

# Caveat RAPtor: Regulation in Resource Allocation and Purchasing

Frank G. Feeley

September 2004





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ALLOCATION AND PURCHASING**

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## Health, Nutrition and Population (HNP) Discussion Paper

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ISBN X-XXXXXX-XX-X

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# Health, Nutrition and Population (HNP) Discussion Paper

## Caveat RAPtor<sup>1</sup>: Regulation in Resource Allocation and Purchasing

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Paper prepared for the World Bank's Resource Allocation and Purchasing Project

**Abstract:** Examines the effect that existing and proposed laws and regulations can have on the feasibility and effectiveness of arrangements for resource allocation and purchasing for the health sector in developing and transitional economies. Reviews effects of laws and regulations on: the medical benefits purchased, the choice of medical provider, and the transaction in which care is provided.

Specific reference is made to recent experience in Russia, South Africa, Chile, and the Philippines, as well as possible precedents from more developed countries. Categories of law and regulation discussed include: provider licensing, monopoly and competition legislation, liability for professional negligence, mandated benefits and permitted exclusions, antidiscrimination laws, appeals procedures and other methods of asserting patient entitlement, rate setting and prohibitions on unauthorized provider charges, capacity controls and purchaser discretion in selecting providers, and patient confidentiality and collection of payment-related data.

**Keywords:** resource allocation and purchasing, health care financing, health law and regulation, health insurance and law.

**Disclaimer:** The findings, interpretations and conclusions expressed in the paper are entirely those of the authors, and do not represent the views of the World Bank, its Executive Directors, or the countries they represent.

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<sup>1</sup> The author has taken the liberty of coining a new pseudo-word in Latin. Since *emptor* is a buyer (as in *caveat emptor*, or buyer beware), and RAP is the acronym for Resource Allocation and Purchasing in this health sector project, then *RAPtor* is a public sector buyer of health care services.



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## FOREWORD

Great progress has been made in recent years in securing better access and financial protection against the cost of illness through collective financing of health care. This publication – *Caveat RAPtor: Positive and Negative Effects of Laws on Resource Allocation and Purchasing Arrangements* by Frank G. Feeley – is part of a series of Discussion Papers that review ways to make public spending on health care more efficient and equitable in developing countries through strategic purchasing and contracting services from nongovernmental providers.

Promoting health and confronting disease challenges requires action across a range of activities in the health system. This includes improvements in the policymaking and stewardship role of governments, better access to human resources, drugs, medical equipment, and consumables, and a greater engagement of both public and private providers of services.

Managing scarce resources and health care effectively and efficiently is an important part of this story. Experience has shown that, without strategic policies and focused spending mechanisms, the poor and other ordinary people are likely to get left out. The use of purchasing as a tool to enhance public sector performance is well documented in other sectors of the economy. Extension of this experience to the health sector is more recent and lessons learned are now being successfully applied to developing countries.

The shift from hiring staff in the public sector and producing services “in house” to purchasing services from non-governmental providers has been at the center of a lively debate on collective financing of health care during recent years. Its underlying premise is that it is necessary to separate the functions of financing health services from the production process of service delivery to improve public sector accountability and performance.

In this Discussion Paper, Feeley reviews the impact of laws and regulations on resource allocation and purchasing in the health sector. Some laws governing the provision of health services — notably provider licensing and liability for professional negligence — predate modern concepts of risk pooling and purchasing. As a result, the role of purchaser as agent is often missing. The author suggests that in many developing countries this leads to an inappropriate regulatory framework for the purchase of health care that needs to be addressed in future reforms.

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Editor of HNP Publications



## **ACKNOWLEDGEMENTS**

My thanks to Jack Langenbrunner for encouraging me to persevere with this piece, and to my research assistant, Sara Alkenbrack, for pursuing difficult to find sources. In addition, my thanks to Igor Sheiman, Sergei Shishkin and their Russian Colleagues who forced me to think “outside the box” usually inhabited by American health lawyers.

The author is grateful to the World Bank for having published this report as an HNP Discussion Paper.



## INTRODUCTION

The simple concept of resource allocation and purchasing (RAP) soon ramifies into a complex structure upon investigation of the market interactions implied by the “purchasing” role. Looking at the impact of laws and regulations on the RAP model further complicates the analysis. Some laws governing the provision of health services—notably provider licensing and liability for professional negligence—predate modern concepts of risk pooling and purchasing and do not directly address the role of an “agent” purchasing services on behalf of patients. Such laws may constrain the actions of the RAP agent and perhaps should be modified in the light of RAP theory.

