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Article — Published Version

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Intereconomics

Suggested Citation: Boscheck, Ralf (2005) : Healthcare reforms and governance concerns: The cases of the United States, the United Kingdom and Germany, Intereconomics, ISSN 0020-5346, Springer, Heidelberg, Vol. 40, Iss. 2, pp. 75-88,
<https://doi.org/10.1007/s10272-005-0139-2>

This Version is available at:

<https://hdl.handle.net/10419/41873>

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Ralf Boscheck*

Healthcare Reforms and Governance Concerns

The Cases of the United States, the United Kingdom and Germany

The USA, the UK and Germany – countries with rather different institutional structures and spending levels – have all put healthcare reforms at the top of their domestic policy agendas. In each case, incentive contracts, intended to deal with shortcomings of the current approach, evoke regulatory concerns. A range of common governance challenges can be identified that market-driven healthcare reforms would need to address.

Average healthcare costs in OECD countries, having risen from 5% of GDP in 1970 to 8.4% of GDP in 2001, are presently estimated to be growing at 5% annually.¹ And yet, as Table 1 indicates, increases in spending do not necessarily translate into higher levels of service or more equal access to it. Nor do more outlays automatically improve a nation's general health status, clinical outcomes or process of care. Hence, countries with rather different institutional structures and spending levels, exhausting conventional funding opportunities and missing out on otherwise important expenditures, have put healthcare reforms at the top of their domestic policy agendas. In each case, the goal is to build a sustainable financial foundation and to contain costs by testing patient needs and efficacious treatment patterns. In each case, determining cost-effective therapies as a condition for coverage amounts to "managing care" and raises concerns about the legitimacy and contestability of results and standards and points to growing problems of healthcare governance. This article cuts across the debate to identify common patterns and potential challenges.

The article first presents a typology of healthcare systems based on funding methods and supply contracts and, challenging often presumed performance differences, points to the need for detailed case analysis. This is followed by a discussion of healthcare reforms in the structurally very different US, UK and German systems. In each case, incentive contracts, intended to deal with shortcomings of the current approach, evoke regulatory concerns. Summing up each country's policy responses, the final part exposes a

range of common governance challenges that market-driven healthcare reforms would need to address.

Healthcare Systems and Performance

The provision of healthcare and insurance typically reflects demand-side and supply-side distortions that prevent competitive markets from functioning effectively. Additional governance mechanisms are needed to ensure an efficient and equitable level of supply.² On the demand side, contracts between patients and insurers blur the link between consumers' price and treatment cost and thereby may artificially fuel demand; they may also cause private insurers or third party payers to screen enrollees based on risks (rather than income) and offer differentially priced or otherwise uneven coverage. On the supply-side, patients' and payers' difficulties in judging the quality and need for treatment may lead to the promotion of unnecessary "supplier-induced" services, the selection of premium priced therapies, or conversely, the unwarranted exclusion from vital cures. To remedy the situation, mechanisms of healthcare governance are to police the quality and effectiveness of care and regulate conditions for patient access as well as the structure, conduct and performance of provider and payer industries. A country's institutional set-up affects its current healthcare performance and likely directions of reforms. Classifying arrangements based on types of

¹ OECD: Health Data 2003, Paris, June 2003; OECD: Panorama, 2004.

² For a review see M. Rothschild, J. E. Stiglitz: Equilibrium in Competitive Insurance Markets, in: Quarterly Journal of Economics, Vol. 90, 1976, pp. 629-649; R. Boscheck: Healthcare Reform & the Restructuring of the Pharmaceutical Industry, in: Long Range Planning, 1996, pp. 629-642; J. P. Newhouse: Reimbursing Health Plans & Providers, in: Journal of Economic Literature, Vol. 34, No. 3, 1996, pp. 1236-1263.

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HEALTHCARE SYSTEMS

Table 1
Healthcare Expenditure and Performance

	USA	UK	Germany
Total expenditure on health (% of GDP)	13.9	7.6	10.7
Total expenditure on health (per capita, US\$ PPP)	4887	1992	2808
Public expenditure on health (% of GDP)	6.2	6.2	8
Public expenditure on health (% of total expenditure on health)	44.4	82.2	74.9
Per capita, US\$ PPP	722	157 (1998)	299
Population aged 65 years and over (% of total population)	12.4	15.9	16.9
Average length of stay (acute care days)	5.8	7	9.3
Life expectancy in years (females at birth)	79.5 (2000)	80.4	80.7 (1999)
Life expectancy in years (males at birth)	74.1 (2000)	75.7	74.7 (1999)
Practising physicians density per 1000 population (head counts)	2.7 (1999)	2 (2000)	3.3
Acute care beds (per 1000 population)	2.9	3.9	6.3
Infant mortality (deaths per 1000 live births)	6.9 (2000)	5.5	4.5

Sources: OECD and national health authorities, most recently available data.

funding method and supply contract therefore offers a first perspective to anchor the discussion.

Funding methods: Three principal sources of healthcare finance differ in terms of coverage, choice, degree of risk selection and the process of fund allocation. *Private insurance* for individuals or groups may provide the principal cover for an entire population or a particular part of it, or may complement public schemes to fund patient cost-sharing requirements, otherwise uninsured risks or premium care. Premia are typically based on age and health status at time of enrolment. *Statutory sickness funds*, operating under tight government regulation, draw payroll taxes, paid by employees and employers, into dedicated funds that are typically governed by social partners. Premia are independent of individual health risk but vary with the overall membership income and risk structure and therefore are often adjusted by government support. *Tax-based healthcare systems* are in principle non-discriminatory and administratively simple, use centrally

Figure 1
Healthcare Systems – Funding Structures and Service Contracts

		Funding Structures		
		Private Insurance	Statutory Sickness Funds	Tax-based
Service Contracts	Integrated Healthcare			
	Prospective Contracting			
	Reimbursement			

or de-centrally collected funds, and rely on political decisions to determine their share of overall budgets. All three funding mechanisms generally involve co-payment depending on the type of service rendered.

Supply-contracts: Medical supply arrangements, particularly in ambulatory and hospital care, are conventionally classified based on the nature of payer-provider relations and the degree of patient choice. *Reimbursement*, i.e. the refunding of payments for services rendered, is typically found in systems where multiple insurers and providers make complex contracts difficult to arrange and cost control is secondary to patient choice. *Prospective contracting* gives payers greater control over total outlays, limits patient choice to a small number of pre-qualified providers and induces cost containment based on budgets, funding caps and fixed price-contracts. *Integrated healthcare* combines funding and service provision in one organisation and by that presumably internalises uncertainties arising from costs and contractual complexities. National health services, staff-based health maintenance organisations (HMOs) and integrated disease management practices fall into this category.

Figure 1 provides a map for healthcare systems based on principal funding mechanisms and types of supply contracts. No OECD country fits neatly into any one class. Also, none of the categories along the vertical and horizontal axes, viewed in isolation, warrants any a *priori* judgement on healthcare performance. Still, recent rankings of funding and supply arrangements, inspiring the current healthcare debate, do just that.³ Some suggest that one's understanding of alternative funding mechanisms alone suffices to

³ See HPCG: Options for Funding, 2003, <http://www.civitas.org.uk/pdf/hpcgSystems.pdf>.

grade their impact on equity, cost-effectiveness and quality of care, technological advance and payer motivation. Others take the specifics of supply contracts, the structure of asset ownership and the importance of profit-incentive alone to indicate “patterns of comparative advantage” in organising different levels of healthcare supply.⁴ Both types of categorisation are conceptually too crude and their performance implications too spurious to be supported by data. They also fail the test of logical scrutiny.

