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Colleen M. Flood\*

Accountability of Health Service  
Purchasers: Comparing Internal  
Markets and Managed  
Competition Reform Models

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*A number of countries, including the U.K., New Zealand, the Netherlands, and the U.S., have attempted to reform their health care systems using "internal market" or "managed competition" reform models. These models signal a departure from reliance on passive indemnity payers or insurers and require proactive purchasers to intervene actively and manage allocation decisions made by physicians. The author explores how these models will ensure the accountability of these new decision-makers to the citizens and patients they ultimately represent. Neither model is found to address accountability 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. It is argued that every type of health system (including Canada's) has long overlooked accountability and governance mechanisms. Decision-makers must have incentives to make decisions which strike the right balance between patients' needs and societal interest, and more generally between equity and efficiency. Solving this key problem demands the attention of policymakers, lawyers, and economists.*

*Plusieurs pays, dont le Royaume-Uni, la Nouvelle-Zélande, les Pays-Bas et les États-Unis, ont essayé de réformer leurs systèmes de santé sur le modèle du «marché domestique» ou de la «concurrence dirigée». Ces modèles marquent un écart du système qui dépendait des paiements des indemnités par des payeurs passifs ou par des assureurs et ils requièrent l'intervention active des acheteurs et leur implication au niveau de la gestion des décisions d'affectations prises par les médecins. L'auteur explore comment ces modèles assureront la responsabilité financière des nouveaux décideurs vis-à-vis les citoyens et les patients qu'ils représentent en fin de compte. Aucun de ces modèles traite suffisamment la question de la responsabilité financière des décideurs. Cependant, le modèle de concurrence dirigée offre la perspective d'un marché personnalisé, d'une voix politique et de mécanismes règlementaires pour présenter le mélange d'incitations le plus efficace. Il a été avancé que chaque modèle de système de santé (incluant celui du Canada) a longtemps ignoré les mécanismes concernant la responsabilité financière et la gérance. Les décideurs doivent avoir des incitations pour prendre des décisions qui créent le bon équilibre entre les*

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*besoins des patients et les intérêts sociaux et plus généralement entre l'équité et l'efficacité. Résoudre ce problème majeur requiert l'attention des politiciens, des avocats et des économistes.*

### *Introduction*

Over the course of the last decade, nearly every major OECD country has either proposed or implemented health care reform.<sup>1</sup> 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. 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 by physicians are cost-effective or even effective.<sup>2</sup> This problem is seen to stem 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. Allocation decisions have been left to physicians as both public and private insurers have acted, historically, as passive "indemnity insurers," reimbursing providers for the costs of all services supplied on a fee-for-service basis. Thus the concern has arisen that the present allocation of resources, both across health needs and between health services used in response to those needs, has been defined by the medical profession. It is argued this has resulted in more expenditures on acute care and expensive technology than is optimal from society's perspective.

In a number of countries, such as the U.K., New Zealand, the Netherlands, and the U.S., there have been recent shifts towards the use of market-like forces in an attempt to improve the efficiency of their respective health care systems.<sup>3</sup> The reform models, "managed competition," "managed care" and "internal markets" (explained below) signal

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1. Organization for Economic Co-operation and Development, *The Reform of Health Care Systems: A Review of Seventeen OECD Countries*, (Paris: OECD, 1994) (hereinafter *OECD 1994 Review of Seventeen Countries*).

2. For example, R. G. Evans, "Going for the Gold: The Redistributive Agenda Behind Market-Based Health Care Reform" (1997) 22 *J. of Health Pol. Policy & 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.

3. Other countries experimenting with market-oriented reform include Finland, Sweden, countries comprising the former U.S.S.R., Germany and Israel.

a departure from reliance on passive indemnity insurers and require proactive purchasers (be they government-appointed authorities or private insurers) to intervene actively in physicians' allocation decisions. The objective is to create greater pressure on the demand or purchasing side than has been the case historically, so as to realize a more appropriate balance between societal and patient needs in the allocation of resources and to ensure the supply of the most cost-effective service in response to a particular need. Despite greater reliance on market-like forces, the ultimate goal of managed competition and internal market reform models is still a redistributive one, namely to ensure access by all citizens to a comprehensive range of health services with allocation occurring on the basis of need rather than ability to pay. Thus market tools are harnessed as a *means* to achieve a social justice end. This latter approach is clearly distinguishable and should not be confused with the present U.S. - style system where, despite government programs for the poor and the aged, a significant proportion of health care resources is distributed on the basis of ability to pay.

By comparison, Canada's approach to reform still reflects that taken by most OECD countries throughout the 1980s, namely to achieve cost containment by reducing the number of inputs into the system. Thus reform is primarily directed towards reducing the numbers and distribution of physicians and other health providers, the numbers of hospitals and hospital beds, and the amount and distribution of technology.<sup>4</sup> Canada's policies are based upon the assumption that the more hospitals, health providers, and technology in a system of full insurance, the greater the increase in cost irrespective of need or outcome.<sup>5</sup> This approach, as an OECD report notes, acknowledges the "limited effectiveness of market forces . . . and eschews policies such as managed competition and the creation of internal markets."<sup>6</sup> However, this cost containment

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4. As recent examples of this sort of reform see the Health Services Restructuring Commission's *Ottawa Health Services Restructuring Report* (February 1997) and *Metropolitan Toronto Health Services Restructuring Report* (March 1997). In the latter report, the Commission recommends the outright closure of nine hospital sites in Metropolitan Toronto, which is estimated to result in a reduction of acute care beds from 6,173 (as at March 31, 1996) to 4,414.

5. 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 and 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 *J. of Health Econ.* 347.

6. *OECD 1994 Review of Seventeen Countries*, *supra* note 1 at 103.

approach is a relatively crude regulatory tool and provides no incentives to rethink and improve the range, mix, and quality of health services supplied. Rather than improving the efficiency with which services are delivered, health providers may simply shift costs. This outcome may take a variety of forms in Canada's health system, including shifting costs to the pharmaceutical sector which is not subject to government cost control (as 66 percent of it is financed by private funding),<sup>7</sup> longer waiting times for publicly funded services,<sup>8</sup> or requiring unpaid family members to provide home-care services.<sup>9</sup>

The experience of the U.K. and New Zealand (both of which spend significantly less on health as a percentage of GDP than Canada) suggests that simply restricting the flow of resources into the system and leaving allocation decisions to health providers operating under hard budgets will result in growing waiting lists and times, growing dissatisfaction with the health system, and cost-shifting.<sup>10</sup> Moreover, 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*. In other words, simply tightening budgets may not result in better allocation decisions but more adroitness in cost-shifting to other payers, to patients, or to society at large. Capping health care expenditures can only be a short-term answer. In the longer term, a system must focus (at the macro level) on the decision-making processes whereby health needs are prioritized so as to balance societal interest with patients' needs. At the micro level, the system must be organized to ensure the selection of the most cost-effective service to satisfy a particular need and to ensure the delivery of quality health services at least cost.

Increasingly, there are calls in Canada to introduce "managed care" in order to make health providers sensitive to and accountable for the

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7. The National Forum noted that expenditures per person on drugs, adjusted for inflation, more than doubled between 1975 and 1994 from \$108 to \$232 per person and that drug expenditures increased faster than any other major category of health care; "Directions for a Pharmaceutical Policy in Canada" in National Forum on Health, *Canada Health Action: Building on the Legacy, Vol. II, Synthesis Reports and Issues Papers* (Ottawa: National Forum on Health, 1997) at 3.

8. For figures on growing waiting lists in Canada see C. Ramsay and M. Walker, *Waiting Your Turn: Hospital Waiting Lists In Canada, 6th ed.* (Vancouver: The Fraser Institute, 1996).

9. See for example, 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.

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

costs of the health services they provide or recommend.<sup>11</sup> As I will demonstrate, although Canada has to date eschewed what are viewed as more “market” reforms such as internal market and managed competition reform, there is in fact a convergence occurring between these types of reform and managed care reform. Similar problems arise in all three types of reform and Canadian policymakers can clearly benefit from analyzing critically the experiences of other countries to date.

In this paper I analyze and compare internal market and managed competition reform models as implemented or proposed in the U.K., New Zealand, the Netherlands, and the U.S. A variety of important issues arise from such a cross-comparison. This paper focuses particularly on the accountability of purchasers (be they government-appointed authorities or competing private insurers) to the citizens they ultimately represent. Accountability and governance issues in general have long been overlooked in health systems, yet such issues are vital from the perspective of ensuring and improving the performance of decision-makers.

Improving accountability should improve the quality of decision-making by reducing agency costs between decision-makers and the citizens they represent. Donahue argues that concerns with efficiency are, at their base, merely part of a concern for the more fundamental issue of accountability.<sup>12</sup> 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.<sup>13</sup> This paper is primarily concerned with ensuring accountability through political and market mechanisms although brief reference is made to professional accountability. First, I 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, where there are insufficient incentives to ensure that purchasers are responsive to the citizens they represent. Next, I 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. Finally, I 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.

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11. See for example, the Nova Scotia government's proposal to pay doctors on a capitation basis: *Good Medicine: Securing Doctors' Services for Nova Scotians* (Halifax: Nova Scotia Department of Health, 1997).

