Technische Universität Berlin

4th Panhellenic Congress Management, Economics & Policy on Health

Towards a regulated system for the provision of public and private health services: (new) trends for health reforms in Europe

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CHARITÉ

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.

The right to establish a hospital would include the **freedom to choose a location**, to determine the **size** and to decide on the **range of technology and services** offered. One could also decide whether services to deliver on an in- or out-patient basis, set **price levels** and **refuse to accept certain patients**.

Also, one had the right to decide on **staffing numbers** and **qualification mix**, the working conditions of the employees and their **salaries**.

Lastly, 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

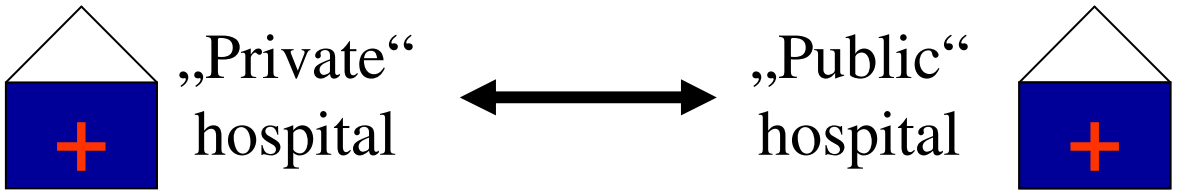
In the other end of the spectrum, the national government (or a subordinated public body such as a Health Authority) establishes hospitals where and at what size deemed necessary according to a public plan.

The **planning 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.

Two types of “non-regulation“



Both hospitals are not regulated:
(1) There are intentionally no regulations to restrict the market behaviour of the hospital owners and/ or managers.
(2) The hospital is subject to public sector ”command-and-control”.
In practice, most hospitals in many countries fall some-where between the two extremes and require more regulation than these two.

Questions:

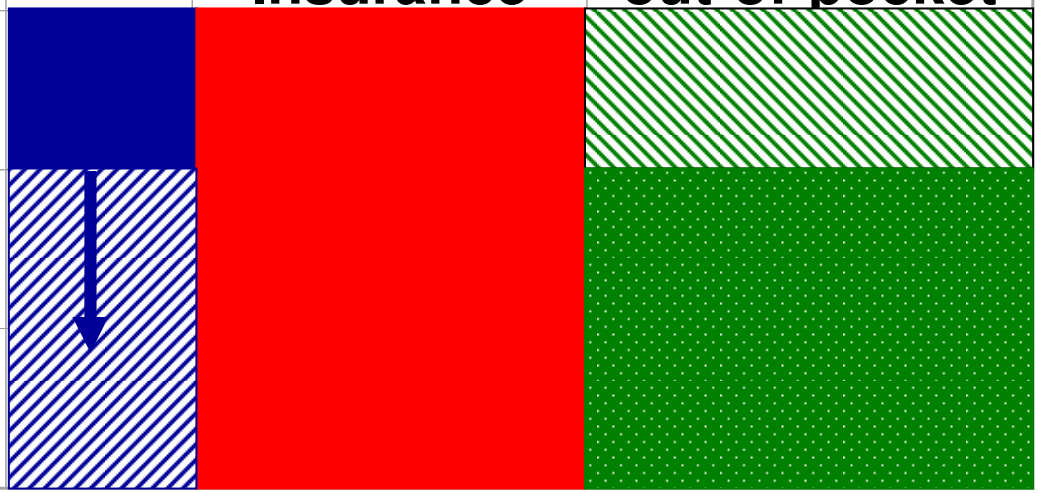
- What is public, what is private?
- Is one „better“ than the other?
- What should the state do?
  - The case for regulation in funding
  - The case for regulation in provision

What is public, what is private?

		Funding	
		“public”	“private”
Pro-vi-sion	“pub-lic”		
	“pri-vate”		

What is public, what is private?

			Funding		
			“public”		“private”
			tax	Statutory Health Insurance	voluntary insurance, out-of-pocket
Pro-vi-sion	“pub-lic”	public			
	“pri-vate”	not-for-profit			
		for profit			

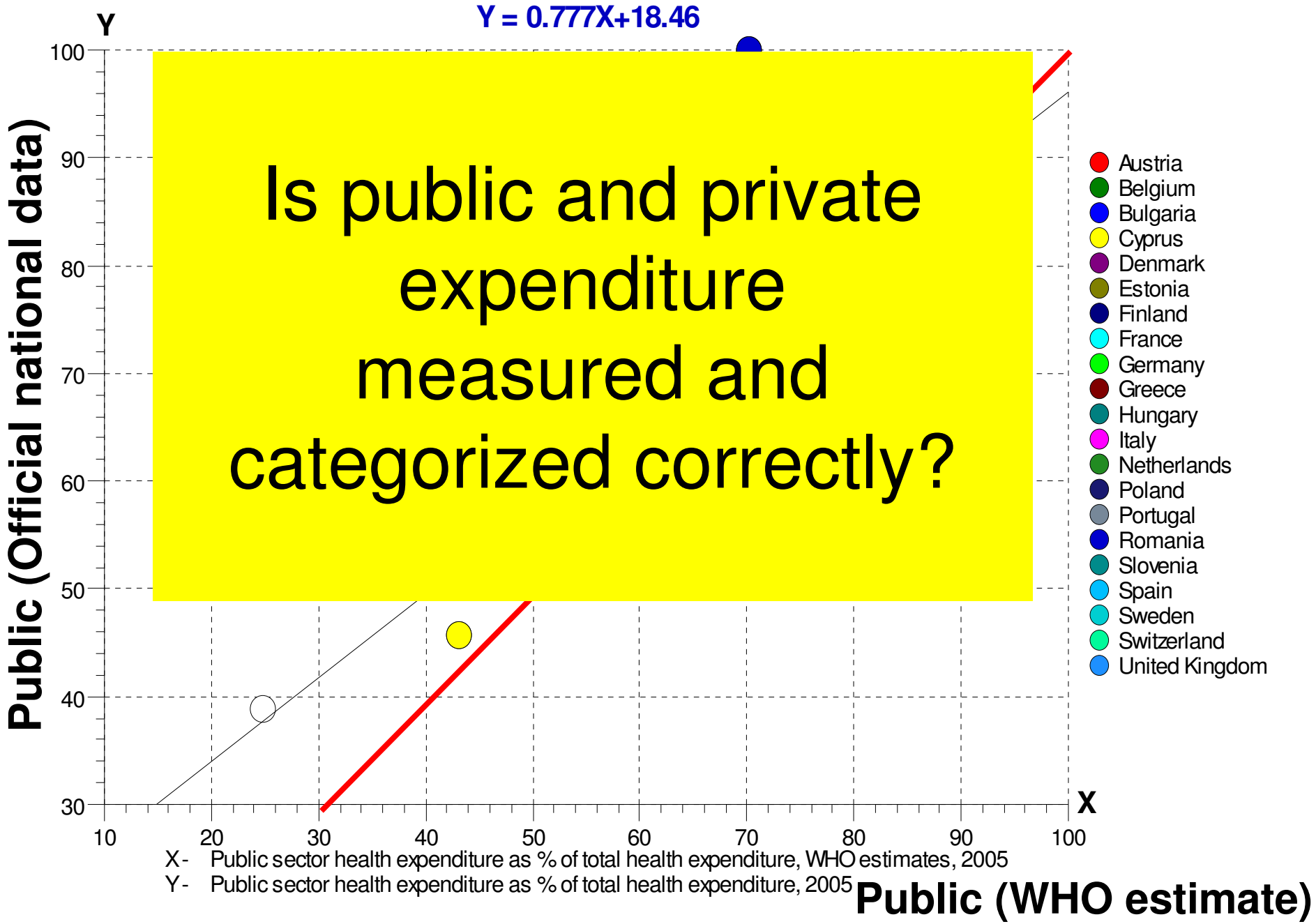


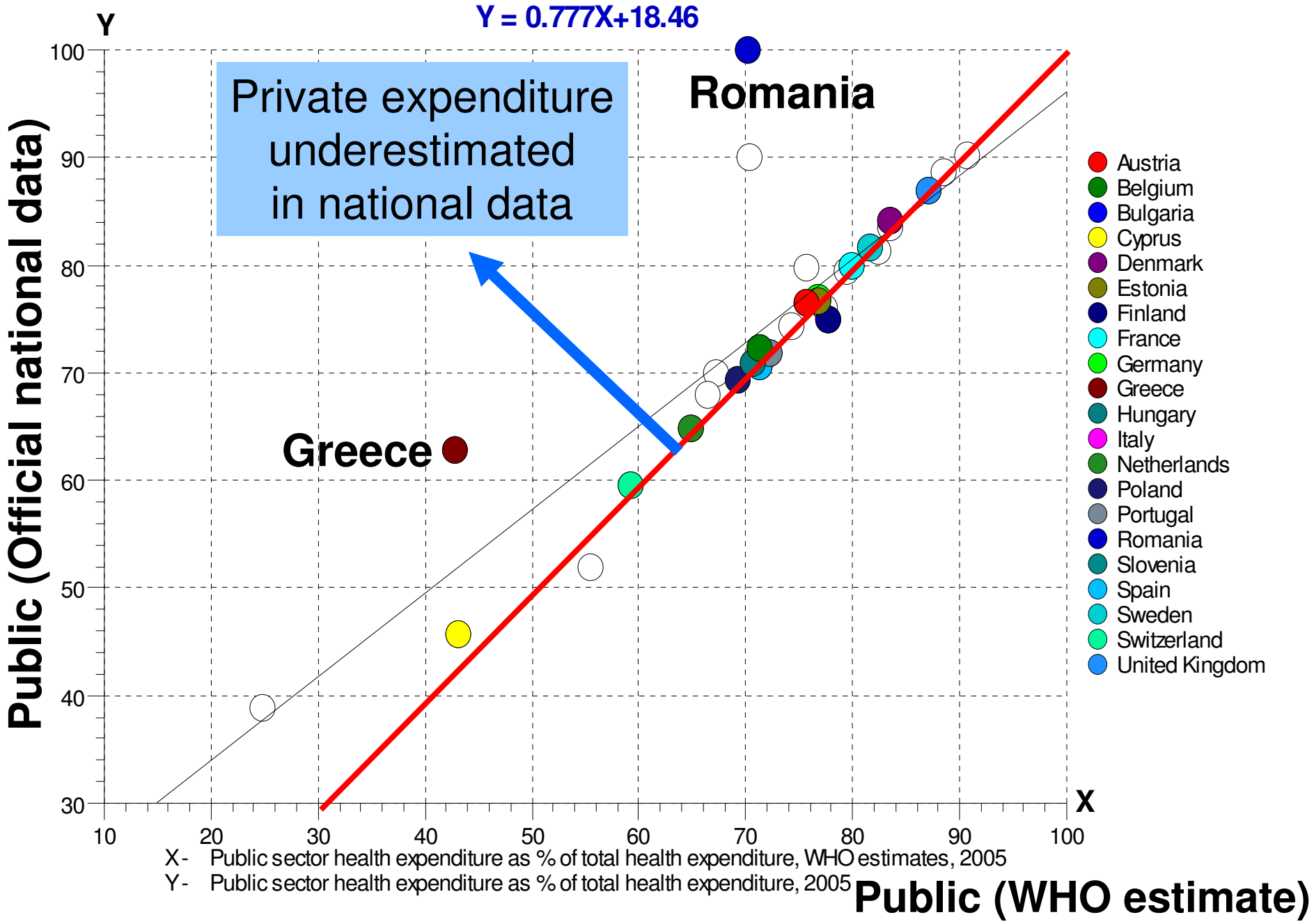
The debate is often …

- Confused by inconsistent terminology
- Missing concepts (and therefore data)
- Biased through prejudice & ideology (in both directions)

The European Observatory‘s aim is to provide evidence, not ideology or ready-made solutions …

