

Palvelutuotannon omistamisen eri mallit – miten muissa maissa?

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Erikoistutkija, Terveyden ja hyvinvoinnin laitos

The Economist

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A hospital case

Sweden is leading the world in allowing private companies to run public institutions

May 18th 2013 | From the print edition

Timeline

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SAINT GORAN'S hospital is one of the glories of the Swedish welfare state. It is also a

“Private health-care companies have several advantages over public organisations (...) Europe should be proud of its public-health services. But if it wants them still to be affordable in the future, it should allow more private companies into the mix.”



YKSITYINEN VS. JULKINEN

KOLME MÄÄRITELMÄÄ

Table 1 Ideal type sectors and accountability (modified from Billis 2010, p. 55)

Core elements	Public	For-profit	Not-for-profit
<i>Ownership</i>	Citizens	Business owners Shareholders	Members
<i>Governance</i>	Public elections	Share ownership Size	Private elections
<i>Operational priorities</i>	Public service and collective choice	Market forces and individual choice	Commitment about distinctive mission
<i>Distinctive human resources</i>	Paid public servants in legally backed agency	Paid employees in managerially controlled firm	Members and volunteers in association
<i>Distinctive other resources</i>	Taxes	Sales, fees	Dues, fees, donations and legacies

Lähde: Tynkkynen 2013

THE IRON CAGE REVISITED: INSTITUTIONAL ISOMORPHISM AND COLLECTIVE RATIONALITY IN ORGANIZATIONAL FIELDS*

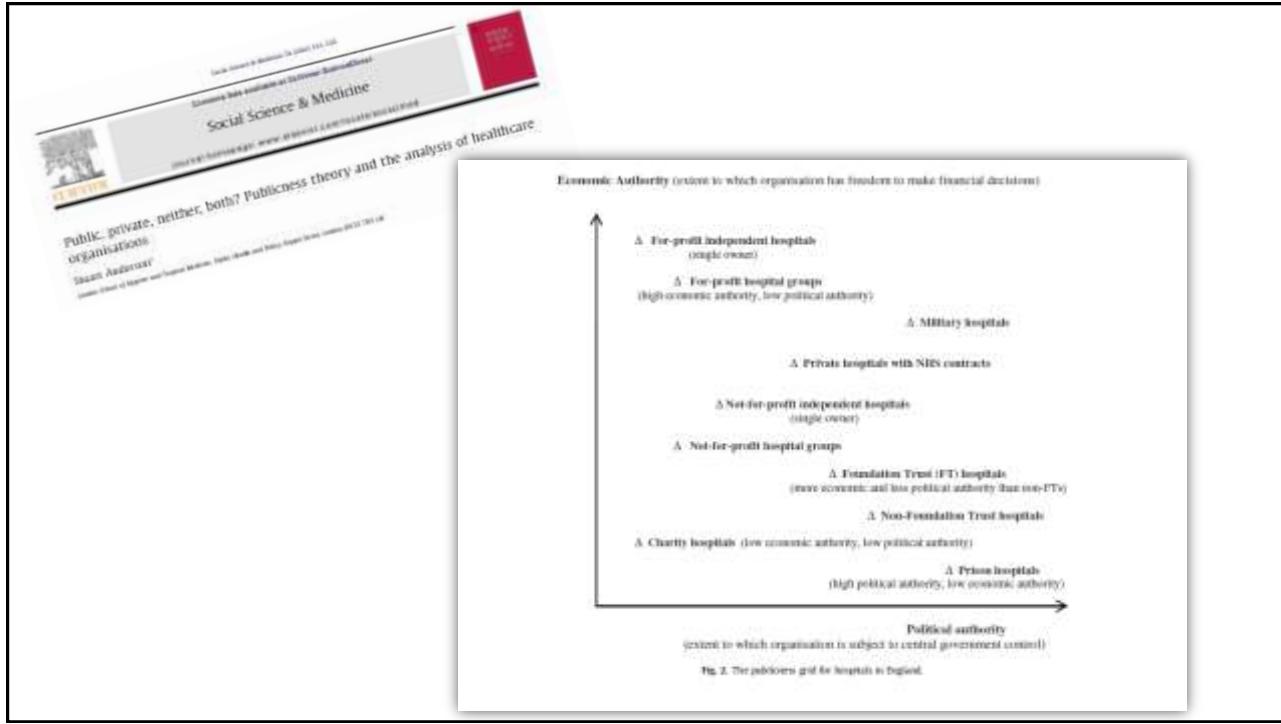
PAUL J. DiMAONO WALTER W. POWELL
Yale University

What makes organizations so similar? We contend that the engine of rationalization and bureaucratization has moved from the competitive marketplace to the state and the professions. Once a set of organizations emerges as a field, a paradox arises: rational actors make their organizations increasingly similar as they try to change them. We describe three isomorphic processes—coercive, mimetic, and normative—leading to this outcome. We then specify hypotheses about the impact of resource centralization and dependency, goal ambiguity and technical uncertainty, and professionalization and bureaucratization on isomorphic change. Finally, we suggest implications for theories of organizations and social change.

