

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

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&

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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

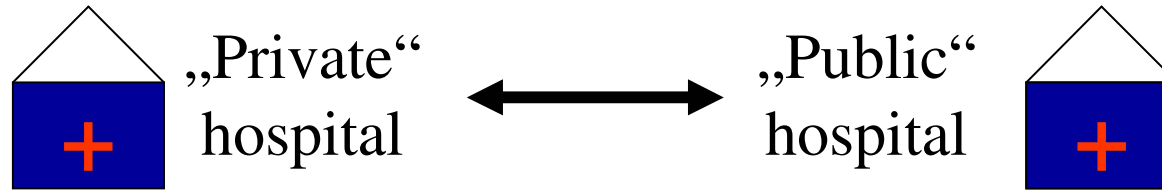
In the other end of the spectrum, the national government (or a subordinated public body such as a Health Authority) establishes hospitals where and at what size deemed necessary according to a public plan.

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

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			

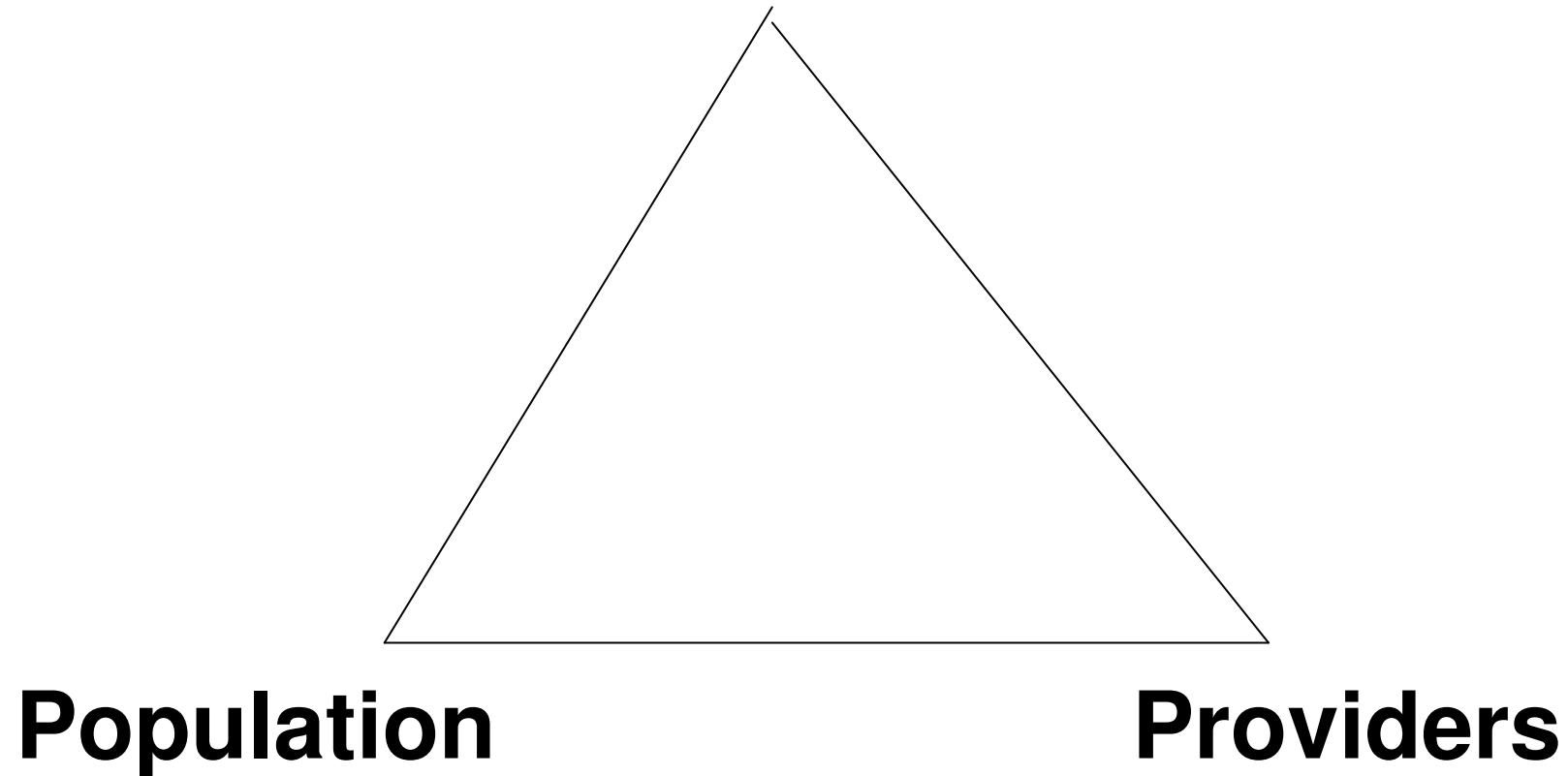
The debate is often ...

