Palvelutuotannon omistamisen eri mallit – miten muissa maissa?

Liina-Kaisa Tynkkynen, FT

Tutkijatohtori, Tampereen yliopisto/Tutkijakollegium

Erikoistutkija, Terveyden ja hyvinvoinnin laitos

"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. "

Health care in America

Going public, and private

The fuss over Obamacare's teething troubles is obscuring a bigger story for investors: American health care is gradually being both nationalised and privatised

Dec 21st 2013 | NEW YORK | From the print edition

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
Ownership	Citizens	Business owners Shareholders	Members
Governance	Public elections	Share ownership Size	Private elections
Operational priorities	Public service and collective choice	Market forces and individual choice	Commitment about distinctive mission
Distinctive human resources	Paid public servants in legally backed *agency*	Paid employees in managerially controlled *firm*	Members and volunteers in *association*
Distinctive other resources	Taxes	Sales, fees	Dues, fees, donations and legacies

Lähde: Tynkkynen 2013

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

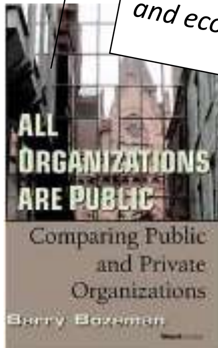
PAUL J. DIMAGGIO WALTER W. POWELL
Yale University

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 structuration on isomorphic change. Finally, we suggest implications for theories of organizations and social change.

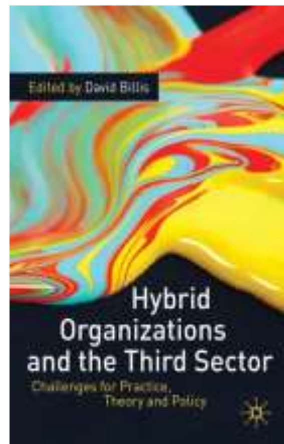
In *The Protestant Ethic and the Spirit of Capitalism*, Max Weber warned that the rationalist spirit ushered in by asceticism had achieved a momentum of its own and that, under capitalism, the rationalist order had become an iron cage in which humanity was, save for the possibility of prophetic revival, 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



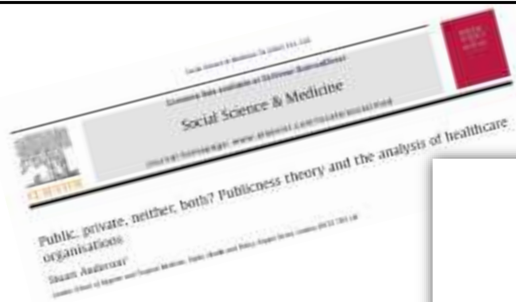
Publicness is 'a characteristic of an organisation which reflects the extent to which the organisation is influenced by political and economic authority'



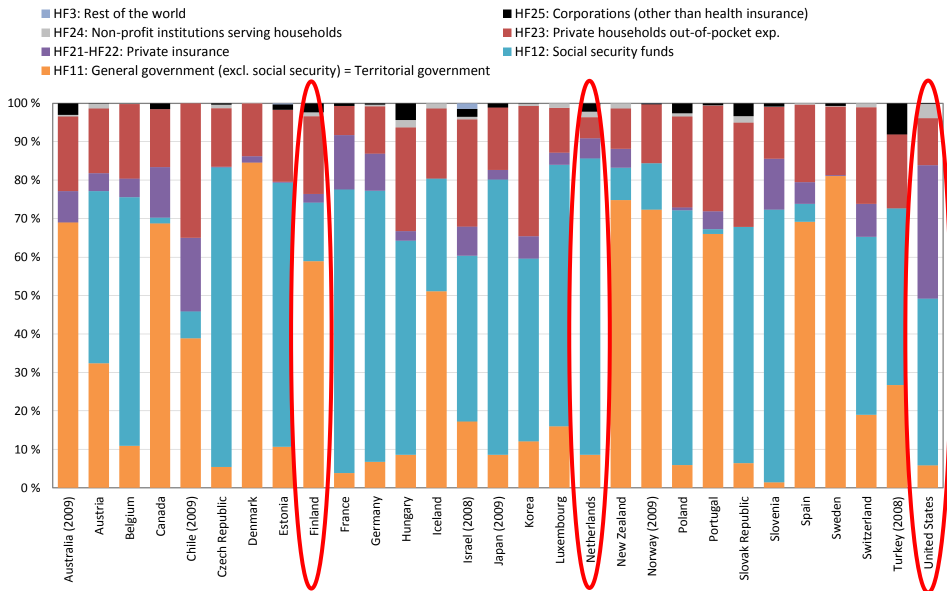
THE 'PUBLICNESS' OF PUBLIC ORGANIZATIONS