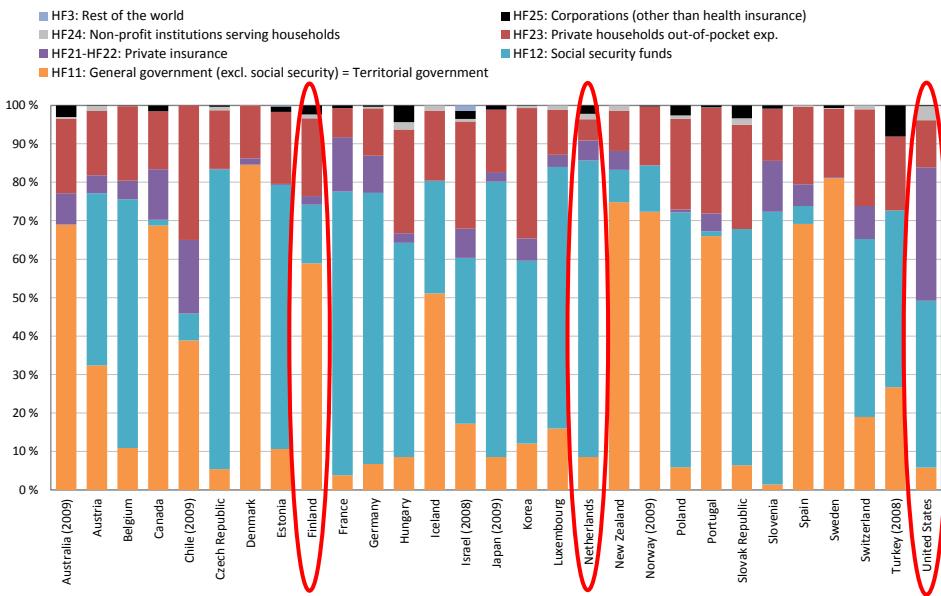
In *The Protestant Ethic and the Spirit of Capitalism*, Max Weber warned that the rationalist spirit ushered in by asceticism had achieved a momentum of its own and that, under capitalism, the rationalist order had become an iron cage in which humanity was, save for the possibility of prophetic revival, imprisoned "perhaps until the last ton of fossilized coal is burnt" (Weber, 1952:181–82). In his essay on bureaucracy, Weber returned to this theme, contending that bureaucracy, the rational spirit's organizational manifestation, was so efficient and powerful a means of controlling

capitalist firms in the marketplace; competition among states; increasing rulers' need to control their staff and citizenry; and bourgeois demands for equal protection under the law. Of these three, the most important was the competitive marketplace. "Today," Weber (1968:974) wrote:

it is primarily the capitalist market economy which demands that the official business of administration be discharged precisely, unambiguously, continuously, and with as much speed as possible. Normally, the very large, modern capitalist enterprises are

