

**The Politics of Market-oriented Reforms:
Lessons from the UK, the US and the Netherlands**

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In the three “millennial” decades surrounding the turn of the 21st century, a wave of enthusiasm for “market-oriented” reforms to public services swept across many advanced nations. In the healthcare arena, these reforms took a variety of forms. Some replaced or augmented hierarchically-integrated arrangements with contractual, and in some cases competitive, arrangements either within the public sector, or between public and private entities, or both. Others created new, publicly-subsidized markets for private insurance. In the process, such reforms re-drew the boundaries between public and private sectors, creating openings for entrepreneurs to bring private finance to bear in new modes of operation. A review of experience in England, the Netherlands and the US, however, shows that features inherent to the politics of health care led governments to limit opportunities for profit, while buffering private entities against financial risk. As a result, increases in the weight of private finance were marginal, and the typical results were to cluster privately-financed providers of health care in niche areas, to increase the degree of concentration in private markets, and in some cases to generate complex corporate structures that greatly complicated lines of accountability. The principal effect of all of these changes, however, was to increase the regulatory role of the state, not to diminish state influence.

In Canada, such developments have been very limited in scope. Nonetheless, the possibility of opening up greater possibilities for contracting between public payers and private providers, and for allowing for the development of a purely private tier in parallel tier have been continually debated and in some cases litigated. This paper reviews experience in England, the Netherlands and the United States with the purpose of informing this Canadian debate.¹

Reforms in three nations: a brief summary

In each of these nations, the founding model of the health care state was transformed in this millennial reform period. Table 1.1 summarizes the changes. In Britain, “internal market” reforms brought in by the Conservative government in 1990 split the NHS hierarchy into separate “purchaser” and “provider” components that were to negotiate contracts for services. These changes were absorbed and mediated by established networks, and appropriated and reshaped by a successor Labour government after 1997. Among other things, Labour established a “Foundation Trust” model giving NHS hospitals yet greater independence in matters of finance and governance, and increased contracting between public payers under central contracts with “Independent Sector Treatment Centres (ISTCs) and requirements that local purchasers follow patient choice of “any willing provider”. The

Conservative/Liberal Democrat Coalition government established after the 2010 election took the internal market concept to what might be considered its logical extreme by delegating the bulk of the NHS purchasing budget to consortia of general practices (Clinical Commissioning Groups, or CCGs), replacing existing NHS purchasing bodies.

In the Netherlands reforms begun in the late 1980s and rolled out over the next two decades transformed a system that had been bifurcated between compulsory social insurance for those in the lower two-thirds of the income distribution and voluntary private insurance for the wealthiest third, into a universal regime of compulsory heavily subsidized and regulated private insurance. The United States moved toward its own unique “complementary” model of universal coverage, aimed at those who fell into the gaps in an existing system grounded in employer-based coverage and “residual” government programs for the elderly and some lower-income groups. The principal targets of the reforms introduced under the Affordable Care Act of 2010 were twofold. First, they enlarged the “residual” role of the state by expanding the established Medicaid program to cover essentially all below certain income limits. Second, they developed a new infrastructure aimed at ensuring coverage for those served neither by employer-based plans nor by government programs, through a combination of mandates, fines, and subsidies, and new health insurance “exchanges” in each state to regulate and subsidize the individual and small-group market.

Canada stands here as the exception: the model of universal single-payer coverage for physician and hospital services, and mixed systems of public and private finance for all other services, has remained intact since its founding in the 1960s. In Canada’s decentralized federal system, each province operated its own public programs under the very general framework of federal legislation governing fiscal transfers to provinces. Through both inaction and, occasionally, deliberate choice, Canadian governments continued to reaffirm the essential design of the single-payer system and the federal-provincial balance, and to follow a path of incrementalism. Ironically the most substantial “privatization” of the Canadian system has occurred not because of policy change, but in its absence – namely, the relative shrinkage of the single-payer world as technological change has moved various services out of the hospital setting.

Public and Private Objectives

To the extent that market-oriented reforms opened up opportunities for private finance in health care, on either the delivery or the payment side, they imported private-sector objectives into the

sphere of the public sector, and opened up opportunities for entrepreneurs. In some key respects, those private objectives were in tension with fundamental public-sector objectives, and the need to respond to those tensions drove public policy toward increased regulation, and drew private actors under a regulatory umbrella. In order to understand these dynamics, we need to consider the collision of objectives with respect to two definitive aspects of entrepreneurial activity: risk-taking and profit-making. Entrepreneurship implies that actors have both the autonomy and the incentive to take risk. Entrepreneurs need sufficient freedom from established institutional constraints that they can pursue independent courses of action. They must also expect to appropriate the gains of their activity, either for themselves or for their clients. In each of these respects, however, certain inherent characteristics of public policy environments, including health care, are ill-suited to entrepreneurial behaviour.

