Balancing Regulation and Entrepreneurialism in Europe´s Hospital Sector

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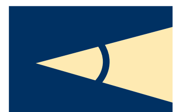

on Health Care Systems

Topics discussed

- What is regulation?
- Why regulate?
- Who regulates?
- How to regulate?
- What to regulate?
  – the example of hospital care

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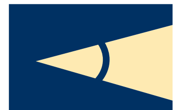

Scenario 1

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,

including the freedom to choose a **location**, determine the **size**, decide on the **range of technology and services** offered, set **price levels** and **refuse to accept certain patients**,

the right to decide on **staffing numbers** and **qualification mix**, the working conditions of the employees and their **salaries**.

There would be **no restrictions on business relationships** with suppliers and other hospitals, including the right for **mergers** and horizontal and vertical **takeovers**.

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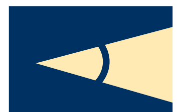


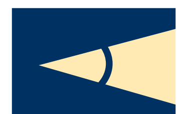
Scenario 2

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 **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 infra-structure, they have **no independent relationships with other actors** and no room for mergers or takeovers.



- Both hospitals are not regulated, either **intentionally not to restrict the market** behaviour of the hospital owners/ managers, or due to public sector **”command-and-control”**.
- There has been a visible move towards more autonomy and market-style mechanisms to providers and other actors and to re-direct politics to **“steer-and-channel”**, requiring regulation.
- Hospitals in most European countries now fall somewhere in between the two extremes and require a carefully calibrated set of regulation.

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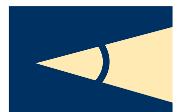

The diversity of hospital types in Europe

- 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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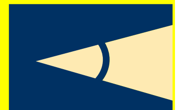
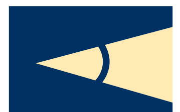


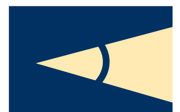
Public-private ownership of hospital beds in Bismarckian countries

	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%	



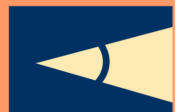
How do countries autonomize?

- 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)



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

European Observatory on Health Care Systems 

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 intro-duced as result of purchaser-hospital split (notable exception: Italy)	Slightly to consi-derably increasing, e.g. in UK and some hospitals in Italy, Spain and Sweden	Moderately to consi-derably increasing, e.g. in UK and some hospitals in Italy, Portugal and Sweden	UK: increasing closeness; other countries decreasing (Italy, Portugal, Spain) or conti-nuously distant (Finland, Sweden)

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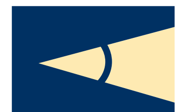

Dimensions and trends in western Bismarckian countries

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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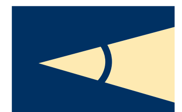

For discussion: CEE and NIS countries

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”)
PLEASE THINK ABOUT THE HOSPITALS IN YOUR OWN COUNTRY AND DISCUSS THE FOLLOWING BOXES FOR THAT COUNTRY – CONSIDER PAST AND PRESENT				