MARIANNE ANTONSEN AND TORBEN BECK JØRGENSEN

INTRODUCTION

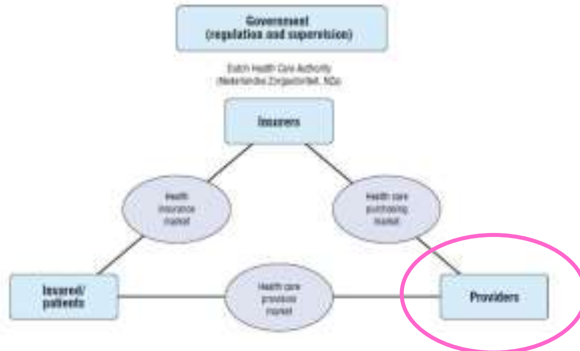


Current Health Expenditure by ICHA-HF Healthcare Financing, 2010



Source: OECD.Stat 2012

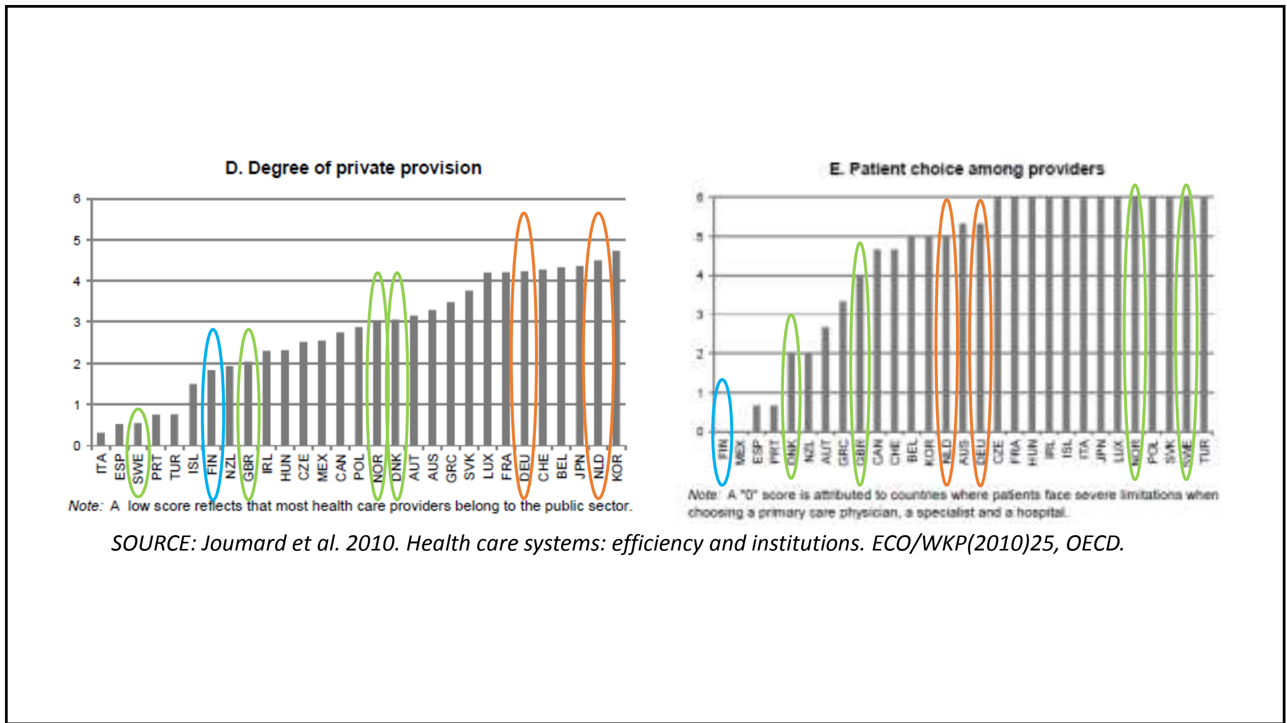
Fig22: Actors and markets in the Dutch health care system since 2006



