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Changes in the control of health care systems in Europe

Implications for professional autonomy

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Major changes are taking place in European health care systems, especially those in the former communist countries. However, in Western European countries reorganization is also on its way, guided by the rhetoric of deregulation and competition. This might lead to a convergence in the institutional control of health care systems, although it appears that different paths have been chosen by Eastern European health care systems and Western national health services. It is argued that the implications of these changes for the professional autonomy of doctors differ and this is influenced by the way health care changes tie up clinical autonomy and economical autonomy.

Key words: professional autonomy, comparative analysis, remuneration, budgets

In the past European health care systems have been classified into 3 broad systems which were health insurance systems, national health service systems and state run socialist health care systems.[1] The boundaries between these systems, however, appear to have become blurred. For example, it has been suggested that with the introduction of market principles and managerialism[2] and as a consequence of European regulation[3] the health care systems of EU countries might converge. Similarly, in Eastern Europe the health care systems are in the process of reorientation and reconstruction as a consequence of the breakdown of the communist economies. The direction of change in these countries is most probably towards health insurance-based systems.[4]

Thus, all over Europe, health care systems are changing. Starting from different origins, they might be converging towards a more or less common model that includes more market elements. These changes may have consequences for the position of doctors within their health care systems and particularly for their professional autonomy or their freedom to use their resources and organize their work.

It has been argued that in the past the market economy model of health care has tended to enhance the professional position of doctors.[5] However, of late it has been argued that the reverse has occurred in that a reduction in professional autonomy of doctors has taken place as a result of the processes of deprofessionalization, proletarianization and corporatization.[6] This argument has been put forward mainly in analyses of the US health care system. The processes behind it, such as a changing relationship between doctors and patients, increased control over doctors' work by third parties and the incorporation of doctors in large, bureaucratic organizations, have also begun to occur in other Western, industrialized countries as a result of the changes described above.[7]

The aim of this article is to examine the implications for professional autonomy of the changes in the institutional control of health care systems in Europe. Of particular interest is what the implications will be of the introduction of market principles into health care systems. The discussion begins by offering a definition of professional autonomy and market principles and then describes some trends in the development of European health care systems with reference in particular to the way these systems are controlled. One way health system changes could be related to professional autonomy is through the incentive structure that influences physicians' behaviour. Thus, in the fourth section of this paper, the question of whether under conditions of cost containment, market-oriented incentives result in changes in professional autonomy is examined. The following section goes on to discuss the reactions to threats of regulation from outside the profession and finally some implications of these issues for research are outlined.

PROFESSIONAL AUTONOMY AND MARKET PRINCIPLES

The key to professionalism and professional dominance is, according to some writers[8], legitimate, organized autonomy. While professional autonomy has a number of dimensions[7], this analysis focuses on 2 key elements: freedom of decision making about clinical matters (clinical autonomy) and working conditions and pay (economic autonomy). We regard professional autonomy as a micro-level consequence of the macro-level process of realizing an organized control by health care professions of the market for their services.[9] It might be assumed, at

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least at a common-sense level, that freedom of decision making is greater in those health care systems which follow market principles to a larger extent. This assumption has been questioned by Döhler[10]: "as opposed to commonly held opinion, there is no positive correlation between the degree of welfare state development and a reduced professional autonomy of physicians" (p.195). Thus, in the following analysis we explore 2 questions. First, under what conditions does the introduction of market principles into health care systems lead to a change in professional autonomy? Secondly, are clinical and economical autonomy differentially affected by health care system changes?

Before we examine these questions we have to elaborate what we understand by market principles in the case of health care. By markets we do not mean the absence of institutions and regulations. Rather, we see markets as a system of rules and regulations that aim at optimal eliciting of demand and at the tuning of demand and supply by the price mechanism. Opposite to markets one can place organizations or hierarchies, where the extent and level of demand is defined by managerial or political decisions and resources are allocated through planning.[11a–c] Health care, even in the most market-like situations, is surrounded by an extended system of rules and regulations. The difference lies in the way allocative decisions are being made. In more market-oriented systems money follows patients, either directly or through third-party payers, while in less market-oriented systems money is allocated by block grants. This distinction applies to physicians' services (fee for service versus salaries) as well as to third-party payers (risk equivalent insurance versus allocation of tax money).

