Privates Kapital und staatliche Steuerung im Gesundheitswesen: Betrachtung aus europäisch-internationaler Sicht

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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 is regulation?
• Why regulation?

- The case for regulation in funding
- The case for regulation in provision
<table>
<thead>
<tr>
<th>Provision</th>
<th>&quot;public&quot;</th>
<th>&quot;private&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&quot;public&quot;</td>
<td>&quot;private&quot;</td>
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</table>

**What is public, what is private?**

**Funding**

- "public"
- "private"
## What is public, what is private?

<table>
<thead>
<tr>
<th>Provision</th>
<th>“public”</th>
<th>“private”</th>
</tr>
</thead>
<tbody>
<tr>
<td>“public”</td>
<td>public</td>
<td>voluntary insurance, out-of-pocket</td>
</tr>
<tr>
<td>“private”</td>
<td>not-for-profit for profit</td>
<td>statutory health insurance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Funding</th>
<th>“public”</th>
<th>“private”</th>
</tr>
</thead>
<tbody>
<tr>
<td>tax</td>
<td>statutory health insurance</td>
<td>voluntary insurance, out-of-pocket</td>
</tr>
</tbody>
</table>
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
Third-party Payer

Population

Providers
Third-party Payer

Population

Providers

prepaid

Taxes

Social Health Insurance contributions

Voluntary insurance

Out-of-pocket

European Observatory on Health Systems and Policies
Third-party Payer

Population Providers

Taxes 34%
Social Health Insurance contributions 25%
Voluntary insurance 19%
Out-of-pocket 18%

60% public

World-wide 2004 (large US market!)
Third-party Payer

Population

Providers

Taxes
- 20%

Social Health Insurance contributions
- 1%

Voluntary insurance
- <1%

Out-of-pocket
- 78%

Developing world (e.g. India)

20% public
Third-party Payer

Taxes 16%
Social Health Insurance contributions 17%
Voluntary insurance <1%

Out-of-pocket 66%

Population → Providers

33% public

China
Third-party Payer

Population Providers

Taxes
Social Health Insurance contributions
Voluntary insurance

65-85% public
Western Europe

Out-of-pocket 10-20%
GDP per capita and public expenditure on health, by country income group

- Low income
- Middle income
- High income
- OECD
- UK

Source: Schieber and Maeda 1997 and OECD 2004
Correlation between private expenditure (as % of total health care expenditure) and the level of fairness in financing

Private expenditure on health as % of total expenditure on health (2002)

Fairness in financial contribution (max. 1.00)

SHI
TAX
MIXED
USA
GR
ROK
CH
CDN
PE
BFIN
IS
F}

Private expenditure on health as % of total expenditure on health (2002)
Correlation between private expenditure (as % of total health care expenditure) and percentage of households with catastrophic health expenditure
Provision/ Delivery
What’s happening?

• Public sector failures
• Markets and competition
• Efficiency and quality: private vs. public
• New public management – private management methods
<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>53%</td>
<td>38%</td>
<td>4% (1990)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-&gt; 15%</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>50%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>Netherlands</td>
<td>14%</td>
<td>86%</td>
<td></td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>Review</th>
<th>Technical efficiency</th>
<th>Prices</th>
<th>Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaillancourt &amp; Rosenau 2002</td>
<td>Lower in for-profit</td>
<td>Higher in for-profit</td>
<td>Lower in for-profit</td>
</tr>
<tr>
<td>Curie et al. 2003 (systematic review)</td>
<td>No difference</td>
<td>Higher in for-profit</td>
<td>Overall no difference</td>
</tr>
<tr>
<td>Hollingsworth 2003</td>
<td>Efficiency: public &gt; not-for-profit &gt; for-profit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Devereaux et al. 2002 (Meta-analysis)</td>
<td></td>
<td>Risk-adjusted mortality 2% higher in for-profit (= lower quality)</td>
<td></td>
</tr>
<tr>
<td>Devereaux et al. 2004 (Meta-analysis)</td>
<td></td>
<td>Prices 19% higher in for-profit</td>
<td></td>
</tr>
</tbody>
</table>
### Quality

