Private Delivery and Public Goals:

Mechanisms for Ensuring that Hospitals Meet Public Objectives

Background Paper

prepared for the World Bank

by

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Executive Summary

How can government ensure that private delivery still adheres to societal goals? In particular, what mechanisms are available to ensure that private hospitals act in accordance with broader public objectives? This complex endeavor is complicated by the fact that there are multiple, often conflicting objectives which might be pursued. An optimal system would provide timely access to quality care for those who need it, at reasonable cost. This is not simple to achieve. This paper applies a conceptual framework to case studies of four jurisdictions - Australia, Canada (the Province of Ontario), Germany, and the Netherlands - to examine policy options and assess the likelihood of success.

This paper begins by distinguishing among three elements of health care systems (financing, delivery, and allocation) and among multiple levels of public and private. The analytical framework employed accordingly includes the following elements:

1. Categorization of hospitals into one of five ownership types:
   Ownership type 1: Public, managed by health system;
   Ownership type 2: Public, managerially independent;
   Ownership type 3: Private Not-for-profit (NFP);
   Ownership type 4: Private For-profit, Small business (FP/s); and
   Ownership type 5: Private For-profit, investor-owned Corporation (FP/c)

2. Specification of which goals the system might wish to attain, with a focus on goals related to access, quality, and cost.

3. Categorization of policy instruments into one of five types, ranging from low-coercion provision of information and encouragement (exhortation), through expenditure (including use of competitive models), taxation, regulation, and public ownership

4. Identification of six categories of actors who might ensure that the goals are being met: individual consumers; individual providers/provider organizations; professional bodies/associations; arm’s length organizations; payers; and
government.

After discussing each element of the framework, aspects of the production characteristics of various goods and services are noted, with particular attention to their *contestibility*, *measurability*, and *complexity*. One size clearly does not fit all. The framework is then applied to consider how policy makers might deal with a series of 7 specific issues illustrating these policy goals: a) capacity (capital planning); b) setting costs and prices; c) determining what services are offered; d) access (determining who would get services); e) health human resources (who can be hired, and what they would be paid); f) quality control within institutions; and g) information provision.

Although many analyses assume that government is the only party attempting to achieve these goals, in practice, we found that a host of other actors are also involved. These vary considerably by policy goal. In particular, quality is usually addressed by professionals, professional associations, and other arm’s length bodies, rather than by government itself. However, in the final analysis, these efforts are usually backed up by some formal mechanisms requiring governmental approval. For example, health professionals may license and regulate their members, but government allows them the privilege of self-regulation, and enforces their monopoly over the provision of certain services.

Similarly, a range of policy instruments have been employed by the jurisdictions examined, which interact in a complex manner. Advocates of the currently popular expenditure mechanisms relying upon competition stress the importance of being able to verify the activities of those receiving contracts for their services; this in turn assumes that measurability is high. However, because production characteristics vary by sub-sector, this is not always true. One can envision monitoring the accuracy of laboratory tests or the purity of pharmaceuticals; it is less simple to see how one would monitor the contents of an office visit to a physician. Monitoring also carries significant transaction costs, particularly if trust is low. Where measurability is not high, most jurisdictions have therefore chosen to operate in a high trust environment where they can rely more heavily on values and stewardship. In turn, such high trust models would appear to be a better fit with NFP or FP/s delivery models than with FP/c, because corporate structures have conflicting imperatives to maximize return on investment to their shareholders.

Our results indeed suggest that incentive structures for FP/c ownership may not coincide
with public goals. In particular, such firms are unlikely to wish to serve those patient groups who would not generate a sufficient profit. Unprofitable clients may be found in certain geographical areas (e.g., poorer communities, which Australia found could not generate enough revenues to support their FP/c hospitals), among particular groups (e.g., those without adequate insurance), in particular disease categories (depending upon the reimbursement structures), or even within disease groups (e.g., if payment is per case, there are incentives to avoid the most expensive cases within that category). Highly competitive models may also undermine tendencies for cooperation. We are accordingly not sanguine about being able to design a purely regulatory regime which would incent FP/c providers to bring about socially desired results with respect to cost or access goals.

However, it is important to note that ownership structure does not act alone. Although not the focus of this paper, the incentives built into allocation formulae may also be crucial. As one example, the literature clarifies that even with public or NFP ownership, linking payments to individuals (e.g., capitation) or otherwise capping reimbursements may lead to ‘quality skimping.’ Capped budgets may reduce the volume of services offered; service-based budgets may increase them. Although theorists have argued that this can be dealt with through proper accountability measures, the literature also suggests that being able to set sufficiently detailed rules, in advance, to ensure incentives do not lead to undesired results is difficult, and that, even if possible, the regulatory and informational requirements necessary to do so would impose sizeable transaction costs. In consequence, it is very hard to regulate capacity without regulation, especially where ownership and management are fragmented.

In contrast, our review suggests that it would be more feasible to ensure quality, regardless of ownership type, if (a rather optimistic assumption) professionals can agree about quality indicators, measure them, and enforce quality standards. Indeed, there is considerable international effort underway to do precisely that. It is obviously critical to ensure both that quality can be measured, and that the watchdogs have sharp enough teeth to enforce agreed-upon measures. In theory, it is not necessary to have public ownership in order to ensure good quality. However, the ability to define and measure quality in many sub-sectors remains elusive.

Our conclusions are thus rather measured. Hospital services tend to be difficult to measure, and highly complex. It is indeed possible to incorporate private hospitals into a health
care system, and have these meet public goals. The systems we have examined do just that. They do not rely exclusively, or even heavily, upon public ownership (of either types 1 or 2). However, neither is it likely that FP/c organizations will voluntarily comply with goals relating to cost or access without imposing an expensive (and often ineffective) regulatory regime. The best compromise - and that used in the countries we analyzed - appears to be reliance upon NFP organizations which themselves are guided by principles of stewardship to the public interest, within a framework of incentives which will encourage (or at least not overly penalize) activities in support of public goals.
1. Introduction

How can government ensure that private delivery still adheres to societal goals? In particular, what mechanisms are available to ensure that private hospitals nonetheless act in accordance with broader public objectives? Although these issues affect most countries, this paper will focus upon industrialized countries where there is enough wealth to be able to provide universal, high quality health care to all who need it, without needing to sacrifice other social goods. In all such countries, the level of health expenditures is high enough that it is feasible to provide a high level of services (defined in terms of quality and timeliness), although this does not necessarily extend to provision of any and all services which might be demanded. The paper will focus only upon those jurisdictions where at least some hospitals are independently owned and operated, and the mechanisms used must accordingly be indirect. It will deal primarily with hospitals, rather than other sub-sectors (e.g., long-term care/nursing homes) where private delivery is common, but care is less complex. The analysis accordingly draws from both general analyses of health care systems, and from brief case studies of four jurisdictions - Australia, Ontario (Canada), Germany, and the Netherlands.

The paper begins by distinguishing among three elements of health care systems (financing, delivery, and allocation) and multiple levels of public and private. The analytical framework employed includes the following elements:

a. Categorization of hospitals by ownership type;
b. Specification of goals the system might wish to attain;
c. Specification of policy instruments which might be used to realize these goals; and
d. Specification of which actors would ensure that the goals are being met.

After discussing each element of the framework, the analysis will then examine how policy makers might deal with a series of specific issues relating to these policy goals. It will conclude with some lessons learned. Specific information about the four case studies used in the analysis are included as appendices. The conceptual framework is similar, but not identical, to that of Saltman and Busse and Harding and Preker.

It is also important to clarify what this paper does not deal with. Questions about the public-private mix in delivery cannot be isolated from other key issues in managing health care systems; neither can a brief paper do justice to all these linked concepts. This paper accordingly
does not address issues of financing, except as they constitute a mechanism for achieving other goals, although the appendix material does indicate how hospitals are financed in each jurisdiction studied. Neither is it concerned with issues of the extent of public-private partnerships, strategies for increasing (or decreasing) the role of private health providers, converting public to private facilities, or overall assessment of the performance of health care systems; for an excellent summary of some of the issues arising, see Harding and Preker.\textsuperscript{3} This paper focuses upon policy instruments and their potential use for achieving a variety of policy goals under various circumstances. It concludes with recommendations about how private ownership of hospitals is likely to affect the ability to pursue policies which promote public objectives.

2. Context: Defining our terms

2.1 Financing, delivery, and allocation

Health care systems have a number of components. Although different writers may use slightly different nomenclatures and break down these functions in slightly different ways, they all note the importance of distinguishing between how services are paid for--which we will term financing, and how they are organized, managed, and provided--which we will call delivery. Health care systems may also explicitly incorporate such other key elements as planning, monitoring and evaluating, or leave these to the workings of market forces.

The missing link connecting financing and delivery, which has sometimes been termed allocation, refers to the incentive structures set up to manage how funds will flow from those who pay for care to those who deliver it. These allocation approaches can be placed on a continuum.\textsuperscript{4} At one end, \textit{patients follow money}; funders allocate global budgets to providers. At the other, \textit{money follows patients}; providers’ revenues are volume-based, and dependent upon attracting clients. Unfortunately for those wishing clear reform prescriptions, there is no one best allocation model which can simultaneously ensure cost control, client responsiveness, and delivery of high quality appropriate care; instead, one is often faced with policy tradeoffs.

Although certain combinations are more common than others, these dimensions of health systems can be viewed separately. One can flow public funds to private delivery, and one can support public delivery through private funds (\textit{e.g.}, user fees for publicly-operated services).
Similarly, both public and private funders can embed various incentive structures in their payment mechanisms. The focus of this paper is on delivery rather than on financing or allocation. It concentrates only upon the implications of using various ownership structures to deliver hospital services, regardless of how these services are paid for, or which incentives are built into allocation models.

2.2 Public and private

There are a number of ways of classifying hospitals, each of which may in turn incorporate a number of different dimensions. For example, the OECD classifies hospitals as: public, private not-for-profit (NFP), and private for-profit (FP). Busse et al. use a classification which incorporates not only ownership structure and the autonomy of hospital management, but also how the hospital is paid (e.g., it defines budgetary organizations as being paid on a line-by-line budget). Preker and Harding focus on five elements of a hospital’s organizational structure: the extent to which hospitals can make decisions about their activities; the degree to which hospitals can keep any surpluses; the extent of reliance on market incentives; the nature of accountability; and the approaches taken to protect social functions which might not be financially viable. Other elements which may be incorporated into typologies include statutory responsibility, and the existence of defined contracts.

### Classification of Ownership Types

<table>
<thead>
<tr>
<th>Ownership type 1</th>
<th>Ownership type 2</th>
<th>Ownership type 3</th>
<th>Ownership type 4</th>
<th>Ownership type 5</th>
</tr>
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<tbody>
<tr>
<td>Public, managed by health system</td>
<td>Public, managerially independent</td>
<td>Private Not-for-profit (NFP)</td>
<td>Private For-profit, Small business (FP/s)</td>
<td>Private For-profit, investor-owned Corporation (FP/c)</td>
</tr>
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The conceptual framework we will employ in this paper separates the classification of ownership type from such other elements as the locus of decision-making, and the policy instruments used. It accordingly classifies ownership type based on Deber’s modification of the OECD classification, which sub-divides the private FP category into small business/entrepreneurs (FP/s) and investor-owned corporations (FP/c), and sub-divides the
public sector by incorporating the distinction between degrees of managerial independence suggested by Preker and Harding. The classification of ownership types we will use thus includes the following five categories.

**Ownership type 1: Public, managed by health system**

This category of hospital is fully owned by the state, and is part of the health care hierarchy. It is similar to what Harding and Preker call a *budgetary organization*. With this ownership type, the hospital is an integral part of the public health service, and all strategic issues are controlled by rules set by the government. The individual hospital administrator has minimal control even over day-to-day decisions about the factors related to the production and delivery of services (e.g., staff mix, staff levels, services offered), which tend to be made centrally. This model was characteristic of the National Health Service in the UK before managerial reforms.

**Ownership type 2: Public, managerially independent**

This category of hospital is also fully owned by the state (at the national, sub-national, and/or local levels), but has been given some degree of managerial independence. For example, the UK has been de-centralizing the National Health Service (NHS) and setting up “trusts” to manage many health services, including hospitals, formerly managed from the centre. These trusts give managers more independence, and are employing more market-derived incentives to encourage efficiency. This category of ownership encompasses both Harding and Preker’s *autonomous organizations* (which are still publicly owned, but which eschew micro-management by government in favour of setting targets and giving hospital managers varying degrees of control over how to meet them) and their *corporatized organizations* (which institutionalize this managerial control by establishing the public hospitals as publicly-owned private corporations). Many hospitals in Australia and Germany fit this category.

**Ownership type 3: Private Not-for-profit (NFP)**

This category of hospital is among the most common in many jurisdictions; it encompasses hospitals owned and operated by religious or other charitable organizations. The terminology used to refer to such hospitals can be confusing; for example, Canada and Australia commonly refer to their NFP organizations as “public hospitals,” although they are neither publicly owned nor publicly managed, and are usually governed by an independent board of
directors. In general, such organizations will not be bound by the same financial or administrative requirements that bind the public sector, although there is often considerable ‘red tape’ involved in maintaining not-for-profit status. Indeed, current demands for ‘accountability’ in some jurisdictions have been increasing public oversight to the extent that they can be seen as moving closer to some variant of ownership type 2. Under most jurisdictions, they will be exempted from many taxes, and indeed may receive additional government grants, and contributions. They can also draw upon volunteers, and receive charitable donations. They may also go bankrupt if they cannot generate sufficient revenues, although in practice this rarely is allowed to occur. Although they can run a ‘surplus’ of revenue over expenditures, they cannot distribute this surplus to individuals in the form of profits. They can spend it in other ways, including higher wages or ‘perks’ to their employees and managers, training/education, research, community service, or subsidizing less profitable services. Some, but not all, of these activities might be judged as ‘public goods’ which benefit the community. NFP organizations are motivated by multiple objectives, rather than just the financial bottom line. They proved to be the most common ownership structure in all of the jurisdictions examined for this paper.

Ownership type 4: Private For-profit, Small business (FP/s)

These organizations do not comply with the legal requirements needed to attain NFP status, but do not have shareholders. In many cases, they are provider-run (e.g., physician offices, many physiotherapy clinics, most of the FP hospitals in Germany and Canada). Some but not all of these organizations may have continuous service relationships with tax funded and/or statutory health insurance payers (e.g., the FP hospitals listed in German regional hospital plans). Like NFP organizations, FP/s businesses are less constrained by government procedural requirements than is the case for the public ownership types; they can also risk bankruptcy. They differ from NFP organizations in that they are usually required to pay taxes, are usually subject to fewer ‘red tape’ (accountability) requirements, are less likely to have to report fully on their activities, and have difficulty in accessing charitable and volunteer resources. They differ from FP/c organizations because they are not under the requirement of providing a return on investment to their shareholders. In some jurisdictions, FP/s providers may be incorporated for tax purposes (e.g., physicians may be allowed to incorporate). We would still classify them as FP/s as long as the ‘profits’ which accrue go to those who provide the clinical services (e.g., the
physician or physiotherapist), as opposed to going to independent shareholder/investors.

**Ownership type 5: Private For-profit, investor-owned Corporation (FP/c)**

These organizations are incorporated, and have shareholders who expect a return on their investment. FP/c organizations resemble FP/s organizations in their requirement to pay taxes, and their difficulty in attracting charitable donations or volunteer labour. However, they have the advantage of being able to access capital through issuing equity. The key distinction between FP/s and FP/c rests in the divided loyalty of FP/c organizations. Because they are corporations, their management can be seen as having a duty to maximize the return on investment and ensure that there are profits to be distributed to their investors. In consequence, there can be conflict between the goal of providing high quality care, and the goal of running a successful business.

FP/c hospitals have a significant presence in the United States, and are found in Australia, but proved to be uncommon in the other countries studied. Indeed, the Netherlands prohibit them, while Canada and Germany discourage FP/c ownership.

### 2.3 Relationship between type of health care system and ownership types

Analysis of health systems in industrialized countries often begins with the OECD classification into three categories, which combine financing and delivery.11 Beveridge-type countries have public financing (through taxation) coupled with public delivery. Examples of Beveridge system type countries are the UK, Sweden, Denmark, and Finland. Bismarckian system are also referred to as social health insurance. Here, funding is quasi-public; most (or all) of the population are required to purchase health insurance from designated third-party payers (often referred to as sickness funds). However, premiums are not risk related, and benefits are often subject to government regulations. Providers tend to be private, albeit often not-for-profit. Examples of Bismarckian systems are Germany, Austria, the Netherlands, France and Belgium. The third major category, Semashko systems, like those in the former Soviet Union, resembled Beveridge systems, having public financing and public delivery (usually, by salaried providers). However, it should be noted that these models are by no means exhaustive, and indeed are insufficient for this analysis. In particular, they do not fully capture new models of delivery (e.g., public contracting), and omit such countries as Canada and Australia, which employ tax-based financing to pay for private delivery. Neither do they deal with relationships within
federal systems; for example, they do not separate tax-based financing which is centralized at the national level from financing decentralized to sub-national units.¹²

In other publications, the OECD has accordingly separated sources of financing from models of provision. The sources of funds include three categorized as public (general taxation, earmarked taxation and social health insurance) and two as private (out-of-pocket payments, and private insurance). The models of delivery include the “integrated” model, where both financing and delivery are public; the “contracting model” with public financing and private delivery; and the “reimbursement model” where both financing and delivery are private, and where patients are responsible for paying providers and then submitting their bills to insurers.¹³,¹⁴

Because Beveridge and Semashko type countries, by definition, use only public hospitals, this study focuses only on systems where care is provided in privately-owned hospitals (which in practice are primarily contracting models). These systems in effect employ insurance-based financing, but the payer may be public (tax-based), quasi-public (e.g., regulated social insurance ‘sickness funds’), and/or private (private insurance, and/or out-of-pocket payments). Hospitals in countries employing an insurance model show a mixture of ownership types, although historically emphasizing public ownership. For example, Busse estimated that public hospitals comprised 69% of beds in Austria; 60% in Belgium, 55% in Germany; and 65% in France. However, the trend towards the ‘new public management’ has been to reduce public ownership in favour of ‘public firms' or private NFP delivery; FP delivery remains far less common.¹,² Not-for-profit ownership accounted for 26% of beds in Austria, 40% in Belgium, 38% in Germany, and 15% in France.⁵ Almost all hospitals in Canada and in the Netherlands would be classified as private NFP. For-profit ownership has not been as common - it accounted for 20% of the beds in France; 18% in Spain, and 10% in Portugal.⁵ However, most of these hospitals would be classified as FP/s rather than FP/c.

Clearly, once one moves beyond Ownership type 1 (public, managed by health system), command-and-control mechanisms become less available to policy makers. Although alternatives to command-and-control are often simply termed ‘regulation’, this paper will decompose the concept into three related elements. First, it recognizes that the analysis will not be ‘one-size-fits-all’ but must be conducted separately for the different goals which the system might wish to attain. For each goal, it will then ask two questions: Who has responsibility?
What policy instruments are used?

3. What goals does the system wish to attain?

This paper will not focus upon the array of goals which apply to any employer (e.g., minimum wage, occupational health and safety, environmental protection, or truth in advertising). Hospitals must abide by them, but the issues involved should not be substantially different than for other sectors with similar characteristics. Neither will it examine such important but non-health goals as a desire to create employment in a particular community, or to encourage scientific research. This paper’s focus is only upon the narrow series of goals which apply specifically to health care, and are justified by an appeal to the public interest, related to what the World Health Organization has referred to as ‘stewardship.’ There are many such goals, and many ways of categorizing them. For example, they can be at varying levels of generality - ranging from what Saltman and Busse refer to as “social and economic policy objectives” (e.g., equity and justice, economic efficiency) through to specific management mechanisms (e.g., planned markets, generic substitution). This paper will look only at goals which seek to accomplish particular outcomes. It accordingly omits the often-important process issue of how things are done, and thus ignores the likely possibility that groups may have goals which relate to process rather than outcomes (e.g., public accountability, ensuring a competitive market, etc.). For example, a focus on outcomes would see whether competition improves efficiency or responsiveness. However, it is perfectly plausible that policy makers have ideological reasons for preferring to promote private (or public) ownership even if it costs more and produces worse outcomes. Such process goals are not the focus of this paper.

The paper will instead focus upon a series of specific questions related to three categories of potential goals--access, quality, and cost. It is nonetheless important to recognize that particular issues cannot be viewed in isolation. The measures addressed to achieve one goal may in turn affect others. As Chinitz has noted, “standards such as capacity limits, quality measures or price regulations that are imposed on one part of the system alter incentives and behaviour in other parts of the system.”
3.1 **Access-related goals**

Access is defined in terms of the ability to obtain medical care. In turn, this can be affected by financial, geographic, organizational, sociological, and psychological factors. Access is highly valued by providers, citizens, and policymakers. At a minimum, access-related goals will address minimizing barriers that may arise from income, ability to purchase insurance, and place of residence. Much of the health care financing debate relates to how best to achieve the desired degree of equity in mitigating financial barriers to obtaining needed care. Policies may also seek to ensure that resources are ‘fairly’ distributed, and the extent to which communities which do not have the economic base to sustain a health care business should nonetheless be assured of having timely access to medical services. In many of the jurisdictions analyzed, access has also become defined as minimizing waiting lists.\(^{18,19}\)

Access-related goals are also linked to discussions of equity, justice and social cohesion; the WHO 2000 report incorporates them under the rubrics of health distribution, and responsiveness of distribution.\(^{20}\)

3.2 **Quality-related goals**

Quality refers to the extent to which the services delivered meet professional standards, and are satisfactory to their consumers. The language of quality may speak of such concepts as safety, efficacy, appropriateness, responsiveness, and health outcomes. In evaluating both the cost and quality of health care, one can look at the various phases of the ‘health care production process,’ including the *input* ‘factors of production’ (*e.g.*, human resources, capital stock and equipment, etc.), the *process* used to produce services, the *output* actually delivered, or the *outcomes*. Donabedian’s widely-cited framework separates the potential factors into: structure/inputs (*e.g.*, how many health professionals, their training, accreditation and skill levels, who will be permitted to perform which activities, etc.); process (including community participation, choice, and use of clinical guidelines or care pathways), and outcomes.\(^{21}\) Specific questions may include the balance between hospital and community care; the extent of linkages across service providers; the extent of innovation; consumer choice; the extent to which medicine is evidence-based; and a host of performance measurements, including safety and health outcomes.
3.3 Cost-related goals

Finally, considerations of cost may look at the total cost, how this cost is distributed, and/or whether there is value for money (cost-effectiveness). Such questions may focus at the macro level, and examine the share of a national economy going to health expenditures (or, more narrowly, to hospital expenditures), focus upon the costs of particular institutions or particular services, focus upon sustainability, look at transaction costs, or examine the prices paid for particular items (including wages for health care workers). Analysts may differ as to whether costs are important for their own sake, or as second-order questions relating to value for money, but all of the jurisdictions examined have placed heavy emphasis on cost containment.22-25

In section 7, we examine a series of specific issues related to these three potential sets of goals.