INSTITUTIONAL CHANGE IN EUROPEAN HEALTH CARE SYSTEMS

In a comparative perspective, the way health care systems change might be analysed in terms of convergence, diffusion or supranational regulation. The convergence hypothesis has been described by Field[1] as follows: "in spite of widely different cultural and historical backgrounds and a variety of types for the management and organization of health services in different societies, the health system of these societies, over time, will tend to resemble each other in their relationship to the society, in their relationship to other subsystems, in their internal complexity, and in their response to roughly similar socio-political forces and technological factors" (p.778; see also Mechanic[12]). The mechanism, assumed implicitly in this definition, is that of gradual adaptation. The direction of change is not specified, although in the economic literature a trend towards centralization is hypothesized.[13]

The breakdown of communist systems shows that there is not necessarily a gradual process of adaptation, but rather a process of diffusion and adoption of concepts and ideas, developed elsewhere. The diffusion of concepts and ideas from one health care system to the other is also illustrated by the uptake of ideas of managed competition. The idea of fundholding general practices, as introduced in the UK, was inspired by the US experience with Health Maintenance Organizations.[14]

The development of European Union health care systems will, at least partly and in the long run, be affected by supranational regulation, although changes are not necessarily (nor most probably) towards what Schneider et al.[3] have called harmonization (uniform systems of insurance and benefits).

In the institutional ordering of health care systems one usually distinguishes between professional control and bureaucratic control[15], where bureaucratic control might relate either to government regulation or to corporatization. However, a new system of control seems to emerge in which managerialism and the structuring of relations through contracts are important features. This departs from bureaucratic control in that less emphasis is placed on internal rules and regulations and from professional control in that other parties involved in contracts, such as third-party payers, increase their influence.[16]

Governance by contracts is traditionally an important feature of health insurance-based systems, but what is changing now in these systems is the power of governments, which appears to be decreasing and the power of health insurance organizations, which appears to be increasing.[17] Where control of inputs used to be important, the emphasis now changes to the relation between input and output or, in other words, efficiency.

Cost containment takes on a different form depending on the type of health care system. In national health service systems (publicly funded and publicly operated systems), cost containment is attempted by shifting responsibility for budgets towards (groups of) providers. In social insurance-based systems (publicly funded or mixed funded and privately operated) responsibility is shifting towards the insurance organizations. In both cases negotiating and contracting becomes more important.

Although these developments might indicate some degree of convergence of the control of health care systems in Europe, there are rather important differences in the point of departure and the path taken of different groups of health care systems. The national health service-type systems of the UK and some of the Scandinavian countries start from a publicly funded and publicly operated system.[18] In this case increasing efficiency is sought, e.g. in the case of the UK, in separating the provision and purchasing of care. This introduces the necessity of contractual relationships between publicly funded and operated organizations, the internal market. Also part of the budgets are shifted to purchasers, such as in GP fundholding. This line is also followed in some Swedish experiments. Although there is some room for private funding as well as private provision, this seems to remain rather marginal.[19]

The health care systems of the former communist countries were strongly tied up with the organization of economic activity, e.g. through separate health care for factory workers. Notwithstanding the important differences between systems, one could say that in general they have ample physician staffing, usually specialized, but often

lack ancillary staff and material and technical equipment.[20] The trend in reorganizations in most countries is towards the introduction of a health insurance system, decentralization, independent health facilities and providers and freedom of choice of the health provider. Although the experience with communism makes it difficult to create legitimation for a publicly funded and operated system, in a national health service-type system, the existing infrastructure could possibly be used more effectively. Moreover, health care providers understandably estimate their income potential to be higher in independent practice with social insurance funding. Breaking up of the existing organizational structures amounts to a process of decorporatization.

The health insurance-based systems (e.g. Germany, Belgium, France and The Netherlands) start from a largely privately operated provision and, depending on the system, public funding through social insurance or a mixed private and public insurance. The trend in reorganization in these systems is towards a lesser role of government and, hence, less regulation of health care supply and facilities. This increases the importance of health insurance organizations, be they private or public, in monitoring the performance of providers, including the possibility of discontinuing contracts. Market elements include competition between insurance organizations and between providers.[21]

INCENTIVE STRUCTURES AND PROFESSIONAL AUTONOMY

Changes in the control of health care systems and particularly the introduction of elements of competition in health care affect the incentive structure that governs the behaviour of health care providers and organizations. Through the incentive structure these changes influence the behaviour of physicians by increasing or reducing their freedom of choice. The link between health system change and professional autonomy is consequently in the way the incentive structure changes the freedom of choice of physicians.

