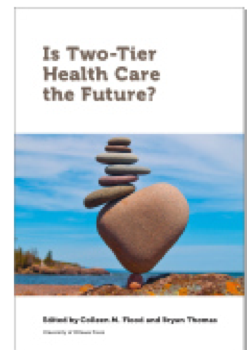
7. The Politics of Market-Oriented Reforms: Lessons from the United Kingdom, the United States, and the Netherlands



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PART II
IS CANADA ODD? LOOKING AT THE REGULATION OF PUBLIC/PRIVATE MIX OF HEALTH CARE IN OTHER COUNTRIES

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CHAPTER 7

The Politics of Market-Oriented Reforms: Lessons from the United Kingdom, the United States, and the Netherlands

Carolyn Hughes Tuohy

In the three "millennial" decades surrounding the turn of the twenty-first century (from the mid-1980s to the mid-2010s), a wave of enthusiasm for "market-oriented" reforms to public services swept across many advanced nations. In the health care arena, these reforms took a variety of forms. For example, some replaced or augmented hierarchically integrated arrangements with contractual and, in some cases, competitive arrangements, either within the public sector or between public and private entities, or both. Others created new, publicly managed markets for private insurance. In the process, such reforms re-drew the boundaries between public and private sectors, creating openings for entrepreneurs to bring private capital to bear in new modes of operation. They did so, however, in very different ways, with different implications for the political and economics of the system, and different equity consequences.

Private capital can provide a base of influence in the health care arena in two principal ways: either through the ownership of the production of health care services and goods (the delivery side), or through the purchase of health care services and goods (the demand side). In each respect, the political and economic power of private capital will depend on how ownership and control of that capital is structured. On the delivery side, private ownership of health care providers can take for-profit, proprietary or not-for-profit ownership forms. On the demand side, private purchasers of health care

may draw on their own individual capital or upon pools of capital controlled by private insurance funds, which may in turn be under for-profit or not-for-profit ownership. On both delivery and demand sides, private capital may be subject to public regulation of varying degrees of stringency. All of these roles for private capital in some way involve those who control it in making fundamental decisions about the allocation of health care: who gets what, when, where, and how.

As systems of public health insurance were established in the twentieth century, they restricted the role of private capital in different ways, by establishing public ownership and employment of health care providers, and by purchasing health services and goods with public funds. From an equity perspective, the most fundamental shift was the supplanting of private finance by public funding on the demand side by entitling some or all citizens to health care at public expense. To the extent that private ownership of health care facilities continued, it could affect what the state paid for health care, but public funding meant that the distribution of access was taken out of private hands in all or part. No advanced democracy, however, has a purely public system, and tensions between public and private objectives continue to exist in different ways in different systems.

The English, Dutch, and American reforms reviewed in this chapter all attempted to use mechanisms modelled on a competitive market to improve the functioning of their health care systems: to increase efficiency, to expand access, or both. However, each had different implications for the role of private capital. In England, the reforms were largely internal to the public system, although they did create more opportunities for privately capitalized providers on the delivery side. The Dutch reforms focused on the demand side, drawing public and private insurers under a common regulatory and financial structure largely controlled by the state. In the United States, a new, heavily regulated, and publicly subsidized market segment for private insurance was created in the form of state-based insurance "exchanges."

The effects of these reforms were correspondingly different but they have at least one trait in common: they show that features inherent to the politics of health care led governments to limit opportunities for profit while buffering private entities against financial risk. As a result, increases in the weight of private capital were marginal, and the typical results were to reinforce the clustering of privately

capitalized providers of health care in niche areas, to increase the degree of concentration among private providers or insurers or both, and in some cases to generate complex corporate structures that greatly complicated lines of accountability. The principal effect of all of these changes, however, was to increase the regulatory role of the state, not to diminish state influence.

In Canada, such developments have been very limited in scope, although provincial governments have experimented in various ways with contracting between public payers and privately owned and operated providers. Although these experiments have been controversial, a far more heated debate surrounds proposals for allowing for the development of a purely private tier parallel to the public system, similar to a long-standing feature of the British system, which was only marginally affected by market-oriented reforms. The remedy sought by *Cambie* in British Columbia, a case discussed throughout this book, could bring Canada closer to this parallel-tier model, and I will therefore review that experience briefly later.[1] On balance, this comparative experience suggests that even if the applicants in *Cambie* are successful in striking down some or all of the laws tamping down a role for private capital, other kinds of regulatory structures will emerge in their place to rebalance public and private interests.

Reforms in Three Nations: A Brief Summary

The founding models of the health care state in Britain, the Netherlands, and the United States closely represented three "ideal types"; the national health service, social insurance, and residual models, respectively. The British National Health Service (NHS) was established in 1948 as a tax-financed, hierarchical system that owned and operated hospitals and employed physicians—either on salary, in the case of hospital-based specialists, or under capitation contracts, in the case of formally independent general practitioners. (This contrasts with Canada's "single-payer system," in which the state pays for physician and hospital services that are provided by privately constituted not-for-profit hospitals and proprietary physician practices.) Alongside this universal public system, a small private system has

1 The discussion in this chapter draws heavily on the much more extensive presentation in C H Tuohy, *Remaking Policy: Scale, Pace and Political Strategy in Health Care Reform* (Toronto: University of Toronto Press, 2018).

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historically operated in parallel. Before and after the internal market reforms, health care services continued to be provided on a purely private basis as an alternative to NHS-funded services, paid for by private insurance or out of pocket by individuals.[2] The reforms did little to change that purely private market. Nonetheless, because the parallel model is often cited in the contemporary debate in Canada, I will review it in some detail later here.

From the mid-twentieth century to the late 1990s, the Netherlands system corresponded to a classic social-insurance model for the population in the lower two-thirds of the income distribution, complemented by voluntary private insurance for those in the upper third. Social insurance was provided through "sickness funds," pooling compulsory contributions from employers and workers. In the 1960s, the system was further undergirded by a tax-financed universal program for long-term and chronic care. The US "residual" model assumed that the principal source of coverage would be employer-based private insurance (publicly subsidized through the non-taxation of health benefits), supplemented by public coverage for certain groups outside the workforce, notably the elderly and disabled (under the US Medicare programs adopted in 1965) and the federal-state Medicaid program for certain low-income categories (adopted at the same time).

