

# **INTERNATIONAL EXPERIENCE WITH MANAGED CARE, MANAGED COMPETITION AND INTERNAL MARKETS: LESSONS FOR CANADA**

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## INTRODUCTION

Every wealthy country distributes some health care on the basis of need and not ability to pay. Even the US has public programs for those over 65 (Medicare) and for the very poor (Medicaid). This goal of redistribution from the wealthy to the poor and from the well to the sick justifies extensive public funding and regulation and the result is that large parts of the health care sector do not operate within the usual rules of the market.

Governments provide public health insurance so that people can get the care they need without fear of the cost. But every country has had to wrestle with how to control the cost of health care. The cost of health care is a function of how many services are provided multiplied by the price of these services.

**Total cost of health care = Number of Services Provided x Price of Services Delivered**

The price of services is, in turn, a function of the cost of inputs which is related to the complexity of the service and the level of compensation for the skill and labour of providers.

How do countries control the number of services provided and the price of services? Looking at the number of services, the obvious answer is that services are only provided to those who are in “medical need”. But there is no objective standard for “medical need” -- it is much more of a subjective concept. Health care treatments may range from being of enormous benefit for many patients (life-saving) to being of only a very small benefit for a few patients. At some point when the benefit of treatment is small we begin to question whether the treatment is really responding to a medical need. Looking at the Canadian system that, like all other publicly funded systems, has to operate within the limits of a public budget, the big question becomes how to prioritize medical needs and medical treatments. Historically Canada and other countries have relied on doctors to distribute the public resources put into health care and it has been assumed that doctors will only deliver care that is “medically necessary.” This means that whatever doctors supply in terms of services and however much that costs will be the natural boundary on health care spending – it must be as doctors are only providing that which is medically necessary. But doctors in Canada are still paid on a fee-for-service basis and thus have no incentive to consider the costs and benefits of the various treatments they recommend or prescribe. Accordingly very little information about a treatment's costs or health care outcomes have been generated and the status quo is perpetuated for want of any evidence that this is a good or a bad thing.

Throughout the 1970s and 1980s nearly all developed countries became concerned about increases in total health care spending. Partly this concern was because a significant portion of health care spending comes from the public coffers. But another reason is that health economists and policymakers were starting to question whether all this additional spending was value-for-money. In other words, increasing spending on *health care* didn't seem to be resulting in large improvements in *health*. Below we take a closer look at the alleged sources of inefficiency, in particular the problems health economists call “moral hazard” and “information asymmetry”.

The first response of Canadian governments to rising health care costs and concerns about inefficiency was **not** to intervene in doctors' decisions about what services to supply or prescribe to whom and in what priority. Rather the first step was to restrain total health care spending by restraining the total number of resources flowing into the system – the number of doctors, nurses,

and other health care providers, the number of hospital beds, technology, etc. Behind this approach lay the assumption that doctors distributed whatever public resources they were given in a fair way and the (misguided) assumption that doctors had sufficient information about the costs and benefits of treatment.<sup>1</sup>

In many countries, governments and private insurers (the payers) have taken additional steps beyond restricting inputs into the system (the numbers of doctors, nurses, technology, etc) or limiting the price charged by providers. They have started to actively manage doctors' previously unfettered decision-making about what health care services should be supplied to which patients, in which priority, and in what time frame. To put it another way, payers have started to put in place incentives for doctors to discriminate and prioritize between patients' health care needs and to stop providing treatments of very little benefit. In broad-brush strokes this can be described as the rise of "managed care." Managed care is at the core of health care reform proposed and/or implemented in most countries through the 1980s and 1990s. For example it is a core part of President Clinton's unsuccessful proposal for managed competition reform in 1993, it has been a source of a revolution in health care delivery in the US private insurance industry, and is a key component of the reforms being implemented in the Netherlands. It is also a key part of internal market reform implemented in the UK and New Zealand. In this paper we seek to explore what lessons Canada can learn from the experiences of these other countries with managed care, managed competition and internal market reform.

## **INEFFICIENCY IN HEALTH CARE MARKETS: MORAL HAZARD AND INFORMATION ASYMMETRY**

Before turning to examine managed care, managed competition reform and internal market reform, let us look more closely at sources of inefficiency in health care markets. Why are health care markets viewed as inefficient? Although the characteristics of health care markets can vary significantly and one must be cautious in generalizing, the problems relate to what economists describe as "moral hazard" and "information asymmetry."

### **i. Moral hazard**

Moral hazard is said to arise when an insured patient, after becoming ill, uses more health care than they would without insurance. This shouldn't be that surprising – why we want insurance is of course so that we don't have to worry about the cost of care when we need it the most. Moral hazard occurs in private and public insurance systems – it doesn't matter where the insurance comes from – it is the fact of insurance that allows us as patients not to worry about the cost of care when we need it.

So on the one hand the good thing about full insurance (whether public or private) is that it buys security and peace of mind but the problem of moral hazard is that full insurance allows us to be totally insensitive to the cost of care we receive. So as a patient, if I have full insurance, I may not think twice in filling a prescription for a drug that is ten times the cost of an alternative even though the only difference is that the cheaper drug makes me feel slight nausea. How big a problem moral hazard is will depend on the kind of health service. So for example, there are very few people who would want more surgery than they are told they actually need or must have because of the very unpleasant side effects and risks associated with surgery. But with full insurance a patient will likely be insensitive to the fact that one hospital is much more efficient at

providing the needed surgery than another. Also, while people may not happily consume more surgical services they may well be happy to use more home care services, massage therapy, or psychotherapy services if they are offered.

## ii. Information asymmetry

In general, doctors know more than their patients about what is wrong with the patient and what health services will benefit the patient. Economists describe this as an “information asymmetry.” As patients we rely on doctors to tell us not only what is wrong with us (diagnosis) but also what is needed to fix the problem (treatment). So really although moral hazard is a problem as discussed above it is really a problem about doctor decision-making to the extent that patients hand over the decision-making reins to doctors. This leads to a phenomenon called “supplier-induced demand”. This is where in the face of fee restrictions doctors provide more services to patients in order to maintain their incomes. So for example, one study showed that when doctor fees were frozen from 1971 to 1976 in Quebec, per capita service use grew at an annual rate of 9.6%. By 1976, per capita utilization was 58% higher than in 1971.<sup>2</sup> Whether or not doctors do actually create demand for their own services is a matter of debate. There are many studies that conclude doctors are influencing demand for their own services.<sup>3</sup> On the other hand, others argue that these studies are inconclusive.<sup>4</sup> Clearly, there will be differences in the ways that doctors respond to financial incentives and there are many factors influencing doctor behaviour.<sup>5</sup> These factors include education and training, the practice of colleagues and peers, and absorption of ethical norms. Doctors will also make trade-offs between working longer hours and generating a higher income by providing more services.<sup>6</sup>

We believe that the important issue is not whether doctors induce demand *for their own services* but that it is doctors who make most of the decisions that drive the costs of the system. Historically, doctors have had little or no incentive to take into account the *cost of things they prescribe or recommend*. Doctors are the gatekeepers to the rest of the system but they have historically been gatekeepers that have not had to weigh the costs and benefits of their decisions. In fact, economists contend, many treatments recommended by doctors are only of marginal benefit or, indeed, are ineffective. Stoddart *et al.* note the estimates of the cost of doctor-generated inappropriate use of health care services varies but are sometimes as large as 30-40% of all services including hospital services and drugs.<sup>7</sup> Many health economists view the fact that doctors are not very sensitive to the cost of the varying services and treatments they supply or recommend as a key cause of cost escalation in health care systems.

## iii. Moral Hazard + Information Asymmetry = Directing Incentives to Doctors

Many health policy analysts view the combination of the problems of moral hazard and information asymmetry as a key cause of escalating costs and inefficiency. In this critique doctors are viewed as having little or no incentive to take into account the costs and benefits of care provided or recommended. Since doctors hold the reins of decision-making with regard to choice of treatment, this leads many health policy analysts to argue that incentives should be trained on doctors **rather** than patients (through user charges or copayments).<sup>8</sup> Obviously there are those that will disagree with this characterization of how health care markets work -- doctors in particular point to the increased information patients have and how patients themselves demand the best possible care. Notwithstanding, this characterization of how health care markets work

and assumptions about the impact of doctors' decisions on total costs underlies many recent reform initiatives around the world.

#### **iv. Absence of Direct Management or Intervention on the Part of Payers**

Historically, both public and private insurers have been passive "indemnity insurers." What this means is that the payers in the system have not tried to actively intervene in doctor decision-making. Historically, doctors have been paid a fee for every service they decided to provide (this is called a "fee-for-service" payment), largely leaving to them determinations of what care to provide and prescribe to whom and when. As governments through the 1970s and 1980s sought to restrain growth in public spending their first response was to limit the number of doctors coming into the system and the public resources that doctors have to work with (e.g. the number of hospital beds, nurses, medical technology). It was assumed that doctors, although they may have to make tougher choices, would still make fair choices between different patients and their medical needs. There were also initiatives taken to put in place "global budgets" for hospitals in an effort to control costs and increase managerial flexibility and also initiatives, discussed above, to control the prices of services. But there was little direct management on the part of payers (public or private insurers) to ensure:

1. the best allocation of resources between different health needs, e.g. whether more should be spent on preventative care than on high tech interventions like organ transplants;
2. the choice of the most cost-effective service in response to each particular need, e.g. requiring that a generic drug be used in treatment of a particular condition as the more expensive drug had only marginal health benefits and is triple the price.

All this started to change in the late 1980s and 1990s albeit in different degrees in different nations. The transition from passive indemnity insurer to prospective block budgets for hospitals to proactive purchasing of all health care services is depicted in the table below.