Clearly, whether or not tax-based systems may be seen to be legitimate, equitable in terms of coverage and able to react to changing circumstances cannot be stated *per se*. Such an assessment requires an understanding of the particular budgetary constraints, the openness and transparency of the political process, and the importance of healthcare concerns relative to other issues at any given stage of the electoral cycle. Likewise, social insurance systems may offer relatively more transparency, given that payers’ contributions do not “get lost” in general tax revenue, but that transparency may not translate into superior performance unless there is choice of insurers and complete mobility of enrollees between them. Next, whether a broad reliance on private insurance results in uneven coverage depends, among other things, on whether such private initiative is voluntary or mandated with regard to some standard package, whether it is linked to employment rather than residence, whether funds can or cannot refuse cover, and insurers find ways to efficiently diversify demographically or occupationally self-selected risk-structures. Evidently, abstract appraisals of funding mechanisms offer very limited insights; the same holds true for broad-brushed assessments of supply-contracts.

For instance, whether reimbursement systems can be expected to enhance price consciousness hinges on the specifics of the payment process, the transparency of the bill, or the extent of co-payment that is required. In any case, retrospective payment only empowers payers and patients to the extent that they can contract providers selectively and are truly able to compare values of differently priced alternatives. In the absence of some understood treatment standard, promoting consumerism in healthcare is not only unlikely to limit supplier-induced service offerings. Instead, it may trigger providers to compete on patient-observable qualities, such as waiting lines, at the possible expense of medical outcome. Next, prospective contracting typically employs financial incentives to induce cost-effective treatment and appropriate healthcare rationing. But there are obvious risks

of quality-shading, wrongful denial of care or providers’ attempts to cross-subsidise constrained activities by less regulated ones. Assessing prospective contracts requires case-by-case analysis based on clear standards of economic and clinical governance and obviously cannot proceed *per se*. Finally, integrated healthcare provision may merely substitute internal monitoring and enforcement efforts for avoided market-based transaction costs. There is a priori no compelling reason to believe that integrated (funding and) provision should or should not be faster in adopting new technology, focus on preventive care rather than treatment, or impose more stifling constraints on clinical autonomy relative to fragmented, market-based finance and supply.

Clearly, discussing the merits of financing structures and provisioning contracts offers just a starting point for further, and inevitably case-based, analysis. Hence, the next part details the current reforms of the US, UK and German healthcare systems that, irrespective of rather different funding structures, involve a common interest in motivating more cost-contained healthcare supply. In each case, financial incentives are apt to bias unavoidable discretion and therefore require regulatory issues to be addressed. However, in each case, removing this first layer of governance concerns not only points to a common lack of clearly defined performance standards and enforcement processes. It rather raises questions with regard to the viability and interaction of operational, regulatory and institutional controls that ought to be addressed prior to detailing the specifics of healthcare finance and delivery. Where are healthcare markets feasible? When are performance contracts required and when do they need to be complemented or replaced by centralised control?

Healthcare Reforms 2003/4: The Case of the United States

In 2002, 14.6% of the US GDP was spent on healthcare, 6.1% more than the OECD average, or 2½ times the OECD norm in purchasing power parity terms. That expenditure will have come close to 15% of GDP by the end of 2004 and, in the absence of corrective action, is projected to swell to more than one-third of GDP by 2030.⁵ The US healthcare system largely but not exclusively relies on private sector finance and

⁴ See K. Eggleston, R. Zeckhauser: Government Contracting for Healthcare, in: J. D. Donahue, J. S. Nye (eds.): Market-based Governance, Washington DC 2002, Brookings Institute Press, pp. 29-65.

⁵ OECD: Health Data 2003, op. cit.; Center of Medicare & Medicaid Services: National Health Expenditure, Washington DC 2002.

delivery, quickly responds to changing consumer preferences and gives access to the latest medical technology.⁶ Yet, voluntary and typically employer-based insurance leaves more than 14% of Americans regularly uninsured with access only to emergency care or care at substantially higher than average cost. Also, US health outcome and quality of care are “not exceptional,” that is to say, other countries attain comparable and better results for less.⁷ Predictably, the current debate on US healthcare reform does not focus on *whether* to contain costs, improve system access or the efficiency of care, but rather on *how*.

The Bush Administration insists on testing the markets: tax incentives and a larger choice of defined-contribution health-insurance packages should leave it to every citizen to determine his or her desired level of insurance cover.⁸ A \$500 billion prescription-drug subsidy is to motivate pensioners to transfer their Medicare coverage to for-profit health maintenance organisations (HMOs). As of 2006, Medicare beneficiaries will be able to join these private health plans for out-patient coverage or sign-up to a stand-alone Medicare prescription drugs scheme. By 2010, the nation’s largest entitlement programme is to vie with private insurers for public funds. In addition, President Bush aims to cap medical liability to ease pressure on ailing malpractice insurers and managed care providers unable to find coverage at acceptable rates.

Still, even though the Administration’s healthcare package managed to overcome legislative hurdles in December 2003, it may not stand to pass the market test. For one, according to the non-partisan Congressional Budget Office, less than 10% of seniors are likely to join a private sector plan.⁹ The rest is said to prefer a financially uncertain Medicare programme to the controversial cost-containment practices of private managed care suppliers. As Medicare membership is expected to double by 2030, this outcome would not only limit the benefit of competition but also expose the government’s inability to offer anything close to comprehensive benefits. Secondly, a Democratic cau-

cus, formed in January 2004, not only opposes any plan to pitch Medicare against private insurers, but, according to a November 2004 Harris Interactive poll, its policy alternatives seem more in tune with public sentiment.¹⁰ The caucus proposes costs containment through the government-controlled bulk-buying and re-importation of drugs, the increased use of generics and stricter regulation regarding competition and managed care fraud. The latter is seen to require a nation-wide “patients’ bill of rights” to strengthen decentralised case-based enforcement in courts.

Clearly, the US Administration and Democrats differ drastically on the direction of healthcare policy. Still, both concur on the need for more delegated healthcare governance albeit by different means – markets or litigation. But so far, neither party has endorsed the necessary criteria to determine efficacious health supply, derive legitimate performance standards and thereby facilitate decentralised control. Why not?

Managed Care and Medicare

US tax treatment of insurance premia encourages employers to offer health plans currently covering around 85% of the American working population and their dependants. Severe rate increases throughout the 1990s, however, not only caused firms to reduce benefits for workers as well as retirees, but also to replace conventional fee-for-service plans by cost-optimised managed care contracts.¹¹ In plan-level comparisons, managed care has since been systematically associated with better health outcome and more innovative, albeit less personal, care.¹² Predictably, by 2001 dramatic cost savings for payers had resulted in 93% of the insured US workforce being covered by managed care arrangements. However, also by that time, specific cost saving practices and cases of abuse had alienated providers and patients so as to trigger regulatory and market reactions against them.

At present, class-action suits draw on common-law theories of breach of contract, fraud and nondisclosure to invalidate the entire range of cost containment methods. Plaintiffs in malpractice suits invoke notions

⁶ D. M. Cutler, M. McClellan: Is Technological Change in Medicine Worth it?, in: Health Affairs, Vol. 20, No. 5, 2001.

⁷ E. Docteur, H. Suppanz, J. Woo: The US Health System: An Assessment & Prospective Directions for Reform, OECD Economic Department Working Papers, No. 350, 27 February 2003. See also Table 1.