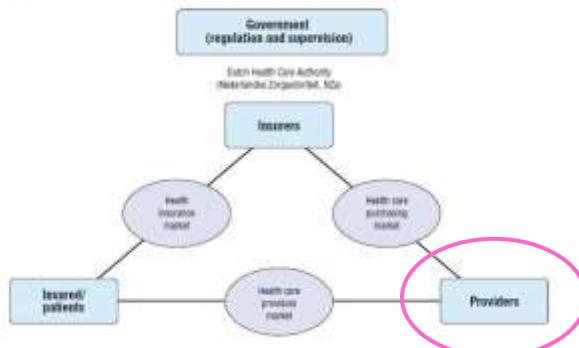


Current Health Expenditure by ICHA-HF Healthcare Financing, 2010



Source: OECD.Stat 2012

Fig22: Actors and markets in the Dutch health care system since 2006



Source: Schäfer et al. 2010

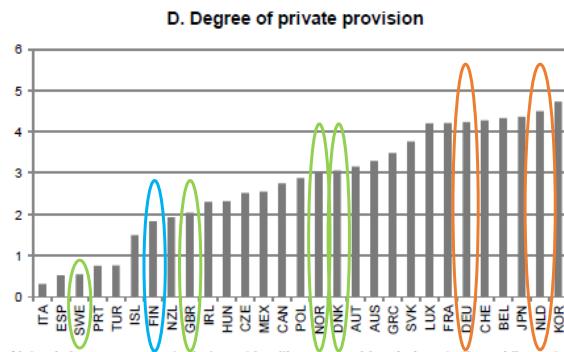
The Privatization of Health Care in Europe: An Eight-Country Analysis

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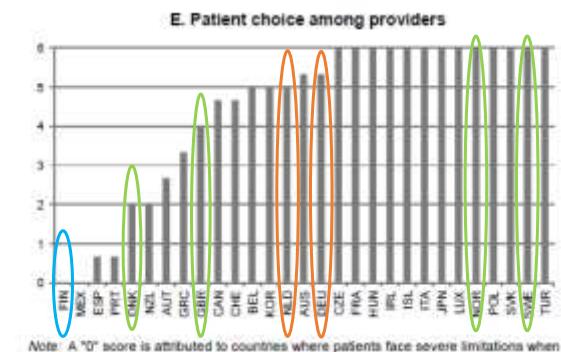
Abstract: This article presents an analysis of recent changes in the public-private mix in health care throughout Europe. The leading question is to what extent systems of provision for health care can be considered to be privatized. The analysis of privatization describes the role that multiple policy reforms have had in health care. The overall picture that emerges from our analysis is diverse, but there is evidence that health care in Europe has become somewhat more private. The growth of the public function in health care spending has come to an end since the 1980s, and in a few countries the private function has increased substantially. We also find that the public function in health care has become more market-oriented. Furthermore, there are signs of privatization in health care in management and operation, as well as in structures. Specific attention is given to the identification of factors that push privatization forward and factors that work as a barrier to privatization.

The history of health care in Europe during the nineteenth and twentieth centuries can be depicted in terms of an ever-extending state involvement (Fox 1986; Rogers Hollingshead, Haag, and Blauwewert 1990; Glaser 1991). Particularly in our twentieth century, everywhere in Europe the state has been the main responsible for health care. The creation of the "health care system" (Miles 1999) was the result of a gradual extension of the scope of state intervention through legislative measures and other state programs concerning a variety of issues, including the legal protection of the medical profession and patients, the quality of health care, access to health care, the payment of medical doctors and other health care agents, the organization of health services delivery, and

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Note: A low score reflects that most health care providers belong to the public sector.



Note: A "0" score is attributed to countries where patients face severe limitations when choosing a primary care physician, a specialist and a hospital.

SOURCE: Joumard et al. 2010. Health care systems: efficiency and institutions. ECO/WKP(2010)25, OECD.

Country	Q27 Predominant mode of provision for primary care services	Q27 Second mode of provision for primary care services	Q28 Predominant mode of provision for specialists' services	Q28 Second mode of provision for specialists' services
Australia	private group practices		private group practices	public hospital
Austria	private solo practices		private solo practices	public hospital
Belgium	private solo practices	private group practices	private solo practices	private group
Canada	private group practices	private solo practices	public hospital	private hospital
Czech Republic	private solo practices		public hospital	private hospital
Denmark	private group practices		private solo practices	
Finland	public centres	private group practices	public hospital	private group practices
France	private solo practices		private solo practices	private clinic
Germany	private solo practices		private solo practices	
Greece	private solo practices		private solo practices	public hospital
Hungary	private solo practices		public centres	public hospital
Iceland	public centres		private group practices	
Ireland	private solo practices		public hospital	
Italy	public centres		public hospital	
Japan	private clinics		private clinic	
Korea	private solo practices		private solo practices	
Luxembourg	private solo practices		private solo practices	private clinic
Mexico	public centres	private solo practices	public centres	private group practices
Netherlands	private group practices	private solo practices	private group practices	private solo practices
New Zealand	private group practices		public hospital	
Norway	private solo practices		private solo practices	
Poland	private clinics	private solo practices	public centres	private solo practices
Portugal	public centres		public hospital	public centres
Slovak Republic	private group practices		private group practices	public hospital
Spain	public centres		public centres	
Sweden	public centres		public hospital	
Switzerland	private solo practices		private solo practices	
Turkey	public centres		public hospital	
United Kingdom	private group practices		public hospital	