Risk

Almost all public policy frameworks, and especially those in which public finance plays a large role, are heavily conditioned by political imperatives to promote (or be seen to promote) values of probity, stewardship, and equity. The high-risk/high-potential-profit model of the private sector fits ill with these norms (Edwards et al. 2002). The potential for failure is an inherent aspect of entrepreneurialism in the private sector: only through failures of less successful enterprises can resources be freed up for reinvestment in more successful enterprises. But as Peter Smith has provocatively commented, it takes a “brave state” to allow organizations delivering public services to fail.²

Market-oriented reforms are predicated in part on the assumption that if those who make decisions about the allocation of resources are required to bear the risk of the costs of those decisions, the resulting allocation will be more efficient than if the costs are spread across the tax base (see, for example, Cheng, Lianos, and Sokol 2014: 62–3). But if the costs of failure will also be borne by the *clients* of those decision-makers, questions of equity might arise. These questions are exacerbated in an arena such as health care, where the very public programs at issue were established in the first instance to socialize risk.

Governments accordingly have a number of motivations to buffer decision-makers against risk under market-oriented reforms. Some are technical considerations: it might take time to develop the necessary regulatory infrastructure to underpin risk-bearing. Some are political pressures: buffering might be necessary to dampen opposition from decision-makers accustomed to operating in an

environment of socialized risk. It also might be necessary to protect clients against the possibility that requiring insurers or providers to bear new risks will cause them to fail, exit the market, or compromise the quality of their offerings, leading to a reduction in the quality and availability of necessary insurance or care in at least some localities or market segments. As governments have attempted to encourage entrepreneurialism in areas such as health care where they are not willing to tolerate the social costs of failure, they have become embroiled in the inherent contradiction of simultaneously expanding and circumscribing the potential for risk-taking. The resulting swings in policy have kept this central condition for entrepreneurialism continually in flux.

We have observed risk-buffering mechanisms of various types in each case of market-oriented reform reviewed here. Some were aimed at limiting the exposure of various entities to risk as a matter of ongoing design. For example, risk buffers were included in the “Fundholding” model established as part of the British internal market reforms of the 1990s, whereby GPs could opt to hold budgets for the purchase of a range of hospital and community services for their patients. Fundholding GPs were allowed to retain surpluses, while financial risk for each practice was limited to £5,000. The same set of reforms gave hospitals greater financial independence as “NHS Trusts,” but their borrowing was held to regulatory limits. The Labour government’s Foundation Trust model continued to impose regulated limits on borrowing, while allowing some greater flexibility: Foundation Trusts were not required to balance year-over-year, and were allowed to retain surpluses.

Other mechanisms were transitional – as, for example, in the gradual increase over twenty years in the risk exposure of insurers in the Netherlands after, as an early step, regional monopolies for social insurers were abolished in 1992. Between 1993 and 2015, retrospective payments from the centre designed to buffer insurers were gradually reduced, raising the proportion of revenue for which insurers were at risk from 3 per cent to 100 per cent. The Dutch process began in a context in which both social insurers and regulators were entering a new world of risk, although the buffering period was arguably far longer than necessary to allow for the development of a risk-adjustment mechanism.

In the United States, the Affordable Care Act of 2010 created a new segment of the market for private insurers by creating conditions for uninsured or underinsured individuals to acquire comprehensive coverage. Insurers participating in the state-based health insurance exchanges were held to conditions of mandatory acceptance of enrollees and community-rating of premiums. But because the new customer base was “a less educated, racially-diverse population that is more likely to cycle on and off government support” (PWC Health Research Institute 2012, 3) than that to which

private insurers were accustomed, transitional risk-buffering mechanisms of reinsurance and “risk corridors” for insurers were also adopted. In this case, however, the buffers were designed to be in effect over three years, from 2014 through 2016 – a much shorter period than in the Dutch case.

Profit

Allowing private actors to profit financially from public mandates and/or public investment attracts the criticism that it privatizes gains while socializing costs. Accordingly policy frameworks that offer platforms for entrepreneurs to deliver public services include regulations aimed not only at cushioning failure, but also at limiting profit. But such regulations can be counterproductive: they can render the arena unattractive to private investors outside certain niche areas; they can drive entrepreneurs to adopt convoluted strategies to preserve areas of profit; and they can fail to achieve the very public objectives of innovation that prompted their adoption in the first place.

Indeed, *once comprehensive universal public coverage is established*, opportunities for private profit across the *full range* of services are typically limited in several ways. With a comprehensive public system in place, demand is insufficient to provide a return on the substantial capital investment required to establish and sustain comprehensive private facilities in the private sector. Therefore providers offering services as private alternatives tend to be concentrated in discrete areas, such as imaging, joint replacement, reproductive services, cataract surgery, as is the case in Britain. Even as governments deliberately moved to create opportunities for private insurers and providers as part of universal systems, they also adopted policies that limit the scope for private profit in various ways, as we shall see.