12. J. D. Donahue, *The Privatization Decision: Public Ends, Private Means* (New York: Basic Books, 1989) at 10.

13. E. J. & L. L. Emanuel, “What Is Accountability In Health Care?” (1996) 124 *Ann. Intern. Med.* 229.

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 accountability and efficiency. Citizens must choose an insurer or purchaser offering a managed care plan that best suits their needs and, if dissatisfied, may “exit” to another insurer or 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.

Although managed competition and internal market models are *prima facie* different, there is arguably 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.<sup>14</sup> In such a case, the group of providers 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 and becoming less compartmentalized.<sup>15</sup>

### I. *The Reform Models*

The language of health care reform is often confusing and there seems to be a small cottage industry inventing phrases and acronyms for the emerging new arrangements between insurers, purchasers, providers and patients. For political reasons, dissimilar reform initiatives may be labelled by the same name.<sup>16</sup> Thus it is important to clarify at the outset what I mean by the terms “internal market reform”, “managed competition reform” and “managed care”.

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14. A lump sum per person to cover all health services for that person over a given period regardless how many services were actually rendered to that person.

15. W. P. M. M. van de Ven, F. T. Schut, & F. F. H. Rutten, “Forming and Reforming the Market for Third-Party Purchasing of Health Care” (1994) 39 Soc. Sci. Med. 1405.

16. 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.” T. R. Marmor, *Understanding Health Care Reform* (New Haven: Yale University Press, 1994) at 12.

### 1. *Internal Market Reform and the Purchaser/Provider Split*

Recent reforms in both 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”), first announced in 1989, were implemented through the *National Health Service and Community Care Act 1990*.<sup>17</sup> In New Zealand, the then Minister of Health released his proposals for internal market reform in 1991,<sup>18</sup> many of which were implemented pursuant to the *Health and Disability Services Act 1993*.<sup>19</sup> In both 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 countries. Prior to reform, health authorities were both purchasers (as they bought all publicly funded hospital and secondary services) and 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 government purchasers.<sup>20</sup>

An exception to the purchaser/provider split in the U.K.’s internal market are “GP Fundholders,” of which there are over 3500. Fundholders receive public funding, in the form of capitated budgets, with which to finance their own services and to buy drugs, diagnostic tests and x-rays, outpatient services and elective surgical services, on behalf of the patients

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17. (U.K.), c. 19 [hereinafter *NHS 1990 Act*].

18. S. Upton, *Your Health and the Public Health — A Statement of Government Health Policy* (Wellington: Minister of Health, July 1991) at 11-19.

19. (N.Z.), No. 22 [hereinafter *NZ Health 1993 Act*].

20. 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 largely to be so.



enrolled with them. Thus the purchaser and provider roles are combined in one enterprise. Similarly, in New Zealand "Independent Practice Associations" ("IPAs") are exceptions to the purchaser/provider split. IPAs 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.<sup>21</sup>

On 8 December 1997, the new Labour government in the U.K. released a White Paper detailing further reforms in the U.K.<sup>22</sup> It is beyond the scope of this article to consider in depth the content of these reforms. The reforms provide for the abolition 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.

## *2. Managed Competition Reform*

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; they 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 the allegiance of customers 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.<sup>23</sup> In the Netherlands, what became known as the Dekker Com-

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21. 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; see L. Malcolm & M. Powell, "The Development of Independent Practice Associations and Related Groups in New Zealand" (1996) 109 N.Z. Med. J. 184 at 186 noting that "IPAs were viewed as vehicles for protecting the status of general practice in the face of considerable uncertainty."

22. See also "The New NHS," A White Paper, 8 Dec. 1997, available at <http://www.officialdocuments.co.uk/document/doh/newnhs/contents.htm>.

23. For a fuller description of managed competition/managed care contracting see A. C. Enthoven, "Consumer-Choice Health Plan (First of Two Parts): Inflation and Inequity in Health Care Today: Alternatives for Cost Control and an Analysis of Proposals for National Health Insurance" (1978) 298 New Eng. J. Med. 650; "Consumer-Choice Health Plan (Second of Two Parts): A National-Health-Insurance Proposal Based on Regulated Competition in the Private Sector" (1978) 298 New Eng. J. Med. 709. More recently, see A. C. Enthoven, "The History and Principles of Managed Competition" (1993) 12 Health Aff. 24. See, however,

mittee (named after its chair Dr. W. Dekker), produced a report in March 1987 which proposed reform of the Dutch health care system following the managed competition model.<sup>24</sup> The reform plan has changed several times since 1987 and implementation has been incremental and is still ongoing.<sup>25</sup> There are similarities between the Dutch reforms and proposals for reform in Russia, Israel and Germany.<sup>26</sup> A version of managed competition was also unsuccessfully proposed by President Clinton in 1993 as a means of reform of the U.S. system.<sup>27</sup>

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 willingness to pay.<sup>28</sup> 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' primary function under this model would be purchasing health services, and they would behave quite differently from present private insurers. Thus, although I will use the term "purchasers" for convenience, it should be remembered that in the context of managed competition reform, they are really "insurers/purchasers" in that they are both purchasing and risk-bearing functions.

In a managed competition system, purchasers would not receive premiums directly. Instead, "sponsors" (who would probably be government-appointed bodies) would receive money either direct from central government<sup>29</sup> 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 or services. Premiums paid on an income-related basis or money received from

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U. E. Reinhardt, "Lineage of Managed Competition" Spring (II) issue (1994) 13 Health Aff. 290 who traces the managed competition idea back to H. M. and A. R. Somers at a presentation in 1971.

24. Advies Van De Commissie Structuur en Financiering Gezondheidszorg (Commission on the Structure and Financing of Health Care), *Bereidhed tot Verandering* (Willingness To Change), ('s Gravenhage: Distributiecentrum Overheidspublicaties, 1987) [hereinafter *Dekker Report*].

25. *OECD Health Policy Studies No. 2, The Reform Of Health Care: A Comparative Analysis of Seven OECD Countries* (Paris: OECD, 1992) at 97 and *Factsheet: Health Care Reform in the Netherlands* (Ministry of Welfare, Health and Cultural Affairs, Fact Sheet V-5-E 1993) at 5.

26. W. P.M.M. van de Ven, et al., "Risk-Adjusted Capitation: Recent Experiences in the Netherlands" (1994) 13 Health Aff. 120 at 121.

27. See White House Domestic Policy Council, *The Clinton Blueprint: The President's Health Security Plan* (New York: Times Books, 1993) [hereinafter *Clinton Blueprint*].

28. 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 2 at 427.

29. In which case the system would be financed through general taxation.

central government are pooled under the auspices of the sponsor. Each individual in the system would periodically (probably annually or biannually) choose their particular purchaser and the sponsor would facilitate this process, making sure that 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 purchaser. The amount paid should reflect the risk-profile of the particular individual so that purchasers are fairly compensated for the risks they cover. It is predicted that, as a consequence, purchasers would have incentives to compete on the cost and quality of services ultimately provided to their enrollees, and in turn would 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.<sup>30</sup>

### 3. *Managed Care*

A managed care arrangement is any contractual or organizational arrangement whereby a purchaser (who may be the government or a private insurer or an employer or a consortium of hospitals or physicians) attempts to influence the price, volume, and quality of health services supplied.<sup>31</sup> Managed care techniques or arrangements can occur in any type of system, be it the Canadian or U.S. model or the internal market or managed competition model.

Managed care reflects a shift from public or private insurers passively reimbursing providers for every service performed or reimbursing policy-holders for all medical expenses incurred. Managed care may involve insurers 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

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30. P. Newman, "Interview With Alain Enthoven: Is There Convergence Between Britain And The United States In The Organization Of Health Services" (1995) 310 *Br. Med. J.* 1652.

31. See generally D. Mechanic, "Managed Care: Rhetoric And Realities" (1994) 31 *Inquiry* 124 and R. J. Arnould et al., "The Role of Managed Care In Competitive Policy Reforms" in R. J. Arnould, R. F. Rich & W. D. White, eds., *Competitive Approaches to Health Care Reform* (Washington, DC: Urban Institute Press, 1993). The American Medical Association defines managed care as "the control of access to and limitation on physician and patient utilization of services by public or private payers or their agents through the use of prior and concurrent review for approval of or referral to service or site of service, and financial incentives or penalties."— as cited by J. K. Inglehart, "Health Policy Report: The American Health Care System" (1992) 326 *New Eng. J. Med.* 962 at 965.

health needs. It may involve 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.<sup>32</sup> This method of reimbursement is known as capitation. In managed care plans, purchasers may choose to be vertically-integrated with health care providers (i.e. the 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 purchaser has elected to contract with or is integrated with, or a surcharge is imposed on patients who choose providers outside of those listed.<sup>33</sup>

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 seek to shift market power from health care providers to themselves. This phenomenon is likely to have far-reaching implications for the future of the U.S. health care system. Enthoven notes that managed care plans (now often referred to by the new buzz-words of "integrated financing and delivery systems") come in a variety of types.<sup>34</sup> Some own their own hospitals, some have preferred providers or close relationships with particular hospitals, and others enter into arm's length contracts.

