Sharing responsibilities : The public-private interface

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DISCUSSION

Robert Launois
Professor of Economics, University of Paris, France

I will take up the three words on which today's discussion has been based: Competition, solidarity and rationing.

Competition first, because it's an ambiguous word. You can understand it in three different ways. There is competition between providers on the basis of the prices they charge their customers, and between the fees they charge to, and the amounts refunded by, health insurance funds. The latter can lead to patient co-payments and prescription charges, either de facto or de jure, when fees exceed a certain level. I doubt if any of you would really want to see this type of competition disappear.

There is a second type of competition between the care providers organised in groups on the one side, and public or private purchasers of health care on the other. This is the British system, with GP (general practitioner) fund-holders and hospital trusts, the first being the purchasers and the second being the service providers. It's a quasi-health market set in the context of national solidarity.

But there is a third form of competition, too, which we find in the Netherlands, as embodied by the Dekker plan and Simons plans. There, a compensation fund is set up at national level which is funded through taxation. This redistributes funds to insurers, either mutual insurers or profit-making private insurers. These get an annual sum irrespective of their legal status but which varies according to the risk profile of the people they insure, the whole being complemented by an individual contribution paid by the persons insured. Competition between organisations in this system is on the basis of the size of the nominal premium or contribution the insurers ask from their subscribers.

What's interesting about all three examples is that competition does not exclude solidarity. Setting aside regulation by price as the Americans do it, most are systems which set up national equalisation funds and redistribute the income to institutions which differ according to the prevailing national health-care system. If you look at the GP fund holders in the U.K., the paying body there is the GP himself. If you take the Dutch system, the institution at the centre of the system is the mutual society or the commercial insurance company. In France the institution would be the regional authority, the Caisse d'assurance primaire, funded on the same basis. These are our points of reference as we work to find the structures best suited to our various national values.

Solidarity also can take on three different meanings. There is solidarity expressed in the terms of "to each according to his needs". This is what in France we call the "mutualisation of risk". And then there is a totally different type of solidarity, which is, "from each according to his means". Then, and this is a development I only heard about this morning, there is a third form of solidarity which incorporates elements of both. If they altered rates according to age and other factors, mutual funds would find themselves mid-way between total equalisation of risk and total individualisation of risk, a situation giving rise to what the Americans probably would call the risk-adjusted premium.

Rationing is the third big buzz-word today. What does it mean? First, today everybody accepts rationing because it's there. No health-care organisation, be it public, private or mutualist, can operate without it.

Rationing is the optimal distribution, where there is a limited budget, of available resources according to the benefit which can be expected from their application.

This morning we had a very interesting discussion. Dr. Brunner of Switzerland, for example, told us that health care had to be rationed; it was self-evident. I agree, it would be a mistake to think otherwise. Anything else would lead people to the illusion that fully effective care is possible without coming up against budgetary constraints. We know that the medical spending curve will not flatten out without budgetary constraints.

So the problem is not to distinguish useful care from useless care, hoping by eliminating the risky or pointless treatments to open up enough potential savings. That's not the problem. The problem today is to distinguish what is very useful from what is only slightly useful. Doctors can help us do this. Our Swiss doctor this morning said that rationed health will mean choices. But let's look out that we don't find ourselves back with the old system. It's not the public that must choose the values on whose basis we are to make sacrifices. We can't ask society to make these choices.

Medicine is too complicated to allow the legislator to determine that one treatment should be used rather than another. So parliaments can't make that sort of detailed decision, either. The proper choices, I believe, will be more and more decentralised, and they will have to be made by individual payer-organisations, the health funds, and implemented at national level.

It's up to each one of us in our decentralised organisations to ask a tough question:

"How can I best use the limited resources available to me as a head of a hospital or as the chief executive of a mutual health fund in the interests of the individuals I'm responsible for and whom I want to serve as best as I can?"

That's very hard to answer and it requires constant inquiry and collective reflection.

This must lead, and this is my conclusion, to a change in medical behaviour. Doctors will inevitably have to change their approach and their ethics because the results-criteria they have been using up to now are immediate, at most short-term. In future, they'll have to look at events and trends outside their immediate area of activity and at the long-term situation of the patient. The doctors have to widen their horizons. Up to now, the idea was to do everything possible for the patient. In future, it'll be: "Don't do anything that hasn't been scientifically proved to be effective."

Finally, we have to go from an individual ethic to a collective ethic. The problem will no longer be to do everything in the fear of being accused of not having helped someone in need. The concept of opportunity cost will have to be brought into decision-making. The fundamental question tomorrow will be, what is the value of the medical service provided and is there perhaps not a disproportion between the scale of resources deployed and the incremental medical benefit provided? If we find such a disproportion, then, even though the medical service might have some benefit, there must be an acceptable option not to provide it -not to save money for the social security system or the mutual health funds but simply to provide better all-round service and to save more lives within the budgetary constraints we must live with.

Paul F.M. Overmars
President, Silver Cross Insurance Group, The Netherlands

You spoke in your excellent paper about the principle of equality. It's the same everywhere: All people are equal but some are more equal than others.