⁸ See US Medicare Prescription Drug, Improvement & Modernisation Act, December 2003. For commentaries see G. Silver: Beyond Markets, in: The Washington Post, November 2004; R. E. Moffit et al.: Will Congress Contain Medicare’s Exploding Costs? Heritage Foundation, 17 December 2004.

⁹ See H. Gleckman: This Medicare Reform is no Cure, in: Business Week, 14 July 2003, Iss. 3841, p. 36.

¹⁰ A Harris Interactive poll of 2,567 US adults of November 2004 shows strong public support (between 75% and 90% of respondents) for each of these democratic positions. See Wall Street Journal health industry edition <http://www.wst.org>.

¹¹ Whereas the former give access to any healthcare provider willing to accept a service-specific rate, the latter limit access to providers that agree to follow efficacious treatment guidelines and accept practice restrictions to that effect.

¹² For a review of studies comparing MCOs across plans and regions see L. C. Baker, M. B. McClellan: Managed Care, Healthcare Quality & Regulation, in: Journal of Legal Studies, Volume XXX (2), 2001, pp. 715-741.

of vicarious liability and negligence to pursue both the supposedly careless physicians and the managed care organisations (MCOs) responsible for his or her selection, management and payment. State and federal legislative initiatives aim to codify patient-plan relations. Patients' bills of rights oblige MCOs to permit independent reviews of treatment decisions, to disclose physician compensation and incentives and to eliminate any contractual limitation on patients' and physicians' legal regress.

Meanwhile, "managed care" itself has moved away from tight plan management. Original, integrated staff-HMOs, employing full-time medical professionals to strictly enforce treatment guidelines, have since lost out to more arm's-length preferred-provider networks offering more patient choice at higher and increasing costs. In 2003, these new plans together enrolled more than 70% of all insured US employees, but with largely dismal financial results. Shifts in bargaining power in favour of informed and price-sensitive payers had slowed premium growth at a time of rapidly rising, non-controllable costs. From the mid-nineties onwards, US drug prices increased annually around 4% above the consumer price index;¹³ and even comparatively open care agreements faced charges for wrongful denial of service, misconduct of affiliated providers and fraud. As a result, the managed care industry began to encounter financial difficulties at a time when legislatures remained deadlocked about the regulatory control¹⁴ which it needed to operate and when the Executive Office thought it would provide the solution to the Medicare problem.

Already in 1997, concern about the financial viability of Medicare, covering US pensioners and qualified disabled and thereby 20% of total health spending, had led to the partial "privatisation" of the system. 14% of the enrollees transferred into Medicare+Choice.¹⁵ Created as part of the 1997 Balanced Budget Act (BBA), that programme gave access to private health plans with equal or better benefits packages and charges monthly capitation fees based on average regional Medicare outlays. After some initial success, however, Medicare+Choice not only failed to attract significant new participation by private health plans, but existing members, under an increased costs and regulatory burden, reduced attractive benefits (such as pay for medication) and consequently were unable to pull in and retain new enrollees.

Governance Concerns

The Bush Administration's bill is to reverse this trend. Its Medicare Advantage extends Medicare+Choice by Intereconomics, March/April 2005

\$500 billion prescription drug benefits as an interim measure until the programme is to compete for public funds. For this scheme to be equitable and fair, intermediation must ensure that all Medicare beneficiaries understand the implications of their healthcare decisions, insurance options are generally available, and adverse effects due to risk-pooling are adjusted. But even then, private health plans will only deliver efficacious treatment solutions and attract enrollees if managed care liability is properly defined, service contracting is efficient, treatment standards lay sound regulatory foundations, and enforcement can be assumed to be objective and technically competent. Here, significant gaps exist.

- First, federal and state legislation is to guide legal claims regarding wrongful denial or substandard provision of care. But "the law is in flux, often insufficient and on occasion confusing".¹⁶ The federal Employee Retirement Income Security Act of 1974 (ERISA), affecting employer-based health care plans, has consistently been held to pre-empt injuries due to wrongful denial but not malpractice of a plan provider. As such, ERISA not only pre-empts facts that would otherwise provide the basis for a state tort action but, by allocating liability for coverage decisions to the MCO and liability for negligent practices to providers, assumes that the funding and provision of care are clearly distinct. Henceforth, to qualify for pre-emption, all MCOs (with the exception of staff HMOs) typically argue that they are involved in benefit determination rather than medical decision-making. But their decisions are often worded in terms of "medical necessity" and tend to affect medical outcome. It may therefore be argued that MCOs de facto make medical decisions but seek to assign the liability for the practice of medicine to their employees or affiliated providers. Still, state courts have held managed care companies directly liable for injuries resulting from malpractice and wrongful denial due to defective cost containment

¹³ See E. Docteur, H. Suppanz, J. Woo, op. cit.

¹⁴ See R. Epstein, A. O. Sykes: Assault on Managed Care: Vicarious Liability, ERISA Pre-emption & Class Actions, in: Journal of Legal Studies, Volume XXX(2), 2001, pp. 625-659.

¹⁵ 86% of the beneficiaries continued to be covered by the conventional prospective payment system that disburses in-patient services and physicians' fees according to national systems of diagnosis-related groups (DRGs) and value scales.

¹⁶ See R. Epstein, A. O. Sykes, op. cit., p. 627.

¹⁷ See *Wilson v. Blue Cross of Southern California*, 271 Cal.Rptr.876 (1989); *Williams v. Health America* 535 N.E.2d717 (Ohio App.1987); *Harrell v. Total Health Care, Inc.* 1989 WL 153066 (Mo.App.)

¹⁸ See *Schleier v. Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.*, 876 F.2d 174 (D.C.Cir.1989).

mechanisms, bad faith and negligence.¹⁷ In addition, vicarious liability has been applied to non-staff HMOs to recognise ostensible agency relationships with providers.¹⁸ Finally, courts upheld claims of breach of fiduciary duty, holding MCOs accountable for undisclosed financial incentives that may compromise the provider's medical autonomy in ways detrimental to patients.¹⁹ Unfortunately, with regard to most of these issues, the case law is mixed; pre-conditions for bringing suits and the need to involve external medical review prior to jury judgement differ between states. In addition, there is uncertainty whether general damage caps, like those related to non-economic or punitive damages, apply to MCO liability suits. The Bush Administration urges lawmakers to follow the example of California, which capped medical injury compensation as early as 1975. Yet alternative changes in tort law, including limits on attorney contingency fees as well as on joint liabilities, may provide more predictable and efficient judicial reviews with lower distorting impacts on healthcare competition.²⁰

- Second, efficient healthcare contracting and the assessment of liability presuppose recognised standards. Since 2001, two competing agencies, the National Committee for Quality Assurance (NCQA) and the American Accreditation Healthcare Commission – better known under its original acronym, URAC (the Utilization Review Accreditation Commission) – set out to harmonise provider contracts for reviews with managed care organisations. Also standards for disease management practices – including patient self-management services, practitioner support, programme content, clinical systems, coordination of care, measuring clinical performance – emerge from self-regulation.²¹ However, in either case one may be concerned about the inclusiveness of the standard-setting process, the legal status and use of guidelines, and their impact on practice innovation, standard evolution and provider competition.
- Third, contesting healthcare performance in markets requires the removal of barriers to competition. A re-

cent Federal Trade Commission (FTC) review of US healthcare competition²² warns against the rise in supplier power and public policy condoned market distortions. Since the appointment of FTC Chairman Timothy Muris in 2001, the agency has taken a more critical view on independent physician associations, unwarranted hospital mergers, as well as on state-licensing laws and state subsidies for special purpose healthcare providers, including non-for-profit hospitals. But is this focus on anti-competitive practices in the provider market met by similar levels of attention at the level of health plans?