In the U.S., managed care developments are ad hoc and are not part of a coordinated 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.<sup>35</sup> There is no specific government regulation at the federal level to ensure competition between managed care plans on the basis of price and quality.<sup>36</sup> In fact, as a result of competition the number of managed care plans who community-rate (i.e. cross-subsidize premiums from low-risk to high-

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32. See J. K. Inglehart, "Health Policy Report: Physicians and the Growth of Managed Care" (1994) 331 *New Eng. J. Med.* 1167.

33. M. A. Rodwin, "Conflicts in Managed Care" (1995) 332 *New Eng. J. Med.* 604.

34. A. C. Enthoven, "On the Ideal Market Structure for Third-Party Purchasing of Health Care" (1994) 39 *Soc. Sci. Med.* 1413 at 1414.

35. In 1995, 40.6 million people were uninsured, more than 10.5 million of whom were under the age of 19 K. E. Thorpe, "Incremental Approaches to Covering Uninsured Children: Design and Policy Issue" (1997) 16 *Health Aff.* 64 at 65.

36. However, in 1996 the U.S. federal government did enact the *Health Insurance Portability and Accountability Act* 1996, PL 104-191 August 21, 1996, 110 Stat 1936 (HR 3103) §301 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 for those who already hold health insurance.

risk individuals) has declined.<sup>37</sup> 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 and it would be largely progressively financed.

## II. *Agency and Public Choice*

Enhancing accountability was cited as a goal of internal market reform in the U.K. and New Zealand.<sup>38</sup> Although accountability is often cited as a key goal it is often unclear what exactly is meant by accountability. To whom and for what is a decision-maker accountable?

In the political sphere, Donahue defines accountability as existing 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.”<sup>39</sup> 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.<sup>40</sup>

Agency costs arise where 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 match those of the principal.<sup>41</sup> Factors reducing agency costs between shareholders and managers in publicly-traded companies are not generally present in the public sector.<sup>42</sup> Consequently, agency

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37. J. Gable, “Ten Ways HMOs Have Changed During the 1990s” (1997) 16 *Health Aff.* 134.

38. 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).

39. Donahue, *supra* note 12 at 23.

40. *Ibid.* at 10.

41. M. J. Trebilcock, *The Prospects for Reinventing Government* (Toronto: C. D. Howe Institute, 1994) at 8.

42. See E. Fama, “Agency Problems and the Theory of the Firm” (1980) 88 *J. Poli. Econ.* 288 at 291-293.

problems are a great deal more complicated in the public sector than within private firms, particularly because the burden of any inefficiency is diffused over many individuals.<sup>43</sup>

Agency cost problems are closely related to public choice analysis.<sup>44</sup> 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.”<sup>45</sup> The theory extends to the actions of politicians, public servants, and interest groups in the public sphere the assumption, made by neo-classical economists, that actors in the private market are principally motivated by self-interest. McAuslan argues that public choice theorists are, in fact, contemptuous of democracy as it has developed in the twentieth century.<sup>46</sup> Although many examples of behaviour supporting public choice theory can be found in the literature,<sup>47</sup> examples of governments and public servants not acting out of self-interest (or at least appearing not to) may also be found.<sup>48</sup> This suggests that public decision-makers cannot always be simply assumed to be acting out of self-interest and that what decision-makers perceive as being in their own self-interest may be a much more complicated matrix of factors than simply financial considerations or building or maintaining political power.

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.<sup>49</sup> This does not mean that public provision or

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43. For a further discussion see C. M. Flood, “Prospects for New Zealand’s Reformed Health System” (1996) 4 Health L. J. 87 at 95.

44. For an introduction and overview of the theory see I. McLean, *Public Choice: An Introduction* (Oxford: Basil Blackwell, 1987).

45. J. Buchanan, *Liberty, Markets and State: Political Economy in the 1980s* (Brighton: Wheatsheaf, 1986) at 19.

46. P. McAuslan, “Public Law and Public Choice” (1988) 51 Mod. L. Rev. 681 at 689; and see M. Kelman, “On Democracy-Bashing: A Sceptical Look at the Theoretical and ‘Empirical’ Practice of the Public Choice Movement” (1988) 71 Va. L. R. 199 at 268; D. A. Farber, “Democracy and Disgust: Reflections on Public Choice” (1991) 65 Chi. Kent L. Rev 161; and D. Farber & P. Frickey, *Law & Public Choice: A Critical Introduction* (Chicago: University of Chicago Press, 1991).

47. In 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, *ibid.* at 689.

48. For 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.

49. G. Brennan & J. M. Buchanan, “Is Public Choice Immoral? The Case For The ‘Noble’ Lie” (1988) 74 Va. L. Rev. 179 at 187-88 argue that public choice theory becomes problematic

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. 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.

How do we operationalize these general observations in a health allocation system? On the purchasing side, what combination of incentives will solve the difficult agency problem of ensuring that purchasers balance society's interests with those of individual patients? Let us begin by looking at the question of to whom and for what the government-appointed purchasers in the U.K.'s and New Zealand's reformed health systems are accountable. 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.

### III. *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 against other areas and requires recognition that, e.g., improved housing and nutrition, and increased employment opportunities may have as important an effect on health outcomes as the consumption of health services;<sup>50</sup>

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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.

50. 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).

- 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 production of services at least cost;
- 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., it must decide how much to spend on health service relative to, for example, education, defence, and tax reductions. 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.<sup>51</sup> President Clinton's (now defunct) proposal for reform did not leave cost

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51. For a discussion see W. P. M. M. van de Ven, "Regulated Competition In Health Care: With Or Without A Global Budget" (1995) 39 *Eur. Econ. Rev.* 786.



control to the workings of a regulated market and instead stipulated that managed competition take place under a global budget.<sup>52</sup> 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.<sup>53</sup> It is unclear whether this reluctance to dismantle price and total budget caps arises because the administrations of these respective countries do not really believe that managed competition will work as theoretically envisaged, or because the overriding concern is to control increases in government expenditures even though such increases may be (possibly) allocatively efficient.

Once the 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, the onus is essentially on them to purchase primary and secondary health care services to benefit the people they represent within their allocated budget.<sup>54</sup> In contracting for health services, these government-appointed purchasers are expected to fulfill 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.<sup>55</sup> Longley notes, however, that there are no constitutional mechanisms for ensuring that the deliberations of the Commission and similar bodies are taken into account and action taken as a result.<sup>56</sup> In New Zealand, the Audit Office audits annually the Regional Health Authorities which must comply with the requirements of the *Public Finance Act*.<sup>57</sup> These sorts of measures ensure a degree of accountability by reducing opportunities for fraudulent use of public money, 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 specify clearly the goals and objectives of purchasers, both in governing legislation and in transparent management contracts. This should facilitate monitoring by the central government of purchasers' performance relative to those

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52. *The Clinton Blueprint*, *supra* note 27 at 102-110.

53. See W. van de Ven & F. Rutten, "Managed Competition In The Netherlands: Lessons From Five Years Of Health Care Reform" (1995) 18 *Aust. Health Rev.* 9.

54. 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.

55. *NHS 1990 Act*, *supra* note 17.

56. D. Longley, *Health Care Constitutions* (London: Cavendish Publishing Ltd., 1996) at 12.

57. (N.Z.), 1989, No. 142.

objectives. Moreover, if purchasers' objectives are clearly and publicly articulated then because of the potential for adverse publicity it is difficult for the purchasers and for central government (as their political masters) to retreat from these objectives in pursuit of their own self-interest. 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 *National Health Service and Community Care Act* and with respect to the application of government money.<sup>58</sup> 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.<sup>59</sup> A "Code of Accountability" is intended to serve as an informal contract between the central government and the Health Authorities, but the Code does not create any statutory duties.<sup>60</sup> The statutory objectives of New Zealand's Regional Health Authorities are couched in general terms, but they are specifically required to meet the Crown's objectives as notified to them.<sup>61</sup> Every such notification is required to be published in the Gazette and tabled in the House of Representatives.<sup>62</sup>

Both in New Zealand and the U.K. the central government publishes annual guidelines setting out the purchasers' objectives in general terms. The U.K. government issues in June of each year a 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 the 1997/98 year.<sup>63</sup> In the longer term, performance will be assessed under three headings: equity, efficiency, and responsiveness.<sup>64</sup> The New Zealand

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58. *NHS 1990 Act*, *supra* note 17, s. 17 & s. 97 (7) (as amended by the *Health Authorities Act* (U.K.) 1995, c. 17, s. 47.).

59. *Ibid.*, s.18.

60. A. Belcher, "Codes of Conduct and Accountability for NHS Boards" (1995) Pub. L. 288; Longley, *supra* note 56 at 121.

61. *NZ Health 1993 Act*, *supra* note 19, s.10.

62. *Ibid.*, s.8(5).

63. See *Priorities And Planning Guidance For The NHS: 1997/98* (Leeds: NHS Executive, June 1996) (hereinafter *U.K. Planning Guidance 1997/98*).