**PERUSTERVEYDENHUOLLON
AVOPALVELUT PÄÖSIN
YKSITYISESTI TUOTETTUJA -
AMMATINHARJOITTAJAT**

Predominant modes for the provision of primary care services and outpatient specialists' services (Paris et al. 2010)

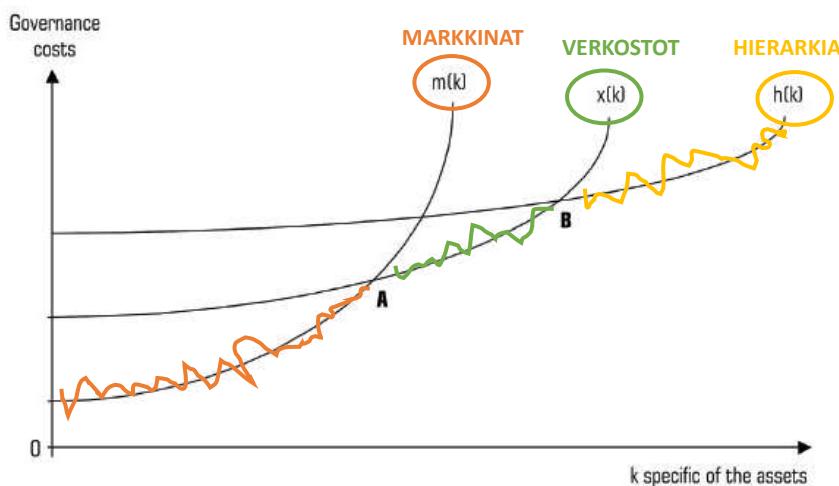
AVOSAIRAANHOIDON PALVELUT JOKO SAIRAALESSA TAI YKSITYISTEN AMMATINHARJOITTAJEN TOIMESTA

Public/private mix in the provision of hospital acute care (Paris et al. 2010)

AKUUTTISAIRAANHOITO
PÄÄOSIN JULKISESTI
OMISTETUSSA
SAIRAALOISSA
TUOTETTU

Country	Q30. Percentage of total acute care beds in:			Q31. Is private practice in the public hospital setting allowed?		
	Publicly owned hospitals	Not-for-profit privately owned hospitals	For-profit privately owned hospitals	For self-employed doctors	For salaried doctors	No
Australia	89.59	14.38	16.03		X	
Austria	72.5	18.8	8.7		X	
Belgium	34	66	0	X	X	
Canada	100	0	0	X		
Czech Republic	91	0	9			X
Denmark	96.7	2.5	0.8			X
Finland	89	0	11			X
France	66	9	25		X	
Germany	49	36	15	X		
Greece	69	3	28		X	
Hungary	n.a.	n.a.	n.a.			X
Iceland	100	0	0			X
Ireland	88	0	12		X	
Italy	81.5	18.7	1.8			X
Japan	26.3	73.7	0	X	X	
Korea	10	65	25			X
Luxembourg	68	29	3	X	X	
Mexico	65	0	35			X
Netherlands	0	100	0	X ^(a)	X ^(b)	
New Zealand	81	9.5 ⁽ⁱ⁾	0.5 ⁽ⁱ⁾			X
Norway	99	1	0			X
Poland	95	0	5	X		X
Portugal	85.7	6.6	7.7			X
Slovak Republic	59.6	0	40.4	n.a.	n.a.	n.a.
Spain	74.23	17	8.77			X
Sweden	98	0	2	X		
Switzerland	82.7	4.8	12.5	X	X	
Turkey	89.5	0	10.5			X
United Kingdom	96	4	0		X	

Figure 1_ Governance mode costs and asset specificity degree



$m(k)$ = governance via market;
 $x(k)$ = governance via contractual rules (hybrid);
 $h(k)$ = governance via hierarchy.

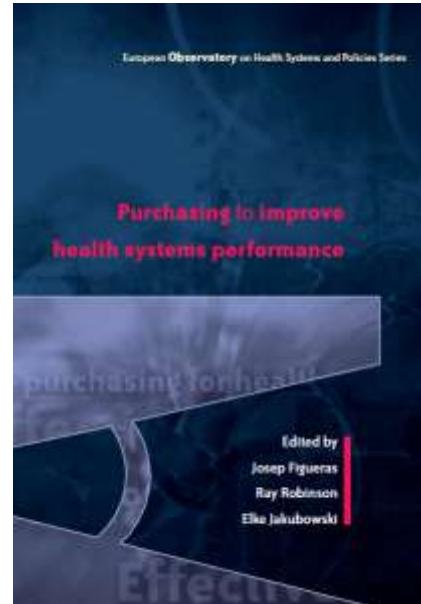
Source: Williamson (1975).