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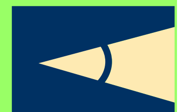
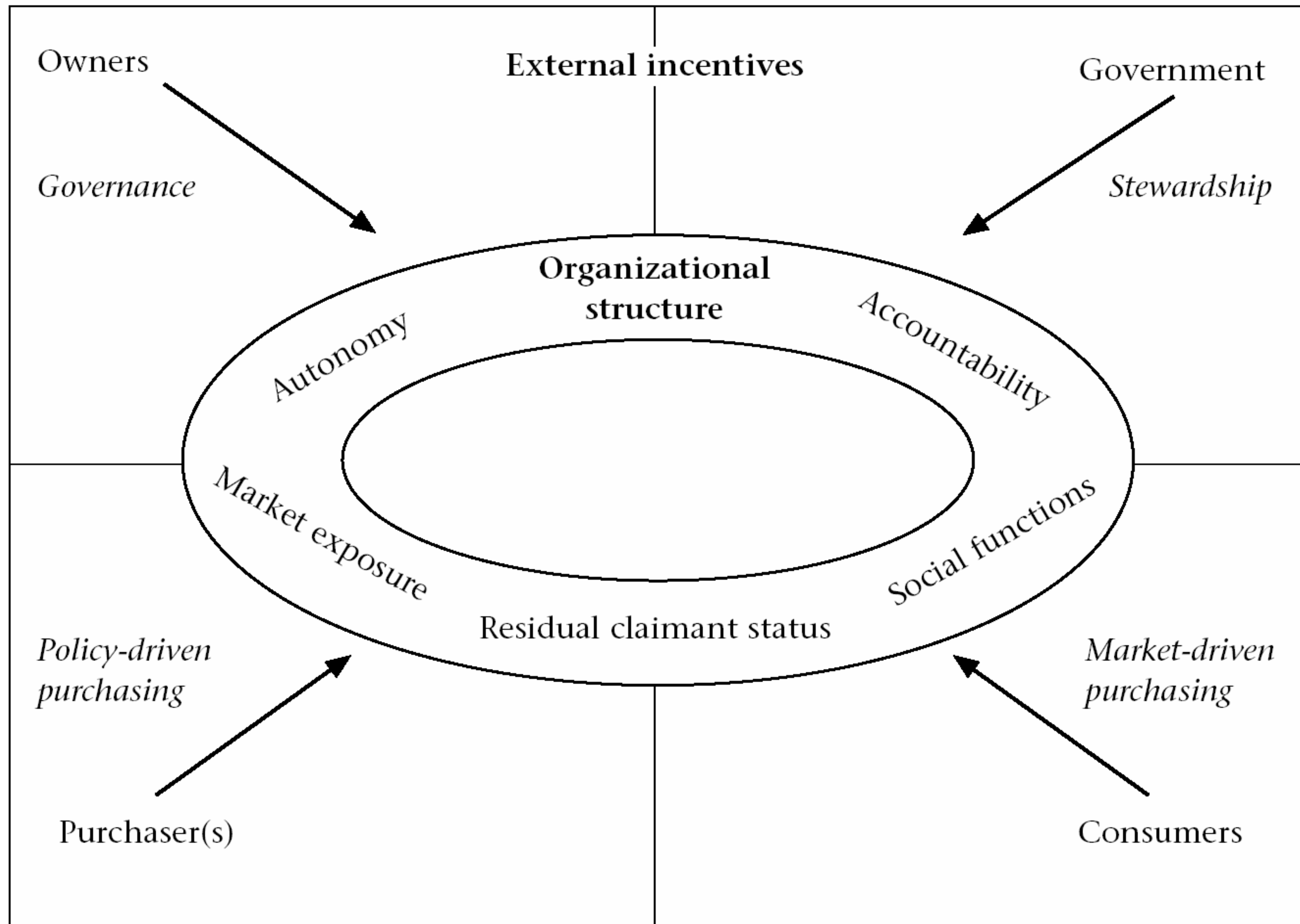
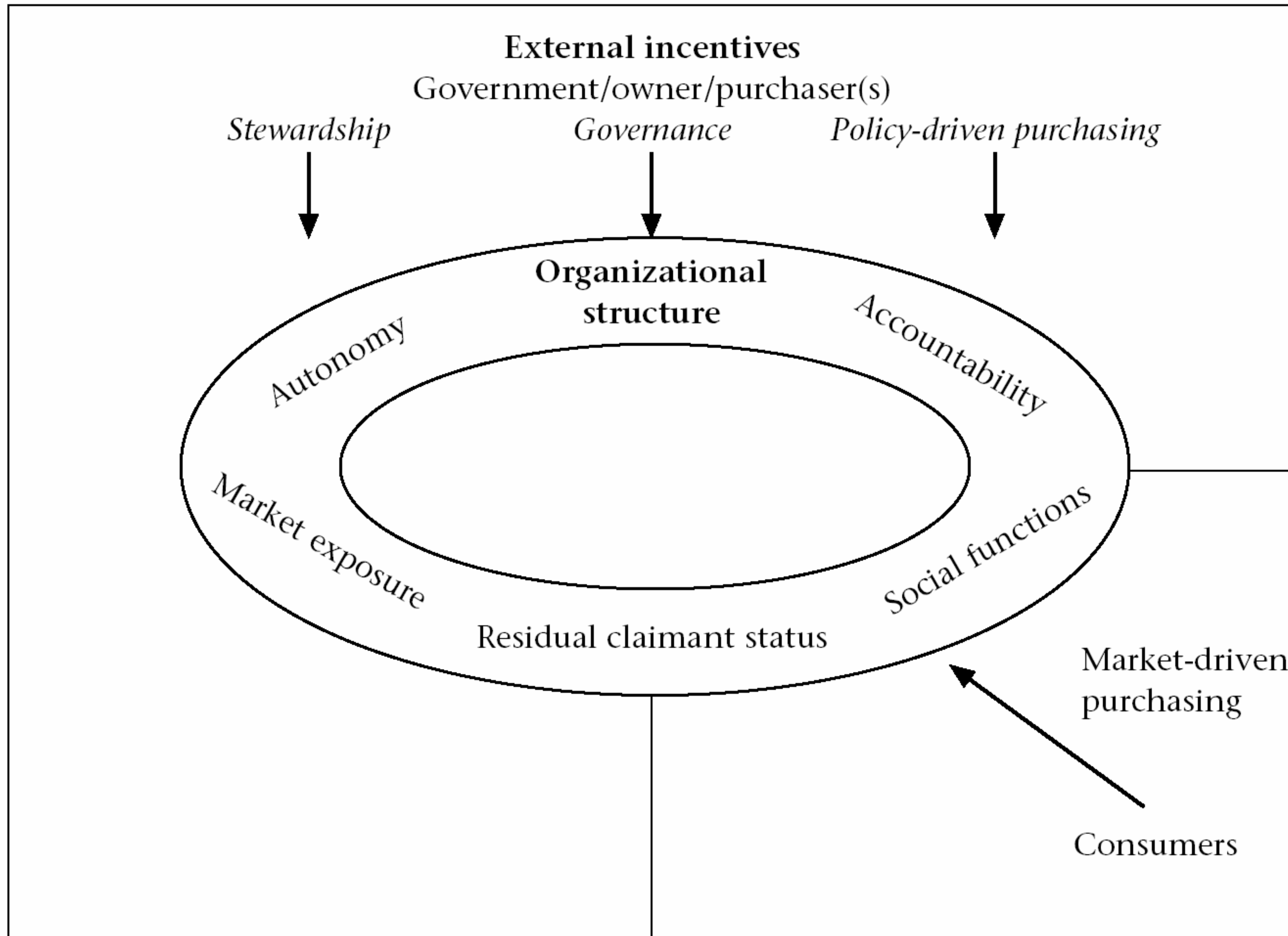