64. Six medium term priorities were set for the 1997/98 year: to work towards developing a primary care led system; to review and maintain progress on the effective purchasing and provision of comprehensive mental health services; to improve the clinical and cost effective

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 the central government. In the 1996/97 policy document, the government set out six principles to provide a framework for purchasing decisions: equity, effectiveness, efficiency, safety, acceptability, and risk management.<sup>65</sup> The government specifies more detailed objectives within those general principles.<sup>66</sup>

It is not sufficient simply to fix goals and objectives — the results must be monitored. Propper notes that monitoring efforts in the U.K. have been 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.<sup>67</sup> 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 Regional Health Authorities are meeting their objectives.<sup>68</sup> To date, however, the central government monitoring unit has been able only to describe current utilization patterns, and there has yet to be any comprehensive evaluation or attempted comparison of purchasers' performances.<sup>69</sup> It is signifi-

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ness of services; to give greater voice and influence to users; to ensure that integrated services are in place to meet the continuing health care needs of the elderly, disabled, vulnerable people, and children; and to encourage 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.

65. Minister of Health, *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) [hereinafter *1996/97 N.Z. Policy Guidelines*] at 11-12.

66. 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, where a choice of effective services for addressing a given health problem exists, to choose the most cost-effective service; *ibid.* at 11.

67. C. Propper, "Agency and Incentives in the NHS Internal Market" (1995) 40 Soc. Sci. Med. 1683 at 1685.

68. 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* (Wellington: Ministry of Health, 1995) [hereinafter *Performance Report*] at 10-11.

69. *Ibid.* at 142.

cantly easier to focus on and pursue those goals and objectives that are easily measurable, such as increased turnover or reduced waiting lists, 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,<sup>70</sup> it would seem important that central governments should give weight to a broad range of performance indices and not simply focus on those that are easiest to measure.

In addition to setting goals and monitoring results, 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.<sup>71</sup> 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.<sup>72</sup> The lack of attention to incentives that influence purchasers is contradictory given that a proactive purchaser is essential to the internal market model, which relies on purchasers to contract astutely 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.<sup>73</sup> 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 incentives, skills and resources necessary to make decisions over time that strike the right balance between patients' needs and societal interest and between equity and efficiency.

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70. A. Mason & K. Moran, "Purchaser-Provider: The International Dimension" (1995) 310 *Br. Med. J.* 231.

71. P. Allen, "Contracts in the National Health Service Internal Market" (1995) 58 *Mod. L. Rev.* 321 at 339.

72. See Flood, *supra* note 43 at 98.

73. 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.

Unlike private firm managers, managers within a government-appointed purchaser do not bear the risk of job loss associated with insolvency or takeover. The central government could, however, negotiate management contracts that tied salaries of managers to a comprehensive range of performance measures.<sup>74</sup> A further possibility might be for government to request tenders for management contracts.<sup>75</sup> The greatest difficulty with all incentives designed to enhance the performance of purchasers lies in the difficulty of measuring and comparing performance.<sup>76</sup> Smith notes that 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.”<sup>77</sup> 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.<sup>78</sup> 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 well-crafted incentives, the 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.<sup>79</sup> 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 occurs 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. It is undoubtedly an important mechanism and, historically, has been relied on as the key if not

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74. See Flood *supra* note 43 at 98.

75. Propper, *supra* note 67 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.

76. See Flood *supra* note 43 at 98-99.

77. P. Smith, “Information Systems and the White Paper Proposals” in A. J. Culyer, A. K. Maynard & J. W. Posnett, eds., *Competition in Health Care: Reforming the NHS* (Hampshire: MacMillan Press, 1990) at 119.

78. Flood, *supra* note 43 at 98.

79. *Ibid.* at 99.

only means by which to ensure the quality and effectiveness of health services supplied. Professional accountability may, arguably, have protected patients from the worst effects of severe and quickly implemented cost-cutting initiatives in many jurisdictions. However, self-regulation 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 with regard to the range and quality of health services supplied.<sup>80</sup> Clearly, professional accountability is being increasingly questioned in terms of its effectiveness as a regulatory tool and other measures to ensure accountability deamd on consideration.

#### IV. *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.<sup>81</sup> The first concept he describes is that of "exit," which is a means of ensuring the accountability of decision-makers through a competitive market. As I have noted elsewhere,

when a dissatisfied customer shifts custom from one firm to another (exits), she not only improves her own personal welfare, but if sufficient other dissatisfied customers exit, then this action in aggregate sends a clear signal to the firm from which customers are exiting that it must remedy inefficiencies or become insolvent. 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 producer collusion.<sup>82</sup>

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

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80. Evans has made the point for many years that all money spent on health services in one form or another results in income for health service providers; R. G. Evans, *Strained Mercy – The Economics of Canadian Health Care* (Toronto: Butterworths, 1984) at 281 and 13 years later see Evans, *supra* note 2 at 440.

81. A. O. Hirschman, *Exit, Voice, and Loyalty – Responses to Decline in Firms, Organizations, and States*, (Cambridge, Mass.: Harvard University Press, 1970).

82. Flood, *supra* note 43 at 100.

processes.<sup>83</sup> 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 buy or the organizations to which they belong.”<sup>84</sup> 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 quality begins to decline.<sup>85</sup>

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.<sup>86</sup> 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.<sup>87</sup> 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. Thus, these citizens rely upon voice to ensure the performance of government-appointed purchasers. The mechanism of voice is 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.<sup>88</sup> 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

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83. Hirschman, *supra* note 81 at 30-43.

84. *Ibid.* at 40.

85. *Ibid.* at 51.

86. *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.*”

87. *Ibid.* at 24.

88. See C. M. Flood, “Will Supplementary Private Insurance Reduce Waiting Lists?” (1996) 11 Canadian Health Facilities Law Guide 1.

which to ensure the performance of purchasers offering managed care plans.

### V. *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 examine five mechanisms to improve voice: devolution, election, consultation, charters of rights and Ombudspersons, and capture of the politically influential.

#### 1. *Devolution*

The first question to consider is what opportunities citizens have to influence their purchaser's decision-making processes. This too is an important question for Canada as a recent popular reform initiative in every province except Ontario has been to devolve responsibility for health care allocation to regional boards.<sup>89</sup> In New Zealand there are four Regional Health Authorities, each responsible for populations of between approximately 680,000 and 1 million people. As of 1 July 1997 there is one national purchasing agency responsible for the whole population of 3.6 million.<sup>90</sup> 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).<sup>91</sup>

The large size of New Zealand's Regional Health Authorities and the U.K.'s new Health Authorities will be conducive to rationalizing and coordinating the purchase of health services, but 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

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89. See J. Lomas, J. Woods & G. Veenstra, "Devolving Authority for Health Care in Canada's Provinces: An Introduction to the Issues" (1997) 156 *Can. Med. Assoc. J.* 371.

90. 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>.

91. News Release by the Department of Health, 96/106, 1 April 1996, "Changes To Health Service Structure Release £139 Million For Patient Care".



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.<sup>92</sup> 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 a particular problem in areas which are not densely populated, in which case the prospect for competition on the supply side seems remote. If the large size of purchasers renders voice ineffective as an accountability-enhancing mechanism, but 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 the central government to various regional agencies. The public's attention is fragmented between central government, purchasers, and public and private providers. It may be difficult to know to whom complaints and concerns should be addressed, rendering voice 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 be avoided successfully 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 of hard decisions for the central government.<sup>93</sup> 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.<sup>94</sup> This

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92. 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 Pol. Policy & Law 660. In those countries where government expenditures account for the great majority of total health expenditures, government has been able to use its monopsony purchasing power to control costs; Health Care Study Group Report, "Understanding the Choices in Health Care Reform" (1994) 19 J. of Health Pol. Policy & Law 499.

93. 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."

94. A. J. Culyer & A. Meads, "The United Kingdom: Effective, Efficient, Equitable?" (1992) 17 J. Health Pol. Policy & Law 667 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

politicization of the health system is reinforced by the central government's continued interference in the operation of both purchasers and providers in both New Zealand and the U.K.<sup>95</sup>

In addition to the 100 Health Authorities in the U.K., there are over 3,500 Fundholders involving around 10,000 general practitioners, who act as purchasers for approximately 40% of the population for a limited range of health services.<sup>96</sup> Fundholding is a form of managed care and Fundholders receive a capitated budget with which to buy drugs and elective surgical services.<sup>97</sup> Paying by means of capitation and transferring financial risk to health providers is essentially a way of devolving purchasing responsibility to a local level. 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 specialty 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. 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 patient's 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

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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 Public Sector 11. See also Longley, *supra* note 56 at 123.

95. For examples in New Zealand see Flood *supra* note 43 at 105, n. 72.

96. See generally the Audit Commission, *What The Doctor Ordered: A Study Of GP Fundholders In England And Wales* (London: HMSO, 1996) (hereinafter *What the Doctor Ordered*). See also "The NHS: A White Paper" *supra* note 22.

97. *Ibid.* 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.