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

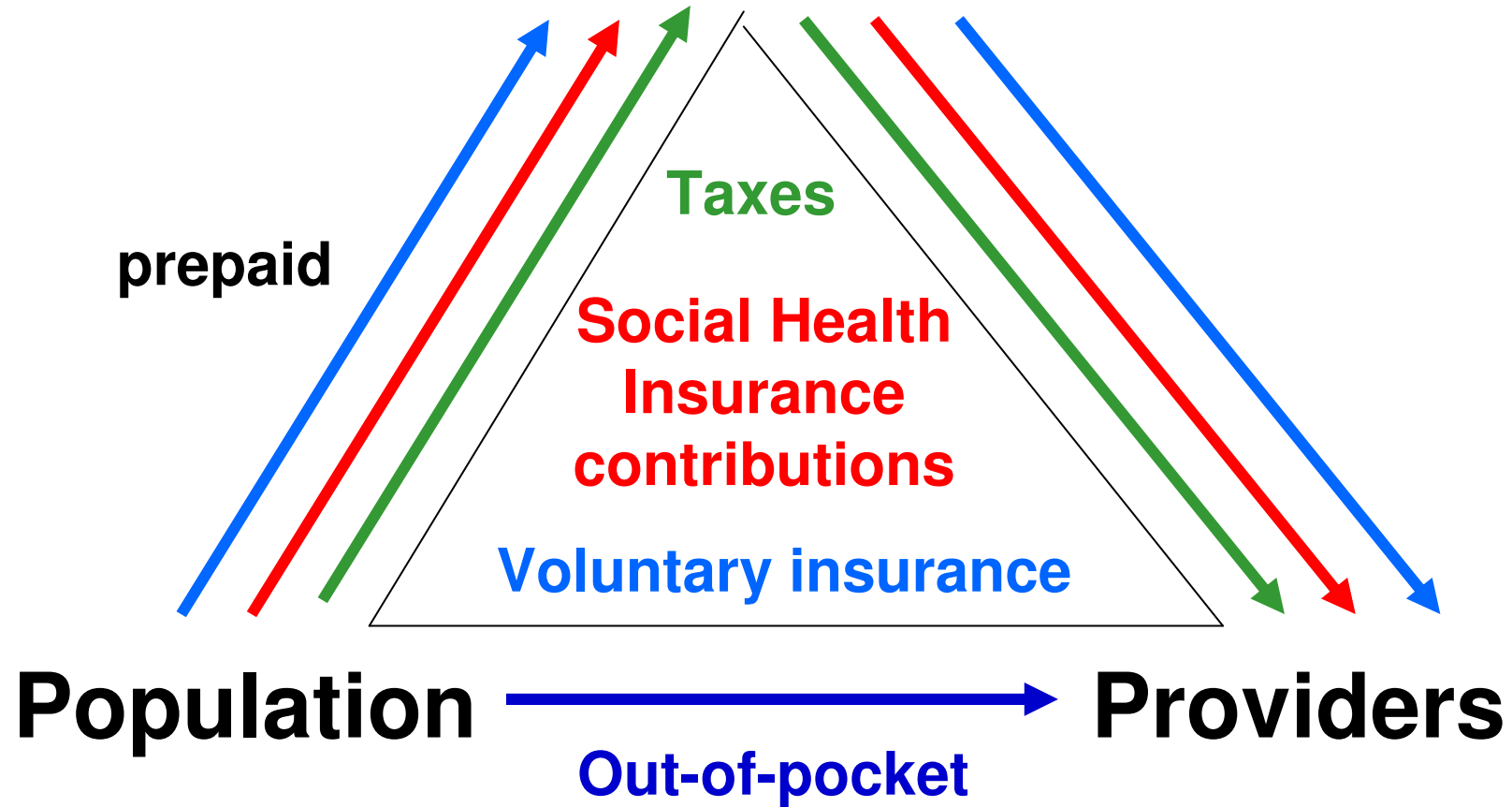
The European Observatory's aim is to provide evidence, not ideology or ready-made solutions ...

