The Politics of Market-oriented Reforms:
lessons from
the U.K., the U.S. and the Netherlands

Presentation to the conference on

Is Two-Tier Care the Future?

Private Finance in Canadian Medicare

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Overview

- What do we mean by “market-oriented” reform or “privatization”?
  - Types of market-oriented reforms
- Reforms in England, the Netherlands and the US
- Private objectives and public values in health care
- Principal lesson: market-oriented reforms are more likely to draw private actors under the umbrella of state authority than to weaken the state

Types of market-oriented reforms

- Changing balance of *power:*
  - Increase weight of private capital vs public authority
- Changing mix of *instruments:*
  - Increase role of voluntary exchange, contracting vs command-and-control

- Can operate on either or both of the *delivery* and the *payment* sides of the provision of health care services

- A "two-tier" system typically refers to an increase in the weight of private capital in paying for health care services

Reforms in England

- Primarily focused on increased role of *contracting* **within** public sector
- Began under Thatcher
  - deliberate rejection of increased role for private insurance
  - Creation of "internal market" – split NHS hierarchy into purchasers and providers; gave providers a more independent base as "trusts."
  - Experimented with "GP fundholding"
- Continued under Labour
  - Greater independence for "Foundation Trusts"
  - More choice for patients
  - Contracting with "Independent Sector Treatment Centres" (*privately capitalized*) in niche areas
- Revised under Coalition
  - Greater independence for purchasers (Clinical Commissioning Groups)
  - But some moves toward re-integration now

Reforms in the Netherlands

- Principally focused on *payment (insurance)* side
- Over 20-year period, moved from a bifurcated system of compulsory social insurance + voluntary private insurance to a universal system of compulsory, formally private but heavily regulated and subsidized private insurance
  - half of premium revenue is collected by the state and flowed to insurers on a risk-adjusted basis
  - Half through community-rated premiums

Reforms in the United States

- Focused principally on *payment* side:
  - Regulation and subsidization of individual and small-group insurance market through "health insurance exchanges" (or "marketplaces")
  - Expansion of Medicaid: public coverage for low income individuals
  - Some increased regulation of employer-based insurance

- Materially affected <10% of the population, but placed compliance obligations on all: individual mandate; reporting requirements

Public vs Private Objectives: Risk

- Underlying assumptions of market-oriented reforms:
  - Re consumers: increased choice
  - Re providers: risk-bearing entrepreneurs allocate resources more efficiently than public-sector decision-makers without a "bottom line"
- But the risks/costs of failure may also be borne by consumers in the form of reduced or lower quality service
- Governments typically buffer private investors against risk, e.g.:
  - risk ceilings established for GP fundholders, provider trust debt limits under the internal market reforms in UK
  - Ad hoc support for deficit spending in England
  - gradual increase over twenty years in the risk exposure of insurers in the Netherlands
  - transitional risk-buffering mechanisms of reinsurance and "risk corridors" for insurers in US health insurance exchanges
  - Start-up funding for exchanges

Public vs Private Objectives: Profit

Once comprehensive universal public coverage is established, opportunities for private profit are typically limited in several ways:

- Demand is insufficient to sustain comprehensive private facilities
  - therefore parallel private providers tend to be concentrated in discrete areas – e.g. imaging, joint replacement, reproductive services, cataract surgery
  - Some private multiservice acute hospitals in England – but private spending is less than 10% of total spending on acute care, concentrated in the 30-64 age category (Nuffield Trust 2013)
- State-imposed limits: Buffering private investors against risk privatizes gains while socializing costs.
  - Response is to include regulations and payment schedules aimed not only at cushioning failure, but also at limiting profit – England (tariff regulation), Netherlands insurance regulation), US (loss ratios)
  - Such regulations can drive entrepreneurs to adopt convoluted strategies to preserve areas of profit (Circle Health in England; Achmea in Netherlands

Given limits on profit, why do private entrepreneurs engage?

- Market share:
  - Allows marketing of other lines (providing/insuring supplementary services; other types of insurance e.g. life, property
  - Increases bargaining power in insurer-provider negotiations, and political clout
- Growth: attractiveness on equity markets
- Leads to concentration of insurance markets; mergers and acquisitions create provider chains

Regulatory response:

- Need to ensure that supplementary services do not become conditions of expedited access or de facto risk selection
- Need to guard against cartelization
- Problems of accountability associated with complex corporate forms

Regulation also driven by permeability of public/private boundary

- Complications in private sector treatment revert to public
- Public component of practice/facility can become guaranteed platform for providers to offer additional care privately – e.g. NHS private beds, Independent Sector Treatment Centers
- Potential for privately-financed services to lead to expedited access to public – e.g. imaging; executive packages

Regulatory response: increased regulation of private providers:

- quality and safety
- Prohibitions/restrictions on expedited access to public sector (NHS consultant contract, Netherlands self-regulation)
- required contributions to public sector (NHS consultant contract requires disclosure and approval of private work; Canadian example -Saskatchewan MRI legislation)
- Lack of systematic evidence of effect

Increased regulation; multiplication and reconfiguration of regulatory bodies

- England:
  - NHS England (rules of purchasing, tariff); Monitor [now within NHS Improvement] (financial health, rules of competition among providers), Care Quality Commission (quality and safety of providers)

- Netherlands:
  - Dutch Healthcare Authority (tariff, rules of competition in insurance and provision markets); Healthcare Inspectorate (quality and safety of providers); Healthcare Insurance Board (rules of coverage, risk adjustment for insurers)

- US:
  - expanded role of Department of Heath and Human Services (rules for health insurance exchanges); health insurance exchanges (rules of coverage by insurers)

Upshot

- Formerly less regulated privately-financed entities now increasingly regulated:
  - England:
    - Care Quality Commission regulates *all* facilities; Monitor regulates *all* hospitals and clinics providing any NHS-funded care
  - Netherlands:
    - private insurers now held to same rules as (former) social insurers
  - US:
    - insurers participating in exchanges must observe same terms and conditions in off-exchange offerings

Implications for Canada?

- Material effect of an increased role for private finance may be marginal, depending on regulatory response

- But *symbolic* effect:
  - Affront to equity?
  - Spillover to other areas, given centrality of health care to "Canadian values?"
  - Erosion of support for public system?
    - No systematic evidence from other jurisdictions; some evidence of *increased* support

  - For discussion ……