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*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

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- 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

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- **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?



	<b>State (Authority)</b>	<b>Private Finance (Capital)</b>	<b>Profession (Skill)</b>
<b>Command</b>	Taxation, Regulation	Hierarchical firms, cartels	Consortia
<b>Exchange</b>	State Enterprise "Internal markets"	Competition	Social Enterprise
<b>Persuasion</b>	Public Education campaigns "Nudges"	Advertising - e.g. new "diseases"	Self-regulation



# Defining features of the health care state: ideas

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- **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

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



# The Role of Institutional Entrepreneurs

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- 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

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- 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

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- 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

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- Other institutional entrepreneurs:
  - ISTCs; commissioning support



# The Dutch Case

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- 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

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- 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

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- 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

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- 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

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- **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

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- 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