Jan van Alphen
President, Silver Cross Imurance Group, The Netherlands

I have a question for Dr. Fiedler.

I understand that you want to finance medication on the basis of solidarity and unlimited entitlement. In the Netherlands, 100% of all pharmaceuticals are consumed by about 35% of the population. About a third of these consume more than 1,000 Dutch guilders-worth per capita per year. Our system allows the high consumption of medication by the chronically ill to be funded out of solidarity, while the cost of other forms of pharmaceuticals is funded in a different way. Would not this sort of distinction be useful in other countries, too?

Dr. Eckart Fiedler
Chairman of the Board, BARMER Ersatkasse, Germany

I don't want to answer that directly but refer instead to what Professor launois said, which I liked very much. At the outset he said that there are three types of competition, solidarity and rationing.

What you've mentioned now as an example of a possible cost distribution can be neatly analysed with the three-tiered model of competition. The first tier is the providers competing on service to meet the patients needs and satisfy him. The second level of service is providers competing on cost for the benefit both of the insurer and the insured. The third level of competition is between the insurers themselves who must strive to use scarce resources as efficiently as possible.

So I can't answer your question by saying that one way is better than the other. You have to see what possibilities are available and how they'll work out in a competitive situation.

But I'd like to emphasise one point. Professor launois said that this sort of competition won't work without solidarity. Competition by itself does not embrace solidarity; it destroys it. Pure competition is the pursuit of self-interest; solidarity is absolutely the opposite. So it is enormously important to define and to set the framework in which the prevalent social compensation system -whatever level we want -determines the rules of the game. That's where we need more intensive discussion.

Jan van Alphen

All right, so should the legislators set the standards for solidarity in competition? Personally, I don't think so. It's not something for the parliament or for society as a whole, nor is it something for the doctors. It's a task for us as insurers.

Professor launois said we must ensure that the doctors change their attitude. Their difficulty is that they will always have to deal with unique and individual cases. If they must go for more efficiency and effectiveness, it means constant, vigilant monitoring by us of every individual case.

Getting them to go along with this will be very controversial but that will be our task. We must avoid rationing as much as possible through more rationalisation and increased effectiveness. The principle is rationalisation rather than rationing.

Pierre Pauchard
Secretary-General, Mutuelle Nationale des Hospitaliers, France

Professor Launois, are you optimistic or pessimistic when you talk about the rationing of health care, which you defined as an optimum distribution of a given budget? It seems to me -perhaps I am an optimist -that we are still in the process of rationing health expenditure. It doesn't seem to me - but I'd like to have your opinion on this -that we are moving towards rationing of care itself.

A second question, Professor: How long would it take to succeed in changing the behaviour of physicians? Is this time scale compatible with the intended changes in France's health-financing and social security systems?

Robert Launois

On your first question: There have always been constraints. The word "rationing" is a fighting word. When you want to hit an adversary hard, especially a politician, you say he is rationing health. It's almost a term of abuse. But everybody is subject to rationing. You won't be eating caviar this evening, because each one of us in our everyday lives makes choices on the basis of the price being charged and the service that we expect to get for it. When the price is excessive compared to the service provided, we refuse to buy.

This behaviour was not explicit when our health-care system was open ended, when the coffers were overflowing, when there were full refunds for hospitals and GPs. But now, things are different: There's cost-cutting in all countries. We just have to make the best of the resources available.

Your second question was about changing the behaviour of doctors. I think we have to be careful. Lay people tend to lecture the medical world, and doctors find this absolutely intolerable. That's not how well get them to change their attitudes or their behaviour.

Paul P.M. Overmars

Another gentleman in the fourth row, please.

Roland Henri
Vice-President, Fédération Nationale de la Mutualité Française, France

It seems paradoxical to me not to address the question of funding when we're talking about cost control. We have a real problem today. Rationing should be seen not just as a reduction in choice but the denial of access to health care to whole segments of the population.

Look at the French situation. There is a considerable recession in the country: We have about 3.5 million unemployed, and this doesn't help social security funding, as anybody knows. Hundreds of thousands of jobless young people have no easy access to health care. Under the age of 25, the young unemployed have no access at all to normal treatment unless their families are covered. Seen against this general backdrop, there are very broad social problems we as mutual insurers should also address. I agree with the view that we have to look at co-operation between the various parties

involved, including the state authorities. We can't blame the doctors for all the difficulties we have today.

On the matter of budgets, we say we can't spend more than a certain percentage of GDP on health but it's not clear what that percentage should be.

For example, what share of total health-care spending in France should each individual bear? How high should premiums be, and how should they be calculated? Our present social security system was set up in 1945. It was an excellent system for its time, but there's been major change in our economy and society since then, so we at the *Mutualité française* think there's an urgent need for reform.

The financial resources are there but the difficulty is making choices. France's public health experts advise caution about basing health management purely on accounting considerations. The needs of society should also be taken into account.

Jean Hermesse
National Secretary, Alliance Nationale des Mutualités Chrétiennes, Belgium

I think it's totally wrong to talk about rationing at a time where we haven't explored all the possibilities of rationalisation by changing the behaviour of prescribers.