**Changing Systems<sup>9</sup>**

|                              | <b>Pre-1980</b>  | <b>1980's</b>   | <b>1990's</b>   |
|------------------------------|--|---|---|
| <b>Role of the Purchaser</b> | <p>public or private indemnity insurer</p> <p>(most systems historically)</p> <p>no active purchaser</p> | <p>public insurers shift to block funding for hospitals</p> <p>-capping the total spent but otherwise a passive payer</p> | <p>proactive purchasing of all health care services</p> <p>-managed care</p> <p>-managed competition</p> <p>-internal markets</p>                         |
| <b>Level of Competition</b>  | <p>-no competition between purchasers or providers</p>   | <p>-no competition between purchasers or providers</p>  | <p>-seeks to foster competition between providers (internal markets) or between insurers/purchasers offering managed care plans (managed competition)</p> |
| <b>Paying Providers</b>      | <p>-fee for service payments (retroactive)</p>   | <p>-prospective annual budgets for hospitals but still generally fee-for-service for doctors</p>                          | <p>-a variety of techniques but may pay on a capitation basis (a fixed sum per annum per person)</p>  |

## **MANAGED CARE, MANAGED COMPETITION, INTERNAL MARKET REFORM**

Concerns about increased public spending on health care and inefficiency in health care have justified a number of reform initiatives in countries like the UK, New Zealand and the Netherlands. Most of the reforms have tried to work within a publicly funded or progressively funded system so as to ensure health care is available on the basis of need and not ability to pay. The reforms have aimed to enhance efficiency through greater management by payers (public and private insurers) and greater competition amongst doctors, hospitals and other health care providers.

The three primary modes of reform are managed care, internal market reform, and managed competition reform. These reform initiatives are inter-related:

1. managed care is an essential component of both internal market reform and managed competition reform and can be a feature of any health care system;
2. internal market reform is a version of managed competition reform modified for single-payer systems like the UK and New Zealand.

### **MANAGED CARE**

Managed care encompasses a wide variety of initiatives.<sup>10</sup> But at the core of managed care is the idea that a payer (who may be the government, a private insurer, an employer or a consortium of hospitals and/or doctors) can influence the treatment decisions made by doctors and other providers. In other words, the payer tries, through a variety of means, to influence or manage the cost, volume, and quality of health services supplied and/or recommended by doctors and other health care providers.<sup>11</sup>

Managed care can form part of any health care system. It is, however, a key feature of recent health reform initiatives in a number of countries. It is the engine that drives managed competition reform and is vital to internal market reform. In the US, since the failure of Clinton's 1993 reform proposals, there has been a managed care revolution in the private sector.

To better describe managed care it is probably best to list some of its features:

- 1) It represents a shift from simply reimbursing hospitals and doctors for every service they provide. In managed care arrangements, payers monitor and review what care is delivered and to whom;
- 2) A payer may limit a patient's choice of providers to those it has contracted with and impose a surcharge on patients who choose providers outside of those listed;
- 3) A payer may seek to contract with or employ doctors whose are more like to promote cost-effective primary and preventive care;

- 4) A payer may pay doctors or groups of doctors and/or other health care providers on a capitation basis, i.e. a fixed sum per patient for a fixed time period (generally per month or per annum);<sup>12</sup>
- 5) A payer may enter into a variety of business relationships with health care providers. For example, a payer (be it the government or an insurer) may own hospitals and employ doctors on a salaried basis. Or the payer can contract with private for-profit or not-for-profit providers on an arms-length basis.

It is best not to think of managed care as any one particular initiative or set of initiatives. Rather it is a shift from the idea of passive payment of costs to active management by payers of doctor and provider decision-making. Managed care turns on the power of incentives -- be they financial, professional, ethical or organizational. It recognizes that, for example, there is no single optimal method of paying providers (i.e. one can't say categorically that it is best to pay providers on a salary basis, fee-for-service basis, capitation basis, global budgets, case-based basis etc.) "All methods generate both adverse and beneficial incentives affecting the volume, quality, and mix of services."<sup>13</sup> Thus what is the best payment method will vary over time and between health care providers. Managed care does not prescribe a recipe or prescription for doctor payment but allows for payers to structure and change incentives in order to influence doctor and provider decision-making.

The US system is the one most typically associated with managed care, although the experience there has been primarily in the privately funded sector. The shift from traditional fee-for-service insurance to managed care has helped control costs in the early 1990s<sup>14</sup> (although it now appears this may have been a "one-time-only" gain, achieved through aggressive negotiations on the part of managed care plans for price discounting by providers).<sup>15</sup> As well, managed care has been shown to confer enhanced benefits and eliminate wasteful overuse of services.<sup>16</sup> It seems that (at least some) managed care organizations put more emphasis on primary and preventative care and less on high-tech curative care. For example, 80% of women aged 50-74 enrolled in the Kaiser Permanente managed competition plan in Northern California had received mammography screening, compared to 25% of women in this age group in the population as a whole, and pediatric immunization rates (DPT, Polio, Measles-Mumps-Rubella) were over 90% in Kaiser plans, compared with a national average of 37%.<sup>17</sup>

But there are concerns about the impact of the managed care revolution on the quality of care delivered and on access for high-risk groups and stories about evil managed care insurers proliferate the popular press. There are two main concerns about managed care in the US:

1. that managed care organizations select through a variety of means healthier enrollees and try to deter or drop unhealthy enrollees (a phenomenon known as "cream-skimming");
2. that managed care plans cut the quality of care delivered in order to make profits.

These concerns have fostered regulatory measures at both the federal and state levels to protect a certain range of entitlements to comprehensive, quality care delivered in a timely and effective manner.



Any general conclusions about the benefits or problems of managed care have to be viewed in the light that there are many different kinds of managed care initiatives in the US. Each version of managed care results in a different mix of incentives for health providers and Mechanic notes that it should be no surprise in the US that there are large variations in practice, levels of performance, and doctor and patient satisfaction.<sup>18</sup> Undoubtedly there is value in closely examining the US laboratory of managed care initiatives. However, from the perspective of garnering lessons that Canada can learn from other countries' experience with reform at a systems level, it is probably of more value to explore how managed care initiatives have played out in jurisdictions like the UK, New Zealand and the Netherlands that seek to ensure access for all citizens to the same range of care. This is because the problems that are apparent in the US with managed care may have more to do with the for-profit environment and the lack of regulatory commitment to ensuring universal access than with managed care itself. In other words, how managed care plays out in a system with a commitment to universal access on the basis of need and not ability to pay may be completely different to how it has played out in the US. With that in mind let us turn to look at managed care as part of managed competition reform in the Netherlands and as part of internal market reform in the UK and New Zealand.

## **MANAGED COMPETITION REFORM**

A managed competition system envisages government regulation of competing private insurers in order to achieve the goal of ensuring access for patients on the basis of need and not ability to pay. It is a system set up to ensure competition on the basis of cost and quality rather than what normally private insurers compete on -- risk avoidance.<sup>19</sup> Insurers are expected to be not only insurers but to be active buyers of care and manage the delivery of care -- to use "managed care".

Although a managed competition system proposes greater reliance on private insurers (or more accurately private management) it is also a system that is largely financed progressively -- people pay in according to what they afford and take out according to their needs. Managed competition might be perceived as US-style reform because it still allows for a significant role for private insurers but it is very different for the goal is to ensure universal coverage of citizens for a range of health care services.

Managed competition requires sophisticated regulation. The regulator has to pool contributions (whether from general taxation revenues or income-adjusted premium payments from individual citizens). The regulator oversees the process of each citizen picking an insurer and then pays, on behalf of each citizen, a risk-adjusted sum to each citizen's chosen insurer. For example, a disabled elderly man would have significantly more paid on his behalf to his chosen insurer than a healthy 30-year-old non-smoking female. Each citizen must also pay a small flat-fee directly to his or her chosen insurer -- the fee must be the same for each and every individual enrolled with the insurer. The idea with the small flat-fee payment is to provide some incentive for insurers to compete on reducing premium price in addition to competing on quality. The managed competition model can be viewed as a sophisticated voucher scheme. It allows a measure of choice by consumers within a progressively financed scheme and is thus a means of enhancing the accountability of the system.<sup>20</sup>

The managed competition model envisages that once insurers have an incentive to compete on cost, price, and quality that they will enter into various forms of managed care relationships with health care providers. In fact, Enthoven, the creator of the managed competition model 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>21</sup>

Managed competition and managed care are concepts that are often confused. Managed competition is a reform model for an entire system where the ultimate goal is to ensure coverage for all, on the basis of need as opposed to ability to pay. Managed care is an important feature of a managed competition system but also may be a feature of other systems that do not aspire to ensure coverage for all. In the US, the managed care revolution is not part of a planned and integrated health system. Insurers in the US still compete on their ability to avoid risk (i.e. to avoid enrolling people who may have high health expenses). Present developments in the US can be distinguished from a managed competition system. In the latter there would be coverage for all citizens, it would be progressively funded apart from a small fixed premium payment, and explicit regulatory mechanisms would be in place to stimulate competition on cost and quality dimensions rather than avoiding covering high-risk and high-cost individuals.

## MANAGED COMPETITION IN THE NETHERLANDS

The Netherlands has been slowly implementing a version of managed competition reform since 1987. There were two goals for this reform. The first goal was to expand the mandatory insurance programs to cover all citizens for most care. The second goal was to encourage competition between the Sickness Funds (the non-profit insurers for the mandatory health insurance scheme covering the poorer 60% of the population) and private insurers (covering the wealthier 40% of the population who choose to purchase insurance).