Source: Schäfer et al. 2010

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

Hans Maarse
University of Maastricht



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 Secon... provision... services
Australia	private group practices		private group practices	public hos
Austria	private solo practices		private solo practices	public ho
Belgium	private solo practices	private group practices	private solo practices	private g
Canada	private group practices	private solo practices	public hospital	private
Czech Republic	private solo practices		public hospital	private
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
Netherlands	private group practices	private solo practices	private group practices	private solo
New Zealand	private group practices		public hospital	
Norway	private solo practices		private solo practices	
Poland	private clinics	private solo practices	public centres	private sol
Portugal	public centres		public hospital	public cen
Slovak Republic	private group practices		private group practices	public hos
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 PÄÄOSIN YKSITYISESTI TUOTETTUJA - AMMATINHARJOITTAJAT

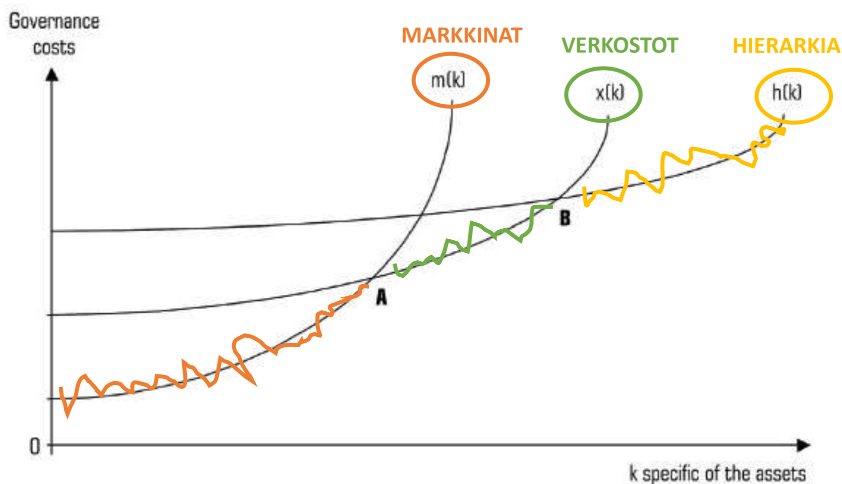
Predominant modes for the provision of primary care services and outpatient specialists' services (Paris et al. 2010)

AVOSAIRAANHOIDON PALVELUT JOKO SAIRAALASSA TAI YKSITYISTEN AMMATINHARJOITTAJIEN TOIMESTA

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

Country	Q30. Percentage of total acute care beds in:			Q31. Is private practice in the public hospital setting allowed?		
	Publically owned hospitals	Not-for-profit privately owned hospitals	For-profit privately owned hospitals	For self-employed doctors	For salaried doctors	No
Australia	69.59	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	16.7	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[2]	X[2]	
New Zealand	81	9.5[1]	9.5[1]			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	

AKUUTTISAIRAANHOITO PÄÄOSIN JULKISESTI OMISTETUISSA SAIRAALOISSA TUOTETTUA



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**."*

Health Services Research

RESEARCH — Open Access

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

Naomi Chambers, Rod Sheaff, Ann Mahon, Richard Byng, Russell Mannion, Nigel Charles, Mark Exworthy, Sue Llewellyn