Figure 9.1 Determinants of hospital behaviour



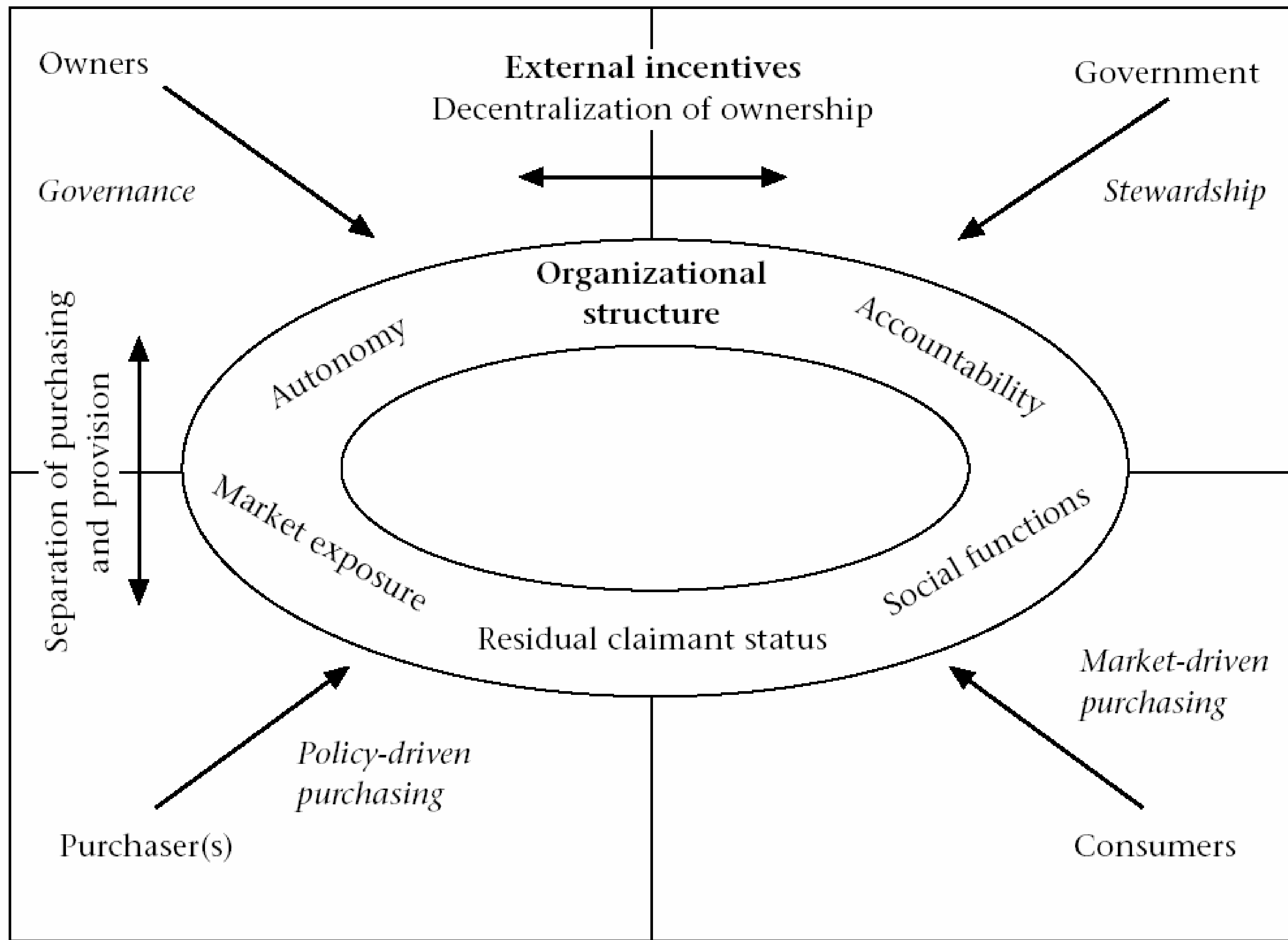
Source: Jakab *et al.* (2001)

Figure 9.2 The hospital environment during communism



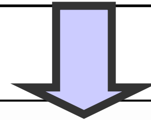
Source: Jakab *et al.* (2001)

Figure 9.3 The hospital environment during transition

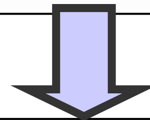


Regulation in the health sector can mean any of these things:

Mandatory rules enforced by a state agency



All state efforts to steer the sector (including state ownership, contracting, taxation and incentives)

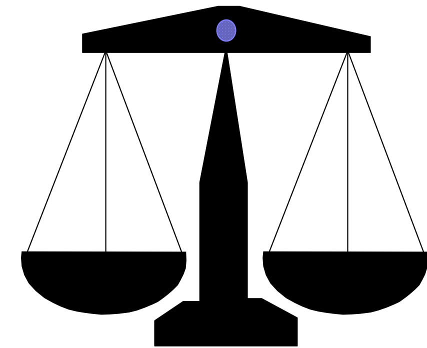


All social control mechanisms (including non-governmental tools as professional norms or societal values)

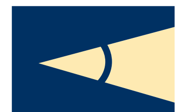
Why Regulate?