4. What policy instruments are available?

Decision makers have at their disposal a range of policy instruments. This paper will follow Doern and Phidd,26 and define them in terms of the degree of “legitimate coercion” involved, as follows: exhortation, expenditure, taxation, regulation, and public ownership. This treatment is common among political scientists, and has similarities to Musgrove’s framework.27 However, it differs slightly from the classification often used by economists, which tend to place a number of different instruments together under the rubric of regulation.3 In particular, in this conceptualization, what are often termed “incentives” would fall under the expenditure and taxation categories of policy instrument, with the term regulation reserved for more coercive approaches. It is also important to note that, although the pendulum has swung to endorsement of less coercive mechanisms, achieving particular policy goals may conflict with the interests of key players. As such, while some policy goals may be attainable using less coercive mechanisms, others may not.
The policy instruments are as follows:

4.1 Exhortation

Exhortation is the least coercive instrument; support and compliance are sought voluntarily, through persuasion and discussion. This aspect of exhortation thus encompasses Musgrove’s inform policy instrument. However, exhortation may also have a strongly symbolic element (e.g., a Ministerial speech, a symbolic appointment). Exhortation mechanisms are commonly used, often as the first step. For example, Harding has referred to information dissemination mechanisms, which ensure that key information (usually about quality) be disseminated to both providers and consumers, through such devices as protocols and other evidence-based guidelines.

It is important to recognize that successful policy making requires that information must not only flow from government, but also to it. For example, Harding has referred to inclusion mechanisms which ensure that “government service and facility planning take into account private sector capacities, and communicate these plans to private providers.” Disease surveillance activities also require that information be collected from, and shared with, private sector providers. Thus, exhortation may need to be backed up by regulation; for example, it may be necessary for government to compel organizations to provide the necessary data if voluntary approaches prove insufficient.

To the extent that exhortation relies upon the provision of information, it presupposes that actors share common goals and will voluntarily seek to achieve common ends.
Accordingly, it also draws upon the values held by policy actors. For example, if there is an ideology/value system of solidarity, there will be little disagreement that a health care system should be arranged to ensure universal coverage for medically necessary care. The World Health Organization has written of the importance of **stewardship** in molding and carrying out these goals. As Harding has noted, trust is thus a significant component of most efforts to attain goals through less coercive approaches; in its absence, “no contract or monitoring arrangements can ensure appropriate service delivery.”

Pure exhortation mechanisms thus differ from the more coercive approaches in that there are no ‘teeth’ involved in enforcing policy goals. Clinical guidelines or care pathways may be suggested, but not mandated. Report cards allow purchasers or consumers to decide where to seek care, but do not otherwise constrain their activities.

As will be noted below, exhortation mechanisms are used extensively in the systems examined, particularly with respect to the quality-related goals. These activities may be carried out by government, but more commonly are left to professional bodies and other non-profit organizations.

### 4.2 Taxation

Taxation as a policy instrument refers to the practice of encouraging (or discouraging) particular behaviours through manipulation of tax incentives/disincentives; it does not refer to the use of tax revenues to fund services (which falls under the expenditure policy instrument) or the mechanisms used to set and collect taxes (which fall under regulation). Although the taxation instrument does involve “setting rules of behaviour backed up directly by the sanctions (penalties) of the state,” the degree of coercion involved is relatively minor. Governments may choose to offer tax concessions for providing particular services, but providers are free to forego these tax breaks if they do not wish to pursue a particular policy objective.

To the extent that most hospitals in the countries under examination are NFP, the taxation instrument plays an important role “under the hood.” NFP status will generally carry with it an exemption from a wide variety of taxes, including property taxes on hospital buildings, profit taxes, or customs duties on health-related equipment and medicines. Governments may choose to give tax breaks to capital investments by FP organizations as long as these fit certain criteria; it
may also encourage charitable donations by allowing individuals to deduct these from their personal taxes. For an excellent summary, see Harding et al. However, the taxation instrument tends to be rather blunt; in the jurisdictions examined, it does not tend to differentiate among NFP providers as a function of their activities, as long as they meet the broad requirements for tax-exempt status.

4.3 Expenditure

Public expenditure is moderately coercive - it involves government distribution of funds to achieve particular aims. Musgrove refers to this instrument as *finance*. Expenditure may take the form of cash, and/or in-kind support (e.g., provision of space or personnel). Funds may flow directly to organizations/facilities, or indirectly via subsidies to particular activities (e.g., training of health professionals, provision of vaccines and pharmaceuticals, care for the poor or other designated groups, or provision of particular services such as family planning or infectious disease control). Funds may be offered on a long-term or short-term basis; for example, government or charities may provide seed funding with the expectation that on-going costs be found from other sources.

Expenditure can come with or without strings, and hence this category includes the mechanisms based upon *competition*. It is important to recognize that different allocation methods carry with them different incentive structures. For example, resources can be directly allocated to particular providers (“patients follow money”) or based on the volume of services provided, including various voucher systems (“money follows patients”). Organizations may be guaranteed funding, or have to compete for it. Organizations may or may not be allowed to retain surpluses. Their budgets may be fixed, or based on volume, case mix, or performance. Payments can be on a *per diem* basis, or on the basis of the expected bundle of expenditures for a particular diagnosis (Diagnostic Related Groups, or DRGs). As Wiley has noted, one can broadly categorize the broad array of financing approaches for hospitals into prospective budgeting and service-based financing; each has implications for performance. For a discussion of the incentives inherent in different payment methods and price setting mechanisms, see Harding and Preker, especially chapter 3.

Expenditure instruments may be, and often are, combined with regulation. Although
most governments require a legislative framework to allow funds to be expended for particular purposes, this alone would not qualify such public payments as regulation for the purposes of this typology. However, contracting (and its cousin, public-private partnerships) can be seen as a form of expenditure linked to expectations about performance; these expectations may be enforced and/or monitored through regulatory mechanisms.

4.4 Regulation

Regulation can be defined broadly as “all mechanisms of both intentional and unintentional social control.”\(^2\) This category includes Musgrove’s mandate and regulate mechanisms,\(^{27}\) and what Harding\(^3\) refers to as control-based regulation. More narrowly, the regulation instruments involve “setting rules of behaviour backed up by directly by the sanctions (penalties) of the state.”\(^{26}\) As such, they can be highly coercive. Because regulation involves shifting the costs of compliance from government to other actors, it can be a deceptively simple mechanism to employ. Accordingly, those being regulated have taken to using the language of “unfunded mandates,” or conceptualizing regulation as a ‘tax’ on providers.\(^{30}\)

It is less commonly recognized that, to the extent that one wishes to ensure that the regulations are being complied with, regulation also imposes costs on the regulator. Enforcement and monitoring can be expensive and difficult.\(^{31}\) As many authors have stressed, it is important to scrutinize the benefits and costs for all parties which are inherent in regulation. For example, regulation is likely to increase barriers to entry and reduce competition, while an absence of regulation may make it less likely that social goals will be achieved.

Regulation can employ legislation, administrative decree, or judicial orders, but in the final analysis relies upon the ability of some party to enforce the rules. For an excellent summary of key issues involved in conceptualizing regulation, see Saltman and Busse\(^2\) and Chinitz.\(^{17}\)

It is important to note that there are also some subtle differences in nomenclature across policy fields. For example, the literature on international public sector reform makes distinctions as to whether the entities being managed fall within the realm of public or private sector law, and often reserve the term regulation for entities that are subject to private sector law. Similarly, Saltman and Busse\(^2\) in their excellent treatment of the advantages/disadvantages of
various regulatory approaches, describe ‘steer-and-channel’ options; this element of their categorization, however, is more closely related to who makes the decision than to the instruments they employ. The framework we employ here would instead treat such mechanisms as decentralization as a means of changing the identity of the decision-maker, rather than as a policy instrument *per se*. Our definition of regulation thus follows the approach of political science, highlighting regulation as imposing the requirement to meet certain obligations, while omitting from the definition such other important dimensions as whether the targets of regulation are public or private, or whether or not these regulations are embodied in the form of legislation.

Regulation can be justified on a number of grounds, usually linked to ideas of protecting the public. Economists speak of the need to correct market failures, which may in turn link to the dimensions of access, cost, and quality. As Harding notes, there are a wide variety of targets for regulation.\(^3\) Regulations may focus on any or all of: a) overall market structure (*e.g.*, licensing and accreditation of health facilities, antitrust and market structure); b) the activities of individual providers/organizations (*e.g.*, their price, capacity, volume, levels and distribution of services, market entry, regulation of production of pharmaceuticals and medical devices); c) the activities within those institutions (*e.g.*, health personnel credentialing, utilization reviews and medical audits, quality of care, and requirements relating to acquisition of technology, capital borrowing, or professional referrals); and d) how providers are linked to consumers of care (*e.g.*, entitlements to care).

As noted below, these regulations may be carried out by various actors. However, even if these are delegated (*e.g.*, to self-regulating bodies), in the final analysis they must be backed up, usually by government, or they would fall into the exhortation category. For example, government may often motivate and oversee self-regulatory activities, including enforcing a professional monopoly over who is allowed to provide particular services. As will be discussed in section 6, the production characteristics of various sub-sectors/services in turn affect the way in which regulation is likely to be employed.

### 4.5 Public ownership

Public ownership can be considered the most coercive policy instrument; it involves government directly running the service in question. This is Musgrove’s *provide* mechanism.\(^{27}\)
Beveridge systems, by definition, employ public ownership, in that hospitals are part of government, and their employees are part of the public sector. In addition, it is not uncommon for certain tasks to be transferred to public ownership once market failure becomes evident. For example, the Netherlands transferred infectious disease control to government. Australia had to take over a private FP/c hospital which was not sufficiently profitable to its owners.32

### 5. Who handles ensuring the goals are being met?

**Typology of stakeholders**

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Policy is not the sole preserve of government. Decisions are made by a host of stakeholders, including:

#### 5.1 Individual consumers

In an entirely free market, it is assumed that the informed purchaser acts to maximize expected utility. Under those circumstances, the individual consumer will ensure that his/her goals are met. To the extent that this market functions on *caveat emptor* (buyer beware) principles, responsibility for failure to attain particular goals would rest with the purchaser, who in theory would not return if dissatisfied. Consumers may be ‘back stopped’ through the courts for situations of fraud (*e.g.*, failure to comply with an agreed-upon contract). Negligence or incompetence may also be resolved through litigation (*e.g.*, malpractice).

Accordingly, some systems use fiscal levers (*e.g.*, co-payments, deductibles) with the purported goal of involving consumers in making ‘cost effective’ treatment decisions.33-36 Although price elasticity certainly exists for many services,37 to the extent that health spending is heavily skewed, such demand-based approaches are of limited use in overall cost control.38
There are a number of reasons why health care does not follow a pure market model. The assumption of an informed purchaser is violated by the high degree of information asymmetry.\textsuperscript{33,35,39} In addition, the presence of third-party payers separates the purchaser from the consumer of services.

A number of approaches thus attempt to give second-order power to care recipients.\textsuperscript{40} One variation, which requires pluralistic funding arrangements, is to allow individuals to select their own insurer, while delegating to payers decisions about which providers will receive contracts, and which services will be covered. Presumably, if insurers do not satisfy their clients, individuals can decide to ‘vote with their feet.’ However, in practice, a number of barriers arise. For example, individuals are less likely to be able to judge the quality of providers unless they require care; the paradox is that it is precisely those individuals who require the most care who are the least attractive clients to rival insurers. The analysis in this paper accordingly differentiates control by payers (considered below) from direct consumer control.

Another variant is a stress on the importance of allowing patients to choose their provider rather than having providers assigned to them. Again, this gives second-order power to patients, in that they can ‘veto’ certain providers by refusing to patronize them (assuming that there is sufficient excess capacity to make such choices feasible). All of the systems under consideration in this paper take the ability of patients to select providers under certain circumstances for granted. However, in a number of jurisdictions (e.g., Germany, Australia), this ability is restricted to community-based care; patients must pay extra for the privilege of selecting their own specialists for in-hospital care.

There are also efforts underway in many countries to empower individual consumers to make wiser choices by providing information about providers (e.g., ‘report cards’) and/or optimal therapy (e.g., decision aids, consumer web sites). For the most part, these are classified as exhortation mechanisms.

5.2 Individual providers/provider organizations

Much health care is provided by health professionals. The concept of professionalism carries with it notions of a clear body of knowledge, recognized training programs, an agency relationship with clients, and a strong code of ethics. Those providing services are thus expected
to act in accord with the ethics of their profession. Such professional norms can be expected to be particularly important in ensuring quality; to a lesser extent, they may also ensure at least a minimal level of access (e.g., professionals are generally reluctant to abandon patients, even if they cannot pay for services). Although such professional values are deemed critical, most analysts argue that they must be embedded within systems. The systems analyzed make heavy, if not always explicit, use of these ‘trust-based’ approaches.

5.3 Professional bodies/associations

The most common way of systematizing professional ethics is through regulation. In most countries, regulated health professionals employ self-regulation. Most jurisdictions back up these professional regulatory bodies (often called ‘colleges’) by requiring any individuals wishing to practice to be members in good standing. These professional associations thus serve to define membership, and to establish and enforce standards of quality and ethical practice. The systems analyzed rely heavily upon these bodies, particularly for achieving quality goals at the individual provider level.

5.4 Arm’s length organizations

This category may be closely linked to professional bodies; it includes NGOs, disease agencies, but also government-linked regulatory bodies. Bodies involved in hospital accreditation may also fall into this category. Such organizations are particularly important in developing countries, but are also involved in exhortation mechanisms (e.g., generating report cards and otherwise scrutinizing providers) in the systems analyzed. In the Netherlands, patients’ organizations educate patients about specific diseases and treatment options. They may give information about prices charged in various institutions, or the services available. In Canada, advocacy groups scrutinize care and issue report cards for such diseases as cancer, or heart and stroke.

Some of the activities of such organizations may be backed up by expenditure or regulatory mechanisms. For example, although hospital accreditation may be voluntary, many jurisdictions prohibit institutions from receiving public funds unless they are accredited.
5.5 Payers

The language of ‘contracting’ is often used to describe delivery options. For example, Harding distinguishes between contract out, defined as government purchase of services “from an outside source that provides the service using its own work force and resources,” less formal subsidy arrangements, and franchising arrangements, which involve an agreement “to operate in a prescribed manner, usually in terms of service quality, services offered, or patients served” in exchange for being given the right to use the brand name. Such approaches require a split between the roles of purchaser and provider, so that payment can be separated from delivery. As such, they are not compatible with the public ownership/delivery models.

Inherent in the language of contracting is the idea of contracts, which in turn implies mechanisms for ensuring that the terms of contracts are complied with. In short, the language of contracting assumes that the payers will use their purchasing power to ensure the attainment of specified goals. One trend is the move towards value-based purchasing. Maio et al conclude that more research is needed, but that evidence to date suggests that very few purchasers are actively involved in promoting quality through their purchasing decisions; many are attempting to shift these decisions to individual employees/consumers. In the UK, where efforts were made to shift purchasing decisions to GPs under Total Purchasing Practices (TPPs), evaluation found that these groups had found it very difficult to shift resources from hospital contracts to other services. The practices had made almost no effort to try to alter quality standards through contracts, or to insist on new protocols of care. The authors concluded that giving purchasing authority to GPs had almost no impact on “achieving efficient and high-quality secondary care services.”

A number of reviews have examined the effectiveness of payer-based approaches to encouraging ‘best practices’. In general, despite a number of attempts and hopeful rhetoric, the evidence is slim that payers can directly affect the quality of delivery, particularly in pluralistic systems. However, some argue that payers can have considerable indirect effects on quality, albeit often in a negative direction, through their influence on the costs which can be charged to particular payers.

5.6 Government
A major role is also played by governments at various levels—municipal, regional, provincial/state, national, and supra-national (e.g., the European Community). Responsibilities may be split, so that even in jurisdictions where one level of government owns or operates hospitals, that level may not have responsibility for paying for them, or for regulating them. In that connection, globalization (including the Internet) may accentuate the mismatch between the jurisdiction where responsibility has been vested and its ability to control activities beyond its borders. As one example, the efforts of one jurisdiction to control direct-to-consumer advertising of pharmaceutical products will have to take into account the possibility that its efforts may be undermined if consumers can still access media originating from other jurisdictions with other rules.

Regardless of which actor makes decisions, it is essential that, at minimum, they have in place a system which provides for collecting information about the activities of the deliverers of services, communicating with them, and (ideally, although not always in practice) monitoring the impact of their decisions.\(^3,47\)

6. Production characteristics: Contestability, measurability, and complexity may differ across sub-sectors/services

The mechanisms used, and the decision makers employing them, may vary, not only by country, but also by sub-sector. For example, the effectiveness of regulation will be related to such jurisdiction-specific factors as the resources available for monitoring and the extent of corruption.\(^3\) Within sub-sectors, it is important to consider such “production characteristics” of goods and services as contestability, complexity, and measurability.\(^1,48\)

The concept of contestability builds upon earlier work by Baumol and Willig; economists adopting this view argue that it is not necessary for government to regulate even natural monopolies, as long as barriers to entry are low to attract new competitors as appropriate.\(^48\) Contestable goods are characterized by low barriers to entering and exiting markets. In contrast, non-contestable goods may be characterized by some or all of: monopoly market power, geographic advantages, high sunk costs, and/or “asset specificity” (a term meaning that it is relatively difficult to transfer assets intended for use in a given transaction to other uses).\(^48\) For example, the equipment and skills needed to perform open heart surgery could not easily be used
for other purposes. In short, a contestable market is easy to enter, and to exit.

Measurability relates to “the precision with which inputs, processes, outputs, and outcomes of a good or service can be measured.” Monitoring performance is easiest when measurability is high. For example, it is relatively simple to specify the performance desired for laboratory tests, or establish quality standards for pharmaceuticals. In contrast, it would be more difficult to specify the activities to be expected of a general practitioner, and hence more difficult to monitor her performance and to ensure quality.

One can clearly argue about the degree of contestability and measurability of particular health care items. Home making is highly contestable; if a firm offering home making services loses a contract, it might go out of business, and the firms gaining the contracts could hire the now-available workers. In contrast, hospitals are characterized by major barriers to entry, including high capital investment requirements, and labour force issues arising from professionalism which affect the availability of the necessary health human resources. One cannot practice as a health professional without considerable training, and registration/licensure in that jurisdiction, and hence new entrants to the hospital market would often have to compete with existing organizations to obtain staff. In addition, government has often set up barriers to entry, in the belief that excess capacity increases costs. Few jurisdictions have wanted to encourage excess capacity for open heart surgery, if for no other reason that the need to maintain sufficient volumes to ensure quality outcomes. Outside large urban areas, hospitals often form natural monopolies in their geographic area.

One key challenge for regulators arises when one begins to consider what makes a market more or less contestable. Preker and Harding’s model clarifies that a number of factors which we might consider inherently desirable--such as expertise and a good reputation--can also be viewed as impediments to contestability. “Once incumbents have invested in activities that result in expertise or generate trust, they enjoy a significant barrier to entry for other potential suppliers, thereby lowering the degree of contestability.” Contestability is thus hampered by the existence of organizations (or individuals) which consumers would wish to retain as care providers, even though they might be able to purchase similar services elsewhere for less money.

Complexity refers to whether the goods and services stand alone, or require coordination with other providers. Even laboratory tests, which are highly measurable, gain much of their
value by being embedded within a system of care, in which providers order tests appropriately, and are aided in interpreting and acting upon their results. Similarly, even the most routinized tasks within a hospital have requirements not common in normal business environments (e.g., food service within a hospital must take account of dietary restrictions, cleaning staff must take account of hazardous materials, and so on).49

A related set of issues involve the balance between competition and cooperation, particularly when quality implies better clinical integration of services. The ethos of provision of services on the basis of need, with the goal of maximizing health outcomes, often conflicts with the ethos of provision of services on the basis of willingness to pay, with the goal of maximizing profits. Advocates of moving to a stewardship model suggest that successful adoption requires that all affected actors be committed to this approach.16 This in turn suggests that there may be some difficulties in implementing a stewardship model in the context of FP/c delivery, because the incentives for FP and NFP providers often differ.1 As Saltman and Busse have noted, “Entrepreneurs inevitably seek to segment markets so as to exploit profitable niches, while publicly accountable regulators try to ensure that the entire market is served efficiently and affordably.”2 Efficiency is also defined differently: “In the private sector, the surrogate symbols for efficiency are, typically, increased profits as well as expanded market share and, in some industries, improved quality of product and service to customers. In the public sector, the surrogate symbols are improved volume and quality of service to clients, as well as generating a financial surplus and, in some sub-sectors, enhanced market share.”2

Saltman and Busse cite a number of examples of “dysfunctional outcomes from unconstrained entrepreneurialism in the health sector” affecting cost, access, and quality.2 These include bankrupt insurance companies, efforts by sickness funds in the Netherlands to design service baskets which will “chase away undesirable (i.e., more expensive) subscribers,”50 and even incompetence and fraud.

In practice, these considerations imply that it is difficult to ‘micro managing’ the activities of others without inducing ‘gaming’ behaviour, particularly when these activities are highly decentralized and difficult to measure. The transaction costs involved in monitoring such activities may very high. In consequence, most of the jurisdictions we have examined place a premium on trust, which reduces transaction costs. As we will note, this often translates into a
preference for NFP (or FP/s) ownership.

7. How have the jurisdictions we are looking at handled these issues?

This paper examines a series of issues in four jurisdictions–Australia, Canada (the Province of Ontario), Germany, and the Netherlands. Brief summaries about how each of the four jurisdictions examined handles these issues are provided in Appendices A to D.

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7.1 Capacity: (capital planning)

For reasons of both access and cost, governments may want to control the building of hospitals. Efficient resource allocation should ensure that supply will locate where there is sufficient demand. However, payment arrangements clearly affect how “demand” is operationalized. In most sectors of the economy, demand is demonstrated by willingness to pay for services at a particular price. In the case of health care, however, this approach must be modified. At one extreme, quality considerations may dictate that certain ‘unnecessary’ or ‘inappropriate’ services should not be provided at all, regardless of demand; indeed, regulatory bodies may deem such provision to be evidence of professional misconduct. Conversely, most societies agree that certain ‘needed’ care should be provided, regardless of ability to pay. From an economic viewpoint, then, the existence of single payers who in effect guarantee that the bills of insured persons will be paid can translate into open-ended commitments to giving ‘blank cheques’ to providers for whatever they choose to do. There is thus the potential for mis-matches between capacity and need. If payment seems likely, providers may ‘over-supply’ a given area. If payment seems unlikely (e.g., the inhabitants are poor), under-supply may occur. Policy makers may thus be focused on eliminating “excess” capacity which increases costs.
disproportionately to the likely benefits, and/or ensuring additional capacity is placed in underserviced areas. Such determinations often become political, especially when hospitals are politically or economically important to local communities. Chinitz argues that capacity-limiting tools are more easily implemented by strong central governments; local interests are more likely to encourage hospital expansion, particularly if the bills will be paid by others.