In all countries you can find a huge diversity in medical practices, differences from one to four in terms of consumption per inhabitant or prescriptions per doctor. These differences can't be explained by pathology alone. To take one specific example, in Belgium the health funds told 20% of the country's highest clinical biology prescribers that if they didn't change their behaviour within a year they would be subject to financial penalties. Within a year, consumption of clinical biology services declined by 30%. This was not thanks to competition, but to an information system designed to highlight excessive disparity and which knocks the bail back into the court of the service provider.

Robert Launois

This is a genuine problem. Epidemiological studies which analyse small geographic zones can show considerable doctor-to-doctor variations in professional practices and prescriptions for a given set of symptoms. But I would criticise the approach you've just described if it were merely quantitative, seeking only to reduce the number of services provided. Doctors shouldn't be allowed to ignore the problem of limited resources and of the value of the resources consumed. Of course, it's easy to say, "Do proper medicine and you'll make savings; eliminate wastage and you'll tap all sorts of potential to finance therapeutic innovation." The problem is translating that into action. The person committing waste will always tend to blame someone else for it.

You eliminate waste only if there's a constraint: No constraint, no waste-elimination. The difference between your view and mine is that you are talking about effectiveness and I'm talking about efficiency solely. I'm an economist, you're probably a doctor...

Oh, you're an economist, too! Well, all I'm saying is that if you reason solely on a medical basis you'll have doctors thinking that economic problems are not important and it's only a matter of guidelines and good clinical practice.

Dr. Eckart Fiedler

I'd like to emphasise that it's enormously important to change physicians' attitudes. That doesn't mean to blame them for everything. But doctors are driven by the ethic that they have to do everything possible for the patient. That can le ad to situations which Professor Light referred to, the intensive-care units doing too much.

We want to change the attitude of doctors because we must use our scarce resources more efficiently. We must get them to stop doing everything for the patient and start doing only what is proved to be efficient. That places huge responsibility on us and we need courage in order to follow this path.

It would be easier for us to let doctors go their own way, to blame them for everything. It's much more difficult to help them in ways that they themselves have a hard time with, and that is acting more efficiently. From this perspective, I believe it's not a question of rationing yes or no, it's about constraints, as Professor Launois said.

In Germany, for example, if a doctor's agreed spending budget is exceeded, we automatically reduce the doctor's fees. It's leading to situations where doctors are voluntarily undershooting their budget by 20%, simply because they don't want anything taken off their fee. Research shows that this doesn't reduce the quality of medical care but may actually enhance it because a series of qualitatively inadequate, expensive and ineffective prescriptions are dispensed with.

The course we have to follow now will be difficult, will involve a lot of dispute and controversy. I say this because, at the end of the day, we may have to bring in elements of coercion.

Paul P.M. Overmars

The last question is for Mr. Groom.

Dr. Kenneth Groom
Secretary-General Federation of International Health Funds, United Kingdom

Thank you very much. I'd like to thank all the speakers for the perspectives that they've given on this subject.

My question to Dr Fiedler is, shouldn't we view the patient more as a partner in the health system?

Dr. Eckart Piedler

The educational work of managed care organisations has indeed started to changed patients'attitudes. Patients ask doctors now whether a prescription is really necessary. I agree with you: Yes, we do need to view the patient more as a partner in the health system. In the past our ambitions were confined to providing total care for him. But now, circumstances are forcing us to change our attitude, and perhaps this is not only good for insurers and doctors but also for the patient.

Robert Launois

I believe there's huge potential for mutualities in this area. Professor Nichol stated the challenges we're facing very clearly: How can we combine different view points, how can we make different objectives converge when at first they seem so contradictory, even though they're all centred around the patient?

I'd think that that the mutual movement has great capacity for social and democratic innovation to resolve these difficulties. It's potentially a very fertile field. We have to place not only the patient but the citizen at the heart of the health system. We have to give the patient-citizen a right to express his views, something which was taken away from him in the past and we have to do so in a decentralised way because health choices can't be centrally regulated. They are local choices, to be made locally, by the carers who have to make decisions and want to know the views of those who directly affected by these decisions, to know if they're the right ones. Parliamentary debate will never resolve this type of issue. For example, which specialists should we specify for what sorts of out-patient visits? Nobody but the parties directly concerned can answer this sort of question.

How can the mutual movement elicit the opinions and expectations of the people it feels responsible for? Is it possible, and, if so, how? Speaking as an individual patient-citizen myself, I know of no social-security body that represents me in any way. I have no real sense of social citizenship. How can small community groups decide on the right choices? We have to find some solution to this problem.

Paul P.M. Overmars

Unfortunately I can't respond to those on the floor who have further questions for the speakers. It's now five o'clock and I've been instructed to finish on schedule. Otherwise, we'll be late for this evening's state reception by the Minister for Health.

It's very difficult at this point to try and to summarise everything that's been said. That's something we'll do in the record of the conference. So let me just very warmly thank all the speakers for their papers and also all those on the floor who took part in the discussion.

Professor Michael Arnold

I think we should also thank the interpreters for their performance, especially the German interpreter. She was working at an absolutely blistering pace. Bravo!