Funding

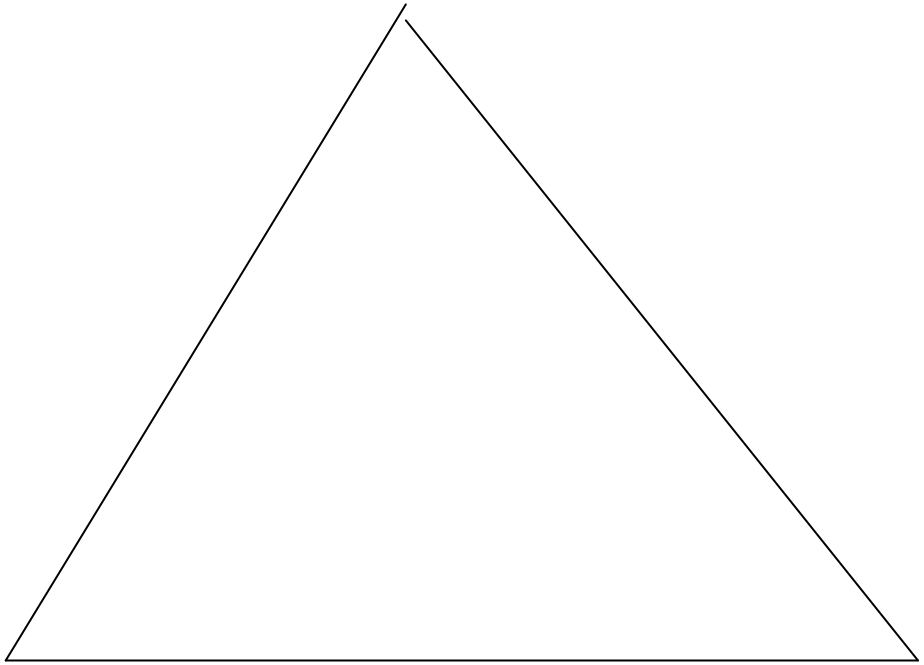

Y = 0.777X+18.46
Y
X
Public (Official national data)
Public (WHO estimate)
100
90
80
70
60
50
40
30
10
20
30
40
50
60
70
80
90
100
Austria
Belgium
Bulgaria
Cyprus
Denmark
Estonia
Finland
France
Germany
Greece
Hungary
Italy
Netherlands
Poland
Portugal
Romania
Slovenia
Spain
Sweden
Switzerland
United Kingdom
Is public and private expenditure measured and categorized correctly?
X- Public sector health expenditure as % of total health expenditure, WHO estimates, 2005
Y- Public sector health expenditure as % of total health expenditure, 2005



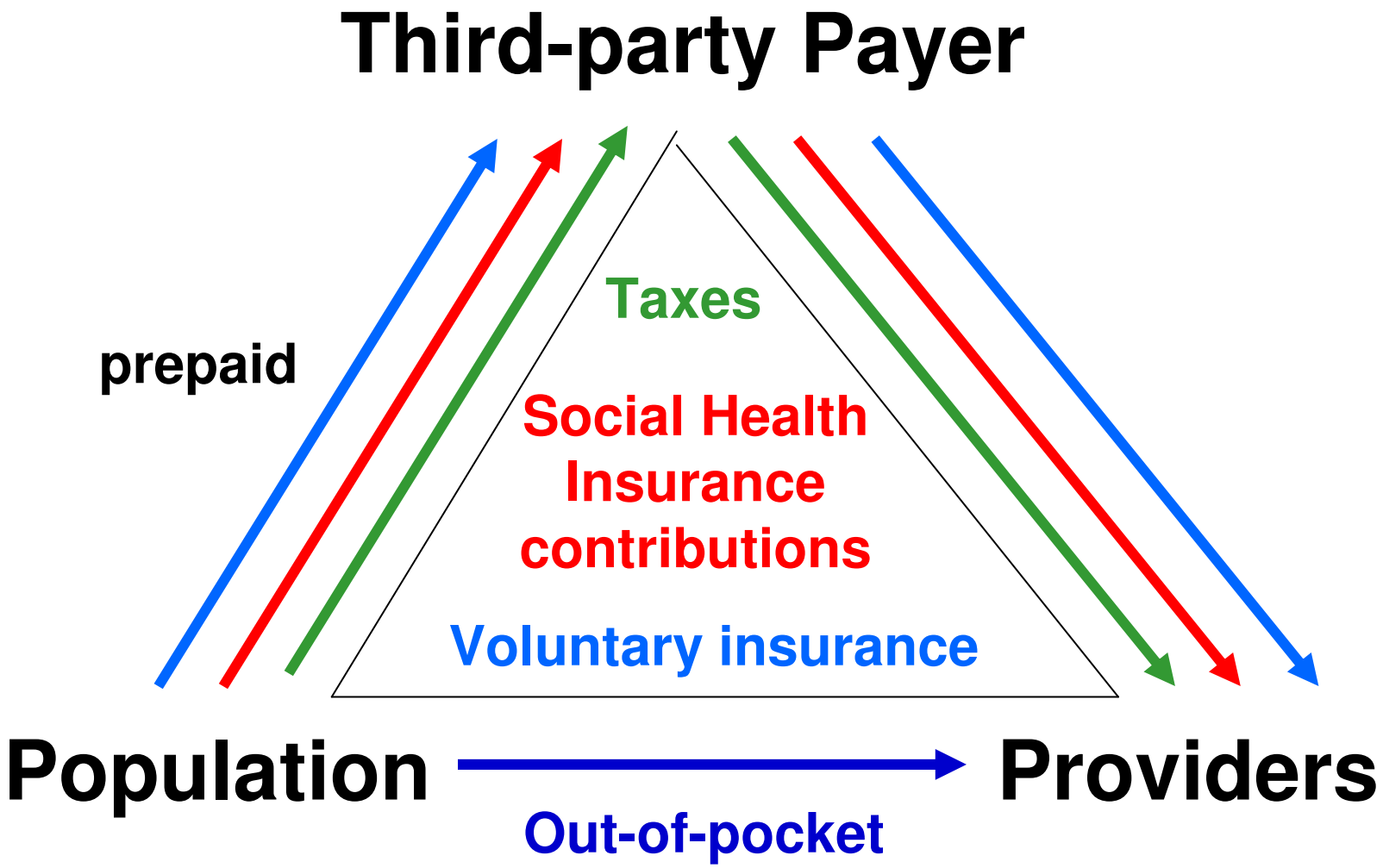
X- Public sector health expenditure as % of total health expenditure, WHO estimates, 2005

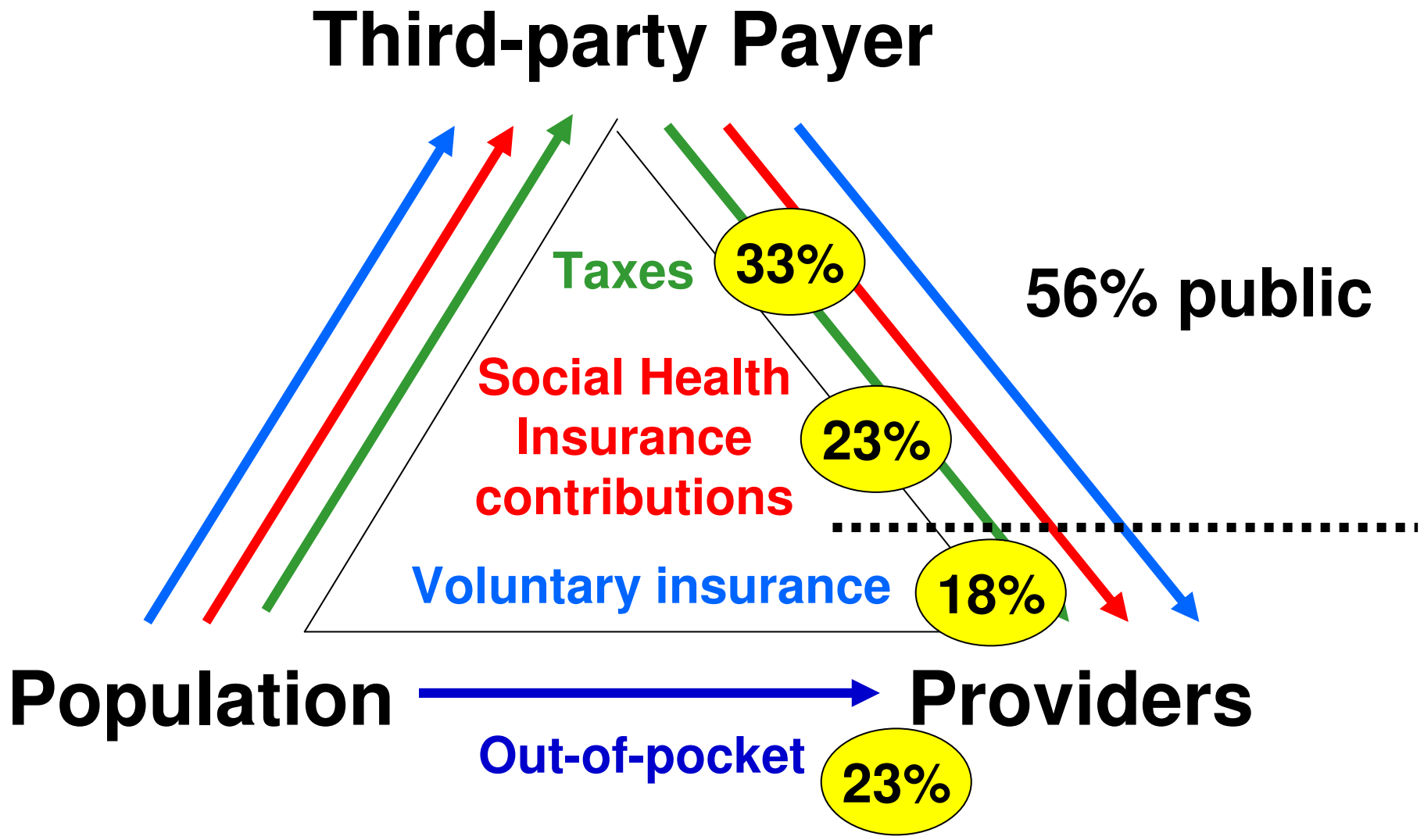
Y- Public sector health expenditure as % of total health expenditure, 2005