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.) result in the benefits of Fundholding outweighing the costs. It is 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 elected to become Fundholders at the commencement of the reforms. As the number of Fundholders has grown, the reports on Fundholders' performances have been far more mixed.<sup>98</sup>

There is a concern that the rapid growth of Fundholding has diminished the Health Authorities' power to plan and coordinate the delivery of services to a large population.<sup>99</sup> Concern has also been raised regarding a perceived lack of accountability of GP Fundholders.<sup>100</sup> 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.<sup>101</sup> 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.<sup>102</sup> It would seem more appropriate for the NHS Executive (i.e., the central government) to

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98. See in general *What The Doctor Ordered*, *supra* note 96.

99. J. Shapiro & C. Ham, "The New Health Authorities" (1996) 2: 2 Health Services Management Centre Newsletter (University of Birmingham) 1.

100. A. Harrison, ed., King's Fund Policy Institute, *Health Care U.K. 1994/95: An Annual Review of Health Care Policy*, (Bristol: J. W. Arrowsmith, 1995) [hereinafter "*Health Care UK 1994/95*"] 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."

101. *What The Doctor Ordered*, *supra* note 96 at 63 and generally 64-79.

102. See *An Accountability Framework For GP Fundholders* (March 1995) as quoted by Longley, *supra* note 56 at 132.

regulate directly the activities of both Health Authorities and Fundholders.<sup>103</sup>

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 switch readily. There is no evidence that patients are moving between Fundholders or from non-Fundholding physicians to Fundholders for reasons other than changing address.<sup>104</sup> The advantages and disadvantages of exit as an accountability-enhancing mechanism are more fully explored in the next section of this paper. It should be noted, however, that in terms of competition between purchasers, Fundholders have a competitive advantage over Health Authorities for a number of reasons. Firstly, Fundholders have not had to compete with respect to a full range of services. Secondly, 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.<sup>105</sup> Thirdly, individuals can only "exit" with their share of public funding to the Health Authority if they can find a general practitioner to enroll with who 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.<sup>106</sup> Thus competition for patient allegiance can only really exist between Fundholders. Finally, 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.

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103. Fundholders are accountable to the NHS Executive (through its regional offices) but day-to-day management is normally through the Health Authorities.

104. See K. Thomas, J. Nicholl & P. Coleman, "Assessing The Outcome Of Making It Easier For Patients To Change General Practitioner: Practice Characteristics Associated With Patient Movements" (1995) 45 Br. J. Gen. Practice 581.

105. A. Maynard & K. Bloor, "Introducing A Market To The United Kingdom's National Health Service" (1996) 334 New Eng. J. Med. 604 at 606.

106. Propper, *supra* note 67 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."

## 2. *Election of Members of Purchasing Agency*

One means of improving voice as an accountability mechanism may 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. Locally-elected members may be more responsive to the exercise of voice by people within the communities they represent and may be more representative of them. In contrast, 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.<sup>107</sup>

The reason often offered for eschewing the possibility of citizens electing the boards of their own purchasers is that government-appointed purchasers will be independent of the political process 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.<sup>108</sup>

The primary problem with reliance on election as a means of ensuring accountability is that many citizens will have to rely on members for whom they may have not voted and with whose policies they do not agree.<sup>109</sup> Moreover, it is unclear whether the decisions made by an elected body would reflect the preferences of any citizen, or would result in a series of compromises that satisfied no-one.<sup>110</sup> There is also the potential problem that elected boards would be dominated by members of the medical profession, who clearly would have a much greater interest in being so elected than ordinary members of the public.

## 3. *Consultation*

Imposing a duty on purchasers to consult widely with the people they represent may overcome problems of access by citizens to large government-appointed purchasers. In the U.K., regulations require Health

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107. Longley, *supra* note 56 at 116 and 122.

108. Flood, *supra* note 43 at 105 and see generally J. A. Morone, "The Ironic Flaw in Health Care Competition: The Politics of Market" in R. J. Arnould, R. F. Rich & W. D. White, eds., *Competitive Approaches to Health Care Reform*, (Washington D.C: Urban Institute Press, 1993) at 207.

109. Flood, *ibid.*

110. See M. J. Trebilcock, "An Introduction to Law and Economics" (unpublished mimeo, University of Toronto, 14 August 1996) at 50.

Authorities to consult with Community Health Councils<sup>111</sup> 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.<sup>112</sup> At least half the members of a Community Health Council are appointed by the 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.<sup>113</sup> 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."<sup>114</sup>

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 disability services; (b) Other persons including voluntary agencies, private agencies, departments of State, and territorial authorities."<sup>115</sup>

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 cooperation 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

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111. There appear to be 207 Community Health Councils in the U.K.; see <http://www.ukpc.org/pub/chclist.htm>.

112. 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.

113. 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.

114. The *National Health Service Act* (U.K.), 1977, c.49, s.12(1) as amended by the *Health Authorities Act*, *supra* note 113.

115. *NZ Health 1993 Act*, *supra* note 19, s.34.

as agents for those people. Moreover, as purchasers may be “captured” by provider groups during the consultation process, it may be inappropriate to *require* purchasers to consult providers.<sup>116</sup> This does not mean that purchasers should not consult health providers but rather that greater weight should be given to consulting citizens.

#### 4. *Charters of Rights and Health Services Commissioners*

Another means of enhancing voice is to stipulate through a “charter of rights” what citizens can expect in terms of entitlements and standards of performance. The use of charters and codes of rights is a means of providing information to patients.<sup>117</sup> Establishment of an independent Health Service Commissioner (acting as a form of health 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 (among other things) how long patients should expect to have to wait for various services.<sup>118</sup> 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.”<sup>119</sup> 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

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116. Flood, *supra* note 43 at at 104.

117. B. Ferguson, “Progress of the UK Health Reforms And The Role Of Information: What Can the ‘Dismal Science’ Contribute?”, Discussion Paper 145 (York: Centre for Health Economics, University of York, 1996) at 13.

118. 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 revascularizations 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, 1996) at 2.

119. The *Health Service Commissioners Act* (U.K.), 1993, c.46, s.3.

complaints regarding the clinical judgments of doctors, nurses, and other clinical professionals.<sup>120</sup> The list of bodies subject to investigation has also been extended to include independent providers and family health service providers. However, the Act continues to 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.<sup>121</sup> This provision is consistent with case law reflecting a general reluctance on the part of courts to intervene in the rationing and allocation decisions made by government authorities and providers within the U.K.'s National Health Service.<sup>122</sup>

In New Zealand, a code of rights for health and disability service consumers was brought into force on 1 July 1996.<sup>123</sup> The ten rights provided for in the code are couched in very general terms.<sup>124</sup> 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.<sup>125</sup> Consumers may appeal to a Health and Disability Services Commissioner in the event of a failure to implement these rights.<sup>126</sup> The

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120. See the *Health Services Commissioners (Amendment) Act* (U.K.), 1996, c.5.

121. The *Health Service Commissioners Act* (U.K.), 1993, c.46, s.3(4) & s.3(5).

122. 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 Ann. Health L. 195. More recently see *R. v. Cambridge Health Authority, ex p. B.*, [1995] 2 All ER 129 (C.A.) 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."

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

124. 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.

125. The *Health and Disability Commissioner (Code Of Health And Disability Services Consumers' Rights) Regulations* (N.Z.), 1996/78, s.3.

126. See the *Health and Disability Commissioner Act 1994* (N.Z.), 1994, No. 88.



powers of the Commissioner are relatively limited.<sup>127</sup> She may, however, refer a matter to the Director of Proceedings who in turn may institute disciplinary proceedings before the Complaints Review Tribunal which has power to award damages, make declarations and order and grant such other relief to the complainant as the Tribunal thinks fit.<sup>128</sup>

Entitlements in both the U.K. and New Zealand are couched in the context of the patient/provider relationship rather than the citizen/purchaser relationship. Without discounting the need for the former, there is a need for a formal codification of the minimum entitlements and rights of a citizen *vis-à-vis* his or her purchaser. Presently, in both the U.K. and New Zealand, access to a Health Services Commissioner does not assist in improving the performance of the Health Authorities.

### 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.<sup>129</sup>

Prior to internal market reform, growing waiting lists were viewed as stemming from the inefficiency and unresponsiveness of the U.K. and New Zealand systems. 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 fifty percent, from 62,000 in 1991 to a reported 93,930 people waiting as of March 1996.<sup>130</sup> Waiting lists are overwhelmingly for elective as opposed to acute surgery. The New Zealand administration has reversed its position from arguing that

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127. 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).

128. *Ibid.*, s. 49 and s. 52.

129. This argument has been made before in earlier writing; 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 88; and Flood, *supra* note 43 at 101.

130. 72,647 people were on waiting lists in 1993 and 77,558 people in 1994; S. Upton, *supra* note 18 at 28 (1991 figure); *Performance Report supra* note 68, Table 17 at 85 (1993 and 1994 figures); L. Dalziel, Opposition health spokeswomen as cited by the *New Zealand Herald* (17 April 1996) (1996 figures).

waiting lists were reflective of the inefficiencies of the old command-and-control system<sup>131</sup> to arguing that waiting lists are not reflective of an inefficient system and that waiting times are a more useful measure.<sup>132</sup> 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 before and after reform. The current administration's response to the problem of lengthening waiting lists is simply to 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.<sup>133</sup> If a 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. As waiting lists have increased so has the proportion of the population with private insurance: from 35% in 1985, to 45% in 1993, to 55% in 1995.<sup>134</sup> The percentage of total health expenditures paid for by private insurance has doubled, from 2.75% in 1990 to 6.18% in 1994.<sup>135</sup>

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 fulfillment 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.<sup>136</sup> 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 may, *prima facie*, appear like "exit" but it is not because the

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131. S. Upton, *ibid.* at 11 where the then Minister of Health states that one of the problems with the (pre-reform) system is that "public hospital waiting times are too long" and goes on to refer interchangeably to the problem of long waiting times and long waiting lists.