Some important features of the managed competition proposals have been implemented but many important aspects have not. Earlier versions of the managed competition reform proposals had provided for the integration of acute and long-term care and proposed extending the Exceptional Medical Expenses scheme (the only insurance scheme in the Netherlands that is mandatory for all citizens) to cover all health care. However, there was concern about how to assess accurately the risk of the need for long-term care as this requires a projection many years into the future.<sup>22</sup> It was determined that it was better to leave these sorts of services to be provided independently of a competition-oriented scheme.<sup>23</sup> As a consequence, the 1995 reforms provide for the retention of a separate Exceptional Medical Expenses scheme, but it has been scaled back to only cover long-term care and mental health care. All other goods and services previously covered under the Exceptional Medical Expenses scheme, such as drugs, medical devices, rehabilitation, and hospital-related home care services are now the responsibility of Sickness Funds and private insurers.<sup>24</sup>

With respect to services considered "curative basic care", which is pretty much everything except long term care and mental health, the government is proceeding with earlier proposals for managed competition at least with regard to Sickness Funds but as yet has made no inroads with regard to private insurers.<sup>25</sup>

What is the relevance of managed competition reforms from a Canadian perspective? It seems highly unlikely that Canada will shift to a regulated system of competing private insurers for hospital and doctor services. Canada does not have the same long and established history in this regard as the Netherlands of regulating private insurers nor does it have the need to have to

accommodate private insurance interests as, for example, the US does in order to achieve a universal plan. However, the managed competition model is of more relevance as Canada considers how to ensure national standards of access to drugs and home care. Quebec has used a managed competition model, regulating competing private insurers, in an effort to put in place universal access for prescription drugs. Is this approach feasible from the perspective of a national Pharmacare plan? Is this a feasible means by which to expand access without relying on taxation-generated revenues but primarily upon employer and employee contributions?

The other way in which managed competition reform in the Netherlands is relevant to Canada is in considering how to fund Health Authorities or budget-holding groups of doctors and other health care providers. Devolution of financial and managerial power away from provincial ministries of health to regional health authorities has been a popular reform initiative in every province except Ontario. Devolving responsibility via global annual budgets is intended to increase managers' flexibility while holding them accountable for efficient performance. However, the prospects for efficiencies are limited if the budgets that health authorities receive are based on historical spending patterns -- this just entrenches old inefficiencies and does not necessarily compensate those authorities that serve more needy areas. As Canadian provincial governments consider how to structure budget allocation formulas for Health Authorities there is much to be learnt from the Dutch experience. Also should health authorities seek to contract with budget-holding groups of health care providers (along the lines of the UK General Practitioner (GP) Fundholders or New Zealand's Budget-holders) then they, in turn, will also need to consider how to structure budget allocation formulas to ensure the efficient delivery of care of adequate quality.

There are a number of difficulties with a managed competition system. Its obvious virtues are its reliance on consumer choice and the potential for efficiencies from competition within a progressively funded system. It aspires to harness market-like forces but within a system that is fair and has much the same redistributive values as the present Canadian system, although very much different in design. It does, however, take both sophisticated regulation and good information to work. Some of the problems that have to be addressed include:

- 1) 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;
- 2) determining the rules for price competition between purchasers;
- 3) the need to define "core" services i.e. the range and quality of services purchasers will compete to provide (or, from the other side of the coin, the need to define consumer entitlements);
- 4) the question of whether consumers have or will have sufficient information to choose wisely between competing purchasers;
- 5) the problem of transactions costs; and
- 6) the problem of supply side monopoly.<sup>26</sup>

By far the largest concern here is the issue of cream-skimming. It is the Dutch response to this problem of cream-skimming that warrants study and consideration in the Canadian system.

In the managed competition model a regulator collects contributions on a progressive basis (usually the proposals require contributions from employers and employees as a percentage of income). Thus the system is financed according to ability to pay as opposed to need. Citizens' contributions do not depend upon their health cost and/or risk profile. The regulator pays on behalf of every individual a fixed annual premium to that individual's chosen insurer in return for which the insurer undertakes to cover all of that individual's health care needs for a comprehensive range of services (as defined by regulation) in that year. As mentioned above, this is in effect a sophisticated voucher scheme. However, if competing insurers receive the **same** premium for every individual they insure then they have an incentive to cream skim. In other words, insurers have a financial incentive to spend time and resources trying to attract the health and young into their plans and to deter the elderly, unwell and the likely unwell from coming into their plan.<sup>27</sup>

There are some obvious regulatory responses to this cream-skimming problem. For example, regulation should require insurers to accept all that seek to enroll in their plan. But cream skimming tactics can be subtle. One tactic may be to contract with certain types of providers, for example not contracting with the best HIV treatment centre. What Dutch policymakers have realized is that the best solution to this problem of cream-skimming is to correct the financial incentives that encourage it. This requires a regulator to risk-adjust the premiums paid so insurers receive **different** premiums that reflect **different** risks. Competing insurers are compensated for the different risks of the people who are covered by their plan and so insurers have no incentive to drop high-risk individuals or avoid them. Appropriately risk-adjusting premiums is essential to ensure fair competition in a managed competition model. If this is not done then those insurers who are better at cream skimming will make more profit than those insurers who are actually more efficient. This kind of risk-adjustment of payment needs to be made to insure the viability of those insurers who have attracted a disproportionate share of people with high health care costs. Similarly, in Canada, health authorities and risk-bearing groups of health care providers should receive risk-adjusted payments so that they can meet the health care needs of the population they service.

An obvious reaction to this is that accurately assessing someone's risk of health care is an impossible task. In a managed competition system all that is required, however, is that payments are adjusted so that each insurer receives a premium per enrollee that reflects the insurers' perceptions of the particular individual enrollee's risk of utilization of health care services. It is insurers' perception of risk that is important as opposed to what the risk is in truth is. If an insurer does not perceive an individual to be of high-risk then the insurer will not try to exclude the person from coverage. Still there may also be safety-nets in place so that if an insurer is just unlucky as opposed to inefficient and has a very high proportion of people with extreme health care costs then the regulator/funder does not become insolvent.

In the Netherlands, the Central Fund regulator has slowly moved towards risk-adjusting payments. In 1993 and 1994 premium payments were differentiated on the basis of age and gender alone and did not include risk factors that could be readily ascertained by competing insurers such as an individual's chronic health status or medical history.<sup>28</sup> Dutch scholars 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>29</sup> They note that it is easy for purchasers to identify those individuals with the greatest non-catastrophic health care expenditures in any year. % 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>30</sup> The inequity of inadequately risk-adjusted premiums has been acknowledged in the Netherlands. As a consequence, in 1993 and 1994, the government only required the Sickness Funds to be financially responsible for 3% of the difference between their actual expenditures on health care services for their enrollees and the total premiums received from the Central Fund regulator.<sup>31</sup> This percentage was subsequently increased to 14% in 1996, 27% in 1997<sup>32</sup> and up to 35% in 1999.<sup>33</sup>

Van de Ven and Schut contend there are a number of misunderstandings that lie at the root of why the Netherlands has been slow to implement a system of adequately risk-adjusting payments.<sup>34</sup> The most relevant of these from a Canadian perspective is the misunderstanding 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>35</sup> 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. This issue clearly then is of relevance in Canada for our capacity to determine risk-factors of different populations vs. individuals may influence what level of devolution is efficient (e.g. to larger Health Authorities, smaller groups of providers, etc) and whether competition between payers or groups of providers is feasible.

Dealing with the issue of cream skinning is the key to managed competition reform and absolutely necessary in terms of protecting vulnerable populations. The role of regulation is crucial in this regard. An important question is whether regulators will have the information needed to calculate risk-adjusted payments. In the former command-and-control health systems of the UK and New Zealand and as is the case in Canada relatively little accessible data has been generated on service usage. In these countries, the initial costs of setting up information gathering systems will likely be significantly higher and the transition more disruptive than in countries like the Netherlands and the US which have historically relied to a greater degree on private insurers and private providers. But arguably this is the kind of information needed to run an efficient health care system no matter what its configuration. Canadian policy-makers would be wise to learn from Dutch policy-makers and scholars as much as possible about the possibilities and limits of risk-adjusting budgets rather than trying to reinvent the wheel here.

## **INTERNAL MARKET REFORM AND THE PURCHASER/PROVIDER SPLIT**

Both the UK and New Zealand have experimented with internal market reform. This reform is a modified version of managed competition reform but does not allow for competition between *payers or insurers*, only for competition between *public and private providers*.

Initially internal market reform was proposed as a response to what was seen as a conflict-of-interest problem in both the UK and New Zealand. This problem was that the regional or area health authorities had responsibility for funding a wide range of secondary care but also had responsibility for managing the public hospitals. There was a concern that the old public hospitals were not performing as efficiently as they could, and that managers within the regional or area health authorities would not contract with the most efficient providers but rather continue to prop

up inefficiencies within the public hospitals. So the original goal of internal market reform in the UK and New Zealand was to split the purchaser and provider roles of regional or area health authorities and make the public hospitals *compete* with each other and other public and private (for-profit and not-for-profit) providers for contracts with public payers.

Internal market reform required government-appointed purchasers (100 Health Authorities in the UK and (initially) four Regional Health Authorities in New Zealand) to bargain and enter into contracts with competing public and private health service providers. A split was created between the purchasing and provision of hospital and other health services: in both the UK and New Zealand, the Health Authorities are not permitted to provide health services directly. On the other side of the split are public hospitals, which in both countries are now managed by crown corporations. In the UK these are called "NHS Trusts" and in New Zealand they are called "Crown Health Enterprises" (later renamed as Hospital and Health Services "HHSs"). Hospitals no longer receive a more or less automatic operating budget as they did prior to the reforms. Rather, hospitals are expected to compete with each other and private providers for contracts with the Health Authorities to supply services. So the term "internal market" is misleading as the market created is not intended to be completely internal to the public sector – rather public and private providers (both non-profits and for-profits) would compete for contracts to serve the public sector.