Third-party Payer



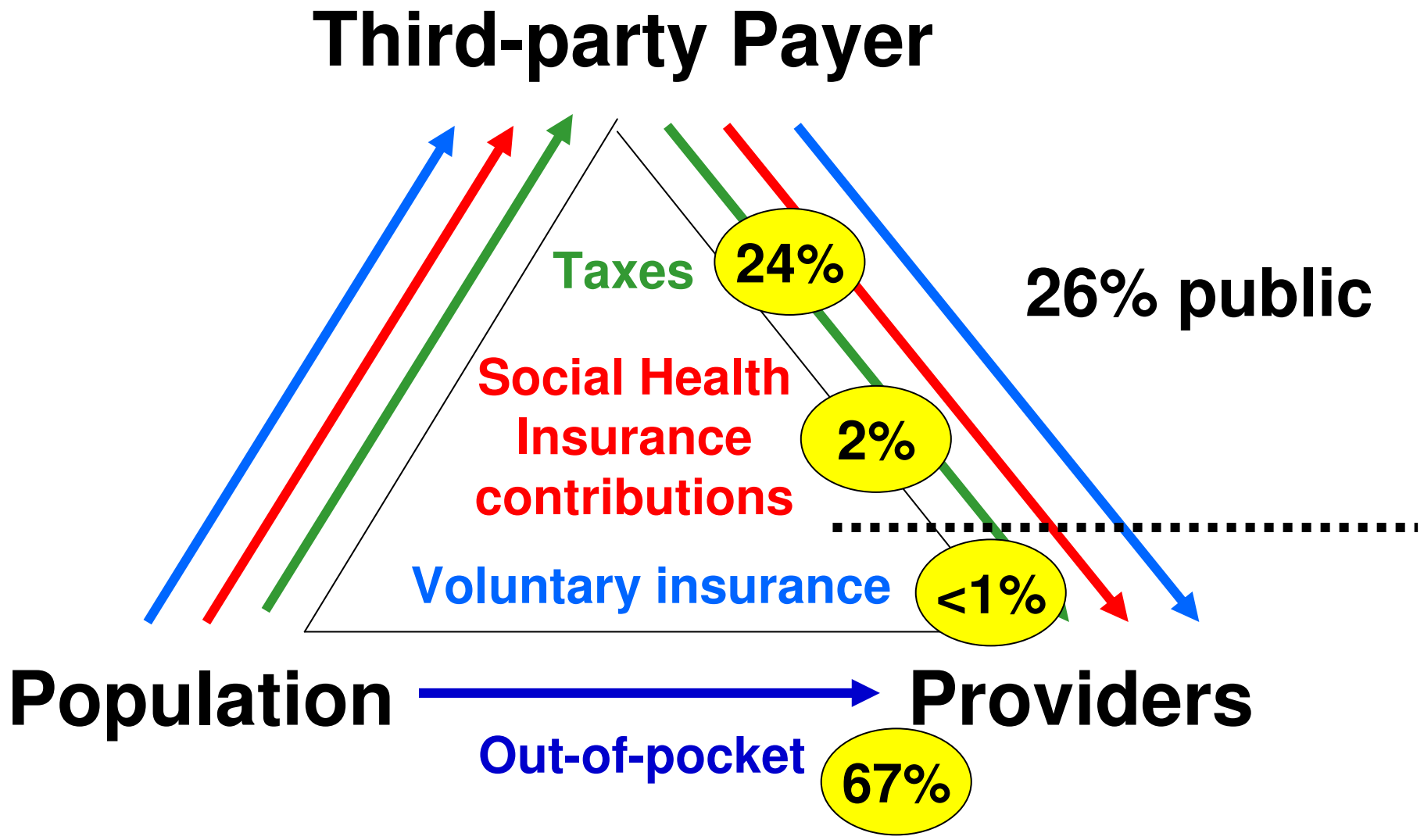
Population **Providers**





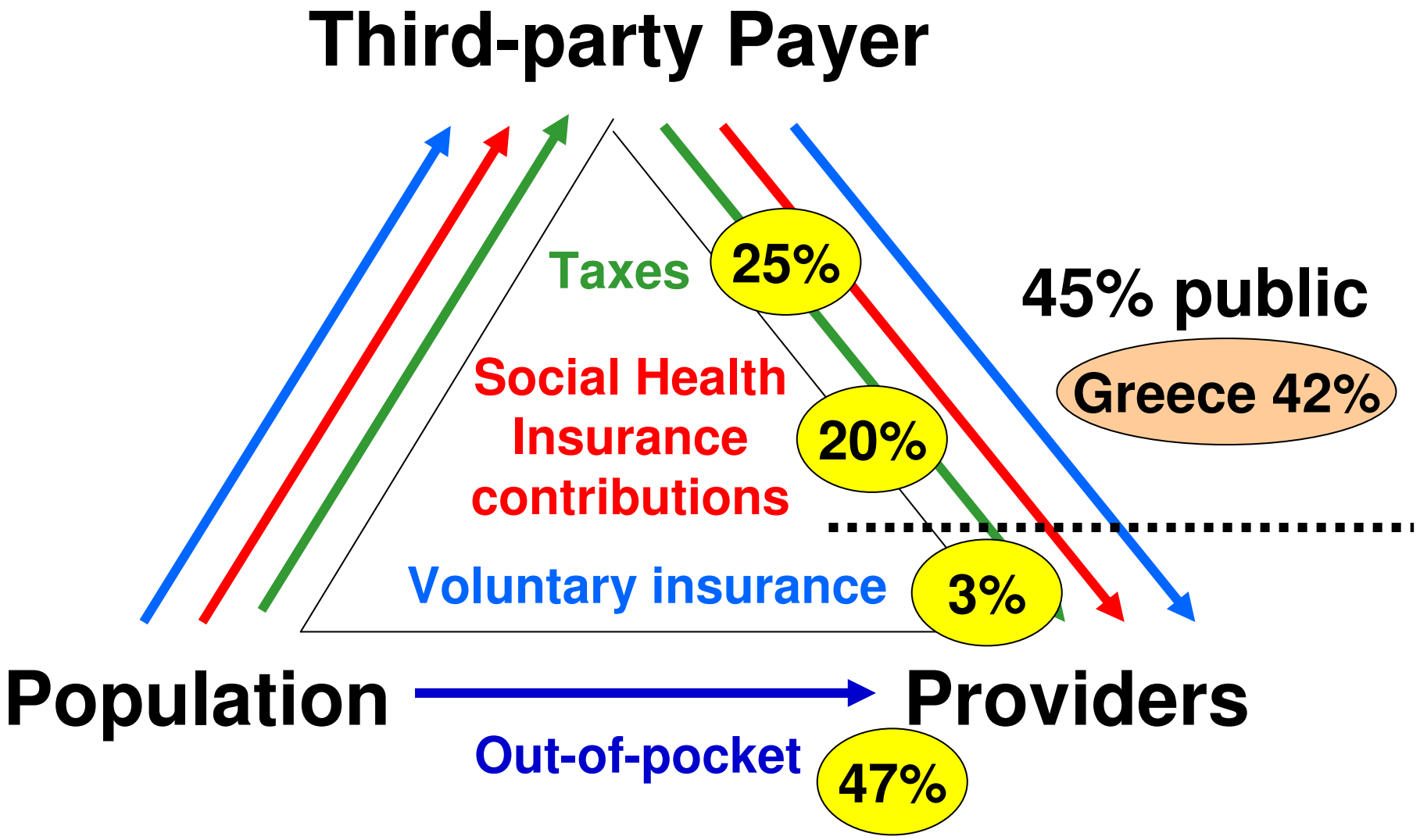
World-wide 2005 *(large US market!)*

European Observatory on Health Systems and Policies 1998-2008



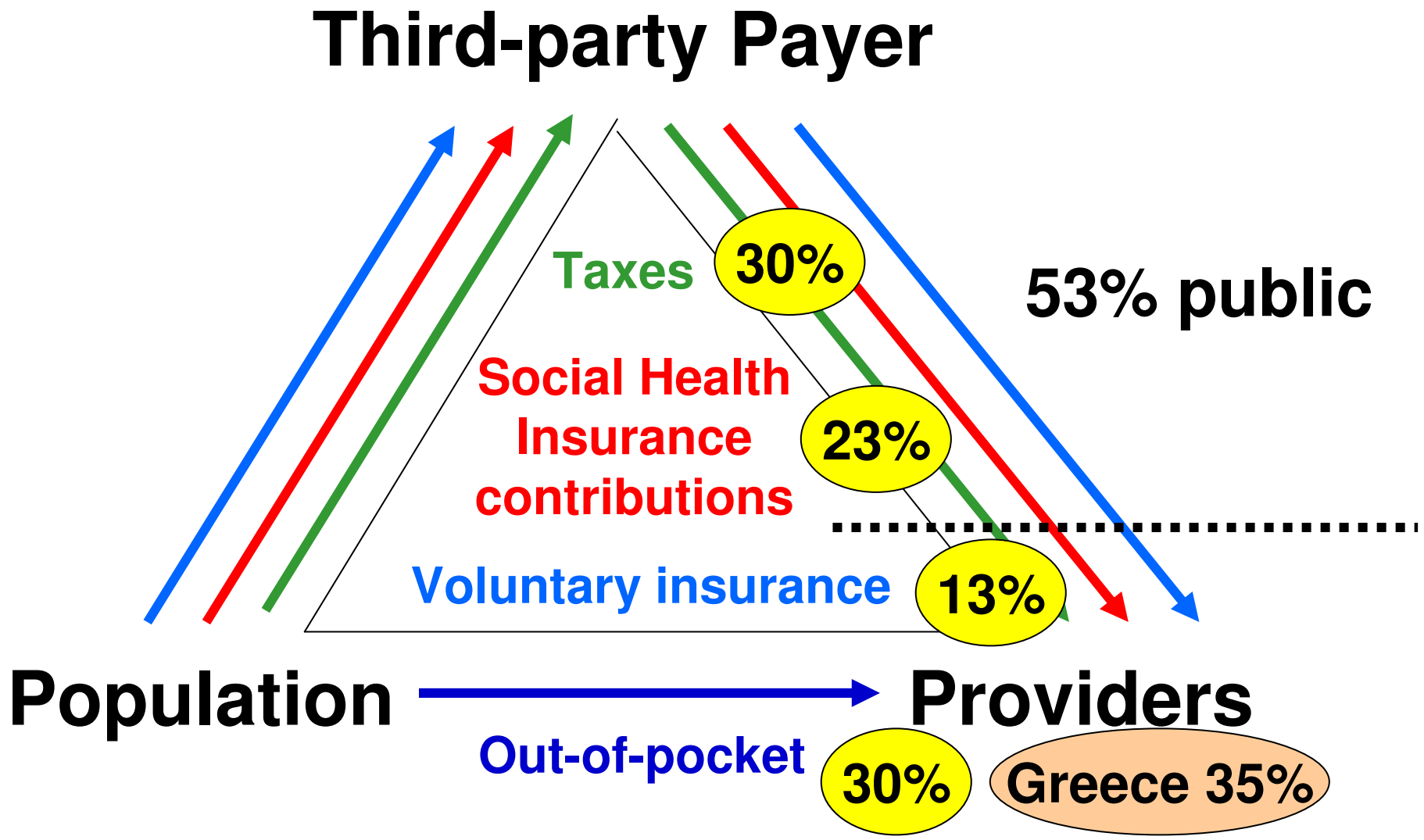
Low-income countries

European Observatory on Health Systems and Policies 1998-2008



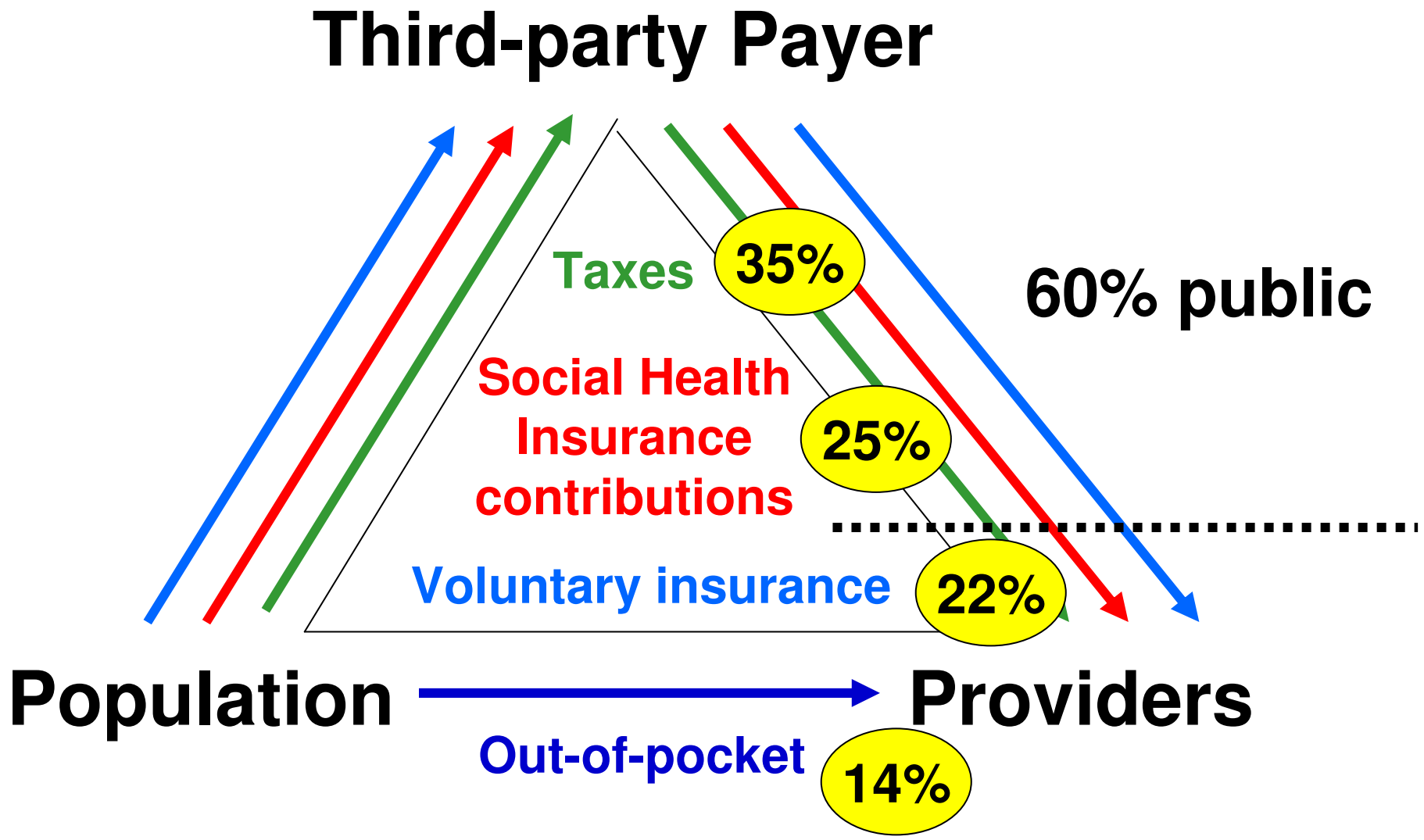
Lower middle income countries