Funding

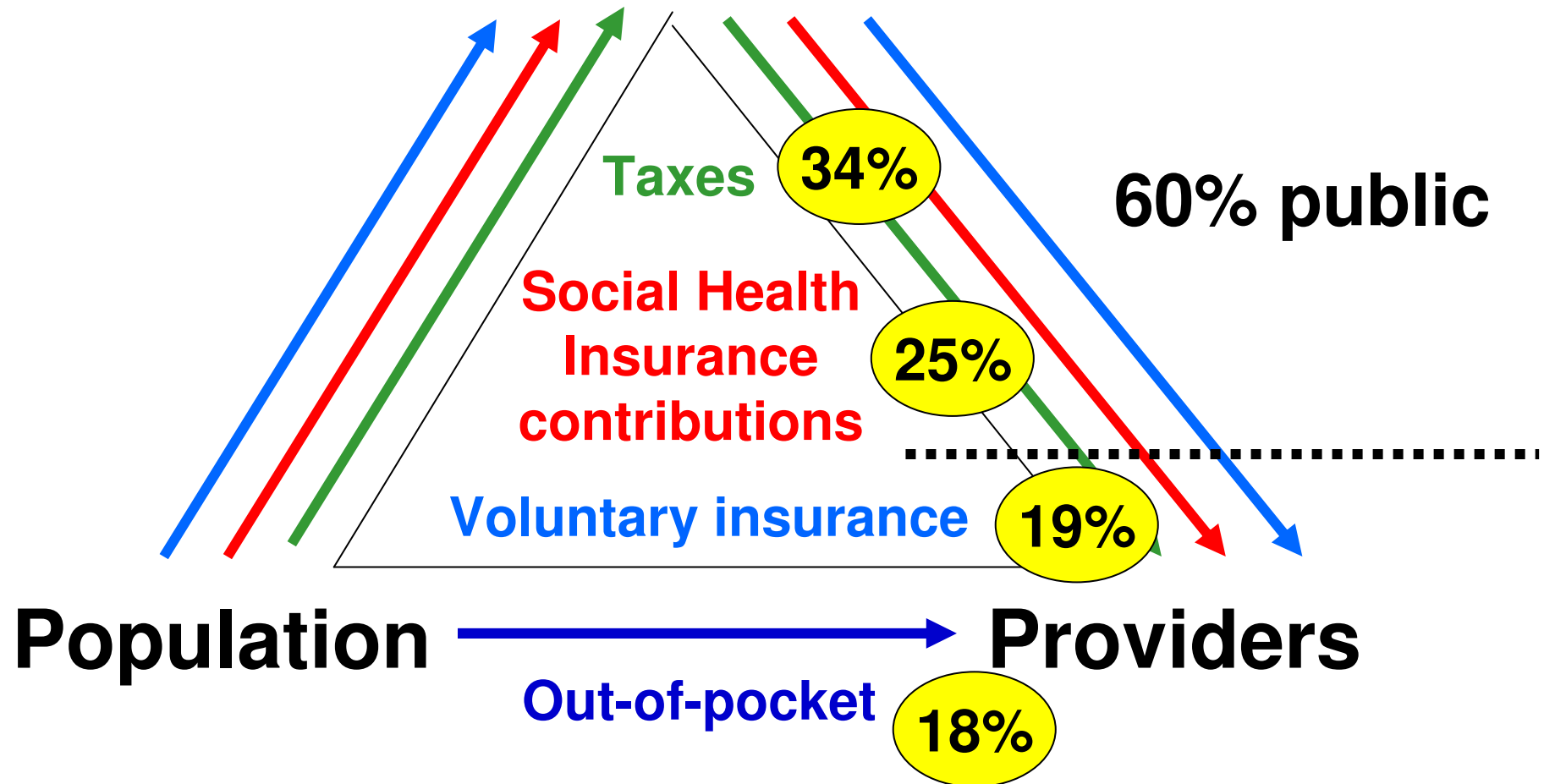
Third-party Payer



Third-party Payer

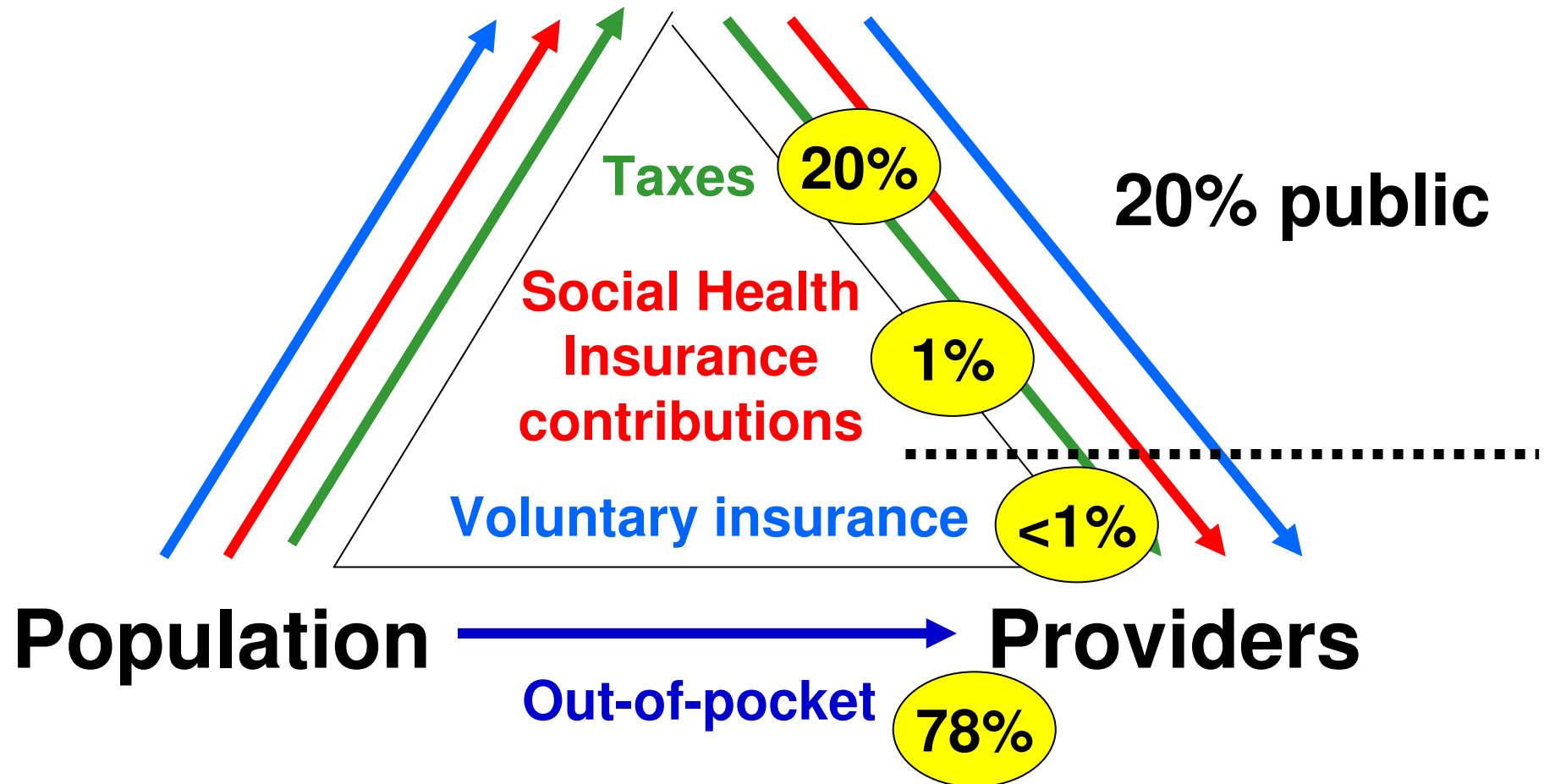


Third-party Payer



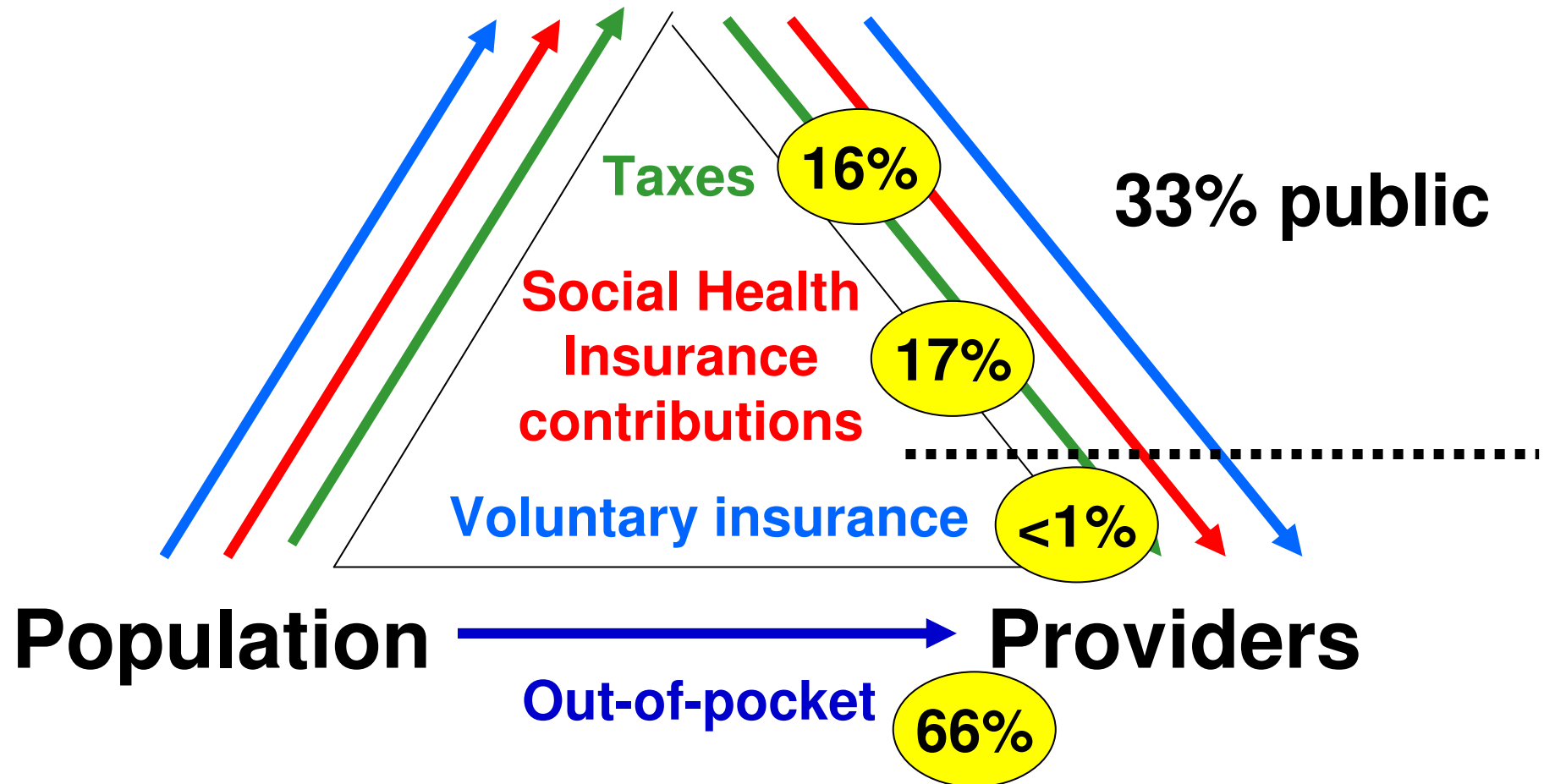
World-wide 2004 (*large US market!*)