Healthcare analysts differ strongly in their views of excess capacity, and hence in their policy prescriptions. As Madden has noted, there is disagreement between those who view excess capacity as a sign of inefficiency which generates high costs to pay for unneeded infrastructure, and those who argue that the forces of supply and demand should ensure that such excess is self-correcting. In the United States, experiments with direct capacity controls through Certificate of Need programs are seen to have failed, but the alternative of leaving capacity decisions to market competition is also seen as problematic.

In the four systems we reviewed, government has accordingly exercised some sort of controls over who could build hospitals, and where these could be located. Such controls may be exercised over the planning of facilities, or on capital. This may be tied to issues of discouraging ‘excess capacity’ in areas where additional facilities are deemed not to be needed, and encouraging additional capacity in areas deemed to be under-serviced. This, in turn, begs the question of who defines ‘excess,’ and what policy instruments can be used. (It also shades into issues of quality assurance, particularly if regulators seek to discourage ‘inappropriate’ utilization.)

The approaches used may draw from several of the policy instruments. Decision makers may use regulation and impose direct controls over whether or not groups can build a hospital. Busse calls this an *ex ante* strategy and notes that it is used in Germany, the Netherlands, and Canada. Germany and the Netherlands allowed new hospitals only according to government planning criteria. Ontario, Canada does not allow private hospitals to open or operate unless licensed by the Province; no new licenses have been granted since 1973.

Since a high proportion of hospital budgets come from public sources, decision makers commonly employ the expenditure instrument alongside of regulation. This takes the form of placing controls on the ability of hospitals to obtain money, either directly from government, or, in Bismarkian countries, from sickness funds. Often, these controls will be linked to whether
particular capacity is incorporated into planning activities. Busse calls this an *ex post* strategy. He observes that Switzerland uses this approach; only listed hospitals qualify to have their services reimbursed under comprehensive health insurance or to receive public subventions. Decisions about whether or not to list a hospital are made at the sub-national (canton) level, although hospitals may challenge these decisions by submitting an appeal to the federal government.5

Pure expenditure decisions may relate to issues of what a government will pay for. For example, capital investment costs are often separated from operating expenditures, and are handled differently in different settings. The Netherlands includes depreciation costs in hospital budgets. Ontario allows only a proportion of such costs, expecting the rest to be generated through fund-raising by the individual hospitals. Germany will directly pay for capital costs “if an investment reflects the hospital plan.”5

Expenditures also create incentives for providers. The jurisdictions examined have experimented at various times with reimbursing on the basis of *per diem* payments, global budgets, particular funding for priority programs, and case-based funding. None have been seen to be fully satisfactory, and modification of the formula continues in most jurisdictions.

Governments may also, in theory, employ taxation (*e.g.* provide tax breaks only for hospitals agreeing to locate in certain areas) but we are unaware of examples where this mechanism has been used in the jurisdictions we examined. Exhortation may be used as ‘moral suasion’ (*e.g.* to encourage organizations to be ‘publicly minded’ in where they locate). In some sense, government encouragement of fund-raising by local communities could be seen as an exhortation mechanism, but to our knowledge this is rarely an explicitly-used mechanism. (Hospitals certainly encourage such fund-raising, but without explicit government involvement.) Finally, when market failure occurs, governments may resort to the public ownership instrument. A striking example occurred in Australia, where the FP/c corporation running the LaTrobe (Victoria) hospital determined that particular services did not generate enough profit to be fiscally viable, and government stepped in to ensure that these services were not lost to the community by re-purchasing the hospital from its private owners (La Trobe, in Victoria). Government also bailed out the FP/c company running the hospital in Modbury, South Australia.1,32
7.2 Costs and Prices

If the assumptions of economic theory are correct, costs should automatically be controlled through the working of market forces. In practice, this is rarely effective. Hospitals are resource intensive. Among the requirements for markets to work is the presence of enough overcapacity to allow competitors to serve the new clients they might attract, or, at least, few barriers to creating this new capacity, along with the potential disappearance of the firms losing business. This in turn implies relatively easy barriers to market entry and exit. As noted above, these assumptions do not apply to hospitals, which tend to have low contestability. These already formidable barriers to entry and exit are accentuated by the strong capacity controls evident in the European and Canadian hospital sectors. Governments in the jurisdictions examined have accordingly recognized that other mechanisms are required to control costs and prices. The countries studied thus supplement their capacity controls with a number of direct controls over prices and/or revenues. These include various combinations of mandatory fee schedules for physicians (none of these jurisdictions encourage, or even allow, price competition for physician services), restrictions on services to private payers, uniform or maximum price/reimbursement for privately paid services, controls on borrowing capital from banks or charging for capital costs, controls over prices, profit margins, reserve levels, and/or investment policies for surplus revenues. A complexity for policy makers is that control over price alone is unlikely to be sufficient to control costs if not accompanied with controls over volume. In consequence, there is a tension between global budgeting (which is relatively effective at cost control, but may create waiting lists), and service-based funding (which tends to decrease waiting lists, but may encourage marginal or even inappropriate utilization). Canada, the Netherlands, and Australia, which use control over global budgets as a policy instrument, have identified waiting lists as a problem; Germany, which has not, instead has identified problems with ‘excess’ bad capacity.18,19

One key policy aim is to preserve financial sustainability. In many jurisdictions, governments do not find it acceptable to allow hospitals to go bankrupt. There is also concern that FP organizations may find it difficult to achieve cost savings without risking unacceptable impacts on quality.

Government may also regulate relations between clients and hospitals, through such
mechanisms as mandated copayments. Saltman and Busse\textsuperscript{\textregistered} include other examples of
government control over costs and pricing, including changes in the reimbursement approach
(service based; contract based, money follows patients, etc.), controls over access to capital,
policies about contracting out of management, and replacing cross-subsidization by explicit
reimbursement. There are often restrictions on horizontal or vertical mergers.

Regulation may be used to specify such things as whether operating surpluses can be
carried over; whether money can be borrowed from banks; whether assets can be sold; whether
mergers are allowed; and whether hospitals can engage in activities outside their ‘core
business.’\textsuperscript{15} Regulation may also be used to set pricing, especially if there is a suspicion of
collusion among providers.\textsuperscript{5}

Expenditure is a commonly-used instrument. The hospitals in the jurisdictions examined
receive most of their budgets from government and/or sickness fund payers. All have universal
coverage, and most prohibit hospitals from charging insured persons for insured services. The
prices paid by insurers are regulated. In many cases, these prices are determined through a
negotiated process involving both hospitals and payers.

### 7.3 What services are offered?

If services require costly capital investment, policy options resemble those used to
control capacity. Saltman has concluded that planning mechanisms are often ineffective,
particularly because providers may be able to tap alternative sources of financing. However,
competitive approaches tend to be less effective than planning at controlling overall costs.\textsuperscript{54}

Government can also stipulate required service hours (e.g., for emergency care), restrict
the types of services offered (e.g., until recently, most German hospitals could not offer
ambulatory care), require organizations to maintain money-losing services (e.g. burn units,
neonatal intensive care, training of health professionals). They may also unbundle activities to
deal with cross-subsidization (e.g., directly pay for medical education rather than assume it will
be paid for from surplus revenues from service provision).

Germany used to have a total regulatory separation between ambulatory care and
hospital-based care. In 1993, they allowed hospitals to offer limited ambulatory surgery and
ambulatory care, largely restricted to pre- and post-inpatient stays. Even when the regulations
were modified, the expenditure instrument discouraged such activities, particularly when funding was on a global budget basis.\textsuperscript{5} It should be recognized that the approach to allocation may make a difference. For example, guaranteed coverage of all expenses incurred, as was the case for many years in Germany, offers incentives to do more. Paying hospitals on a service basis (per procedure) also encourages them to provide more services. In contrast, paying hospitals through fixed global budgets will discourage them from offering services, and may increase waiting lists.\textsuperscript{19} DRG funding gives an incentive to concentrate upon profitable diagnoses, as well as to increase efficiency. However, these incentives are not related to ownership type; they can be (and are) used by both public and private payers to attempt to influence both public and private providers.

Ontario has used the regulation instrument to some extent (e.g., it has designated some hospital programs as “protected” and hence immune from internal budget cuts within hospitals receiving public funds), but much of the control over which services will be offered occurs through the expenditure instrument, and through exhortation (e.g., the idea that a hospital should serve its community). Among the exhortation instruments are ongoing mechanisms for regular communication between hospitals, payers, and government, which exist in all of the jurisdictions studied.\textsuperscript{3}

7.4 Access - who gets services?

Who can get services in hospitals? In countries without universal coverage, there are issues about uncompensated care, and incentives for hospitals to avoid uninsured (or poorly insured) clients. However, with universal coverage, there should not be financial barriers. Nonetheless, hospitals are likely to specialize in services most likely to be profitable, which means a role for the expenditure instruments in setting the rates they will be paid. In theory, government can mandate delivery of services to all patients, independent of insurance status or potential profitability, to minimize adverse selection. It can also disallow provision of services to private patients, or conversely, restrict private hospitals to delivering services to private payers only. Regulations may apply to all clients, or only to those paid from public sources.\textsuperscript{5} Governments may also seek to enforce waiting time guarantees, although these have been used primarily in Beveridge countries.\textsuperscript{5} Regulations may also be used to control requirements for
accessing specialized services (e.g., there may be a requirement for referral by general practitioners). Individuals may or may not be allowed to select their providers; extra fees may or may not be charged for that privilege. In Ontario, specialists prefer to have patients referred from general practitioners, but direct access is allowed, and patients have full choice of the hospital (and doctor) they use, subject to availability. In Germany, individuals may select their own hospital, but must be referred by their general practitioner, and take whatever hospital-based specialists are assigned unless they pay additional fees.

In practice, these regulatory controls are extremely difficult to implement or enforce. Hospitals can use many mechanisms to avoid unwanted clients, and monitoring these activities would require extensive micro management. Rather than rely upon regulation, the jurisdictions examined all have universal (or almost universal) coverage for hospital and medical services, and rely heavily upon expenditure instruments (i.e., paying the bills to ensure access) and trust that providers will usually seek to give optimal care to their patients.

7.5 Health human resources

Health care is not delivered by buildings, but by skilled personnel working within well-functioning systems. Policy makers may direct their activities to any or all of such issues as: Who can be hired at all? What activities can be performed by whom? What are the pay/fee levels? What are the hours which can be worked? What are the staffing levels? (Usually, this involves setting minimum levels, because maximum levels will be constrained by available budgets.) The need for an improved global health workforce strategy has been recognized.55 There is considerable variation in who controls decisions about such issues as the number and skill mix of employees, and their pay levels, but hospitals are rarely fully free to determine which human resources they will use. Germany sets minimum standards for staffing numbers and mix; most other countries do not. However, certain “controlled acts” can only be performed by regulated health professionals; even if customers were willing, few jurisdictions will allow surgery to be performed by unskilled workers. In some cases, professionals can delegate activities to less trained workers, with varying requirements for supervision. These standards have regulatory backing from professional organizations. Indeed, health professionals failing to comply with the standards of their profession can lose their license to practice. To the extent
that provider organizations will only employ authorized health professionals, losing one’s license means a loss of livelihood. Poor practice may also be enforced through the courts (e.g., malpractice).

Jurisdictions may accordingly leave these matters to be determined by the individual hospitals, within the parameters of available budgets and professional requirements. In many jurisdictions, labour unions bargain about activities, pay levels, hours, and even staffing levels. For example, although the Ontario government does not control staffing levels, union agreements will control wage levels, benefits, and to a certain extent, working conditions for unionized hospitals. In some Canadian Provinces, unions bargain on a province-wide basis. In others, such as Ontario, locals bargain independently, but there is a basic standard agreement, with some local variations. Another source of control over staffing levels rests with voluntary accreditation bodies, which set baseline standards. These standards tend to be process related; usually, they will not require fixed numbers of nursing hours per day, but will attempt to set quality standards. Ontario relies upon professional bodies to set and enforce standards. In the final analysis, however, such standards are backed up by government through legal and regulatory mechanisms.

It is also important to recognize that not all of those delivering services in hospitals are hospital employees. In particular, many systems rely upon service provision by fee-for-service physicians who have ‘privileges’ at a hospital, but are not paid by it. Others may employ salaried physicians, who may or may not be permitted to have private practices outside of the institution. In some jurisdictions, there is a mix, with particular specialties (e.g., radiology, laboratory medicine, emergency physicians) more likely to be employees. In that connection, seemingly unrelated regulatory endeavors concerning physicians may have enormous impact on the activities of hospitals. This is particularly noticeable in Australia, which has implemented considerable regulation about physicians. Australia has a mixture of public hospitals (largely falling into Ownership type 2) and private hospitals (Ownership types 3-5). There has been a certain tension between public and private, compounded by physician policies. Australia’s public hospitals employ salaried physicians, but allow them to maintain private practices. As government enforced cost control within public hospitals, a considerable gap opened between what a doctor would be paid privately, and what he/she would receive for delivering the same
services within the public hospital. Compounding it were efforts to restrict the number of physicians as another cost control mechanism. As a result, the public hospitals have found it more and more difficult to attract enough physicians to deliver services and maintain access. Indeed, in some locations, the shortage of surgeons is so great that certain services are in effect unavailable within the public hospital; others have extremely long waiting lists.56

7.6 Quality control within institutions

Access to services is of minimal value if the services provided are of low quality.

At one level, quality will be affected by expenditure, and overly aggressive cost control may in turn result in diminished quality. Critics have argued that FP hospitals may be under particular pressure to perform financially, with adverse effects on care.57 Many of these arguments have come from unions, which are understandably unhappy at efforts to de-skill and cut wages. One example was the Port Macquarie Base Hospital in Australia, where the FP/c corporation owning the institution fired their CEO and their director of clinical services and quality for resisting cost-cutting plans (e.g., to replace nurses by less skilled assistants). The hospital was able to ignore their community advisory council, but found that significant opposition arose from the medical staff. Community opposition then led to scrutiny by a parliamentary inquiry, formal reviews, and insistence that information be made public.32 However, it is noteworthy that similar problems have arisen within hospitals of all ownership types as a result of budget constraints.

Although insufficient resources may harm quality, there is no guarantee that an abundance of resources will guarantee it. Every health care system examined has in place some mechanism for quality management. However, this is usually delegated to health care professionals. This observation provides a corrective to the belief that public institutions (Organization type 1) subject to command-and-control from governments cannot be considered to be regulated.2 On the contrary, even public hospitals are likely to rely upon outside bodies to license the providers working there, and assess their quality.

A number of policy instruments can be used. Exhortation is the underpinning of the healthcare technology assessment (HTA) movement, which seeks to assess clinical interventions and suggest best practices. Some are arm’s length associations. The Cochrane Collaboration is
“an international non-profit and independent organisation, dedicated to making up-to-date, accurate information about the effects of healthcare readily available worldwide.” In addition, an increasing number of HTA bodies have been set up at the national level. In general, their work “informs” decision making, but they are not given decision-making authority. The movement is strongly international. One umbrella organization, the International Network of Agencies for Health Technology Assessment (INAHTA) has 42 members from 21 countries, including Australia, Canada, Germany, and the Netherlands. To qualify for membership, the organization must be a not-for-profit organization which both relates to a regional or national government, and receives at least half of its funding from public sources. The focus is often upon pharmaceuticals. Information may flow to patients, health professionals, and the general public, as well as to purchasers of services (particularly, government, hospitals, and sickness funds). The UK’s National Institute for Clinical Excellence, part of the National Health Service (NHS), has an ambitious mandate “to provide patients, health professionals and the public with authoritative, robust and reliable guidance on current ‘best practice.’”

An exhortation mechanism which is often tied to expenditure and regulation is accreditation (of facilities) and licensure (of health professionals). These are usually delegated to professional bodies/associations. Depending upon the jurisdiction, they may be mandatory (e.g., physicians are not allowed to practice medicine unless they hold a current license from the relevant professional association), quasi-mandatory (e.g., some payers will not flow money to hospitals unless they are accredited), or voluntary. All of the countries studied for this paper have arm’s length bodies which conduct hospital accreditation. For example, France employs a quasi-independent public agency, the National Agency of Accreditation and Evaluation in Health, which collects information about the operation of health facilities, whether public or private.

A number of the national accrediting bodies have joined together into The International Society for Quality in Health Care (ISQua), which is leading efforts to establish an international accreditation council (i.e., accreditation of accreditation). The Australian Council on Healthcare Standards, the Canadian Council on Health Service Accreditation, and the Institute of Accreditation of Hospitals, The Netherlands have all served on the ISQua ALPHA Council, which also has links to such organizations as the World Bank.
Among the difficulties are establishing clear quality measures. As Chinitz notes, “every measure of quality is subject to controversy over validity.”\textsuperscript{17} There is also some variation in whether accreditation looks for minimum standards, or seeks ongoing performance improvement.

Quality assurance is not static. As one example, the SARS outbreak in Toronto, Ontario reinforced the need to take both surveillance activities and infection control procedures in Canadian hospitals to a higher level in order to deal with the threats of emerging diseases.\textsuperscript{64}

Regulatory instruments are also employed to back up these exhortation mechanisms. “Most countries have statutory inspectorates to monitor compliance of hospitals with published licensing regulations,” with particular attention to such issues as fire safety, hygiene, and radiation protection.\textsuperscript{65}

In theory, accordingly, there is no reason why FP hospitals could not be subject to the same quality standards as public or NFP hospitals. In practice, there are some suggestions that the internal stewardship values may dissipate, and that monitoring is not sufficient to fill the void. Certainly, opponents of FP hospitals have come up with a number of ‘horror stories;’ private corporations have been known to hire fewer and cheaper staff, avoid costly activities, and even commit fraud. A recent meta-analysis have suggested that outcomes are worse in FP hospitals.\textsuperscript{57} However, such comparisons are difficult, and it is unclear the extent to which the horror stories are representative. Clearly, there is enormous variation in the costs and quality of institutions; there are excellent FP hospitals, and mediocre NFP ones, as well as the reverse. FP hospitals tend to be smaller, fill niche markets, and treat less complex cases, meaning that comparisons require often complex statistical adjustments.\textsuperscript{1} Judging the sector is made more difficult by trade secrets. In a competitive environment, no one expects corporations to give detailed information about their costs and activities to their rivals. However, this often means that information is lacking, and accountability impaired.

7.7 Information provision

Exhortation depends in large part upon the availability of information. To the extent that policy makers assume that purchasers of services will ensure optimal results through wise decisions, there may be a need to ensure that accurate information is available to them.
Accordingly, government may chose to regulate how hospitals can advertise the services they offer. They may seek to empower patients through such mechanisms as Patients’ Bill of Rights.

To facilitate monitoring, they may also require that hospitals submit key information, both to monitoring bodies (e.g. relating to quality, access, disease surveillance/reportable diseases) or even to the public (e.g., disclosure of performance).

8. Conclusions

Ensuring that hospitals meet public objectives is a complex endeavor. It is complicated by the fact that there are multiple, often conflicting objectives which might be pursued. An optimal system would provide timely access to quality care for those who need it, at reasonable cost. This is not simple to achieve.

Although many analyses assume that government is the only party attempting to achieve these goals, in practice, a host of other actors are involved. These vary considerable by policy goal. In particular, quality is usually addressed by professionals, professional associations, and other arm’s length bodies, rather than by government itself. However, in the final analysis, these efforts are usually backed up by some formal mechanisms. For example, health professionals license and regulate their members, but government allows them the privilege of self-regulation, and enforces their monopoly over provision of certain services. A physician may not practice medicine if not a member in good standing of the relevant professional college. Individuals without nursing training may be prohibited from performing controlled acts. Thus, the interface among these actors is a complex one.

Similarly, the policy instruments available range from low-coercion provision of information and encouragement (exhortation), through expenditure, taxation, regulation, and public ownership. Again, these instruments interact in a complex manner, and unintended impacts are common. As Saltman and Busse have recognized, entrepreneurialism must be balanced with “the necessary countervailing regulation.” Among their “four rules of the regulatory road” is the recognition that regulation is a means, not an end in itself, and a stress on the importance of monitoring activities. (As they put it, “Trust, but verify.”)

What, then, are the limits of what Busse terms social entrepreneurship, which he defines as achieving “public goals with the aid of private-sector principles, including an orientation
towards opportunity-seeking, a focus on innovation, the taking of commercial risks, and an acceptance of responsibility in terms of the success or failure of business management.”5 Busse has noted four important preconditions which he believes are essential: Trust, linked to a rejection of attempts to micro-manage in favour of “a clear division of tasks between the government and the hospital, as part of which the rules of the game are laid down in advance while performance is audited retrospectively.”5 (In our terms, this entails a rejection of ownership model 1); Transparency and public accountability, embedded in “a clear, strong and independent system of accountability and control on the basis of which adjustments can be made;”5 Supervision, requiring that rules of the game be set in advance, and audited; and Entrepreneurial skills, including the ‘political’ skills of managing stakeholders and the media.

In turn, this requires attention to the fact that incentive structures for FP/c ownership may not coincide with public goals. In particular, such firms are unlikely to wish to serve those patient groups who would not generate a sufficient profit. Unprofitable clients may be found in certain geographical areas (e.g., poorer communities, which Australia found could not generate enough revenues to support FP/c hospitals), among particular groups (e.g., those without adequate insurance), in particular disease categories (depending upon the reimbursement structures), or even within disease groups (e.g., if payment is per case, providers may have an incentive to avoid the more complex cancer cases, or the diabetics with significant co-morbidity). Indeed, the literature clarifies that even with public or NFP ownership, linking payments to individuals (e.g., capitation) or otherwise capping reimbursements may lead to ‘quality skimping.’17 The literature also suggests that being able to set sufficiently detailed rules, in advance, to control such incentives is difficult, and that, even if possible, the regulatory and informational requirements necessary to do so would impose sizeable transaction costs. The literature also stresses that it is very hard to regulate capacity, especially where ownership and management are fragmented.17

In practice, the requirements for social entrepreneurship may thus be difficult to implement. The emphasis on the ability to verify assumes that measurability is high. This will vary by sub-sector. One can envision monitoring the accuracy of laboratory tests or the purity of pharmaceuticals; it is less simple to see how one would monitor the contents of an office visit to a physician. Monitoring also carries significant transaction costs, particularly if trust is low.
Where measurability is not high, most jurisdictions have therefore chosen to operate in a high trust environment where they can rely more heavily on values and stewardship. As Chinitz suggests, when there are strong common norms and values, direct supervision may not be as necessary.\textsuperscript{17} High trust models would thus appear to be a better fit with NFP or FP/s delivery models than with FP/c, where there are conflicting imperatives to maximize return on investment to shareholders. Highly competitive models may also undermine tendencies for cooperation. We are accordingly not sanguine about being able to design a purely regulatory regime which would incent FP/c providers to bring about socially desired results with respect to costs or access.