Nonetheless, there were a number of reasons for some private actors to take up these opportunities. First, they saw a platform within the public sector as an opportunity to establish a clientele to which they could market other lines of service or insurance. Second, they saw such opportunities as a way to expand market share, making them more attractive to investors, and/or increasing their bargaining power in negotiating with providers to build networks and establish rates of payment. Accordingly, what we observe cross-nationally is a concentration of market for both private insurance and private service (the latter in the form of provider chains). In each of the countries under review, market-oriented reforms did not change but rather reinforced these dynamics, as outlined in the following section.

The role of private finance under British, Dutch and American health care reforms

Britain:

In Britain, a private system has historically operated in parallel to the universal public system. Before and after the internal market reforms, health care services continued to be provided on a purely private basis as an alternative to the NHS, paid for by private insurance as noted above or by individuals out-of-pocket. The reforms did little to change that purely private market. Nonetheless because the parallel model is often cited in the contemporary debate in Canada, I review it in some detail here. An excellent overview of this purely private sector can be found in a report by the Kings Fund (2014) and a few points can be summarized. The small private market is heavily concentrated in elective surgery: it is estimated that only about three percent of GP visits as compared to about 13 percent of elective surgery take place on a private basis (ibid.: 3, 4). The private hospital market is dominated by a few large chains, with the seven largest first accounting for about 75% of the market. This degree of concentration, considerably higher in London, has drawn attention from the Competition and Markets Authority, which in 2011 launched an investigation that led initially to orders to two large firms to divest themselves of certain hospitals. The ruling was successfully appealed by the firms, and the final result was a regime in which hospitals were required to report publicly information on their prices and other data (Competition and Markets Authority 2017).

Only a small minority of the British population takes out private insurance: having risen sharply in the 1980s, the proportion has remained in the 10 – 12% range over the past two and a half decades although the content of those policies varies widely (Foubister et al. 2006: 40, 55; King’s Fund 2014: 3; LaingBuisson 2017). Private insurance accounted for only about 3.3% of total health expenditure in the UK in 2016 (United Kingdom 2018). The balance between employer-based and individually-purchased coverage shifted over time, as employer-based coverage rose from roughly half of the total in the 1980s to about 82% in 2011 (Kings Fund 2014: 2). Coverage rates are highest in the 40-64 age group and lowest for those over 65 (Foubister et al. 2006: 50-51). The industry is concentrated in a few large firms: the largest two insurers accounted for an estimated 62.5 percent of coverage in 2003, and the largest four accounted for 78 percent (ibid. 61). Given their niche focus, relatively healthy enrolled population and industry concentration, the large private health insurers in England are generally more profitable than are the more comprehensive private insurers in the US (ibid. 71). Unlike the case in many other nations including the US, Canada and Australia, there is no tax subsidy in Britain for employer-based

insurance: on the contrary, such coverage is not only taxed as income but is also subject to an additional tax on insurance premiums (Kings Fund 2014: 5). The Thatcher government in the late 1980s briefly considered a proposal to radically reform the system of health care financing around a voucher model built on a much larger role for private finance. That model was rejected in favour of the “internal market” reforms aimed at public-sector purchasers and providers.

Although the internal market reforms thus had little impact on private insurers they did open up opportunities on the *delivery* side for private entities to provide NHS services under contract with public purchasers. (Only one entity, Bupa, is both an insurer and a health care provider.) Until 2000 NHS purchase of care from private providers was almost infinitesimally small, amounting to less than 1 per cent of the total NHS budget. From 2000 onward, the Labour government began to experiment in marginal ways to involve non-NHS entities in the provision of NHS-funded services, initially to deal with long wait times for NHS providers and later to expand patient choice. In 2005, the NHS began to contract centrally with privately owned specialty clinics as “Independent Sector Treatment Centres” for the provision of limited range of diagnostic services and a limited range of elective surgery to NHS patients at a premium above normal NHS rates.³ A requirement of the contracts was that the availability of providers in the public sector could not be reduced – that is, the clinics could not “poach” providers from the public sector (Turner et al. 2011: 524). In addition, in 2008, the government began to allow patients to choose “any willing provider” for the provision of NHS-funded services. (The term was later revised to “any qualified providers” to recognize that the eligible pool of providers had to be certified by the Care Quality Commission.) As well as proprietary and for-profit firms, qualified private-sector providers included “social enterprises” owned by employees and/or beneficiaries, most of them spun off from public sector organizations.

These initiatives had a substantial impact within the small private sector. The share of income for private hospital facilities derived from public sources increased from 14 per cent in 2005 to 25 per cent in 2010 (LaingBuisson 2012). NHS spending on secondary care commissioned from ISTCs and other private sector providers increased by 150% from 2006/07 and 2011/12 (Arora et al. 2013: 12). But this represented a marginal change from the perspective of the much larger public sector. Total funding awarded to private sector providers amounted to about 6 per cent of total NHS spending in 2014, according to the Department of Health and NHS England, and the chief executive of NHS England indicated that he did not expect that proportion to increase substantially (Campbell 2014; Iacobucci

2014). Using Department of Health data, the British Medical Association estimated the proportion to be 7.7 percent in 2016/17 (British Medical Association 2018: 2).