Third-party Payer



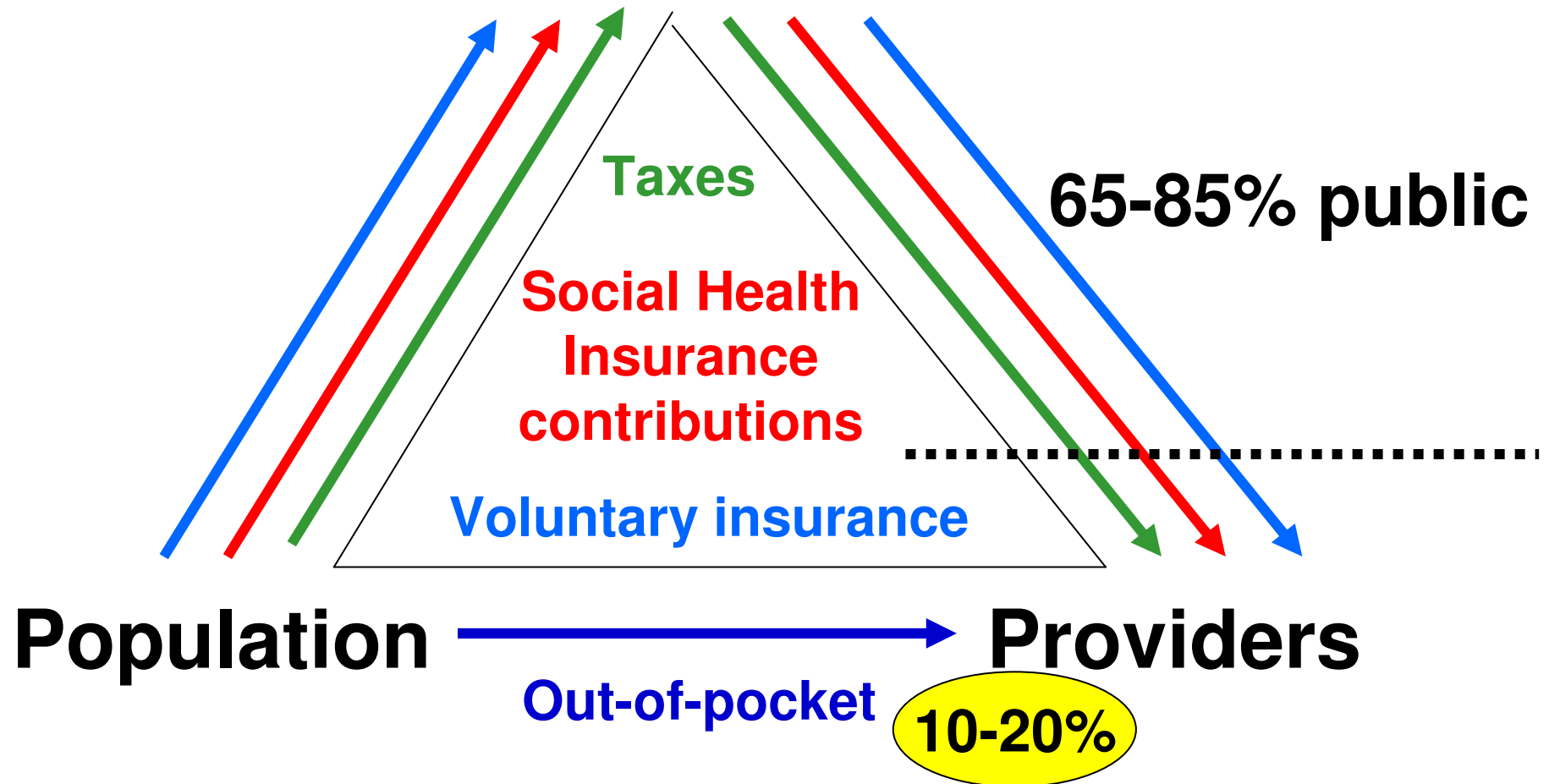
Developing world (e.g. India)

