care providers. Insurers may enter into managed care arrangement with providers which may restrict which providers a patient can obtain services from. Thus, it is not so much competition between health care providers that is emphasized, but competition between private insurance plans and their affiliated providers. A sponsor could, however, require plans to allow individuals some freedom of choice, for example, allowing a second opinion and allowing patients to change general practitioners when they are unhappy with their practitioner.

c. Management by a Sponsor and the Elimination of Risk Rating
A key player in Enthoven’s managed competition model is the “sponsor” which has the critical role of structuring and adjusting the market for competing health insurers offering managed care plans.\footnote{Enthoven, "The History and Principles of Managed Competition" supra note 20.} Enthoven originally envisaged that the sponsor would be a government body. In light of the dependence of the present U.S. system on employer sponsored insurance, he subsequently indicated that a large employer could also act as a sponsor. For the purposes of discussion of the managed competition model in this dissertation, I will assume that the sponsor will be a government-appointed body. A sponsor acts on behalf of most individuals within a particular
region thus consolidating market power on the purchasing side of the health insurance market. In order to encourage small employers and others to enroll with a sponsor Enthoven suggested that enrollment with a sponsor be a pre-condition to being able to treat insurance premiums as tax-deductible. Due to its monopsony position a sponsor is able to use its market power to dictate the terms upon which it will allow health insurers to offer insurance to its enrollees. The goal of a sponsor is to ensure that the insurers operating in its jurisdiction compete on the basis of price and quality rather than on risk selection.

Enthoven’s managed competition model requires that government contributions or employer subsidies be set at the price of the lowest cost insurance plan in the region thereby making consumers more conscious of the cost of more expensive plans. Thus, managed competition seeks to stimulate price competition at the level of the annual premium for comprehensive health care services rather than at point-of-service between patients and health providers. Price competition is further stimulated by the fact that all insurance plans are required to offer a core set of services, the quality of which is regulated by a government-appointed authority. This means that, according to the model, consumers know they can safely shift to the lowest-cost plan without a basic entitlement to coverage and quality being compromised.

Sponsors must establish rules of equity regarding how the private insurance plans in their respective jurisdictions will compete. Under Enthoven’s model, insurance plans must accept all who seek to enroll within them (subject only to capacity restraints), and are not permitted to exclude individuals who wish to enroll with them on the basis of pre-existing conditions nor are they allowed to differentiate in the premiums charged to enrollees on the basis of their health history or status. In this latter regard, sponsors are able to monitor plans as all individuals must enroll in and change plans through their local sponsor. Thus, sponsors can investigate those plans that have a high number of disenrollees or who, for example, provide no oncology services so as to avoid treating high-cost cancer patients. Sponsors must calculate the risk value that each plan bears and surcharge plans that have a more favorable risk composition to subsidize those plans in which more high risk people are enrolled. Thus, sponsors have a very important role to play in the managed competition model although very little is said about their composition, their skills, the financial and other incentives they face, how to ensure their accountability nor how they will calculate risk-adjusted payments.

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1158 Ibid. at 37.
1159 Ibid. at 29.
Appendix 4

Table 1
Percentage of Total Health Expenditures Funded by the Public Sector in Selected OECD Countries

<table>
<thead>
<tr>
<th></th>
<th>U.K.</th>
<th>N. Z.</th>
<th>Neth.*</th>
<th>U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1960</td>
<td>85.2%</td>
<td>80.6%</td>
<td>33.3%</td>
<td>24.5%</td>
</tr>
<tr>
<td>1970</td>
<td>87.0%</td>
<td>80.3%</td>
<td>84.3%</td>
<td>37.2%</td>
</tr>
<tr>
<td>1980</td>
<td>89.6%</td>
<td>83.6%</td>
<td>74.7%</td>
<td>42.0%</td>
</tr>
<tr>
<td>1990</td>
<td>83.5%</td>
<td>81.7%</td>
<td>71.3%</td>
<td>42.4%</td>
</tr>
</tbody>
</table>

*These figures clearly include the compulsory contributions made by the poorer 60% of citizens to the Sickness Funds and thus do not come from government’s general taxation revenues.

Table 2
Expenditures on Hospital Services As A Percentage of Total Health Expenditures in Selected OECD Countries

<table>
<thead>
<tr>
<th></th>
<th>U.K.</th>
<th>N.Z.</th>
<th>U.S.</th>
<th>Neth.</th>
<th>OECD av.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970</td>
<td>49%</td>
<td>55.7%</td>
<td>44.1%</td>
<td>55.1%</td>
<td>43.4%</td>
</tr>
<tr>
<td>1980</td>
<td>56.1%</td>
<td>55.3%</td>
<td>48.9%</td>
<td>57.3%</td>
<td>49.7%</td>
</tr>
<tr>
<td>1990</td>
<td>44%</td>
<td>56.3%</td>
<td>46.2%</td>
<td>51.8%</td>
<td>46.1%</td>
</tr>
</tbody>
</table>

---

1160 **OECD Health Systems: Facts and Trends, supra** note 73 at 252, Table 7.1.1.
1161 *Ibid.* at 28, Table 4.
### Appendix 4