What is the difference between internal market reform and managed competition reform? In an internal market citizens do not have any choice of payer or insurer – care is purchased on their behalf by Health Authorities and citizens cannot shift, as they can in a managed competition system, with a risk-adjusted voucher to another Health Authority or to another insurer. Instead, as described in the "Accountability" section of this report, citizens must rely upon political voice (lobbying, consultation, patients' charters of rights etc) to try to ensure that their particular Health Authority does a good job on their behalf.

There was an important exception to not having a choice of purchaser in both the UK and New Zealand. Both countries experimented with devolving capitated budgets (a payment per person per year to cover a range of health care) to groups of family doctors. This can be thought of managed care from the bottom up rather than the top-down. These groups of family doctors effectively become mini-insurers for the patients enrolled with them but for a more limited range of care than insurers in a full-fledged managed competition system.

In the UK "GP Fundholders" were created. Fundholders were originally viewed as an "add-on" to internal market reform but rapidly assumed increasing importance. GP Fundholders were groups of general practitioners (family doctors), serving at least 5,000 patients. Prior to 1 April 1999, over 3,500 Fundholders received public funding, in the form of capitated budgets (i.e. an amount per person enrolled with the Fundholder), with which to buy drugs, diagnostic tests and x-rays, outpatient services and approximately 20% of hospital and community services, on behalf of the patients enrolled with them. In New Zealand "Independent Practice Associations" were established although they were subsequently referred to as Budget-holders and now as Primary Care Organizations. Budget-holders are groups of doctors of varying size, some of which were paid on a capitated basis to cover the cost of specified services for their patients such as drugs, diagnostic texts, x-rays etc. Budget-holding was not as wide-spread or as systemic as GP Fundholding in the UK and the degree of actual capitation was not large. The New Zealand Budget-holders were more like negotiating bodies for collections of family doctors.

In both New Zealand and the UK there have been significant modifications of the original internal market reform proposals. In New Zealand, the new Labour/Alliance coalition elected in November 1999 entered upon yet another round of major reforms, the result of which has been to move away from the competitive contracting-out approach introduced in the 1993 reforms. The reforms abolish the Health Funding Authority and once again combine the purchasing and ownership roles of publicly provided hospital services under District Health Boards, thus largely returning the system to its pre-1993 configuration. In the UK, the New Labour Reforms of December 1997 called for the abolition of GP Fundholders as of 1 April 1999. They have been replaced by 481 new organizations called "Primary Care Groups" (which when fully independent will be called "Primary Care Trusts") serving an average population size of 100,000. Primary Care Groups are large groups of general practitioners and community nurses, which in addition to managing the budgets for primary and community care will also, eventually, be responsible for purchasing services from the public hospitals (NHS Trusts.) The key difference is that unlike GP Fundholders citizens cannot shift with a risk-adjusted share of funds from one Primary Care Group to another. They must rely on their local Primary Care Group.

### **WHAT WAS THE IMPACT OF INTERNAL MARKET REFORM?**

Internal market reform in the UK has been associated with increases in spending. Spending on government funded health care has continued to increase in real terms by 3% per annum over the reform period.<sup>36</sup> In 1990, the UK spent 6.2% of GDP on health care services compared to an OECD average of 7.6%. In 1998, the UK spent 6.7% of GDP on health care services compared to an OECD average of 8.2%.<sup>37</sup> With respect to access and long waiting lists the UK internal market did seem to have some early success in addressing this problem and this appears to have been because of direct financial incentives geared towards reducing the length of waiting lists. However, in more recent times waiting times seem to be on the increase again.

Internal market reform in New Zealand has been associated with increasing health care spending. New Zealand's total health care spending absorbed 8.1% of GDP in 1998,<sup>38</sup> and this is the first time that New Zealand's figure has come close to the OECD average (8.2%).<sup>39</sup> In recent times the rate of growth in spending has increased and between 1988 and 1998, the average growth rate in per capita spending was 6.1% per annum compared to an OECD average of 4.8%.<sup>40</sup> The growth of waiting lists has been of significant concern in New Zealand, particularly the length of time spent on waiting lists for non-emergency surgical services. Waiting lists only seemed to increase through the reform period. Recently there has been a sharp decline in the numbers recorded waiting for care (in 1999, 62,581 people were on waiting lists<sup>41</sup> compared with 91,253 people 1997.<sup>42</sup>) The decline is likely correlated with the introduction in 1999 of a 'booking system' in which patients are not "booked" in for surgery unless the system can provide the service within two years. Patients whose needs cannot be met within two years are referred back to their general practitioner to "manage" their condition. Now there are informal waiting lists just to get on the waiting lists!

Looking solely at costs and waiting times does not give us a real sense of the impact of internal market reforms in both the UK and New Zealand. The fact that spending is going up in the UK and New Zealand may not necessarily be a bad thing but may be reflective of other benefits being achieved as part of internal market reform -- for example, higher quality care, more responsiveness on the part of providers to patients' concerns, better health outcomes, better information generation, fairer return to labour, etc. So let us look more closely at the benefits and costs of internal market reform.

In general it does not appear in either the UK or New Zealand that internal market reform radically changed how the respective systems work.<sup>43</sup> There was no significant change in how health needs were prioritized, the sorts of health care services supplied, or change in the skill-mix of providers supplying care.<sup>44</sup> In New Zealand in late 1996 it was noted “the health reforms have yet to yield the original expectations. By a range of measures (e.g. average length of stay, personnel costs, bed numbers) the pace of performance seems, if anything, to have weakened since the advent of the reforms.”<sup>45</sup>

Evidence about efficiency gains in both the UK and New Zealand is mixed. The New Zealand government acknowledged that reform has not resulted in public hospitals achieving anywhere near the 30% efficiency gains hoped for and that performance may, if anything, have weakened.<sup>46</sup> Soderlund found in the UK that efficiency gains occurred when public hospitals became independent “NHS Trusts” rather than being directly managed by a Health Authority. These efficiency gains included lower hotel costs per episode and significantly lower direct treatment and diagnostics costs.<sup>47</sup> Sonderlund, however, notes the possibility that the hospitals that became NHS Trusts would have become more efficient anyway (i.e. the more efficient hospitals sought to become NHS Trusts first). Also even if NHS Trusts operate more efficiently this does not mean that the system as a whole is more efficient. The total costs for the system may still be greater where hospitals are NHS Trusts as opposed to directly managed by Health Authorities. For example, empirical work conducted in South Africa suggests that private for-profit hospitals are able to produce more outputs at lower cost than directly managed public hospitals.<sup>48</sup> However, when the total costs faced by the government in contracting out are included in the analysis (such as the extra administrative costs in negotiating contracts), costs per episode of care are more costly for the private for-profit hospitals than for directly managed hospitals.

Why did internal market reform not turn out to be as transformative as hoped? The three key problems were:

1. a lack of incentives to reward smart purchasing;
2. a lack of information about the costs of production of care and the benefits/quality thereof which resulted in benchmarks from earlier years simply being rolled over; and
3. transactions/administrative costs.

In addition, the implementation of internal market reform was profoundly affected by the existing structure of interests in each country, a matter which is discussed in much greater detail in the Political Economy paper that forms part of this Report to the Senate.

### **Lack of Incentives to Reward Smart Purchasing**

Some contend that the idea of contracting out to competing public and private providers is itself inherently flawed and that this explains why internal market reform in the UK and New Zealand was not as successful as first envisaged. However, others argue that a lack of attention to the incentives that influence purchasers in both the UK and New Zealand was probably fatal to internal market reform. The reform model hinged on wise bargaining by the government-appointed Health Authorities with competing providers for a variety of health care services. But



internal market reform paid little or no attention to how to ensure the Health Authorities themselves did a good job. This contributed to the inertia within the system. Also management of the Health Authorities and of the large public hospitals continued to be government-appointed both in the UK and New Zealand. The political nature of the system put up walls to change as it was much safer, politically, for management within the Health Authorities and within the public hospitals to maintain the status quo than to take risks that may jeopardize one's political life. The political incentives were all geared to strongly punish mistakes whilst only weakly rewarding gains and achievements. This results in stickiness in the system, as historical utilization patterns were simply rolled over.

### **Lack of Good Information**

Another reason why internal market reform did not radically change the pattern of provision is due to a lack of good information about the cost, benefits and efficiencies of care. This made it difficult to structure new contract arrangements and to set new performance indicators. In both New Zealand and the UK, the year prior to internal market reform was used as a benchmark for price, volume, and quality standards, resulting in entrenchment of historical inefficiencies. The inertia problem was compounded by the fact that budgets set for the UK Health Authorities and New Zealand's Regional Health Authorities were based on historical consumption patterns, although there are efforts underway in both countries to distribute funds on a per-capita weighted basis.<sup>49</sup>

The kind of contracts that Health Authorities in both the UK and New Zealand entered into did not result in radically different incentive structures from that which were in place prior to internal market reform. Generally, in both the UK and New Zealand, contracting continued to consist primarily of "block contracts" (global budgets -- a fixed sum for an unspecified number of services, similar to the global budgets used in Canada to pay hospitals).<sup>50</sup> Acute and emergency care, mental health care services, and primary care were generally purchased pursuant to block contracts.<sup>51</sup> Cost per case or fee for service contracts are used for a small number of services.<sup>52</sup> Cost and volume contracts were used for elective surgery so that essentially providers receive a fee for each service provided but the total amount they can receive in a particular period is capped. This resulted in some perverse incentives with some NZ public hospitals ("Crown Health Enterprises") providing all contracted elective surgery in a relative short-time period and then closing down surgical theatres for the rest of the year.<sup>53</sup>

A problem related to a lack of good information was that particularly early on in the contracting process that contracts put too much emphasis on those aspects of performance that were measurable – output, turnover, cost, etc. It was apparent in the early stages of the New Zealand reforms that too much attention was being devoted to issues of cost and turnover and subtle indicators of quality were being ignored. The New Zealand experience is instructive that "rich" conceptions of performance are required and aspects of quality that are difficult to measure require particular attention to ensure that they are not sacrificed in the pursuit of more readily measurable performance indicators. The UK too at first put too much emphasis on things that were readily measurable. The New Labour Reforms at the end of 1997 also wisely recognized the importance of pursuing broad performance measures with a specific emphasis on the quality of care delivered:

The New NHS will have quality at its heart....This must be quality in its broadest sense: doing the right things, at the right time, for the right people, and doing them right -- first time. And it must be the quality of the patient's experience as well as the clinical result -- quality measured in terms of prompt access, good relationships, and efficient administration.<sup>54</sup>

### **Administrative Costs**

A key concern about internal market reform in New Zealand and the UK was increased transactions costs or administrative costs -- essentially the additional costs of all the paper work and new management needed for contracting out.<sup>55</sup> In the UK, the New Labour Reforms of December 1997 responded to concerns over increased transactions costs in the internal market by mandating a shift to long-term contracts with NHS Trusts of at least three years in duration.<sup>56</sup> Similarly, in New Zealand, increasingly greater emphasis was given to cooperation and long-term contracts.<sup>57</sup>

Of course what really is important is not whether paper work and administrative costs have increased but whether the gains from reform outweigh these costs. The problem is that comparison is difficult given the lack of information regarding costs and benefits in the old command-and-control systems and apparent government resistance to seriously analyze the effects of internal market reform in New Zealand and, to a lesser extent, in the UK. So it is not really clear-cut whether the benefits were worth the costs and opinions vary significantly on this.