COMMISSIONING

"EVERYTHING'S BEEN OUTSOURCED,
WHAT'S LEFT FOR ME TO DO?..."

From passive to strategic purchasing

"Which interventions should be purchased, how they should be purchased and from whom."



Gullone et al. BMC Health Serv Res (2013) 13:104
DOI 10.1186/1472-6963-13-104



Open Access

The practice of commissioning healthcare from a private provider: learning from an in-depth case study

Maureen Chambers¹, Ned Shattock¹, Ann Maher¹, Richard Byng², Russell Morrison¹, Nigel Charles¹, Mark Enevold¹, Sue Uren^{1,2}

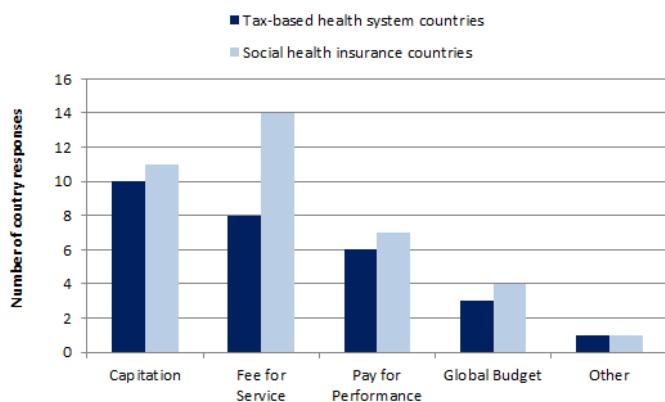
From The Limits of Market-based Reforms
Birmingham, UK, 1 October 2012

Table 1 Six media of power exercised in commissioner-provider relationships

Media of power	Description and source
Medium 1 – Negotiated order (interbureaucratic)	Conflicts are managed to produce a "negotiated order" [11]. The emphasis is on stationarity [12]. Negotiated order is characterised by explicit or tacit mutually agreed arrangements between commissioners and providers about their involvement in and responsibilities for commissioning. Such mutually agreed arrangements might relate to information sharing and the division of labour, for example.
Medium 2 – Provider competition (intermediated)	This medium of power relates to commissioners' attempts to manage competition between providers [13]. Three key features of this include the criteria for selecting providers, the range of providers and noncommissioner - buyer side monopoly [14].
Medium 3 – Financial incentives	Commissioners may employ a number of financial incentives to influence provider behaviour. These may relate to: who of payment [15], timing of payment, terms and conditions, bonuses, penalties and remissions [16].
Medium 4 – Ideological and disciplinary control (professional and political Ideology)	Ideological and disciplinary controls through discursive "orders" may be employed by commissioners. In these regulators [17-19]. For example these might relate to technical or scientific knowledge such as evidence-based practices, occupational ethics and norms of conduct, political and economic belief-systems and appeals to higher managerial and political authority such as "targets", regulations or managerial order.
Medium 5 – Judicial governance (contracts and law)	Legal and regulatory mechanisms may be used by commissioners in various ways [20]. This medium of power might relate to contract specifications, the use or threat of coercive enforcement of contracts, legal rights and the use of arbitration.
Medium 6 – Managerial performance of commissioning (managerial performance report cards)	Commissioners have a range of managerial mechanisms and resources to draw on when negotiating with providers [21]. These include decisions about which relationships are needed, the role of external supporting bodies, scrutiny of provider performance, providing models of commissioning and delegation of commissioning roles and responsibilities.

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Mode of payment and financing in primary care (OECD 2016)



SOURCE: OECD Health Statistics 2013, Health Systems Characteristics Survey 2012, and Secretariat's estimates. Information as of April 2014.