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

**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

<table>
<thead>
<tr>
<th>Study*</th>
<th>No. of facilities</th>
<th>No. of patients</th>
<th>% weight</th>
<th>PFP/PNFP payments ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Van Ness⁷</td>
<td>333</td>
<td>NA</td>
<td>13.7</td>
<td>1.09 (0.98–1.22)</td>
</tr>
<tr>
<td>Kauer⁸</td>
<td>56</td>
<td>NA</td>
<td>15.1</td>
<td>0.93 (0.88–0.99)</td>
</tr>
<tr>
<td>Dickey⁹</td>
<td>342</td>
<td>561</td>
<td>8.9</td>
<td>1.73 (1.36–2.20)</td>
</tr>
<tr>
<td>Dranove et al¹⁰</td>
<td>314</td>
<td>NA</td>
<td>14.4</td>
<td>0.98 (0.90–1.07)</td>
</tr>
<tr>
<td>McCue et al¹¹</td>
<td>84</td>
<td>NA</td>
<td>10.5</td>
<td>1.62 (1.34–1.97)</td>
</tr>
<tr>
<td>Sloan et al¹²</td>
<td>2 360†</td>
<td>7 079</td>
<td>8.4</td>
<td>1.51 (1.17–1.94)</td>
</tr>
<tr>
<td>Keeler et al¹³</td>
<td>358†</td>
<td>384 000</td>
<td>15.8</td>
<td>1.13 (1.09–1.16)</td>
</tr>
<tr>
<td>McCue et al¹⁴</td>
<td>131</td>
<td>NA</td>
<td>13.2</td>
<td>1.20 (1.06–1.36)</td>
</tr>
</tbody>
</table>

Pooled random effects estimate \( (p = 0.001) \)

\( I^2 = 0.903 \)

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**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*

<table>
<thead>
<tr>
<th></th>
<th>€ Mittelwert</th>
<th>Relative</th>
<th>Standardabweichung</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public</td>
<td>2655,37</td>
<td>99.7</td>
<td>315,407</td>
</tr>
<tr>
<td>Not-for-profit</td>
<td>2652,99</td>
<td>99.6</td>
<td>296,999</td>
</tr>
<tr>
<td>For-profit</td>
<td>2723,45</td>
<td>102.3</td>
<td>444,872</td>
</tr>
<tr>
<td>Overall</td>
<td>2663,22</td>
<td>100</td>
<td>328,203</td>
</tr>
</tbody>
</table>

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

- **On funding**: public is fairer than private -> strong case for public funding/ insurance and strong regulation of private insurance
- **On provision**: more difficult with research pointing against private for-profit – more evidence from other countries needed

Differences are very likely not due to ownership 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

FUNCTIONS THE SYSTEM PERFORMS

- Stewardship (oversight)
- Creating resources (investment and training)
- Delivering services (provision)
- Financing (collecting, pooling and purchasing)

GOALS / OUTCOMES OF THE SYSTEM

- Health (level and equity)
- Responsiveness (to people’s non-medical expectations)
- Financial protection and fair distribution of burden of funding
- Efficiency
Stewardship, regulation and entrepreneurialism

“Rowing less, steering more“ – clear division of competencies 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!
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)
Types of regulation by intention and impact

1. Pro-competitive regulation that stimulates market opportunities

2. Pro-competitive regulation that restricts individual market-driven behaviour

3. Regulation restricting hospitals to achieve social objectives as access, social cohesion, public health/safety, quality, and sustainable financing

4. Regulation without good reasons
1. Pro-competitive regulation that stimulates market opportunities

- Replace input-oriented budgets with contract-based performance-related reimbursement
- 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
- EU regulations on free movement of services
2. Pro-competitive regulation that restricts individual market-driven behaviour

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

• **Access:** disallow patient selection, mandate non-scheduled admissions, require physician staffing around the clock, allow patient choice

• **Quality:** require accreditation, QA programmes, public disclosure of results (e.g. ranking lists)

• **Efficiency:** There may be a case to restrict certain ambulatory services if they can be delivered more efficiently outside hospitals.

• **Prices:** Set uniform or maximum price/reimbursement or regulate that it is done by self-governing actors
Schlussfolgerungen

• Internationale Evidenz legt Vorsicht bei „mehr privat“ nahe

• „Mehr privat“ erfordert mehr Regulierung, z.B. Verpflichtung zu Offenlegung Qualität (CH), RSA/ Risikopool in der PKV (NL/ SLO), einheitliche Vergütung …

• Aber: gute Regulierung braucht solide Daten -> wenn nicht freiwillig, dann verpflichtend