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European hospital reforms in times of crisis: Aligning cost containment needs with plans for structural redesign?

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ABSTRACT

Hospitals have become a focal point for health care reform strategies in many European countries during the current financial crisis. It has been called for both, short-term reforms to reduce costs and long-term changes to improve the performance in the long run. On the basis of a literature and document analysis this study analyses how EU member states align short-term and long-term pressures for hospital reforms in times of the financial crisis and assesses the EU's influence on the national reform agenda. The results reveal that there has been an emphasis on cost containment measures rather than embarking on structural redesign of the hospital sector and its position within the broader health care system. The EU influences hospital reform efforts through its enhanced economic framework governance which determines key aspects of the financial context for hospitals in some countries. In addition, the EU health policy agenda which increasingly addresses health system questions stimulates the process of structural hospital reforms by knowledge generation, policy advice and financial incentives. We conclude that successful reforms in such a period would arguably need to address both the organisational and financing sides to hospital care. Moreover, critical to structural reform is a widely held acknowledgement of shortfalls in the current system and belief that new models of hospital care can deliver solutions to overcome these deficits. Advancing the structural redesign of the hospital sector while pressured to contain cost in the short-term is not an easy task and only slowly emerging in Europe.

1. Introduction

The current financial and sovereign debt crisis has accelerated questions of efficiency and sustainability in the healthcare sector at large. A decline in tax revenues and the volume of social security contributions against the background of pre-existing cost drivers of increasing demand for health services due to ageing societies, higher patient expectations and costly medical innovations presents a challenge to the maintenance of the current scope of service provision in many EU member states. It has therefore given new impetus to reform efforts for cost savings and efficiency gains in the hospital sector [1]. Early analyses of the impact of the crisis on health systems anticipated the use of short-term measures to control costs and the need to

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improve efficiency in the long run [2,3]. Both contributions have suggested specific reforms for the hospital sector, such as reduction of overcapacities, change of payment systems, or better co-ordination of care.

Although reforms are not limited to the hospital sector, there is a need to take a closer look at hospitals for several reasons. First, they are prone to (short-term) cost control measures because of the considerable share (20–50%) of the overall health budget they consume [4] and, second, the assumed potential for reducing inefficiencies due to variances in cost and outcomes [5,6].[1] Third, because hospitals are still the central nod in the provision of care, any reform of specialised or pathway type of care arrangements will involve hospitals. Moreover, the move from hospital-centred systems to integrated care systems will require a different type of hospitals to serve the needs of European populations. In that regard, to plan the right long-term policy decisions is of equal importance. Short-term reforms are not sufficient to address underlying cost drivers, more profound reforms are needed to secure sustainability [2,3]. Secondly, strategic decisions (e.g. capital spending) will impact on the way hospital *and* non-hospital care is delivered for the decades ahead, for example, patients are increasingly treated within pathway care models that transcend different in- and outpatient arrangements [7].

Two kinds of reforms are discerned in the analysis. Following up on Schneider [2], short-term reforms are aiming at reducing health expenditure while leaving the structures – the logics of organisation and regulation – of providing, financing and paying services – in the health systems unchanged. Examples include, delaying investments, reducing administrative costs and lowering the remuneration for providers and producers [2]. In contrast, we regard long-term reforms as those reforms aiming at increased performance of health systems in the long run by altering the structures, relationships and institutions within existing systems. Structural reforms involve for example the move to deinstitutionalised care provision or new models of provider payment to contain the rise of expected health costs, to adapt services to changing needs and expectations and to secure a sustainable base for financing care in the future. As stated above, both, short-term and long-term reforms are important, even more so, as the current financial crisis exacerbates the problem of immediate budget constraints and questions the sustainability of health care system on the background of increasing future needs in the long run.

The aim of the study is to analyse how EU member states align short-term and long-term pressures for hospital reforms in times of the financial crisis and to chart the ways the EU is influencing the context of these national reforms. With the help of a literature and documentary analysis this paper first assesses what kind of hospitals reform strategies have been embarked on in EU member states during the current crisis. Second, we describe current EU policies linked to the current hospital reform agenda and assess the potential influence of this process.

2. Methods

Our findings are based on a growing stock of published reports, scientific articles and policy documents that chart the implications of the financial crisis on health systems or on constituents thereof. Literature has been searched by screening the databases of Medline & WebofKnowledge, the volumes 2009 to mid-2013 of leading health policy journals and hand-searching the websites of institutions dealing with hospitals or the health effects of the crisis in Europe. Comparative works covering the entire EU as well as single country analyses written in English have been considered. The retrieved sources have been analysed for the data on hospital reforms using the framework applied in two linked WHO European Observatory studies on policy responses to the financial crisis for the entire health systems [10,11].

This framework charts the policy responses according to (1) the decision on the level of expenditure, (2) the policy domains to implement the envisaged changes and (3) their effect on health system goals. First, general decisions are taken to alter or preserve the level of public expenditure for health within the overall governmental budget when tax revenues decline in times of crisis. Governments are faced with the question whether or not to cut resources for the health sector (vis-a-vis other public domains) and if so, in which domains of the health sector (primary, secondary care, prevention, long-term care, etc.). Second, the policy tools to implement the envisaged general expenditure changes are subdivided according to financing and contributions, volume and quality of care and cost of care. Third, the effect of reforms can be analysed in relation to the fulfilment of health system goals. According to the WHO European Observatory framework these goals include health status, financial protection, efficiency, equity, quality, responsiveness, transparency and accountability. The described framework supports the description of health system responses according to the outlined three facets, however, does not imply a linear sequencing of actions [10].

Because we focus explicitly on hospital care services in EU member states we provide an overview of changes to expenditure levels, then we screen the reform efforts to establish how they are directly and/or indirectly affecting the operations of hospital services and discern them according to the WHO European Observatory framework [10] by:

- *Financing and reimbursement*: hospital budgets, user charges and provider payment.
- *Volume and quality of hospital services*: scope of the basic benefit package, waiting time.
- *Operational costs*: prices of medical goods, health professionals, capital investments, re-organisation of the hospital system.

[1] Some variance is accounted by factors outside the health care sectors (e.g. socio-economic situation of a country, lifestyle of population) and may reflect as well certain choices (inputs into the health care system). A considerable part of variance can be linked to variation in medical practice (even within countries).