Country	Primary care physician payment	Out-patient specialist payment	In-patient specialist payment
Australia	PFS	PFS	Salary
Austria	PFS/Cap	PFS	Salary
Belgium	PFS	PFS	PFS
Canada	PFS	PFS	PFS
Croatia	PPG	PFS/Salary	Salary
Czech Republic	PFS/Cap	PFS	Salary
Denmark	PFS/Cap	Salary	Salary
Finland	Salary/Cap/PFS	Salary	Salary
France	PFS	PFS	Salary
Germany	PFS	PFS	Salary
Greece	Salary	PFS/Salary	Salary
Hungary	Cap	Salary	
Iceland	Salary	PFS	Salary
Ireland	PFS	Salary	Salary
Italy	Cap	Salary	Salary
Japan	PFS	PFS	PFS
Korea	PFS	PFS/Salary	PFS/Salary
Luxembourg	PFS	PFS	
Mexico	Salary	Salary	Salary
Netherlands	PFS/Cap	PFS	
New Zealand	PFS/Salary	PFS/Salary	PFS/Salary
Norway	PFS/Cap	PFS/Salary	Salary
Poland	Cap	PFS/Salary	Salary
Portugal	Salary	Salary	
South Africa	Cap	Salary	
Spain	Salary/Cap	Salary	Salary
Slovenia	Salary	Salary	
Switzerland	PFS	PFS	
Turkey	PFS/Salary	PFS/Salary	PFS/Salary
United Kingdom	Salary/Cap/PFS	Salary	Salary

Note: Cap means capitation, PFS fee-for-service; (*) in Poland, around half of physicians who work in hospitals receive salary; second half is self-employed and is remunerated according to contracts.

Source: OECD Survey on health system characteristics 2009-2009 and OECD estimates.

PREDOMINANT MODES OF PHYSICIAN PAYMENT (Paris et al. 2010)

Tabell 3.4 Ersättningssystemens utformning

	Kapitationersättning			Glesbygds- ersättning	Besöks- ersättning (listade)	Mänskaterad er- sättning	
	Alder	ACG	Socio- ekonomi			Täcknings- grad	Övriga mål
Hälsland	x				x	x	x
Västmanland	x			x	x		x
Stockholm	x				x	x	x
Gotland	x ¹			x	x	x	x
Kronoberg	x			x	x	x	x
Region Skåne	x ²	x	x			x	x
Uppsala	x			x ³	x		x
Östergötland	x	x	x	x	x	x	x
VG region	x	x	x	x	x	x	x
Södermanland	x	x	x	x	x	x	x
Jönköping	x	x	x	x	x	x	x
Kalmar	x	x	x		x	x	x
Blekinge	x					x	x
Värmland	x	x	x	x	x		x
Orebro	x		x	x	x		x
Dalsland		x	x	x	x	x	x
Gävleborg	x	x	x	x	x	x	x
Västernorrland	x	x	x	x	x		x
Jämtland	x	x	x	x	x		x
Västerbotten	x	x	x	x	x		x
Norrbotten	x	x	x	x	x		

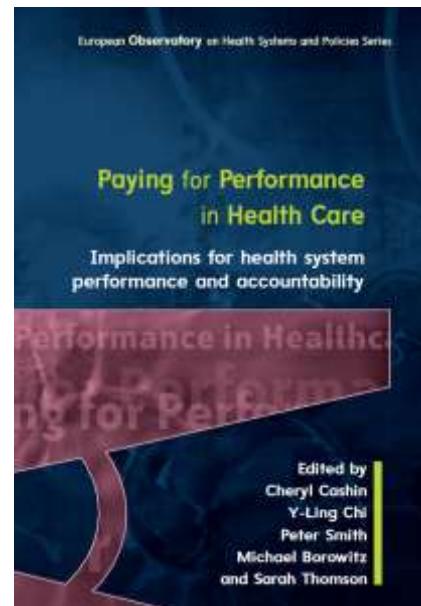
¹ Särskild ersättning utgår även för personer med biståndsbeslut om särskilt boende.² Gäller endast läkemedelsersättning³ Patienter boende i förutbestämda geografiska områden genererar ett extra påslag på kapitationersättningen

Källa: Konkurrensverket

Maiden sisällä
maksuperusteet voivat
vaihdella paljonkin eri
järjestäjätahojen välillä
– esimerkkinä Ruotsin
21 maksujärjestelmää