- Fourth, contesting healthcare performance by legal means requires patients to be given proper legal standing and courts to be adequate. Recognising the former, the Clinton Administration's Consumer Bill of Rights and Responsibilities, issued in March 1998, was to strengthen the patient's role and confidence in the healthcare system. Since then, its underlying principles have spawned a plethora of divergent Patients' Bills of Rights offered by states, providers, health plans, and patient groups.²³ Codes typically address concerns about information disclosure, access to providers and services, participation in treatment decisions, respect and non-discrimination, health data, as well as complaints and appeals. But operational standards and enforcement mechanisms are often ill-defined and not every state that endorses a Patients' Bill of Rights also adopts the necessary complementary legislation and administrative guidance. Still, even with all this in place, deficient substantive standards not only heighten enforcement complexity and the risk of abuse, but also may effectively void the opportunity of direct enforcement.²⁴ For example, patient rights in the state of New Jersey, originally envisioned as privately enforceable by patients against providers through a civil liability, were ultimately limited to enforcement exclusively by the State Department of Health and Senior Services. Even if one were to admit the informational advantage of public medical professionals, how transparent and contestable is the agency's deliberation? Recently proposed specialised healthcare courts, if adopted, may help to address procedural concerns but cannot mitigate the lack of substantive direction.²⁵

Clearly, current US healthcare reforms raise a

¹⁹ See *Shea v. Eisenstein*, 107 F.3d.625 (8th Cir.1997); *Weis v. CIGNA Healthcare, Inc.*, 972 F.Supp.748 (S.D.N.Y. 1997).

²⁰ See Medical malpractice law gets results in California, in: *Modern Healthcare*, Vol. 34, Issue 29, July 2004, and also C. Kolodkin: *Tort Reform and Its Impact on Medical Malpractice Insurance*, 2003, <http://www.irmi.com/expert/Articles>.

²¹ The American Association of Health Plans (AAHP), for instance, maintains a National Guidelines Clearinghouse (NGC) including more than 1100 guideline summaries.

²² Federal Trade Commission: *Improving Health Care: A Dose of Competition*, Washington DC 2004.

²³ Advisory Commission on Consumer Protection and Quality in the Healthcare Industry: *Quality First*, Washington DC 1998.

²⁴ For an overview see M. Silver: *Patients' Rights in England and the United States of America*, in: *Journal of Medical Ethics*, Vol. 23, Issue 4, 1997, pp. 213-221.

number of regulatory concerns. Yet, particularly given the importance and contentiousness of cost containment in both US private healthcare and Medicare and given the emphasis on decentralised healthcare governance, one may wonder why there is so little effective legislative guidance at the state and federal level.

The Case of the UK

Created in 1948 as a tax-financed and integrated system, the UK's National Health Service (NHS) purports to provide universal and decidedly equitable services, i.e. based on clinical needs rather than ability to pay. Public sector providers deliver care in cooperation with self-employed General Practitioners (GPs) who are compensated in line with a centrally agreed mix of fee-for-service and capitation and act as "gatekeepers" for non-emergency hospital services. Strict enforcement of budget limits across the system helped to contain national healthcare expenditure to 7.6% of GDP in 2001, much lower than in the Nordic countries, France, the Netherlands and Germany. But it also caused understaffing and waiting lists and positioned the UK close to the bottom of the OECD in terms of its overall capacity and perceived willingness to respond to patients' needs.²⁶ Over the last two decades, various reform initiatives managed to increase the level of funding and, within limits, enhance the efficiency of supply.²⁷

Most recent proposals, spearheaded by Prime Minister Tony Blair and Health Secretary John Reid, however, face harsh criticism most importantly, but not exclusively, from the Labour bench. Their suggestions to rely more on patient choice, turn hospitals into autonomous, locally run "foundations", offer doctors better pay for tighter control, and to address capacity problems by outsourcing to international medical suppliers are seen to amount to "privatisation by stealth". Unison, the healthcare union, rejects any attempt to adopt "US-type healthcare management practices". Former Labour health secretary Frank Dobson remains sceptical about the public's ability to make informed choices about healthcare and thus the extent to which healthcare markets are possible. Chancellor Gordon Brown insists that, in order to avoid a two-

²⁵ Attempts to lower malpractice costs have led to the introduction of a variety of reform proposals in 2003/4. One bill, introduced by Senator Michael Enzi (R.Wyo.) in July 2003, seeks to establish special healthcare courts to resolve claims. Another model would define classes of avoidable injuries and create administrative panels to resolve these claims. See T. Fong, J. Tieinan: Politics front and center, in: *Modern Healthcare*, Vol. 34., Issue 2, 12 January 2004, pp. 26-29.

²⁶ For comparative data see E. Docteur, H. Suppanz, J. Woo, op. cit.; and V. Koen: Public Expenditure Reform: The Healthcare Sector in the UK, OECD Department of Economics, Working Paper No. 29, 2000.

tier system, the foundation status be extended to all hospitals, which, at total governmental borrowing limits, however drastically reduces individual financing capacities. By contrast, Tory shadow health secretary Liam suggests undertaking a proper market check by introducing a "patient passport" that would entitle citizens to 60% of the NHS costs for any operation performed at a private clinic.

Hence, by the end of 2004, Labour remains deeply divided on issues of public hospital management and Conservatives view "patient choice" as the key to electoral recovery. Yet, while largely focused on inpatient care, the public debate on UK healthcare reforms almost completely neglects significant changes in primary care and their impact on the operation and governance of the NHS. Market incentives are already in place but regulatory structures are severely lacking.

From Quasi-Markets to Contestable Services!?

The 1999 Health Act terminated the Tory "quasi-market" experiment. For ten years, hospitals and providers of specialist services had to act as semi-independent "trusts" and compete for "business" generated by district health authorities (HAs) and fund-holding GPs. While splitting purchasing from provision had helped to clarify some costs and prices, the "quasi-market" had also magnified problems in controlling contractual performance and discriminatory practices, particularly in the absence of any patient choice of health authorities, providers and procedures. In addition, patients benefiting from dealing with fund-holding GPs in terms of service quality and speed of admission had made it important for GPs to generate larger numbers of costly referrals to qualify for fund-holding status. Correcting for all of this, New Labour's healthcare reforms were to create a "third way" relying on "co-operation and contestable relations" between "stifling top-down command and control" and a "random and wasteful grass roots free for all".²⁸ In practice this means using market incentives

²⁷ Two surges in public expenditure – under Tory and Labour governments – lifted national health spending from 6% of GDP in 1990 to its present level. To reach the 2003 EU expenditure of about 9% of GDP by 2006 would require a real increase in the NHS budget by 9.7% p.a. until then. But none of the necessary means – tax increases, a reshuffling of public sector priorities, increased private co-payment – appear popular with voters. Also, critics point out that increasing funding in the past only revealed the NHS's seemingly infinite capacity for absorbing extra spending without any apparent improvement. In addition, it is not obvious why the UK should try to reach the EU level when its biggest spenders endeavour to pay less. It may be for these reasons that Labour in 2001 decided to increase the NHS budget by merely 6.1% p.a. and to introduce a set of initially popular structural reforms.

²⁸ Department of Health: White Paper on Healthcare Policy, London 1997.

to increase capacity while attempting to retain central control over decentralised service delivery.

