Balancing Regulation and Entrepreneurialism in Europe’s Health Care Sector

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Topics discussed

Why a study on regulation and entrepreneurialism?

• What is regulation?
  • Why regulate?
  • Who regulates?
  • How to regulate?
  • What to regulate?
  – using the example of hospitals

Who is the Observatory and what does it?
Scenario 1

In an entrepreneur’s ideal world, one could set up a hospital, determine how to run it and be responsible for all losses and profit, including the freedom to choose a location, determine the size, decide on the range of technology and services offered, set price levels and refuse to accept certain patients, the right to decide on staffing numbers and qualification mix, the working conditions of the employees and their salaries.

There would be no restrictions on business relationships with suppliers and other hospitals, including the right for mergers and horizontal and vertical takeovers.
Scenario 2

The national government - or a subordinated public body such as a Health Authority – establishes hospitals where and at what size deemed necessary according to a public plan. The authorities determine the technology installed and the range of services offered. Services are delivered free to all citizens at the point of service, hence no prices need to be set.

Staffing and working conditions are decided by the public authorities and standard public salaries apply. As the hospitals are part of the public health services infrastructure, they have no independent relationships with other actors and no room for mergers or takeovers.
• Both hospitals are not regulated, either intentionally not to restrict the market behaviour of the hospital owners/ managers, or due to public sector ”command-and-control”.

• There has been a visible move towards more autonomy and market-style mechanisms to providers and other actors and to re-direct politics to “steer-and-channel”, requiring regulation.

• Hospitals in most European countries now fall somewhere in between the two extremes and require a carefully calibrated set of regulation.
## Public-private ownership of hospital beds in Bismarckian countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Public</th>
<th>Not-for-profit</th>
<th>For profit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>69%</td>
<td>26%</td>
<td>5%</td>
</tr>
<tr>
<td>Belgium</td>
<td>60%</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>France</td>
<td>65%</td>
<td>15%</td>
<td>20%</td>
</tr>
<tr>
<td>Germany</td>
<td>55%</td>
<td>38%</td>
<td>7%</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>50%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>Netherlands</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*European Observatory on Health Care Systems*
How do countries autonomize?

- purchaser-hospital (provider) split
- introduction of contractual relationships between purchasers and hospitals (like in Bismarckian systems)
- increase decision-latitude of hospital about services, staffing etc.
- increase financial autonomy ("residual claimant" status)
Regulation in the health sector can mean any of these things:

- **Mandatory rules enforced by a state agency**
- **All state efforts to steer the sector** (including state ownership, contracting, taxation and incentives)
- **All social control mechanisms** (including non-governmental tools as professional norms or societal values)
Why Regulate?
Rationale for Health Sector Regulation

To achieve social objectives, e.g.:

- Equity and justice: Ensuring needs-based access to health care for the whole population including elderly, poor, rural etc.
- Social cohesion through NHS or SHI
- Individual choice of provider and/or insurer.
- Health and safety: worker protection, public health, health service effectiveness
- Economic efficiency
Why Regulate?
Rationale for Health Sector Regulation

To address the question “How are we going to make it work better?”, e.g. by:

• effectiveness and quality of services: assessing cost-effectiveness and deciding upon benefits basket (incl. positive/negative lists), training health professionals, accrediting providers,

• patient access: gate-keeping, co-payments, rules for subscriber choice among third-party payers, GP location planning,

• provider behaviour: transforming hospitals into public firms, capital borrowing,

• rules for contracting between payers and providers
Who Regulates?
“Governmental” Regulation

De facto more complicated:
• Parliament/ legislative branch: laws
• Cabinet/ executive branch: decrees
• Courts/ juridicial branch: rulings
• Devolution to regional/ local authorities
• Independent Regulatory Authorities/ Agencies
Who Regulates?
(Enforced) Self-Regulation

Degree of government enforcement

Low
- Purely private self-regulation

High
- State-mandated self-regulation
  - e.g. certification by professional associations, contracts between sickness funds and providers
Self-Regulation
Advantages and Disadvantages

**Advantages**
- High commitment to own rules.
- Low costs to government.
- Enforcement and complaints procedures more effective.