European Observatory on Health Systems and Policies 1998-2008



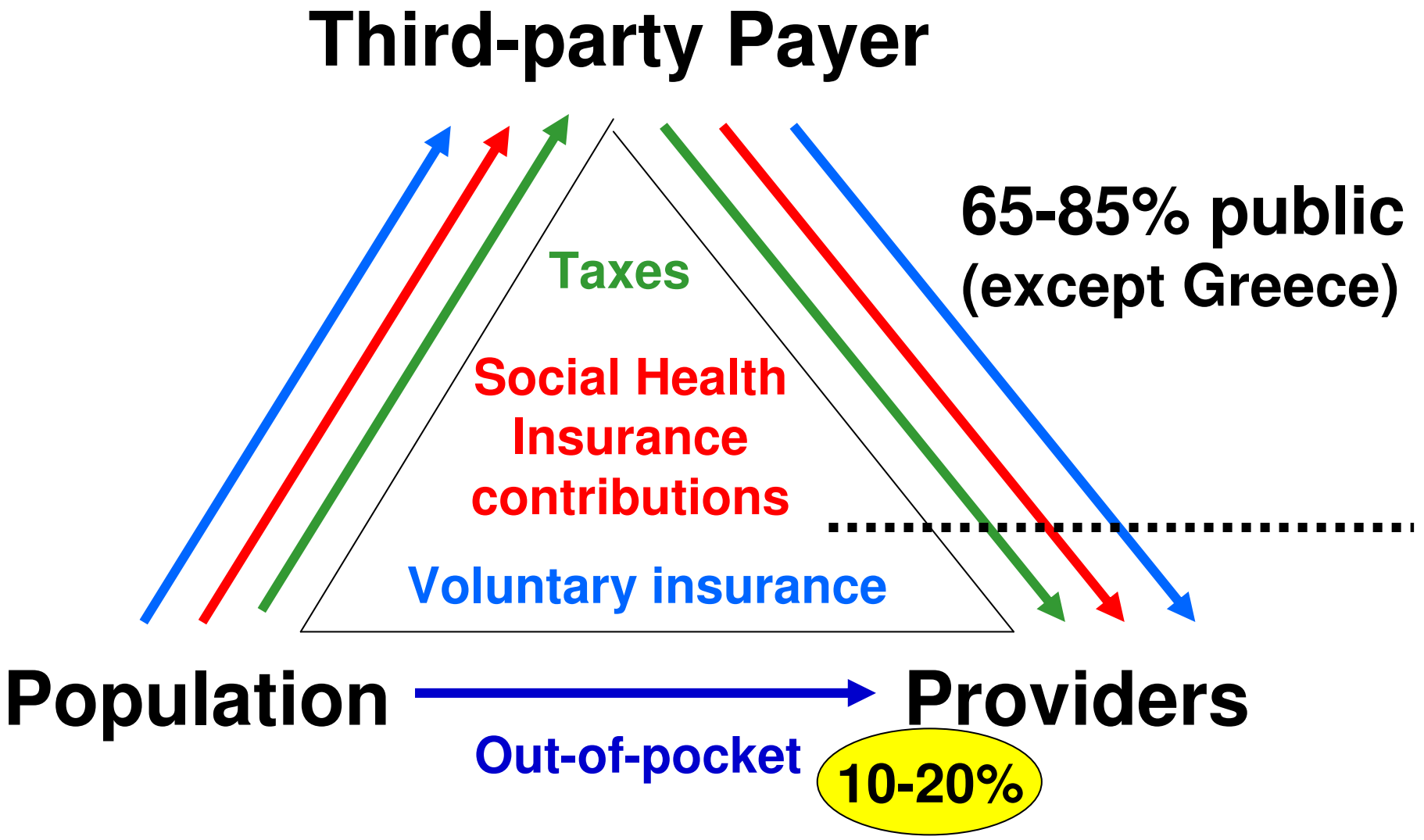
Upper middle income countries

European Observatory on Health Systems and Policies 1998-2008



High-income countries

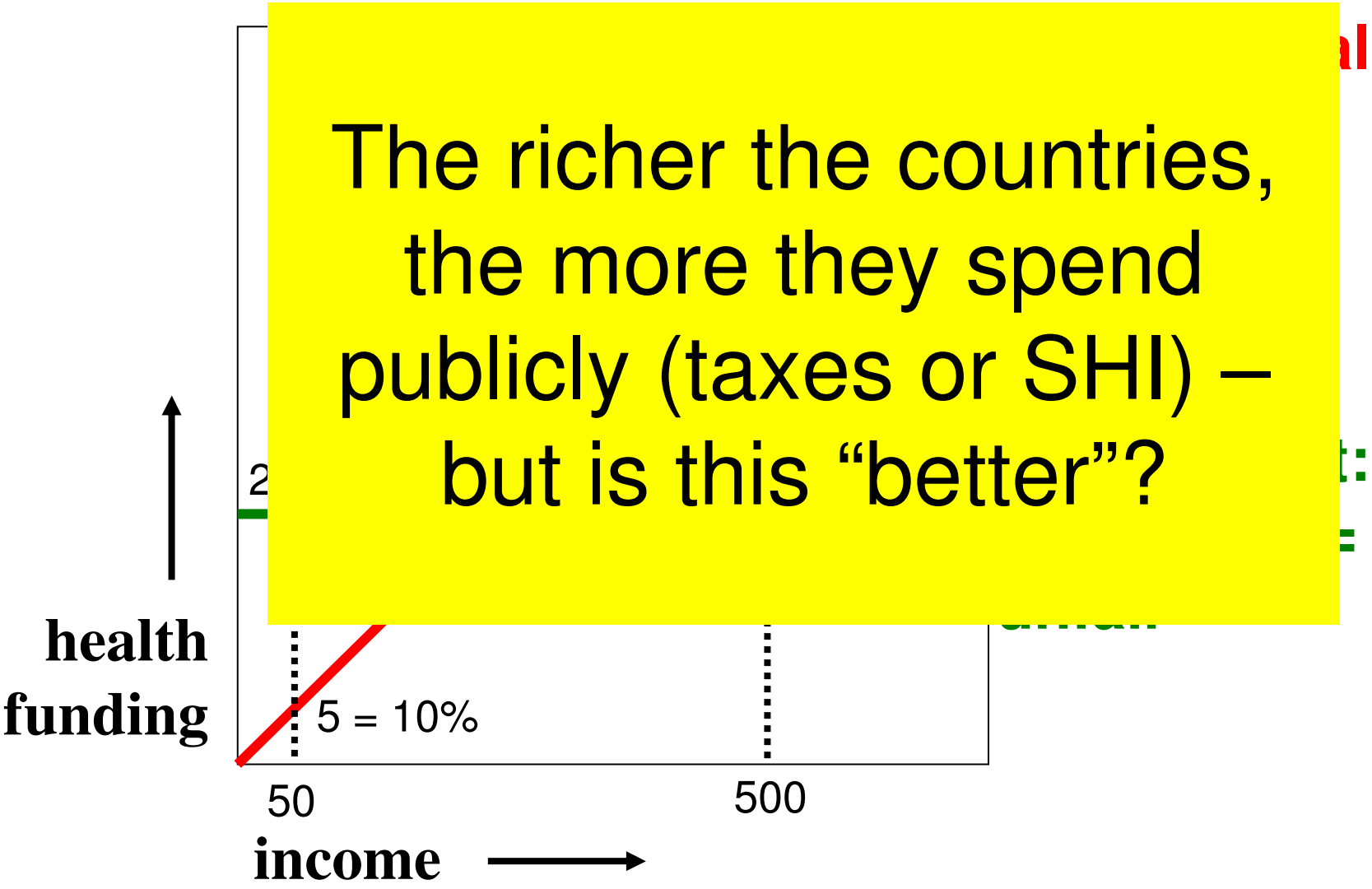
European Observatory on Health Systems and Policies 1998-2008



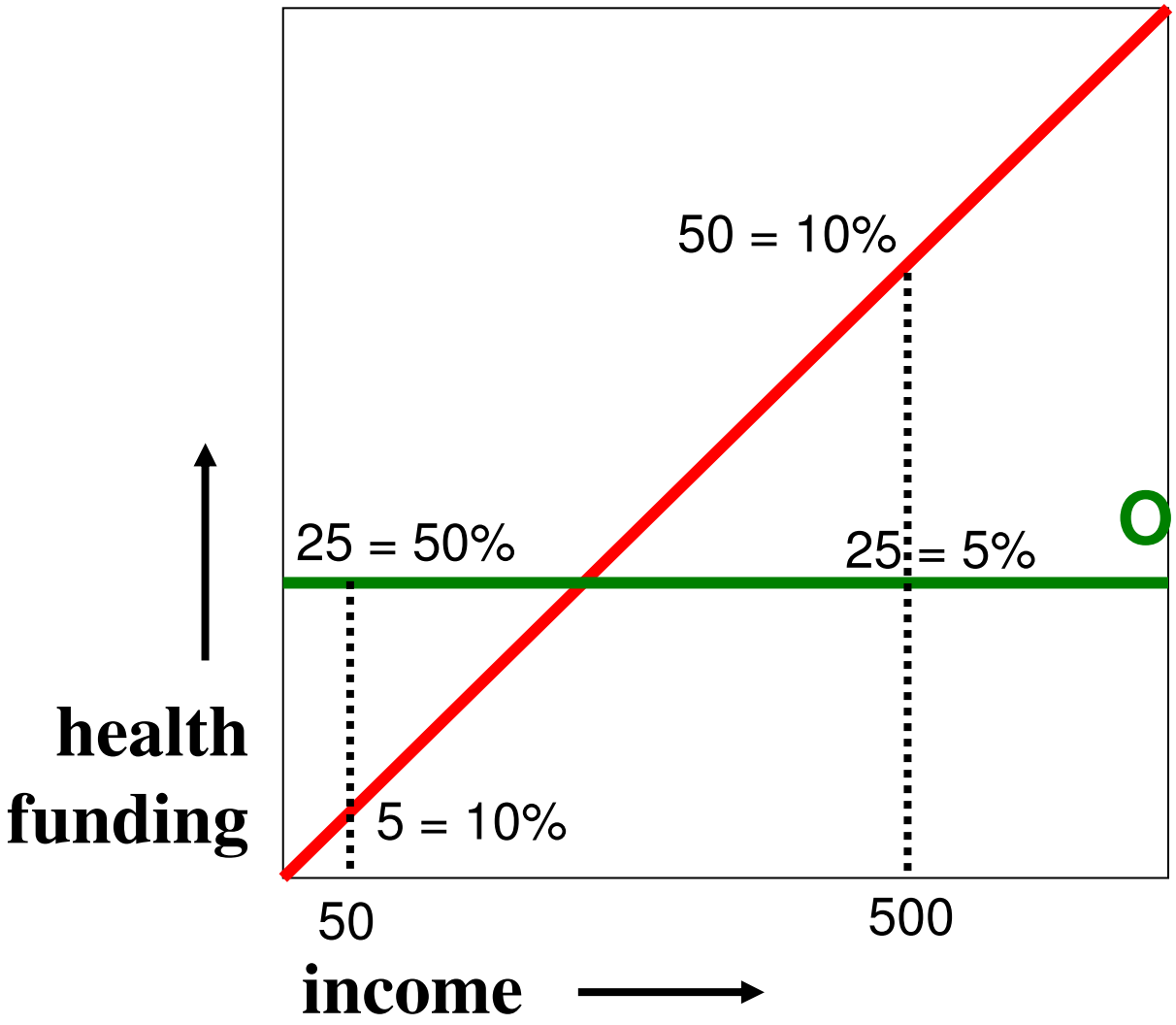
Western Europe

European Observatory on Health Systems and Policies 1998-2008

SHI contributions:

