Project HeaRT: Health Reporter Training. John Lister

THE BUSINESS AND ECONOMICS OF HEALTH CARE

The Health Care Industry

- $4.7 trillion annual turnover (WHO)
- Health workforce 59.2m (WHO 2006)
- EU countries spent more than €1 trillion a year on healthcare in 2009.
- 2010 report shows that €56 billion of this was lost to fraud in Europe annually and €180 billion globally.
- Fraud & waste in USA $500-$850 bn/year equal to 18-30% of the $2.76 trn spent

Health systems

- Normally categorised by principal system of payment for health care or insurance: all but USA deliver almost universal cover.
  - Beveridge systems (UK, Scandinavia, Spain, Italy) based on taxation
  - Bismarck systems (Germany, France, much of Central and Eastern Europe, South Korea, Japan) based on workplace insurance
  - Hybrid systems combine some of both (few are "pure" systems with no specifics)
  - US: private health insurance (employer/individual)

Public and private providers

- Bismarck and Beveridge systems can allow services to be purchased from private sector, whether for-profit or non-profit
- In Canada tax-funded system buys universal coverage from non-profit private hospitals
- In Europe most hospital provision is public sector, with some exceptions
- Health care “reforms” often focus on increasing this private sector share of collective health budgets

Public and Private hospitals in EU

data HOPE

Country ZE15	DE	AT	BE	BG	CY	DK	SP	EE	FI
number hospitals	3 460	272	214	262	96	67	741	51	370
acute care hospitals	2 166	177	146	209	x	22	545	33	x
Acute care beds	531 300	48 800	50 200	38 000	2 900	16 800	115 600	5 700	11 700
% beds public	74,7%	76,2%	35,5%	98,3%	46,8%	96,0%	66,2%	89,9%	96,6%
% beds private	**25,3%**	**23,8%**	**64,5%**	**1,7%**	**53,2%**	**4,0%**	**33,8%**	**10,1%**	**3,4%**
Country ZE15	FR	GR	HU	IE	IT	LV	LT	LU	MT
number hospitals	2 890	319	179	179	1 296	119	181	x	10
acute care hospitals	1 599	268	138	53	1 110	80	80	10	10
Acute care beds	225 900	42 000	59 600	11 900	201 400	12 400	19 100	2 300	1 200
% beds public	65,5%	72,0%	97,3%	na	77,0%	95,0%	99,7%	40,0%	91,1%
% beds private	**34,5%**	**28,0%**	**2,7%**	**na**	**23,0%**	**5,0%**	**0,3%**	**60,0%**	**8,9%**
Country ZE15	NL	PL	PT	CZ	RO	UK	SK	SI	SE
number hospitals	198	844	209	363	416	x	144	29	81
acute care hospitals	110	x	170	200	x	x	100	20	80
Acute care beds	51 000	178 100	32 400	63 300	96 100	x	33 000	7 700	20 000
% beds public	15,0%	96,3%	74,8%	80,1%	99,6%	na	94,9%	99,1%	97,0%
% beds private	**85,0%**	**3,7%**	**25,2%**	**19,9%**	**0,4%**	**na**	**5,1%**	**0,9%**	**3,0%**

health CONFERENCE 2010

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Connecting Leaders in Technology and Healthcare

A larger private share of increased health spending?

- According to PriceWaterhouseCooper (2010) spending on health in OECD countries is forecast to increase by 50% between 2010 and 2020, to reach 14.4% of GDP
- They expect a total of $68 trillion to be spent on "non infrastructure" health in the OECD, Brazil, Russia, India and China in the decade.
- PwC expects this to bring a move to Public Private Partnerships, in a market that will be worth **$7.5 trillion** per year

For-profit and non-profits

- Non-profit businesses are also in the private sector: their staff are not public employees
- Most US hospitals are still ‘not for profit’
- “Social enterprises” run as businesses, and may even have shareholders, but do not distribute profits
- But non-profits must compete with and alongside for-profits: they need a surplus
- Their policies and ethos needs to be similar to for-profits: their management regime also.
- Some non-profits involve heavy stakes from private equity and others (Circle Health)
- Social enterprises vulnerable to big corporations

Private finance, public liability

- Use of private finance to build new hospitals and facilities for public sector health providers has gathered pace since 1997
- British government has led the way with hospital projects worth £11 billion set to incur repayments totalling £64 billion under the Private Finance Initiative (PFI)
- Similar models, also known as PPP/PPIP now rolling out in Canada, Australia, Sweden, Spain, Portugal, Turkey – and even Lesotho