132. 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" (1996) 4 Health Care Analysis 130 at 131.

133. 1996/97 N.Z. Policy Guidelines, *supra* note 65 at 24-25.

134. 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", *New Zealand Herald* (15 June 1995).

135. Muthumala & Howard, *ibid.* at 58, Appendix 4.

136. Hirschman *supra* note 81 at 59.

decision-maker suffers no financial loss 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, purchasers have greater opportunity to operate inefficiently with fewer demands placed upon their resources once quality-conscious individuals have exited to the private sector.

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.<sup>137</sup> In contrast with New Zealand's striking failure to reduce waiting lists, the U.K. seems to have been relatively more successful (at least until more recent times) in reducing both waiting lists and waiting times for elective surgery. The number of individuals waiting for elective procedures fell by 2.9% in the period December 1994 to March 1995,<sup>138</sup> at which point there were 1,040,161 people on waiting lists. Approximately the same number of people were on waiting lists at 30 September 1995.<sup>139</sup> 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.<sup>140</sup> However, it appears that waiting lists have started to increase once 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%.<sup>141</sup>

The impetus to deal with waiting lists and times appears to have originated from the central government, and through top-down control

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137. C. Propper & A. Maynard, *The Market for Private Health Care and the Demand for Private Insurance in Britain*, Discussion Paper No. 53 (York: University of York, 1989).

138. *Health Care UK 1994/95*, *supra* note 100 at 38, Table 13.

139. 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."

140. News Release by the Department of Health, *ibid.* T. Besley, J. Hall & 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.

141. J. Snell, "Action Team Appointed to Tackle Rising Waiting Lists" (1997) Health Services J. 4 as quoted by W. Bartlett, "Regulation, Trust and Incentives: Contractual Relations and Performance in the NHS Quasi-Market" (Paper prepared for the conference Institutions, Markets and (Economic) Performance: Deregulation and its Consequences, Utrecht University, 11-12 December 1997).

the goal of containing waiting lists and times has become a primary goal in the priorities set by the 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 supplying health services, 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 was the U.K. system, at least for a time, 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 results 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 overall performance of the system. Secondly, unlike New Zealand, the vast majority of people in the U.K. rely on the public system for the delivery of *all* their services, such that the political ramifications of not dealing with the waiting list problems have become too high. Voice is thus 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%.<sup>142</sup> This is a relatively small percentage in comparison with the estimated 55% of New Zealand's population with private insurance. Given that nearly 89% of the U.K.'s population are totally dependent on the public system for fulfillment 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.

Empirical work conducted in the U.K. has examined 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.<sup>143</sup> They also found that individuals who express dissatisfaction with the NHS are more likely to purchase private insurance and that the

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142. 1993 figures estimated in *Laing's Review of Private Healthcare 1994* (London: Lain & Buisson Publications Ltd., 1994) at 140, Table 3.1.

143. T. Besley, J. Hall & I. Preston, *supra* note 140.

privately insured tend to be “better off, better educated, middle-aged and more inclined to support the Conservative party.”<sup>144</sup> 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 found that individuals with private insurance were less likely than those without to support additional spending on the public system; however, this result must be treated with caution as a significant majority of those with private insurance did support additional spending on the NHS.<sup>145</sup> 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 insurance covering long-term care for the elderly.<sup>146</sup> 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.<sup>147</sup> 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

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144. *Ibid.* at 1.

145. *Ibid.* at 34.

146. The *Finance Act* (U.K.) 1989, c.26, s.54. See *The Economist* (15 March 1997) at 18.

147. See, e.g., *Alberta Health Care Insurance Act*, R.S.A. 1980, c. A-24, s.17 and *Ontario Health Insurance Act* R.S.O. 1990, c. H.6, s.14. However, Newfoundland, Nova Scotia, New Brunswick, and Saskatchewan do not appear to have explicit legislation prohibiting private insurance that overlaps the public scheme.

quality of Canada's health care system and to protect what are perceived as being core values.<sup>148</sup> 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.<sup>149</sup> 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.<sup>150</sup> 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.

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 the pressure on publicly-funded services, and thus reduces waiting lists. 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 long as is likely if no private surgical beds are provided.<sup>151</sup> 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 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).<sup>152</sup> This

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148. The National Forum, *supra* note 7 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."

149. Ramsay & Walker, *supra* note 8 at 6.

150. See Flood, *supra* note 43.

151. P. Davis, *Health and Health Care in New Zealand*, (Auckland: Longman Paul, 1981) at 135.

152. Flood, *supra* note 43 at 103.

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.

### *6. Conclusions on Voice and Political Accountability*

In this section I have tried to address the various mechanisms through which to enhance voice and thereby 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 have to be weighed against the extra transactions costs and the 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. 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. 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.

## VI. *Exit And Market Accountability*

In addition to political accountability, purchasers' accountability may be enhanced through a competitive market. If citizens were (to use Hirschman's terminology) entitled to "exit" taking with them a risk-adjusted share of government funding then, *prima facie*, there would be 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 with 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.<sup>153</sup> 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" process envisaged 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 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, sending a clear signal to competitors as to their relative performance. 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

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153. See Malcolm & Powell, *supra* note 21. 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.



“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.”<sup>154</sup> In Enthoven’s model, a sponsor may be a governmental agency, an employer, or a purchasing cooperative. Clinton’s proposals for reform required government-appointed Regional Health Alliances to collectively oversee health coverage for over 80 percent of the population under the age of 65.<sup>155</sup> 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 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; the need to solve the basis upon which price competition will occur; and the need to define “core” services. This term refers to the range and quality of services purchasers will compete to provide (or, put another way, the need to define consumer entitlements). Other problems include the question of whether consumers have or will have sufficient information to choose wisely between competing purchasers, the problem of transactions costs, and the problem of supply side monopoly.

### 1. *Cream Skimming*

When a consumer exits from one 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 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 private health insurance market, high risk individuals may be either priced out of, or simply excluded, from the insurance

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154. A. C. Enthoven, “The History and Principles of Managed Competition” (1993) 12 *Health Aff.* 24 at 29.

155. See the *American Health Security Act of 1993*, H.R. 3600, 103d Cong., S. 1757, 1st Sess. (1993).

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.<sup>156</sup> As a consequence, a growing proportion of the population is left without health insurance. Similarly in the Netherlands, prior to managed competition reform, there was increasing concern that risk-rating by private insurers was making insurance unaffordable for elderly and unhealthy people and that some high-risk groups were being denied coverage altogether.<sup>157</sup>

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 coverage is provided for all of that individual's health care needs for a core 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 or a high risk of incurring such costs in the future.<sup>158</sup>

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156. V. R. Fuchs, "Economics, Values, and Health Care Reform" (1996) 86 *Am. Econ. Rev.* 1 at 20.

157. *Factsheet*, *supra* note 25 at 2.

158. For a discussion of cream skimming see J. P. Newhouse et al., "Adjusting Capitation Rates Using Objective Health Measures and Prior Utilization" (Spring 1989) *Health Care Financing Rev.* 41; F. T. Schut, "Workable Competition in Health Care: Prospects for the Dutch Design" (1992) 35 *Soc. Sci. Med.* 1445; R. C.J.A. van Vliet & W. P.M.M. van de Ven, "Towards a Capitation Formula for Competing Health Insurers. An Empirical Analysis" (1992) 34: 9 *Soc. Sci. Med.* 1035; W. P.M.M. van de Ven & R. C.J.A. van Vliet, "How Can We Prevent Cream Skimming in a Competitive Health Insurance Market? The Great Challenge for the 90's" in P. Zweifel & H. E. Frech III, eds. *Health Economics Worldwide* (Netherlands: Kluwer Academic Publishers, 1992) at 23; R.C.J.A. van Vliet, "Predictability of Individual Health Care Expenditures." (1992) 59 *J. Risk & Insurance* 443. R.C.J.A. Van Vliet & W.P.M.M. Van de Ven, "Capitation Payments Based on Prior Hospitalizations" (1993) 2 *Health Econ.* 177; W. P.M.M. van de Ven et al. "Risk-Adjusted Capitation: Recent Experiences in the Netherlands" (1994) 13 *Health Aff.* 120; van de Ven, Schut & Rutten, *supra* note 15; J. P. Newhouse, "Patients at Risk: Health Reform and Risk Adjustment" (1994) 13 *Health Aff.* 132; M. Giacomini, H.S. Luft & J.C. Robinson, "Risk Adjusting Community Rated Health Plan Premiums: A Survey of Risk Assessment Literature and Policy Applications" [1995] *Ann. Rev. Public Health* 401; and E. M. van Barneveld, R. C. J. A. van Vliet & W. P. M. M. van de Ven, "Mandatory High-Risk Pooling: An Approach to Reducing Incentives for Cream Skimming" (1996) 33 *Inquiry* 133.