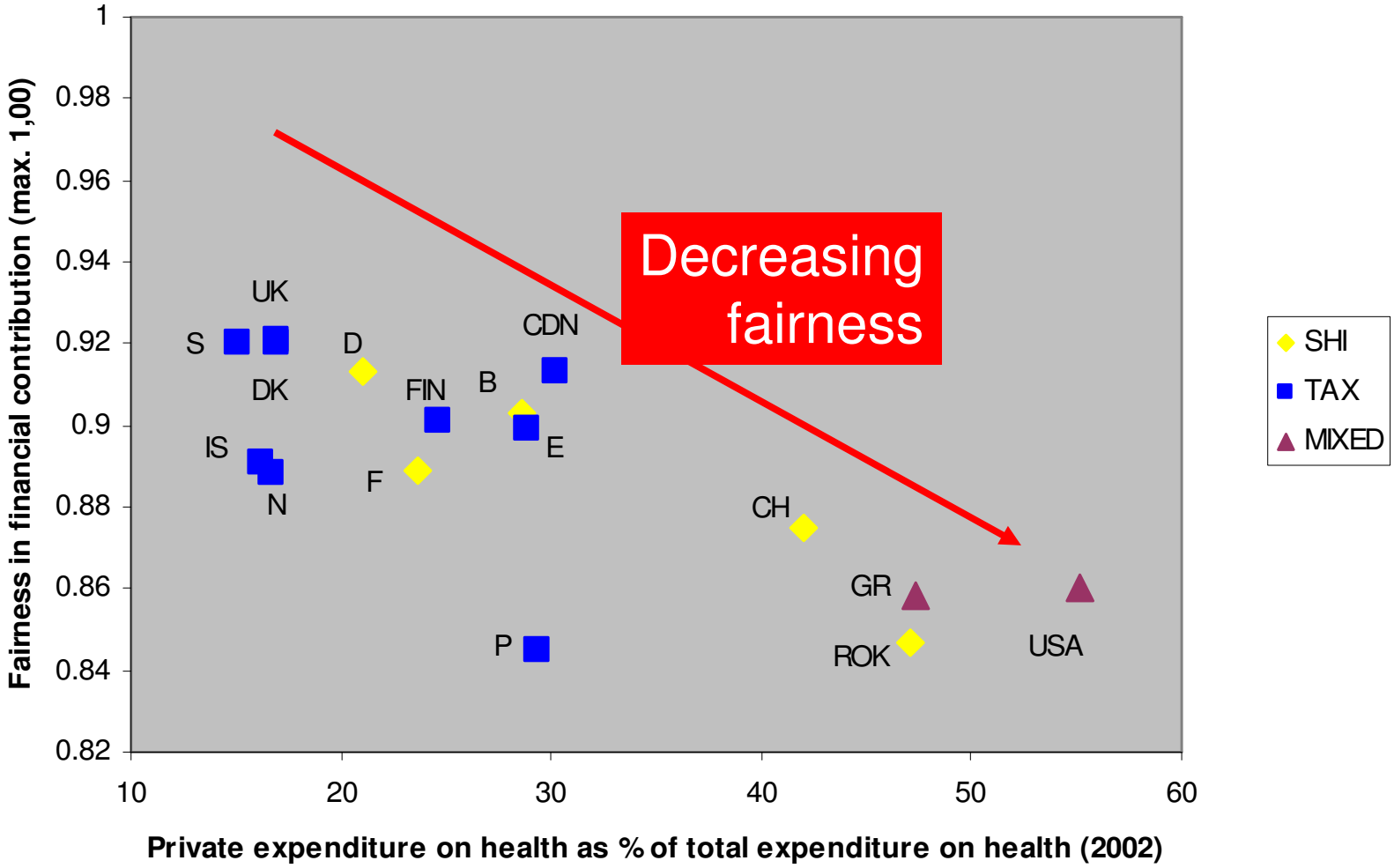


SHI contributions: proportional = fair

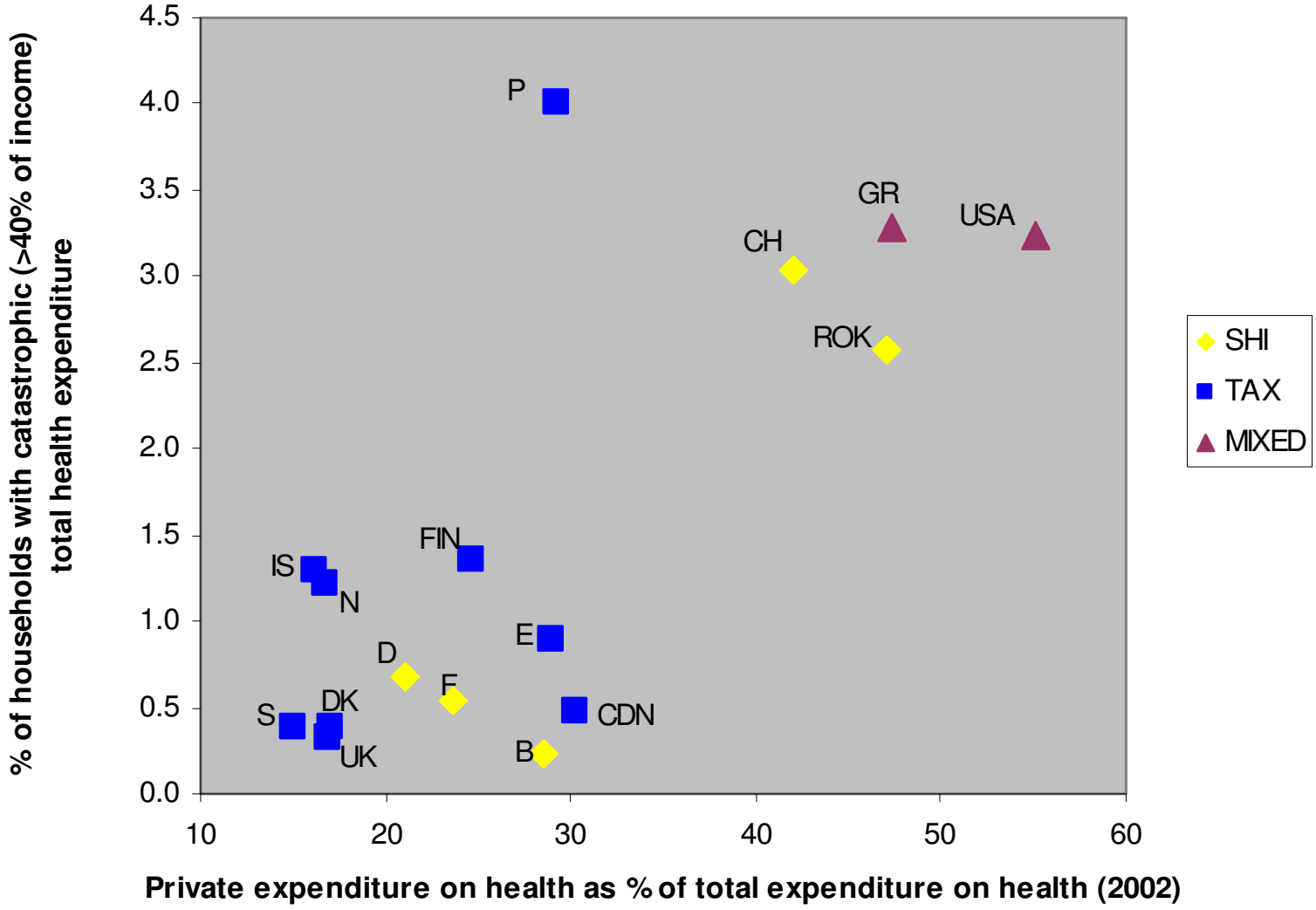


Out-of-pocket: regressive = unfair

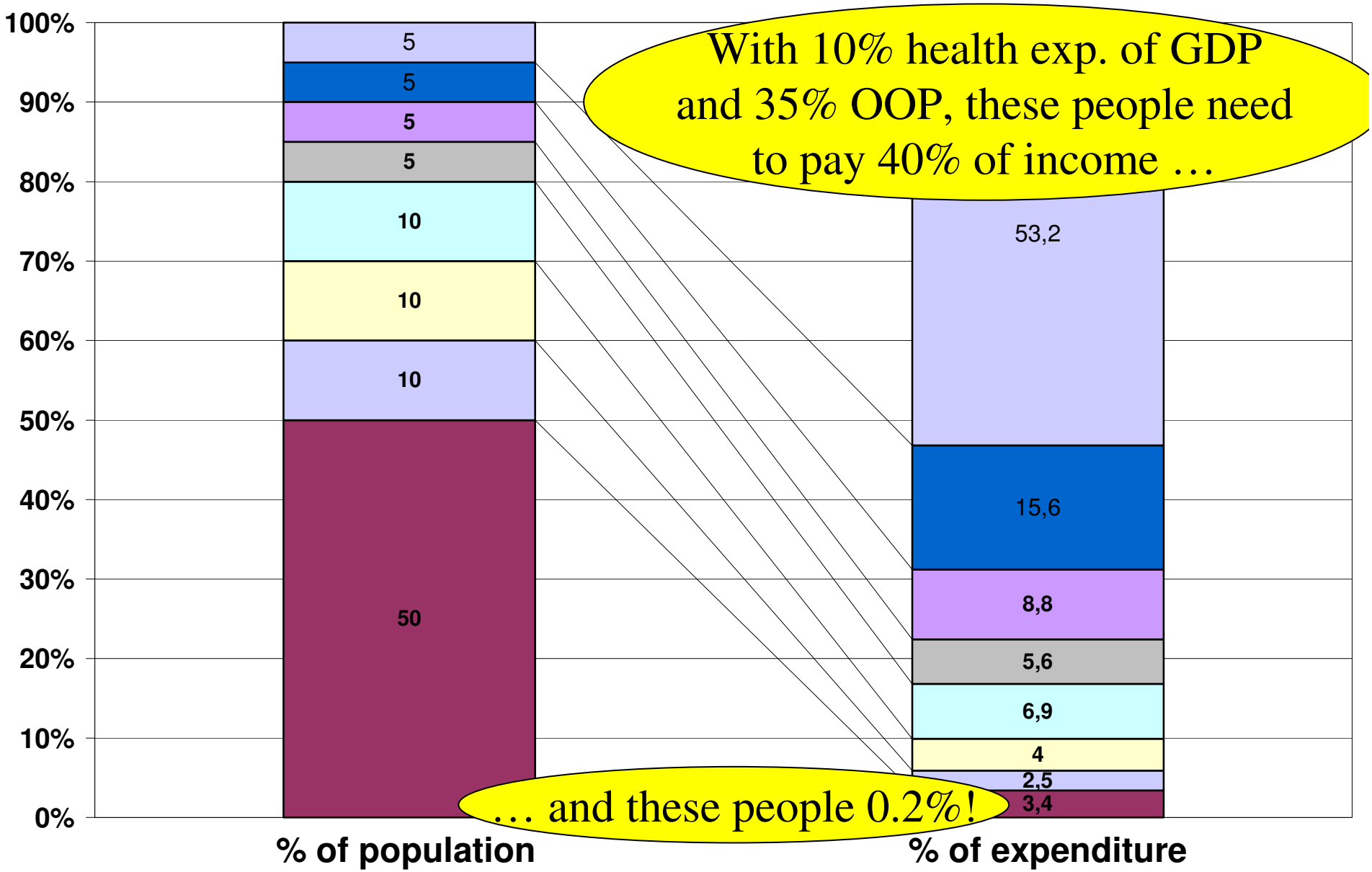
Correlation between private expenditure
(as % of total health care expenditure)
and the level of fairness in financing