Rationale for Health Sector Regulation

To achieve **social objectives**, e.g.:



- Equity and justice: Ensuring needs-based access to health care for the whole population including elderly, poor, rural etc.
- Social cohesion through NHS or SHI
- Individual choice of provider and/or insurer.
- Health and safety: worker protection, public health, health service effectiveness
- Economic efficiency



Why Regulate?

Rationale for Health Sector Regulation

To address the question **"How are we going to make it work better?"**, e.g. by:

- effectiveness and quality of services: assessing cost-effectiveness and deciding upon benefits basket (incl. positive/ negtive lists), training health professionals, accrediting providers,
- patient access: gate-keeping, co-payments, rules for subscriber choice among third-party payers, GP location planning,
- provider behaviour: transforming hospitals into public firms, capital borrowing,
- rules for contracting between payers and providers

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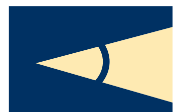
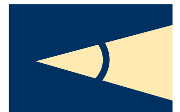


Who Regulates?

“Governmental” Regulation

De facto more complicated:

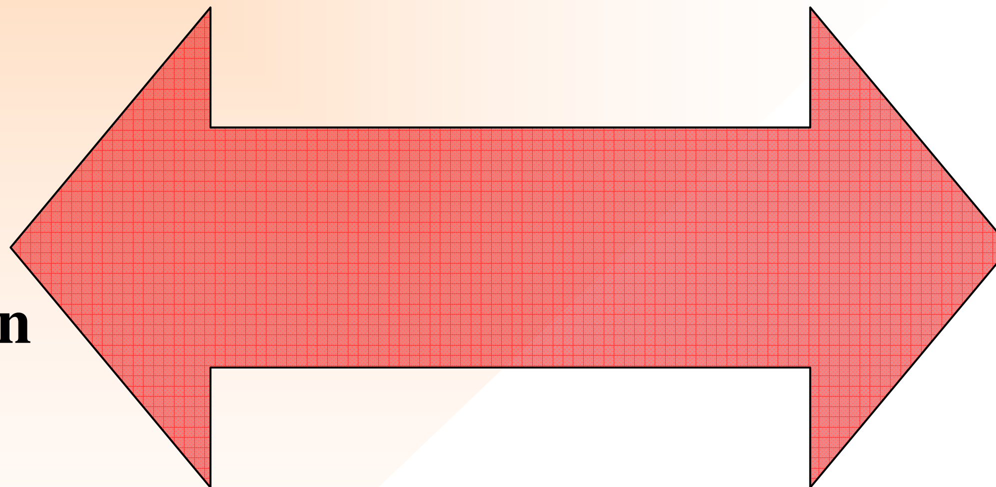
- Parliament/ legislative branch: laws
- Cabinet/ executive branch: decrees
- Courts/ juridicial branch: rulings
- Devolution to regional/ local authorities
- Independent Regulatory Authorities/ Agencies



Who Regulates?

(Enforced) Self-Regulation

Low *Degree of government enforcement* **High**



Purely private self-regulation

State-mandated self-regulation

e.g. certification by professional associations, contracts between sickness funds and providers

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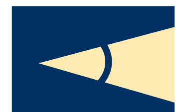
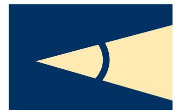


Self-Regulation
Advantages and Disadvantages

Advantages	Disadvantages
• High commitment to own rules. • Low costs to government. • Enforcement and complaints procedures more effective.	• Professional self-interest. • Legal oversight may be problematic. • Inappropriate for areas as antitrust regulation.