In each of these nations, the founding model of the health care state was transformed in the past three decades. Table 7.1 summarizes the changes. In Britain, internal market reforms brought in by the Conservative government in 1990 split the NHS hierarchy into separate "purchaser" (demand) and "provider" (delivery) components that were to negotiate contracts for services. These changes were absorbed and mediated by established networks, and appropriated and reshaped by a successor Labour government after 1997. Among other things, the Labour party established a "Foundation Trust" model, giving NHS hospitals yet greater independence in matters of finance and governance, and sought to increase the potential for patients to choose among providers of publicly funded services. The Conservative–Liberal Democrat Coalition government established after the 2010 election took the internal market concept

2 As part of the founding bargain with specialist physicians (known as consultants), NHS hospitals could also offer services to privately paying patients in so-called pay beds.

even further on the demand side by delegating the bulk of the NHS purchasing budget to consortia of general practices. These statutory organizations, known as Clinical Commissioning Groups (CCGs), drew general practices together on a regional basis for the purpose of purchasing hospital and community services, while leaving the provision of primary care in the hands of the practices themselves.

Table 7.1. Shifts in health care policy frameworks in the United Kingdom, the Netherlands, the United States, and Canada, 1987–2017

Country	Founding Model (as of the 1980s)	Post-Reform Model (as of 2017)
United Kingdom	*National Health Service* services provided through unified regional state hierarchy	*Internal market* purchaser/provider split formal distancing of the state
Netherlands	*Social insurance* sickness funds plus private insurance	*Mandatory insurance, comprehensive model* comprehensive regulation of universal mandatory insurance
United States	*Residual* tax-subsidized employer-based private insurance as norm plus public programs for the elderly and poor	*Mandatory insurance, complementary model* universal mandatory* insurance employer-based private insurance as norm, plus public programs for the elderly and poor, plus managed competition and subsidies in individual and small-group markets
Canada	*Single-payer plus mixed market* single-payer for physician and hospital services; mixed market for all other services	*Single-payer plus mixed market* single-payer for physician and hospital services; some changes in organization and remuneration increased cross-provincial variation in mixed market; some changes in eligibility, especially with respect to drugs

* In December 2017, the tax penalty enforcing the mandate was repealed as part of tax-reform legislation passed on party-line votes by a Republican-controlled Congress, and signed by the Republican president. The mandate itself remains in effect but is the subject of continuing litigation and is unenforced.

Source: C H Tuohy, *Remaking Policy: Scale, Pace and Political Strategy in Health Care Reform* (Toronto: University of Toronto Press, 2018).

Most of these reforms were effectively internal to the public system, aimed at structuring relationships among purchasers and providers along market lines without changing the principles of tax-based funding and universal first-dollar (or rather first-pound) coverage. Initially, for example, hospitals were established as NHS Trusts with greater financial independence, subsequently expanded by the Labour government based on a "Foundation after Trust" model. Trusts were allowed to borrow within regulated limits, and Foundation Trusts were not required to balance year-over-year, and were allowed to retain surpluses. The original internal market reforms also included a fundholding model, whereby GPs could opt to hold publicly financed budgets for the purchase of a range of hospital and community services for their patients. Though fundholding was formally abolished by the Labour government elected in 1997, the involvement of GPs in purchasing decisions continued under various guises. More significantly, fundholding had spurred GPs into an ongoing political engagement that shaped the CCG model embraced by the Coalition government after 2010.

Although primarily focused on the public sector, the British reforms did include some openings for private capital on the delivery side—that is, for providing publicly financed services, especially as the reforms were extended under successive governments, as will be discussed below.

In the Netherlands, reforms begun in the late 1980s and rolled out over the next two decades, which transformed a system that had been bifurcated between compulsory social insurance for those in the lower two-thirds of the income distribution and voluntary private insurance for the wealthiest third. The new system was a universal regime of compulsory insurance, financed on a roughly fifty-fifty basis by community-rated premiums[3] charged by insurers and income-scaled contributions collected by the state (effectively taxes) and distributed to insurers according to the risk profile of their enrolled populations. Although all insurers were formally constituted under legislation governing private corporations, and one of the largest insurers is part of a large for-profit corporate entity,

3 Income-scaled subsidies were also provided for the payment of these premiums.

the strong public role in regulation and finance renders this unique model effectively "public."[4]

The United States moved toward its own unique "complementary" model of universal coverage, aimed at those who fell into the gaps in an existing system grounded in employer-based coverage and "residual" government programs for the elderly and some lower-income groups. The principal targets of the reforms introduced under the *Affordable Care Act* of 2010 were twofold.[5] First, they enlarged the "residual" role of the state by expanding the established Medicaid program to cover essentially all below certain income limits. Second, they developed a new infrastructure aimed at ensuring coverage for those served neither by employer-based plans nor by government programs, through a combination of mandates, fines, and subsidies, and new health insurance "exchanges" in each state to regulate and subsidize the individual and small-group market in which private insurers would compete on terms defined by federal and state regulators. Most importantly, insurers participating in the state-based health insurance exchanges were required to cover a defined comprehensive package of benefits at "community rates" that could vary across individuals only by broad age and tobacco-use categories.

Public and Private Objectives

To the extent that market-oriented reforms opened up opportunities for private capital in health care, on either the delivery or the payment side, they imported private-sector objectives into the sphere of the public sector and opened up opportunities for entrepreneurs. In some key respects, those private objectives were in tension with fundamental public-sector objectives of equity and stability, and the need to respond to those tensions drove public policy toward increased regulation of private actors. Understanding these dynamics requires attention to two definitive aspects of entrepreneurial activity: risk-taking and profit-making. Entrepreneurship implies that actors have both the autonomy and the incentive to take risk. Entrepreneurs need sufficient freedom from established institutional

4 For example, the OECD treats all spending for the basic compulsory coverage package, whether by insurers or the state, as public spending.

5 *Patient Protection and Affordable Care Act*, Pub L No 111-148, 124 Stat 119 [*Affordable Care Act*].