In systems with social or private health insurance, a variety of laws govern risk pooling and revenue collection roles as well as resource allocation and purchasing behavior. These rules are particularly important if the statutory structure does not explicitly incorporate all of the population into a single risk pool or coverage scheme. Recent reforms in the regulation of South African health insurance schemes explicitly address abuses that can arise when only a portion of the population is included in insurance schemes and the government health service provides for uninsured individuals as well as for services not covered by the private RAP arrangements and too expensive for an individual to purchase out of pocket (Soderlund 1998, p197).

Rules governing risk pooling and revenue collection are dealt with elsewhere in this book. A note of caution is warranted in designing accompanying financial solvency requirements for RAP purchasers: respect the differences between provider-based managed care schemes, where the provider incurs most or all of the financial risk, and schemes where the purchaser pays independent providers according to the amount of care delivered. To encourage the development of health maintenance organizations (HMOs) in the United States, the federal government passed a law in the 1970s changing some of the rules applied to this developing innovation. Financial solvency guarantees can be less stringent for provider-based managed care schemes, since the provider has the ability to expand output at modest marginal cost to meet medical demands in excess of expectations. The “pure” insurer, however, must pay out cash for each service and needs a larger financial cushion. Similarly, community finance schemes with modest benefit packages need less of a solvency guarantee than nationwide insurers. To demand too much in solvency guarantees will inhibit the development of potentially innovative schemes.

In this paper, we focus on the laws and regulations that affect the purchaser’s ability to act as an effective agent in buying health services. We look not only at laws already in place but also at laws that may be contemplated to regulate the purchaser’s activity in:

- Deciding which services to purchase (“What to pay for”)
- Selecting the providers that will offer the services and determining the conditions under which they will do so (“Whom to pay”)
- Determining the amount and method of payment for services (“How much and how to pay”).

## A TYPOLOGY OF RAP ARRANGEMENTS

RAP concepts span a spectrum of purchasing arrangements that begins with systems integrating the financing and direct provision of care by ministries of health and runs through integrated nongovernmental HMOs to social health insurance, private and community health insurance. At the far end of this spectrum, individuals purchase health services with their own resources; no entity acts as an agent on their behalf to enhance efficiency, effectiveness, or equity. The area of interest lies in the part of the spectrum that begins with HMOs (where there is some blurring of the “purchaser” and “provider” roles) through to private and community health insurance. Under all these arrangements, a RAP agent makes decisions to purchase services on behalf of the patients. We ask how existing (and potential) laws can:

- Improve the ability of the agent to enhance the effectiveness and efficiency of care
- Enhance equity in the treatment of patients with varying medical needs and ability to pay for care
- Make services more responsive to individual patient needs.

One important element to consider in the legal analysis is the extent to which the RAP agent has concentrated purchasing power. If both the service provider and the patient have a wide choice of different RAP agents, each agent may exercise greater freedom to set the terms by which it purchases care. A disgruntled provider or patient may move to an alternative purchasing arrangement. But such fragmented arrangements have inherent problems in developing large risk pools or require complicated mechanisms to adjust for differences in risk and level inequalities in the ability to pay premiums.

If the RAP agent acts on behalf of most or all of the patients in a geographic region, it captures the broad pool of medical risks and may internalize some of the necessary resource transfers across groups (high and low income, well and sick, productive and dependent). But the power it has, as a “single purchaser” must be subject to stricter rules on its purchasing behavior. At a minimum, it will be required to provide greater procedural protections for individuals damaged by a purchasing decision. If a RAP agent with monopsonistic power refuses to purchase covered services from a particular provider, that provider will be driven out of business, even though it complies with national licensing standards. Aggrieved providers will seek procedural protection of their economic interests, if not an outright guarantee of provider status as long as they are duly licensed. The purchaser may not refuse or withdraw a contract without adhering to published rules for such decisions or without a hearing before an impartial body. Implementing regulations should provide procedural protection without discouraging the RAP purchaser from making difficult decisions that will improve equity, efficiency, or quality. Procedures should permit community insurance schemes with a very small share of the relevant market a freer hand to contract with a small number of providers and in doing so leverage better prices or service levels for its patients.