In contrast, our review suggests that it would be more feasible to ensure quality, regardless of ownership type, if (a rather optimistic assumption) professionals can agree about quality indicators, measure them, and enforce quality standards. Indeed, there is considerable international effort underway to do precisely that. It is obviously critical to ensure both that quality can be measured, and that the watchdogs have sharp enough teeth to enforce agreed-upon measures. In theory, it is not necessary to have public ownership in order to ensure good quality. However, the ability to define and measure quality in many sub-sectors remains elusive. As Chinitz wrote: “the pursuit of outcome and quality measures turns out to be a kind of ‘technocratic wish’ that remains largely unfulfilled and does not appear to be capable of removing uncertainty from the medical care system.”\textsuperscript{17} Assumptions that patients can judge act as the judges and enforcers of quality appear even more problematic. Despite efforts to develop report cards, and enhance patients’ rights, few believe that these measures alone, however desirable in their own right, can ensure quality.

Our conclusions are thus rather measured. It is indeed possible to incorporate private hospitals into a health care system, and have these meet public goals. The systems we have examined do just that. They do not rely exclusively, or even heavily, upon public ownership (of either types 1 or 2). However, neither is it likely that FP/c organizations will voluntarily comply with goals relating to cost or access without imposing a costly (and often ineffective) regulatory regime. The best compromise - and that used in the countries we analyzed - appears to be reliance upon NFP organizations which themselves are guided by principles of stewardship to the public interest, within a framework of incentives which will encourage (or at least not overly
penalize) activities in support of public goals.

Acknowledgments

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Table 1: Selected indicators for the cases studied

<table>
<thead>
<tr>
<th>Variable</th>
<th>Canada</th>
<th>Australia</th>
<th>Germany</th>
<th>Netherlands</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (millions)(^1)</td>
<td>31.4</td>
<td>19.7</td>
<td>82.5</td>
<td>16.1</td>
</tr>
<tr>
<td>Population density(^1)</td>
<td>3</td>
<td>3</td>
<td>230</td>
<td>390</td>
</tr>
<tr>
<td>Acute care hospital beds/1,000 pop(^2) - (2000)</td>
<td>3.2</td>
<td>3.8</td>
<td>6.4</td>
<td>3.5</td>
</tr>
<tr>
<td>Hospital discharges (all causes) / 100,000 pop(^3) (2000)</td>
<td>9,391</td>
<td>15771</td>
<td>19,730 (1999)</td>
<td>9,266</td>
</tr>
<tr>
<td>Average LOS acute care (days)(^4)</td>
<td>7.2</td>
<td>6.1</td>
<td>9.6</td>
<td>9.0</td>
</tr>
<tr>
<td>Total expenditure on health, % GDP(^5) (2000)</td>
<td>9.2</td>
<td>8.9</td>
<td>10.6</td>
<td>8.6</td>
</tr>
<tr>
<td>Total expenditure on health, % GDP(^5) (2001)</td>
<td>9.7</td>
<td>9.2</td>
<td>10.7</td>
<td>8.9</td>
</tr>
<tr>
<td>Total expenditure on health, PPP/capita(^2) (2000)</td>
<td>2580</td>
<td>2363</td>
<td>2780</td>
<td>2348</td>
</tr>
<tr>
<td>Total expenditure on health, PPP/capita(^2) (2001)</td>
<td>2792</td>
<td>2513</td>
<td>2808</td>
<td>2626</td>
</tr>
<tr>
<td>Public expenditure on health, % total(^5) (2000)</td>
<td>70.9</td>
<td>68.9</td>
<td>75</td>
<td>63.4</td>
</tr>
<tr>
<td>Public expenditure on health, % total(^5) (2001)</td>
<td>70.8</td>
<td>67.9</td>
<td>74.9</td>
<td>63.3</td>
</tr>
</tbody>
</table>


\(^2\) OECD Health Data 2003 - Frequently Asked Data; data for 2000 (most recent available for all four jurisdictions) (downloaded from [http://www.oecd.org/document/16/0,2340,en_2825_495642_2085200_1_1_1_1,00.html](http://www.oecd.org/document/16/0,2340,en_2825_495642_2085200_1_1_1_1,00.html))
Appendix A: Case study, Australia

A-1 Australia in brief

Australia has a population of approximately 19 million, on a land mass roughly the size of Western Europe. Its Constitution established a federal system of government, with a Commonwealth (national) government, plus eight sub-national units (six States and two Territories). The Commonwealth has a monopoly on income tax collection, but transfers resources to the States and Territories. The States have powers in all areas not specified as federal responsibilities.

Initially, the Commonwealth had a minimal role in health care, restricted to quarantine. In 1946, a constitutional amendment allowed a larger federal role in both financing and delivery. At present, responsibility for health care is shared, resulting in complex arrangements. In 1995, the Council of Australian Governments (COAG) attempted to codify the responsibilities of various levels of government; they agreed that the Commonwealth should take leadership in public health standards and research, while leaving to the States and Territories responsibility for managing and coordinating provision of services and maintaining direct relationships with providers. The private sector was seen as being an important participant in both financing and delivery.

At the time of writing, the States and Territories have primary responsibility for delivering and managing public health services, regulating health providers, and funding and delivering a range of services, including school health and maternal and child health. They also own and operate those acute care hospitals classified as “public.” The States and Territories have adopted a variety of governance models for their public hospitals, ranging from centralized management control (Ownership type 1) in Queensland, to regionalized area health services in New South Wales and more informal networking structures in Victoria (Ownership type 2). The Commonwealth government takes a leadership role in public health and policy direction. It is directly responsible for insuring (funding) nursing homes, physician services and most other outpatient medical services, and pharmaceuticals, under the auspices of the Medical Benefits and Pharmaceutical Benefits Schemes, which are managed by the federal health insurance commission. The national government also gives annual block grants to State/Territory
governments to assist with funding the public hospitals. These grants are based on negotiated five year Australian Health Care Arrangements (AHCAs) and go into the general revenues of the sub-national governments. However, they carry with them a number of national conditions, including a prohibition against user charges for public hospital services (although user fees are allowed for certain services). Local (municipal) government plays a relatively small role in health care. The private sector is heavily involved in both delivering health care and in financing it (through private health insurance). One estimate is that in 1997-98 approximately 46% of health expenditure was directly funded by the Commonwealth, with another 24% flowing from State and local governments (including indirect Commonwealth funds in the form of grants to general revenues of the sub-national units), and the remaining 31% from such private sources as private health insurance, voluntary private contribution schemes, and out-of-pocket user fees.

Australia has seen several approaches to financing health care services, at times implementing universal coverage, and at times abolishing it. In the mid 1940s, a system of free hospital care was introduced, which the Commonwealth government then forced the States to dismantle in the early 1950s. Subsequent changes of government led first to the introduction of universal insurance (Medibank), and then to its privatization. Depending upon the policy preferences of the government of the day, policy has swung between the extremes of public delivery (resembling the UK system), and public subsidy for private health insurance (resembling the US).

The current system contains elements of both. The universal national system currently in place for financing care, referred to as Medicare, was established in 1984. It covers physician services, pharmaceuticals, public hospital care, nursing homes, ambulances, medical aids and appliances, non-institutional services such as community health, and health research. Those services not included in Medicare (including private hospital care, and treatment by health professionals other than physicians) are paid for privately, either directly by service recipients, or through optional private health insurance. The current Commonwealth Government has announced its view that strong private sector involvement in health services provision and financing is essential to the viability of the Australian health system. Private insurance can be purchased to cover hospital charges, a portion of medical fees in hospitals, allied health /
paramedical services (such as physiotherapists’ and podiatrists’ services) some complementary and alternative services, and some aids and appliances (such as eye glasses). In general, private coverage was used primarily for elective procedures; people would use public hospitals for more serious care. To encourage Australians to purchase insurance early and retain it as long as they live, the government has used the expenditure mechanism to subsidize the purchase of private health insurance; there is a 30% open-ended rebate on private health insurance premiums provided to individuals who acquire private health insurance, which replaced a means-tested dollar limited rebate which had been introduced in 1997. This is coupled with taxation mechanisms, such as an exemption from the 1% Medicare surcharge on high income earners and penalties on those who take out health insurance after they reach age 30. This package of measures was accompanied by an aggressive, publicly-funded publicity campaign (exhortation). Government has also attempted to trim direct public expenditures on health and divert these funds to private insurance, arguing that a viable private health industry will improve choice of health services for Australians. As a result of the Commonwealth efforts in this regard, there has been an increase in the proportion of Australia’s population covered by private health insurance from 33% in 1996 to approximately 45% in 2001. Nonetheless, there has been some evidence of subsequent decreases (to 43% in 2002), with the lowest retention rates in the younger age groups.

The private insurance industry is regulated by the Commonwealth government, which has registered over forty private health insurance funds. The government has used regulations to require insurers to maintain community rating (charging the same rate, regardless of risk). However, this exposes insurers to moral hazard, since those most likely to use services are most likely to purchase private insurance. An interim approach has been a mandatory system of reinsurance across health insurance funds; this has proven insufficient, and government is accordingly relaxing their restrictions on basing premiums on actuarial risk. The policy of encouraging private coverage has been highly controversial, and the extent to which it represents cost saving rather than cost shifting is under heavy debate in Australia.

State/Territory governments are also responsible for the regulation of health care providers as well as for the licensing and approval of private hospitals. The majority of doctors are self-employed private for-profit providers (FP/s). Most primary care provided by
general practitioners in private practice is reimbursed by the publicly-funded insurance system on a fee-for-service basis. A small proportion of physicians are salaried employees of Commonwealth, State/Territory or local governments. General practitioners in primary care act as gatekeepers, with access to specialist medical services requiring referral. Specialists in public hospitals are either salaried or paid on a per-session basis. Salaried specialist doctors in public hospitals can treat some patients in these hospitals as private patients; such private patients are charged additional fees, and doctors usually contribute some of this fee income to the hospital.

A-2 Hospitals in Australia

The terms of the AHCAs provide all Australians access to “free” hospital care (without co-payments) based on medical need, if they receive this care from public hospitals. There is an extensive list of “supplementary” items for which co-payments are levied (dental services, assistive devices such as hearing aids, some surgical supplies, prostheses with the exceptions of artificial limbs or implanted protheses, and pharmaceuticals at a level consistent with the Pharmaceutical Benefits Scheme statutory co-payments). However, people must pay for care received in private hospitals. These costs can be covered through private insurance. In addition, should they wish to select their own doctor, Australians may choose to be “private” patients within public hospitals, and pay accordingly. Government has accordingly sought (with limited success) to encourage people to register as “private” patients, to provide an additional revenue stream to offset public expenditures. They have also sought, again with limited success, to encourage private FP delivery, which shifts costs from taxpayers to private insurers.

In 1996-97, hospitals represented approximately 36% of the total of 44.3 billion in health expenditures (8.4% of GDP). This had fallen to 32.2% of $66.6 billion by 2001/02. The hospital sub-sector consists of a mix of public, private NFP, private FP/s, and private FP/c hospitals. Australia tends to use the term “public” to refer both to hospitals directly owned and operated by the States/ Territories, but also to a number of NFP hospitals owned and operated by religious groups or charities but funded by government to provide ‘public’ services. State/Territory governments set the budgets they assign to the publicly-funded hospitals in their jurisdiction. In addition, there are FP/s hospitals owned by physicians, hospitals owned by
private insurers, and (unusual among the jurisdictions studied) a growing investor-owned FP/c sector.

The investor-owned chains have had a mixed record of success. Prior to the increase in private hospital coverage in the later half of the 1990s, the large private hospital chains were not generating the profit margins originally anticipated, forcing government to “bail out” the private providers. Most recently, however, access to government revenue through services to public patients, the increased private coverage, co-location strategies whereby private hospitals are located in close proximity to public hospitals and share resources with them, and government subsidies have altered the situation.32,80

From 1991-92 to 1996-97 the bed supply in private hospitals increased by 10.7% while patient days increased by 19.7%; the growth over this period was largely accounted for by the investor-owned chain hospitals, with a 31.9% increase in beds and a 50.7% increase in patient days. In contrast the public hospital bed supply fell by 6.4% over the same period. In consequence, by 1997-98, the private hospital sector made up 22% of the hospital sector in terms of expenses, almost doubling over the decade. The growth has since stabilized, and was estimated at 23% for 2001-02).80,83 In 1998-99, there were 50,851 acute care beds in “public” hospitals, and 23,746 acute beds in private facilities.67 This increased slightly by 2001-02, to 51,461 public and 24,465 private beds.

Public and private hospitals, however, are not perfect substitutes for each other. Accident and emergency facilities, as well as technologically complex and highly specialized services, remain concentrated in the public sector. Large urban public hospitals provide most of the more complex types of hospital care such as intensive care, major surgery, organ transplants, renal dialysis and specialist outpatient clinics.67 Private hospitals tend to provide less complex non-emergency care, such as simple elective surgery. Free-standing centres for same-day surgery and other non-inpatient operating room procedures are found mostly in the private sector, although many public hospitals also provide such services within their site.67 As the private FP/c sector increases however, some private hospitals are increasingly providing complex, high technology services. However, issues relating to medical liability have led private hospitals to re-examine which services they can safely provide, and to no longer offer some more specialized care (e.g., paediatric surgery).
In consequence, private hospitals are heterogeneous, and the distinctions between public and private hospitals are increasingly blurred. While ‘public’ hospitals include both large government-owned facilities, and some facilities originally established by religious or charitable organizations but now directly funded by government, there are also NFP private hospitals run by religious and charitable organizations. The State governments may flow funds to private FP firms to provide public hospital services under contractual arrangements. In addition, Commonwealth subsidies account for approximately 15% of private hospital revenues. The line is further blurred by the increasing practice of co-locating private and public facilities on the same campus. Co-location has been encouraged by State governments, under the argument that private investors gain access to new markets, while the public sector benefits from cost-sharing of capital intensive equipment, infrastructure costs, and support services such as laundry and maintenance. These strategies are also intended to be attractive to physicians who will find it easier to work in both the public and private systems.

Australia also has a network of specialized mental health care organizations, including publicly-operated psychiatric hospitals, units in general hospitals, and community based programs. Historically, these mental health services have operated separately from mainstream health services, but the Commonwealth, State and Territory Governments are currently working under the National Mental Health Strategy to mainstream and integrate mental health services and replace the separate psychiatric hospitals with community based and general hospital services. The Australian system differentiates between the regulatory framework employed in the “public” and private hospital sectors. It relies upon expenditure, exhortation, and regulation for the publicly-funded hospitals. In contrast, the private sector operates under an extensive regulatory framework at the State/Territory level. The State of Victoria has justified this approach by noting that “Private hospitals obviously operate much more autonomously than public hospitals and are not subject to control measures including the withdrawal of government funding, the appointment of hospital boards and the provision of performance based funding which can be linked to the achievement of quality criteria.” Public hospitals also operate under a mandatory accreditation system, whereas private hospitals are subject to government inspection.
A-3 How has Australia handled these issues?

A-3.1 Capacity: (capital planning)

For publicly-funded hospitals, government employs expenditure in deciding where to build. Regulation is employed for private hospitals who must seek approval from the State Ministries of Health before purchasing land, constructing a new private hospital, or changing the number of beds or the services provided. Capital funding is the responsibility of the State/Territory governments since the Commonwealth does not provide funds for capital purposes. Given the limited ability of the State/Territory governments to generate revenue independent from the Commonwealth, this has led to various public private arrangements to fund construction activities.79

There were 4.0 available acute and psychiatric hospital beds per 1000 population in 1997-98 in Australia; down from 6.4 in 1980 and just below the European Union average of 4.4. States differ, however, in the extent to which they have sought to limit or encourage private hospitals. In 1997-98, the national ratio of 2.8 public acute beds and 1.2 private acute beds per 1000 population varied in mix, from no private beds in the Northern Territory to 1.0 private bed per 1000 population in New South Wales to 1.7 in South Australia.79

The State of Victoria, with 2.6 public and 1.3 private hospital beds per 1000 population, has identified a desirable maximum bed to population ratio of 4.1 acute public and private beds per 1000 population. They also implemented guidelines which require that applications to develop new or changed hospital facilities should be based on a redistribution of existing beds from over to under-serviced areas of the State. The use of the bed cap is intended to avoid duplication and prevent over servicing, and to achieve equitable distribution. The regulations note that private operators cannot ‘warehouse’ or hold beds if a facility is not operating. This State government does not allow the conversion of public to private beds. The Australian Competition and Consumer Commission has also played a role in the allocation of private hospital beds, such as making recommendations when various private hospital providers sold their facilities.

There is considerable variation across States. Although these restrictions were intended to cover planning of both public and private hospitals, some State governments have not used the
bed guidelines to formally assess proposed developments in the publicly-funded sector, but have instead relied upon expenditure, using a combination of case-mix funding and government budget control. These measures have been seen as sufficient to control patient volume in the publicly-funded hospital sector.84 Other States employ capital planning guidelines.

A-3.2 Costs and prices

There are, ostensibly, no costs to “public” patients for services in publicly-funded hospitals. Persons eligible for medicare are entitled to “free accommodation, and medical, nursing and other care as public patients in State/Territory-owned hospitals, designated non-government religious and charitable hospitals, or in private hospitals which have made arrangements with governments to care for public patients.”67

The myriad of user charges and de-listed activities, however, can result in significant out-of-pocket expenses.

If patients choose to be treated as private patients, whether in public or private hospitals, they receive government subsidy in the form of payments to the private physician, equivalent to 75% of the Medicare Benefits Schedule Fee. Government explicitly does not control what fee physicians can charge; all charges over and above the 75% of the Medicare Benefits Schedule fee are paid by the patient, either out-of-pocket or through private insurance coverage.67 The Commonwealth government does regulate the fees which can be charged to private patients by public hospitals. Private hospitals are free to set their own rates. Recently, these fees have been controlled by the rates negotiated by the private insurance funds, since most patients seeking care in private hospitals have private insurance. One mechanism to maintain lower rates was a regulatory intervention by the Australian Competition and Consumer Commission in 1999; it prevented the three largest Sydney private hospitals from pooling their market strength, and required them to negotiate separately with the funds.

A review of comparisons between public and private hospitals in Australia concluded that private hospitals appear to generate higher administrative costs, offer more costly procedures at a higher unit cost, with questions about the quality of care.85

A-3.3 What services are offered?
There are few obvious controls over which specific services can be offered by hospitals. In some States, the registration of private hospitals specifies the services they can provide. In Victoria for example, the Secretary to the Department of Human Resources is required to state on a certificate of registration “the kinds of prescribed health services that may be carried on in the premises” of a private hospital and makes it an offence to provide health services for which a facility has not been registered. The specification, however, is at a high level (i.e., medical, surgical, obstetrics, emergency, coronary care, intensive care, rehabilitation, organ transplantation, infertility treatment, radiation oncology and psychiatric).

Governments have some control over the public hospitals through expenditure; recently States have also used regulation to strengthen their control over governance. For example, in the State of Victoria, government has taken greater control over the appointment of board members, and the strategic and service planning requirements. In contrast, they appear to assume that competition will ensure that private hospitals will provide what is necessary. In general, private hospitals tend to work autonomously. Indeed, this tendency is leading to pressure to remove capacity controls to allow the market to work more efficiently. The department of Human Services in Victoria has argued that deregulation of the industry by removing the bed cap would “facilitate the efficient allocation of resources within the acute hospital sector,” adding that the bed cap has not guaranteed consumer access to the right type of hospital bed, as evidenced by waiting list for various surgical procedures and low occupancy in segments of the private hospital sector. The removal of the bed cap, it is argued, would facilitate improved competition between the public and private sectors to address these challenges and ‘facilitate the expansion of patient facilities and encourage private hospitals to provide a greater array of health care services”86 This stance appears to be based on faith, rather than on any evidence that the market will ensure appropriate distribution, or recognition that the usual aim of bed caps is the control (rather than the expansion) of hospital capacity and services.

A-3.4 Access - who gets services?

All Australians, in theory, have full access. However, the development of a two-tier system has raised some concerns about waiting lists for publicly-financed services, particularly surgical services. There is some concern that surgeons prefer to treat private patients. Also, the
increasing demands on the emergency departments of public hospitals (who are required to ‘take all comers’) has driven up their waiting lists for elective procedures; these constraints do not apply to the same degree in private hospitals. There is concern about both the structure of the financing arrangements, and the availability of surgeons. As Birrell has noted: “The expansion in the proportion of Australians with private hospital insurance means that surgery is generally available for the more affluent and for those with the foresight, means and willingness to make the required financial sacrifice. Further growth in the demand for surgeons to work in the private sector is likely to be at the expense of the hours that surgeons work in the public sector. The tendency for waiting lists to grow within the public sector is thus a reflection of this situation and the parallel reluctance of governments to finance growth in the public hospital system.”

The system also incents ‘cream skimming’ by private hospitals, and is claimed to leave complex, expensive care to the public sector.

As noted, physician reimbursement arrangements provide incentives to work in the private system. Surgeons receive a higher fee-for-service payment for work in the private hospital system or on private patients seen within the public hospital system than for equivalent work in the public system, where they are paid on an hourly basis. “If surgeons wished to maximize their pecuniary interests they would work exclusively in the private sector. They do not, in part because there is insufficient work in the private sector and in part because there are other non-financial incentives.” The Australian Competition and Consumer Commission (ACCC) has suggested that one approach might be to further increase the number of surgeons, and criticized the Royal Australasian College of Surgeons (RACS) for its stringent management of training and accreditation programs. This suggestion appears to represent a clash of policy goals; a strategy of increasing physician supply might address access issues, but would also make it more difficult to control costs through the mechanism of controlling capacity.