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constraints such that they can pursue independent courses of action. They must also expect to appropriate the gains of their activity. In each of these respects, however, certain inherent characteristics of public-policy environments, including health care, are ill-suited to entrepreneurial behaviour.

Risk

Almost all public-policy frameworks are heavily conditioned by political imperatives to promote (or be seen to promote) values of probity, stewardship, and equity. The high-risk/high-potential-profit model of the private sector fits ill with these norms.[6] The potential for failure is an inherent aspect of entrepreneurialism in the private sector; only through failures of less successful enterprises can resources be freed up for reinvestment in more successful enterprises. But as the British economist Peter Smith has provocatively commented, it takes a "brave state" to allow organizations delivering public services to fail.[7]

Market-oriented reforms are predicated in part on the assumption that if those who make decisions about the allocation of resources are required to bear the risk of the costs of those decisions, the resulting allocation will be more efficient than if the costs are spread across the tax base.[8] But if the costs of failure will also be borne by the *clients* of those decision makers, questions of equity might arise. These questions are exacerbated in an arena such as health care, where the very public programs at issue were established in the first instance to socialize risk.

Governments accordingly have a number of motivations to buffer entrepreneurs against risk under market-oriented reforms. Some are technical considerations: it might take time to develop the necessary regulatory infrastructure to underpin risk-bearing. Some are political pressures: buffering might be necessary to dampen opposition from entrepreneurs accustomed to operating in an environment of socialized risk. It also might be necessary to protect clients against the possibility that requiring insurers or providers to bear new risks will cause them to fail, exit the market, attempt to shed high-risk and high-cost individuals, or compromise the quality of their offerings, leading to a

6 Charles Edwards et al. "Public Entrepreneurship: Rhetoric, Reality, and Context" (2002) 25 Intl J Public Administration 1539.

7 Personal communication, 19 September 2012.

8 See, C Cheng, I Ioannis & D Sokol, eds, *Competition and the State* (Redwood City, CA: Stanford University Press, 2014) 62–63.

reduction in the quality and availability of necessary insurance or care in at least some localities or market segments. As governments have attempted to encourage entrepreneurialism in areas such as health care, where they are not willing to tolerate the social costs of failure, they have become embroiled in the inherent contradiction of simultaneously expanding and circumscribing the potential for risk taking.

We have observed risk-buffering mechanisms of various types in each case of market-oriented reform reviewed here. Some were aimed at limiting the exposure of various entities to risk as a matter of ongoing design. For example, contracts with "independent sector treatment centres (ISTCs)" under the Labour government were for given volumes of service, at a premium above standard NHS rates, whether or not those services were actually chosen by patients. Other mechanisms were transitional—as, for example, the gradual increase over twenty years in the risk exposure of insurers in the Netherlands after, as an early step, regional monopolies for social insurers were abolished in 1992. Between 1993 and 2015, retrospective payments from the centre designed to buffer insurers were gradually reduced, raising the proportion of revenue for which insurers were at risk from 3 per cent to 100 per cent. The Dutch process began in a context in which both social insurers and regulators were entering a new world of risk, although the buffering period was arguably far longer than necessary to allow for the development of a risk-adjustment mechanism.

In the United States, private insurers participating in the exchanges created under the *Affordable Care Act* faced unfamiliar risks because the new customer base was "a less educated, racially diverse population that is more likely to cycle on and off government support"[9] than that to which private insurers were accustomed. Transitional risk-buffering mechanisms for insurers were accordingly adopted, although they were designed to be in effect over only three years, from 2014 through 2016—a much shorter period than in the Dutch case.

9 PWC Research Institute, "Health Insurance Exchanges: Long Options, Short on Time" (2012), online: *PricewaterhouseCoopers* <www.pwc.com/us/en/health-industries/health-insurance-exchanges/assets/pwc-health-insurance-exchanges-impact-and-options.pdf>.

Profit

Allowing private actors to profit financially from public mandates and/or public investment attracts the criticism that it privatizes gains while socializing costs. Accordingly, policy frameworks that offer platforms for entrepreneurs to deliver public services include regulations aimed not only at cushioning failure but also at limiting profit. For example, the US *Affordable Care Act* established regulatory limits on the scope for profit for private insurers, not only within the new state-based regulated exchanges but even outside those exchanges, by establishing permissible "medical loss ratios." It required insurers in the individual and small-group market to spend at least 80 per cent of premium revenue on medical benefits, which conversely meant that no more than 20 per cent could go to administrative costs (including executive compensation) and profits. (The limit in the large-group market was 85 per cent.) But such regulations can be counterproductive: they can render the arena unattractive to private investors outside certain niche areas; they can drive entrepreneurs to adopt convoluted strategies to preserve areas of profit; and they can fail to achieve the very public objectives of innovation that prompted their adoption in the first place.

Nonetheless, there were a number of reasons for some private actors to take up these opportunities. First, they saw a platform within the public sector as an opportunity to establish a clientele to which they could market other lines of service or insurance, such as supplementary coverage for health care services not covered by public plans or even non-health insurance, such as property and casualty insurance. Second, they saw such opportunities as a way to expand market share, making them more attractive to investors, and/or increasing their bargaining power in negotiating with providers to build networks and establish rates of payment.

The Role of Private Capital under British, Dutch, and American Health Care Reforms

Britain

Although the internal market reforms of the 1990s, discussed above, had little impact on private insurers, they did open up opportunities on the *delivery* side for privately constituted and capitalized entities to provide NHS services under contract with public purchasers. (Only one entity, Bupa, is both an insurer and a health care provider.)

Until 2000, NHS purchase of care from such private providers was infinitesimally small, amounting to less than 1 per cent of the total NHS budget. From 2000 onward, the Labour government began to experiment in marginal ways to involve non-NHS entities in the provision of NHS-funded services, initially to deal with long wait times for NHS providers and later to expand patient choice. In 2005, the NHS began to contract centrally with privately owned specialty clinics as ISTCs, as discussed above, and, in 2008, the government began to allow patients to choose to receive a range of elective services[10] from "any willing provider" approved for the provision of NHS-funded services. A requirement of the contracts was that the availability of providers in the public sector could not be reduced—that is, the clinics could not "poach" providers from the public sector.[11] As well as proprietary and for-profit firms, qualified private sector providers included "social enterprises" owned by employees and/or beneficiaries, most of them spun off from public sector organizations.