What follows are brief discussions of the laws that *may* exist, or be adopted, in a country and their impact on the operation of an efficient RAP arrangement. In general, countries at the lowest levels of development show the least development of such laws and regulations, often having little more than a very basic licensing law for physicians or inpatient hospitals. Such rules rarely

specify more than minimum educational attainment (and occasionally “good moral character”) in the case of physicians, or minimal standards for ownership and physical structure in the case of hospitals. No reference is made to laws that control investment or general corporate operations for all businesses, including health providers.

To obtain some idea of the issues in countries with a more elaborate legal infrastructure affecting health providers and purchasers, we draw on the available literature on regulation and health insurance in South Africa, Chile, and the Philippines. No pretense is made to a full-scale legal analysis in these countries or to an accurate description of the laws worldwide. Instead, we seek to set out here an annotated checklist for local legal analysis to serve those who ask: “Does my country have an effective RAP arrangement? Could it be improved, and what role might the law play in such improvements?”

## **REGULATING WHAT IS PURCHASED**

### **COVERED BENEFITS**

Many statutory schemes regulate the purchaser’s flexibility in determining which services to purchase. There are several reasons for doing this:

- A defined minimum benefit package may establish a basis for competitive purchasing; “managed competition” as envisioned by Enthoven (1993). Purchasers must offer the same benefits, and can compete on price and quality, not through subtle variations in the benefit package.
- Purchasers can be required to offer the benefits that the regulator deems cost effective, having high externalities and public health benefits, or particularly important for social protection.
- Defined benefits can prevent private insurers from dumping high-cost cases on the public health care system, as has happened in South Africa (Soderlund and Khosa 1997, p. 349)

Required benefits may also be a form of “regulatory capture,” in which provider groups mandate coverage by the purchasing arrangement so that they can expand the market for their services. Should psychotherapy (if covered) be limited to psychiatrists, or must purchasers also pay psychologists and social workers for the service? Sometimes patient and provider groups collaborate to mandate a benefit. For example, women’s groups and obstetricians may lobby for coverage of family planning or infertility services.

As an economy grows and health care expenditures increase, the need to fix a reasonable minimum benefit package becomes greater. In the very early stages of developing RAP schemes, a minimum benefit scheme may prevent poorer groups from achieving the benefits of risk pooling. In some African community health insurance schemes, only inpatient benefits are covered. A “sound” benefit package would seem to include both inpatient and outpatient benefits so as to prevent unnecessary hospitalization. The acceptable annual premium for a health financing scheme in a rural village may be enough for basic inpatient coverage but inadequate to cover one or two outpatient visits as well. Risk pooling in that market is better achieved without a mandated combination of outpatient and inpatient benefits. Other poor communities may

choose to focus their premiums on obtaining local primary care and drug supplies and leave inpatient benefits to the government. Mandated benefit packages in such a circumstance can inhibit the development of RAP schemes.

### **EXCLUDED BENEFITS**

In addition to the positive requirement for a minimum benefit package, a government may want to limit the ability of a purchaser to exclude certain benefits for many other reasons:

- To prevent the purchaser from “cream skimming” a risk pool by denying benefits to those with chronic or congenital diseases.
- To reduce the burden on the public safety net (as in South Africa).
- To prevent deceptive marketing by insurance companies, which hide the exclusions in the small print of the insurance contracts.
- To enhance the level of economic protection provided by a RAP scheme.

Balanced against these reasons for limiting exclusions is the purchaser’s need to make the health plan affordable. Thus, limits on exclusions are more acceptable as incomes rise, and patients demand broader coverage and can afford higher premiums. However, one form of exclusion must usually be permitted, but must always be closely regulated. This is the classic “preexisting condition” exclusion where a patient is not covered (for some period of time) for the costs of a medical condition existing at the time he joined the purchasing scheme. No risk pool will work if members can join only when they have immediate major medical needs. The purchaser must pool the resources, and medical needs, of the healthy and the sick.

Where RAP coverage is mandatory and continuous for all, it is reasonable to bar preexisting condition exclusions. Where coverage is optional, some other approach must be taken. The period of the preexisting condition exclusion can be limited. Or such exclusions can be banned if the patient has continuous coverage with other RAP schemes. Or all schemes can have an “open enrollment” period once each year, when they must accept all applicants, who must then stay enrolled for a fixed period of time. Whatever route is taken, this is one area in which laws governing RAP schemes should be clear and explicit.

