Technische Universität Berlin

Hospital autonomy and regulation in the Europe

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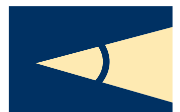
Scenario 1

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 (which has been the norm in some European countries), 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.

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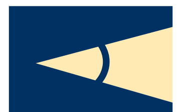
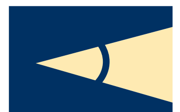


Two types of “non-regulation“

Both hospitals are not regulated. In the first case, there are intentionally no regulations to restrict the market behaviour of the hospital owners and/ or managers, in the latter case the hospital is subject to public sector ”command-and-control”. In practice, most European hospitals fall some-where between the two extremes and require more regulation than these two.



The diversity of hospital types in Europe

- insufficient and misleading traditional classification (e.g. in OECD database): public, private not-for-profit, private for profit
- public hospitals encompass wide range from "budgetary" via „autonomous" to „corporatized"
- public autonomous = private not-for-profit?
- what about "public enterprises" with partly private ownership?
- big differences between contracted and other private for-profit hospitals

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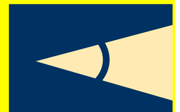

Public-private ownership in Bismarckian countries

	Public	Not-for-profit	For profit
Austria	69%	26%	5%
Belgium	60%	40%	
France	65%	15%	20%
Germany	55%	38%	7%
Luxembourg	50%	50%	
Netherlands		100%	

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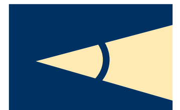

Regulation requires autonomy and autonomy requires regulation

- The main emphasis of governments in many European countries has been on making hospitals autonomous (or even corporatized);
- but: road to autonomization varies widely

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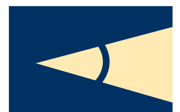

How do countries autonomize?

- purchaser-hospital (provider) split
- introduction of contractual relationships between purchasers and hospitals (like in Bismarckian systems)
- increase decision-latitude of hospital about services, staffing etc.
- increase financial autonomy (“residual claimant“ status)

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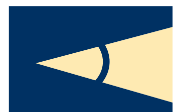
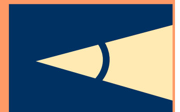


Caveats

- autonomization may lead to greater control of hospitals by central government (UK)
- pursuing devolution (e.g. to regions) and hospital autonomization may be contradictory actions (e.g. if regional governments have other ideas)
- certain forms of corporatization (e.g. public enterprise with shares) may lead to full privatization, even if contrary to initial plans



Dimensions and trends in western Beveridge countries

Purchaser-hospital split	Relationship between purchaser and hospital	Decision-latitude for hospital about services, staffing etc.	Financial autonomy of hospital	Closeness to regulator ("regulator-hospital split")
Traditionally not existing; fully introduced in UK, Finland, Italy, Portugal and to a lesser extent in Spain, Sweden and Denmark	Traditionally part of the same hierarchy; contractual arrangements introduced as result of purchaser-hospital split (notable exception: Italy)	Slightly to considerably increasing, e.g. in UK and some hospitals in Italy, Spain and Sweden	Moderately to considerably increasing, e.g. in UK and some hospitals in Italy, Portugal and Sweden	UK: increasing closeness; other countries decreasing (Italy, Portugal, Spain) or continuously distant (Finland, Sweden)

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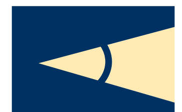

Dimensions and trends in western Bismarckian countries

Purchaser-hospital split	**Relationship between purchaser and hospital**	**Decision-latitude for hospital about services, staffing etc.**	**Financial autonomy of hospital**	**Closeness to regulator ("regulator-hospital split")**
Traditionally existing	Traditionally collective contracts between sickness funds as purchasers and hospitals; in Austria and France increasing governmental involvement through regional purchasing agencies	Usually limited; no uniform direction of reform	Existing and arguably increasing through prospective forms of reimbursement, at least if they allow retention of profits	Generally distant; increasing closeness in Austria and France

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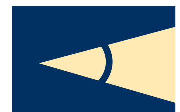

Types of regulation by intention and impact

- Pro-competitive regulation that stimulates market opportunities
- Pro-competitive regulation that restricts individual market-driven behaviour
- Regulation restricting hospitals to achieve social objectives as access, social cohesion, public health/ safety, quality, and sustainable financing
- Regulation without good reasons

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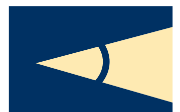
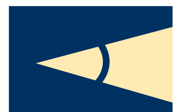


Pro-competitive regulation that stimulates market opportunities

- 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



Pro-competitive regulation that restricts individual market-driven behaviour

- Include case-mix adjusters into flexible reim-bursement system (i.e. restrict adverse selection)
- Restrict (horizontal) mergers and acquisitions of other hospitals
- Restrict (vertical) mergers, acquiring and operating other healthcare institutions