### **Benefits of Internal Market Reform**

The two main benefits of internal market reform have been the generation of information about the costs and benefits of services and the integration of funding for a wide range of care in one purchasing agent which has enabled coordination and enhanced accountability.

#### **i. Generation of Information**

Although the evidence about efficiency gains is mixed a clear benefit of internal market reform has been the generation of information about the cost and benefits of services.<sup>58</sup> It is true though that the costs of producing this information have not been small and there is no conclusive evidence that these costs are outweighed by the benefits of use of this information to improve service purchase and production. However, an efficient system needs this kind of information so internal market reform may be viewed as an important step in its generation. One manager of a New Zealand Regional Health Authority described the benefits of internal market reform as follows:

- it has made the Crown Health Enterprises (public hospitals) focus on what they are doing in terms of services, volumes and costs. In the past their information on each has been poor and there have been failures to link costs to services and volumes;
- it has created a currency for service debates, we now have some way of doing trade-offs between services;

- the purchaser now has a currency to use in its resource allocation work across services;
- the contracts have quality requirements, which encourage Crown Health Enterprises (public hospitals) to monitor the quality of their services.<sup>59</sup>

A report prepared for the incoming New Zealand government in 1996 noted internal market reform had "enabled greater focus on evidence-based practice, increased service integration, increased accountability for primary care and the development of better information within the health system."<sup>60</sup>

## **ii. Integration of Funding**

Another feature considered positive by most commentators in both the UK and New Zealand was the integration of funding for a wide range of care in one body. Thus, for example, in New Zealand, old silos of funding were merged and Health Authorities became responsible for paying for a full range of health and disability services. An important aspect of accountability is to ensure that the purchaser has or is responsible for the funding for a broad range of health care services and thus can make efficient substitution decisions between different services. It has been argued that some of the benefits of internal market reform in New Zealand, namely "increased service integration" and "increased accountability for primary care", are largely attributable to integration of financing for secondary and primary services. It is further said that these gains could have been achieved completely independently of other much more controversial features of the reform process.<sup>61</sup>

## **MANAGED CARE IN INTERNAL MARKETS**

Although *in general* internal market reform has not resulted in significant changes there was one aspect of reform that seemed to create a real impetus for change. The GP Fundholding scheme, a form of managed care, resulted in some of the most significant changes to the UK. Similarly, in New Zealand, it has been argued that Budget-holders (now Primary Care Organizations) are the key to effecting real change.<sup>62</sup> Most of the comments here will relate to the Fundholding experience in the UK as the New Zealand experience with Budget-holding was not as wide spread or systematic and there is little evidence about its impact.

Paying a group of providers on a capitation basis (a sum per person per year to cover some or all of their health care needs) is a way to devolve financial risk and purchasing responsibility to a local level. In effect groups of physicians become mini-insurers for the people they serve. This idea can be viewed as quite distinct from the rest of the internal market reforms and the purchaser/provider split -- Fundholders/Budget-holders are both *purchasers* of care and *providers* of care.

## **BENEFITS OF FUNDHOLDING**

The benefits of Fundholding are many. Being paid on a capitated basis is an incentive to purchase the most cost-effective mix of services on the part of their patients. In the UK any surplus or savings made by Fundholders was not kept as profit, but reinvested back into the

Fundholding practice to buy things like new technology, nursing support, patient amenities, etc.<sup>63</sup> Paying Fundholders on a capitated basis also provides some incentive to emphasize primary and preventative care and keeping people healthy so they don't subsequently become a drain on the Fundholder's budget. Another attractive feature of Fundholding is that a patient is likely to have a much closer relationship with his/her physician than some distant and remote Health Authority serving a large population with whom they have no personal relationship. Arguably then a physician, acting as a purchaser, is more likely to be responsive to patients' concerns, at least to the extent possible within a limited budget. Also if a patient doesn't like the way the Fundholder is acting as a purchaser then the patient can shift, with his/her risk-adjusted voucher, to another. This sends a clear signal to Fundholders to be responsive to patients or risk losing funds.

So we can see that Fundholding differed from the balance of the internal market reforms that suffered from a failure to put in place incentives for good purchasing behaviour and suffered from a lack of good information. Glennerster concludes that GP Fundholders were better contractors than Health Authorities as they had better information about health care needs and more motivation to improve service standards.<sup>64</sup> In particular, they were able to reduce waiting times for their patients. However, it does seem that as the Fundholding scheme grew the reports on Fundholders' performances became far more mixed, indicating the early positive reports may have been a function of the nature of those physicians willing to take up the challenge of Fundholding.<sup>65</sup> The Fundholders' good performance may in part have been due to the advantages afforded them in the internal market design. For example, because Fundholders were relatively small, they could also switch their contracts without resulting in a financial loss for the public hospitals (NHS Trusts) and other providers. If, however, a Health Authority shifted their contracts away from a NHS Trust, this would have serious financial consequences for the Trust and there would likely be political influence brought to bear not to upset the status quo.<sup>66</sup>

Nonetheless it does seem clear that there were significant benefits from Fundholding. The Audit Commission found that a majority of Fundholders were able to:<sup>67</sup>

- a. Obtain better information from specialists in order to improve the care of a patient once discharged from hospital;
- b. Solve longstanding local problems such as access, lack of courtesy to patients, inconvenient pathology collection times, etc;
- c. Achieve more cost-effective prescribing;
- d. Benefit patients via reinvestment back into the practices in terms of more nurses, technology, amenities etc);
- e. Benefit from the freedom to refer where the family doctor wished;

The Audit Commission also found that a substantial minority of Fundholders were able to:

- a. reduce waiting times;
- b. obtain greater responsiveness from providers and improve communication;

- c. obtain Patient's Charter targets (named nurse, waiting time to see a doctor in accident and emergency, etc.;
- d. improve amenities for their patients such as food, car-parking, courtesy of staff, etc;
- e. achieve more appropriate referrals;
- f. reduce inappropriate outpatient follow-up appointments;
- g. locate more convenient therapy services (physiotherapy, counselling);
- h. develop local providers.

In a sense Fundholding was a victim of its own success for it resulted in a two-tier system to the extent that Fundholders were bargaining for quicker care for their patients relative to those patients whose physicians were not participating in the Fundholding scheme. The specter of a two-tier system was one of the reasons given by the New Labour government in dismantling Fundholding and shifting to Primary Care Groups. In doing so, however, the new Labour government sought to keep the positive features of Fundholding

## **THE PROBLEMS WITH FUNDHOLDING**

### **i. Cream-skimming**

As with managed competition in the Netherlands the obvious problem with Fundholding is the risk of cream-skimming. In response to this concern the UK put in place "risk corridors". Essentially, Fundholders bore financial liability for up to £6,000 per annum for any patient. The Health Authority paid for any costs incurred beyond this sum.<sup>68</sup> Such a measure capped a Fundholder's financial exposure and reduced the incentive to cream skim, but also removed any incentive Fundholders had to be sensitive to the cost of services beyond £6,000.

There was no evidence that cream skimming was a serious problem in Fundholding practices; however, the Audit Commission did find an inverse relationship between the proportion of Fundholding practices in an area and the average degree of social deprivation to be highly significant statistically.<sup>69</sup> In other words, Fundholding was more likely to be established in areas where on average their patients were likely to be healthy. Even if cream skimming was not a problem in the UK it is difficult to know whether this is due to the use of risk corridors. The lack of cream skimming behaviour could also be attributed to the ethical norms of physicians deterring them from cream skimming. Shifting purchasing responsibility to groups of health care professionals may be viewed much more positively than shifting responsibility to competing private insurers as in managed competition reform because there will be the expectation that doctors' ethical norms would act to deter cuts in quality that would harm patients.