### **MEDICAL NECESSITY**

Even the cleverest lawyers will lag behind the complexity of medical care and the advancing science of evidence-based medicine. It is impossible to draft a structural law, or even a regulation, that can comprehensively mandate benefits and define all permitted exclusions. There will always be cases in which a particular treatment may be of great benefit to one patient, of negligible benefit to another. The need to distinguish between such cases is usually accommodated by a stipulation that the purchaser pays only for “medically necessary” treatments. But what is “medically necessary”? Most statutory language provides a poor guide. In assessing the legal structure for a RAP arrangement, it is perhaps better to concentrate on an appeals mechanism (see below and the example of Chile), instead of trying to craft a definition that will apply to every RAP plan and every case.

## **SERVICES RESERVED TO OTHER PARTS OF THE HEALTH SYSTEM**

Purchasers may try to avoid including in the benefit package services provided free by the government, particularly preventive services and treatment of infectious diseases such as tuberculosis. Where the government mandates that treatment for certain conditions occur in government-controlled institutions—as it does with psychiatry in Russia—a purchaser will often avoid including such services in the benefit package, for it would otherwise be forced to replace tax dollars with RAP funds.

Excluding these government services may be rational. In Africa, governments are better in offering some primary care services such as vaccinations and prenatal care than in providing district hospital treatment for illness and accidents. Thus, it is reasonable to permit a community health insurance plan to require its members to use these government preventive services and reserve scarce premium dollars for other services where quality is available only with the payment of user fees. On the other hand, such an approach can fragment care. If clinical and preventive cares take place at different sites, patients may not seek the preventive services that would lower treatment costs. Where most health care funding flows through RAP arrangements and not through direct government-provided services, it is usually desirable to require the RAP plans to include the full range of services, even though they could be obtained from government clinics. This is more likely to result in cost-effective and comprehensive care. In low-income countries where direct government funding is still a significant part of health spending and is focused on preventive and primary care, leaving to the purchaser the decision to exclude some government-provided services may be reasonable.

## **NONDISCRIMINATION**

Though not immediately apparent, laws that ban discrimination generally may have an impact on a RAP system's freedom to define covered benefits. If a country has a strong law barring discrimination against individuals with HIV/AIDS, does this mean that the RAP arrangement must cover antiretrovirals? Do laws mandating equal protection for women mean that a maternity benefit must be included in a RAP arrangement? If drug or alcohol abuse is considered a psychiatric condition, must treatment for these be covered to the full extent of any psychiatric benefit?

There is no single answer to this question. Sometimes antidiscrimination statutes may specify that they apply to medical benefits. More often a general principle is stated, and the implications for RAP arrangements are not thought through at the time of passage.

In performing a review of local laws that might affect a RAP scheme, the first step is to list existing antidiscrimination laws and identify any portions of these laws or implementing regulations that are specific to medical care benefits. If the laws are silent, the question must then be asked, "Should RAP arrangements accept this ambiguity or seek clarifying legislation?" For the purchaser, the greatest freedom in designing a benefit package is desirable, and a scheme should not be required to provide a benefit that it cannot afford. At the moment, any argument by extension from AIDS antidiscrimination laws that a community-financing scheme in Africa must cover antiretrovirals would render such schemes unmarketable. In severely afflicted countries, the required premium would be beyond the capacity of even the middle class (let alone rural farmers), until drug prices decrease. Some community health financing schemes may want to

cover maternity benefits, while others may consider them a predictable and “normal” expense and will choose a benefit package oriented more toward infectious diseases and accidents. While it is true that this decision may reflect the prejudices of a group of older males who control the purchasing scheme, preempting these decisions will not encourage the expansion of community RAP arrangements.

Where multiple RAP schemes develop in a poor country, leaving benefit decisions to the schemes is probably preferable to preempting benefit design through antidiscrimination legislation. Development of RAP schemes may be encouraged by a clear legal statement that the selection of a benefit package is *not* subject to litigation under antidiscrimination laws. On the other hand, where there are a few well-funded RAP schemes, it is likely that arguments for additional benefits (like antiretrovirals) will be made under antidiscrimination statutes. In such cases, it may be better to have the decision subject to specific legislative action amending the minimum benefit package. The costs and benefits can then be publicly weighed, rather than attempting to achieve the same result through litigation of ambiguously worded anti-discrimination laws.