One high-profile exception to the concentration of private-sector services in niche areas nonetheless drew wide attention. Circle Health, a hybrid public/private entity, took over the operation of a failing NHS hospital under contract with the NHS. Under a complex and opaque corporate structure, Circle Health was a limited-share company, 49 per cent owned by an employee-owned partnership (Circle Partnership) and 51 per cent owned by a publicly listed holding company (Circle Holdings) whose major investors were venture capitalists and hedge funds.⁴ This structure was further complicated by a separate entity to finance real estate acquisitions, and by financial arrangements involving loans within the broad corporate family. (A somewhat analogous hybrid arrangement occurred in the case of the large Dutch insurer Achmea discussed above.) Essentially these structures and processes allowed Circle Partnership access to a deep pool of private capital, while providing a guaranteed revenue stream to the holding company in the form of interest payments. Any losses incurred by Circle Partnerships would be contained to that one entity.

After winning a number of NHS contracts under the Independent Sector Treatment Centres program, Circle Partnership took over the operation of a failing NHS hospital (Hinchingbrooke), under a ten-year contract commencing in 2011. This was the first time the operation of an entire NHS hospital had been placed in private hands, and the initiative gained close attention across the health policy community and the broad political spectrum. It was greeted with alarm on the left (NHS Support Federation 2012) and heralded on the right (Levy 2014; Moore 2013). The contracting process was criticized by the National Audit Office (United Kingdom 2012). Once in operation, the arrangement was nonetheless generally favourably assessed from impartial perspectives (Hodgson 2014; King's Fund 2014). In May 2014 a long-standing annual hospital rating survey by CHKS Ltd. awarded Hinchingbrooke first place in its quality-of-care ranking. Progress towards eliminating the hospital's operating deficit, however, lagged well behind plan. Then, in a startling turn of events in January 2015, the quality regulator, the Care Quality Commission, issued a starkly negative assessment, triggering a decision by Circle to exit its contract.

The experience of Circle Health provided fodder for both left and right critiques. The broad regulatory architecture and operational culture of NHS hospitals, including Hinchingbrooke, presented a complex and largely unfamiliar environment for equity investors. The hospital sector offered the potential for neither growth nor profitability in the relevant term. Although Circle's complex structure

guaranteed a stream of interest payments to its for-profit arm, it required “patient capital” if it were to turn around a failing entity. Furthermore, although Circle had been able to demonstrate growth in recent years by expanding the number of its other niche-based NHS contracts, there was little prospect that it would take on another full-range hospital, at least until the Hinchingsbrooke experiment had been assessed. Finally, instances of failures in the quality of care in publicly financed NHS hospitals had triggered extensive central intervention, and private investors had no appetite for seeing through such a process. Thus both left and right appeared to be correct: private sector providers had no inherent advantage, and some inherent disadvantages, over NHS-based providers of the broad range of hospital services, at least within the existing structure of the NHS.

Recently, the NHS leadership has moved to re-integrate purchasing and provision functions through administrative action, without legislative change, as signaled with the emphasis on integrated care models in the strategic document *Five Year Forward View* issued by the then-new NHS Chief Executive in 2014. The implementation of that vision has been incremental and uneven – beginning with the requirement that CCG commissioners collaborate with providers in developing strategic plans, and proceeding to the development of various models of collaboration and integration among providers such as “integrated care partnerships” (ICPs). In 2017 the NHS announced that, building on their strategic plans, commissioners and providers in certain areas would be encouraged to come together as “integrated care systems” (ICSs). One possible type of ICS, not implemented as of mid-2018, envisaged drawing providers together as an “accountable care organization” (ACO) (drawing a term from American usage) responsible for providing comprehensive care under a single contract with a CCG. These developments gave rise to some concerns that they would provide a vehicle for a greater role for private providers in networks spanning NHS and non-NHS providers. Indeed, legal challenges to the ACO model delayed its implementation even on a limited basis. A leading authority on the NHS, however, discounted these allegations. Evoking the cautionary tale of Circle Health, he noted that “there are limited opportunities to generate profits from NHS contracts” and pointed out that the new models had in fact emerged “through the leadership of NHS organisations rather than via market testing.” He concluded “[p]rivate providers may be brought in by NHS organisations where they have distinctive expertise to offer, for example in providing analytical support, but this has occurred throughout the history of the NHS and is not the result of [these new] developments” (Ham 2018).