Third-party Payer



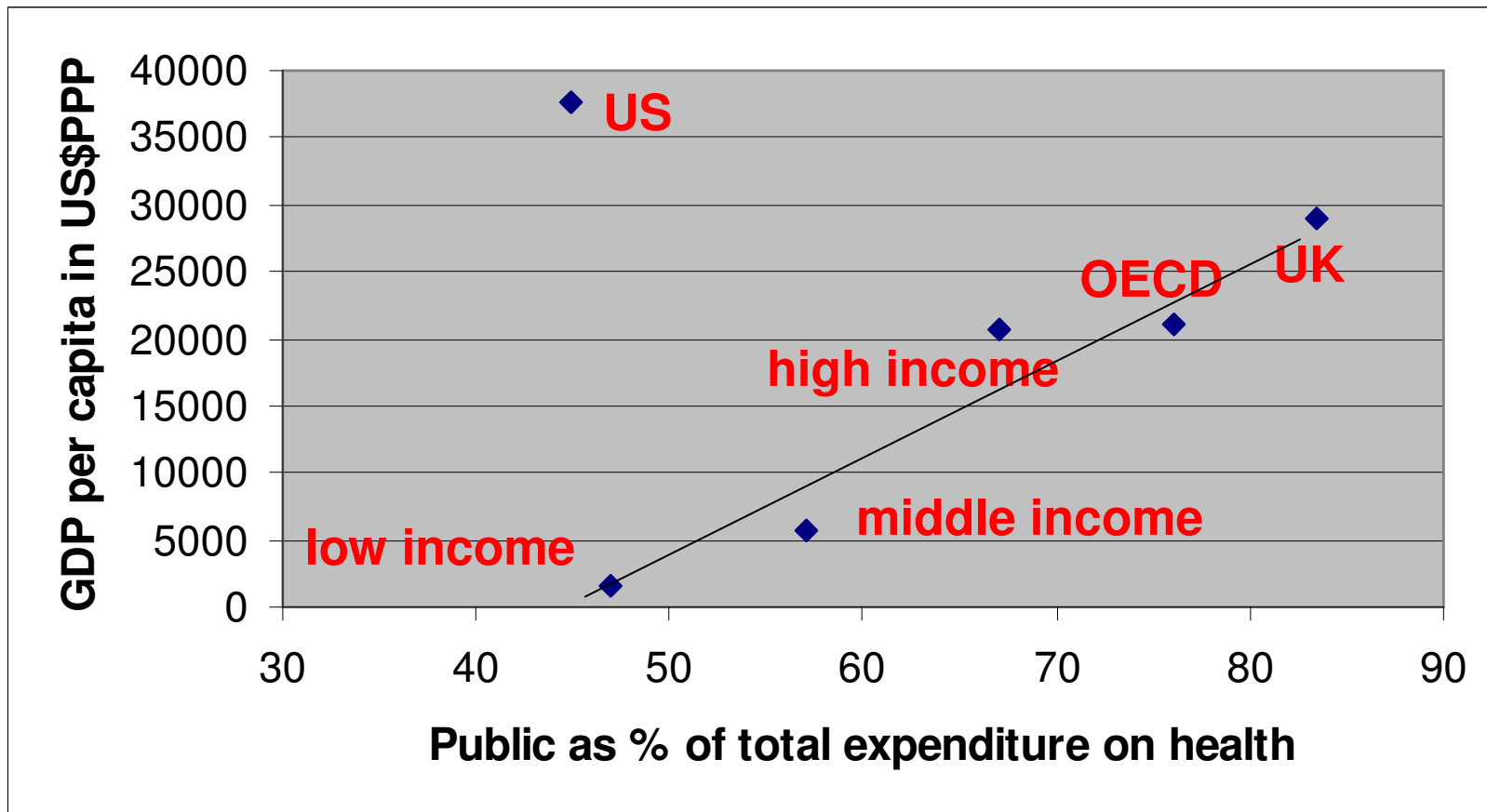
China

Third-party Payer



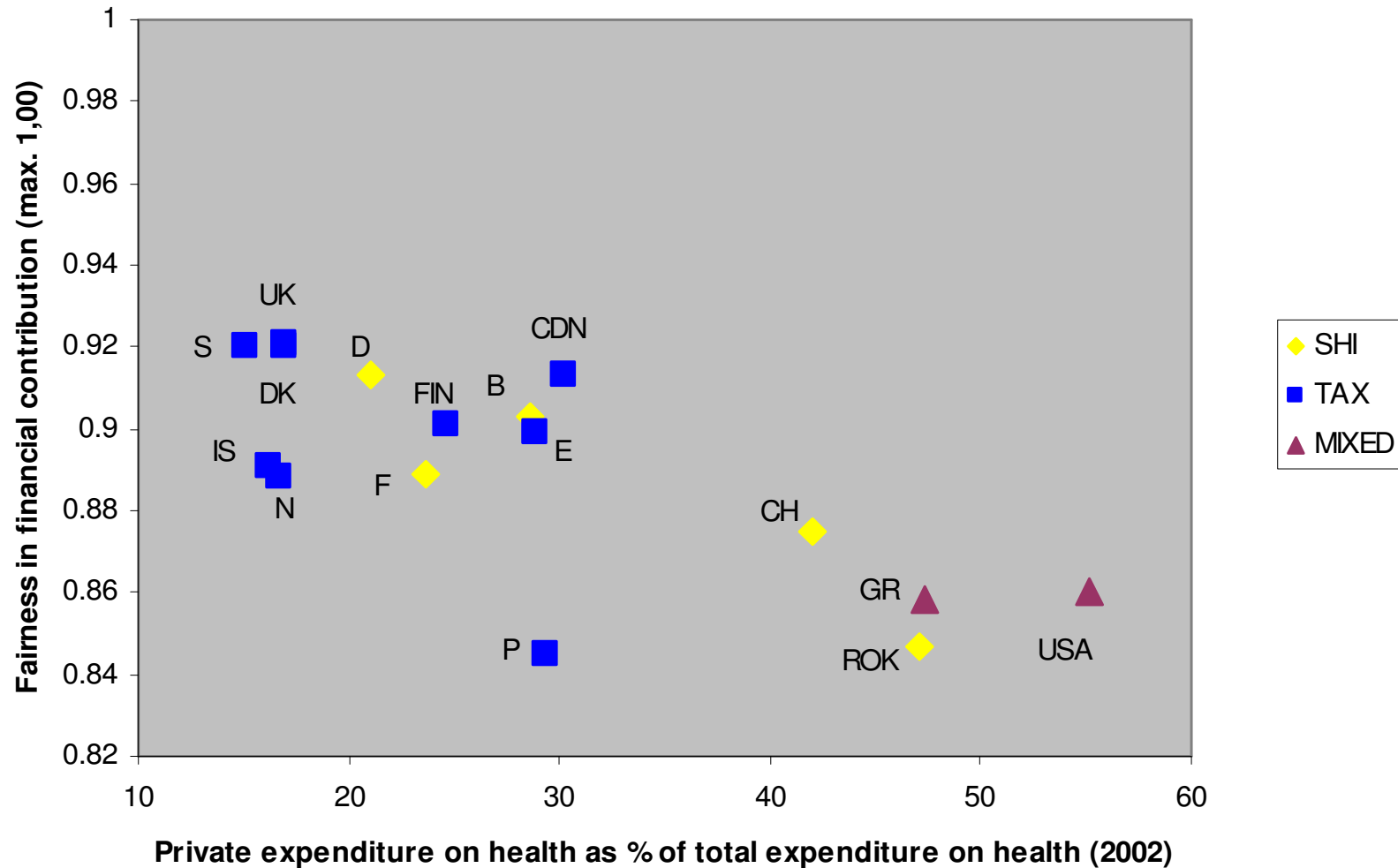
Western Europe

GDP per capita and public expenditure on health, by country income group

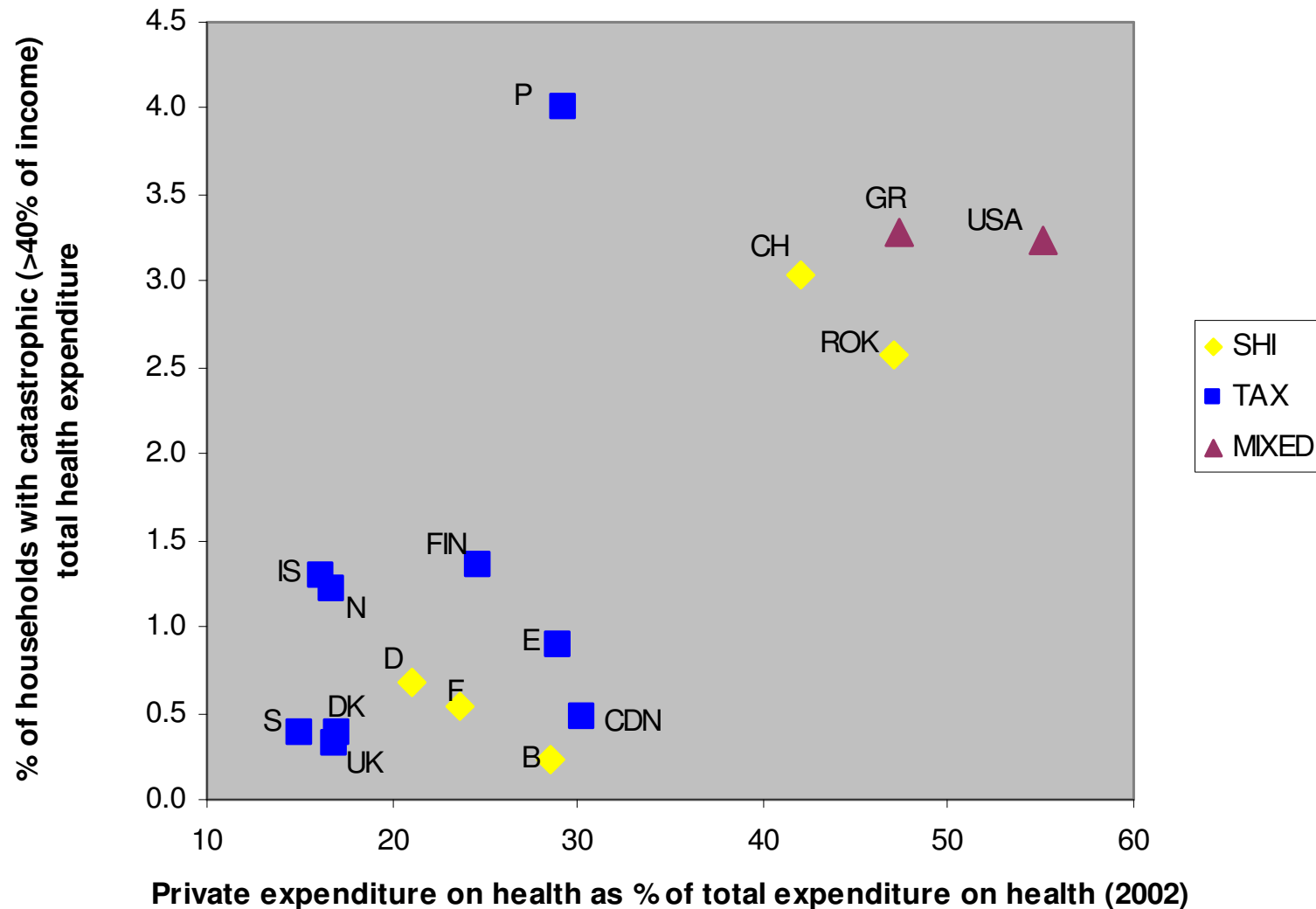


Source: Schieber and Maeda 1997 and OECD 2004