### APPEALS PROCESS

At some point, any RAP arrangement must say “No” to payment for some services that could be offered by a medical provider. Certain well-established services (transplants) may be categorically rejected as exceeding the purchaser’s ability to pay or as ineffective in relation to the cost (routine tonsillectomies). In addition, however, most purchasing arrangements will reserve the right to reject services that are not medically necessary, as discussed above. Should there be recourse for the patient that wants the service and the provider willing to offer it?

Many nascent purchasing arrangements have yet to encounter this issue, but they will as patient and provider sophistication increase. In Russia, for instance, the Federal Mandatory Health Insurance (MHI) Fund invested substantial effort in developing sanctions that insurers could impose on providers who denied services or delivered unnecessary services. The draft regulations also specified procedures for enforcement, but ignored the possibility that the insurer might prevent a patient from receiving a covered service (Federal Compulsory Health Insurance Fund 1999). But when asked if they were developing comparable procedures for aggrieved patients denied a service by the insurer, Federal Fund officials responded that they did not think this was needed. They had not considered that the insurer might deny payment for a service deemed unnecessary or that the patient might claim that the service needed was, in fact, a covered benefit. No patient appeals procedure was being developed.

Chile, which has an extensive private health insurance system coupled with a Government safety net of social insurance, has a well-developed appeals mechanism that might be a model for other countries. Complaints against the private insurers (ISAPREs) can be filed with the responsible regulatory authority, and there is a well-defined process from initial complaint through informal dispute resolution to arbitration, where the burden of proof lies with the insurer. In 1997, the insurer won 28 percent of these contests, while the insured was fully or partially victorious in 59 percent (Jost, pp. 15–16, Nexis printout).

The appropriate level of patient protection and appeal will vary from society to society and will generally increase with the scope of the benefit and education of the covered population. For simple community financing schemes, a formal appeal process will be too expensive and perhaps unnecessary. But some avenue of appeal may benefit the community-financing movement, particularly where the population is skeptical of other insurers that are perceived to shirk claim-payment obligations. Where medical care is expensive and large RAP schemes few, some avenue of patient appeal becomes imperative. The outlines of the appeal system should be included in a law structuring a “single payer” arrangement, while general principles for appeals should be stated for more disparate RAP arrangements. The procedures should be as simple and swift as possible and should give due consideration to the purchaser’s need for efficiency as well as the patient’s desire for care.

## **REGULATING THE CHOICE OF PROVIDERS**

The choice of providers is regulated usually by licensing of physicians and hospitals, and sometimes by antitrust and competition laws. Many West European countries try to control health care spending by limiting the supply of beds and expensive medical equipment. Some countries by law require the purchaser to accept any qualified provider.

### **PROFESSIONAL AND FACILITY LICENSING**

Even the least developed countries usually have a law that requires licensing of physicians and hospitals. Often, medical associations are delegated the authority to license physicians. Licenses are frequently given for life and rarely withdrawn. Even if the government retains the licensing authority and requires periodic renewal, few physicians lose their license because of incompetent practice. While the government retains the authority to license hospitals, the regulations are usually poorly developed and antiquated. Enforcement can be nonexistent or corrupt. In short, a purchaser will want to require that a provider hold a license, but this should not be the sole criterion for a provider’s participation in a RAP arrangement.

One possible way of enforcing high standards is to add to the licensing requirement a stipulation that the provider hold further qualifications granted by self-regulatory bodies such as a society of specialist physicians. While the standards developed for such accreditation are likely more rigorous than government licensing regulations, enforcement and withdrawal of accreditation may be haphazard. One alternative, used in the Philippines, is to authorize the national purchaser to establish its own accreditation program (Hindle, Acuin, and Valera 2001). In the absence of such a statute, the purchaser can develop “conditions of participation” in its provider contracts that permit it to enforce standards of quality or performance. In Russia, this has resulted in a de facto incorporation into the health insurance program of outdated medical quality standards descended from the Soviet era. It would be better if Russian purchasers developed more modern evidence-based standards, but they generally defer to health authorities. No firm rule can be established for the “best” statutory structure, but it is advisable that the law either mandates or permits the insurer to enforce standards in addition to the minimums associated with professional licensure.