Netherlands:

In the Netherlands, the reform culminating in 2006 placed all health insurers under private law which allowed them to distribute profits to shareholders, but also instituted a moratorium on such distribution. The move to a common platform consolidated a concentration of the insurance industry that had been underway even prior to the beginning of the reforms in the late 1980s. By 2014 there were in total nine “business groups” comprising 26 insurance firms. The four largest firms accounted for more than 90 percent of all health insurance coverage (Kroneman et al. 2016: 33).

Three of those firms were not-for-profit; the fourth (Achmea) was structured as a mutual nested within a complex and continually evolving for-profit corporate entity (Tuohy 2018: 469-70). Notwithstanding their private status, insurers drew half of their revenue for the basic insurance package through the public treasury in the form of centrally collected and risk-adjusted compulsory premium payments. In this context, strong norms existed regarding moderation in profit-making. In setting the compulsory premiums, public authorities make an assumption about the level of the additional flat-rate premium that insurers will charge to generate the remainder of their premium revenue. The Dutch Authority for Consumers and Markets reports that: “[H]ealth insurers are expected not to make a lot of profit, even though profit-making is a core element of the free-market principle. Policymakers seek to influence this dilemma by making statements about ‘desirable’ behavior by health insurers when setting the [compulsory] premiums and, at the same time, the Minister incorporates such calls in the nominal premium calculation (Monitor Financial Sector 2016: 14-15). As for the insurers themselves, the one insurer that is part of a for-profit undertaking takes pains to present itself as socially responsible: “Achmea’s key focus is ensuring long-term services for its customers. We want to create profit in order to remain financially sound and be able to continue investing in new products and services. However, short-term shareholder profit is never our aim ... We aim to earn a socially-responsible and accepted return on our health insurance activities” (Achmea 2014: 6, 16).

In practice, the profit margins of Dutch health insurers were below those of other insurance lines. The weighted average “loss ratio” (losses and expenses for benefits paid relative to total premium revenue) on the basic compulsory insurance package was 1.005 in 2007 and 2008 immediately after the reforms were fully implemented (meaning insurers on average lost money covering the basic package) but edged into the profitable range thereafter, registering .97 and .98 in 2013 and 2014 respectively (Monitor Financial Sector 2016: 24). Taking all of their costs and revenues into account (including those related to supplementary health insurance and investments), health insurer profits averaged 5 percent

as a share of gross premiums in 2012, lower than any other single line of insurance (Bikker and Popescu 2014: 14-15), even though there is some evidence that in the post-reform period health insurers chose to seek profit over pursuit of market share in order to add to their solvency buffers (ibid: 23).

The Dutch reforms also deregulated prices for a range of hospital services (known as Segment B services). Some of these services were also offered by day surgery clinics, which, unlike hospitals, could be constituted on a for-profit basis. The number of such clinics grew rapidly after a policy change allowing for “independent treatment centres” in the late 1990s, reaching almost two hundred a decade later – many established by hospitals themselves. As in England, however, these clinics functioned in niche areas and offered relatively uncomplicated, high-volume elective procedures such as surgery for cataracts and varicose veins. They accounted for a tiny portion, estimated in 2013 at about 2.3 per cent, of all medical specialist care (Schut and Varkevisser 2013: 185). In contrast to England, where Independent Sector Treatment Centres were paid a premium above the fee for hospitals, Dutch clinics provided care on average about 20 per cent more cheaply than hospitals – although, without adjusting for case mix, it is impossible to know whether this difference resulted from greater efficiency or less complicated cases (Schäfer et al. 2010: 178).

The 2006 reforms retained the long-standing ban on for-profit hospitals. The political climate nonetheless created uncertainty as to how long the for-profit ban would remain in place, and gave private entrepreneurs the incentive to establish footholds, gambling that the regulations would be loosened further (Bouddiouan 2008: 10). Different models that would permit for-profit hospitals under various constraints were proposed and extensively debated without resolution from 2008 onward (Maarse and Paulus 2011: 131). Meanwhile, in two cases, private entrepreneurs stepped in to invest in hospitals facing bankruptcy, and in both cases significant public funding was also provided (van der Zwart, de Jonge, and van der Voordt 2009: 4). Other private entrepreneurs began to consider complex corporate structures to include for-profit arms in non-clinical areas such as real estate and ancillary services.⁵

Hospital capital financing provided another route of entry for private finance, especially after a change in the hospital financing formula allowed capital costs to be included in the pricing of services. Prior to 2008 hospital capital projects required central approval, and funding was guaranteed either through loan guarantees and incremental additions to hospital budgets over long amortization periods. After 2008 these guarantees were progressively withdrawn (Schäfer et al. 2010: 120), providing yet another reason for hospitals to seek increased scale in order to reassure potential private investors.