**A-3.5 Health human resources - who can you hire? What do you pay them?**

Australia employs regulation to mandate general staffing patterns. There are regulations which require “proprietors to ensure that a sufficient number of appropriately educated or experienced nursing or other health professional staff is on duty and that the needs of patients are met promptly and effectively.” In Victoria it is regulated that Members of the Nursing staff must
be currently registered under the Nurses Act 1993. These performance-driven requirements work within the context of nursing staff ratios mandated through the Enterprise Bargaining Agreement, which specifies specific nurse-to-patient ratios. In addition, a number of collective agreements require proprietors to commit to “ensuring that staffing levels are appropriate, thus ensuring the delivery of quality patient care and keeping with best practice principles which take into account patient acuity.” Private hospital proprietors must also inform State government when they appoint or terminate a Director of Nursing, CEO, Medical Director, as well as when one of these positions is vacant.

Hospital-based training of physicians is largely funded by State governments. A separate body, the Australian Medical Workforce Advisory Council (AMWAC), provides recommendations regarding the number of training positions which should be funded. Cost control efforts have led government to attempt to reduce the supply of physicians, including limiting the training spots they will fund. One result is considerable potential for cost and blame shifting, because health service provision is a State issue, and university education a national one. Most training of health professionals occurs in the public sector, although there is some limited training in privately-owned institutions. Reforms are currently being implemented to the university sector, and more extensive health workforce planning efforts are under development.

### A-3.6 Quality control within institutions

State/Territory governments have responsibility for hospitals. The government-funded (“public”) hospitals are influenced through exhortation and expenditure, backed up by regulation. For example, the State government of Victoria mandates accreditation by the Australian Council on Healthcare Standards,\(^8^8\) and pays an accreditation bonus to successfully accredited public hospitals. It also employs various performance indicators, including conducting patient satisfaction surveys, monitoring unplanned readmissions, publishing cleaning standards, and requiring that hospitals produce quality plans.\(^8^4\) It mandates a clinical risk management and infection control strategy.\(^8^7\) However, under existing legislation in most States, accreditation cannot be mandated for those hospitals not receiving public funding; neither are accreditation standards enforceable. Certain State governments (e.g., Victoria) have also expressed unease at delegating responsibility for regulating the industry to agencies not directly
answerable to the Parliament. However, under existing legislation in most States, accreditation cannot be mandated for those hospitals not receiving public funding; neither are accreditation standards enforceable. State/Territory governments are also responsible for the Quality of Care and regulation of private hospitals.

Although the rhetoric speaks of relying upon market forces and competition to ensure quality of care, there are also extensive regulatory provisions, depending upon the State. For example, the State of Victoria incorporates provisions in the *Health Services Act, 1988* which specify Guidelines for the Development of Acute Hospital Services, as well as in the regulations under The Health Services (Private Hospitals and Day Procedure Centres). A Governance Reform Panel has also recommended significant strengthening of the regulatory approach for Victorian public hospitals. In general, each State has a state-level Health Act combined with regulations. These have different titles; New South Wales employs the *Private Hospitals and Day Procedure Centres Act 1988*; South Australia has the *South Australian Health Commission Act 1975*; Western Australia the *Hospitals and Health Services Act 1927*; Tasmania the *Hospitals Act 1918*; and Queensland the *Private Health Facilities Act 1999*.

In contrast to the exhortation approaches used for publicly-funded hospitals, in Victoria private hospitals receive mandatory annual inspections by the Department of Human Services to assess standards of care against a detailed questionnaire covering issues such as safety, patient rights, records maintenance, staff education, the availability of equipment and infection control. In addition to annual inspections, private hospitals are inspected before opening, following any major renovation, and if a quality complaint is received. The regulatory framework specifies such items as the level of equipment that is appropriate for the type of patients and procedures performed; requirements relating to information, privacy and treating patients with dignity; and employment of “sufficient and appropriately qualified nursing staff.” The private sector is also subject to the same rules regarding infection control, safety, and standards of care which apply to publicly-funded hospitals.

The private hospital regulations in Australia have the force of law and do carry penalties for non-compliance. In Victoria, penalties are expressed in ‘penalty units’ whose value is set by the Sentencing Act 1991; the current value is $100 per unit. Penalties range from 10 penalty units for failure to have an appropriate system to properly identify patient rooms to 80 penalty units.
units for failure to develop and implement an effective infection control management plan. In addition to such penalties, government retains the ability to revoke the registration of a private facility (in effect putting that proprietor out of business) if a proprietor fails to comply with the regulations, or it is determined that a proprietor is not likely to comply. Such sanctions are not used lightly, but they do exist.87

In other States, however, there are some concerns about the ability to maintain and monitor quality. Pollock et al. cite the example of the Joondalup Health Campus in Western Australia, which contracted out the management of a public hospital. A 1997 report by the Western Australian Auditor General found “serious limitations of the quality standards employed within the contract” and few limitations on preventing “opportunistic behaviour.” Specific issues related to the ability to limit the quantity of services provided “where the Operator considers it not to be in its commercial interest,” the risk of inappropriate early discharges “to minimise operational costs,” and incorrect coding of treatments to maximize reimbursements.85

Although a number of the regulations are relatively broad in nature, there are examples that suggest the potential for increasingly stringent regulation of the sector should that be deemed necessary. For example, Victoria includes specific requirements for rooms to be identified by a “letter or number” clearly noting the number of beds and/or recovery chairs normally in the room in order to ensure that “patients can be easily located and evacuated in times of emergency.” There is also a requirement for an electronic nurse call bell system so that patients and staff can call for assistance. A specific regulation also exists to “ensure that a system or mechanism is installed to control the outlet temperature of hot water” to prevent scalding; it was introduced after a coroner’s inquest into the death of an elderly women from hot water burns at a nursing home.87

In its regulatory impact statement on the proposed private hospital regulations, the State of Victoria identifies three reasons why such regulation is essential: to set a minimum standard; counter-balance information asymmetry (between patient and provider); and to give State government ability to enforce obligations under the AHCAs. The State noted, however, that there are other factors that encourage private hospitals to provide and demonstrate quality care. Many have entered into purchaser-provider agreements with government. Others have
voluntarily accredited with a recognized accreditation agency as a condition of such contract or to demonstrate commitment to quality service. “Nevertheless, accreditation is by no means universal within the industry and, in a competitive environment, incentives will always exist for less scrupulous operators to cut corners.” It accordingly argues that “The only certain way in which private hospitals and day procedure centres can be compelled to provide quality health services is by regulation.87

Among the organizations using exhortation measures to develop guidelines, the Australian Safety and Efficacy Register of New Interventional Procedures - Surgical (ASERNIP-S) performs systematic reviews of new and emerging surgical technologies and techniques and produces clinical practice guidelines.90 It is a part of the Medical Services Advisory Committee that provides information to the national Minister for Health and Aging about the effectiveness, safety, and cost-effectiveness of health technologies.91 Although it is an exhortation body, it is said to “inform” expenditure decisions by the Commonwealth Government. It is a member of the International Network of Agencies for Health Technology Assessment (INAHTA).59

Although not mandatory, accreditation is common; 90% of private hospitals, 85% of bush nursing hospitals and 60% of day procedure centres have been accredited by the Australian Council on Health Care Standards Evaluation and Equality Improvement Program (ACHS EQUIP), the International Organisation for Standardisation Quality Management System 9000 (ISO 9002) and/or the Quality Improvement Council Quality Improvement and Community Services Accreditation (QICSA).

A-3.7 Information provision

The clash between the corporate values of maintaining privacy about their activities, and values of accountability to the public has meant that detailed information about the costs and activities of privatized hospitals is not always available. Private hospital are required by regulation to give individual patients information about the fees they will be charged on or before their admission. From a more system-wide perspective, critics have suggested that the introduction of corporate governance mechanisms, and the abolition of community representation on hospital boards represent an “insidious shift to ideas which undermine the
notion of citizenship.”

A-4 Australia, summary

Australia is the only case examined which has attempted to make extensive use of FP/c hospitals. In our judgment, this experience has not been particularly encouraging, although we recognize that insufficient information may be available to make an informed judgment. The government has expressed considerable faith that market forces alone will improve cost-effectiveness and allocative efficiency. Critics note that the resulting system requires extensive regulation and public subsidization. Indeed, the total share of private financing of the system has been reduced from 11% to 6%. As Gray noted, “far from generating greater private sector contributions to the overall health system, thus relieving pressure on public hospitals, as the Government claimed, taxpayer dollars have been used to replace private dollars.” Gray has argued that the beneficiaries of this public expenditure are the physicians who wish to work in the private sector, private hospitals, and the private health insurance industry, while the losers are “the majority of Australians who rely entirely on Medicare, who could have their services significantly upgraded with these tax dollars, now totaling approximately $2.5 billion annually.”

An unexpected consequence of the emphasis on FP/c delivery has been a shift from co-operative to litigious relationships between the private sector and the government. Again, fears have been expressed that the resulting environment will harm social capital and lead to further regulation. In 1996, for example, a contract was signed between the Victorian State government and Australia Health Care Ltd (AHC) for the provision of a 257 bed public hospital, to be owned and operated by this FP/c company. AHC operated 16 hospitals nationally. The hospital was not profitable, and was estimated to be the single largest contributor to AHCs reported financial loss of $79 million in 2000. In February 2000 AHC alleged that the State government had breached the contract and issued proceedings in the Supreme Court of Victoria seeking compensation. The AHC accused the State government of refusing to honour its contractual obligation to pay ‘appropriately’ for a range of services including mental health, child and adolescent community health, women’s health and a suicide prevention programme. The Victorian Minister for Health stated that the losses incurred by Australian Hospital Care meant it
could no longer guarantee the hospital’s standard of care, and the hospital was transferred back to public ownership.\(^{32}\)

Australia thus warrants careful monitoring to see whether the results of this experiment with FP/c delivery meets the hopes of its advocates, or the fears of its opponents.
Appendix B: Case study, Canada (Province of Ontario)

B-1 Ontario, Canada in brief

Canada has a federal form of government, with a national government (in Ottawa) and thirteen sub-national governments (ten Provinces, plus three sparsely populated northern territories). Under Canada’s constitution, health care is under provincial jurisdiction. However, there is considerable variability in the fiscal capacity of these sub-national governments. Accordingly, the national government provides considerable funding to the Provinces in an effort to “equalize” fiscal capacity and allow the provision of relatively equivalent levels of service across the country. Arguments about the amount of funding and the extent of ‘strings’ attached to it have ensured that federal-provincial fiscal arrangements are persistent causes of friction within the federation.66,92-95

The Canadian Institute for Health Information (CIHI) collects and publishes health expenditure data. It has estimated that about 70% of health expenditures come from the public sector, largely but not exclusively paid by Provincial governments. This is heavily related to sector. The public share for physician costs is estimated at 98.9%, and the public share of hospital costs at 92%. In contrast, CIHI estimates that 38.5% of drug costs, and 8.5% of expenditures for other health professionals outside of hospitals, come from public sources. The public share of total health expenditures has dropped from 76.2% in 1975 to 69.9% by 2003, largely as a result of a shift of care from hospitals to home and community. Indeed, the proportion of health costs going to hospitals has dropped from about 44.7% of total health expenditures in 1975, to 30.0% by 2003.96,97

Each Province acts as the single-payer for all those services insured under the public plan in their Province; funds are raised by taxation, and come from Provincial general revenues. All Provinces have a department within their provincial government responsible for health care services. The precise arrangement of programs within departments varies. For example, some Provinces combine health and social services, while others do not. Ontario’s activities are centred in the Ministry of Health and Long Term Care (MoHLTC, formerly called the Ministry of Health). The federal government flows its contribution into the general revenues of each Province. To receive federal funds, the insurance plan within each Province must comply with
national standards, as designated in the *Canada Health Act*, 1984 (CHA). This legislation incorporates earlier federal statutes (the 1957 *Hospital Insurance and Diagnostic Services Act*, and the 1966 *Medical Care Act*) and maintains their terms and conditions. To respect Provincial jurisdiction, the national government does not micro-manage precise coverage decisions, but does require that all Provincial health insurance plans be publicly administered, and provide universal coverage to all legal residents of that Province for all “medically necessary” insured services, without co-payments or other impediments to “reasonable access” to insured services by insured persons. There are no federal restrictions on how this care is delivered as long as it is publicly financed. For historical reasons, the federal definition of insured services is based on who provides care (physicians), and in what setting (hospitals). As care moves out of hospitals to non-physician providers at home or in the community, the Provinces can still choose to cover it, but the federal act does not require this.98,99

Physicians are independent FP/s providers; almost all practice in solo or group practice and are paid fee-for-service, on the basis of a fee schedule negotiated between the Provincial governments and the Provincial medical associations. Both general practitioners and specialists may work in both private offices and in hospitals; they must be granted ‘privileges’ by that hospital to work there. They are usually paid by fee-for-service through the Provincial health insurance plan, although certain specialists (particularly laboratory medicine) may be salaried by individual hospitals. For the most part, physicians' services provided to hospital patients are not included within hospital budgets, but are paid through Provincial health insurance plans. A small number of alternative practice plans have replaced fee-for-service payment for physicians in some hospitals; they are administered by the participating physicians, who in turn decide how to allocate those funds. Such practice plans are gaining in popularity and acceptance, particularly among physician groups whose practice is predominantly hospital-based and whose workloads are unpredictable (e.g., emergency medicine, medical imaging, critical care, and anaesthesia).

One predictable consequence of the way insured services are defined is a tendency by Provincial governments to respond to fiscal constraints by shifting costs away from the public purse through ‘passive privatization’ (e.g., encouraging early discharge from hospitals, de-insuring community-based rehabilitation services). There are limits to the effectiveness of this
strategy, particularly when patients respond by returning to hospitals to seek “free” services which could have been provided more efficiently through alternate levels of care. Health reformers are recognizing the inefficiency of emphasizing hospital-based delivery. Following a series of national investigations reviewing the health care system, leading to two major reports by a Commission chaired by Roy Romanow, and a Senate committee chaired by Michael Kirby, better (and more uniform) coverage for acute home-based services is now on the political agenda.100,101

All Provinces have passed legislation to operationalize the Canada Health Act requirements and define insured services for their Province (e.g., they all require that medically required hospital and physician services be fully covered). Beyond this basic similarity, however, and despite the CHA principle of portability, there are some differences in coverage at the margin from Province to Province. For example, although home care is not required to be an insured service under the CHA, it is provided to some extent in all Provinces, with the extent of coverage (and co-payments) varying widely. Where some Provinces cover the full extent of assessed nursing requirements, others limit coverage to a monthly dollar amount, a certain number of hours or to the equivalent cost of institutional care; home rehabilitation is fully covered in some Provinces and not at all in others.101 Ontario does provide assessment and case management, plus some in-home nursing, rehabilitation and personal care services. However, budgets have been capped, and patients and their families often supplement these by purchased services.

Because there are variations in how health care is delivered and regulated, this case study will focus on one Province, Ontario. Ontario spent 9.6% of GDP for health care in 2003, a level slightly below the national average (10.0%). Ontario also had a somewhat smaller public share (65.8%). One reason for focusing on Ontario is that over the past decade all other Provinces have set up some sort of regional authorities, which include hospitals.102-105 Although these regional authorities are nominally not-for-profit (rather than public) organizations, they do consolidate decision-making levers in fewer hands.106,107 Provinces are also changing regional boundaries and regional responsibilities. In contrast, regionalization has not occurred in Ontario’s hospital sector (although certain sectors, such as public health and home care, have been regionalized on a sector-specific basis), and Ontario’s hospitals remain largely independent
(and hence a better case study if examining the ability of governments to ensure that they meet public objectives).

Ontario is Canada’s industrial heartland, and home to about 12 million people (about 1/3 of Canada’s population). Although the Province covers over one million square kilometres (415,000 square miles)—an area larger than France and Spain combined—about 80% of the population is concentrated in the urban areas along the Great Lakes, bordering the United States. Canada has encouraged extensive immigration, and much of this population has settled in the “Golden Horseshoe” area around Toronto. Toronto has been called the most multi-cultural city in the world; more than 70 languages are spoken. These patterns of population present challenges in delivering healthcare to rural and remote areas, as well as to the large and multi-ethnic populations in the cities.

B-2 Hospitals in Ontario

Ontario’s regulatory structure specifies the following types of Hospitals: Public Hospitals, Private Hospitals, Provincial Psychiatric Hospitals and Federal Hospitals.

Most hospitals are classified as “public hospitals”, which, despite their name, are private not-for-profit organizations incorporated under the provincial Corporations Legislation, or by a separate Act of the Legislature. As a result of a number of mergers among these hospitals, there are currently 211 public hospital sites in Ontario, governed by 155 hospital corporations recognized in the Public Hospitals Act. Most Ontario hospitals are governed by a Board of Directors. Each hospital Board has legal and management responsibility for its hospital and is accountable to the ministry for the use of the grants it receives from the Province, which the Province refers to as “provincial subsidy grants.”108 The “public” hospitals employ over 200,000 individuals, and estimate that they receive assistance from another 50,000 volunteers. Hospitals tend to have strong support in their individual communities.

The remaining hospital types serve niche markets. There are eight small private hospitals regulated under the Private Hospitals Act. These hospitals (Ownership type 4) represent less than one half of 1% of the Province’s total allocation to hospitals. The Provincial Psychiatric Hospitals are public (Ownership type 2); they are owned by the Province and operated directly by the Provincial MoHLTC under the Mental Hospitals Act. They are funded solely by, and
report directly to the MoHLTC; their staff are civil servants. However, the Province has made a policy commitment to divest itself of these hospitals and turn them into “public” (NFP) hospitals. The federal government has also transferred much of its direct service capacity to the “public” hospitals. The federal government has direct responsibility for the health care needs of specific populations (veterans, armed services, aboriginal peoples) but largely satisfies these requirements (with the exception of military hospitals for troops deployed overseas) by purchasing acute services from public hospitals in the relevant Provinces. The federal government has retained direct operational responsibility for a number of Chronic Care hospitals to service the veteran population. Much like the Provincial psychiatric hospitals, the veterans’ facilities are owned and operated directly by the federal government and staffed by civil servants.

Within each Province, hospitals are organized into a voluntary association. In the provinces with regional health authorities, these organizations are now composed of the health authorities rather than (or in addition to, depending on the Province) the individual hospitals. Ontario, however, retains individual hospital boards, although numerous hospital amalgamations and mergers have recently occurred. The provincial hospital/health authority associations have a national-level umbrella association, the Canadian Healthcare Association. The Ontario Hospital Association (OHA) is the voluntary non-profit organization which represents all Ontario public hospitals, plus the Province’s psychiatric hospitals, and a number of other associate and affiliate members. It advocates on their behalf with government.109

The Ontario Provincial government describes the responsibilities of hospitals and government on their web-site, under “Hospitals : Frequently Asked Questions.”110 The description includes the explicit recognition that “Each hospital determines its priorities to address the needs of the communities it serves and allocates its budget accordingly.”

Within Ontario, the Health Insurance Act defines the medical (physician) services to be provided by hospitals, while funding for hospital services is governed under the authority of the Public Hospitals Act. At present, hospitals receive most of their funds through annual global (or base) budgets from the Provincial government. Although hospitals are supposed to be notified in March for the upcoming fiscal year, in recent years, it has not been uncommon for such announcements to be delayed until well into that fiscal year, in turn impairing the ability of
hospitals to plan their activities. Many hospitals have responded by running deficits in the expectation that the Province would be forced to cover those expenses; this in turn has discouraged those hospital boards which made often unpleasant cuts in order to remain within their budgets. The current provincial government has promised to provide better information to hospitals and make commitments for longer time periods, in return for clearer accountability as to the hospitals’ use of funds.

Budget allotments to Ontario hospitals are based primarily on past allocations and annual adjustments to reflect changes in costs. Because this approach perpetuates historical inequities and is seen as penalizing efficient hospitals, there has also been considerable attention, in partnership with the Ontario Hospital Association, to devising new, blended funding formulas, which will incorporate elements of case mix and population growth, but to date these account for only a minor proportion of hospital funding. In addition, special program funding is available for particular services which are designated as “new/expanded programs” and for certain specialized high cost services, such as cardiovascular and dialysis services and treatments.

B-3 How has Ontario handled these issues?

B-3.1 Capacity: (capital planning)

Ontario exerts tight control over capital planning through a combination of the expenditure and regulation governing instruments.

Ontario does not allow the building and operating of a hospital without approval of the Ministry of Health. Both public and private hospitals receive operating funding for their operation from the MoHLTC, and must comply with similar conditions, although they have differing legislative authority.

The Public Hospitals Act provides the legislative authority to regulate and fund the operations of the public (NFP) hospitals in Ontario. The Province also gave itself the power to direct hospitals to cease their operations or to merge with other organizations, although this was highly contentious and tested through an (unsuccessful) court challenge. These activities were operationalized through an arm’s length agency, the Health Services Restructuring Commission (HSRC), which “reviewed reports, recommendations and public submissions of cities examining
the future of their hospitals. It then decided how hospitals should change, including if any of the hospitals should close. The HSRC completed its mandate and was closed March 28, 2000.\textsuperscript{110}

Ontario places considerable barriers in the way of allowing new private hospitals. The Private Hospital Act specifies that "No person shall use a house as a private hospital except under the authority of a licence issued under this Act" and further that "No person shall use the term "hospital" or "hôpital" in connection with a house unless such use is duly authorized." Article 3 (1) of the Act allowed only private hospitals whose licenses were issued before October 29, 1973 to stay in existence, and banned licensing any new for-profit hospitals under this legislation. The eight small private FP/s hospitals already open were ‘grandparented’ by the Act. These private hospitals are not ‘general hospitals;’ they serve niche markets. For example, none have an emergency department and only two provide any acute services at all (one provides only endoscopy, and another is a centre of excellence for hernia repair); another concentrates on addiction treatment, and the remainder of the private hospitals provide long-term and chronic care services. The Act also specifies that any transfer of license or transfer of share capital of a corporation holding the license of a grandparented facility requires prior approval of the Minister of Health. Thus, allowing new private hospitals would require new legislation. This, in turn, would be highly contentious; there is considerable and vocal opposition to the idea of private FP hospitals in Canada, accompanied by some support from advocates of market-based approaches.

However, since 1991, a number of private FP clinics have been licensed under the Independent Health Facilities Act. About 100 are diagnostic facilities funded by the ministry to provide specific classes of diagnostic tests. Although these are not classified as hospitals, 25 ambulatory care facilities have also been licensed and funded under this act to “provide surgical and other physicians’ services that were historically performed only in hospitals (\textit{e.g.}, cataract and laser eye surgery, dialysis, laser dermatologic surgery, plastic surgery and gynecologic surgery). The IHF program funds the costs of carrying out the procedures that are not included in the OHIP fee paid to physicians."\textsuperscript{111} The Province accordingly has the ability to control how many of such private clinics can open; it has either encouraged or discouraged them, depending upon the (often ideological) preferences of the party in power.