## MONOPOLY AND COMPETITION

Antitrust and monopoly laws may limit RAP purchasing arrangements. The analysis will vary from country to country, depending on the governance of the RAP arrangement (public or private), the structure of the health care system, and the specific pro-competition rules. In general, RAP purchasers should be free to choose providers in order to maximize efficiency and quality. If multiple purchasers operate in a market, the question of *tying*—locking a provider into a purchasing arrangement to the exclusion of other purchasers—may arise. If providers consolidate to increase their negotiating power with purchasers, a monopoly or oligopoly may be created to the detriment of consumers and purchasers. Yet consolidation of providers may also permit desirable downsizing of an inefficient health system. No hard and fast rule on the application of antimonopoly laws is possible, but—“caveat RAPtor”—the purchaser should check competition laws before designing purchasing arrangements that exclude other purchasers or providers.

## CERTIFICATE OF NEED AND PLANNING APPROVAL

Many countries in Western Europe attempt to control total health care spending by limiting the supply of expensive medical equipment or the construction or reconstruction of hospital beds. Even the United States experimented with a “Certificate of Need” law for health system investment, recognizing that medical costs obey Roemer’s law, with utilization, and insurance payments, expanding with installed capacity

To understand the implications of such capacity control, one must first know if a population is served by a single or multiple RAP arrangements. If there is a “single payer” for the country or the region, it should play a role in the approval of major capital investment. In effect, this could even be delegated to the purchaser, which has the best knowledge of cost implications for any investment. However, the providers, and the Ministry of Health, may object. They may want capacity to offer services that the purchaser does not want to pay for. This usually results in negotiations during the approval process. If approval is granted, the single RAP purchaser usually has little choice but to pay for services in the approved facility, unless the approval specifically exempts it from such obligation. As single-payer RAP arrangements develop, statutes delineating their role in the approval process are desirable.

Where multiple RAP arrangements (private insurers, community-based schemes, industry-based sickness funds) serve a single medical market, the questions become more complex. An individual purchaser cannot (and should not) control the planning decision, although it should have an opportunity to be heard in the approval process. But what happens once a decision is made and the new investment approved? Is each purchaser obligated to accept the new or expanded facilities within its provider network? For efficiency purposes, the answer should be “No.” The purchaser should have the flexibility to decide if it can obtain care more efficiently by negotiating with a subset of approved providers. Perhaps it can obtain a lower price for a tertiary procedure by concentrating all its cases in a single location. But providers will argue that approval of the investment implies an obligation for each purchaser to pay for patients that reach the facility. Of course, the purchaser can still utilize gatekeeping arrangements to keep patients away from a facility it considers superfluous or expensive. Operationally, decisions will be simplified by a law that clarifies the purchaser’s freedom to exclude (or not exclude) providers that otherwise have the necessary planning approvals

### **“ANY WILLING PROVIDER”**

“Any willing provider” laws, though usually seen as a reaction to the growth of the managed care movement in the United States, can become an issue wherever a purchaser seeks to trim its commitment to an excessive network of practitioners or facilities. Such laws state that the purchaser must accept as a provider any qualified practitioner willing to accept the general terms (e.g., price, payment conditions) of a provider contract. The purchaser cannot selectively contract with providers in order to drive down prices or to limit capacity in the provider network so as to reduce unnecessary procedures performed to generate additional income. This is currently an issue in the Philippines, where the national health insurance system must accept all accredited providers, thus limiting its ability to negotiate more favorable rates in return for greater patient volume (Hindle, Acuin, and Valera 2001).

Lest this seem a problem peculiar to litigious American health providers, consider the circumstances of the former Soviet Union. Most cities have more hospitals and beds than necessary. If all the doctors currently practicing in the system were to seek to make a living through fee-for-service practice, the purchaser could not afford the total cost or would have to pay prices so low that the doctor could not make an acceptable wage (effectively what has happened). A purchaser—single or multiple—could achieve great efficiency benefits by contracting selectively with the best pieces of the existing health system. In fact, this has not happened in Russia and most of the former Soviet Union (FSU) countries. Where insurers have been created, they have been under great pressure to include all providers in the payment scheme. A few have attempted to negotiate preferential arrangements for their insureds with the best facilities, but the purchasers have generally been ineffective in downsizing the system. If the opportunity exists and downsizing is necessary, a country should consider passage of a law specifically permitting purchasers to contract selectively.