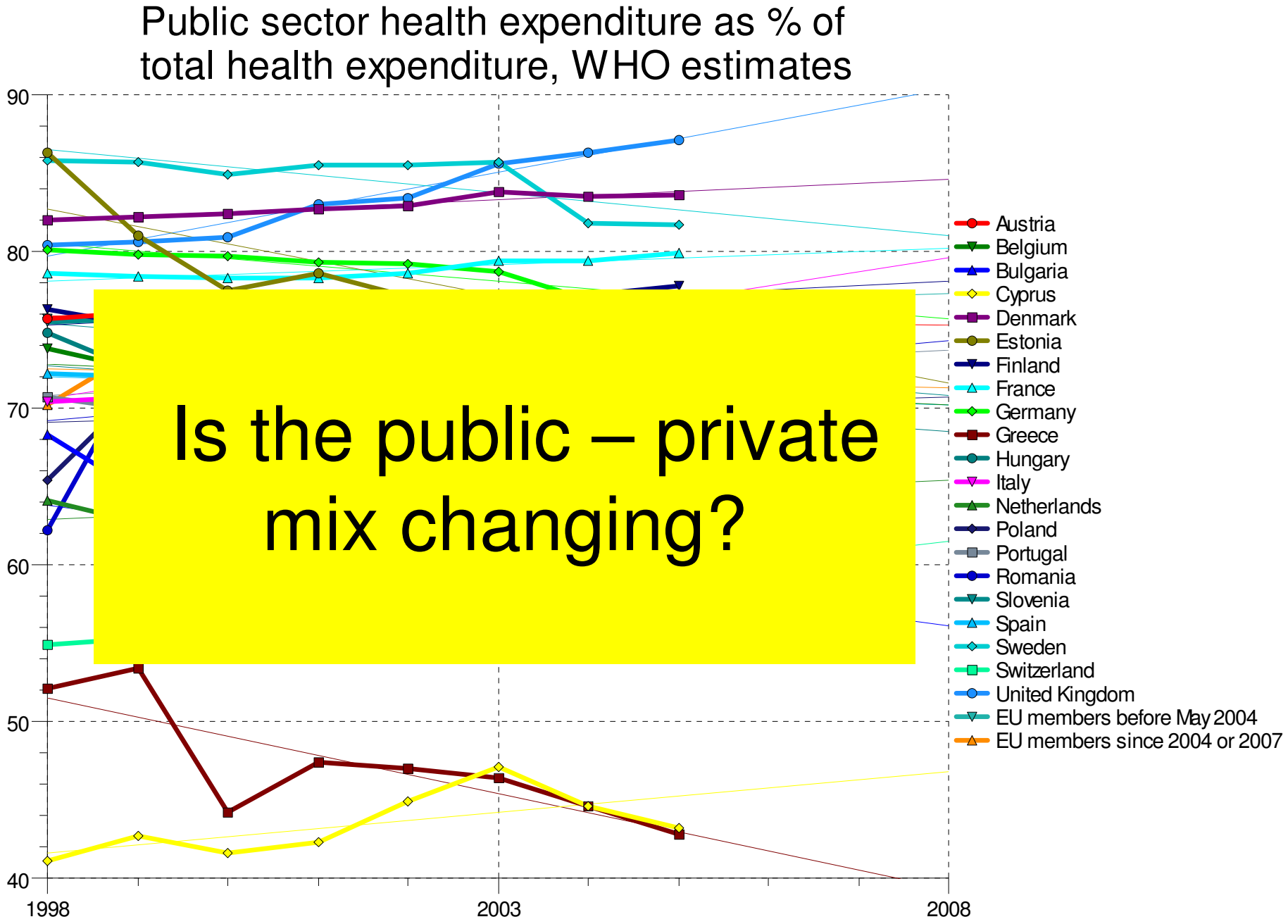


Correlation between private expenditure (as % of total health care expenditure) and percentage of households with catastrophic health expenditure

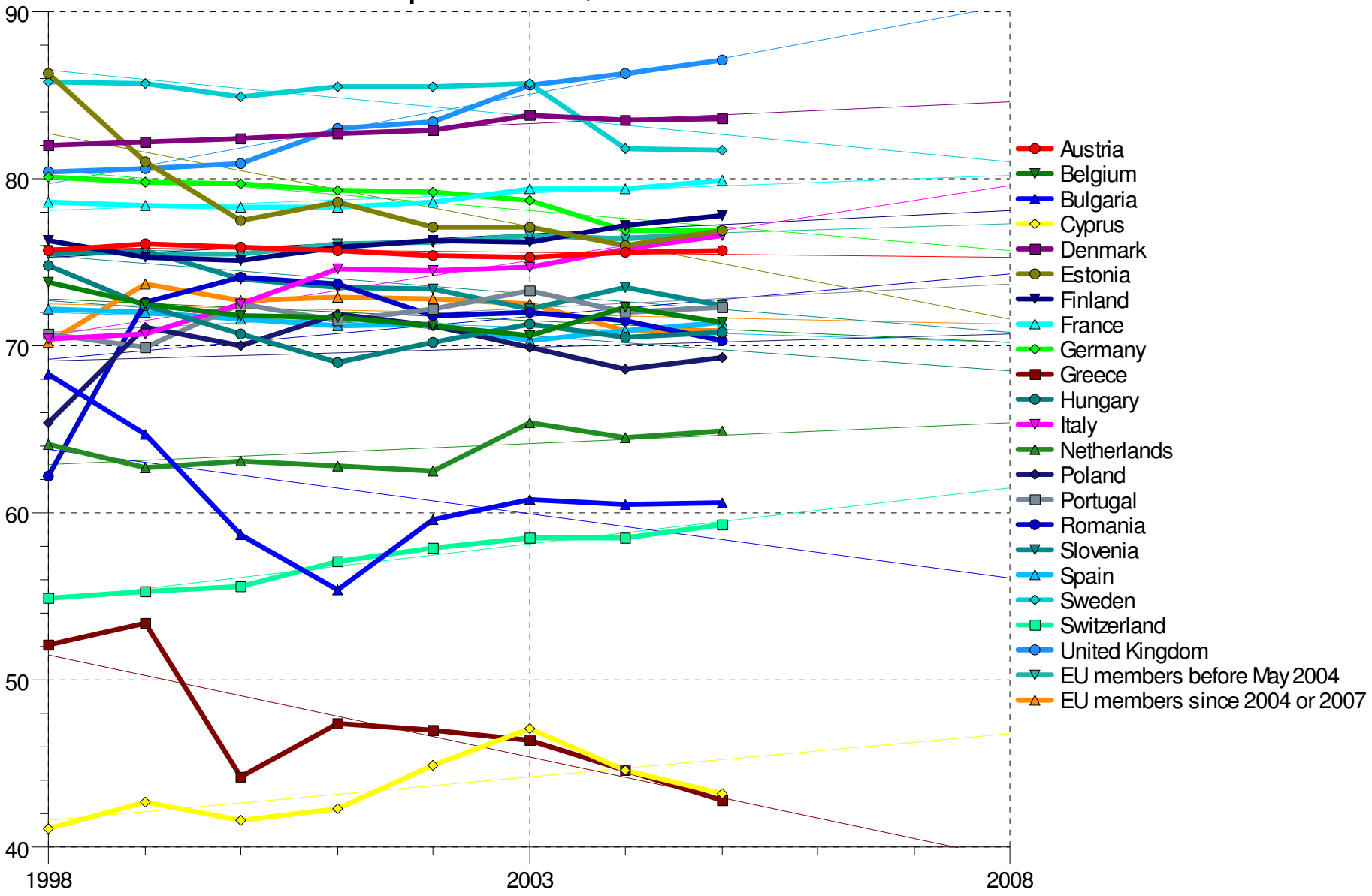


The well-known 20/80 distribution – actually the 5/50 or 10/70 problem (German data 2000/2001)




Public sector health expenditure as % of total health expenditure, WHO estimates
90
80
70
60
50
40
1998
2003
2008
Is the public – private mix changing?
Austria
Belgium
Bulgaria
Cyprus
Denmark
Estonia
Finland
France
Germany
Greece
Hungary
Italy
Netherlands
Poland
Portugal
Romania
Slovenia
Spain
Sweden
Switzerland
United Kingdom
EU members before May 2004
EU members since 2004 or 2007

Public sector health expenditure as % of total health expenditure, WHO estimates



EU15: 75.7 -> 76.8; Greece: 52.1 -> 42.8; new EU: 70.2 -> 70.9

Conclusions on funding

1. Public is fairer than private
2. Public share increases with wealth (also in EU)

-> **Evidence provides strong case for**

- **public funding/ insurance**
- **strong regulation of private insurance**

Provision/ Delivery

What's happening?

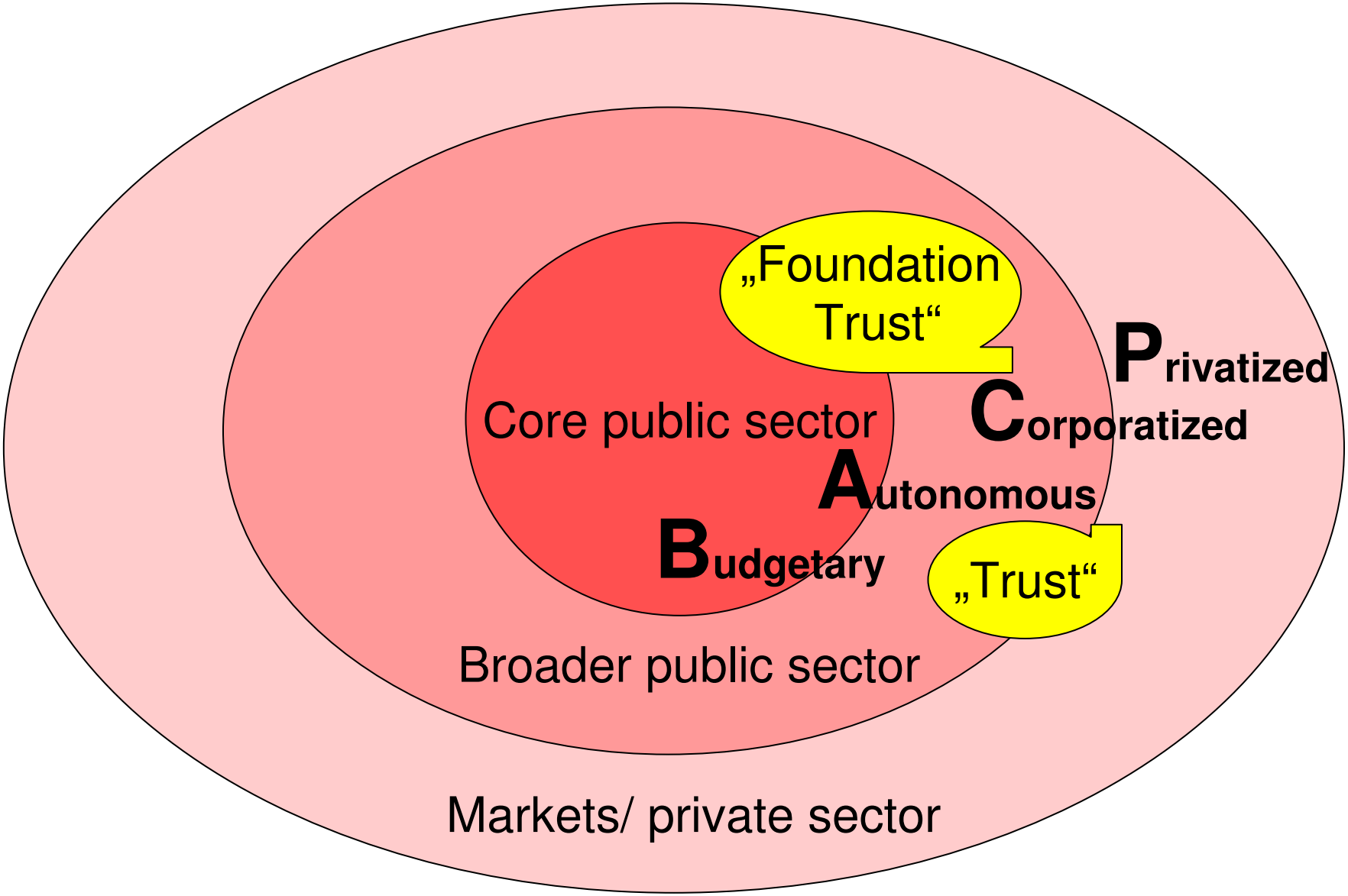
- Public sector failures
- Markets and competition
- Efficiency and quality: private vs. public
- New public management – private management methods

Public-private ownership of acute care hospital beds in SHI countries

	Public	Not-for-profit	For profit
Austria	69%	26%	5%
Belgium	60%	40%	
France	65%	15%	20% (↓)
Germany	53%	38%	4% (1990) -> 15%
Luxembourg	50%	50%	
Netherlands	14%	86%	

But reality is more complex:

- public hospitals encompass wide range from „command-and-control“ (or “budgetary“, B) via „autonomous“ (A) to „corporatized“ (C)
- public hospitals may be under public or private law
- what about “public enterprises“ with partly private ownership? or PPPs = private investment into “public“ hospitals?
- big differences between contracted and other private for-profit hospitals



For explanation please refer to „A Conceptual Framework for the Organizational Reform of Hospitals“ (Harding/ Preker, Worldbank)

The hospital landscape is getting more varied (and in many countries more "private") – but is this "good" or "better"?

Possible criteria:

- Quality
- Prices (costs to purchaser)
- Efficiency
- Public accountability
- Contribution to social objectives (access, public health etc.)