Towards P4P

*"Rewarding achievement
of targeted performance
measures"*



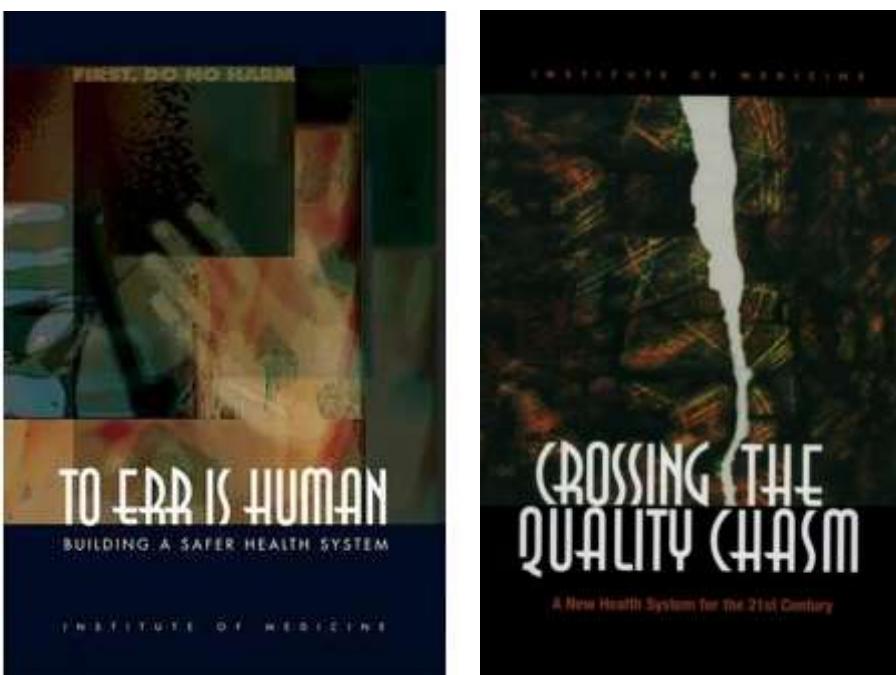


Table 1.2 P4P definitions

<i>Organization</i>	<i>P4P definition</i>
AHRQ	Paying more for good performance on <i>quality metrics</i> (Source: AHRQ, undated).
CMS	The use of payment methods and other incentives to encourage <i>quality improvement</i> and patient focused high value care (Source: Centers for Medicare and Medicaid Services, 2006).
RAND	The general strategy of promoting <i>quality improvement</i> by rewarding providers (physicians, clinics or hospitals) who meet certain performance expectations with respect to health care quality or efficiency (Source: RAND Corporation, undated).
World Bank	A range of mechanisms designed to enhance the <i>performance of the health system</i> through incentive-based payments (Source: World Bank, 2008).
USAID	P4P introduces incentives (generally financial) to reward attainment of <i>positive health results</i> (Source: Eichler & De, 2008).
Center for Global Development	Transfer of money or material goods conditional on taking a <i>measurable action or achieving a pre-determined performance target</i> (Source: Oxman & Fretheim, 2008).

Source: OECD, 2010.

P4P-ohjelmien tavoitteita perusterveydenhuollossa

- Ennaltaehkäisy
- Kroonisten sairauksien hoito
- Toiminnan tehokkuus
- Asiakastyytyväisyys
- IT-palveluiden käyttö

Table 1.4 Summary of objectives for P4P programmes in primary care

Country	Preventive care	Management of chronic diseases	Efficiency	Patient satisfaction	Uptake of IT services	Others
Australia	X	X			X	X
Chile	X	X	X	X		X
Czech Republic	X					X
France	X	X	X			
Korea, Rep. of			X			
Mexico	X	X	X	X		
New Zealand	X	X				X
Portugal	X	X	X	X		
Spain	X	X	X	X		
Sweden	X	X	X	X	X	
UK	X	X	X	X		
US	X	X	X	X	X	X

Source: OECD work on health systems characteristics 2012 and authors' estimates, unpublished.

Source: Cashin et al. 2014

P4P-ohjelmien tavoitteita erikoissairaanhoidossa

- Tietyt kliiniset tulokset
- Hoidon tarkoitukseen mukaisuus
- Asiakaskokemus
- Asiakastyytyväisyys

Table 1.5 Summary of objectives for P4P programmes in hospitals

Country	Clinical outcomes of care	Use of appropriate processes	Patient satisfaction	Patient experience
Australia				X
Korea, Rep. of	X	X		
Portugal	X	X	X	X
Spain	X	X		X
Sweden	X	X		X
UK	X	X	X	X
US	X	X	X	X

Source: OECD work on health systems characteristics 2012 and authors' estimates, unpublished.

Source: Cashin et al. 2014



Älykkäästi suunnitellut sosiaali- ja terveydenhuollon markkinat?