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

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

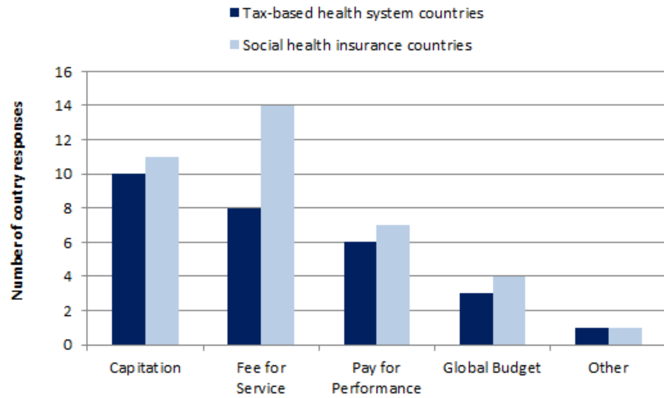
Media of power	Description and sources
Medium 1 – Negotiated order (relationality)	Conflicts are managed to produce a "negotiated order" [11]. The emphasis is on relationality [12]. Negotiated order is characterised by explicit or tacit mutually agreed arrangements between commissioners and providers about their involvement in and responsibilities for commissioning. Such mutually agreed arrangement might relate to information sharing and the division of labour, for example.
Medium 2 – Provider competition (contestability)	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 monopsonisation – buyer side monopoly [14].
Medium 3 – Financial incentives	Commissioners may employ a number of financial incentives to influence provider behaviours. These may relate to units of payment [15], timing of payment, terms and conditions, bonuses, penalties and exemptions [16].
Medium 4 – Ideological and disciplinary control (professional and political ideologies)	Ideological and disciplinary controls through discursive "orders" may be employed by commissioners in their negotiations [17-19]. For example these might relate to technical or scientific knowledge (such as evidence based practice), occupational ethos and norms of conduct, political and economic belief-systems and appeals to higher managerial and political authority such as "targets", regulators or managerial elite.
Medium 5 – Juridical governance (contracts and law)	Legal and regulatory mechanisms may be used by commissioners in various ways [20]. This medium of power might refer to contract specifications, the use or threat of coercive enforcement of contracts or legal rights and the use of arbitration.
Medium 6 – Managerial performance of commissioning (managerial performance repertoires)	Commissioners have a range of managerial mechanisms and resources to draw on when negotiating with providers [21]. These include decisions about which stakeholders are involved, the role of external supporting bodies, scrutiny of provider performance, prevailing models of commissioning and delegation of commissioning roles and responsibilities.

MARKKINOILLE TULO

SOPIMINEN

HINNOITTELU JA KANNUSTEET

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 physicians payment	Out-patient specialists payment	In-patient specialists payment
Australia	FFS	FFS	Salary
Austria	FFS/Cap	FFS	Salary
Belgium	FFS	FFS	
Canada	FFS	FFS	FFS
Czech Republic	FFS/Cap	FFS/Salary	Salary
Denmark	FFS/Cap	Salary	Salary
Finland	Salary/Cap/FFS	Salary	Salary
France	FFS	FFS	Salary
Germany	FFS	FFS	Salary
Greece	Salary	FFS/Salary	Salary
Hungary	Cap	Salary	
Iceland	Salary	FFS	Salary
Ireland	FFS	Salary	Salary
Italy	Cap	Salary	Salary
Japan	FFS	FFS	FFS
Korea	FFS	FFS/Salary	FFS/Salary
Luxembourg	FFS	FFS	
Mexico	Salary	Salary	Salary
Netherlands	FFS/Cap		FFS
New Zealand	FFS/Salary	FFS/Salary	FFS/Salary
Norway	FFS/Cap	FFS/Salary	Salary
Poland (*)	Cap	FFS/Salary	Salary
Portugal	Salary	Salary	
Slovak Republic	Cap		Salary
Spain	Salary/Cap	Salary	Salary
Sweden	Salary	Salary	
Switzerland	FFS	FFS	
Turkey	FFS/Salary	FFS/Salary	FFS/Salary
United Kingdom	Salary/Cap/FFS	Salary	Salary

Note: Cap means capitation, FFS 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 2008-2009 and OECD estimates.

StatLink http://dx.doi.org/10.1787/[illegible]

PREDOMINANT MODES OF PHYSICIAN PAYMENT

(Paris et al. 2010)

Tabell 3.4 Ersättningssystemens utformning

	Kapitationsersättning			Glesbygdsersättning	Besöksersättning (listade)	Målrelaterad ersättning	
	Ålder	ACG	Socio-ekonomi			Täckningsgrad	Övriga mål
Halland	x				x	x	x
Västmanland	x			x	x		x
Stockholm	x				x	x	x
Gotland	x[1]			x	x	x	
Kronoberg	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
VG region	x	x	x	x		x	x
Sörmland	x		x	x	x	x	x
Jönköping	x		x	x	x	x	x
Kalmar	x		x		x	x	x
Blekinge	x					x	x
Värmland	x	x	x	x	x		x
Örebro	x		x	x	x		x
Dalarna		x	x	x	x	x	x
Gävleborg	x		x	x	x	x	x
Västernorrland	x		x	x	x		x
Jämtland	x		x	x	x		x
Västerbotten	x		x	x	x		x
Norrbotten	x		x	x	x		