For-profit vs. not-for-profit: systematic reviews in USA

Review	Technical efficiency	Prices	Quality
Vaillancourt Rosenau 2002	***Lower*** in for-profit	***Higher*** in for-profit	***Lower*** in for-profit
Curie et al. 2003 (systematic review)	No difference	***Higher*** in for-profit	Overall no difference
Hollingsworth 2003	Efficiency: public > not-for-profit > for-profit		
Devereaux et al. 2002 (Meta-analysis)	Risk-adjusted mortality **2% higher** in for-profit (= ***lower*** quality)		
Devereaux et al. 2004 (Meta-analysis)	Prices **19% higher** in for-profit		

Quality

Study	No. of hospitals	No. of patients	% weight
Shortell[12]	653	144 159	1.43
Keeler[13]	220	4937	0.04
Hartz[14]	2368	3 107 616	11.38
Manheim MH[15]	1252	1 537 660	9.78
Manheim FS[15]	1617	2 228 593	2.59
Kuhn[16]	2580	3 353 676	12.34
Pitterle[17]	3482	4 529 206	14.11
Mukamel[19]	1653	5 298 812	17.21
Bond[20]	3224	4 210 468	12.66
Yuan Medical[21]	3316	7 386 000	11.90
Yuan Surgical[21]	3316	4 396 000	5.05
Lanska[22]	799	16 983	0.00
McClellan[23]	2875	181 369	1.48
Sloan[24]	2360	7079	0.03
Totals	26 399	36 402 558	100.00

Random effects pooled estimate

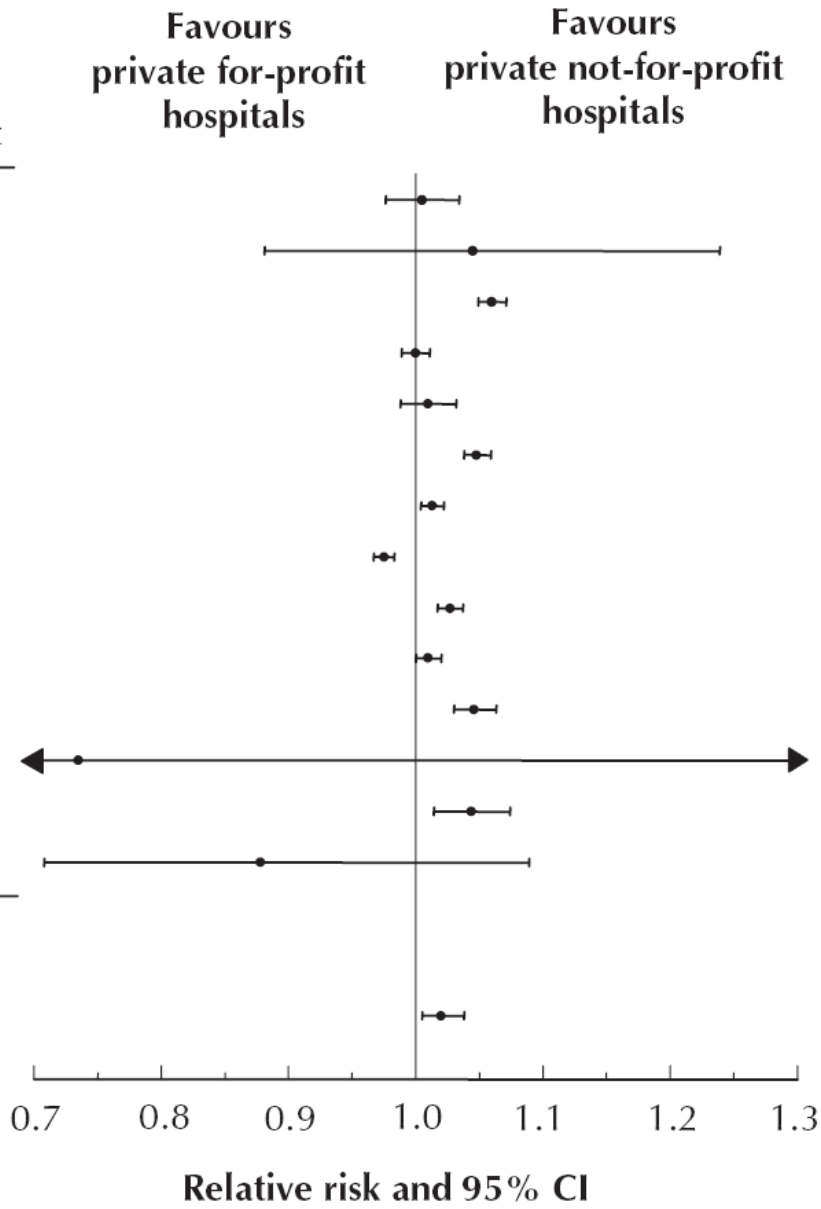


Fig. 2: Relative risk of hospital mortality for adult patients in private for-profit hospitals relative to private not-for-profit hospitals. CI = confidence intervals.

Prices

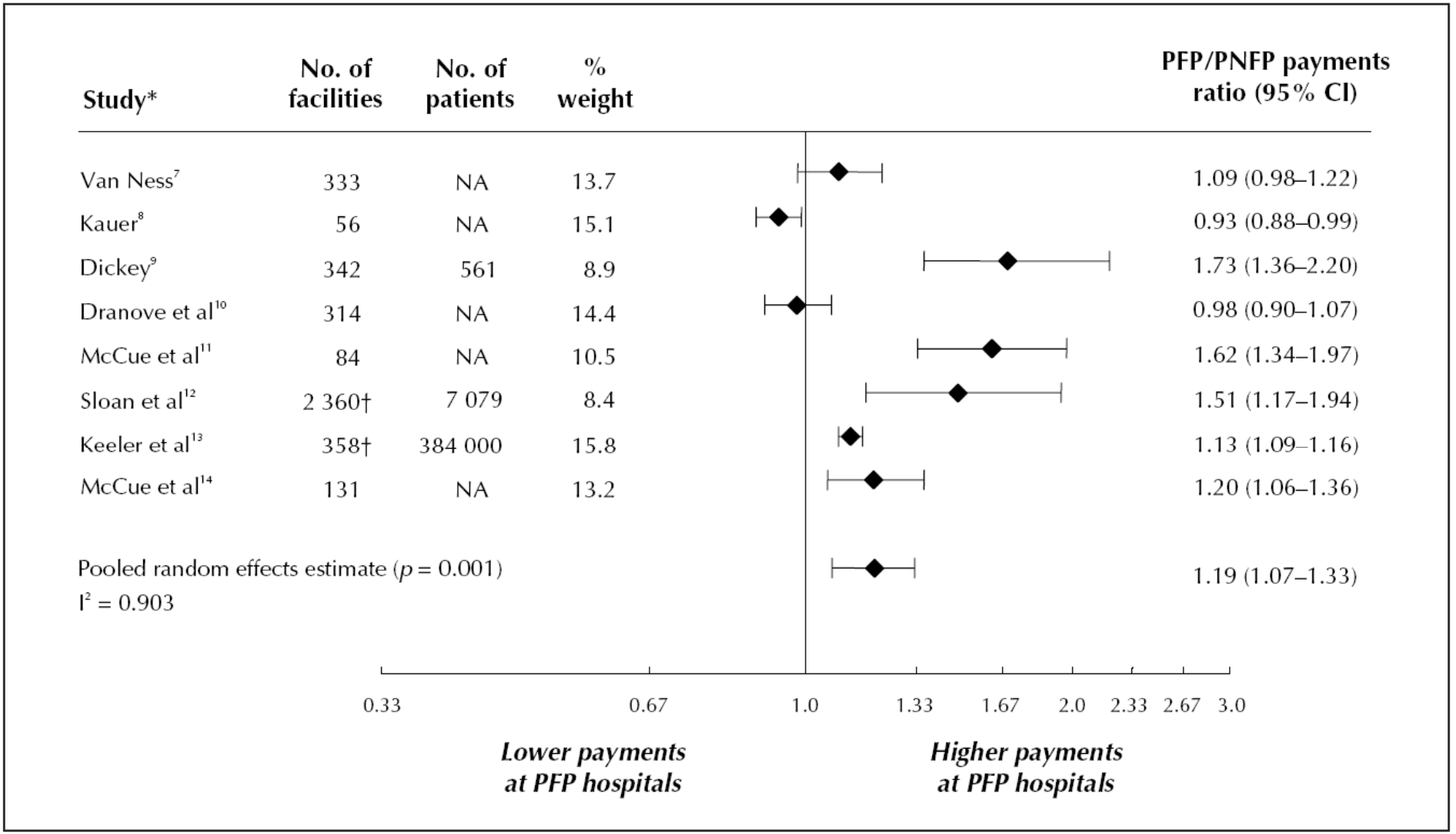


Fig. 2: Relative payments for care at private for-profit (PFP) and private not-for-profit (PNFP) hospitals. Note: CI = confidence interval.
*The studies are in chronological order by midpoint of the data collection period. †Approximation from investigator.

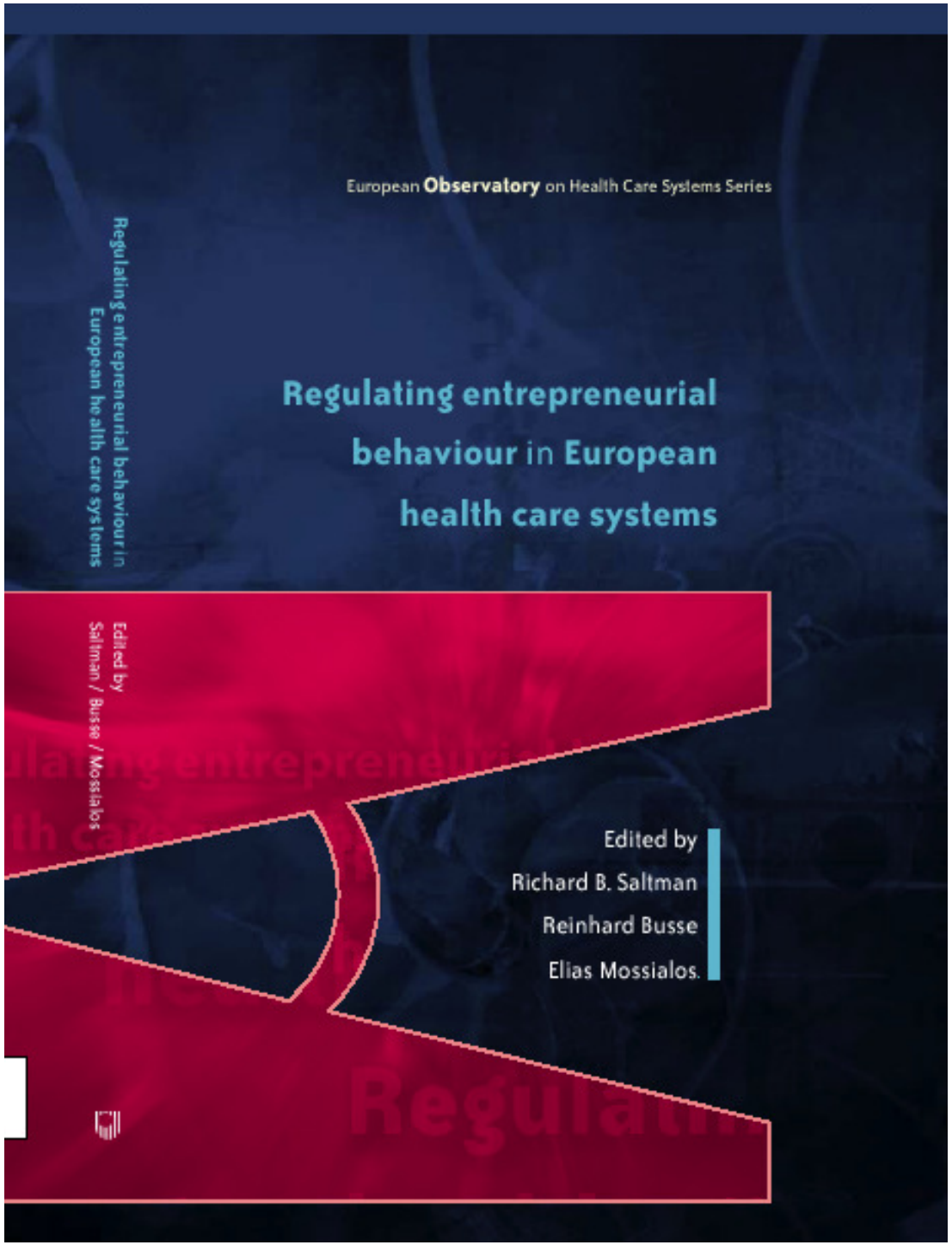
Our own calculation for Germany (2003) confirms this:
Average base rates adjusted for case mix*

	€ Mittelwert	Relative	Standardabweichung
Public	2655,37	99.7	315,407
Not-for-profit	2652,99	99.6	296,999
For-profit	2723,45	102.3	444,872
Overall	2663,22	100	328,203