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



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



Provision/ Delivery

What's happening?

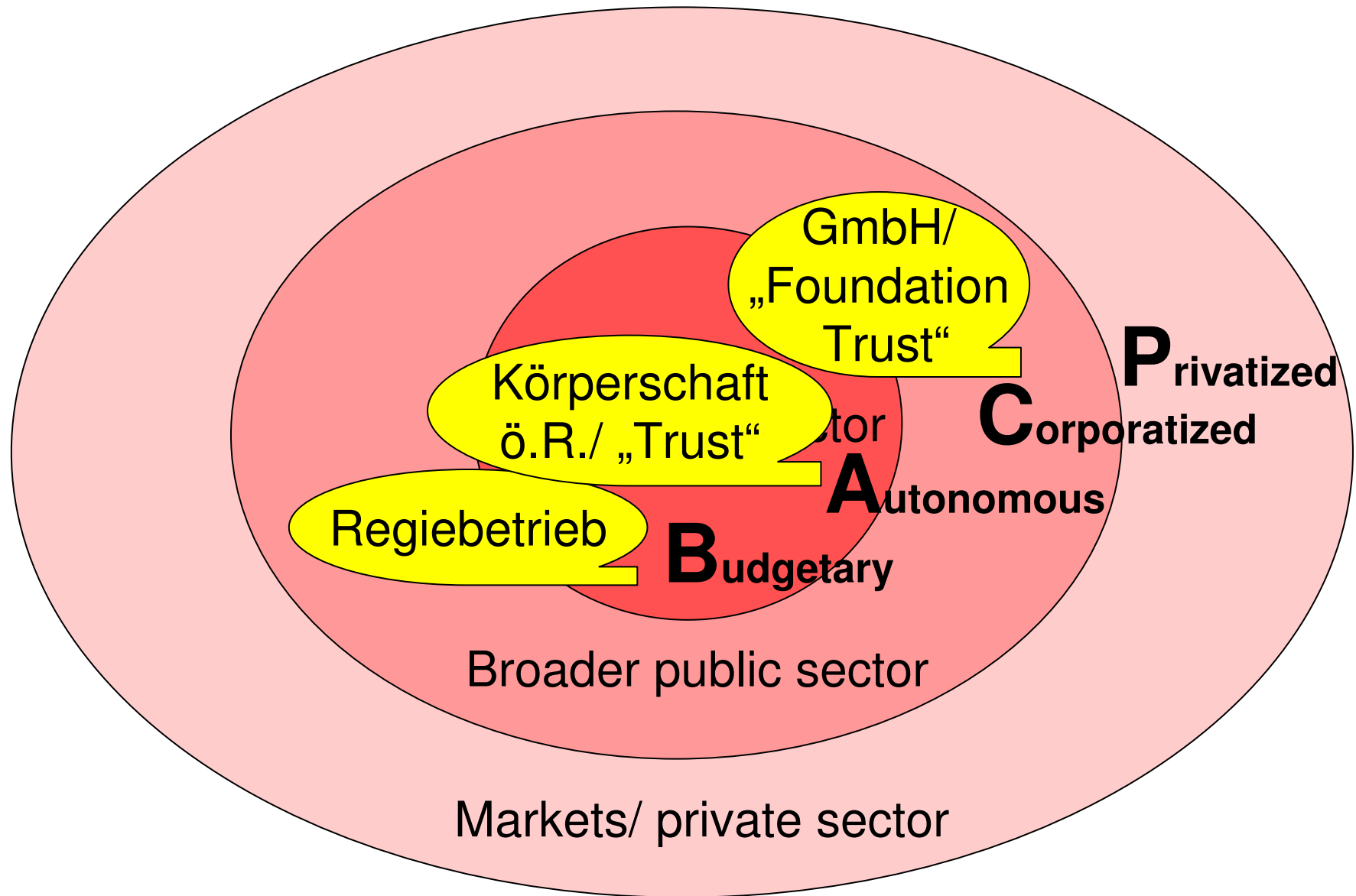
- Public sector failures
- Markets and competition
- Efficiency and quality: private vs. public
- New public management – private management methods