Initially, fund-holding practices were abolished and GPs, as independent contractors, were directed to cluster into regional and managerially independent primary care groups (PCGs), typically covering 100,000 patients with an average of 50 GPs. Operating under an annual accountability agreement with local health authorities, their role was to evolve from advising HA purchasers to owning and operating community health services, so-called primary care trusts (PCTs), which were permitted to retain surpluses and invest these to improve patient care. Since then, National Service Frameworks, issued by the Department of Health,²⁸ extended the roles of primary care and by that the tasks of GPs and PCTs to include chronic disease management and the management of self-care. At present, new contracts for general practitioners offer pay rises of up to 50% over the next three years in return for expanding the range of treatments on offer. These agreements are between the health services and the practice rather than the GP, which is expected to allow much more flexible forms of employment not just for doctors but also for practice nurses. Put differently, the role of the GP changes from a non-integrated purchaser to an integrated service provider under annual agreements and budgetary responsibility with health authorities. In the language of US managed-care, the new contracts for GPs turns these staff-HMO relations into agency contracts.

Extending from this, new contracting formats are set to consolidate and "industrialise" the UK's primary care. Top practices increasingly turn into franchise operations, bailing out failing GPs. By the end of 2005, 80 privately run diagnosis and treatment centres (DTCs) are expected to offer walk-in ambulatory care – from speedy analytical procedures to day-surgery. Global players, such as the US United Health group are expected to take 20% of the general practice market; meanwhile the UK's GlaxoSmith-Kline announced its intention to set up a national disease management operation that would bid for PCO contracts.³⁰

A second set of initiatives, at the heart of the 2004 UK healthcare debates, addresses capacity and efficiency concerns in non-ambulatory healthcare services. Top-performing hospitals, selected to operate

as autonomous, locally run "foundations," are to be able to raise private finance and more free to set staff pay. During transition they are to be benchmarked and coached in hospital management techniques developed by the leading US insurer, Kaiser Permanente. The goal is to minimise hospital stay and focus on outpatient care including teaching patients and their families how to self-manage care. Operations are overseen by a new national regulator and answer to boards of governors that are elected by patients. In addition, as of September 2003, international healthcare corporations have begun to offer "flex capacity" for an estimated 250,000 surgical procedures on a £2bn contract. In parallel, hospital consultants, typically maintaining private offices while being paid by the NHS, have been offered new contracts and pay increases of up to 20% for accepting tighter government control over their working practices. Finally, to obtain the benefits from additional capacities and to create more transparency across the entire NHS, the system will be put onto an integrated IT platform. A five-year contract has been awarded to deliver a National Electronic Booking System, which, in its first application, is intended to give patients a limited choice over the date and hospital at which they attend an in-patient appointment.

Governance Concerns

A high-profile report by the Nuffield Trust³¹ praised the NHS for attempting to undertake one of the most comprehensive and ambitious healthcare reforms in the world. Still, one may wonder how the restructuring of service relations and budgetary and regulatory controls interact in Labour's "third way" to ensure proper healthcare governance.

To begin with structural conditions in *in-patient care*, the foundation status drives hospitals to compete with one another and international contractors for qualified staff, capital and services. However, maintaining tight financial control by the Treasury, in line with prudent public finance, not only de-motivates management³² but may ultimately disadvantage foundations relative to private competitors in input markets. In output markets, relying on patient choice – by way of electronic booking – begs the question how patients assess service quality, particularly if weak service standards and the entry of GPs and PCTs into disease management may shift competition towards patient observable characteristics. According to the UK Consum-

²⁸ Department of Health: White Paper on Healthcare Policy, London 1997.

²⁹ Department of Health: Chronic Disease Management and Self-care, London 2002.

³⁰ J. Carvel, P. Stephenson: The American Dream, in: The Guardian, 26 May 2004.

³¹ Nuffield Trust: Quest for Quality in the NHS, London 2003.

³² Foundation Hospitals Strangled by Red Tape, in: The Times, 31 August 2004.

ers' Association, less than half of the public is aware of the three-star quality rating for foundation hospitals published by the Healthcare Commission.³³ Health authorities may therefore not only need to certify and monitor treatment guidelines but possibly match types of cases to types of service providers.

With regard to *primary care*, granting PCTs regional exclusivity may be seen to mitigate the risk of discriminating against high cost patients but sacrifices competitive checks on the quality and efficiency of services commissioning and provision. Alternatives controls are difficult to achieve. Budgetary controls are cumbersome within a PCG of typically 50 GPs operating across varying clinical practice, patient characteristics and levels of sickness. Allowing PCGs or PCTs to claim financial surpluses may induce the centre to devolve indicative budgets, standards and profit sharing and thereby internalise the monitoring tasks. However, lacking effective benchmarking, it may also foster collusion among practices to share the rent. Certainly, recent developments in primary care may ultimately provide "corporate" performance standard, but the expected consolidation is apt to reduce the number of performance comparators that any commissioning organisation or regulator would require. Substitution opportunities remain nevertheless limited. On their input side, PCGs and PCTs are permitted to change a supplier only as a "last resort" and hence cannot use the threat of switching to exact superior performance. On the output side, enforcement problems are even more severe than those encountered in dealing with US managed care providers. UK PCTs are largely equivalent to US HMOs bar patient choice, which magnifies the need for legislative guidance, regulatory control and broadened enforcement.

Addressing this concern, UK health authorities impose a system of clinical governance involving 50 indicators to benchmark effective delivery of care, fair access, patient-care experience and health outcome. A New Health Development Agency tracks public health status, commissions research and evaluates recommendations. The National Institute of Clinical Excellence (NICE) produces and disseminates clinical guidelines and referral protocols and should drive good practice based on clinical evidence and cost-effectiveness. In line with these, doctors and medical professionals are subjected to annual performance appraisals. A Commission for Health Improvement (CHI) has been set up to monitor the implementation

of the standards set by the National Service Frameworks and NICE guidance on a regular basis (every three years) and by special demand from the Secretary of State. At last, all of these are to provide inputs in evolving the UK's Patient Charter.

However, the implementation of the system is still rather weak. A recent review of UK healthcare regulation, undertaken on behalf of the National Audit Office, ranks items such as patient complaints, adverse incidence reporting and continued professional development as "largely addressed". The study however attests "little progress" to critical areas such as patient and public involvement, clinical audits or adherence to treatment standards.³⁴ To give an illustration, regional PCTs, inconsistently implementing NICE standards, pervert what was "to end the lottery in UK healthcare practice" into "post-code prescription" designating the fact that, irrespective of existing treatment standards, otherwise comparable geographic areas differ by a factor of 5 in per-head drug consumption. This calls for a review not only of PCTs' budgetary controls but also of regulatory standards and the status of patient rights.

With regard to the former, Community health councils (CHCs) are meant to review health services within their districts. But they are directly funded by the NHS, set their own priorities and, given voluntary membership, often do not represent the underlying demographic profile. With regard to the latter, the UK Patient's Charter mentions a limited number of patient rights related to access, quality assurance, and complaint management. Yet so far, the Charter itself has not conferred legally enforceable patient rights and does not provide for any external monitoring and enforcement mechanisms.³⁵

Hence, the sum of initiatives presently under review in the UK, if properly enacted, effectively "disintegrates" the NHS into more managerially autonomous healthcare contractors. Yet, as long as market relief, especially in primary care, is largely foreclosed, there is a heightened need for regulatory supervision. To be effective, regulatory control needs to be devolved and based on clearly defined performance criteria and patient rights.