Another set of controls arise from the treatment of capital expenses. The federal Canada Health Act requires that insured persons be fully insured for “medically required” services
provided within hospitals or by physicians, but does not require that Provincial insurance plans fund capital expenditures. However, most Provinces do pay at least a proportion of capital costs. In Ontario, the Province covers between 50% and 70% of the vast majority of ‘approved’ capital projects; the hospital is required to raise the remaining funds.112 At present, the Ontario MoHLTC manages capital construction through the Health Capital Program (located within the Ministry's Corporate Services Group). This Program provides financial assistance to hospitals towards the cost of approved capital construction. Approval of capital projects requires that they follow the Ministry's capital planning process, which typically also requires approval of a functional plan by the Ministry. Operating funding for new capital construction is provided following approval of a pre-construction operating budget. In many cases, however, where capital construction replaces existing facilities there is an expectation that the operation of the new facility be done within the existing funding allocation. The operating funding they receive from the MoHLTC explicitly excludes building depreciation from reimbursable operating expenses. Constrained government budgets have also made it difficult for hospitals to obtain the government share for approved construction. As a result, a considerable capital backlog currently exists which is the source of considerable policy pressure. The previous government turned to public-private partnership (P3) arrangements to obtain the capital costs; these would be defrayed (at higher total cost) through contract and lease arrangements, which would in effect allow them to be incorporated into operating budgets.113 The current government is less enthusiastic. Although current plans are unclear, it appears that they may carry through with the existing plans in modified form, which clarify that the private partners do not own the facility.

Another major source of government control is through expenditure linked with regulation. Although public hospitals do have other sources of funding, including charitable donations, operating revenues from ancillary operations (i.e. retail operations, preferred accommodation, parking), fees charged to uninsured persons (usually individuals coming from outside that Province), fees from workers’ compensation or automobile insurance, and research grants (for academic health science centres), approximately 85% of the operating costs of public hospitals are funded through transfer payments from the MoHLTC. This varies with hospital; in smaller rural hospitals this proportion is typically closer to 95%, while in large urban academic health science centres it can be as low as 75%. At the time of writing, these operating grants are
largely composed of a base grant (global budget) carried forward from one year to the next, with an inflationary increase set by the Province. In addition, funding adjustments are also made at the margin that are intended to reward hospitals which operate more efficiently. Additional adjustments are also provided on a volume basis for specialized programs. Hospitals are allowed to retain their surplus and are expected to absorb their deficits.

The MoHLTC also amended the Act to give it authority to change these terms unilaterally. The Ontario Public Hospitals Act includes the provision that “5(1)The Minister may pay any grant, make any loan and provide any financial assistance to a hospital if the Minister considers it in the public interest to do so.” The Act now gives the Minister of Health and Long Term Care the ability to “impose terms and conditions on grants, loans and financial assistance provided under this section” as well as the power to “amend or remove the terms and conditions or impose new terms and conditions.” The Minister can also demand repayment as a condition of providing funds “in the manner determined by the Minister.” Grants can be reduced, suspended, or terminated, as long as “the Minister considers it in the public interest to do so.”

These capacity controls have been quite effective in reducing bed numbers. However, operating budgets have been so rigidly controlled that Ontario hospitals are now working at extremely high occupancy rates (often exceeding 95%), and perceive themselves unable to meet the demands upon them. There is also public perception of excessive waiting lists which is driving current public policy, although this perception may not accord well with actual data.

**B-3.2 Costs and prices**

Ontario’s reliance on a fixed-budget approach to hospital expenditure affects the relationship between doctors and hospital administrators. Physicians are paid on fee-for-service and have incentives to increase service volume; hospital budgets are fixed and encourage limiting volumes. The Canada Health Act provides for a dollar-for-dollar withholding of federal contributions from any Province which allows direct charges to insured persons for insured services, and provincial governments (including that of Ontario) accordingly prohibit hospitals from levying such charges. However, costs for uninsured services are left to the judgement of the individual organizations, subject to market forces. Hospitals accordingly have discretion
primarily as to their charges for both uninsured services (which only account for a very small portion of their activities) and to certain uninsured persons. Charges for insured services delivered to individuals resident in other Provinces are paid by their Provincial health plan, and are set through inter-provincial negotiations to comply with the Canada Health Act requirement for portability across provinces. The Provinces annually publish a list of agreed upon ‘inter-provincial rates’ to be billed for services provided to patients from other provinces. Charges to other insurers, such as automobile insurance or Workers’ Compensation, are also set province-wide, with heavy involvement from provincial governments. Hospitals are permitted to charge out-of-country patients whatever they find appropriate.

### B-3.3 What services are offered?

Control over the services offered rests to some extent with the individual hospitals. The MoHLTC ensures a certain degree of accountability from the hospital sector through various regulatory and expenditure mechanisms. Hospitals are required to submit annual Operating Plans to the MoHLTC; these clarify what they intend to do in the coming year. They are required to submit in-year “variance reports” to notify government of deviations from these plans, and also submit data indicating what they actually did. Ministry approval of Operating Plans is required before hospitals implement any changes to the services they provide. Hospitals must also submit data (on a common form) to report on the outcomes. However, hospitals retain considerable autonomy in making such decisions. The reports submitted to the provincial government include financial and statistical details about where resources are allocated at the departmental (i.e. medical, surgical, ambulatory) as well as broad staffing categories (administration, medical, nursing, allied health professional), and broad activity reporting in terms of patient days and ambulatory visits. For inpatients, individual patient abstracts are required to be submitted to the Canadian Institute of Health information. However, to protect the privacy of patients and institutions, detailed information is difficult to obtain outside government; CIHI reports are on an aggregated basis.

Recently, the Ontario government introduced legislation (Bill 8, the Commitment to the Future of Medicare Act, 2003) which includes provisions giving the Minister of Health and Long Term Care broad power to impose accountability arrangements with hospitals. In its initial
form, the legislation has aroused considerable opposition from hospitals for bypassing the role of
the independent hospital boards of directors, and it is being modified. Nonetheless, it is likely
that this legislation will give more direct powers to government than currently exist. Since
hospitals are still private NFP, the act relies on expenditure mechanisms (e.g., the ability to
direct and/or penalize a hospital CEO for noncompliance).

Government also has incorporated some direct regulatory controls under Regulation 964
of the Public Hospitals Act, which classifies hospitals. The current classification system can be
seen as having two components. Several of the categories are mutually-exclusive, and based on
such factors as size (e.g., more or less than 100 beds), general/specialized, and teaching/non-
teaching status; for example, there are categories for general, chronic, convalescent, psychiatric,
and both general and special rehabilitation hospitals. To train medical students, teaching
hospitals must have written agreements with both an affiliated university medical school, and the
arm’s length regulatory body (the Royal College of Physicians and Surgeons) which accredits
post-graduate specialty programs. The remaining classifications, however, are based on the
services which hospitals are allowed to offer, and thus allows the MoHLTC to micro-manage
any services it decides to list. Since this list is included in regulations (rather than in the
legislation), the provincial government thus retains considerable regulatory authority over which
services will be offered in which institutions, should it wish to exercise it. However, this power
is coupled with expenditure, since the Province will be expected to fund these programs. In
some cases, a hospital will only offer those services; in others, it will offer them within a general
hospital which also offers other services. At the time of writing, regulations dealt with specific
groupings for: “hospitals that treat patients suffering from cancer, that undertake research with
respect to the causes and treatment of cancer and that provide facilities for the instruction of
medical students;” “hospitals for the treatment of patients suffering from alcoholism and drug
addiction” (with no facilities currently listed in this category); “separate organized facilities
approved as such by the Minister, to provide local diagnostic and treatment services in a
community or district to handicapped or disabled individuals requiring restorative and adjustive
services in an integrated and co-ordinated program;” “hospitals for the treatment of patients
suffering from alcoholism and drug addiction and providing facilities for giving instruction to
medical students of any university as evidenced by a written agreement between the hospital and
the university with which it is affiliated;” “hospitals that may charge and accept payment from other hospitals for the performance of computerized axial tomography scans;” “hospitals that may acquire and operate magnetic resonance imaging equipment and may charge and accept payment from other hospitals for the performance of magnetic resonance imaging;” “hospitals used as transplantation centres;” “hospitals that may acquire and operate extra corporeal shock wave lithotripsy equipment;” “hospitals that may provide in vitro fertilization services;” “hospitals that provide biosynthetic human growth hormones;” “hospitals that may act as distributing centres for drugs for cystic fibrosis treatment and that provide drug-related therapy for cystic fibrosis treatment;” “hospitals that may act as distributing centres for drugs for thalassemia treatment and that provide drug-related therapy for thalassemia treatment;” and hospitals that operate ambulatory care centres (N = 5).114

The large number of programs not specified in these regulations, however, are within the scope of individual hospitals to determine, subject to the availability of resources (staff, capital budgets, operating budgets). There are also considerable controls through accreditation by arm’s length organizations.

B-3.4 Access - who gets services?

Because government uses the expenditure instrument to provide universal coverage to all Canadian residents for hospital and physician services, there is little need to regulate access beyond those provisions. However, there are provisions within the Public Hospitals Act requiring hospitals to accept as a patient anyone who has been “admitted to a hospital by a physician pursuant to the regulations” who “requires the level or type of hospital care for which the hospital is approved by the regulations.” The Act specifically allows hospitals to refuse to admit individuals who are not residents of Ontario (or their dependants), unless “by refusal of admission life would thereby be endangered.” Hospitals may also refuse to admit “any person who merely requires custodial care.”114

It is worth noting that the supply-side budgetary controls employed in Canada (and in the Netherlands) may have been too effective; certainly, they have led to perceptions of rationing by waiting list.19 Current policy activities are thus seeking to alleviate access issues through a combination of improved accountability, better systems management, and increased resources.
B-3.5  Health human resources - who can you hire? What do you pay them?

Ontario hospitals have the autonomy to determine their work force and desired skill mix. Within that framework, however, professional bodies regulate individual activities. A hospital wishing to provide surgical services will have to have enough qualified surgeons, nurses, and other health professionals to satisfy their appropriate professional organizations, as well as to meet accreditation requirements. A majority of hospitals also operate in a unionized environment and therefore are subject to collective bargaining agreements as negotiated through the Ontario Hospital Association on a provincial basis, with some minor items open to local agreements. Both unions and professional bodies will also exert an influence over skill mix and staffing levels, through the process for establishing annual operating plans which requires their involvement. However, one approach hospitals have used to deal with constrained budgets has been to substitute part-time and casual labour for full time jobs. This in turn has led to a perceived nursing shortage, and the MoHLTC has suggested that the new accountability framework for hospitals will contain a requirement that hospitals increase their proportion of full-time nursing jobs.

B-3.6  Quality control within institutions

Quality control is delegated to the medical staff and board of the individual hospitals. The Public Hospitals Act includes provisions for establishing a medical advisory committee, and for ensuring that the hospital establish by-laws requiring the chief (or president) of the medical staff (with the advice of heads of medical departments when the hospital is organized into departments) “to advise the medical advisory committee with respect to the quality of medical diagnosis, care and treatment provided to the patients and out-patients of the hospital.” The Act goes on to require any such responsible officers of the medical staff to take action whenever they become “aware that, in his or her opinion a serious problem exists in the diagnosis, care or treatment of a patient or out-patient.” The Act sets forth a graduated response; initially, they “shall forthwith discuss the condition, diagnosis, care and treatment of the patient or out-patient with the attending physician, and, if changes in diagnosis, care or treatment satisfactory to the officer are not made promptly, he or she shall assume forthwith the duty of investigating, diagnosing, prescribing for and treating the patient or out-patient, as the case may be, and shall
notify the attending physician, the administrator and, if possible, the patient or out-patient that
the member of the medical staff who was in attendance will cease forthwith to have any hospital
privileges as the attending physician for the patient or out-patient.” If they cannot discuss the
problem with the attending physician, they must “proceed with his or her duties as prescribed in
this section as if he or she had had the discussion with the attending physician.” There is also a
responsibility to inform two members of the medical advisory committee within twenty-four
hours of his or her action under these sections, and to file a written report with the secretary of
the medical advisory committee within forty-eight hours. The responsibilities can be delegated,
but ultimate accountability remains with the designated officer. Provisions are also made for a
detailed written report by the medical advisory committee to the hospital administration.

Although these activities are thus legally the responsibility of hospital boards (rather than
of government), the Ontario government does have residual authority to make directives when
matters of public safety arise. For example, during the SARS epidemic, the Province, through its
Commissioner of Public Security, and Commissioner of Public Health/Chief Medical Officer of
Health, issued a series of Directives to all Ontario hospitals, concerning such questions as
discharge procedures and SARS screening. Although the language began in terms of “advise”
(rather than require), the remainder of the language was far more directive - using such
vocabulary as “must” and “will.”

The Independent Health Facilities Act also contains provisions allowing the MoHLTC to
set and monitor performance standards and activity levels (although the extent to which this
actually occurs is less clear).

Nationally, there are exhortation approaches to quality, including technology assessment
and clinical guidelines. At a national level, the Canadian Coordinating Office on Health
Technology Assessment does systematic assessments, with a concentration upon pharmaceutical
products.116 The Province of Quebec has its own technology assessment council, and the
Province of Alberta’s Heritage Foundation for Medical Research also performs some technology
assessment activities, as well as acting as a funding body for medical research. All three bodies
are members of the International Network of Agencies for Health Technology Assessment
(INAHTA).59 Ontario does not at this time have a distinct external technology assessment unit
linked to government, although these evaluation activities are performed by strong research
teams located at a number of the Province’s universities and research institutes. Increased attention has also been paid to reducing medical error, and in December 2003, the federal and provincial governments established a new arm’s length NFP organization, the Canadian Patient Safety Institute, with a mandate of establishing and encouraging best practices.

Another exhortation mechanism used for quality assurance is accreditation. Canadian Hospitals are accredited by the Canadian Council on Health Services Accreditation (CCHSA). This national, non-profit, independent organization employs voluntary assessors “to help health services organizations, across Canada and internationally, examine and improve the quality of care and service they provide to their clients.” Although accreditation is voluntary, it is both virtually universal and highly prized. Accreditation has moved beyond the NFP sector; the small number of FP hospitals and the considerable number of FP long-term care facilities also submit to this voluntary accreditation and similarly boast of their success.

At the provincial level, another exhortation mechanism is The Hospital Report Research Collaborative, led by the University of Toronto. This group, in partnership with the Ontario Hospital Association, has developed methods and produces a series of annual reports on hospital performance in Ontario using the balanced scorecard format, presenting a limited number of broadly based indicators with a star system of ratings which resemble those used for hotel or restaurant ratings. These reports, aimed at the general public and in some cases distributed through CIHI, examine a broad range of sectors including acute care, emergency department care, complex continuing care, rehabilitation and mental health.

Bill 8, the Commitment to the Future of Medicare Act, 2003, currently being debated and amended in the Ontario legislature, includes provision for introducing a Health Quality Council in the Province. At the national level, an embryonic Health Council also plans to gather information and has expressed the hope that its exhortation activities will lead to quality improvement.

**B-3.7 Information provision**

In addition to the exhortation approaches described above, the Canadian Institute for Health Information (CIHI) publishes a wide variety of reports on the performance of the health care system and the health of Canadians. A number of advocacy groups also issue report cards
on particular diseases.120

B-4 Canada, summary

In summary, the fiscal control exerted through the expenditure mechanism of global budgets has been both a success and a source of tension. International comparisons of health care expenditures have suggested that this mechanism has served both Ontario and the other provinces well in providing a macro-level control expenditure growth.121 Many would argue that the instrument is too blunt and that the search for efficiency has led to too little “surge capacity” to handle emergencies.64,122,123

Neither level of government is eager to keep increasing resources to hospitals. Provinces are responding with efforts to ‘tweak’ hospital funding formulas and incorporate greater accountability for the funds spent. The severe fiscal restraints of the 1990s, coupled with unwillingness to reduce services, have resulted in many Ontario hospitals running large operating deficits and failing to sufficiently maintain their capital infrastructure. The tax cuts of the previous neo-liberal provincial government left a large (and hidden) deficit which their successors are attempting to deal with; this has limited their ability to make increased resources available to all of the sectors which felt themselves ‘starved’ under the previous regime. Chronic operating deficits thus continue to be a source of concern and alternatives to government funding for capital are constantly being considered and attempted (e.g., private bond issues, private-public partnerships, large fund-raising campaigns by individual hospitals). There are no FP/c hospitals as of this writing. Health policy is being played out against the backdrop of an impending federal election, federal-provincial battles, and some desire on the part of the public to implement the reforms suggested by the Kirby and Romanow processes.101 The extent to which governments will continue to rely upon stewardship, exhortation, and expenditure is thus unclear, but in the near term, policies are likely to remain incremental.
Appendix C: Case study, Germany

C-1 Germany in brief

Germany is a federal republic consisting of 16 sub-national units (known in Germany as Länder). It has a population of 82 million, and is a member of the European Community. In 1990, the former East Germany (Deutsche Demokratische Republik) and West Germany (Bundesrepublik Deutschland) were reunified; the health care system is based on the arrangements in place in the former West Germany.

Germany pioneered the Bismarckian system, which combines private delivery with multiple quasi-public financers. Jurisdiction for health care is shared, not only among levels of government, but with the private sector. The federal government has responsibility for setting frameworks which regulate the activities of the private insurers and providers, including defining benefit packages and eligibility criteria, setting reference prices for pharmaceuticals, and bargaining wage rates. It also has responsibility for certain other activities deemed of national importance. The Länders are responsible for the capital expenditures needed to maintain all hospital infrastructure in their jurisdiction, independently of actual ownership. (Länder own some, but not all, hospitals.) They also have the authority to finance medical education, supervise health care professionals, and responsibility for public health, health promotion and disease prevention. Responsibility for insuring individuals and paying providers, including hospital operating costs, has been delegated to a series of not-for-profit sickness funds, and for-profit private insurers. There is considerable variation across Länder in fiscal capacity, political culture, the amount spent on hospital capital, and the number of hospital beds per capita. Because the Länders had to agree to all decisions affecting hospitals, the federal cost-containment activities have dealt almost exclusively with issues outside the hospital sector.

An arm’s length organization, Concerted Action in Health Care (Konzertierte Aktion im Gesundheitswesen), brings together all major stakeholders (providers, insurers, unions, employers, government) at the national level to propose frameworks for negotiation. These guidelines would be considered an exhortation mechanism; they must be “taken into account” when setting physician fees and hospital budgets, but they do not bind negotiations. However, to the extent that finances for the sickness funds are employment-based, the national government is
highly concerned that increases in health care costs will have adverse implications for jobs and economic growth.

All individuals with incomes below a certain cut-off are required to be members of the statutory social insurance plan and buy coverage from one of the many NFP sickness funds (Krankenkassen and Ersatzkassen). Those with incomes above that cut-off may also purchase such coverage, and many choose to do so. However, they have the option of leaving the statutory plan and purchasing private insurance. About 92% of the population are insured through the German sickness funds; most of the rest have private insurance, with only 0.3% being uninsured. Due to mergers, the number of sickness funds has fallen from about 1221 in 1993 to 453 in 1999 and 396 in 2001. Similarly, the number of private insurers has fallen from 64 (as of 1993) to 52; many are NFP, but 23 to 25 (with a market share of about 46%) were FP/c corporations traded on the stock market. This arrangement is in contrast with the otherwise similar Dutch system, which has a far lower income cut-off, and does not currently permit higher income individuals to purchase social insurance (See Appendix D).

Germany has a relatively high level of health expenditures, whether measured as a proportion of GDP, as total spending per capita, or as spending from public sources, which has led to perceptions that reform is needed. Siciliani and Hurst suggest that this higher level of expenditure, coupled with service-based funding, may account for the fact that Germans do not report issues around waiting times, in stark contrast with the Netherlands and Canada, which employ global budgets to control capacity.

To control costs, Germany has sought to use the expenditure instrument of market competition among sickness funds within a strong regulatory framework intended both to ensure that health providers are not adversely affected, and all Germans retain access to insurance (i.e., to discourage cream skimming). Due to the German tradition of “cozy, cartel-type arrangements” to maintain the autonomy of organizations, Brown et al have concluded that “Germany has crafted a handsome framework for the management of competition but has yet to figure out how to manage care.”

Germany is unusual in the high degree of separation between physicians practicing in the community, and those who are hospital-based. Ambulatory physicians were given a monopoly over ambulatory health care in 1931. In consequence, all ambulatory care, primary and
outpatient secondary care, is provided by office-based physicians (most of them working in solo practice). This has been described as a political victory over hospital-based physicians, as well as over other health professionals, including nurses. This monopoly has meant that public health physicians could not treat patients, sickness funds could not buy pharmaceuticals, and hospitals could not provide outpatient care. The consequence has been a clinical, financial, and planning separation between inpatient and outpatient care which policy is only now beginning to address. Accordingly, Germany has differed from many other nations in that a considerable proportion of minor surgery has been provided in the ambulatory sector under fee-for-service arrangements in private practice, rather than in hospital outpatient or day surgery departments. German patients are free to select their own ambulatory doctors from among the practitioners affiliated with their sickness fund. Patients can go directly to specialists practicing outside hospitals without having to use a primary care gatekeeper. Primary care doctors do control access to hospital care, but do not treat hospitalized patients. Any patients wishing to select their own hospital specialist would have to pay an additional fee to that physician, which is often shared with the hospital. Over the past decade, slow efforts are being made to encourage better integration of care and relax the prohibition against ambulatory care in hospitals, but much remains to be done.

C-2 Hospitals in Germany

German hospital statistics distinguish between “general” and “other” hospitals; about 90% of hospitals (and beds) are in general hospitals. Germany has around 2030 general hospitals, of which 790 would be classified as public (owned by Länder, counties, or cities), 820 as private NFP (owned by churches or other charitable organizations), and 420 as private FP. On average, the public hospitals are much larger (and include the academic hospitals), while the FP hospitals are quite small; the bed shares are estimated to be 55% public, 38% NFP and 7% FP. In 1994, beds in university hospitals accounted for 8.3% of all general and psychiatric hospital beds. The hospital supply represents a slight decrease from 1990 estimates of 2182 hospitals, with 47% (62% of beds) public, 38% (34% of beds) NFP, and 15%(4% of beds) FP. However, the FP hospitals tend to be, in the classification employed in this paper, FP/s; they are often owned by a head physician and almost never by an investor-owned corporation. To evade the
price controls imposed by sickness funds, they do gain much of their revenue by serving privately insured patients. Only 2.7% of beds existed in hospitals which did not have contracts with sickness funds (and hence served only privately insured patients with no eligibility for public financing of capital costs).