In order to minimize cream skimming, managed competition models require purchasers to accept all who seek to enroll 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 citizens 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).<sup>159</sup> This arrangement reduces opportunities for the use of subtle cream skimming tactics. A sponsor may also monitor movement by individuals between purchasers to insure that such movement is not the result of cream skimming behaviour.<sup>160</sup> 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 cream skimming will result in the demise of firms 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 sponsors 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 incentive which encourages it. 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 to enroll in their particular plan. An adjustment in this regard must be effected in any event to allow the continued viability of those purchasers with whom a disproportionate share of enrollees with high health costs have enrolled. 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

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159. See for example Enthoven (1993), *supra* note 23 at 33.

160. J. E. Fielding & R. Rice, "Can Managed Competition Solve Problems of Market Failure?" (1993) 12 Health Affairs 216 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."

better on price and quality dimensions. The premiums must be adjusted so that each purchaser receives a premium per enrollee that reflects their *perceptions* of the particular individual enrollee's risk of utilization of health services. It is purchasers' perceptions of risk which are important as opposed to what the actual risk may be, for the latter 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 to pay 85-90% of a risk-adjusted premium on behalf of each and every individual to that individual's chosen purchaser. 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, such as an individual's chronic health status or medical history.<sup>161</sup> 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.<sup>162</sup> 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.<sup>163</sup> The inequity of inadequately risk-adjusted premiums has been acknowledged in the Netherlands. In 1993 and 1994, the government required that Sickness Funds 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.<sup>164</sup> This percentage was subsequently increased to 14% in 1996 and 27% in 1997.<sup>165</sup>

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.<sup>166</sup> The first misunderstanding is the

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161. van Barneveld, van Vliet & van de Ven, *supra* note 158.

162. van Vliet & van de Ven, "Towards a Capitation Formula For Competing Health Insurers," *supra* note 158.

163. van de Ven et al., "Risk-Adjusted Capitation: Recent Experiences in the Netherlands," *supra* note 26 at 123.

164. W. P. M. M. van de Ven & F. T. Schut, "The Dutch Experience with Internal Markets" in M. Jerome-Forget, J. White, & J. M. Wiener, eds., *Health Care Reform through Internal Markets: Experience and Proposals* (Montreal: IRPP, 1995) 95 at 104. Sickness Funds are 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.

165. Personal correspondence with Dr. Frederick Schut, Erasmus University, Rotterdam 24 March 1997.

166. van de Ven & Schut, *supra* note 164 at 110-111.

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.<sup>167</sup> 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.<sup>168</sup> 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 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.<sup>169</sup> The third misunderstanding is the assumption that if perfectly risk-adjusted premiums were paid then purchasers would have no incentive to operate as efficiently as possible.<sup>170</sup> 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 to predict *partially* the risk of any individual's future needs. The cream skimming incentive only arises where there is a *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 premiums as the price is effectively determined by the sponsor. This issue is discussed further below under the problem of facilitating price competition.

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167. *Ibid.* at 110.

168. S. S. Wallack et al., "A Plan For Rewarding Efficient HMOs" (1988) 7 Health Aff. 80 at 84.

169. van de Ven & Schut, *supra* note 164 at 110-111.

170. *Ibid.* at 111.

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 bear financial liability only 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).<sup>171</sup> Such a measure caps the risk incurred by a Fundholder, thus diminishing (but not eliminating) the incentive to cream skim, but also removing 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 (yet) that cream skimming is a serious problem in Fundholding practices; however, the Audit Commission did find the inverse relationship between the proportion of Fundholding practices in an area and the average degree of social deprivation to be highly significant statistically.<sup>172</sup> 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. 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, to the possibility 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.

Undoubtedly, cream skimming is a potentially serious problem. However, it must be remembered that such behaviour on the part of purchasers sends a signal not only to those individuals whose risk has crystallized but to other individuals that this particular purchaser is untrustworthy at the time that it is needed the most. Thus, the need to maintain a good 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 among most people, who anticipate needing such services. 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 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 purchasers treat the most vulnerable groups in order to foster a sense of

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171. *The National Health Service (Fund-Holding Practices) Regulation* (U.K.), 1996, S.I. 1996/706, s.21.

172. *What The Doctor Ordered*, *supra* note 96 at 10.

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 purchaser *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.

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 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.

## 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.<sup>173</sup> 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.<sup>174</sup> 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 tying contributions to the lowest priced plan

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173. In 1994 this averaged to approximately 200 guilders (U.S.\$120) per person per annum: van de Ven & Schut, *supra* note 164 at 102.

174. Enthoven, (1993), *supra* note 23 at 32.

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 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 has to be put in context. There may be a concern that managed competition would 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” like Canada’s) that rely on private financing for important services such as general practitioner services, drugs, and home-care services, 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.<sup>175</sup>

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175. 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.



### 3. *Defining Core Services and Entitlements*

Defining what range and quality of health services will be made available by competing purchasers and what citizens should be able to expect as entitlements is important to managed competition reform. Ideally, citizens 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.<sup>176</sup> 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, in order 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).<sup>177</sup> 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).<sup>178</sup> 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 (subsequently known as the Dunning report) dealing with the rationing of services.<sup>179</sup> 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.<sup>180</sup> The sieve approach provides guidance on what services

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176. L.A. Berthgold, “Perspectives: Benefit Package” (1993 Supp.) 12 Health Aff. 99 at 100.

177. *Factsheet*, *supra* note 25 at 3.

178. van de Ven & Schut, *supra* note 164 at 101.

179. Government Committee On Choices in Health Care, *Choice In Health Care* (Rijswijk: Ministry of Welfare, Health and Cultural Affairs, 1992) (English version).

180. The 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 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.

should be 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.<sup>181</sup> 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.<sup>182</sup> 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.<sup>183</sup> 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. It 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 physicians' 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 physicians 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

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181. 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) at xvii 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 L. J.* 2697.

182. For a fuller description of the processes see Halligan, *ibid.* at 2708-11.

183. See *ibid.* at 2711-12.

health services that should trump more utilitarian concerns.<sup>184</sup> Arguably individuals should have certain 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.<sup>185</sup> 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 found it impossible to develop a specific list of priorities in treatment.<sup>186</sup> Significant discretion is thus left in the hands of the Regional Health Authorities, who may find it easier to revert to the default option of largely maintaining historical service patterns.

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184. 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).

185. *NZ Health 1993 Act*, *supra* note 19, s. 6.

186. *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).

In the U.K., there is no body equivalent 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.<sup>187</sup> 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.

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 judgments of individual health care providers. These issues must begin to be addressed by communities as the growth of costly technology coupled with aging populations and increasing expectations will stretch the ability of systems to meet demands for health services.<sup>188</sup> Some may argue that determining core services is a misguided endeavour that will stymie innovation and result in inflexibility in the system.<sup>189</sup> 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 define specific entitlements and standards. 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 judgments 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.<sup>190</sup>

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187. See the (1996) 312 Br. Med. J. edition which is devoted to moving the debate forward on the rationing of health care in the U.K.

188. Evans notes that it is not the ageing of the population *per se* that is problematic but the rising rates of *per capita* utilization on the part of the elderly; R. G. Evans, "The Canadian Health-Care Financing and Delivery System: Its Experience and Lessons for Other Nations" (1992) 10 Yale L. & Policy Rev. 362 at 387.

189. See M. Rachlis, "Defining Basic Services and De-Insuring the Rest: The Wrong Diagnosis and the Wrong Prescription" (1995) 152 Can. Med. Assoc. J. 1401 at 1403. See also R. Deber, "Beyond the Canada Health Act: the Public-Private Mix," paper presented for the Ninth John Olin Annual Conference in Law and Economics, Canadian Law and Economics Association, September 26, 1997.

190. The National Advisory Committee on Health and Disability is required to consult with such members of the public, providers, and other persons as the committee considers appropriate; *NZ Health 1993 Act*, *supra* note 19, s.6.

#### 4. *Citizen Choice*

One must consider the key question of whether citizens can make effective choices between competing purchasers in a managed competition system. The argument is sometimes made by opponents of the concept of managed competition that citizens are not capable of distinguishing between the merits of competing purchasers. Certainly it appears that in the present U.S. system, many Americans do not understand the differences between health plans and may not be making effective choices, although reportedly the vast majority (70%) are satisfied with the choices they have made in the past.<sup>191</sup> In any event, the U.S. experience is not necessarily translatable to a managed competition system, where a sponsor would be required to facilitate choice. There would still be, of course, potential for purchasers to confuse citizens 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.<sup>192</sup> There should be an insistence on plain language and a requirement that any limitations on coverage be clearly spelt out on the front page of the policy. Everyone 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 comparison of purchasers difficult.<sup>193</sup> 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 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 that they are capable of disseminating this information to consumers? Individuals make difficult decisions about when to visit their doctor,

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191. See S. L. Issacs, "Consumers' Information Needs: Results Of A National Survey" (1996) 15 Health Aff. 31 at 35.