[1] Särskild ersättning utgår även för personer med biståndsbeslut om särskilt boende.
[2] Gäller endast läkemedelsersättning
[3] Patienter boende i förutbestämda geografiska områden genererar ett extra påslag på kapitationsersättningen

Källa: Konkurrensverket

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

Towards P4P

"Rewarding achievement of targeted performance measures"

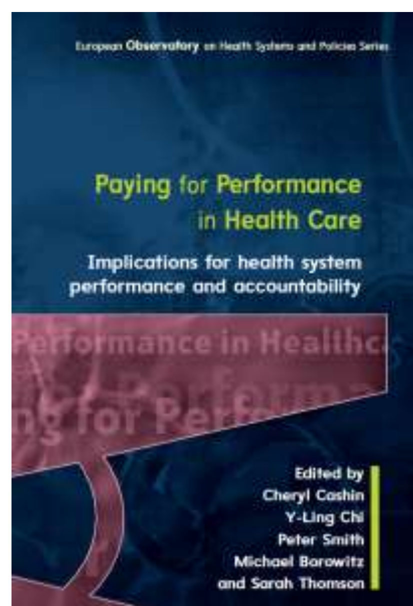


Table 1.2 P4P definitions

Organization	*P4P definition*
AHRQ	Paying more for good performance on ***quality metrics*** (*Source*: AHRQ, undated).
CMS	The use of payment methods and other incentives to encourage ***quality improvement*** and patient focused high value care (*Source*: Centers for Medicare and Medicaid Services, 2006).
RAND	The general strategy of promoting ***quality improvement*** 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 ***performance of the health system*** through incentive-based payments (*Source*: World Bank, 2008).
USAID	P4P introduces incentives (generally financial) to reward attainment of ***positive health results*** (*Source*: Eichler & De, 2008).
Center for Global Development	Transfer of money or material goods conditional on taking a ***measurable action or achieving a pre-determined performance target*** (*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		X
New Zealand	X	X				
Portugal	X	X	X	X		
Spain	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 tarkoituksen 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-KAISA TYNKKYNEN

Markkinat ovat yhä useammin julkisen palveluvastuun politiikan esityslistalla. Palveluja ostetaan, ulkoistetaan, yksityistetään ja kilpailutetaan – tai ainakin julkista palvelutuotantoa verrataan yksityiseen palvelutuotantoon. Tämän myötä myös julkisen palvelun käsite saa uusia merkityssisältöjä. Yksityiset toimijat hoitavat yhä enemmän julkisen ... den sääntelyä yksi... merkittävän julkis... tehtäviä.

Muuttuvan yksi...

markkinat olisivat. Mielikuvissa voi muodostua jopa klassisen vapaan markkinoiden ideaalin mukainen ostaja-kuluttajan ja tuottaja-myyjän välinen win-win-suhde, kunhan vain haitallinen sääntely poistetaan. Toisen ääripään mielikuvassa hyvä, kansalaisille vastuullinen ja tasa-arvoa suojeleva julkinen toiminta korvautuu palve-...

	Tuotannon ohjauksen ulottuvuus		
Palvelujen jakautumisen ulottuvuus	**Rahoittajan suuri vaikutus**	**Käyttäjän suuri vaikutus**	**Tuottajan suuri vaikutus**
Kollektiivinen vastuu	Ohjatut markkinat	Käyttäjälähtöiset markkinat	Lehmänkauppamarkkinat
Yksilöiden vastuu	Etuuksia supistavat markkinat	Kahden kerroksen markkinat	Yksityissektorilähtöiset markkinat

LÄHDE: YHTEISKUNTAPOLITIIKKA 78 (2013):6

Melting public–private boundaries in European health systems

”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!

LIINA-KAISA.TYNKKYNEN@STAFF.UTA.FI