³⁴ K. Walshe, P. Cortvriend, A. Mahon: The implementation of clinical governance. A survey of NHS trusts in England, Manchester Centre for Healthcare Management 2003. For example, the report identifies that in the case of Alzheimer some areas in the UK spent over £10 on anti-depressant drugs while other comparable areas barely spent £2.

³⁵ See J. Halford: Patient's rights, public law and the Human Rights Act, in: Consumer Policy Review, July/August 2001, pp. 118-125.

³³ J. Carvel: NHS reforms hit as elite hospitals are downgraded, in: The Guardian, 20 July 2004.

The Case of Germany

On 17 October 2003, the German healthcare reform passed its final hurdle in the opposition-dominated Bundesrat to take effect from 1 January 2004. A key plank of Chancellor Schröder's "Agenda 2010" to kick-start the economy, the plan was to eliminate illicit deficits of statutory health insurances (SHI), cut health spending by €20 billion by 2007, and, in the process, drive down insurance premia from currently 14.4% to 12.15% of individual gross salary. "A revolutionary achievement" in the eyes of its supporters, the reform has since been criticised for representing a major policy shift to win over political opponents even at the price of dismantling the welfare state and overburdening patients and employees. In a broader context, the measures reveal a remarkable continuity in terms of policy objectives and interest group bargaining. Their impact depends on the interaction of various elements of healthcare governance.

German healthcare is recognised for its high quality of service, technical excellence, and rather uninhibited use of expensive diagnostics and "free" amenities – from homoeopathy to psychoanalysis. According to the World Health Organisation, the country ranks within the top 6 in terms of equity of access, fairness in finance and service responsiveness, but it is placed 25th in efficiently achieving these goals.³⁶ Germans spend more on healthcare than anyone else in the world, except for the Swiss and Americans: €2,740 per head per year, amounting to 11% of GDP, nearly a third more than the EU average. Total statutory insurance premia has been stable around 6% of GDP since the mid 1980s, but the relative fall of wage income to GDP and the decline in statutory insurance membership raised the contribution's share of gross salary. As the second most important driver of non-wage labour costs, maintaining stable insurance rates is seen to be a matter of competitiveness. As such, it has been a key objective of German healthcare reforms for more than three decades; the 2003 plan applied to it a mix of cost-containment, extra-funding and regulatory guidance.

As of 1 January 2004, over-the-counter drugs and various elective surgeries lost reimbursement, subsidised transportation, maternity and funeral benefits were cancelled, remuneration rates within the hospital sector and for ambulatory and dental services were frozen for a year. Direct access to specialist services without referral by general practitioners entailed an

office fee, while evidence of health behaviour, prevention and the participation in disease management programmes were to be rewarded. All medical services required co-payment equivalent to 10% of cost, maximum 2% of gross income. The pharmaceutical industry faced reference pricing on branded drugs (by 2005), a 10% increase in discounts to sickness funds and changes in distribution – mail order, consolidation and pharmacist fees. Extra funding was expected from increased taxes on cigarettes (€1 per pack), "office-fees" per consultation, and a 13.3% increase in the income threshold for mandatory insurance. Finally, an independent body was to develop treatment guidelines and assess drug benefits.

The reform may appear minor, but its impact is not. Of the planned savings of €9.9 billion in 2004, €5.8 billion resulted from increased employee contributions; calculating in co-payment and lost reimbursements, patients covered up to 60% of treatment costs. Providers and the pharmaceutical industry added c. €1 billion. But neither the allocation nor the level of burden appear worrisome. Rather, it is the lack of regulatory controls with regard to the treatment of the chronically ill and the need to entice cooperation of corporatist stakeholders that should cause governance concerns.

Statutory Insurance, Ambulatory Monopoly and Corporatist Cost Containment

The history of institutionalised German healthcare traces a struggle between statutory sickness funds, office-based physicians and other non-medical and medical professionals. Created at the height of social and economic crises of the 1880s to ensure income support in cases of illness, German statutory health insurance schemes always have been worker-employer-managed and governed under political supervision within set social and legal standards. Over time, raising the income ceiling for mandatory membership and adding new occupational and social groups, like unemployed, pensioners and disabled persons, made it possible for these funds to cover an estimated 92% of the population of the reunited Germany in 1992.³⁷ All along, services increased relative to monetary benefits and the pay-as-you-go principle of contributions and expenditure ensured proper funding.

Up to the beginning of the 1990s, historical structures and incentives of the statutory health insurance system had largely remained untouched. Sickness funds, acting jointly in purchasing ambulatory serv-

³⁶ World Health Organisation: World Health Report: Shaping the Future, Geneva 2003.

³⁷ Coverage increased from 10% of the population in 1883 to 88% in the FRG and 100% in the GDR in 1987.

ices, allocated global budgets to regional physician associations holding the monopoly of ambulatory care. These in turn distributed funds to members based on the total number of performed procedures at given point values. Insurers compensated hospitals' running costs through a combination of procedure fees and per diems. The 1977 Health Insurance Cost Containment Act and, linked to it, the Concerted Action in Healthcare, a round table of rival corporatist organisations, required statutory sickness funds to stabilise insurance contributions. Still, corporatist self-regulation was no match for missing cost standards, and strong financial incentives that resulted from non-competitive service provision and sickness funds able to pass on costs to captive members. Consequently, German healthcare reforms of the 1990s were to effect cost-containment by legislating changed incentives and structural reforms. During that time, minor shifts in the direction of healthcare policy mirrored changes in political coalitions and associated stakeholder interests.³⁸

Christian and Social Democrats both backed the 1992 Health Care Structure Act. The bill introduced co-payment, fixed budgets and spending caps for major healthcare sectors, replaced full cost coverage by itemised prospective fees in hospitals, opened ambulatory surgery to competition from hospitals, and gave almost all fund enrollees the freedom to choose a sickness fund. To ensure fair competition, a risk compensation scheme was set up to redistribute contributions among insurers.

Under the conservative-liberal coalition, the Health Insurance Contribution Rate Exoneration Act (1996) and the 1st and 2nd Health Insurance Restructuring Act (1997-98) shifted the focus from cost containment to an expansion of private pay. A positive list for drug reimbursement, introduced in 1992, was cancelled as were spending caps for pharmaceuticals and budgets in ambulatory care. Instead, increased co-payment for in-patient and rehabilitative care, pharmaceuticals and medical aids expanded funding.

With the 1998 Act to Strengthen Solidarity in Statutory Health Insurance, the incoming SPD-Green coalition reversed what it perceived to be excessive privatisation and reinstalled the 1993 budgets and a

positive list of reimbursable drugs. Over the following four years, initiatives aimed at strengthening primary care, opening up ambulatory services, reforming the hospital payment system based on diagnosis-related groups (DRGs) and flat fees, and developing new models for selective contracting with service providers. In addition, regulations were initiated to change the existing structure of drug supply and to set up an independent body of quality control. Also, to eliminate discriminatory behaviour of sickness funds, aimed at attracting healthy enrollees and forcing out expensive ones, enrollees were required to stay with a new insurer for at least eighteen months following their entry and a fund's compensation was tied to its morbidity structure, turning the chronically ill from "bad risks" into attractive patients to care for. Finally, early drafts of the 2003 Healthcare Reform³⁹ extended previous initiatives towards extra-funding and cost-containment, structural changes in sickness fund competition and the quality and integration of service provision. The final version reflects the political constellation in the Bundesrat and the relative position of stakeholder interests.