Hospital funding is complex. Between 1972 and 1992, the basic regulation of hospital care fell within the 1972 federal framework law, the Hospital Financing Act (Krankenhausfinanzierungsgesetz). It incorporated guidelines concerning the technical aspects about how hospital operating costs will be financed (Bundespflegesatzverordnung) and accounted for (Krankenhausbuchführungsverordnung). The framework introduced the ‘dual financing’ principle whereby hospital capital was separated from operating expenses, but neither was made a federal responsibility. Instead, the framework gives public authorities at the Länder level responsibility for financing and planning hospital physical plant, including buildings, beds, and medical equipment. Paying operating costs was the responsibility of the insurers (sickness funds and private insurance), supplemented by out-of-pocket contributions by patients. There is some ambiguity as to whether the Länder’s responsibility extends to paying for building maintenance and repairs. All Länder except Bavaria have refused to pay these costs since 1993. From a policy viewpoint, decisions about capital investment and capacity are accordingly divorced from obligations to meet the operating budgets of those institutions.

In turn, each Länder has established its own hospital laws, and developed an annual plan specifying existing capacity, and indicating where new capital investments would occur. The individual hospitals, however, act independently, and are responsible for their own economic performance. Hospitals are only loosely organized. Membership in hospital associations is voluntary. Each individual hospitals separately negotiates its budget with the relevant regional sickness fund.

There have been a number of approaches to setting hospital budgets. The approach to budget setting, although not the actual amounts, is set nationally. The 1972 Act introduced the “full cost cover” principle, which meant that the hospitals would be fully reimbursed for all of their spending. This is only gradually being modified, and even now, hospitals tend to receive full compensation through post hoc adjustments.

Hospital budgets are established individually and annually through negotiation between
each hospital and all of the sickness funds which had paid more than 5% of that hospital’s revenues in the previous year, although the results are binding on all sickness funds sending patients to that hospital. In practice, the sickness funds form working groups within each region to conduct these negotiations, and also involve the organizations of private health insurers. There were estimated to be over 3000 negotiations each year.\textsuperscript{129}

The sickness funds accordingly use expenditure to control hospital activities. The precise approach, and the resulting incentives, have varied over time. The 1972 Act specified full cost reimbursement for all costs incurred. The 1984 Hospital Restructuring Act shifted to prospectively computed \textit{per diem} fees; the negotiators would determine a budget which specified volume targets for each specific service which that hospital would expect to provide for members of all of the sickness funds, and then divide the budgeted amount by the estimated number of inpatient days to be provided to compute a constant \textit{per diem} payment for that hospital. The payment would thus continue to vary across hospitals (\textit{e.g.}, to reflect differences in the services they might provide) but not across sickness funds, or even across patients within that hospital.\textsuperscript{68}

In 1985, Germany moved towards “flexible” prospective budgets, which attempted to group hospitals into relatively homogeneous groups and then benchmark their costs and activities in deriving the \textit{per diem} payments. The idea was to pay the full costs for an “efficient” hospital only, to give incentives for less efficient hospitals to reduce their expenditures. The rates were still negotiated, however, and the definition of efficiency, unsurprisingly, often became highly political. The flexible budgeting system included provisions to reward hospitals for under-provision (they would be still paid a proportion of the daily rate even for the “missing” days), and penalize them for over-provision (they would receive only a fraction of the \textit{per diem} for services provided above the target level).\textsuperscript{19}

The Health Care Structure Act (\textit{Gesundheitsstrukturgesetz}, 1992), which introduced legally fixed budgets or spending caps for the major sectors of health care, moved even further from the former system of full-cost recovery for hospitals to the first stages of a prospective payment system where, beginning in 1996, payments for selected treatments would be based on case mix. This act also began to break down the separation between ambulatory and hospital care, allowing scope for such innovations as allowing ambulatory surgery in hospitals.\textsuperscript{126}
Between 1993 and 1995, overall budget growth for hospitals was constrained to increase from the 1992 base budget level only as much as the increase in the average wage of all those insured by sickness funds (i.e., the growth of income of the sickness funds as a whole), as estimated by the federal minister. In 1996, computation of hospital operating costs became based on three components: a general *per diem* component for the hospital at a level considered sufficient to cover the ‘hotel costs’ of food and lodging (which would be relatively constant across patients), a component intended to reflect the specific (higher) costs of certain hospital departments (e.g., intensive care units), and an additional lump-sum component which would be paid for certain expensive specialized treatment services, such as cancer therapy or organ transplants. In 1999, the Reform Act of Statutory Health Insurance 2000 called for moving to a new system based on Diagnosis Related Groups (DRG), with the precise model to be negotiated between the national organizations for hospitals, sickness funds, and private insurers. They have selected and appear to be implementing a model based on the Australian DRG system. Remuneration rates within the hospital sector were again frozen for one year in 2002. More changes appear likely.

C-3 How has Germany handled these issues?

C-3.1 Capacity: (capital planning)

As noted above, hospitals, regardless of ownership type, receive capital costs from state governments if (and only if) they are included in that Länder’s hospital plan. Although hospital capital costs are not a federal responsibility, after reunification, the federal government did implement a special aid program (of several billion Deutsche Marks) to upgrade hospital and nursing home infrastructure in the former FRG.

Germany perceives overcapacity to be a problem. Acute care beds availability is among the highest in OECD countries with a ration in 2000 of 6.4 beds per 1,000 population. German hospitals have moved proactively to reduce length-of-stay, beds, and admissions, but these still exceed the levels found in many other developed countries. Much of the decrease has been among public hospitals, whose bed numbers have decreased between 1990 and 1998 by 24% (from 387,207 to 295,382 beds), dropping from a 62.8% to 55.3% share of total beds. In
contrast, there has been a minimal decrease in bed numbers among NFP hospitals (2%), with their share rising from 33.5% to 37.9%, and an actual increase of 59% for FP hospitals (from 22,779 to 36,118 beds), with their share up from 3.7% to 6.8%. This implies that capacity controls were more easily imposed upon the publicly-owned facilities. Despite bed reductions, Germany’s bed capacity has remained about 150% of the European Union average. However, in contrast to Australia, Canada, and the Netherlands, where supply-side controls do lead to rationing by waiting lists, waiting lists are not seen as an issue in Germany.

Although the Länder are responsible for developing hospital plans specifying how many hospitals are required in their region, as well as the specialties and beds for each hospital, there is considerable variation in how tightly they choose to control the hospitals; each state may use its own criteria. States appear to make different trade-offs between equity and efficiency, since there are variations in beds per capita, costs per bed day and costs per case.

The Health Insurance Contribution Rate Exoneration Act (1996), and the First and Second Statutory Health Insurance Restructuring Acts (1997) attempted to implement cost control by increasing co-payments, including for inpatient care. It also attempted to relieve the pressure on the Länder to provide capital expenditures by levying an annual flat premium of DM 20 on each insured person to pay for the restoration and repair of hospitals. Most of these measures were then repealed by The Act to Strengthen Solidarity in Statutory Health Insurance (1998).

The expenditure instrument cannot be used to force closures of hospitals which have been included within that region’s hospital plan. Indeed, there are legal requirements to ensure that the negotiated budget will be large enough to allow each hospital to provide the care needed by its catchment population for the approved functions.

C-3.2 Costs and prices

As noted above, the operating costs of hospitals are largely paid by insurers. These are controlled by expenditure instruments, backed by regulation, through the mechanism of negotiated budgets. A variety of incentives have been tried, including per diem and service-based funding approaches; these are still being modified.

The hospitals are allowed to collect additional revenues from private patients, but must
reimburse the hospital for the use of hospital facilities used to treat them. These funds may then pooled and distributed to the physicians working in that hospital, depending upon the rules of that Länder. Over time, the government has exerted increased control over the contracts between the hospital and the head physician. The new hospital financing act requires that between 20 and 40% of these private fees be included within the hospital’s budget.\textsuperscript{133}

Any hospital, regardless of ownership type, is eligible to apply for public funds from the Länder in which it is located. Hospitals are also able to borrow funds directly from the private sector for capital financing, although this is subject to approval by the Länder government. Decisions are made on the basis of need and cost-effectiveness (\textit{e.g.}, whether the cost of such borrowing would be less than using public funds).\textsuperscript{136}

Recently, government has attempted to increase competition among hospitals by removing the regulation which prohibited them from making profits.\textsuperscript{129} The same regulations mean that hospitals can run deficits.\textsuperscript{126} Nonetheless, there is little evidence that hospitals would be permitted to go bankrupt.

\textbf{C-3.3 What services are offered?}

Decisions about what services will be offered by each hospital are largely controlled by the individual hospitals, although heavily influenced by the results of negotiations with sickness funds about expenditure, and with Länder about which hospitals would be part of the hospital plan for that state. The 1972 Act had imposed few controls; hospitals were in effect guaranteed full cost coverage for the services they chose to provide, although there were obviously exhortation limitations on how much they would take advantage of this freedom. From 1984, prospectively calculated \textit{per diem} costs clearly introduced incentives to minimize cross-subsidization within their institution. However, staff numbers and bed days were negotiated. More controls are being introduced on their activities, including service-based funding. All represent efforts to use expenditure instruments to control activities.

The strong separation between inpatient and ambulatory care has had a major impact on which services are offered; with the exception of teaching hospitals, which were permitted to have outpatient departments and provide ambulatory care, much specialist care occurs outside hospitals. The separation has been seen as leading to duplication of equipment and repetition of
tests, and also as interfering with continuity of care. Nonetheless, it is changing only slowly.
Subsequent policies have made it easier for ambulatory doctors to be able to use hospital
facilities, and for hospital doctors to perform outpatient and day surgery. Yet the ambulatory
physicians maintain control over ambulatory services provided within hospitals (other than
teaching hospitals). Those services would be paid from the ambulatory care budget (controlled
by the physicians) rather than from the hospital budget, and could be provided within a hospital
only if a qualified office-based specialist was not available in the area. In addition, either the
hospital departments would have to be authorized to provide such care by the sickness funds,
and/or the hospital physicians would have to join the association of office-based physicians. The
HSA of 1993 specified three occasions under which hospitals could render outpatient care: 1) if
it is required to determine whether inpatient treatment is necessary (pre-inpatient care); 2) if it is
required to assure and improve the effectiveness of inpatient treatment (post-inpatient care), or
3) if ambulatory surgery can be substituted for inpatient surgery.

Both pre-inpatient and post-inpatient care would be covered by the lump sum payable for
the particular set of services. This left most outpatient care firmly outside the hospital sector.

The Reform Act of Statutory Health Insurance (2000) included measures to strengthen
primary care, and further overcome the strict separation between the ambulatory and inpatient
care sectors. It also modified the payment system for hospital care, introduced new requirements
for health technology assessment and quality assurance, and measures to support patients’ rights.
In theory, sickness funds can de-contract hospitals, but only if all agree, and have the approval of
the state government. Additional measures have been introduced in 2002. Even so, in 1997,
only 45% of hospitals were offering ambulatory surgery, and only 55% ambulatory pre- and/or
post-inpatient care.

Determination of services is primarily controlled by the expenditure instrument, in that
the negotiated budgets incorporate considerations of which services will be offered for the
prospective payment. Individual payers have little influence, because the negotiated decisions
are binding on all sickness funds. Individual providers (especially physicians) have considerable
influence in deciding which services they wish to offer.

C-3.4  Access - who gets services?
Almost all Germans have insurance coverage. Their access to hospitals, except for emergencies, is determined through referral from an office-based physician. However, individual patients appear to retain choice about where they will go. Should they wish to select a specific hospital-based physician, however, they will have to pay extra. Sickness funds do not appear to employ selective contracting. Access does not appear to vary by nature of insurance; privately insured people and sickness fund members have equal access to all hospitals included in the hospital plan for their region. However, the ambulatory (private) clinics do not always take all comers; some are available only to those paying privately. These clinics do not receive any public funds for their capital expenses.\textsuperscript{133}

Siciliani and Hurst concluded that the combination of virtually universal insurance coverage, high hospital capacity, extensive ambulatory day surgery, and fee-for-service payment for ambulatory physicians, has led to minimal waiting times in the German health care system.\textsuperscript{19}

The literature expresses considerable concern that the German experiments with managed competition among insurers may accentuate emerging problems of cream skimming (which the Germans refer to as “raisin picking”).\textsuperscript{130} This may in turn lead to access difficulties for individuals deemed expensive to serve.

**C-3.5 Health human resources - who can you hire? What do you pay them?**

Pay scales are set by collective bargaining. Staffing levels are also subject to some negotiation within the budget setting process (including guidelines about nursing time standards). Accordingly, much of the control is based on expenditure. Almost all hospital workers in public and NFP hospitals, including hospital-based physicians, are employees of the hospitals. Their salaries are determined by a collective bargaining process at the national level which applies to all government employees; employees are classified into categories and compensated according to pay grade levels.\textsuperscript{129} Thus, these hospitals do not have control over the wage levels for their employees.\textsuperscript{131} For that reason, there is an exemption in the budgetary controls to allow the negotiated \textit{per diem} rates to be corrected should wages increase beyond the level anticipated.

In contrast, the FP hospitals pay their doctors on a fee-for-service basis, according to a schedule that is laid out by the federal government. The doctors must remit a portion of these
fees to the hospital.  

C-3.6 Quality control within institutions

All physicians, dentists, pharmacists or veterinarians must be members of their “professional chamber,” analogous to the professional colleges in some other jurisdictions (e.g., Canada, the US). These chambers are organized at the Länder level. Germany does not consider most non-physician health workers (including nursing and physiotherapy) to be health professionals and they do not have “chambers,” although they do have voluntary organizations with a professional focus. As a result, there are fewer regulatory or exhortation controls arising from non-physician professional organizations.  

Since the Health Care Reform Act, the hospital and sickness funds are obligated to incorporate quality assurance into their contracts. Recently, the federal minister of health and the advisory council on health care (Sachverständigen-rat im Gesundheitswesen) declared a Qualitäts-offensive which called for improved quality assurance.  

Germany employs exhortation through technology assessment at the national level. The German Agency for Health Technology Assessment at the German Institute for Medical Documentation and Information is mandated by law to maintain information systems on drugs, medical devices, and health technology assessment and evidence. (For example, the Federal Ministry of Health ordered its technology assessment activities under the Second Law on the Reorganization of the Statutory Health Insurance of 23 June 1997.) It is a member of INAHTA.  

A German Centre for Quality in Medicine has also been announced. However, its role was planned to extend beyond exhortation in developing evidence-based guidelines; it was to be given the ability to make decisions about the statutory benefits package (currently the responsibility of organizations of ambulatory physicians, and sickness funds). The fate of this reform is unclear.  

In 1999, Germany established an independent voluntary accreditation programme for hospitals.  

In 2001, Germany began to establish procedures to promote disease management programs for chronic illness. The approach is an exhortation one, involving negotiating which
diseases are suitable for such programs (with representatives from sickness funds, physicians and hospitals), developing guidelines, and then hoping that providers will choose to adopt these in order to improve care.  

C-3.7 Information provision

The national government produces some overall data about the health care system (e.g., the biennial report of the German Ministry of Health on the health system; a new Basic Health Report published for the first time in 1998, the Hospital Diagnosis Statistics published by the Federal Bureau of Statistics). Data comparing hospital mortality rates, costs, and similar variables are available, but “neither payers nor providers may advertise their self-proclaimed superiority to competitors.”

Germany has a Patient’s Charter, which focuses on information rights. It has sought to explicitly empower patients within the system as a quality improvement mechanism.

C-4 Germany, summary

Although Germany employs a number of regulatory mechanisms, the system is heavily de-centralized and relies heavily upon expenditure mechanisms. Most hospitals are either public or NFP; the FP hospitals tend to be FP/s rather than FP/c. The system is also less hospital-centric than in many other nations. The system would appear to be rather effective at providing quality care, although less effective at controlling capacity or costs.
Appendix D: Case study, the Netherlands

D-1 The Netherlands in brief

The Netherlands is a member of the European community. It is relatively decentralized, with 12 provinces and 646 municipalities. However, responsibility for planning and implementing health policy rests with the national government, in the Ministry of Health, Welfare, and Sport.

The political culture is highly consultative, and has placed a high premium on negotiating rather than imposing agreements. However, it also seeks to balance this with transparency, innovation, and efficiency. This has resulted in a shift in who makes policy decisions, from the previous corporatist system employing consultative bodies at the national level with strong representation from both government and stakeholders, including providers and professional organizations, to new “official, permanent organizations instituted by the government and with specific, legal responsibilities” which explicitly exclude direct involvement by interest groups (stakeholders) seen as being in conflict of interest, although they may still be involved on expert committees. Similarly, the system must balance the high value it places on equity and solidarity against a policy framework which also stresses competition and paying one’s own way if one can afford to do so.

Its health care system falls into the Bismarckian category, with financing by private insurers and delivery by private providers. The health insurance system also separates “exceptional medical expenses” from ordinary health insurance. About 75-77% of health financing comes from social health insurance premiums and 14-15% from private insurance plans, with the remaining expenditure coming from individual out-of-pocket payments (5-7%) and direct government contributions (5-7%).

Most acute medical services, including hospital care (up to one year), pharmaceuticals, physician services, some physiotherapy, and basic dental care, are considered part of ordinary health insurance. Government uses regulation to define the basic benefits package. As defined in the Ziekenfondswet (ZFW), those with incomes below a pre-set cut off (variously estimated at between 62% and 64% of the population) are required to buy this coverage from one of about 30 competing ziekenfonds (sickness funds); this social health insurance component was estimated
to account for approximately 36% of Dutch health expenditure in 2001. Sickness fund premiums are geared to income rather than to risk; there is minimal cost-sharing. On the theory that people should not be subsidized unless they could not afford to pay for themselves, those with incomes above the (relatively low) cut-off are not eligible for compulsory insurance; in 2002, this was set at 30,700 euros. (This is in contrast to the somewhat similar German plan, described in Appendix C, which uses a higher cut-off, and permits but does not compel the more affluent to opt out of social insurance.) Higher income individuals and their families are free to purchase Voluntary Health Insurance from a private firm; most (variously estimated at between 28% and 34% of the total population) do so. There are also separate insurance plans for government employees. Premiums for the private plans are risk-rated, and the privately insured also pay high co-payment fees. Those individuals under the social insurance plans face no direct charges for these insured services; those with private insurance pay for their medical care on a fee-for-service basis and are reimbursed by their insurer. In order to make sure the private health insurers accept seniors and high-risk individuals, the Dutch government began to offer a subsidized benefits package at a legally set premium in 1986. In addition, the government has announced plans to allow self-employed individuals to become eligible to be insured through sickness funds, regardless of their incomes. The government has announced its intention to abolish the distinction between the private and compulsory insurance systems by 2005, and to further emphasize regulated competition instead of centrally-directed regulation.

Despite many differences, those insured through sickness funds and private schemes use the same health facilities, see the same doctors and receive the same quality of care.

Both sickness funds and private insurers can also sell risk-rated coverage to any willing to pay the premiums for certain ‘extras’ not included in the standardized benefits package, such as adult dental care and orthopedics care. Private insurance thus acts both as a complement (by covering those who are not eligible to enrol in the sickness funds because their income is above the specified ‘cut off’) and as a supplement. The number of sickness funds has decreased as a result of mergers from 53 in 1985 to 26 by the end of 1992; there have also been strategic alliances between sickness funds and private health insurers to increase market share.

The Exceptional Medical Expenses, Algemene Wet Bijzondere Ziektekosten (AWBZ) provides mandatory coverage to the entire population against such potentially catastrophic risks
which private insurance would not cover; passed in 1968, it currently includes specialized facilities for the mentally or physically disabled, home nursing, psychiatric care, and long-term care.\textsuperscript{138} The premium is income related up to a certain limit. AWBZ funds are managed by both sickness funds and private health insurance; they are retrospectively reimbursed for all medical expenses. Providers are paid on the basis of set fees. There are no co-payments from care recipients for most services, but co-payments are allowed for certain hotel-type expenses and some home care services.\textsuperscript{141} AWBZ provides only a small proportion of the budgets of acute general hospitals.

In recent years, there have been considerable reforms in the insurance system, as the government has encouraged greater competition among insurers. The Dekker committee provided a blueprint for a managed competition model, although this was not fully implemented.\textsuperscript{142,143,146-150} However, this competition exists within a strict regulatory framework, much of which has been delegated to a number of arm’s length bodies. One is the Health Care Insurance Council CVZ (\textit{College Voor Zorgverzekeringen}), which since July 1999 has been responsible for the administration and financial management of the two insurance laws ZFW and AWBZ. CVZ is semi-autonomous; it can carry out its work independently of the central government, but it is accountable to the Minister of Public Health, Welfare and Sport (VWS). Unlike its precursor, the Sickness Funds Council (\textit{Ziekenfondsraad}), CVZ no longer directly represents stakeholders, but has a smaller board directly appointed by the minister.\textsuperscript{137}

The government has announced its intention to “restrict its own role in order to create more room for negotiation between the other parties involved. This implies a shift in the decision-making power and in financial risks, from the government to these parties.”\textsuperscript{138} Nonetheless, the government and the semi-autonomous agencies reporting to it appear to exert considerable control over the parameters within which both insurers and providers must operate.\textsuperscript{139} There are, however, ongoing issues about how to harmonize the Dutch system with requirements of the European Union. In particular, if the insurance system is seen as being private, it may be necessary to apply the general EU rules for insurance markets, which may in turn imply fewer rules against risk selection. As in all of the systems examined, cost control is also an ongoing issue, but the economy has been healthy enough to sustain the relatively generous benefits.
D-2 Hospitals in the Netherlands

Most hospitals are private NFP organizations (stichtingen). As of 1989, there were 225 hospital foundations, most of which were owned and operated by religious denominations (Catholic and multiple Protestant denominations), although the religious character has largely faded. About 40 were classified as public (operated by municipal governments).151 The municipal hospitals were subsequently transferred to NFP status. In 1999, mergers had reduced the number of hospitals to 136;141 as of 2004, the number has been estimated to have fallen to 110. Small general hospitals have almost completely vanished; in 1992, only 13 general hospitals had fewer than 200 beds.145

Acute care hospitals can be divided into three categories in the Netherlands: general, academic and specialty hospitals. Specialty hospitals provide only specialized medical services, such as orthopedics, pediatrics, respirology and rehabilitation. General and academic hospitals both provide outpatient and hospitalized services, with highly specialized services being restricted to being delivered in academic hospitals. As of 1990, about 3/4 of acute care hospitals were classified as general, 22% as special, and 5% as academic. Some academic hospitals are public; their employees are civil servants.145 Others are independent, and have labour contracts with their physicians. Thus, most hospitals would be classified by our typology as falling into Ownership type 3, with academic hospitals being Ownership type 2. For-profit hospitals were explicitly prohibited by Article 15 of the 1971 hospital law.