These initiatives had a substantial impact within the small private sector. The share of income for private hospital facilities derived from public sources increased from 14 per cent in 2005 to 25 per cent in 2010.[12] NHS spending on secondary care commissioned from ISTCs and other private sector providers increased by 150 per cent from 2006/07 and 2011/12.[13] But this represented a marginal change from the perspective of the much larger public sector. Total funding awarded to private sector providers amounted to about 6 per cent of total NHS spending in 2014, and the chief executive of NHS England indicated that he did not expect that proportion to increase

10 Under both central and local contracts, the principal services commissioned from private providers were hip and knee replacements. The proportion of those services purchased by the NHS from private-sector providers increased from about 4 per cent to about 19 per cent between 2006/07 and 2011/12. S Arora et al, *Public payment and private provision* (London: Nuffield Trust and Institute for Fiscal Studies, 2013) 12.

11 S Turner et al, "Innovation and the English National Health Service: A qualitative study of the independent sector treatment centre programme" (2011) 73 Social Science & Medicine 522 at 524.

12 LaingBuisson, "Hospitals Competing for a Static Private Healthcare Pot" (2012), online: <www.laingbuisson.co.uk/MediaCentre/PressReleases/LaingsReviewPressRelease201112.aspx>.

13 S Arora et al, *Public payment and private provision* (London: Nuffield Trust and Institute for Fiscal Studies, 2013) 12.

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substantially.[14] Using Department of Health data, the British Medical Association estimated the proportion to be 7.7 per cent in 2016/2017.[15]

One high-profile exception to the focus of private sector providers on niche areas nonetheless drew wide attention. Circle Health, a hybrid entity with a complex and opaque corporate structure comprising for-profit and not-for-profit elements, took over, under contract with the NHS, the operation of a failing NHS hospital. After a promising start,[16] Circle Health struggled to eliminate the hospital's operating deficit, and after receiving a starkly negative assessment of its clinical services from the quality regulator, the Care Quality Commission (CQC), Circle Health chose to exit its contract.[17]

The experience of Circle Health sheds light on the inherent tensions in involving for-profit entities in the provision of publicly funded services. The broad regulatory architecture and operational culture of NHS hospitals presented a complex and largely unfamiliar environment for equity investors. The hospital sector offered the potential for neither growth nor profitability in the relevant term. Although Circle's complex structure guaranteed a stream of interest payments to its for-profit arm, it required "patient capital" (i.e., investors willing to wait for returns in the longer term) if it were to turn around a failing entity. Private investors had little appetite for seeing through such a process, especially given the increased level of central NHS oversight that had been triggered by several instances of failures in the quality of care in publicly financed NHS hospitals.

Recently, the NHS leadership has moved to re-integrate purchasing and provision functions through administrative action, without legislative change, as signaled with the emphasis on integrated-care models in the strategic document *Five Year Forward View*

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14 D Campbell, "Private firms on course to net £9bn of NHS contracts" *The Guardian* (19 November 2014), online: <www.theguardian.com/society/2014/nov/19/private-firms-nhs-contracts-circle-healthcare-bupa-virgin-care-care-uk>; G Iacobucci, "A Third of NHA Contracts Awarded since Health Act Have Gone to Private Sector, BMJ Investigation Shows" (2014) 349 BMJ g7606. >

15 British Medical Association, *Privatisation and independent sector provision in the NHS* (London: BMA, 2018) at 2.

16 UK, The King's Fund, *The UK private health market* (London: King's Fund, 2014), online: *The King's Fund* <www.kingsfund.org.uk/sites/default/files/media/commission-appendix-uk-private-health-market.pdf>.

17 UK, HC Committee of Public Accounts, *An update on Hinchingbrooke Health Care NHS Trust*, 2014/15–46.

issued by the then-new NHS Chief Executive in 2014. In subsequent implementation documents, the NHS has suggested several types of integrated care systems, giving rise to some concerns that these entities could provide vehicles for a greater role for private providers in networks spanning NHS and non-NHS providers. A leading authority on the NHS, however, discounted these allegations, among other things evoking the cautionary tale of Circle Health to point out that that "there are limited opportunities to generate profits from NHS contracts."[18]

Netherlands

In the Netherlands, because the reform legislation that came into effect in 2006 was the culmination of a twenty-year process, both health insurers and government regulators had had a long time to prepare for the new world of compulsory comprehensive coverage. The first phases of the reforms applied only to the social (public) insurers, abolishing their regional monopolies and allowing them to compete nationally. This further drove a concentration of the insurance industry through mergers and acquisitions (many involving both public and private insurers) that was already underway in the 1980s, and resulted in a market dominated largely by not-for-profit firms with regional bases but national presences. The move to a common platform in 2006 consolidated this concentration: by 2014, there were in total nine "business groups" comprising twenty-six insurance firms. The four largest firms accounted for more than 90 per cent of all health insurance coverage.[19]

Three of those firms were not-for-profit; the fourth (Achmea) was structured as a mutual insurer, nested within a complex and continually evolving for-profit corporate entity.[20] Notwithstanding their private status, insurers drew half of their revenue for the basic insurance package through the public treasury in the form of centrally collected and risk-adjusted compulsory premium payments.

18 C Ham, "Making sense of integrated care systems, integrated care partnerships and accountable care organisations in the NHS in England" (London: King's Fund, 2018), online (blog): <https://www.kingsfund.org.uk/publications/making-sense-integrated-care-systems>.

19 M Kroneman et al, "The Netherlands: Health System Review 2016" 18(2) Health Systems in Transition 1 at 33.

20 C H Tuohy, *Remaking Policy: Scale, Pace and Political Strategy in Health Care Reform* (Toronto: University of Toronto Press, 2018) 469–470.