JUHANI LEHTO & LIINA-KAISSA TYNKKYNNEN

Markkinat ovat yhä useammin julkisen palvelustuun politiikan esityslistalla. Palveluja ostetaan, ulkoistetaan, yksityistetään ja kilpailuteetaan – tai ainakin julkista palvelutoimantoa verrataan yksityiseen palvelutoimantoon. Tämän myötä myös julkisen palvelun käsite saa uusia merkityssäältäjä. Yksityiset toimijat hoitavat yhä enemmän julkisen ja sääntelyä yksi merkittävä julkis tehtävä.

Muutuvan yksityisen ulottuvuuden ai-

markkinat olisivat. Mielikuvissa voi muodostua jopa klassisen vapaan markkinoiden ideaalilla mukainen ostaja-kulttuurin ja tuottaja-myymälän välinen win-win-suhde, kunhan vain harvallinen sääntely poistetaan. Toisen läripiän mielikuvassa hyvä, kansalaissille vastuullinen ja tasa-arvoa suojeleva julkinen toiminta korvaautuu palve-



Tuotannon ohjaukseen ulottuvuus

Palvelujen jakautumisen ulottuvuus	Rahoittajan suuri vaikuttus	Käyttäjän suuri vaikuttus	Tuottajan suuri vaikuttus
Kollektiivinen vastuu	Ohjatut markkinat	Käyttäjälähtöiset markkinat	Lehmänkauppa-markkinat
Yksilöiden vastuu	Etuksia supistavat markkinat	Kahden kerroksen markkinat	Yksityissektorilähtöiset markkinat

LÄHDE: YHTEISKUNTAPOLITIIKKA 78 (2013):6

Melting public–private boundaries in European health systems

ROBERT E. WILHELM

Summed debates about the separateness of either predominantly public or predominantly private health services arrangements have tended to be more ideologically charged than conceptually precise. Ultimately, the public/private split in European systems has often been more sharply defined in principle than in practice. This redefined isolation was further consolidated during the 1990s by reforms that isolated publicly owned hospitals and health centers from their daily operations by separating them from the rest of the system. More recently, however, there have been some reacquaintances that cannot easily be characterized as either purely public or private. This article presents a conceptually rigorous three-part classification of post-public arrangements that can provide a theoretical baseline from which to judge future cross-boundary developments.

Keywords: cross-boundary arrangements, private health care, privatization, public health services

Pursuit of “mixing the most” seems to stand and fall between the two extremes of absolute public and absolute private care. It is an all-or-nothing solution, trapping the theories of compartmentalization and separation. Opponents/beneficiaries altogether, associated with private good administration, the role of social workers. The term “cross-boundary” has come to be associated uniformly for 20 years’ ago the sentence at the time for a wide variety of health services managers in Europe and elsewhere in the world. The author’s private advice is that it is now time to move beyond the extremes (e.g., no room in market to argue in efficiency), and with varying degrees of idealism, try to find an approach to have business enterprises function in the public sector.

Over the recent decades, however, many remarkable long-lasting changes have been taking place in European health systems, and these changes indicate that traditional public/private boundaries are beginning to fade away in a number of countries.

This article focuses on the characteristics and implications of these changes in post-public arrangements in European health policy. It begins by setting out a general definition of privatization, using a specific four-point checklist. The next section discusses the main types of post-public arrangements, as well as the associated costs.

definition. Having established both the conceptual and operational ground rules, the paper then moves to analyze how a range of cross-boundary combining techniques of care can be used to extend the notion of “mixing public/private distinction,” to extend policies and structures used to improve total institutional and service delivery. Finally, the paper concludes by suggesting how public accountability within publicly sponsored hospitals, primary care, and health care services. The paper concludes with a brief consideration of potential issues concerning the private patient and staff.

DEFINING PRIVATIZATION
The stated question around the concept of privatization—“Are there people or not? Is mixing of public care over to private ownership?” This non-annual discussion of theory or day-to-day exchange for large companies, first off, or smaller ones, or it could mean the reappreciation of private ownership of health care services and institutions. The central requirement is an explicit shift in ownership of capital. Examples of privatization in the health care system come from the utility, telecommunications, and transportation sectors (cf. Williamson).

Reduced government in the model of ownership of assets can help out in the administrative efficiency and cost reduction of health care delivery. First, privatization has little if anything to do with the association of competence location. Second, increased leisure

“The challenge to policymakers in both publicly operated and social-health-insurance-based health systems will be to ensure that these new arrangements evolve in socially as well as economically appropriate directions.”

KIITOS!

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