### **REGULATING THE PURCHASING TRANSACTION**

To protect consumers, some countries allow patients or their families to sue for negligent medical care. Some countries also set by law maximum and minimum prices for health care services and drugs and forbid direct payments. “Patient privacy” in the internet age is an issue in developed countries.

### **LIABILITY FOR PROFESSIONAL NEGLIGENCE**

Countries in the Anglo-Saxon common law tradition permit a patient or his heirs to sue a medical provider for “breach of the duty of care” when he is injured (or killed) by deficient medical treatment. Other countries provide by statute for compensation for damages in the event of such professional malpractice. The frequency of litigation is a function of many factors besides the extent of malpractice in the medical care system. In India, damages resulting from physician and hospital negligence have been brought within the scope of the Consumer Protection Law to facilitate recovery by injured patients (Bhat, p. 267–68).

The first question to be asked of RAP arrangements and professional negligence is: “Does the RAP purchaser have any role to play?” If it has paid additional medical costs due to medical negligence, the purchaser has an economic interest in recovering these costs from a provider found liable for the injury. This could be accomplished by a simple statute that requires the

inclusion of such costs in the allowable recovery and gives the insurer a lien on the recovery if the patient's claim is successful. The third-party purchaser may, however, want to waive recovery of such costs, thus reducing the volume of litigation and its cost to the health care system. If the purchaser is confident of its ability to select providers and eliminate the incompetent, it will want to use information about professional negligence in its decisions to grant or continue provider status.

Should the purchaser go beyond passive recovery of its costs or use information on professional negligence to take an active role in assisting the patient to recover? This occurs in the Russian MHI system, where the insurer seeks to position itself as the defender of the patient's interests. In addition to penalizing deficient providers and recovering the medical costs associated with negligent care, insurers do attempt to recover some damages on behalf of the patient. A third-party purchaser should have much greater expertise than a patient in assessing the quality of care and the extent of a provider's negligence. Using the purchaser to determine the level of a patient's recovery might be an administratively efficient way to replace the large frictional costs of individual case litigation. However, the extent to which patients will be willing to cede to an insurer the protection of their interests, and their right of recovery, will vary greatly. The number and amount of recoveries in the early years of the Russian MHI system were small (Federal Compulsory Health Insurance Fund 1999), and do not provide a basis for assuming that the third-party purchaser will be more zealous in protecting the damaged patient's interests than the common law system or the consumer protection law in India.

#### **DETERMINING RATES OF PAYMENT**

Some countries have legislation that fixes maximum or minimum prices for health care services. In addition, where medical societies are powerful, they may influence fees by publishing suggested fee levels. Peer pressure (and self-interest) then motivates members to maintain these fee levels. Without entering the debate on the economic merits of price legislation, it is clear that such rules should not be applied to RAP arrangements. If the RAP purchaser can obtain prices below the statutory minimum, it should be allowed to do so. As long as the purchaser assures quality and access, the patient will benefit. A purchaser might also want to pay above the maximum for a service, perhaps to guarantee quality or to encourage a provider to include supplementary services or bundle separate fees into a single price for a procedure or diagnosis.

In addition to the general question of minimum or maximum fees, special issues arise around incentives the purchaser may incorporate in its fee structure. Should a purchaser be allowed to offer the provider incentives (through capitation, fee withholding, or other mechanisms) to reduce the volume of services provided or obtained through referral? This has been a basic tool of the managed care industry in the United States but was also used to some effect with fundholding general practitioners (GPs) in Britain and has been tried at various sites in Russia such as Maroyaroslavets rayon in Kaluga oblast and in Tula oblast. The economic principles behind RAP schemes suggest that the freedom to cut such "deals" should not be constrained. On the other hand, consumers and providers may feel that such incentives create an unacceptable conflict with the doctor's Hippocratic obligation to act in the patient's best interests. Indirect incentives (available to a more extensive system of providers, rather than an individual) will likely be preferable to those that directly increase a doctor's take-home pay by denying care. The GP fundholding experiment used indirect incentives, where the practice benefited (by offering

better facilities or supplementary services), but savings did not go directly into the physician's pocket. RAP system designers will find it difficult to dictate that there be no constraint on incentive structures, but they can lobby for greater freedom and must design the purchasing arrangement with these constraints in mind.