*without one private for-profit with base rate = € 6200

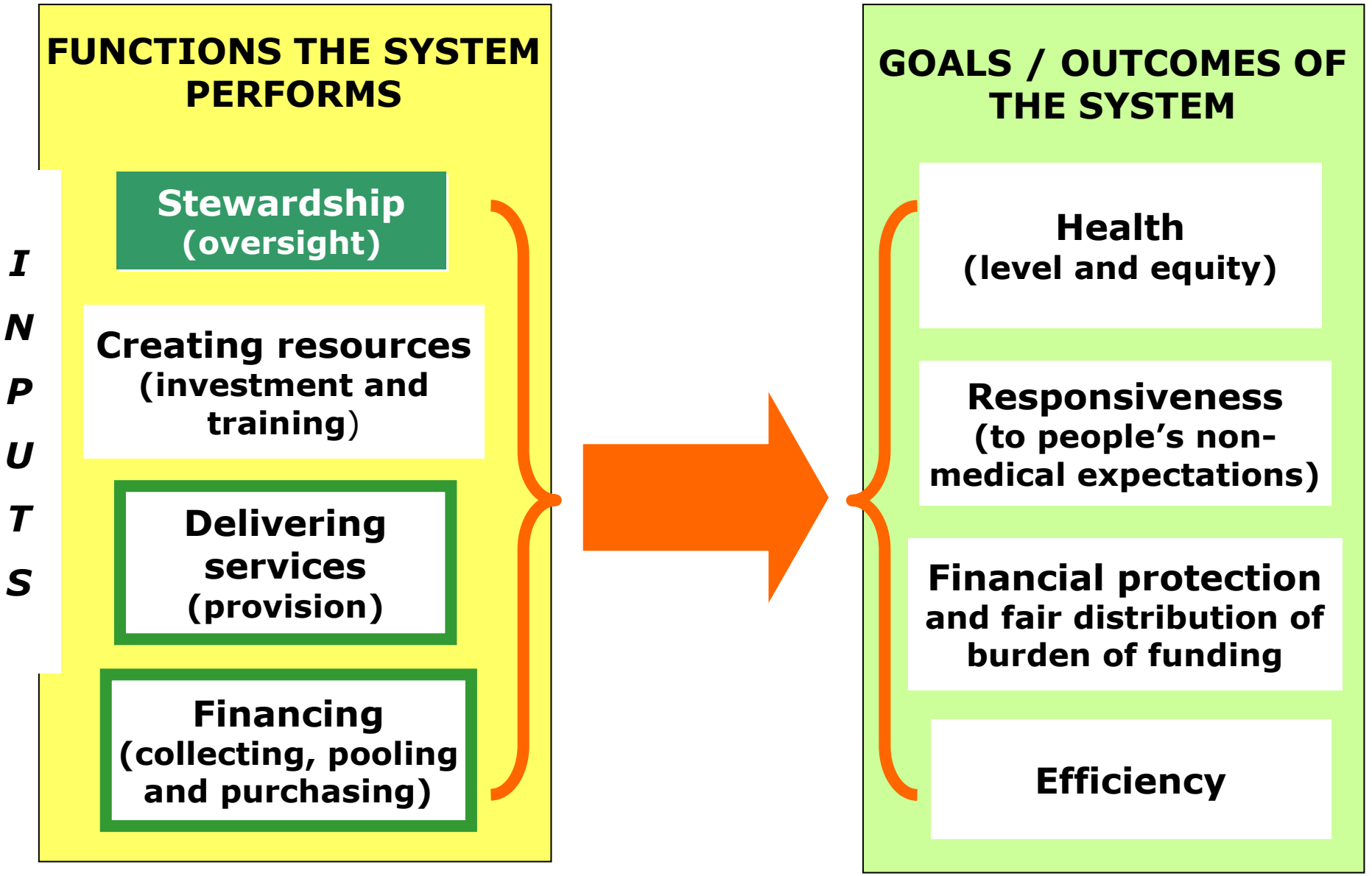
Conclusions on provision

- Research points against private for-profit regarding quality and efficiency
  –> more evidence from other countries needed
- Differences are very likely not due to ownership *per se* but to (dis)incentives and (non-) regulation
  –> coherent set of regulation for both public and private hospitals needed



What should the state do?

WHO Health Systems Framework

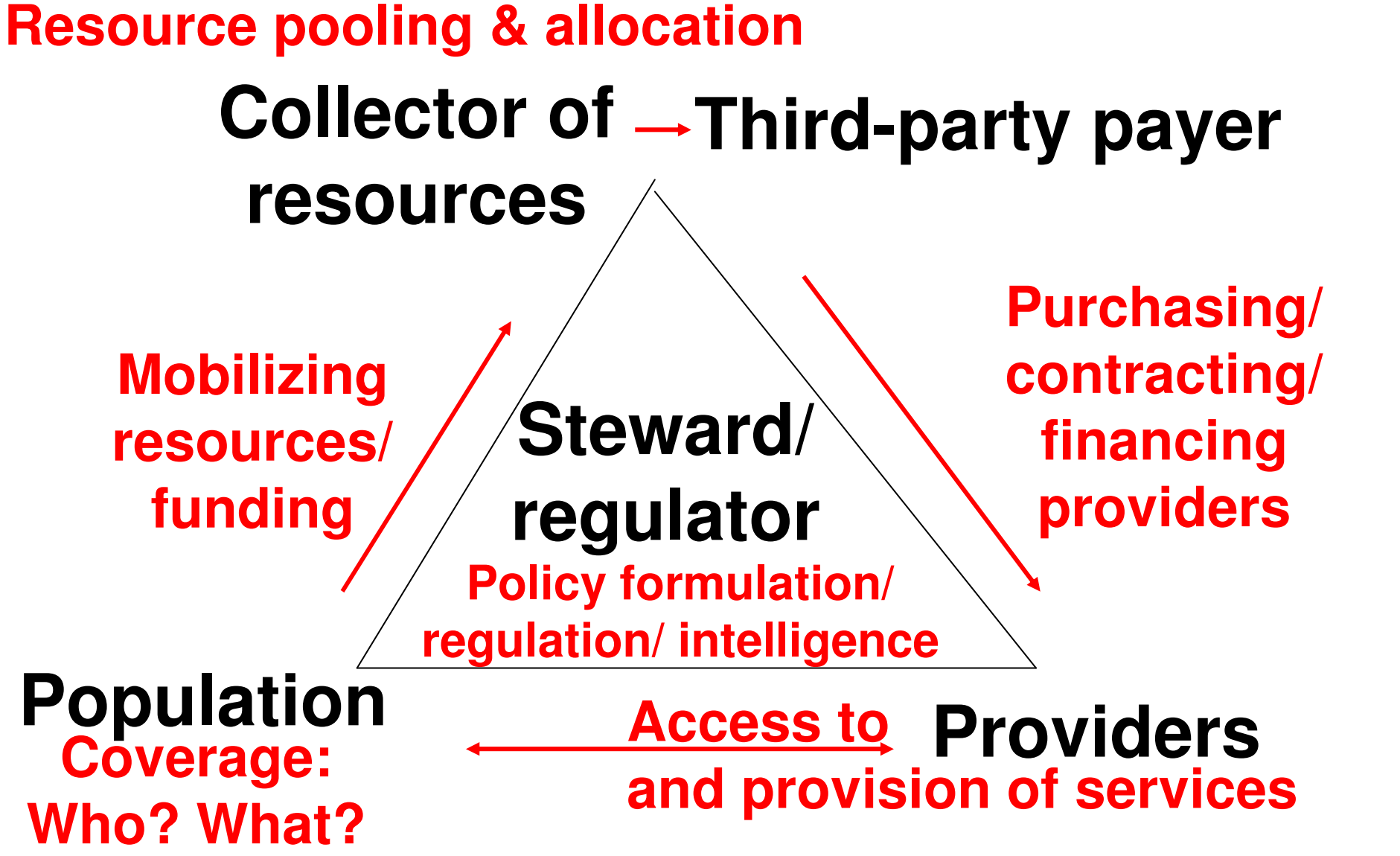


Stewardship, regulation and entrepreneurialism

"Rowing less, steering more" – clear division of compentencies with role of state = stewardship:

- ***Health policy formulation*** – defining the vision and direction for the health system
- ***Regulation*** – setting fair rules of the game with a level playing field (including possibly promotion of entrepreneurial activity!)
- ***Intelligence*** – assessing performance and sharing information

... but not providing care!



Functions

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Resource pooling & risk-related allocation

Collector of resources → **Third-party payer**

Competing sickness funds under public law

>95% income-based contribution (SHI); <5% community-rated premium

Steward/ regulator

Ministry of Health / Federal Joint Committee

Collective contracts & prices plus a few selective contracts & negotiated prices

Population

Universal coverage; broad benefit basket

Free access restricted only on voluntary basis

Providers

Public/ not-for-profit/ for profit mix

The German model

Resource pooling & risk-related allocation

Collector of resources → **Third-party payer**

Competing insurers under private law

55% income-based contribution (SHI, tax); 45% community-rated premium

Collective contracts & gov.-fixed prices -> selective contracts & negotiated prices

Steward/ regulator

Ministry of Health & regulating agencies

Population

Universal coverage; broad benefit basket

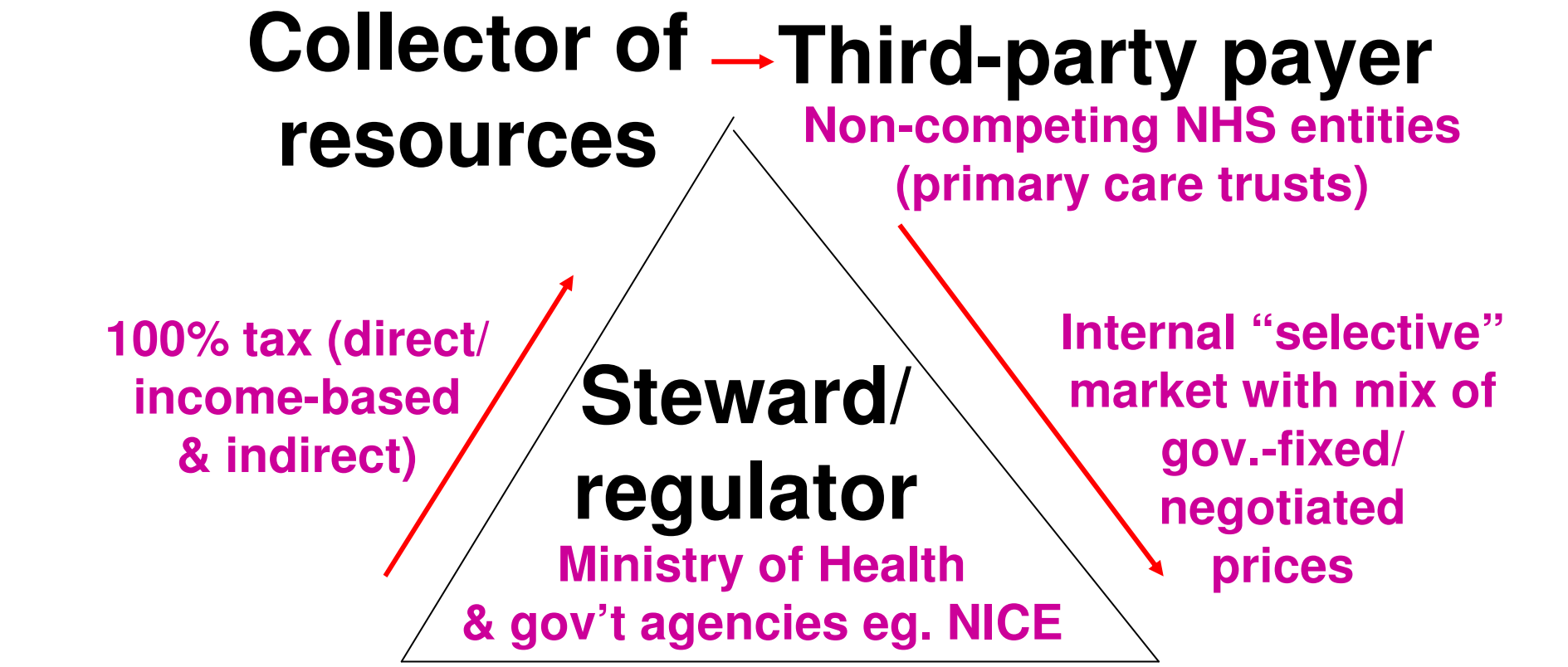
Access restricted by gatekeeping and contracts

Providers

All hospitals not-for-profit

The Dutch model

Resource pooling & risk-related allocation



The UK model

Overall conclusions

- Public and private entities are here to stay
- Careful regulation is needed to ensure that both contribute to reaching overall health system objectives (access, quality …)
- Coherent framework required, but there is more than one way to do it!

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Presentation and further material at:

http://mig.tu-berlin.de

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