Physicians are independent FP/s providers; this means that they are not fully controlled by the hospitals, in which they act as independent contractors. General practitioners (GPs) are the gatekeepers for specialty services, except in emergencies. They practice in solo or group settings and are paid through capitation for their registered client base. Specialists tend to be based in only one hospital.148,152 However, the budget of a hospital is determined separately from the budget of the physician specialty groups within the hospital.153 The vast majority of specialists in the acute hospitals are paid through fee-for-service, with fees based on a national fee schedule determined in national deliberations between representative organizations of medical specialists, private health insurers and sickness funds.154,155 There has been a tendency to try to introduce a variety of alternative payment methods; these vary among different hospitals. Some specialty associations, such as that for pediatricians, have agreed to become hospital
employees and abandon fee-for-service payments; most continue to resist what they see as endangering their independent professional status. The government has announced plans to begin to bundle specialist and hospital costs into new diagnostic related group-based systems of funding.

The Hospital Planning Board (CBZ, Commissie Bouwzaken van het College voor Ziekenhuisvoorzieningen) is a public body with monitoring and advisory duties. In addition, the 1982 National Health Tariffs Act (WTZ, Wet Tarieven Gezondheidszorg) provides a framework for regulating fees for health professionals and prices and budgets for health care facilities. The framework applies to both social health insurance and to private insurance; the Netherlands does not allow providers to charge such tariffs unless there is a statutory basis for them. Before 1983, the Central Agency for Hospital Tariffs (Centraal Orgaan Ziekenhuistarieven, or COZ), an arm’s length body dominated by stakeholders from the national hospital and sickness fund associations, negotiated guidelines for hospital reimbursement and approved each hospital’s annual budget estimate. Payment was based on agreed per diem charges, which aligned the incentives of physicians and hospitals to promote utilization. After that date, the WTZ introduced a new mechanism which allowed for greater governmental involvement. The COTG (Centraal Orgaan Tarieven Gezondheidszorg), an arm’s length organization with membership from national organizations of hospitals, sickness funds, and private insurance companies, was given the legal authority to review and approve negotiated prices; it also developed policy guidelines, gave advice to the Minister of Health, and provided an arbitration mechanism if the parties could not agree. However, the Ministry had the authority to limit the room for negotiations by giving binding instructions about policy guidelines. This transformed the expenditure instrument by giving it more regulatory teeth; its decisions were legally binding, and enforced by the then-Ministry of Welfare, Health and Culture. The main innovation was to replace the COZ guidelines which had been used to calculate the per diem charges used to pay hospitals by capped annual global expenditure limits, established through negotiation between sickness funds, private insurers and hospitals. This exercise was intended to enforce cost control by controlling volume; it also shifted the balance of power between medical staff and hospitals. In 1999, the COTG was replaced by another arm’s length advisory body, the National Health Tariffs Authority (CTG, or College Tarieven Gezondheidszorg), with
responsibility for approving global budgets, as well as for setting maximum fees for ambulatory care services. 137,156

The basis for constructing these budgets has also varied over time. As noted, budgets had initially been based on a per diem payment, which encouraged volume. In 1983, the Netherlands introduced budgeting based on a fixed, historical basis; this was then replaced by functional budgeting in 1988, which sought to ensure that hospitals providing the same functions received equal budgets. The formula included elements based on the population in the hospital’s catchment area (availability), the number of authorized beds and specialist units (capacity), and the projected service volumes (production); the latter was determined in annual negotiations between the hospital management and the payers (both sickness funds and private health insurers). 12,140 In 1992, the availability component averaged 15% of hospitals’ budgets, capacity 34% and production 48%, with the remaining 3% for specific high cost treatments; however, the precise numbers are being altered as the model is fine-tuned. 145 The COTG approach to approving the annual negotiated hospital budgets included sub-division into a generalized allowance for inflation and institution-specific increments to reflect approved new services. Hospitals were allowed to provide services other than those approved by COTG, but the sickness funds did not have to pay for them. 151 Because the functional budgeting system incorporates a volume component, it is somewhat more open-ended than the model it replaced.

In general, the Dutch system gives considerable autonomy to individual hospitals, enabling each to be “quite independent in its policies and behaviour without jeopardizing its financial security.” 151 Analysts note that it is difficult for government to interfere, and hence difficult for it to enforce policy directions. However, most of the pro-competition reforms have concentrated upon insurers rather than on providers. As one example, at the time of writing, there is no freedom of contracting; all approved hospitals had to receive contracts from all insurers operating in their catchment areas.

D-3 How has the Netherlands handled these issues?
D-3.1 Capacity: (capital planning)

The government uses regulation and expenditure instruments to control capacity. As Busse notes, both NFP hospitals and public hospitals in Bismarckian countries “are usually subject to the same amount of regulation as public hospitals concerning capacity planning, resource allocation and reimbursement, quality assurance, etc.”

Regulation is based upon the Hospital Facilities Act (Wet Ziekenhuisvoorzieningen) of 1971, revised in 1979, which gives the Ministry of Health the right to control major hospital construction activities and their structure (e.g., the number of beds, medical specialist units, and/or facilities for top-clinical care). The Act regulated not only general hospitals, but also mental hospitals, institutions for the mentally handicapped, and nursing homes. In the past, this act was also used for planning purposes, with each provincial government required to prepare hospital plans, based on pre-set bed needs standards. The country is divided into 27 health care regions for planning purposes. The provincial draft plan can be short-term (including specific proposals for a 4 year period) or longer term (a more general inventory and evaluation); it must then be submitted to the Minister for approval. The National Board for Hospital Facilities provides advice to the Minister. Once accepted, the plan is used by health insurers. They must reimburse services provided by hospitals in the approved plan. In contrast, hospitals not in the approved plan must close; the Hospital Facilities Act contains provisions for hospital closings. Neither are sickness plans allowed to pay the operating costs of services provided with capital equipment which was not approved by government. In recent years, there has been little emphasis on regional plans, particularly since the government’s goal has been to reduce capacity.

In the past, the aggregate hospital investment budget in the Netherlands was divided into 12 provincial sections, another section for national projects, a section for small investments (with expedited procedures), and a general section “for bottlenecks and calamities.” Each section prepared priority lists using preset criteria, but the final lists appeared to be highly subject to political pressure and lobby activity, particularly by hospitals. In three of the 12 provinces, there was an experiment with provincial health councils having to approve the annual allocation of new capital expenditures for their hospitals, but this does not appear to have been a powerful instrument. The tendency instead was to reduce the number of investments subject to
government approval, and give more autonomy to hospitals, subject to guidelines based on hospital size (in square meters) and limits on annual depreciation costs.\textsuperscript{145}

As a result of these regulatory requirements, hospitals may not be constructed or renovated without successfully completing a declaration and licensing process which requires a detailed plan for each affected hospital service in that specific geographical area. Constructing hospitals required successful completion of a detailed four-step process, all of which require approvals from the Minister, and input from the National Board from Hospital Facilities.\textsuperscript{157} Many observers considered this process to be overly micro-managed,\textsuperscript{5} and overly dependent upon responding to provider requests (reactive) rather than incorporating proactive mechanisms to ensure that any gaps identified in the planning process will be filled.\textsuperscript{157} Smaller capital investments do not require a license, and are met from the operating budget of that hospital.\textsuperscript{145}

The government has used this Act for cost containment goals, such as reducing the number of hospital beds. The bed reductions are, in theory, voluntary, because the Act does not grant government the right to cut hospital beds. Government has accordingly employed the expenditure instrument; in the process of negotiating hospital construction or other expansions, hospitals have encouraged to “voluntarily” reduce their bed numbers. It also incorporated a hospital building ceiling, introduced in 1974, to limit approved hospital capital expenditures. The ceiling had become sufficiently low by 1990 that a “huge backlog of building projects” had resulted.\textsuperscript{145}

The bed-to-population ratio has dropped, although there is some variation in the numbers given in different sources. Maarse notes that it declined from 4.2 per thousand population in 1981 to 3.5 in 1990, with a target of 2.8 in 1998.\textsuperscript{145,152} Boot places the numbers at 5.2 in 1980 and 3.7 in 1998.\textsuperscript{157} This has been accompanied by a reduction in the number of hospitals – from 256 in 1970, to 143 in 1998– and an increase in size–from 282 beds per hospital in 1970 to 404 in 1998.\textsuperscript{157} The process has resulted in a fairly equal distribution of hospital beds across the country.\textsuperscript{5} One factor encouraging mergers is that the rates for production items were higher for larger hospitals than for smaller ones, meaning that merged hospitals could thereby increase their total budgets.\textsuperscript{145} However, even with the reduced ratio, the bed occupancy rate was a relatively low 66.73, suggesting that there were still enough beds available to meet service needs.\textsuperscript{141}

The mechanisms for controlling specialized services covered by AWBZ are somewhat
different from the mechanisms for controlling ordinary hospital services. Hospitals cannot provide AWBZ or ZWF care unless they are given permission to do so, although patients can then select where they wish to go for care. However, once permission is given, every provider must contract with every insurer.  

Government also appears to control the number of medical students and interns who can be trained. They also appear to have had control over how many beds and specialist units were authorized; this in turn affects the prospective budget set for the hospitals.  

Exhortation approaches are also employed. For example, recently, a European Union network of the governmental or semi-governmental organizations who deal with planning and building health facilities was established. The Netherlands Board for Hospital Facilities is a member of this embryonic EU Health Property Network. The network does not have decision-making authority; it produces reports and suggests best practices.

This emphasis on supply-side controls does not fit well with the official policy goal of the Dutch government to rely upon market forces. Government has therefore announced intentions to downplay these regulatory approaches, although these policies do not appear to have yet been implemented. There is as yet little evidence as to whether these market-based approaches will be effective in achieving the hoped-for goals. The intention is to replace much of the regulation with expenditure, using decisions about funding construction costs “as the main tool for creating an efficient, well-balanced and accessible health care system, as building health care institutions in accordance with the national health care vision implies decisions about the kind and size of facilities and its running costs.”

D-3.2 Costs and prices

Supply and prices of health services are also regulated from the top. An aggregate budget limit is set in the Ministry of Health’s annual Financial Report on Health (Financieel Overzicht Zorg); in 1997, this report was re-named to Jaaroverzicht Zorg, and in 1999, to Zorgnota. At various times, this has either been an exhortation mechanism or a firm expenditure limit accompanied by reductions in aggregate funds made available. For example, in 1994, the Dutch Cabinet announced measures intended to reduce labour costs; these policies limited the availability of health care funding.
Most hospital funds (85% in 1992) come from *per diem* charges for inpatient care. Charges for care under AWBZ and under ZFW are subject to government approval, and annual maximums are set. The Sickness Fund Act (*Ziekenfondswet*) and the Exceptional Medical Expenses Act (*Algemene Wet Bijzondere Ziektekosten*) specifically prohibited reimbursement for services provided by FP health centers or private clinics. Service prices for hospitals were set by the Central Agency for Health Care Tariffs (COTG). In 1998, the national Parliament approved a law which would integrate payments for the hospital-based medical specialists into hospital budgets (*Integratiewet medisch-specialistische zorg*).

Insurers have faced considerable restrictions on their ability to selectively contract. Private insurers were allowed to selectively contract with self-employed health care professionals, but until 1992, sickness funds were obliged to contract with all providers serving their clients. Both private insurers and sickness funds were mandated to insure with all hospitals in their region, although the government has announced its intention of abandoning this requirement. These requirements have made cost control difficult, because the sickness funds were obligated to pay for every hospital and specialist service as long as it was delivered in accordance with the relevant contracts and national permits. The sickness funds were expected to break even; any surplus funds would be returned to the central sickness fund account, and any deficit would be covered by the same source. Hospitals can charge insurers separately for outpatient activities; the approach used varies with hospital.

Hospitals in the Netherlands are able to borrow funds directly from the private sector for capital financing. The national government used to guarantee hospital loans, but stopped doing so in an effort “to encourage hospitals to behave like other private market companies.” Thompson and McKee estimate that 80-90% of funds for a typical project result from private loans, with the remainder coming from either accumulated savings, charity, or other investors. The costs are then fully recovered through a surcharge on patient charges to the insurance funds. Interest costs for loans to cover deficits from hospital payment shortages were also fully reimbursable, although government subsequently attempted to plug this loophole through administrative measures. Hospitals are also allowed to earn and retain surplus revenues.

The incorporation of volume-based components made the payment system more open ended, with corresponding difficulties in ensuring that expenditure targets were met. COTG
studies noted that between 60 and 70% of hospitals were running deficits between 1986 and 1990, with about 15% having a negative reserve.\textsuperscript{145}

Efforts to use regulation were not seen by policy analysts as having been particularly successful. Saltman and de Roo concluded that “In response to official limitations on their resources, [the hospitals studied] sought to (a) reduce expenditures in areas they controlled directly, (b) generate new revenues from the government, and (c) place certain joint and/or legally embarrassing activities beyond the regulatory grasp.”\textsuperscript{151} Policy proposals to move to a greater emphasis on competition appear to assume that these expenditure approaches will prove more successful, although there is little evidence base to support that contention. Indeed, it is worth noting that the supply-side budgetary controls employed in the Netherlands (and in Canada) may have been \textit{too} effective; certainly, they have led to perceptions of rationing by waiting list.\textsuperscript{19}

\textbf{D-3.3 \textit{What services are offered?}}

The Hospital Facilities Act also regulates the number of medical specialist units and high-cost care and investments in medical equipments. In the early 1980s, as part of a command-and-control regulatory approach, the national government created a formal licensing system for certain expensive technologies under Article 18 of the Hospital Facilities Act. As of 1990, article 18 applied to renal dialysis, kidney transplantation, radiotherapy, complex neurosurgery, heart surgery, percutaneous transluminal coronary angiography, neonatology, clinical genetic research, and in vitro fertilization; bone marrow, liver and pancreas transplantation and positron emission tomography were added in 1993. The process was not seen as working well in practice. It was time-consuming, and hospitals were able to invest in the facilities before they were licensed and gain subsequent approval.\textsuperscript{145} Most requests were eventually approved. This approach is being replaced by a competition-based approach which attempts to use market-based expenditure mechanisms to control health policy.\textsuperscript{151}

Hospitals negotiate contracts with the specialists who will practice there. Despite the tight control of specialists, the total number of specialists has grown by 18.5\% and the number of specialist units per hospital has increased from 29 to 53 units from 1981 to 1995. With the decline in number of beds, hospitals are becoming specialty centres and losing their traditional
hotel functions. Contracts between the hospital and its medical staff gave the medical staff the right to approve (by majority vote) whether new specialists or new services would be added to the hospital. This contract was based on a national model, developed between the National Association of Hospitals (Nationale Ziekenhuis Raad) and the National Association of Specialists. However, the change in expenditure approach from output based financing to fixed budgets changed the relationship between doctors and hospital administrators. Physician incomes depend upon volume; hospital budgets require limiting volumes.

The funding model was also seen as placing barriers on innovation. For example, attempts to implement integrated care models have encountered difficulty, because there are no mechanisms available to finance services which span hospitals and home. Nonetheless, the international trend to replace inpatient by outpatient and day care has been seen in the Netherlands, with strong substitution effects noted. This has been hampered by regulation. The Sickness Fund Act does not permit sickness funds to contract with freestanding ambulatory care centres; these accordingly can sign contracts only with private insurers. Similarly, hospitals could only be paid by sickness funds or private insurance companies, and the AWBZ was prohibited from reimbursing hospitals. Thus, it was difficult to set up innovative delivery models, such as special nursing wards, or specialized diabetes nurses, because the funding would have to be negotiated between ZWF and AWBZ. In consequence, there is a heavy dependence upon trust, creativity, and willingness to work together to overcome such barriers. The competitive models are seeking to encourage hospitals to compete with one another on service packages, and on the prices they charge to the sickness funds.

D-3.4 Access - who gets services?

Access to specialized services is controlled by individual providers - GPs act as gatekeepers for their patients. Professional codes of ethics are important exhortation instruments affecting how care is allocated. Because of the way in which contracts are negotiated, analysts argue that there are no obvious economic incentives to treat patients with private health insurance differently from those with social insurance, with the exception of some differences at the margin (e.g., the incentive for capitated GPs to refer patients with ZFW to specialists to move them off their fixed budgets). Private insurance does not enable queue jumping.
However, the expenditure limits on departmental budgets can be highly restrictive. Budgets for hospitals are calculated based on the number of people in the service area, the number of licensed hospital beds, and the volume of production units; when the annual departmental budget is reached, the hospital specialist cannot treat any more patients in that fiscal year.¹⁴¹ There is a reported tendency for preferred access to health care facilities for employees, since some employers are willing to pay if that will reduce their benefits costs for employees unable to work while waiting in the long queues of the Dutch health system; and hospitals and sickness funds are willing to participate.¹⁶⁰,¹⁶¹

However, to be included within the compulsory health insurance plans, services must be deemed ‘medically necessary.’ Defining necessity is notoriously difficult, and services not meeting these criteria may be valuable. Thus, a body of services not defined as ‘medically necessary’ can nonetheless be covered by supplementary insurance. There is considerably less regulation of these procedures, but they only accounted for about 3% of health expenditures in 1997.¹⁴⁷

D-3.5 Health human resources - who can you hire? What do you pay them?

The pre-1983 system included detailed guidelines, including maximum spending on various categories of personnel per patient-day and/or per occupied bed. Payment was on a per diem basis. This gave hospitals incentives to increase volumes to prevent deficits and to grow staff numbers. The introduction of global budgeting replaced these explicit controls with an expenditure instrument, which was intended to encourage hospitals to operate more efficiently.¹⁴⁵ At present, control over numbers and mix of staff rests in the hands of the provider organizations.

One key exception is physicians, who are largely independent contractors rather than hospital employees. As of the late 1980s, the Association of Sickness Funds (Vereniging van Nederlandse Ziekenfondsen) negotiated detailed fee schedules annually with the National Association of Specialists; this schedule applied only to those patients covered by the sickness funds. Hospital specialists were not eligible to sign contracts with sickness funds for reimbursement unless they were members of the medical group in the particular specialty practicing in that hospital. The payers (sickness funds) accordingly enforce the control held by
professional associations over the qualifications of the specialists allowed to practice in hospitals.\footnote{151}

**D-3.6 Quality control within institutions**

A relatively recent innovation is the Quality of Care Institutions Act (Kwaliteitswet Zorginstellingen), passed in 1996. It requires that all institutions providing care, whether public or private, must fulfil four requirements: a) provide ‘responsible care’ (defined broadly as care that is competent, needs-based, effective, suitable, and patient-focused, but in practice left to be defined by the individual providers); b) make clear what they are doing to achieve and maintain that ‘responsible care’; c) systematically protect and improve the quality of care they provide; and d) publish an annual report that elaborates the quality control policies they have applied and reports on the quality of care they have delivered. In our terms, this is an exhortation mechanism with regulations ensuring that hospitals put a system in place (without specifying what that system would be), and report about their activities. In practice, implementation has been slow; Okma has observed that “ten years after it passed, less than 10 per cent of institutions had implemented quality systems, although most are working on that.” (Personal communication, April 28, 2004)

There are also regulatory mechanisms in place for health professionals.

Considerable concern has been expressed that expenditure limits have adversely affected quality of care, with particular attention to waiting lists.\footnote{145}

A number of other quality control activities are largely voluntary (exhortation) but highly valued; these are managed by arm’s length provider organizations. For example, in 1998, the Netherlands implemented a system of hospital accreditation, based on the Canadian model, through the Institute of Accreditation of Hospitals.\footnote{153,162} Other exhortation mechanisms supported by provider organizations or arm’s length bodies include the guidelines and evidence-based medicine consensus documents produced by the Dutch College of General Practitioners (Nederlands Huisartsen Genootschap, NHG) and the Dutch Institute for Healthcare Improvement (Centraal Begeleidingsorgaan voor de Intercollegiale Toetsing, CBO). The Health Care Insurance Board (College voor zorgverzekeringen - CVZ) is the body which supervises the private sickness funds.\footnote{163} It also has
taken on a health technology assessment role, advising the government which health interventions, including pharmaceuticals, should be reimbursed under the current health insurance system. It is a member of the International Network of Agencies for Health Technology Assessment (INAHTA).59

The Dutch have also established a system of peer review for specialists, using an accreditation approach. “Each specialist is required to belong to a group of four to eight like-minded specialists, which is reviewed every five years. The specialists need not be working in the same hospital.” The process is controlled by health professionals, including the board of the relevant specialist society.162,164-166

There are also legislative provisions that health care providers establish a committee to deal with client complaints about staff members in each institution. (The Care Sector Clients’ Right of Complaint Act, WK CZ, Wet Klachtrecht Cliënten Zorgsector 1995).137

D-3.7 Information provision

A number of mechanisms have been discussed above, including the quality assurance approaches, and the requirements for information inherent in the budget negotiation processes. The government has also introduced a number of patients’ rights provisions. For example, the Care Institutions Clients’ Right of Participation Act (WMCZ, Wet Medzeggenschap Cliënten Zorginstellingen 1996) obliges providers to establish consumer councils to advice them on various issues.137 An extensive network of over 300 patient and consumer associations are also involved in such activities as advocating on behalf of patients and providing information.167

Within government, planning bodies exist within the National Institute of Public Health and the Environment (RIVN, Rijksinstituut voor Volksgezondheid en Milieu) and the Social and Cultural Planning Office (SCP, Sociaal en Cultureel Planbureau) which conduct research and provide information. Information is also received and produced by the four main consultative bodies to the Ministry of Health, Welfare and Sport: the Health Council (GR, Gezondheidsraad), the Council for Health Research (RGO, Raad voor Gezondheidsonderzoek), the Council for Public Health and Care (RVZ, Raad voor de Volksgezondheid en Zorg) and the Advisory Council on Social Development (RMO, Raad voor Maatschappelijke Ontwikkeling). Of these, the RVZ is most directly applicable to hospitals, with a mandate to advise on such aspects as
costs, funding, organization, staffing, and waiting lists. The State Inspectorate of Health (IGZ, Inspectie voor de Gezondheidszorg) also reports on the state of health care.\textsuperscript{137}

\textbf{D-4 The Netherlands, summary}

The Dutch system is currently caught between the present system of regulatory controls over supply, price, and budget, and the government’s preferred policy direction of allowing these issues to be managed through a competitive market. Much of the attention of policy analysts has been devoted to competition among sickness funds, rather than to their relationship with hospitals. There is a push to deregulate government controls over capacity and prices and allow them to be controlled by insurers using competitive expenditure approaches.\textsuperscript{137} However, even proponents of this demand-driven model still insist that existing quality control legislation should be maintained, along with controls over geographical distribution, and capacity controls over “very expensive technologies.”\textsuperscript{141} They also pre-suppose considerable exhortation limitations upon hospital activity (\textit{e.g.}, strong stewardship), which may be simplified because there are no FP/c hospitals within the Dutch system.
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