**Disadvantages**
- Professional self-interest.
- Legal oversight may be problematic.
- Inappropriate for areas as antitrust regulation.
Who Regulates?  
Government versus Self-regulation

Who regulates what depends upon:

- The type of **activity** being regulated.
- The **segment** of the health system being regulated (hospitals, physicians, insurers).
- The **capacity** of various regulators.
- A variety of **national factors** including institutional structure and cultural traditions.
Government Versus Self-regulation
The International Experience

• **Efficiency** (e.g. capacity, antitrust) regulation is mainly governmental.

• **Quality** issues are good candidates for *self-regulation*.
How to Regulate?
Overall Regulatory Strategies

Legal controls
“The stick”
Providers must conform to legislative requirements and face punishment if they don’t.

Incentive Schemes
“The carrot”
Providers modify their behavior in response to incentives.
Types of regulation by intention and impact

- Pro-competitive regulation that stimulates market opportunities
- Pro-competitive regulation that restricts individual market-driven behaviour
- Regulation restricting hospitals to achieve social objectives as access, social cohesion, public health/safety, quality, and sustainable financing
- Regulation without good reasons
Pro-competitive regulation that stimulates market opportunities

- Replace input-oriented budgets with contract-based performance-related reimbursements
- Allow retention of surplus/profit
- Allow patients to choose the hospital for treatment (with or without GP guidance)
- Let money follow patient choice of hospital
- European Union regulations on free movement of services
Pro-competitive regulation that restricts individual market-driven behaviour

• Include case-mix adjusters into flexible reimbursement system (i.e. restrict adverse selection)
• Restrict (horizontal) mergers and acquisitions of other hospitals
• Restrict (vertical) mergers, acquiring and operating other healthcare institutions
Regulation restricting hospitals to achieve social objectives

- Regulate minimum service hours
- Mandate delivery of services to everybody
- Make accreditation/ quality assurance/ health technology assessment mandatory
- Mandate the public disclosure of performance ("league tables")
- Set uniform or maximum price/ reimbursement or regulate that it is done by self-governing actors
What areas need to be regulated?

• To enable hospital care: establishment of hospitals, capacity and technology
• To specify and reward hospital services: access, types, quality and prices
• To protect hospital employees
• To steer the business behaviour of hospitals: e.g. mergers, financial reserves, advertisements
Enabling hospital care

- Planning of capacities, ex-ante (= before hospitals are built) or ex-post (= contracts for existing hospitals)
- Combining planning with money for investments
- “Certificate of need“ for high technology
Specifying and rewarding hospital services

- **Access:** disallow patient selection, mandate non-scheduled admissions, require physician staffing around the clock, allow patient choice
- **Types of services:** There may be a case to restrict certain ambulatory services if they can be delivered more efficiently outside hospitals.
- **Quality:** require accreditation, QA programmes
- **Prices:** transparency and administrative ease are advantages of uniformly regulated prices but ...
Protecting hospital employees

• equal treatment, opportunities and pay for men and women (76/207/EEC and 75/117/EEC)
• right to part-time work (97/81/EC; 98/23/EC)
• safeguarding of employees’ rights in the event of transfers of undertaking, businesses or parts of businesses (77/187/EEC; 98/50/EC)
• working times (93/104/EC)
Finally, remember that regulation is an inherently political and cultural process. There is no universally appropriate model.

Illustrations of this can be found in: R.B. Saltman/ R. Busse/ E. Mossialos: *Regulating entrepreneurial behaviour in European health care systems* European Observatory on Health Care Systems series Open University Press, February 2002
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• The HiTs will be updated every 2-3 years.
• Production is based on co-operation: In-country authors provide inside knowledge, external reviewers add a broad range of views and editors guarantee a similar standard across all countries.
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