Governance Concerns

Since the beginning of the 1990s, German healthcare reforms have aimed at cost containment and the stabilisation of contributions principally by means of competition among sickness funds, performance contracting with providers, and co-payment for reasons of demand management and funding. All along the overall continuity of German healthcare plans stemmed from the institutionalised representation of stakeholders, like the Concerted Action in Healthcare that since 1978 had been called upon to help in the formulation and implementation of policy. While the goal had been to create a forum for the early participation of many interest groups in the reform process, it appears that the extension of membership over time ended up concentrating power in the hands of focused but incompatible stakeholders.

Consequently, the budgets, reinstalled by the SPD-Green coalition in 1997, were cancelled by the same government in 2001 in exchange for regional and national agreements among physicians and sickness funds self-regulating maximum spending as well as economic and financial goals. Predictably, sectoral budgets soon gave way to fee-for-service arrangements that expanded service quantity and costs.⁴⁰ Also, proposals with regard to selective contracting

³⁸ All along, minor modifications in healthcare policy reflected political constellations and associated stakeholder concerns (SPD: labour and funds; CDU and FDP: office-based physicians and providers; Greens: relatively younger electoral base) or Länder responsibilities for hospital finance or research-based pharmaceutical industry. For a detailed discussion see N. C. B a n d e l o w: Chancen einer Gesundheitsreform in der Verhandlungsdemokratie, in: *Aus Politik und Zeitgeschichte*, B33-34, 2003.

³⁹ I.e. the initial two bills to Parliament in 2002 and the draft reform brought to Parliament on 16 June 2003.

⁴⁰ N. C. B a n d e l o w, op. cit.

with specialist providers were diluted to only pertain to newcomers; established specialists have an option, but are unlikely to seek exclusive fund relations. Next, the positive lists of drugs covered by insurance, reintroduced by the SPD-Green coalition in 1997, was removed from the 2003 bill, chiefly in response to fears of the Association of Research-Based Pharmaceutical Companies (VFA) that this list would achieve its purpose, i.e. cause doctors not to prescribe unlisted medicine. The VFA also opposed the setting up of a German Centre for Quality in Medicine to formulate binding treatment guidelines and undertake cost-benefit analyses on new drug introductions. Instead, the association encouraged the government to build on existing structures and procedures for quality assurance and technology assessment.⁴¹

Nevertheless, with its 2001/2 reform of risk adjustment, the Social Democratic-Green coalition not only changed the incentive of sickness funds towards procuring most efficacious services, but it also began to involve self-governing bodies in a process to integrate fragmented healthcare – starting with the chronically ill. For the proposed disease management programmes (DMPs) to provide for efficient, integrative healthcare delivery, evidence-based guidelines needed to be established, accredited, applied and enforced. The Ministry of Health therefore asked the Federal Committee of Physicians and Sickness Funds and the Federal Coordination Committee to identify the chronic diseases that were to be managed and to propose procedures for patient enrolment and programme evaluation, develop evidence-based treatment guidelines and quality assurance measures. Based on these minimum requirements, sickness funds were to contract service providers and work out treatment protocols to be accredited by the Federal Insurance Office. As a result, for a given medical condition, providers face the same guidelines and documentation requirements irrespective of the sickness fund; funds themselves had to work out the specifics of patient enrolment, patient information and plan evaluation.⁴² Some regulatory concerns clearly remain.

- First, mandatory risk adjustment not only promotes the offering of disease management programmes but provides an incentive to maximise the number of enrollees – for example, by signing up patients even if they are not chronically ill. Thus there is a need for clarity on who decides which patient can, should or

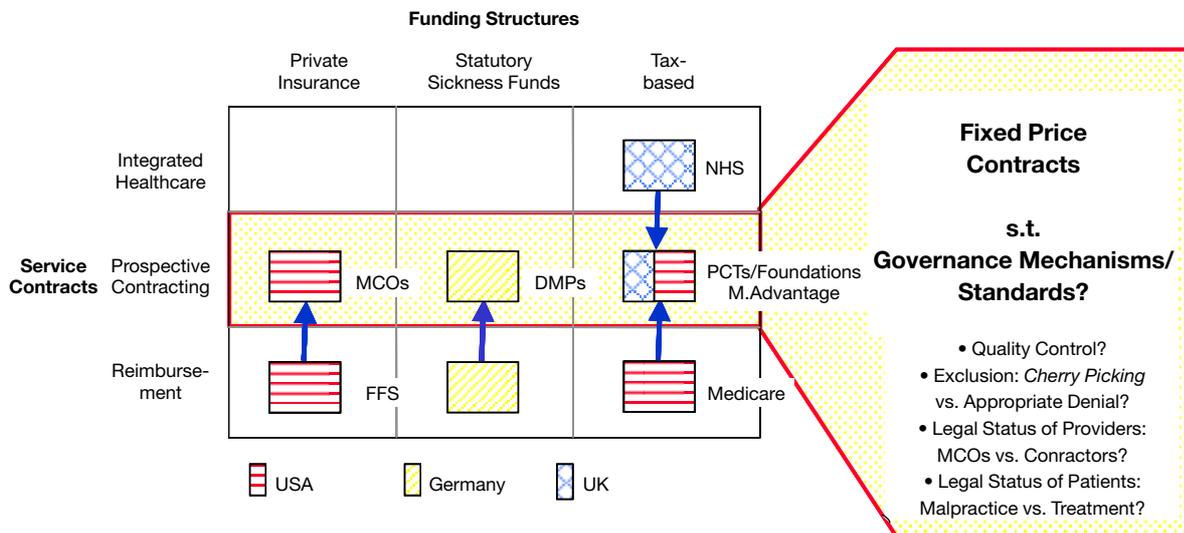
must enrol, and on what basis, and on how to monitor the process.

- Second, risk adjustment ultimately means that funds are compensated based on the average expenditure of all DMP participants across sickness funds. At a given average price per treatment, disease management programmes will profit by lowering cost of delivery and will have no interest in improving care beyond some stipulated and observable performance. Hence, the quality of service ultimately delivered to the patient needs to be monitored and enforced.
- Third, adjusting therapy guidelines to reflect new evidence and treatment opportunities entails a cascading process involving the Coordination Committee, the Federal Insurance Office, sickness funds, and service providers. The current system of standard setting – reflecting the need to achieve uniformity as well as the buy-in of stakeholders – may delay technological advance. An independent organisation, based on a review of all viable information, is apt to be faster in setting uniform standards. But the project of setting up a German Centre for Quality in Medicine has, for all practical purposes, just been shelved. Alternatively, a pluralistic system, like the one operating in the USA, may speed up the development of competing guidelines but – depending on their use – may open the door to litigation to identify the “correct” reference for any given case. The needed process for developing standards clearly depends on whether they are ultimately used as mere practice guidelines, evidence of professional norm, or as legally binding reference in court.
- Fourth, and related, for managed care commitments to be decentrally enforced, German patient rights need to be given legal standing and complemented by secondary regulation regarding access to data and institutions. So far, even though German courts have tackled patients’ rights to information, deficits remain with regard to patients’ right to inspect their medical records, and, especially in cases of chronic diseases, to be clearly informed about their condition, treatment and prognosis. To the extent that civil law establishes individual rights, some of them are restricted by the social security system. Collectively, patients as patient organisations do not participate in developing guidelines.

⁴¹ For a general statement of the VFA’s position see <http://www.vfa.de/presse/artikel/vfareformkonzept.html>. For a discussion on stakeholder interests w.r.t. the Centre for Quality in Medicine see Health Policy Monitor: Center for Quality in Medicine – Draft Bill, Policy Paper of the Bertelsmann Stiftung, 2003.

