Health Care Reform and the Political Dynamics of Entrepreneurialism:
Diversification of Purchasing and Provision in the NHS in Comparative Perspective

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Overview

- Defining features of the health care state: power, instruments, organizing principles
  - The hybridization of health care systems
- Phases of welfare-state politics: establishment, retrenchment, redesign
  - The role of institutional entrepreneurs
- Two cases: England and the Netherlands
- Policy implications
Defining features of the health care state: power and instruments

- **Balance of power** across the state, private finance, medical profession (authority, capital, skill)
  - Determines *lines of accountability* - whose preferences dominate?

- **Mix of instruments** - hierarchy, exchange, peer control
  - Determines *sanctions* - what is at stake?
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<thead>
<tr>
<th>Command</th>
<th>State (Authority)</th>
<th>Private Finance (Capital)</th>
<th>Profession (Skill)</th>
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<td>Taxation, Regulation</td>
<td>Hierarchical firms, cartels</td>
<td>Consortia</td>
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<td>Exchange</td>
<td>State Enterprise</td>
<td>Competition</td>
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<td>“Internal markets”</td>
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<td>Persuasion</td>
<td>Public Education</td>
<td>Advertising - e.g. new “diseases”</td>
<td>Self-regulation</td>
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<td>campaigns “Nudges”</td>
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Defining features of the health care state: ideas

- Organizing principles - basis of entitlement and obligation (citizenship, labour market status, etc.); function of the state (regulator, funder, etc.)
  - Basis of legitimacy
  - e.g. Bismarck, Beveridge, single-payer, residual
## Evolving Politics of the Welfare State

<table>
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<th>Agenda</th>
<th>Politics</th>
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| Access      | **Redistributive:** *High politics*  
creating entitlements and institutions,  
establishing revenue sources |
| Cost control| **Retrenchment:** *Blunt cuts; Stealth*  
drift, conversion, layering, displacement,  
exhaustion |
| Efficiency  | **Hybridization:** *Strategic alliances*  
enhancement of particular elements of the  
established system, selective incorporation of  
new and complementary elements. |
The Role of Institutional Entrepreneurs

- Boundary-spanners; operate at the *interstices* of the public and private sector

- Combine public and private resources to create “value” through new organizations - e.g. public and private funding; publicly-enforced mandates + private capital

- Emerge in contexts of heterogeneity and uncertainty - e.g. “moments” of reform that put pieces of the system into play
The English Case

- GPs were well positioned to play the role of institutional entrepreneur: publicly-funded “independent contractors”

- Fundholding introduced as relatively minor aspect of 1990s internal market reforms - became popular beyond expectations (>50% by 1997)

- Quickly politicized: galvanized opposition to “two-tier” medicine among other GPs who pursued “locality commissioning” relationship with HAs
The English Case

- Both groups established political associations (now NHS Alliance and NAPC) and links with politicians
  - Milburn and universalization of locality commissioning through PCT/PEC model
  - Lansley and GP consortia
  - Clinical Commissioning Coalition supports Health and Social Care legislation
The English Case

- Other institutional entrepreneurs:
  - ISTCs; commissioning support
The Dutch Case

- 20-year reform process moved from bifurcation of social insurers and private insurers to “universal managed competition”
- First wave “liberated” social insurers from regional monopolies to compete nationally
The Dutch Case

- Entrepreneurs took advantage of unique mixes of public resources (including publicly-mandated social insurance contributions) and private capital
  - distinction between sickness funds and private insurers blurred some not-for-profit sickness funds drawn into broader holding companies with private insurers and other for-profit entities - complex corporate structures
  - private insurers established sickness funds as divisions
The Dutch Case

- As risk-adjustment mechanisms were being developed, insurers were buffered against loss by government subsidies
  - But opportunities for profit also very limited by regulation.
  - Entrepreneurial activity aimed at increasing market share
- Investments in information technology by insurers created an enhanced potential for risk selection on the basis of morbidity.
  - But also allowed regulators to respond by incorporating measures of morbidity into their risk adjustment formulae
The Dutch Case

- These developments “softened up” the ground for final round of reform in 2006
  - Erosion of social/private distinction
  - accustoming market actors (including consumers) to the new landscape.
- But new industry structure was highly concentrated.
  - Number of sickness funds: 53 in 1985, 26 by 1993, 22 by 2003
  - Four large corporate umbrellas accounted for almost 90 percent of the market by 2009
  - increased market power of the insurers vis-à-vis providers: insurers in more concentrated markets were able to negotiate more favourable prices with hospitals
Implications

- Shift in instruments (↑ exchange-type: puts professional resources and private finance at risk) and organizing principle (shift in direction of single-payer in UK, health care coverage as obligation as well as right of citizenship in NL)

- Shift in balance of power - to private finance; or increased state regulation??
Implications

- **Upside:**
  - Entrepreneurialism has generated potential counterweights to dominance of hospital-based providers (potential for commissioners and insurers to develop sophisticated purchasing capacity)

- **Downside:**
  - Limited opportunities for profit have driven development of highly complex corporate structures with for-profit wings or niches - greatly complicate accountability mechanisms to police conflicts of interest
Implications, cont’d

- Burden of proof should be on institutional entrepreneurs to demonstrate that they are meeting public objectives.

- Gives greater urgency to one of the central projects of health policy - the design of accountability frameworks to allow for an assessment of performance against objectives.