In this context, strong norms existed regarding moderation in profit-making. Insurers are free to set their own flat-rate premiums, but in setting the compulsory income-scaled premiums, public authorities make an assumption about the level of the additional flat-rate premium that insurers will charge to generate the remainder of their premium revenue. The Dutch Authority for Consumers and Markets reports that "health insurers are expected not to make a lot of profit, even though profit-making is a core element of the free-market principle. Policymakers seek to influence this dilemma by making statements about 'desirable' behavior by health insurers when setting the [compulsory] premiums … and, at the same time, the Minister incorporates such calls in the nominal premium calculation."[21] As for the insurers themselves, the one insurer that is part of a for-profit undertaking takes pains to present itself as socially responsible, declaring that it aims at "ensuring long-term services for [our] customers," and abjures a focus on " short-term shareholder profit" in favour of "a socially responsible and accepted return on our health insurance activities."[22]

In practice, the profit margins of Dutch health insurers were below those of other insurance lines. In fact, insurers on average lost money covering the basic package in the first two years of the new compulsory regime but edged into the profitable range thereafter.[23] Even taking all of their costs and revenues into account (including those related to supplementary health insurance and investments), health-insurer profits averaged 5 per cent as a share of gross premiums in 2012, lower than any other single line of insurance,[24] even though there is some evidence that, in the post-reform period, health insurers chose to seek profit over pursuit of market share in order to add to their solvency buffers—a matter of importance for both for-profit and not-for-profit entities.[25]

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21 Netherlands Authority for Consumers and Markets, Monitor Financial Sector, *Competition in the Dutch health insurance market* (Interim report) (The Hague: Netherlands Authority for Consumers and Markets, 2016) 14–15.

22 Netherlands, Achmea, *Achmea Annual Report 2013* (Zeist, Netherlands: Achmea, 2014) 6, 16.

23 Netherlands Authority for Consumers and Markets, *supra* note 21 at 24.

24 J A Bikker & A Popescu, "Efficiency and competition in the Dutch non-life insurance industry: Effects of the 2006 health care reform" (25 September 2014) De Nederlandsche Bank Working Paper No 438, online: *Social Science Research Network* < https://ssrn.com/abstract=2501932>.

25 Netherlands Authority for Consumers and Markets, *supra* note 21.

The Dutch reforms also deregulated prices for a range of hospital services (known as "Segment B" services) beginning in 2005. Some of these services were also offered by day-surgery clinics, which, unlike hospitals, could be constituted on a for-profit basis. The number of such clinics grew rapidly after a policy change allowing for "independent treatment centres" in the late 1990s. As in England, however, these clinics functioned in niche areas and offered relatively uncomplicated, high-volume elective procedures such as surgery for cataracts and varicose veins. They accounted for a tiny portion, estimated in 2013 at about 2.3 per cent, of all specialist medical care.[26] In contrast to England, where ISTCs were paid a premium above the fee for hospitals, Dutch clinics provided care on average about 20 per cent more cheaply than hospitals—although, without adjusting for case mix, it is impossible to know whether this difference resulted from greater efficiency or less complicated cases.[27]

The 2006 reforms retained the long-standing ban on for-profit hospitals. The political climate nonetheless created uncertainty as to how long the for-profit ban would remain in place, and gave private entrepreneurs the incentive to establish footholds, gambling that the regulations would be loosened further.[28] Meanwhile, hospital-capital financing provided another route of entry for private capital, especially after a change in the hospital-financing formula allowed capital costs to be included in the pricing of services. Prior to 2008, hospital-capital projects required central approval, and funding was guaranteed either through loan guarantees or incremental additions to hospital budgets over long amortization periods. After 2008, these

26 F T Schut & M Varkevisser, "The Netherlands" in L Siciliani, M Borowitz & V Moran, eds, *Waiting Time Policies in the Health Sector: What Works?* (Paris: OECD, 2013) 185, online: *OECDiLibrary* <https://doi.org/10.1787/9789264179080-13-en>.

27 W Schäfer et al, "The Netherlands: Health System Review" 12(1) Health Systems in Transition 1 at 178.

28 Z Bouddiouan, "Redefining the Boundaries in Health Care: Hospitals and Public and Private Equity Investors." (Master's thesis, Erasmus University, 2008) [unpublished]; J van der Zwart, H de Jonge & T van der Voordt, "Private Investment in Hospitals: A Comparison of Three Healthcare Systems and Possible Implications for Real Estate Strategies" (Paper delivered at 3 TU Research Day on Innovation in Design and Management of Health Care Facilities and Healthy Environments, Rotterdam, 2009) 4, online: *ResearchGate* <www.researchgate.net/publication/49690684/download>.

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guarantees were progressively withdrawn,[29] providing yet another reason for hospitals to seek increased scale in order to reassure potential private investors.

United States

As in the Netherlands but on a much more limited scale, private insurers in the United States were drawn into a scheme of regulated and subsidized insurance through public agencies—in this case, the state-based exchanges. Even before the reforms, insurers that focused on business under contract with governmental insurance programs (primarily Medicare and Medicaid) generally had lower profit margins than those that focused on the commercial sector.[30] The *Affordable Care Act* established further regulatory limits on the scope for profit, not only within the exchanges but across the board, by establishing permissible medical-loss ratios. As noted earlier, it required insurers in the individual and small-group market to spend at least 80 per cent of premium revenue on medical benefits, which conversely meant that no more than 20 per cent could go to administrative costs (including executive compensation) and profits. (The limit in the large-group market was 85 per cent.)

In the event, as in the Netherlands, private insurers struggled to make any profit in the exchanges in the early years of the reforms.[31] These low returns were somewhat offset by the temporary risk-buffer payments noted above. And by 2017, despite the uncertainty created by Republican attempts to repeal and/or undermine the reforms, profitability had improved considerably[32]— but continued to come in well below the margins typical in other areas of the financial

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29 W Schäfer et al, "The Netherlands: Health System Review" (2016) 12(1) Health Systems in Transition 1 at 120.

30 D Donahue, "Profit Margins Converge for Top Health Plans" (1 November 2013) Healthcare Business Strategy Monthly Brief, online: *Mark Farrah Associates* <www.markfarrah.com/uploaded/mfa-briefs/profit-margins-converge-for-top-health-plans.pdf>.

31 C Cox, A Semanskee & Larry Levitt, "Individual Insurance Market Performance in 2017" (Issue Brief, Kaiser Family Foundation, May 2018), online: *Kaiser Family Foundation* <www.kff.org/health-reform/issue-brief/individual-insurance-market-performance-in-2017/>.