### **ii. Administrative and Transactions Costs**

The creation of 3500 additional purchasers in the form of Fundholders obviously was likely to increase the administrative and transactions costs in the UK system. The New Labour Reforms criticized the "spiralling" transactions, management, and administrative costs associated with Fundholding and culture of competition.<sup>70</sup> The real question is, however, were these increased costs outweighed by other efficiency gains? The answer given by the Audit Commission is no.<sup>71</sup> For the year ending 1994/95, the Audit Commission calculated that Fundholders received a total of £232 million of public monies to cover the costs of staff, equipment, and computers needed for managing Fundholding. On the other side of the ledger, the Audit commission reports that Fundholders made efficiency savings of £206 million over the 1994/95 year.<sup>72</sup> Once this is deducted from the total costs, there is a shortfall of £26 million. The actual shortfall may be even greater as the Commission was not able to calculate the management and transaction costs incurred by Health Authorities and health providers in dealing with Fundholders. One NHS Trust (public hospital) did say that it costs four times as much to negotiate contracts with thirteen Fundholders, accounting for 4% of the trust's incomes, as it does with the Health Authority, accounting for 91% of its income.<sup>73</sup>

The fact that the transactions/administrative costs associated with Fundholding seemed to outweigh efficiency gains does not mean that a shift to Fundholding would not be a beneficial policy initiative in Canada. First, it is possible that the existence of GP Fundholders was a force for raising the performance of the entire system. Second, the calculation undertaken by the Audit Commission only looks at whether Fundholding results in reduction in costs and does not attempt to value quality improvements like greater choice, better health outcomes, faster recovery and return to work etc. The Audit Commission noted "Fundholding was also intended to bring improvements in the quality of patient care, for example shortened waiting times, improved facilities or a wider choice. Depending on how well Fundholders have performed in this respect, the balance could tip in favour of Fundholding." The concern about transactions/administrative costs may be an argument for increasing the size of Fundholders but is not by itself an argument against the Fundholding model. The new Primary Care Groups, proposed by the New Labour Reforms of December 1997, are a step in the right direction to the extent that they are increasing the size of purchasers. However, the new Primary Care Groups will not compete with each other and have no explicit financial incentives to engage in good decision-making.

### **THE NEW LABOUR REFORMS: VALIDATION OR CONDEMNATION OF FUNDHOLDING?**

The latest reforms in the UK call for the elimination of GP Fundholders but they also are a validation of the Fundholding idea as it seeks to give financial responsibility for all health care services to groups of doctors and community nurses and to align clinical and financial responsibility. The White paper containing the Labour proposals noted "[p]rimary care professionals ...understand patients' needs and they deliver most local services. That is why they will be in the driving seat in shaping local health services in the future."<sup>74</sup> However, as was the case with the balance of the internal market reform and the mandatory purchaser/provider split little attention has been given to ensuring that there are incentives in place to reward doctors and nurses in the Primary Care Groups for making good purchasing decisions. People can't shift from one Primary Care Group to another – they are monopoly payers. Also because they are such large groups of doctors and nurses (50--60 general practitioners) the incentive to do make cost-effective decisions is muted as a much larger group shares the benefits.<sup>75</sup>

## **LESSONS FOR CANADA OF INTERNAL MARKET REFORM**

The experience with internal market reform in the UK and New Zealand is of relevance to Canada. Alberta's Bill 11 allows for for-profit private clinics to operate and receive public funds alongside public hospitals and clinics. Similarly within Ontario, "Community Care Access Centres" are required to contract out to competing for-profit and not-for-profit home care agencies and, as was the case in the UK and New Zealand, are not allowed to provide home care services directly. More recently the Ontario provincial government has announced plans to contract out publicly funded care to private for-profit providers in order to "fight the crisis of escalating Medicare costs".<sup>76</sup> What can Canada learn from the experience with internal market reform in the UK and New Zealand?

### **Incentives for Purchasers**

In general, internal market reform did not effect significant change in the patterns of care delivered or the skill-mix or nature of providers. In part this was because no attention was given to what incentives the Health Authorities would have to do a good job buying care. The role of the Health Authorities as purchasers was essential but internal market reform paid little or no attention to how to ensure the purchasers themselves did a good job. Where payers did have incentives to engage in active purchasing, as the GP Fundholders did in the UK, there was impetus for positive change. Thus as Canada starts to experiment with internal markets it should consider the incentives in place to make the payers/purchasers of care do a good job. It should also be careful not to, as was initially the case in both the UK and New Zealand, to put too much emphasis in contracts on those aspects of performance that are readily measurable (turnover, cost reductions) at the expense of more abstract indicators of quality.

### **Lack of Information**

Another difficulty faced was that the pre-existing top-down systems had not generated information about the costs and benefits of different services. This made it difficult for purchasers to change pre-existing patterns of delivery and created a strong force to simply roll over existing budgets and performance indicators. Budget-holding or Fundholding groups of doctors fared much better in this regard as they likely have better knowledge of the costs and benefits of care. The internal market reform process did, however, provide a stimulant for the generation of information about costs and benefits of care. As Canada starts to experiment with internal markets it needs to be aware of the limitations that will be imposed as a result of a lack of good information about the costs and benefits of services. This kind of information is essential to the efficient operation of a health care system regardless of its configuration and the costs of internal market reform may be viewed as the price necessary to stimulate the generation and use of this kind of information.

### **Increased Administrative and Transactions Costs**

Internal market reform has resulted in increased transactions and administrative costs. Whether or not these have been counter-balanced by efficiency gains is not clear. Also some of the gains from internal market reform – such as increased generation of information – are difficult to value. In particular, there seems to have been many positive results flowing from Fundholding in the UK. Fundholding did not result in reductions in public spending – but did produce other benefits

of increased consumer choice, reorienting the system to be bottom-up instead of top-down, and stimulating improved performance on the part of other public providers.

## CONCLUSION

In conclusion there is much for Canada to learn from experiences in other jurisdictions with competition-oriented reform like managed care, managed competition, and internal market reform.

The Netherlands' experience with managed competition reform is of relevance to Canada as it considers alternatives for implementation of national programs for Pharmacare and Home-care. The idea of regulating private insurers to ensure national coverage offers the prospect of funding these schemes through employer and employee contributions rather than solely through taxation revenues. The biggest problem with the managed competition model is the risk of cream-skimming, which is where insurers try to avoid high-risk people. The Netherlands' experience with risk-rating budgets to try to counteract the cream-skimming problem has applications to Canada as it considers the feasibility of managed competition. But it is also of relevance as provincial ministries wish to shift budgets paid to Health Authorities from those based on historical spending patterns to those that reflect the underlying risk of the population served. Finally it is of relevance if Canada considers experimenting with competing groups of health care providers like the GP Fundholders in the UK.

There are a number of initiatives across Canada that are suggestive of a movement towards experimenting with internal market reform as occurred in the UK and New Zealand. Caution should be taken in simply replicating the mandatory purchaser/provider split that was at the core of internal market reform in the UK and New Zealand. Internal market reform has not been associated with efficiency gains and the pattern of service delivery and the skill-mix of providers has not changed significantly.

Why didn't it work? The idea of the purchaser/provider split is theoretically flawed. The problem in the previous rigidly integrated health authorities of the UK and New Zealand was not that they managed hospitals but that they managed hospitals badly and did not have incentives to buy care from other more efficient providers. Thus, attacking the potential conflict of interest in being both the purchaser of government funded health care services and being a significant provider attacked the symptom but not the root of the problem. Also, internal market reform suffered from the high transactions costs and lack of good information about the costs and benefits of services which made it easy to roll-over existing arrangements from the pre-reform period. Thus in considering the prospects for internal market reform Canada should take a hard look at what incentives purchasers (Health Authorities) will have to do a good job. Policy-makers also need to be aware of the limitations that will be imposed in a shift to internal market reform as a result of a lack of good information about the costs and benefits of services. However, the costs of internal market reform may be viewed as the price necessary to stimulate the generation and use of this kind of information.

Another important consideration for Canada, which does not spring out when looking at the experience of the UK and New Zealand, are the implications of Canada's commitments under the General Agreement on Trade and Services (GATS) and the North American Free Trade Agreement (NAFTA). Increasing attention has recently been paid to the possible impact of GATS and NAFTA on the future of Canada's health care system.<sup>77</sup> If competition was promoted either between payers (as per managed competition) or between providers (as per internal market



reform) will Canada be precluded from subsequently changing the system because of the presence of foreign companies? At a time when Canada's health system is in a state of flux and there is much talk of a need for reform, a balanced assessment of the implications of international trading agreements is required.

In the UK (and to a lesser extent New Zealand) the most important source of change was empowering groups of family doctors to become purchasers of a range of care. GP Fundholders were groups of general practitioners (family doctors), serving at least 5,000 patients. There were over 3,500 Fundholders in the UK who received capitated budgets (i.e. an amount per person enrolled with the Fundholder), with which to buy drugs, diagnostic tests and x-rays, outpatient services and approximately 20 per cent of hospital and community services, on behalf of the patients enrolled with them. GP Fundholders seemed to be a source of real change. That this is true resonates with a recent statement in the World Health Organization Report 2000:

Because resources are limited, there will always be some form of rationing but prices should not be the chief way to determine who gets what care. Both hierarchical bureaucracies and fragmented, unregulated markets have serious flaws as ways to organize services: flexible integration of autonomous or semi-autonomous health care providers can mitigate the problems.<sup>78</sup>

The GP Fundholding experiment was not without difficulties including the concern of increasing administrative and transactions costs. Nonetheless, the GP Fundholding experiment in the UK warrants very close attention in Canada as it looks for innovative ways to render Medicare more efficient and responsive to the people it serves.

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<sup>1</sup> In addition to limiting the resources flowing into the publicly funded system, Canada has also tried to restrict the price of services. Provincial governments use their purchasing power to bargain with provincial medical associations as to the prices to be paid for various services. A similar process occurs in the Netherlands and Australia at a national level. The degree to which these kind of negotiations actually restrict cost increases is unclear as effectively there are monopolies on both sides of the bargaining table -- provincial governments on one side and medical associations on the other. Provincial governments in Canada have also sought to constrain the total spent by doctors in a fee-for-service system by putting a cap on the total that can be billed by doctors and clawing back sums above that cap. They have also put in place provincial drug formularies that assess the cost-effectiveness of different drugs before putting them on the list to be publicly funded in programs for the poor and the elderly.