192. E. W. Hoy, E. K. Wicks, & R. A. Forland, "A Guide to Facilitating Consumer Choice" (1996) 15 Health Aff. 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."

193. Fielding & Rice, *supra* note 160 at 222.

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 a purchaser once a year.

There is a great deal of anecdotal evidence that unacceptable restrictions of choice occur in the U.S. as a result of managed care.<sup>194</sup> Again this problem has to be put in context. The U.S. system has been described as a “parody of excess and deprivation”<sup>195</sup> 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 by sponsors if it were considered that purchasers were unduly restricting patients’ choice of providers.

Sponsors will also have to monitor and disseminate information to citizens 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 relying on competition as a means of enhancing accountability if the alternative is internal market reform where a government-appointed monopsony purchaser stimulates competition between health providers. Consideration must be given to providing for the needs for citizens who live with a physical or mental

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194. See generally G. Anders, *Health Against Wealth: HMOs and the Breakdown of Medical Trust* (Houghton Mifflin, 1997).

195. A. C. Enthoven & R. Kronick, “A Consumer-Choice Health Plan for the 1990s: Universal Health Insurance in a System Designed to Promote Quality and Economy, I” (1989) 325 *New Eng. J. Med.* 854.

disability or who are chronically or terminally ill. These citizens may be particularly vulnerable to reductions in the quality of health services,<sup>196</sup> 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).

### 5. *Transactions Costs and the Problem of Supply Side Monopoly*

One must consider the transactions costs inherent in offering a choice of competing purchasers. The greater the number of purchasers the greater the choice for citizens and the greater the competitive vigour (provided that sponsors are able to prevent cream skimming). However, a large number of purchasers bring with it the prospect of higher transactions costs and a diminution of purchasing power *vis-à-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.<sup>197</sup> Also, purchasers will wish to be of a relatively large size to enhance their market power *vis-à-vis* health providers.<sup>198</sup> For example, in response to the prospect of competition between purchasers there has been an integration of sickness funds and private insurers in the Netherlands. Between 1987 and 1991, thirteen mergers took place involving 33 Sickness Funds, so that the number of independent Sickness Funds was reduced from 46 to 26.<sup>199</sup> Industry observers predict that as a result there will eventually be only 10 to 15 national chains of health insurers serving the Dutch population of 15 million.<sup>200</sup> Thus, transactions costs in the Dutch reformed health

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196. See the comments of M. Schlesinger & D. Mechanic, "Perspective, Challenges For Managed Competition From Chronic Illness" (1993) 12 Health Aff. 123 at 130-131.

197. For example Wallack et al., *supra* note 168 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 *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)."

198. See *OECD Health Policy Studies No. 2*, *supra* note 25 at 99.

199. 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 266.

200. As noted by van de Ven & Schut, *supra* note 164 at 97-98 and 105-106.

allocation system may eventually be significantly reduced. The problem may, in fact, prove to be 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.<sup>201</sup> 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.

As with the other problems of managed competition, the issue of transaction costs must be put in perspective. 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 four Regional Health Authorities and one Accident Compensation Corporation purchaser there are 61 Independent Practice Associations, all acting as purchasers.<sup>202</sup> As managed care flourishes in these internal markets (or for that matter in any system) the effective number of purchasers increases and consequently transaction costs will increase. Moreover, the present number of government-appointed purchasers in the U.K. and New Zealand has been centrally determined and there do 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.<sup>203</sup>

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. It is beyond the scope of this paper to discuss this issue in depth, but there are mechanisms to deal with the problem of supply monopoly

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201. See F. T. Schut, *Competition in the Dutch Health Care Sector*, (Ph.D. dissertation, Erasmus University, Rotterdam, 1995) at 224 [unpublished].

202. See "Report on Ministry of Health, Managed Care Conference, 2-4 May 1996, Managed Care Applied" at <http://www.enigma.co.nz/hcro/9607/9607/s07.htm>.

203. 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 four 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).



on the side. This would include regulation, anti-trust laws, the doctrine of essential facilities, public ownership of monopolies, and joint bargaining with monopolies on the part of purchasers. 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.

### 6. *The Residual Role Of Voice*

The preceding analysis shows 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. The role of government in managed competition systems, while different, is thus no less crucial than in any other health allocation system that seeks 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 purchaser and its affiliated provider until the next point in time when they can exit. 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 not have the resources to pay for the services personally while trying to obtain satisfaction from the purchaser. Thus, charters of rights, access to a Health Services Commissioner or Ombudsperson, and associated remedies remain relevant.<sup>204</sup> These administrative processes are all means by which enrollees are able to exercise their voice to protect the quality of services received.

### *Conclusion*

Where government-appointed purchasers do not face competition, the system relies on political accountability or voice to render purchasers

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204. 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. in 1993/1994, President Clinton's proposal provided the most detailed framework for adjudicating disputes between purchasers and enrollees.

accountable. Significant and complex agency questions arise in this respect. The theory of internal market reform requires purchasers to be accountable to the citizens 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 citizen choice and enhancing public participation, but neither the regulatory framework nor the allocation of resources reflects these goals. 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 managers of government-appointed purchasers 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 paper has canvassed a range of possibilities for strengthening the use of voice on the part of citizens as a means to ensure the accountability of both purchasers and government in internal market systems. Arguably, 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.<sup>205</sup> Possibilities include further devolution of purchasing power, mandatory consultation, local elections of purchasers, and providing citizens 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 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 in comparison with the *prima facie* simplicity of the exit or market mechanism. Man-

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205. Longley, *supra* note 56 at 155.

aged 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. Individuals dissatisfied with their current purchaser 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 significant 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 the latter left 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;<sup>206</sup>
- 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);
- g. there is 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.

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206. Hirschman, *supra* note 81 at 82-83.

The Achilles' heel of managed competition reform is whether or not sponsors have the ability to deal adequately with the cream skimming problem so as to encourage price and quality competition. Solving this problem is crucial in order to protect vulnerable populations in managed competition systems. 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 (such as 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.<sup>207</sup> 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 choice is facilitated.

The most significant advantage offered by an internal market system with government-appointed monopsony purchasers over a managed competition system is that of potentially lower transaction costs and increased market power on the demand side. First it must be noted that extra transaction costs are only a problem if they are not set off by concomitant efficiency gains. It is of course difficult to calculate the efficiency gains of a managed competition system as one has never been fully implemented anywhere. It must also be recognized in the context of comparing the managed competition model with an internal market model that the problems of transaction 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 was encouraged (till the announcement of the most recent reforms in December 1997) from the bottom up by way of GP Fundholding. The transaction costs of Fundholding are potentially higher than those associated with a managed competition system. One must therefore question the wisdom of the U.K.'s further expansion of the Fundholding initiative. One must also question a reliance upon competing Fundholders as opposed to competing purchasers on the ground 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

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207. See M. Matsaganis & H. Glennerster, "The Threat Of 'Cream Skimming' in the Post-Reform NHS" (1994) 12 J. Health Econ. 31.

(particularly for vulnerable patients), it may be better to encourage competition between large purchasers and regulate the degree to which these entities 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.”<sup>208</sup> 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; eliminate cream skimming; stimulate competition on price and quality; facilitate choice by citizens and to ensure that the quality of services provided is adequate.<sup>209</sup> It is a serious mistake to assume that government’s role is not as critical where there are competing purchasers as it is where governmental agencies act as the sole purchasers of services. Political accountability and voice continue to have a large and important role to play.

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). Pressure will periodically force 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 its dismissal as “powdered rhino horn”<sup>210</sup> or an “American style reform” would indicate. The very strong resistance to any hint of Americanization of the Canadian health system indicates that at least for the foreseeable

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208. D. Dranove, “The Case For Competitive Reform In Health Care” in R. J. Arnould, R.F. Rich & W. D. White, eds., *Competitive Approaches to Health Care Reform*, (Washington, DC: Urban Institute Press, 1993) at 79.

209. For a comment on the problems inherent in Clinton’s managed competition plan see generally L. D. Brown & T. R. Marmor, “The Clinton Reform Plan’s Administrative Structure: The Reach and the Grasp” (1994) 19 *J. Health Pol., Policy & Law* 193.

210. Evans, *supra* note 2 at 462.

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 whilst satisfying social justice goals, then 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 as to what other measures could be taken to reform the present Canadian system that would be more politically acceptable.

In most 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, benefits have clearly 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.<sup>211</sup> Integrating funding for secondary, primary and drug services in regional

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211. The National Forum's 1997 recommendations to investigate ensuring universal access in the public system to pharmaceuticals consumed outside hospitals and to home care services speaks to the need for comprehensiveness in order to avoid cost-shifting; National Forum on Health, *Canada Health Action: Building On The Legacy Vol. II, Synthesis Reports and Issues Papers* (Ottawa: National Forum On Health, 1997).

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 on its own. A rigid purchaser/provider split, like rigid vertical integration, can be criticized as application of an inflexible and indiscriminate solution to health service markets that are very different and dynamic. 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 are of primary importance.

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.