The United States:

As in the Netherlands but on a much more limited scale, private insurers in the US were drawn into a universal scheme of regulated and subsidized insurance through public agencies, in this case the state-based exchanges. Even before the reforms, insurers that focused on business under contract with government programs (primarily Medicare and Medicaid) generally had lower profit margins than those that focused on the commercial sector (Donahue 2013). The Affordable Care Act established further regulatory limits on the scope for profit, not only within the exchanges but across the board, by establishing permissible “medical loss ratios” (MLRs). It required insurers in the individual and small-group market to spend at least 80 percent of premium revenue on medical benefits, which conversely meant that no more than 20 percent could go to administrative costs (including executive compensation) and profits. (The limit in the large-group market was 85 percent.)

In the event, as in the Netherlands, private insurers struggled to make any profit in the early years of the reforms. Average loss ratios for insurers on business in the individual market rose from the 80-84% range in the three years before the new regime was in place (2011-13) to 96-103% in the three years after (2014-2016), although performance varied across insurers (Cox, Semanskee and Levitt 2018: 2). These low returns were somewhat offset by the temporary risk buffer payments noted above. (Note that these loss ratios are not a measure of final profit, which includes revenue from all sources including investment.) This experience led to a considerable shake-out of the exchange marketplaces, with a number of insurers exiting. Thus, again as in the Netherlands although not to the same degree, the individual insurance market became much more regionally concentrated. Data for 2017 suggested that, despite the uncertainty created by Republican attempts to repeal and/or undermine the reforms, loss ratios had improved considerably for the remaining insurers, averaging 82% (*idem.*). More limited data for the six largest Blue Cross Blue Shield plans showed a similar pattern. With improved profitability in 2017, the overall profit margins of those plans ranged from less than one percent to more than seven percent (Farrah Associates. 2018) – well below the margins typical in other areas of the financial sector. Many large insurers who had exited the exchanges, moreover, continued to offer managed care plans under contract with the expanded Medicaid program, which were on balance profitable (Council of Economic Advisers 2018)

The Regulatory Response:

These various attempts to incorporate private-sector providers of insurance and/or service into overall regimes of universal coverage gave rise to an increase in regulation, both in anticipation of and in reaction to the ways in which private-sector objectives could subvert public purposes. There were various ways in which, at least hypothetically, the intersection of public and private sectors could have such negative effects. Where providers offered both publicly- and privately-financed products, there was the danger that the latter could become de facto screens for access to the former. For example, supplementary insurance for services more likely to be attractive to relatively healthy populations could be packaged with basic public insurance in marketing as a way for insurers to effectively “cream-skim” the market. On the healthcare delivery side, private payment for certain enhancements to publicly-funded services, such as higher-quality lens for cataract surgery, could become a condition for faster access to the procedure. The public component of the practice or facility could become guaranteed platform for providers to offer additional care privately. Where providers offered the same service on both a publicly- and a privately-funded basis, the public system could effectively feed patients to providers who would then encourage them to receive the service, and/or supplementary services on a private basis. These risks are in addition to those that derive from the more traditional existence of private systems in parallel to the public system: the risk that care in the public sector will suffer if providers are drawn away into private practice, or the risk that private treatment will impose costs on the public sector if complications occurring in niche-based practices revert to the broadly-based public sector for remedy.

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

England:

From the institution of the internal market reforms in the 1990s to the present, central regulatory agencies were continually reconfigured along three intersecting lines of regulation. One was primarily economic, focused on the financial health of providers, the price of services and the efficiency of local delivery in local catchment areas (the latter focus blurred by unresolved tensions between

contradictory desires for strategic planning and provider competition). A second line concerned quality of care, including wait times for care, and cycled through emphases on the establishment and monitoring of centrally-determined targets on the one hand or self-monitoring and reporting on the other). A third line related to the purchasing or commissioning of service, driven by concerns about access to and integration of various types of treatment and care. Various agencies evolved along each of these lines. The principal developments were the establishment of Monitor as the central economic regulator (beginning in 2004 as the regulator for Foundation Trusts and eventually extending its reach to all providers of NHS services, including those in the private sector) and of the Care Quality Commission (CQC), as the successor to a string of quality-and-safety regulators in 2009. In 2010, the mandate of the CQC was extended to all providers of care, public and private, who were required to maintain registration with the CQC. The CQC launched a comprehensive regime of regulation for the private sector in 2014 and issued its first report in 2018. The third line of regulation, regarding commissioning, rests with the central executive of the NHS, established as an agency (NHS England) separate from the Department of Health in 2013.