⁴² For a discussion see R. B u s e : Disease Management Programs in Germany’s Statutory Health Insurance System, in: Health Affairs, Vol. 23, Issue 3, 2004, pp. 56-67.

Figure 2
2004 Healthcare Reforms: Moving towards Prospective Contracting and Governance Concerns



In sum, although focused stakeholder interests limit the extent of structural reforms in the German healthcare system, disease management programmes may help to overcome the fragmentation of service provision and contain costs in dealing with the chronically ill. Still, the question is how to make use of market-driven incentives if market-creating standards are deficient and those that are most directly affected by discretionary service provision are hardly able to challenge standards and outcomes in markets or courts.

2003/4 Healthcare Reforms – Different Origins and Common Governance Concerns

Figure 2 sketches the crux of the current US, UK and German reform projects. The 2003/4 Bush Administration’s Medicare bill offers financial incentives and prescription drug benefits to follow the private sector trend of substituting health maintenance contracts for fee-for-service arrangements. German initiatives in 2003/4 largely shift financial burdens; for disease management programmes to trigger structural reforms, services need to be integrated and accreditation made independent – both in the face of vested interest. The US Medicare Advantage and German disease management programmes respond to shortfalls in itemised reimbursement systems and the resulting excessive consumption of healthcare. The initiatives presently reviewed in the UK, if enacted, would effectively disintegrate the NHS to obtain contestable performance contracts in primary and hospital care. UK foundation hospitals, PCTs and the new contracts to GPs and hospital consultants apply market controls to

overcome the inefficiencies of centralised, integrated planning.

Each case embraces prospective contracting to deal with the shortcomings of the current system. This “convergence” around fixed-price agreements, in each case, affects treatment decisions, limits patients’ choice and payers’ financial commitments. But the evident risk of unwarranted exclusion from vital cures and overall sub-optimal healthcare supplies raises a variety of regulatory concerns.

On the surface, US, UK and German initiatives respond rather differently to growing demands for governance. The US relies on decentralised market and judicial reactions to challenge healthcare performance, but the system is severely hampered by unclear procedural and substantive standards. Labour’s NHS reform relies on a central system of clinical governance, but treatment methods differ by region. Germany’s model of accredited corporatist self-regulation is held to benefit from superior information in structuring treatment guidelines and enforcement mechanisms, but there is concern about the legitimacy of rules, their potentially anti-competitive impact and the feasibility of external supervision.

Put differently, each case points to a common lack of performance standards which casts in doubt the viability and interaction of operational, regulatory and institutional controls. Quality norms and treatment standards are essential to price competitive healthcare services, and to distinguish proper treatment from malpractice and the wrongful from the justified denial

of service. In the absence of such standards, economic incentives involved in capitation contracts and other fixed-price arrangements are bound to push unclear regulatory limits. Any appeal to professional ethics is and ought to be of little consequence when dealing with mechanisms that are explicitly designed to foster optimising behaviour. Incentive contracts should not confront subjects with moral dilemmas but be guided by proper standards and methods of enforcement.⁴³ By the same token, the unclear notion of malpractice as “departure from accepted medical care”⁴⁴ cannot but drive up the number of fraudulent court cases and the level of malpractice insurance premia. And as a result, healthcare professionals avoid introducing new treatment methods, practising “defensive medicine” if they practise at all. But tort reforms,⁴⁵ aimed at capping medical injury compensation or limiting attorney’s contingency fees, cannot be the primary response to the problem – clearer substantive standards are. Yet, if murky standards hamper operational and regulatory governance and fuel concerns for legitimacy, why do they persist? The answer relates both to professional inertia and stakeholder interest as well as to society’s non-acceptance of managed care as rationing.

Historically, practice guidelines in the US, the UK or Germany chiefly focused on quality enhancement and were broadly supported by the professional elites.⁴⁶ The shift towards cost effectiveness however not only raised concern for the erosion of professional autonomy, but also changed the question from *how?* to *how much?*, *for what?*, and *for whom?* As a result, political authorities and healthcare providers began to shift the responsibility for managing care.

Like any standard, treatment guidelines emerge *de facto* if the benefits from acceptance outweigh the cost of switching. Non-compliance is an option only for independent professionals operating in environments where emerging practice standards are considered to

offer guidelines at best but do not present evidence of professional consensus or a legal standard in court. In any other case, deviation from “practice” may entail some form of penalisation in employment relation, payers’ denial of payment for treatment or legal liability. By permitting the necessary ancillary conditions in line with their specific regulatory contexts, US, German and UK legislatures may therefore drive the acceptance of cost-efficient treatment standards without explicitly assuming responsibility. Of course, this means delegating decision-making to healthcare suppliers and, to some extent, manifests itself in a diluted system of governance and cost control. But consider the alternative! It would mean setting treatment standards *de jure* and assuming responsibility for explicitly rationing healthcare services – *ex ante*. It would mean listing the type of intervention for which society would be willing to pay or unwilling to pay and/or set criteria, such as age, prior health behaviour or expected quality of life years after therapy, to determine when and when not to treat. This may be the unavoidable future for most OECD healthcare systems anyway, but given a choice it is a future on which most political authorities would prefer to pass.

Summary and Conclusion

Current healthcare reforms in the US, the UK and Germany embrace prospective contracting to deal with shortcomings of the current system. The evident risk of sub-optimal healthcare supplies raises a variety of regulatory concerns. Most importantly, ill-defined substantive standards and the unclear legal status of various stakeholders make it difficult to define the extent and allocation of liabilities, rights and obligations. This not only puts limits to constituting healthcare markets but also complicates proper judicial enforcement. It may be argued that standards are lacking, precisely because setting them would make healthcare rationing explicit and would open up the debate on the extent and enforceability of patients’ rights to specific treatment relative to society’s interests in allocating limited, common resources in other ways. Governments, needing to bridge an ever-growing gap between funding and treatment possibilities and societal expectations, will have to force a debate on the underlying issues.⁴⁷

⁴³ N. Frohlich, J. A. Oppenheimer: The Incompatibility of Incentive Compatible Devices and Ethical Behavior: Some Experimental Results and Insights, *Public Choice Studies*, 25, 1995, p. 49.

⁴⁴ World Law Direct defines medical malpractice as “any treatment, lack of treatment, or other departure from accepted standards of medical care, health care or safety on the part of a health care provider that causes harm to a patient”. World Law Direct, “Medical Malpractice”, July 25, 2004, <http://www.worldlawdirect.com>.

⁴⁵ Tort reforms that only focus on capping medical injury compensation may not be sufficient. California’s Medical Injury Compensation Reform Act (MICRA), passed as early as 1975, has reduced awards by an average of 30%. However, it did so by capping recoveries for non-economic damages at \$250,000 and limiting attorney’s contingency fees. As a result “the net recovery by injured patients and their families fell only 15% (while) payments to plaintiffs’ lawyers dropped 60%”. See “Medical malpractice law gets results in California”, in: *Modern Healthcare*, Vol. 34, Issue 29, 19 July 2004.

⁴⁶ See A. J. Rosoff: The Role of Clinical Practice Guidelines in Health Care Reform, in: *Journal of Law & Medicine*, Vol. 1, No. 2, October 1994.

⁴⁷ For a discussion of this issue see R. Boscheck: Healthcare Rationing and Patient Rights, in: *INTERECONOMICS*, Vol. 39, No. 6, November/December 2004, pp. 310-313.