32 *Ibid*; Farrah Associates, "Improved Profit Margins for Leading Blue Cross & Blue Shield Plans in Third Quarter 2017" (2018), online: *Mark Farrah Associates* <www.markfarrah.com/healthcare-businessstrategy/Improved-Profit-Margins-for-Leading-Blue-Cross-and-Blue-Shield-Plans-in-Third-Quarter-2017.aspx>.

sector. This experience led to a considerable shakeout of the exchange marketplaces, with a number of insurers exiting the exchanges.[33] Thus, again, as in the Netherlands although not to the same degree, the individual insurance market in particular regions became much more concentrated. Many large insurers who had exited the exchanges, however, continued to offer managed-care plans under contract with the expanded Medicaid program, which were, on balance, profitable.[34]

Regulatory Implications of Market-Type Reforms

A common feature[35] of attempts by governments to use market-type mechanisms to achieve public purposes, in health care and other arenas, is that these reforms entail an elaboration of the regulatory presence of the state, as governments anticipate and react to the ways in which private-sector objectives could subvert public objectives. For example, where providers offered both publicly and privately financed products, there is the danger that the latter could become de facto screens for access to the former. Such might occur if supplementary insurance for services more likely to be attractive to relatively healthy populations were packaged with basic public insurance in marketing as a way for insurers to effectively cream off the market. On the health care delivery side, private payment for certain enhancements to publicly funded services, such as higher-quality lens for cataract surgery, might become a condition for faster access to the procedure. The public component of the practice or facility could become a guaranteed platform for providers to offer additional care privately. These risks are in addition to those that derive from the more traditional existence of private systems in parallel to the public system: the risk that care in the public sector will suffer if providers are drawn away into private practice, or the risk that private treatment will impose costs on the public sector if

33 US, Department of Health and Human Services, *Health Plan Choice and Premiums in the 2017 Health Insurance Marketplace* (ASPE Research Brief, October 2016).

34 US, Council of Economic Advisers, *The Profitability of Health Insurance Companies* (Washington, DC: Office of the President of the United States, 2018).

35 Steven Vogel, "Why Freer Markets Need More Rules" in Mark K. Landry, Martin A. Levin & Martin Shapiro, eds, *Creating Competitive Markets: The Politics of Regulatory Reform* (Washington, DC: Brookings Institution, 2007) at 25–42.

complications occurring in niche-based practices revert to the broadly based public sector for remedy.

In each of the three countries reviewed here, market-oriented reforms were accompanied by a growth and reconfiguration of regulatory bodies. Although their principal focus was on the regulation of the insurance and delivery of the comprehensive basic package of services to which universal (or near-universal) access was to be ensured, the effect was also to increase regulatory oversight of private insurers and providers across the board.

England

From the beginning of the internal market reforms in the 1990s to the present, central regulatory agencies were continually reconfigured along three intersecting lines of regulation. One was primarily economic, focused on the financial health of providers, the price of services, and the efficiency of local delivery in local catchment areas (the latter focus blurred by unresolved tensions between contradictory desires for strategic planning and provider competition). The principal economic regulator was Monitor, established in 2004 as with a mandate to oversee Foundation Trusts, later extended to all providers of NHS services, including those in the private sector. A second line concerned quality of care, including wait times for care, and cycled through emphases on the establishment and monitoring of centrally determined targets on the one hand or self-monitoring and reporting on the other. The CQC, established in 2009, was the successor to a previous string of quality and safety regulators. In 2010, the mandate of the CQC was extended to all providers of care, public and private. The CQC launched a comprehensive regime of regulation for the private sector in 2014 and issued its first report in 2018. A third line of oversight related to the purchasing or commissioning of service, driven by concerns about access to and integration of various types of treatment and care. This line rested with the central executive of the NHS, established as an agency (NHS England) separate from the Department of Health in 2013. The marbling of responsibilities among these various agencies and the Department of Health for matters of quality, price, financial integrity, capacity, and integration of service presented ongoing challenges, and drove various reorganizations over time. In ongoing attempts to manage these intersections, a number of agencies were consolidated, and, in 2018, a further consolidation was announced that effectively established

a regionally tiered hierarchy of regulators that integrated their operations while remaining statutorily separate agencies. In short, market-style reform in England generated a plethora of regulatory bodies and regulation, leading to recent attempts at rationalization.

Netherlands

In the Netherlands, a somewhat similar multi-pronged, complex, and shifting regulatory structure was developed as part of the twenty-year transition from the bifurcated social/private-insurance model to one of universal regulated insurance. From 1995, the quality and safety regulation of providers rested largely with a Healthcare Inspectorate, formed from the merger of three pre-existing sectoral inspectorates. A 2000 reorganization reconfigured the regulatory structure for social insurers, creating new agencies. Then with the establishment of the universal regime in 2006, all insurers were drawn under a powerful new regulatory body, the Dutch Healthcare Authority (NZa), building upon and further streamlining the structural changes of the previous decade by consolidating the tariff-regulation function and the financial and governance oversight of all insurers. The mandate of the NZa also explicitly included the promotion of conditions for effective competition, including policing risk-selection activity. A separate Healthcare Insurance Board (later reorganized to become the National Health Care Institute) continued to administer the central fund for the compulsory insurance package, including the risk-adjusted allocations to all insurers, and also played an increasingly important advisory role in the regulatory process for determining the content of the compulsory package.[36] As in England, then, the adoption of market-type reforms in the Netherlands generated an elaboration and ongoing reconfiguration of the regulatory supra-structure.

United States

Although the American reforms focussed largely on the individual and small-group market, and otherwise left the existing system of employer-based coverage essentially alone, the *Affordable Care Act* did contain provisions addressed to all private health insurers regardless of their clientele. Notably, it banned underwriting practices such as the denial or withdrawal of coverage based on

36 JK Helderman, et al, *Dike-Reeve of the Health Care Polder* (Nijmegen, Netherlands: Radboud University, Institute for Management Research, 2014).