Business models reshape the public sector

- Bismarck systems already have split between "purchaser" (independent insurance funds) and public/private "providers" of health care
- Beveridge systems are being "reformed" to create a similar division, and create a competitive **market**
- Public sector hospitals being given autonomy & required to behave like businesses (UK, Portugal, Spain, Sweden, Turkey, etc) or privatised (Germany, Poland)

Creating a market in health

- Market can involve competition between public sector providers; public-private competition, and also potentially competition between "purchasers" – rival insurance funds
- Reflects prevailing ideology of "neoliberal" governments since 1980s
- Other "reforms" include 'Turkish model': each patient allowed a fixed amount from health budget, and may then have to "top up" to cover cost of treatment from a free choice of providers – this is a break from ensuring universal cover.

Are markets appropriate?

- Claims that competition leads to improved quality & efficiency and pushes down prices: are these claims valid for health care?
- A few of argued that they are – mainly from London School of Economics
- Many argue the contrary – pointing to the high cost, waste and inefficiency of US health care system, and to established critiques
  - For an efficient market in health care, **3 essentials**:
    - All decisions to be taken by consumer
    - Consumers must know value and costs of their purchase
    - Consumers must pay full cost and receive full value
    - But NONE of these apply to health care
      - (Blank & Burau 2007:117-8)

More problems with markets

- Excess capacity required (very costly to provide additional hospital capacity, both in resources and in scarce manpower)
- Exit of failing providers from market is politically damaging and explosive for governing party
- Entry into market is costly and difficult, with uncertain returns
- Private sector profit margins are far higher than those allowed in public sector budgets
- Private sector wants to avoid risk, expense, commitment: run for profit, not as a service.
- Result is cherry-picking (cream-skimming): competition for most lucrative and low risk services: public sector retains the rest

More problems with markets

- Markets are NOT a mechanism that can ever ensure equity of access to services
- Health inequalities – poorest tend to suffer more ill-health, while lacking ability to pay
- **"Inverse care law"** – health care most needed by those least able to pay market cost of care … very young, very old, very poor, etc.
- Market can only function with public/state support (even in USA: Medicare & Medicaid).
- Public intervention means regulation
- Regulation blunts competition, increases costs

Private insurance

- The main private means to fund health care is private health insurance: advantages include
  - Enables relatively affluent people to finance their own care so public resources can focus on poor
  - May stop wealthy from excessive use of public health services
  - Mobilises additional resources that can improve care for poor as well as rich
  - Encourages innovation and efficiency
  - Increased choice for the consumer
    - From Mossialos et al 'Funding health care: options for Europe' p 111

Downsides to private insurance

- Two-tier system that does not guarantee any benefit for poor: private sector runs for shareholders
- Rich enabled to opt out of "risk pool" – leaving pool of higher risk people sharing less resources
- Elderly and those with pre-existing conditions can be deemed "uninsurable"
- Complexity of choices between different schemes
- Low-contribution schemes leave poor with large uninsured liabilities ("co-pays" and "deductibles") which are major cause of bankruptcies in US
- Cover geared to limited range of services offered by private hospital sector – big gaps in cover

Private hospitals

- In Europe most private hospitals SMALLER than public sector (average size 50 beds in UK)
- Higher cost per patient
- They are free to select which services to offer
- Small workforce: no multidisciplinary teams
- Doctors employed only on sessional basis
- No training of staff – instead compete with public sector for pool of trained staff
- Dependent on public sector services
- Effectively subsidised by public sector

Does private = more efficient?

- No consensus: ideological debate
- WHO (2000) urged more attention to improved efficiency to maximise results from limited resources and increase access
- Inefficiencies include:
  - excessive length of stay in hospital;
  - over-staffing; under-staffing (costly agency staff)
  - use of branded instead of generic medicines;
  - stock wastage and medical errors
  - over-treatment (private sector) and under-treatment (public and private sector)

Public v private

- Analysis of 317 reports on efficiency found "public provision may potentially be more efficient than private"
  - Studies in the US have shown non-profit hospitals to be more efficient that for-profits , while the opposite has been found in Taiwan
  - In 1991-96 the efficiency of German private hospitals decreased by 20%.
    - Hsu (2010) The relative efficiency of public and private service delivery, WHO
  - The lack of decisive evidence underlines the fact that the business & economics of health care reflect political and ideological differences