In this section we focus on 2 elements of the incentive structure. The first is the way physicians are paid for their services. The second concerns the scope of budgets available for physicians' services, i.e. whether they refer to national or regional (macro-) budgets or to specific budgets for small groups of providers (micro-budgets). In this section we elaborate on the argument put forward by Döhler[10] who states that "loss of professional autonomy occurs when the physician is forced to take into account external – especially economic – calculation" (p.179).

Systems of remuneration

One mechanism through which elements of competition are introduced in health care, is remuneration systems for physicians' services. Here, we focus specifically on the relationship between remuneration systems and clinical and economic autonomy. Remuneration systems vary in the extent to which they encourage competition and profitability. At one end of the continuum of the incentive structure is payment through salary where there is no competition between doctors for patients or contracts. On the other hand, the fee for service reimbursement system creates incentives for doctors to compete for patients. Capitation systems fall somewhere in between the 2 extremes.

Remuneration systems differ in the degree to which they tie up clinical and economic decisions. Under a salary system clinical decision making and its economic consequences are unrelated, whereas under fee for service systems clinical decisions have direct consequences for economic outcomes. Under capitation systems clinical decisions indirectly affect economic outcomes by maintaining patient lists.

These relationships within incentive structures have important implications under conditions of scarcity of resources. If there is a cost containment programme, it is possible under a salary system to control economic costs without directly intervening in clinical decision making. In fee for service systems interventions aimed at constraining costs will try to influence the volume and/or the price of services. Hence, they will have a direct impact on clinical decision making. This line of reasoning suggests, therefore, that under conditions of cost containment the introduction of market principles in the form of changes in the system of remuneration might have negative consequences for clinical autonomy.

The introduction of fees for separate services instead of salaries or capitation payments increases the extent to which clinical decisions affect the amount of money earned by physicians. The more clinical decisions affect the income earned by physicians, the more attempts at cost containment by government or insurance organizations will be directed towards influencing clinical decision making and, hence, reduce clinical autonomy.

The very tight economic situation of the former communist countries makes cost containment necessary. In this situation, the introduction of health insurance and market elements in health care might not result in the increase of professional autonomy that providers hope for.

Macro-budgets

Depending on the system of financing health care, cost containment has different consequences for professional autonomy. In health care systems that rely mainly on private insurance, macro-budgets, if they exist at all, are mainly retrospective targets and not real budget caps. Apart from trying to reduce demand, cost containment is only possible by influencing clinical decision making. In health care systems that rely mainly on social insurance or taxation, cost containment aims more at negotiating a macro-budget.[22] In this case cost containment affects the economic situation of physicians; there is less money to divide, but there is no direct intervention in clinical decision making. The stricter the control over the total amount of resources allocated to health care, the less necessary is individual control over medical decisions.[23] Macro-budgets with income negotiations might be more protective of threats to professional autonomy than

macro-budgets with fee negotiations. As Döhler[10] puts it, "It looks as if existing cost containment institutions and procedures, in particular regulations of doctors' income, lead away from incursions into professional autonomy" (p.196). Macro-budgets with fees for services might lead to fee inflation. Individual physicians have an interest in increasing the number of highly paid services they can bill for, but in increasing their number of services the level of reimbursement of the services will decrease for all physicians, while the collective interest is in maintaining an equilibrium. The larger the group of physicians sharing a budget (as in macro-budgets), the higher the chances of fee inflation. The external effects on the other physicians of individual physicians rendering more services give impetus to internal organization and regulation in the form of mutual control through audit or the acceptance of external control.[24]

Micro-budgets

Micro-budgets as in GP fundholding at least in theory may increase the accountability of GPs to the funding authority. At the same time, as the fund also extends to the actions of other primary care team members, it might also increase managerial control of GPs over the other team members. The historically dominant position of the medical profession within the health care division of labour, coupled with the new role of GPs in the management and control of resources, may mean that they are actually more able to control the division of labour and to delegate unwanted tasks and duties to practice nurses and other members of the primary care team.[25]

Micro-budgets have also been introduced at the level of hospitals in various health care systems. Hospital budgets combined with fee for service payment for specialists lead to tensions between hospital management and specialists, in particular when specialists' fees are not part of the hospital budget, as in The Netherlands. In GP fundholding accountability is based on the level of agreed-upon budgets and not on the number of separate services. In hospitals with fee for service specialists accountability is based upon levels of clinical production. Hence, although in both cases accountability to authorities outside the profession increases, GP fundholding will have fewer consequences for clinical autonomy.