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pre-existing conditions, and the establishment of annual or lifetime caps on benefits, which had previously been variously constrained under the terms of some employer plans and under regulations in a number of states. As noted above, it also required insurers to spend a specified proportion (which varied across markets) of their premium revenue on benefits. The more consequential requirements for mandatory enrollment, community rating of premiums, and limits on copayments that were placed on insurers who wished to qualify for participation in the state-based exchanges have been noted above. The point to be made here is that these regulations also related to off-exchange activity. Significantly, insurers participating in the exchanges also had to respect these requirements *even for plans offered off the exchanges*. And all insurers were required to offer the basic mandatory package of benefits, and to cover at least 60 per cent of actuarial costs,[37] *whether or not they offered plans through an exchange*. (Insurers participating in the exchanges were also required to offer a range of plans, covering 80–85 per cent of actuarial costs.) Each insurer was also required to maintain a single state-wide risk pool for all its plans, and thus to cross-subsidize among its own policyholders.

In an unintended development, the *Affordable Care Act* reforms also boosted the activity of a number of private web-based entities that had been developing over a decade to assist consumers in online searches for appropriate coverage. At first, because of restrictions on web-based brokers administering federal subsidies, a cumbersome "double redirect" process of ping-ponging the applicant between the broker's site and the federal site was employed. Finally, in May 2017, the Department of Health and Human Services announced a new "proxy direct enrollment pathway," to be available for certain enrollments beginning in 2018, through which consumers would be able to complete the full process, including application for subsidy, through web brokers under agreements with federally facilitated exchanges or state-based exchanges, provided that the web brokers complied with a set of regulatory conditions.[38]

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37 At this level, insurees could expect to have to cover 40 per cent of their health care expenses through deductibles and copayments. This was the requirement for the least expensive plans offered on the exchanges.

38 T Jost, "CMS to Expand Direct Enrollment on HealthCare.gov" (17 May 2017), online (blog): *Health Affairs* <https://www.healthaffairs.org/do/10.1377/hblog20170517.060181/full/>.

Thus were private web brokers, as well as insurers themselves, drawn into the public regulatory orbit.

The Private Market in Britain

As noted above, a purely private market (on both delivery and demand sides) has existed in Britain in parallel to the public system from the beginning of the NHS. Although this sector was little affected by the internal reforms with which I am concerned here, it merits some attention because of its relevance to the current Canadian debate. An excellent overview can be found in a report by the Kings Fund,[39] a health think tank, and a few points can be summarized. The small private market is heavily focused on elective surgery; it is estimated that only about 3 per cent of GP visits, as compared to about 13 per cent of elective surgery, take place on a private basis.[40] The private hospital market is dominated by a few large chains, with the seven largest accounting for about 75 per cent of the market. This degree of concentration, considerably higher in London, has drawn attention from the UK's Competition and Markets Authority, which, in 2011, launched an investigation that led initially to two large firms being ordered to divest themselves of certain hospitals. The ruling was successfully appealed by the firms, and the final result was a regime in which hospitals were required to publicly report information on their prices and other data.[41]

Only a small minority of the British population takes out private insurance: having risen sharply in the 1980s, the proportion has remained in the 10–12 per cent range over the past two and a half decades, although the content of those policies varies widely.[42] Private insurance accounted for only about 3.3 per cent of total health

39 UK, The King's Fund, *The UK private health market* (London: King's Fund, 2014), online: *The King's Fund*, <www.kingsfund.org.uk/sites/default/files/media/commission-appendix-uk-private-health-market.pdf>.

40 *Ibid* at 3–4.

41 UK, Competition and Markets Authority, *Private healthcare market investigation* (London: Competition and Markets Authority, 2017), online: www.gov.uk/cma-cases/private-healthcare-market-investigation.

42 T Foubister et al, *Private Medical Insurance in the United Kingdom* (Copenhagen: European Observatory on Health Systems and Policies, 2006) 40, 55; UK, The King's Fund, *The UK private health market* (London: King's Fund, 2014) 3, online: <www.kingsfund.org.uk/sites/default/files/media/commission-appendix-uk-private-health-market.pdf>; LaingBuisson, "Hospitals Competing for a Static

expenditure in the United Kingdom in 2016.[43] The balance between employer-based and individually purchased coverage shifted over time, as employer-based coverage rose from roughly half of the total in the 1980s to about 82 per cent in 2011.[44] Coverage rates are highest in the forty to sixty-four age group and lowest for those over sixty-five.[45] The industry is concentrated in a few large firms: the largest two insurers accounted for an estimated 62.5 per cent of coverage in 2003, and the largest four accounted for 78 per cent.[46] Given their niche focus, relatively healthy enrolled population, and industry concentration, the large private health insurers in England are generally more profitable than the more comprehensive private insurers in the United States.[47] Unlike the case in many other nations, including the United States, Canada, and Australia, there is no tax subsidy in Britain for employer-based insurance; on the contrary, such coverage is not only taxed as income but is also subject to an additional tax on insurance premiums.[48]

Although, as noted, the reforms discussed here were not aimed at this private sector,[49] they did nonetheless have some impact on private-sector firms. First, private providers were regulated at the interface between public and private sectors; for example, they were subject to central economic regulation (aimed at ensuring the financial stability of providers) if they provided any services under contract with the NHS. Other controls were embedded in these contracts,

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Private Healthcare Pot." (2017), online: <www.laingbuisson.co.uk/MediaCentre/PressReleases/LaingsReviewPressRelease201112.aspx>.

43 UK, Office for National Statistics, *UK Health Accounts: 2016 Statistical bulletin* (2018), online: <www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/bulletins/ukhealthaccounts/2016#financing-of-healthcare>.

44 UK, The King's Fund, *The UK private health market* (London: King's Fund, 2014) 2, online: <www.kingsfund.org.uk/sites/default/files/media/commission-appendix-uk-private-health-market.pdf>.

45 T Foubister et al, *Private Medical Insurance in the United Kingdom* (Copenhagen: European Observatory on Health Systems and Policies, 2006) 50–51.

46 *Ibid* at 61.

47 *Ibid* at 71.

48 *Supra* note 44 at 5.