The various arm's-length bodies and agencies had different degrees of independence. The three most significant bodies – NHS England, Monitor, and the Care Quality Commission – were “executive non-departmental public bodies,” technically under the “sponsorship” of the Department of Health, whose secretary of state is ultimately accountable to Parliament for their “independence, effectiveness and efficiency” (United Kingdom 2007, 14–15). (This generic responsibility for these bodies is in addition to the specific responsibilities assigned to the secretary by specific legislation). The marbling of responsibilities among the various agencies and the Department of Health for matters of quality, price, financial integrity, capacity, and integration of service presented ongoing challenges and drove various reorganizations over time. For example, NHS England set the structure of the national tariff of prices, while Monitor established the price levels. More significantly, responsibility for ensuring an appropriate level and mix of capacity in any given area was tangled: Clinical Commissioning Groups, under guidance from NHS England, decided on the providers with whom they would contract; Monitor was responsible for seeing that the configuration of the “sector” in any given area functioned in the interests of patients; and the Care Quality Commission was responsible for licensing providers. In ongoing attempts to manage these intersections, a number of agencies were consolidated with Monitor in 2016 to become NHS Improvement. In 2018 NHS England and NHS Improvement announced a plan to integrate their operations in a regionally-tiered hierarchy, while remaining statutorily separate agencies – a move eerily

similar to a regime of Strategic Health Authorities that had existed in various configurations from 2002 to 2013.

The Netherlands:

In the Netherlands, a somewhat similar multi-pronged, complex and shifting regulatory structure developed as part of the twenty-year transition from the bifurcated social/private insurance model to one of universal regulated insurance. Along the way, the corporatist aspects of the regulatory regime were diminished or removed. From 1995, quality and safety regulation of providers rested largely with a Health Care Inspectorate, formed from the merger of three pre-existing sectoral inspectorates. The council responsible for provider price regulation was reconstituted as the Board for Health Care Tariffs (CTG using the Dutch acronym) in 2000. Until 2000, regulation of social insurers was largely in the hands of a Sickness Fund Council, in existence for fifty years. In 2000 the Sickness Fund Council was reconfigured into two new agencies. The regulation of the scope of coverage and contribution rates and the administration of risk-pooling went to a new Health Care Insurance Board (CVZ). A new Supervisory Board for Health Care Insurance (CTZ), assumed the oversight of the governance and financial probity of social insurers. Until 2006, private health insurers generally fell outside the purview of either of these bodies and were regulated instead under the regulatory regime for all private insurance.

This new structure did not last for long, however. With the establishment of the universal regime 2006, all insurers were drawn under a powerful new regulatory body, the Dutch Health Care Authority (NZA) building upon and further streamlining the structural changes of the previous decade. The NZa integrated the functions (and much of the infrastructure) of the Board for Health Care Tariffs and the Supervisory Board for Health Care Insurance, assuming both the tariff-regulation function and the financial and governance oversight of all insurers. The mandate of the NZa also explicitly included the promotion of conditions for effective competition, including policing risk-selection activity. The Health Care Insurance Board continued to administer the central fund for the compulsory insurance package, including the risk-adjusted allocations to all insurers, and also played an increasingly important advisory role in the regulatory process for determining the content of the compulsory package. In 2014 the CVZ became the National Care Institute (Helderman et al. 2014).

The United States:

Although the American reforms focussed largely on the individual and small-group market, and otherwise left the existing system of employer-based coverage essentially alone, the Affordable Care Act did contain provisions addressed to all private health insurers regardless of their clientele. Notably, it banned underwriting practices such as the denial or withdrawal of coverage based on pre-existing conditions and the establishment of annual or lifetime caps on benefits – which had previously been variously constrained under the terms of some employer plans and under regulations in a number of states. As noted above it also required insurers to spend at least 80-85 percent of their premium revenue on benefits, and also limited various forms of co-payment to a maximum of 40 percent of charges for covered benefits under any individual policy. Much more consequential, however, were the requirements placed on insurers who wished to qualify for participation in the state-based exchanges or “marketplaces.” They were required to cover a defined comprehensive package of benefits at community rates that could vary across individuals only by broad age and tobacco use categories, and to meet higher limits on co-payments. Significantly, insurers participating in the exchanges also had to respect these requirements even for plans offered off the exchanges. All insurers were required to offer the basic mandatory package of benefits, and to cover at least 60 per cent of actuarial costs⁶ whether or not they offered plans through an exchange. (Insurers participating in the exchanges were also required to offer a range of plans covering higher levels of actuarial costs.) Each insurer was also required to maintain a single state-wide risk pool for all its plans and thus to cross-subsidize among its own policy-holders.

In an unintended development, the ACA reforms also boosted the activity of a number of private web-based entities that had been developing over a decade to assist consumers in online searches for appropriate coverage. “Web-based brokers,” aimed primarily at the individual market, and “private exchanges,” aimed primarily at the employer market (although that distinction was not hard-and-fast) operated under a variety of auspices, including ownership by retailers, other third parties, and insurers themselves (PWC Health Research Institute 2012: 12–13). These private entities effectively competed with the new state and federal exchanges for unsubsidized applicants. In 2012, moreover, the Department of Health and Human Services (HHS) issued policy guidance under which private web-based brokers enter into agreements with federal or state-based exchanges to perform various enrolment-related functions. For the first few years, however, only the public exchanges could administer federal subsidies: the information technology necessary to allow private entities access to the federal data hub

in order to administer subsidies while satisfying privacy protection requirements was slow to be developed. In the meantime a cumbersome “double redirect” process of pin-ponging the applicant between the broker’s site and the federal site was employed. Finally, in May 2017, HHS announced a new “proxy direct enrollment pathway” to be available for certain enrolments beginning in 2018, through which consumers would be able to complete the full process, including application for subsidy, through web -brokers under agreements with federally facilitated exchanges or state-based exchanges, provided that the web brokers complied with a set of regulatory conditions (Jost 2017). Thus were private web-brokers, as well as insurers themselves, drawn into the public regulatory orbit.