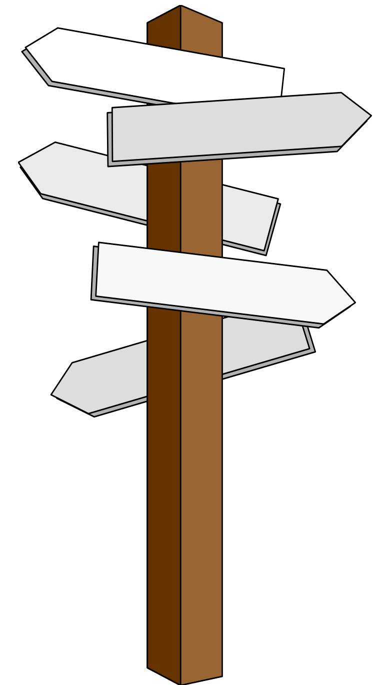


Who Regulates?

Government versus Self-regulation

Who regulates what depends upon:

- The type of activity being regulated.
- The segment of the health system being regulated (hospitals, physicians, insurers).
- The capacity of various regulators.
- A variety of national factors including institutional structure and cultural traditions.



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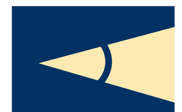

Government Versus Self-regulation

The International Experience

- Efficiency (e.g. capacity, antitrust) regulation is mainly *governmental*.
- Quality issues are good candidates for *self-regulation*.

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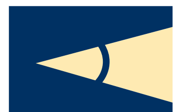


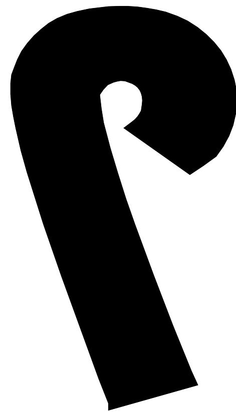
How to Regulate?

Overall Regulatory Strategies

Legal controls

"The stick"

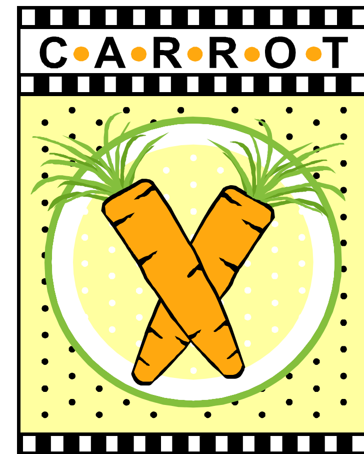
Providers must conform to legislative requirements and face punishment if they don't.

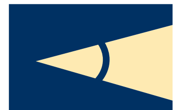


Incentive Schemes

"The carrot"

Providers modify their behavior in response to incentives.





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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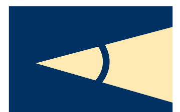
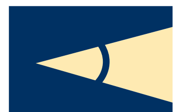


Pro-competitive regulation that stimulates market opportunities

- Replace input-oriented budgets with contract-based performance-related reimbursements
- 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
- European Union 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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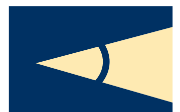
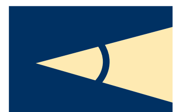


Regulation restricting hospitals to achieve social objectives

- 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

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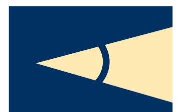
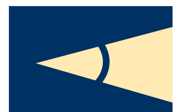


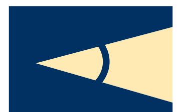
Enabling hospital care

- 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



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
- 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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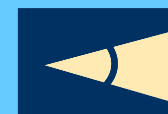

Finally, remember that

regulation is an inherently political and cultural process. There is no universally appropriate model.

Illustrations of this can be found in:
R.B. Saltman/ R. Busse/ E. Mossialos:
Regulating entrepeneurial behaviour in European health care systems
European Observatory on Health Care Systems series
Open University Press, February 2002

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