49 The Thatcher government in the late 1980s briefly considered a proposal to radically reform the system of health care financing around a voucher model built on a much larger role for private finance, before rejecting that option in favour of the internal market reforms aimed at public-sector purchasers and providers.

such as the "anti-poaching" provision noted above.[50] Specialist physicians working in both public and private sectors were required by their contract to spend a specified number of hours in the public sector. But even in their purely private activities, privately owned and operated facilities were drawn under the ambit of the quality regulator that was a product of the reforms (the CQC) and held to the same standards as NHS providers *whether or not they were offering NHS-funded services*. Because the remedy sought in the *Cambie* case would bring Canada closer to the British parallel-sector model, it is worth noting that actual experience in Britain suggests that effecting that remedy would not likely achieve the freedom of action expected by the plaintiffs, especially if they spanned the public-private boundary by offering services on both a publicly and a privately paid basis.

Summary—and Implications for Canada

There are lessons in this review of experience of market-oriented reforms for both government policy-makers and private actors. The first concerns the unexpected and unintended consequences of reform, especially for those who might have expected a diminution of the role of government. The effect of all of the reforms discussed was increasingly to draw private providers, insurers, and brokers under the regulatory umbrella of the state, and to increase the overall weight of social control of individual behaviour.[51] This phenomenon more generally has led scholars to speak of the emergence of "regulatory capitalism"[52] or the "post-regulatory state."[53] The nugget of this insight is the recognition of the increasing *interconnectedness* of forms of social control as governments seek to act through what has been called "meta-regulation": stimulating, steering, guaranteeing, and auditing private mechanisms of market governance and professional self-regulation.[54]

50 See note 11.

51 Tuohy, *supra* note 1 at 561–62.

52 D Levi-Faur, "The Global Diffusion of Regulatory Capitalism" (2005) 598 Annals of the American Academy of Political and Social Science at 12.

53 C Scott, "Regulation in the Age of Governance: The Rise of the Post Regulatory State" in J Jordana & D Levi-Faur, eds, *The Politics of Regulation: Institutions and Regulatory Reforms for the Age of Governance*, (Cheltenham, UK: Edward Elgar, 2004).

54 *Ibid* at 664.

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A second lesson concerns unanticipated developments among privately capitalized providers and insurers of health care themselves. Where reforms were deliberately aimed at universalizing or substantially expanding coverage by regulating private insurers and subsidizing their clientele (as in the Netherlands and the United States), the incentives facing private-sector entrepreneurs as they sought to take advantage of public mandates drove a further concentration of the insurance industry, especially in regional markets. Because regulatory constraints limited the potential for profit, insurers and providers sought to increase profits by expanding their customer/patient base—both to realize economies of scale and to buttress their positions in negotiating contracts in which the currency was "enrolled lives" and catchment areas. In both the Netherlands and the United States, this dynamic propelled a series of mergers on both the demand and, to a somewhat lesser extent, the delivery sides of the market. A corollary development was an increasing complexity of structures of accountability. In some cases, this complexity of the regulatory structure was mirrored in the corporate structures of the regulatees themselves, as they sought to limit the reach of regulators and, especially, the application of strictures against profit-making. In both the Netherlands and the United Kingdom, private firms such as Achmea and Circle Health were part of intricate ownership structures that allowed for-profit parent companies to benefit from the business of the not-for-profit that held public mandates or contracts.

A third lesson is not new but is reinforced by experience under the reforms. The presence of universal public coverage for a comprehensive range of services (as in Britain and the Netherlands) means that private providers are likely to focus on niche areas of provision. This has long been the lesson of the parallel private market in the United Kingdom, and those niche focuses were reflected under public contracting with private providers (with the rule-proving exception of a failed private contract to run an NHS hospital). In the Netherlands, public contracts with private clinics as part of the reforms also displayed this niche-based phenomenon.

None of these reforms shrank the fiscal presence of the state in the health care sector.[55] The public share of total health expen-

55 This observation seems to hold for market-oriented reforms in the welfare state more generally; see, e.g., F Castles, *The Future of the Welfare State Crisis Myths and Crisis Realities* (Oxford: Oxford University Press, 2004).

diture, and the share of health care spending in public budgets, grew in the Netherlands and the United States from 1985 to 2012, while remaining relatively constant in the United Kingdom.[56] But while market reforms did not diminish the influence of the state in fiscal terms, the organizing principles underlying state influence did change. The state's legitimate functional role was increasingly understood to be one of regulation and contracting, rather than direct management, even where, as in the Netherlands and United States, the scope of public authority expanded. Ironically, only in Canada, where market-oriented reforms in the physician and hospital sectors were explicitly resisted, did the fiscal share of the state contract, as the design of the single-payer system failed to keep pace with technological change. Even so, the public share continued to dominate, shrinking from 76 per cent to 70 per cent from the 1970s to the 1990s.

So, what can we expect in Canada? Should there be an opening to a greater role for private clinics, either in contracting with the public sector or on a purely private basis? Experience in other nations suggests that the material effect would likely be marginal and confined to niche areas, and would be constrained by new forms of regulation. Concerns have been raised that accustomation to a greater role for private finance could undermine political support for the public system. Evidence of such an effect in other nations is mixed,[57] and it has not been studied in the Canadian context, where the principle of coverage on "uniform terms and conditions" is a key component of a health care system that has come to be emblematic of "Canadian values."

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56 Tuohy, *supra* note 1 at 548, 559–61.

57 Tuohy and colleagues find limited evidence that an *increase* in the private share of finance was likely to fuel public demand for increased public spending in eleven nations, not including Canada. C H Tuohy, C M Flood & M Stabile, "How Does Private Finance Affect Public Health Care Systems? Marshalling the Evidence from OECD Nations." (2004) 29 J Health Pol Pol'y & L 359 at 388. Burlacu and Immergut, however, find that individuals who switched from public to private insurance, or who took out supplementary private insurance coverage in Germany, became *less* supportive of the public system. D Burlacu & E M Immergut, "Welfare State Institutions and Welfare State Attitudes: Using Privatization to Gain Causal Leverage on the Problem of Attitude Formation" (Paper prepared for presentation at the 114th APSA Annual Meeting, Boston, 30 August–2 September 2018).

Private capital can play a role in systems of universal coverage, within well-considered policy frameworks. The evidence presented in this chapter has suggested both the opportunities and the challenges inherent in developing such frameworks. Canadian policy-makers have so far avoided these questions, allowing the scope of public coverage to shrink de facto. That may no longer be a tenable stance.