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	<i>Lower</i> in for-profit	<i>Higher</i> in for-profit	<i>Lower</i> in for-profit
Curie et al. 2003 (systematic review)	No difference	<i>Higher</i> 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 (= <i>lower</i> 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

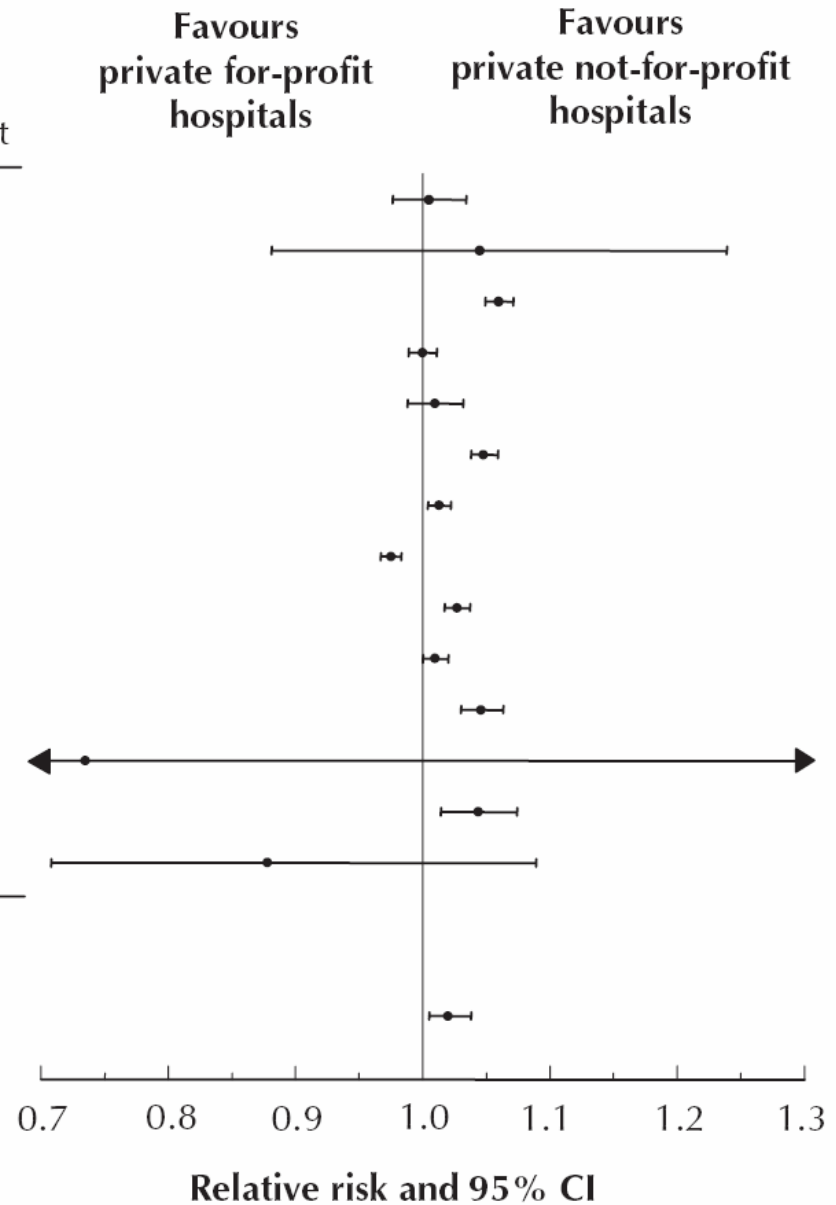


Fig. 2: Relative risk of hospital mortality for adult patients in private for-profit hospitals relative to private not-for-profit hospitals. CI = confidence intervals.