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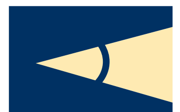
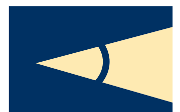


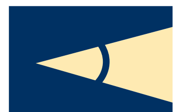
Regulation restricting hospitals to achieve social objectives

- Regulate minimum service hours
- Mandate delivery of services to everybody
- Make accreditation/ quality assurance/ health technology assessment mandatory
- Mandate the public disclosure of performance ("league tables")
- Set uniform or maximum price/ reimbursement or regulate that it is done by self-governing actors



What areas need to be regulated?

- To **enable hospital care**: establishment of hospitals, capacity and technology
- To **specify and reward hospital services**: access, types, quality and prices
- To **protect hospital employees**
- To **steer the business behaviour** of hospitals: e.g. mergers, financial reserves, advertisements



Enabling hospital care

- Planning of capacities,
  ex-ante (= before hospitals are built) or
  ex-post (= contracts for existing hospitals)
- Combining planning with money for investments
- “Certificate of need“ for high technology

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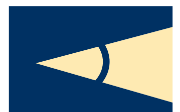
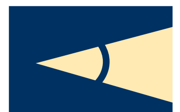


Specifying and rewarding hospital services

- Access: disallow patient selection, mandate non-scheduled admissions, require physician staffing around the clock, allow patient choice
- Types of services: There may be a case to restrict certain ambulatory services if they can be delivered more efficiently outside hospitals.
- Quality: require accreditation, QA programmes, public disclosure of results (e.g. ranking lists)
- Prices: transparency and administrative ease are advantages of uniformly regulated prices but ...



Protecting hospital employees

- equal treatment, opportunities and pay for men and women (76/207/EEC and 75/117/EEC)
- right to part-time work (97/81/EC; 98/23/EC)
- safeguarding of employees' rights in the event of transfers of undertaking, businesses or parts of businesses (77/187/EEC; 98/50/EC)
- working times (93/104/EC)

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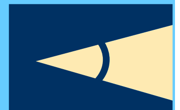

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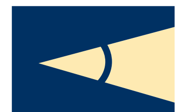
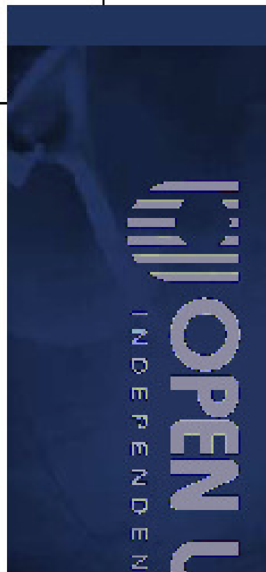
Steering the business behaviour of hospitals - the UK example

The UK-NHS has addressed this topic in a guidance titled ***"The operation of the NHS internal market: Local freedoms, national responsibilities"***.

Besides the question of **mergers**, the guidance regulates the exit of providers as well as conduct concerning **pricing and costing** as well as **collusive behaviour**. Examples of collusive behaviour are given: price-fixing, market-sharing agreements, collusive provider tendering for contracts, **lack of competition** at the contract renewal stage, and unjustifiable purchaser support for inefficient units. The difficulties of detection are acknowledged, especially as providers may engage in tacit rather than overt collusion. The **penalties** for collusion are cancellation of the contracts and "management action".





Regulating entrepreneurial behaviour in European health care systems

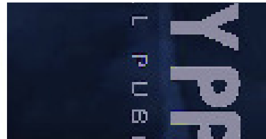
- What have been the major trends in entrepreneurial behaviour and regulation in European health care?
- To what degree do approaches to regulation and entrepreneurialism differ amongst subsectors and countries across Europe?
- What does the evidence show about successes and failures, and which successful options are open to policy-makers?

A wide range of entrepreneurial initiatives have been introduced within European health care systems during the last decade. While these initiatives promised more efficient management, they also triggered concerns about reduced equity and quality in service provision.

This book explores emerging regulatory strategies that seek to capture the benefits of entrepreneurial innovation without sacrificing the core policy objectives of a socially responsible health care system. It opens with an extended essay on current trends and evidence across health care subsectors and across countries, presenting a wide range of alternatives for policy-makers, and assessing their relative advantages and disadvantages. It then reviews entrepreneurialism and regulation in

Chapter 6: Regulating entrepreneurial behaviour in hospitals: theory and practice.

y Busse R, van der Grinten T, Svensson P-G.



Hochschule in Hannover.

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The contributors

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