PROFESSIONAL REACTIONS TO EXTERNAL THREATS OF REGULATION

Self-regulation is a characteristic reaction of professions towards external threats. Standards, protocols and peer review have by now been introduced on a voluntary basis in different fields of professional behaviour. Their introduction has been triggered by health services research documentation of variations in professional behaviour that cannot be explained by clinically relevant differences in patients' characteristics.[26]

The development and publication of protocols appears to have had 2 consequences. Firstly, they are used as the basis for third-party payers to introduce forms of prospective payment. Secondly, they also provide users of health care and consumer organizations with information which allows them to judge the quality and appropriateness of care. Outside regulation of drug prescribing is a good example of how successive cost containment measures tend towards influencing professional autonomy. The volume and cost of pharmaceutical prescriptions differ strongly between countries and so does the trend in volume and cost over time.[27] Influencing patient demand through co-payments appears not to be able to contain prescribing costs. Attempts at professional self-regulation by groups of physicians, e.g. through agreements on preferred drug lists, auditing or involving community or hospital pharmacists, are promising. However, by their very nature these attempts are small-scale activities, developing only over time. Indicative drug budgets for GPs (as, for example, in the UK) might speed up these developments by limiting economic autonomy in this respect without directly intervening in clinical autonomy.[28] In some other health care systems (The Netherlands, Germany and proposed in Sweden) reference price systems have been or will be introduced. In these systems only the price of a cheap reference drug within an equivalent group will be reimbursed by the health insurance organizations. If the physician prescribes or the patient insists on having a drug that exceeds the reference price, the patient will have to pay the difference. A system like this indirectly intervenes in the freedom of clinical decision making, whilst the introduction of a restricted drug list would directly affect the freedom of decision making.

CONCLUSION

In the preceding sections we have formulated ideas and hypotheses that give a tentative answer to the question as to what consequences the introduction of market principles in health care has for clinical and economical autonomy of doctors. In summary, we think that clinical and economical autonomy will be differentially affected by the health care system changes going on in Europe. The reason for this is that health system changes differ in the degree to which they tie up clinical decisions and their economic effects. This in turn might depend on the following groups of conditions:

- cost containment measures and levels of funding,
- systems of remuneration and
- the scope of budgets (micro- or macro-budgets).

A comparative study of health care systems should, of course, focus on monitoring the changes that are currently occurring both east and west. As important, however, is the theoretical analysis and subsequently the testing of hypotheses on the relations between changes in the institutional control of health care systems, the incentive structures and the behaviour of professionals.

Reduction of professional autonomy could well occur as a result of the changes in Western health care systems, but not where they might be expected most on the basis of common-sense ideas. We do expect them not so much in national health systems with budget caps, but rather in fee for service systems with fiscal austerity and strong cost containment policies. Self-regulation, as a reaction to

external threats to autonomy, might have unintended consequences. The voluntary development and introduction of standards and protocols might delay external intervention by governments and insurance organizations and, hence, keep professional autonomy safe. At the same time it provides patients and their organizations with information. The claim that increasing knowledgeability is a source of deprofessionalization, becomes more substantial as standards of care are being published both by professional organizations[29] and by consumer organizations. The largest Dutch consumer organization, Consumentenbond, recently published excerpts from standards of care developed by the Society of General Practitioners in its monthly.

The changes occurring now in Eastern Europe form a natural research laboratory for health services research. Will the professional autonomy of medicine be enhanced by the breakdown of existing structures? Attempts to reorganize as a profession by starting new professional associations and redesigning medical education, will not automatically grant them professional autonomy particularly in a situation of rising public expectations that cannot be fulfilled. Moreover, the poor economic situation may force a newly established insurance system to control physicians' cost-generating activities tightly. Hence, lack of public legitimation and support might lead physicians in these countries from the whims of state control (at the macro-level and at the level of day to day practice) to the external regulation by insurance organizations, especially when fee for service is chosen as the method of payment.

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