<sup>2</sup> M.L. Barer, R. G. Evans & R. J. Labelle, "Fee Controls as Cost Control: Tales from the Frozen North." (1988) 66(1) *The Milbank Quarterly* 1.

<sup>3</sup> Increases in the volume of doctors' services in the US during the Medicare doctor fee freeze over the period 1984 to 1986 were associated with a continuing rate of increase in per enrollee doctor expenditures of 10% or more during each

of the years that fees were frozen - J. Mitchell, G. Wedig & J. Cromwell, "Impact of the Medicare Fee Freeze on Doctor Expenditures and Volume: Final Report" (Baltimore MD: Health Care Financing Administration, 1988) as cited by K. M. Langwell & T. Menke, "Controlling Costs of the US Health Care System: Trends and Prospects", in R. J. Arnould, R.F. Rich & W.D. White, eds., *Competitive Approaches to Health Care Reform* (Washington DC: Urban Institute Press, 1993) at 38. In the US, Fuchs has found that a 10% higher surgeon per capita ratio in any particular area will result in a 3% increase in the number of operations and an overall increase in price indicating that surgeons may be influencing demand for their own services - V. R. Fuchs, "The Supply of Surgeons and the Demand for Operations" in V. R. Fuchs, ed., *The Health Economy* (Cambridge, Mass: Harvard University Press, 1986) at 147; Evans argues that despite the historical increase in the number of doctors per capita in Canada and the US, doctors' average income and workload have not fallen as market theory would normally predict indicating that providers are able to influence demand for their own services - R.G. Evans, *Strained Mercy: the Economics of Canadian Health Care* (Toronto: Butterworths, 1984) at 87. For further examples of studies suggesting that doctors respond to financial incentives, see D. Hemenway *et al.*, "Doctors' Responses To Financial Incentives: Evidence From A For-Profit Ambulatory Care Center" (1990) 322(15) *New Eng. J. Med* 1059; B. J. Hillman *et al.*, "Doctors' Utilization and Charges for Outpatient Diagnostic Imaging In A Medicare Population" (1992) 268(15) *JAMA* 2050; J. M. Mitchell & E. Scott, "Doctor Ownership Of Physical Therapy Services: Effects On Charges, Utilization, Profits, and Service Characteristics" (1992) 268(15) *JAMA* 2055; J. M. Mitchell & J. H. Sunshine, "Consequences Of Doctors' Ownership Of Health Care Facilities - Joint Ventures In Radiation Therapy" (1992) 327(21) *New Eng. J. Med.* 1497; and A. Swedlow *et al.*, "Increased Costs And Rates Of Use In The California Workers' Compensation System As A Result Of Self-referral By Doctors" (1992) 327(21) *New Eng. J. Med.* 1502.

<sup>4</sup> See, for example, J. Hurley & R. Labelle, "Relative Fees and the Utilization of Doctors' Services in Canada" (1995) 4(6) *Health Economics* 419; and P. C. Coyte, "Review of Doctor Payment and Service Delivery Mechanisms" (1995 April) *Ontario Medical Review* 23.

<sup>5</sup> See the discussion by C. E. Phelps & C. Mooney, "Variations in Medical Practice Use: Causes and Consequences" in R. J. Arnould *et al.*, *supra* note 3 at 171-2.

<sup>6</sup> J. Hurley & R. Labelle, *supra* at note 4.

<sup>7</sup> See G. L. Stoddart, M. L. Barer, R. G. Evans & V. Bhatia, "Why Not User Charges? The Real Issues - A Discussion Paper" (Ontario: The Premier's Council on Health, Well-being and Social Justice, September 1993) at 6.

<sup>8</sup> The problem of co-payments, apart from the obvious justice concerns of deterring those on low-incomes from obtaining the care they need, is that citizens may simply respond to user charges or copayments in the public sector by buying supplementary private insurance to cover those costs. The purchase of private insurance would deflate any effect the charges may have had on utilization. In response to this kind of problem, Australia prohibits private insurance for the 15% "gap" between the public subsidy and the fee charged by family doctors (there are no user charges for certain disadvantaged groups). But in general most countries recognize that the use of copayments and user charges is not the best way to limit the utilization of care and instead rely on other mechanisms.

<sup>9</sup> From C.M. Flood, *International Health Care Reform: A Legal, Economic and Political Analysis* (London: Routledge, 2000) at 111.

<sup>10</sup> A. C. Enthoven, "On the Ideal Market Structure for Third-Party Purchasing of Health Care" (1994) 39(10) *Soc. Sci. Med.* 1413 at 1414.

<sup>11</sup> See generally D. Mechanic, "Managed Care: Rhetoric And Realities" (1994) 31(2) *Inquiry* 124; and R. J. Arnould, R.F. Rich & W.D. White, *supra* note 3.

<sup>12</sup> See J. K. Iglehart, "Doctors and the Growth of Managed Care", (1994) 331(17) *New Eng. Jnl. of Med.* 1167.

<sup>13</sup> H. Barnum, J. Kutzin & H. Saxenian "Incentive and Provider Payment Methods", World Bank draft paper, online: [http://www.worldbank.org/html/extdr/hnp/hddflash/workp/wp\\_00051.html](http://www.worldbank.org/html/extdr/hnp/hddflash/workp/wp_00051.html).

<sup>14</sup> See R. Miller & H. Luft, "Managed Care Plan Performance since 1980: A Literature Analysis" (1994) 271(19) *JAMA* 1512; and J. Zwanziger & G. A. Melnick "Can Managed Care Plans Control Health Care Costs?" (1996) 15:2 *Health Affairs* 185.

<sup>15</sup> S. Heffler *et al.*, "Health Spending Growth Up in 1999: Faster Growth Expected in Future" (March/April 2001) 20:2 *Health Affairs* 193.

<sup>16</sup> For a detailed analysis of the origins and empirical research on managed care see S. Glied, "Managed Care" (Columbia: 2000) [forthcoming in the *Handbook of Health Economics*]. Glied concludes that empirical research shows managed care lowers costs and utilisation rates, but that less evidence is available on its health outcome effects.

<sup>17</sup> W. R. Moon, 1993, Presentation on the Kaiser Foundation Health Plan to the Regional Conference of the International Federation of Health Funds, Mmabatho, South Africa (September 14-15) as quoted in H. Barnum, J. Kutzin & H. Saxenian, "Incentive and Provider Payment Methods" World Bank draft paper, online: [http://www.worldbank.org/html/extdr/hnp/hddflash/workp/wp\\_00051.html](http://www.worldbank.org/html/extdr/hnp/hddflash/workp/wp_00051.html)

<sup>18</sup> D. Mechanic, *supra* note 11.

<sup>19</sup> 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(12) *New Eng. Jnl. Med* 650; and A. C. Enthoven, "Consumer-Choice Health Plan (Second of Two Parts): A National-Health-Insurance Proposal Based on Regulated Competition in the Private Sector" (1978) 298(13) *New Eng. Jnl. Med* 709. More recently, see A. C. Enthoven, "The History and Principles of Managed Competition" (1993) 12 *Health Affairs (Supp.)* 24. See, however, U.E. Reinhardt, "Lineage of Managed Competition" (1994) 2 *Health Affairs* 290, who traces the managed competition idea back to H. M. & A. R. Somers at a presentation in 1971.

<sup>20</sup> For a discussion of enhancing accountability through consumer choice see C.M. Flood, *supra* note 9 at chapter 4.

<sup>21</sup> As quoted by P. Newman, "Interview With Alain Enthoven: Is There Convergence Between Britain and The United States In The Organization Of Health Services?" (1995) 310(6995) *BMJ* 1652.

<sup>22</sup> OECD, *Health Policy Studies No. 2, the Reform of Health Care: A Comparative Analysis of Seven OECD Countries* (Paris: OECD, 1992) at 99.

<sup>23</sup> W. P. M. M. Van De Ven & F. T. Schut, "Should Catastrophic Risks Be Included In A Regulated Competitive Health Insurance Market" (1994) 39:10 *Soc. Sci. Med* at 1468.

<sup>24</sup> F. T. Schut & H. E. G. M. Hermans, "Managed Competition Reform in the Netherlands and its Lessons for Canada", (1997) 20(2) *Dalhousie L. J.* 437 at 458.

<sup>25</sup> F. T. Schut and H. E. G. M. Hermans, *ibid.* at 452.

<sup>26</sup> For a full discussion see C.M. Flood, *supra* note 9.

<sup>27</sup> 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 Review* 41; F. T. Schut, "Workable Competition in Health Care: Prospects for the Dutch Design" (1992) 35(12) *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* (Boston: Kluwer Academic Publishers, 1992) at 23; R.C.J.A. van Vliet, "Predictability of Individual Health Care Expenditures" (1992) LIX(3) *The Journal of Risk and Insurance* 443; R.C.J.A. van Vliet & W. P. M. M. van de Ven, "Capitation Payments Based on Prior Hospitalizations" (1993) 2 *Health Economics* 177; W. P. M. M. van de Ven, R. C. J. A. van Vliet, E. M. van Barneveld & L. M. Lamers, "Risk-Adjusted Capitation: Recent Experiences in the Netherlands" (1994) 13:5 *Health Affairs* 120; 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(10) *Soc. Sci. Med* 1405; J. P. Newhouse, "Patients at Risk: Health Reform and Risk Adjustment" (1994) 13:1 *Health Affairs* 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) *Annu. 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: A Means For Reducing the Incentives for Cream Skimming" (1996) 33(2) *Inquiry* 133.

<sup>28</sup> E.M. van Barneveld, J.A. van Vliet & W.P.M.M. van de Ven, *supra* note 27.

<sup>29</sup> J.A. van Vliet & W.P.M.M. van de Ven, *supra* note 27.

<sup>30</sup> W.P.M.M. van de Ven, R.C.J.A. van Vliet, E.M. van Barneveld and L.M. Lamers, *supra* at 123.