Implications for Canada:

The effect of all of these market-oriented approaches to ensuring universal coverage was increasingly to draw private providers, insurers and brokers under the regulatory umbrella of the state, and to increase the *overall weight of social control* of individual behaviour (Tuohy 2018: 561-2). This phenomenon more generally has led scholars to speak of the emergence of “regulatory capitalism” (Levi-Faur 2005) or the “post-regulatory state” (Scott 2004). The nugget of this insight is the recognition of the increasing *interconnectedness* of forms of social control as governments seek to act through what has been called “meta-regulation”: stimulating, steering, guaranteeing, and auditing private mechanisms of market governance and professional self-regulation (Scott 2006: 664). Moreover, the incentives facing private sector entrepreneurs as they have sought to take advantage of public mandates drove a further concentration of power. Because regulatory constraints limited the potential for profit, insurers and providers sought to expand their customer/patient base – both to realize economies of scale and to buttress their positions in negotiating contracts in which the currency was “enrolled lives” and catchment areas. In both the Netherlands and the United States, this dynamic propelled a series of mergers on both the demand and, to a somewhat lesser extent, the supply sides of the market. A corollary development was an increasing complexity of structures of accountability. In some cases, this complexity of the regulatory structure was mirrored in the corporate structures of the regulatees themselves, as they sought to limit the reach of regulators and especially the application of strictures against profit-making. In both the Netherlands and the UK private firms such as Achmea and Circle Health were part of intricate ownership structures that allowed for-profit parents to benefit from the business of the not-for-profit that held public mandates or contracts.

None of these reforms shrank the fiscal presence of the state in the health care sector.⁹ The public share of total health expenditure, and the share of health care spending in public budgets, grew in the Netherlands and the United States from 1985 to 2012, while remaining relatively constant in the UK (Tuohy 2018: 548, 559-61). But while market reforms did not diminish the influence of the state in fiscal terms, the organizing principles underlying state influence did change. The state's legitimate functional role was increasingly understood to be one of regulation and contracting, rather than direct management, even where, as in the Netherlands and the United States, the scope of public authority expanded.

Ironically, only in Canada, where market-oriented reforms in the physician and hospital sectors were explicitly resisted, did the fiscal share of the state contract as the design of the single-payer system failed to keep pace with technological change. Even so this contraction was marginal: the public share shrank from 76 per cent to 70 per cent from the 1970s to the 1990s. The Canadian state actually expanded its presence in the prescription drug and long-term care sectors, even as these areas of mixed finance grew more rapidly than did the physician and hospital sectors covered by the single-payer model.

So, what can we expect in Canada should there be an opening to a greater role for private clinics, either in contracting with the public sector or on a purely private basis? Experience in other nations suggests that the material effect would likely be marginal and confined to niche areas, and would be constrained by regulation. Concerns have been raised that accustomation to a greater role for private finance could undermine political support for the public system. There is no systematic evidence from other jurisdictions to support this concern, however, and indeed there is limited evidence that an increase in the private share of finance is likely to fuel public demands for increased public spending (Tuohy, Flood and Stabile 2004: 388). Nonetheless, the symbolic effect of such a shift in policy could be greater, in a context in which the principle of coverage on "uniform terms and conditions" is a key component of a system that has come to be emblematic of "Canadian values."

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

¹ The discussion in this paper draws heavily on the much more extensive presentation in Tuohy (2018).

² Personal communication, 19 September 2012.

³ Principal among these services were hip and knee replacements. The proportion of those services purchased by the NHS from private-sector providers increased from about 4 percent to about 19 percent between 2006/07 and 2011/12 (Arora et al. 2013: 21).

⁴ See also "Circle health – the 'social enterprise' run by the world's hardest hedge fund managers," *Observer*, 13 November 2011, available online at <http://www.theguardian.com/business/2011/nov/13/circle-health-social-enterprise-hedge-fund-manager?INTCMP=SRCH>.

⁵ Author's interview with a Dutch entrepreneur and consultant, 15 June 2010.

⁶ At this level, insurees could expect to have to cover 40 per cent of their health care expenses through deductibles and co-payments.

⁹ This observation seems to hold for market-oriented reforms in the welfare state more generally; see, for example, Castles (2004: Chapter 2).

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