#### Table 3

**Inpatient Medical Care in Selected OECD Countries, 1991**

<table>
<thead>
<tr>
<th>Country</th>
<th>Beds per 1000 pop.</th>
<th>Beds per capita</th>
<th>Admission rate (% of pop.)</th>
<th>Average length-of-stay (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Netherlands</td>
<td>11.4</td>
<td>3.7</td>
<td>10.9</td>
<td>33.8</td>
</tr>
<tr>
<td>New Zealand</td>
<td>7.6</td>
<td>1.6</td>
<td>13.9</td>
<td>11.7</td>
</tr>
<tr>
<td>U.K.</td>
<td>5.9b</td>
<td>2.0</td>
<td>19.3</td>
<td>14.0</td>
</tr>
<tr>
<td>U.S.</td>
<td>4.7a</td>
<td>1.2</td>
<td>13.7a</td>
<td>9.1a</td>
</tr>
<tr>
<td>OECD (24 countries)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td>8.4</td>
<td>2.5</td>
<td>16.2</td>
<td>14.4</td>
</tr>
</tbody>
</table>

*a = 1990, b = 1989.*

---

**Inpatient Medical Care in Selected OECD Countries, 1991 (cont.)**

<table>
<thead>
<tr>
<th>Country</th>
<th>Occupancy rate</th>
<th>Employees per bed</th>
<th>Physicians per 1000 pop.</th>
<th>Physician contacts per capita</th>
</tr>
</thead>
<tbody>
<tr>
<td>Netherlands</td>
<td>88.6</td>
<td>2.2</td>
<td>2.5a</td>
<td>5.4</td>
</tr>
<tr>
<td>New Zealand</td>
<td>57.3</td>
<td>2.0d</td>
<td>1.9</td>
<td>3.8</td>
</tr>
<tr>
<td>U.K.</td>
<td>80.6e</td>
<td>2.6d</td>
<td>1.4</td>
<td>5.7b</td>
</tr>
<tr>
<td>U.S.</td>
<td>69.0</td>
<td>3.5</td>
<td>2.2</td>
<td>5.6</td>
</tr>
<tr>
<td>OECD (24 countries)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td>75.0</td>
<td>2.0</td>
<td>2.5</td>
<td>6.1</td>
</tr>
</tbody>
</table>


---

*\(^{1162}\)This table is a condensed version of that compiled by Schieber *et al.*, *supra* note 90 at 106, Exhibit 4, from OECD data and their own estimates.*
Appendix 4

Table 4
Health Status Indicators in Selected OECD Countries

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>6.5</td>
<td>8.9</td>
<td>7.4</td>
<td>8.3</td>
<td>9.4</td>
</tr>
</tbody>
</table>

No. of deaths per 1000 live births

| % babies with low birth weights | 4.9% | 7.1% | 6.4% | 5.9% | 5.4% |

Life exp. at birth for females

<table>
<thead>
<tr>
<th>Life exp. at birth for males</th>
<th>80.2 yrs</th>
<th>78.9 yrs</th>
<th>78.8 yrs</th>
<th>78.7 yrs</th>
<th>79.2 yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989</td>
<td>74.1 yrs</td>
<td>72 yrs</td>
<td>73.2 yrs</td>
<td>72.9 yrs</td>
<td>72.9 yrs</td>
</tr>
</tbody>
</table>

No. of yrs of potential life lost per 100000 fem. 1989

<table>
<thead>
<tr>
<th>No. of yrs of potential life lost per 100000 males 1989</th>
<th>2750</th>
<th>3877</th>
<th>3191</th>
<th>3748</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989</td>
<td>4247</td>
<td>6961</td>
<td>4929</td>
<td>6186</td>
</tr>
</tbody>
</table>

---

1163 Data taken from *ibid.* at 108. Exhibit 5 except for data on years of potential life lost which is taken from OECD Health Systems: Facts and Trends. *supra* note 73 at 67, Table 3.2.4.
1164 Female population aged 0–64 from all causes except suicide — 1989 figures.
1165 Male population aged 0–64 from all causes except suicide — 1989 figures.
### Appendix 5

**Changing Systems**

<table>
<thead>
<tr>
<th></th>
<th>Pre-1980</th>
<th>1980's</th>
<th>1990's</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Role of the Purchaser</strong></td>
<td>public or private indemnity insurer (most systems historically) no active purchaser</td>
<td>public insurers shift to block funding for hospitals -capping the total spent but otherwise a passive payer</td>
<td>proactive purchasing of all health care services -managed care -managed competition -internal markets</td>
</tr>
<tr>
<td><strong>Level of Competition</strong></td>
<td>-no competition between purchasers or providers</td>
<td>-no competition between purchasers or providers</td>
<td>-seeks to foster competition between providers (internal markets) or between purchasers offering managed care plans (managed competition)</td>
</tr>
<tr>
<td><strong>Paying Providers</strong></td>
<td>-fee for service payments (retroactive)</td>
<td>-prospective annual budgets for hospitals but still generally fee-for-service for physicians</td>
<td>-a variety of techniques but may pay on a capitation basis (a fixed sum per annum per person)</td>
</tr>
</tbody>
</table>
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IMAGE EVALUATION
TEST TARGET (QA-3)

1.0  1.1  1.25  1.4  1.6

1.0  1.1  1.25  1.4  1.6

150mm

6"

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