Prices

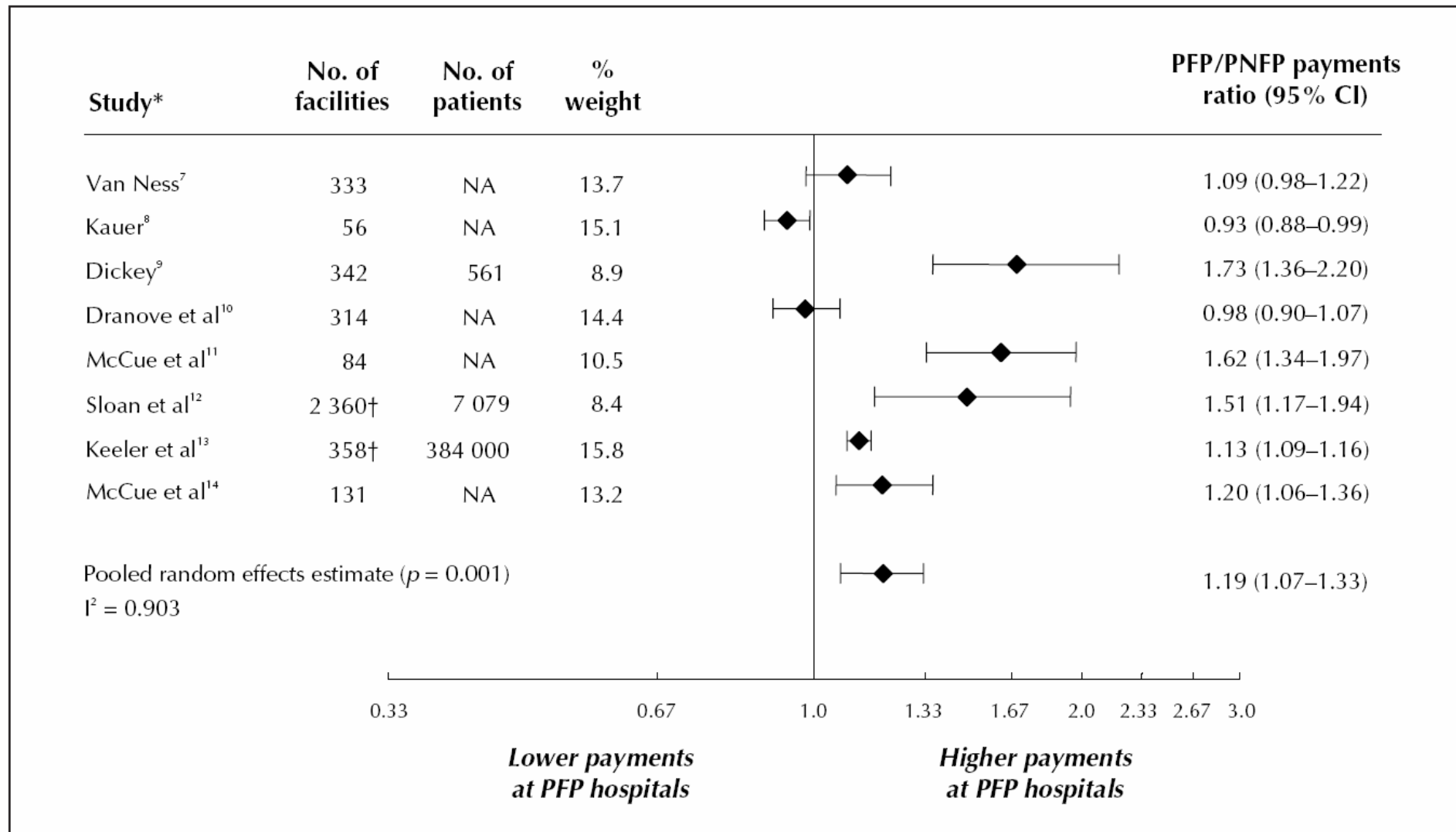


Fig. 2: Relative payments for care at private for-profit (PFP) and private not-for-profit (PNFP) hospitals. Note: CI = confidence interval.

*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	Standardab weichung
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 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

European **Observatory** on Health Care Systems Series

Regulating entrepreneurial behaviour in
European health care systems

Regulating entrepreneurial behaviour in European health care systems

Edited by
Saltman / Busse / Mossialos

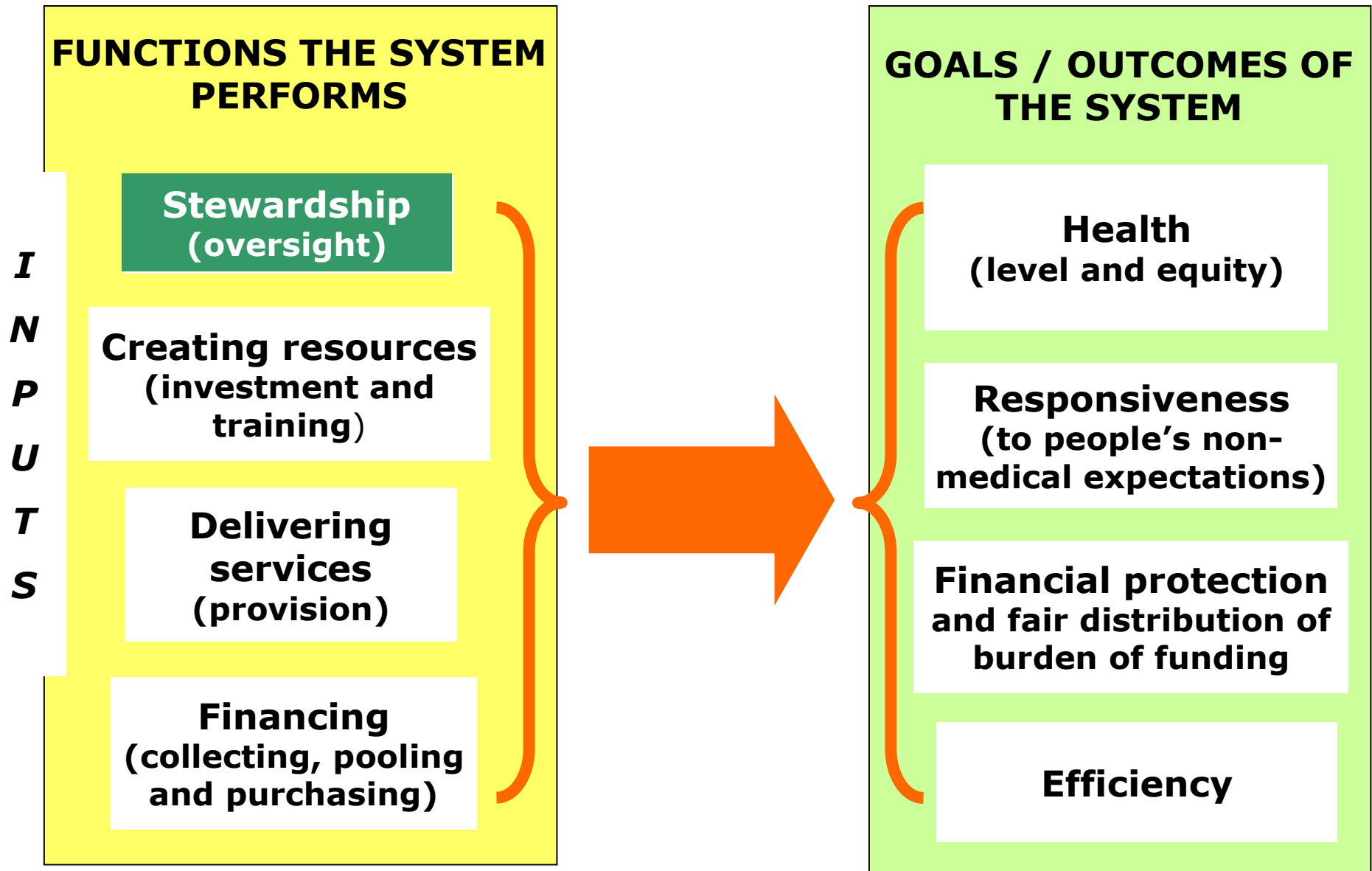
Edited by
Richard B. Saltman
Reinhard Busse
Elias Mossialos.



Regulating

**What should
the state do?**

WHO Health Systems Framework



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*