### **ENFORCING LIMITS ON DIRECT PATIENT PAYMENT**

Limits on direct patient payment must be enforced in any country that has a tradition of "gray market" health care payments and should be part of the statutory structure for any general RAP arrangement. Such a law makes it illegal for a provider to charge a patient for covered services unless such direct payments (e.g., copayments and deductibles) are specifically permitted under the terms of the purchasing arrangement. Although this condition seems obvious, it is often overlooked. One of the reasons Korean health care costs grew so rapidly after the introduction of widespread health insurance was that there was no limit on charging for most services in addition to collecting the insurance payment. In effect, insurance just lowered the price to the consumer, thus increasing the demand and providing only modest financial protection to those with high medical need (Yang, pp. 240, 246). Under the Philippines National Health Insurance scheme, the purchaser pays only a portion of hospital costs. When the scheme raised payments to reduce out-of-pocket costs and make scheme benefits more accessible for the poor, hospitals raised their prices and continued to collect the difference directly from the insured patients (Hindle, Acuin, and Valera 2001).

What sanction should be invoked if a provider is shown to demand illegal supplements to RAP payments? The simplest and most direct sanction is to terminate provider status in the RAP scheme. Where the RAP scheme is generous, and a single purchaser is responsible for the entire medical market, this should be sufficient to obtain provider compliance, unless the provider can survive on a "cash and carry" trade with the rich. Where the purchaser is one of many in the market, such a sanction may be insufficient. The provider may leave the RAP scheme and charge cash to the beneficiaries of schemes that pay poorly, while complying with the ban on supplementary payments where he deems the purchaser's allowance to be adequate. A stronger sanction (used by some U.S. jurisdictions) places the professional license at risk if the provider demands payments not authorized by the agreement with the purchaser. Such a sanction usually requires a more complicated legal process but can be very effective. The purchaser must have a carefully crafted contract with each provider and a clear definition of services that are *not* covered and supplementary payments that are allowed.

It is often argued that laws barring supplementary payments cannot, or will not, be enforced without a general understanding that the purchaser's payments and permitted supplements are "adequate." What is adequate depends on market conditions in the country and the expectations of practitioners. In some FSU countries, insurance payments are so low that cash supplements or "gifts" are considered inevitable. However, it would be better to shrink the provider network or limit the covered benefits and specifically permit certain supplementary payments instead of allowing the tradition of unregulated gray market payments to continue.

### **PRIVACY, DATA AND BENEFIT MANAGEMENT**

Conflicts between the privacy of medical records and a purchaser's "need to know" the details of the care purchased have been a concern in the most developed countries. There, privacy is a

major consumer issue, and electronic claims processing systems enable purchasers to amass (and potentially misuse) a vast amount of medical information. However, as RAP arrangements become more sophisticated in newly industrializing and transitional economies, the same concerns will arise, particularly if providers are paid on a fee-for-service basis.

One way around the privacy concern is to capitate providers to provide all or a portion of the care needed by enrolled members. This puts the provider at risk of “excess utilization” and eliminates the need to report diagnoses and procedures to the purchaser. Such an approach has been tried with a number of community health financing schemes, which pass premiums through to a local provider that offers the full range of covered benefits.

In the absence of such capitation arrangements, the law should clarify the right of the insurer to obtain medical data needed to audit the quality and necessity of the care purchased. This can be done by statute or by having the patient sign a “limited release” at the time of treatment so that the provider will waive direct payment and bill the purchaser. In all countries, but particularly where the sophistication of claims processing is developing and the level of patient education low, language stating the following principles should be included in statutes that structure the RAP arrangement:

- The right of the purchaser to audit medical records
- The right of the purchaser, as a condition of payment, to obtain information routinely on patient diagnosis and services received
- The obligation of the purchaser to hold any patient information confidential and not to release it to employers or use it for any purpose other than the validation of claims.

Assessing the impact of the law on a RAP scheme is not simple. Additions or deletions from the statute book must take into account the nature of the RAP arrangement, the presence of single or multiple payers, the level of economic development and feasible premiums, and the existing capacity of the medical care system. But without the analysis outlined here, and the necessary actions by legislators and regulators, a law (or its absence) can derail the most carefully laid plans of economists and medical managers.

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