<sup>31</sup> 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.

<sup>32</sup> Personal correspondence with Dr. Frederick Schut, Erasmus University, Rotterdam 24 March 1997.

<sup>33</sup> E. van Doorslaer & F.T. Schut, "Belgium and the Netherlands Revisited" (2000) 25:5 *Journal of Health Politics, Policy and Law* 875.

<sup>34</sup> W.P.M.M. van de Ven & F.T. Schut, *supra* note 27 at 110--111.

<sup>35</sup> *Ibid.* at 110.

<sup>36</sup> Public Expenditure Analyses to 1995-96, Treasury 1993 cited in A. Maynard, "Can Competition Enhance Efficiency In Health Care? Lessons From The Reform Of The UK National Health Service", (1994) 29:10 *Soc Sci Med* 1433 at 1434, Table 1. For the recent figures see 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, December 11th--12th, 1997) at 44. Bartlett cites T. Palleson, *Health Care Reforms in Britain and Denmark: The Politics of Economic Success and Failure* (Aarhus: Forlaget Politica, 1997) for the contention that the efficiency of the UK system actually fell by 5% over the reform period.

<sup>37</sup> OECD, *OECD Health Data 2000: A Comparative Analysis of 29 Countries* (Paris: OECD, 2000); tables generated on file with author [hereinafter OECD 2000].

<sup>38</sup> *Ibid.*

<sup>39</sup> *Ibid.*

<sup>40</sup> New Zealand Ministry of Health, "Health Expenditure Trends in New Zealand 1980-99" (Wellington: August 2000) at 47, online: <http://www.moh.govt.nz>.

<sup>41</sup> The 1999 waiting list figure is 62,581 from the New Zealand Health Information Service (NZHIS). This did not come from an official publication, as NZHIS no longer publishes this information routinely. An analyst at NZHIS, Chris Lewis, supplied this data in a spreadsheet format, a copy of which is on file with the authors. NZHIS was also used as the source by the Department of Health in an Official Information Act Request response to the same question dated August 6, 1998. The precise URL for this document is

<http://210.48.125.104/4c25666b0006e461/c43c7844c94e08cd4c2566d300838b43/1c7d3c02bba5bd914c2566700076274b?OpenDocument> The 1999 estimated population figure is 3,803,900 from Statistics New Zealand "New Zealand Official Yearbook On The Web (1999)", online: <http://www.stats.govt.nz>

<sup>42</sup> Based on a waiting list figure of 91,253 from New Zealand Health Information Service (see explanation above) and 1996 census figure of 3,681,546 from Statistics New Zealand, 30<sup>th</sup> New Zealand Census of Population and Dwellings, online: <http://www.stats.govt.nz>.

<sup>43</sup> See generally C.M. Flood, *supra* note 9 and C.H. Tuohy *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain, and Canada* (New York: Oxford University Press, 1999).

<sup>44</sup> In the UK see D. Hughes, S. McClelland & L. Griffiths, "Cinderella Services in the NHS Internal Market: Does Contracting Make a Difference?" (1997) 20(2) *Dalhousie Law Journal* 400 at 402, who note in particular that the two studies considered by them "provide no evidence of any significant transfer of expenditure from the acute sector towards primary care and community health care services, and highlight certain pressures that continue to pull resources towards acute care."

<sup>45</sup> Crown Company Monitoring Advisory Unit, "Crown Health Enterprises: Briefing to the Incoming Minister", (Wellington: Crown Company Monitoring Advisory Unit, 1996).

<sup>46</sup> *Ibid.* at 21.

<sup>47</sup> N. Sonderlund, "Hospital Casemix, Costs, And Productivity In The NHS Internal Market", (Paper presented to the International Health Economics Association Inaugural Conference, Vancouver, 19-24 May 1996) at 15.

<sup>48</sup> J. Broomberg, A. Mills & P. Masobe "To Purchase Or To Provide? The Relative Efficiency Of Contracting Out Versus Direct Public Provision Of Hospital Services In South Africa", (Paper presented to the International Health Economics Association Inaugural Conference, Vancouver, 19-24 May 1996).

<sup>49</sup> In the UK, see H. Glennerster & M. Matsaganis, "The UK Health Reforms: The Fundholding Experiment" (1993) 23 *Health Policy* 179 at 182.

<sup>50</sup> A. McGuire & P. Anand, "Introduction: Evaluating Health Care Reform" in P. Anand & A. McGuire, *Changes in Health Care: Reflections on the NHS Internal Market* (Basingstoke: MacMillan Business, 1997) at 4, note that block contracts dominate in the UK

<sup>51</sup> In New Zealand, see T. Ashton, "Contracting For Health Services In New Zealand: Early Experiences", (Paper presented at International Health Economics Association Inaugural Conference, Vancouver, 19-23 May 1996) at 9. See also the 1994/95 contract between the Southern Regional Health Authority and Canterbury Health Limited signed respectively by the parties on 17 October 1994 and 19 October 1994 - on file with the author [hereinafter *Canterbury Health 1994/95 Contract*].

<sup>52</sup> See for example, *Canterbury Health 1994/95 Contract*, *ibid.* at cl. D04.

<sup>53</sup> See B. Orsman, "Bolger Shares Dim View of Hospitals: Closing Doors for Surgery Undermines Confidence", *New Zealand Herald* (17 April 1996) 5.

<sup>54</sup> See "The New NHS: Modern, Dependable, A White Paper", Cm 3807 (8 December 1997) section 3.2, online: <http://www.official-documents.co.uk/document/doh/newnhs/contents.htm> (date accessed: 15 March, 1999).

<sup>55</sup> See T. Ashton, "Contracting the Kiwi Way: Costly or Constructive?", (Paper presented at the CHEPA 10th Annual Health Policy Conference, Hamilton, Ontario, 21-23 May 1997) at 7.

<sup>56</sup> "The New NHS: Dependable Modern, A White Paper", *supra* note 54 at sections 9.11-9.17.

<sup>57</sup> See Ministry of Health, "Evaluation of the Performance of the Health Funding Authority for the Period 1 January-31 March 1998", online: <http://ariadne.plain.co.nz/42/96101720.htm> (date accessed: 1 November 1998).

<sup>58</sup> P. Howden-Chapman, "Doing the Splits: Contracting Issues in the New Zealand Health Service" (1993) 24(3) *Health Policy* 273; P. Howden-Chapman & T. Ashton, "Shopping for Health: Purchasing Health Services Through Contracts", (1994) 29(1) *Health Policy* 61, and T. Ashton, "Contracting the Kiwi Way: Costly or Constructive?", *supra* note 55.

<sup>59</sup> Letter from L. McKenzie, Manager Medical and Surgical Services, Central RHA, 18 March 1997 - on file with author.

<sup>60</sup> Minister of Health, "Healthy New Zealanders: Briefing Papers for the Minister of Health 1996: Vol. 1, Key Policy Issues" (Wellington: Ministry of Health, 1996) at 5.

<sup>61</sup> *Ibid.*

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<sup>62</sup> See L. Malcolm, "Learning the Health Lessons, and Working Out What to Do Next?", *The Press* (17 October 1996), online: <http://ariadne.plain.co.na/42/96101720.htm> (date accessed: 1 November 1998).

<sup>63</sup> The National Health Service (Fund-holding Practices) Regulations (UK) 1996, S.I., 1996/706.

<sup>64</sup> H. Glennerster, "GP Fundholding - Wild Care or Winning Hand?", in R. Robinson & J. LeGrands, eds., *Evaluating the NHS Reforms* (London: King's Fund Institute, 1994).

<sup>65</sup> See in general, the Audit Commission, "What the Doctor Ordered: A Study of GP Fundholders In England and Wales" (London: HMSO, 1996) [hereinafter called What the Doctor Ordered].

<sup>66</sup> H. Glennerster, *supra* note 64.

<sup>67</sup> What the Doctor Ordered, *supra* note 65 at 38-39.

<sup>68</sup> National Health Service (Fund-Holding Practices) Regulation (UK), 1996, S.I. 1996/706, s.21.

<sup>69</sup> What The Doctor Ordered, *supra* note 65 at 10.

<sup>70</sup> See The New NHS: Modern Dependable, *supra* note 54 at sections 2.18-2.19.

<sup>71</sup> See generally What The Doctor Ordered, *supra* note 65.

<sup>72</sup> *Ibid.* at 7.

<sup>73</sup> *Ibid.* at 66, Exhibit 26 and 82.

<sup>74</sup> The New NHS: Modern Dependable, *supra* note 54 at section 5.1.

<sup>75</sup> For a discussion see J. Sussex, *Controlling NHS Expenditure: The Impact of Labour's NHS White Papers* (London, Office of Health Economics, 1998) at 29.

<sup>76</sup> R. Mackie, "More private health care in store: Ontario prepared to increase use of for-profit firms to cut costs, Clement says", *Globe and Mail* (20 March 2001), online: <http://www.globeandmail.com/gam/Health/20010320/UDOCSSM.html>

<sup>77</sup> See for example Gottlieb & Pearson (commissioned by the Canadian Health Coalition), "International trade standards and the regulatory power of governments at the end of the 20<sup>th</sup> century – with special emphasis on public health standards and the Canadian public health system", online: <http://www.healthcoalition.ca/gottlieb.htm>; M. Sanger, "Reckless Abandon: Canada, the GATS and the Future of Health Care" (Ottawa: Canadian Centre for Policy Alternatives, March 2001); Registered Nurses Association of Ontario, "Submission to the DFAIT Consultations on the General Agreement on Trade in Services (GATS)", 29 June 2000; and B. Appleton, "International agreements and national health plans", in *Health Reform: Public Success Private Failure* (London: Routledge, 1999) at 88-104.

<sup>78</sup> World Health Organization Report: Chapter Three, Health Services: Well Chosen, Well Organized? at 47.