

Norway - Brief on Decentralized Hospital Governance

Acknowledgments and disclaimer

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1 Introduction

The Norwegian government has begun a review of its current model of decentralized hospital governance. At present, the hospital sector is mostly public, where groups of public hospitals are organised as separate legal entities with separate boards. These groups of hospitals are termed local health enterprises, and are owned by four regional health enterprises. Regional health enterprises take decisions based upon rules set by law (e.g. that give legal rights to patients), as well as conditions for grants and specific meetings related to their role as the owner of local public hospitals (much as the owners of private companies use the annual general meeting to influence the running of those companies). The regional health enterprises are appointed by the Ministry of Health. They may choose to organise several general meetings with the local health enterprises each year.

In the present Norwegian debate, some argue that the existing system establishes an appropriate division of labour between democratically elected bodies and professional managers directly influenced by close-to-customers stakeholders. Conversely, others argue that the existing model lets non-elected CEOs make decisions that should be taken by elected politicians and that the Minister for Health should have more direct decision-making responsibility; in addition, they argue that there are too many decision levels.

The Norwegian government has appointed a commission to assess the existing model of hospital decentralization and governance in the public sector. The commission is tasked with assessing experiences from other countries in the above areas and to explore possible alternative models. Its mandate specifies that the state shall continue to own and have the responsibility over the hospital sector.

The commission is asked to consider three distinct alternatives to the current model:

- abolish the regional health enterprises and let the Ministry of Health instead directly own and govern the local health enterprises.
- abolish the regional health enterprises and let a specific newly established directorate for hospitals govern the local enterprises (in Norway there are a number of directorates that are responsible for the running of various tasks under different ministries; they are not independent -the Parliament will consider the respective Minister as responsible- but they will function more autonomously than ministries).
- Merge the regional health enterprises into one National Health Enterprise that functions differently from directorates.

In this context Norway wants to learn more about how other countries organise the macro level of the hospital sector and the division or sharing of responsibilities.

In response to Norway's request for support, the European Observatory on Health Systems and Policies has undertaken this rapid review of experiences in a selection of European countries.

2 Conceptual approach and dimensions assessed

2.1 Conceptual approach

In 2011, the European Observatory published the study [Governing public hospitals. Reform strategies and the movement towards institutional autonomy](#). This study analyzed hospital governance models in the public sector of a number of European health systems, and, drawing on that evidence, developed a conceptual model to examine key hospital governance characteristics and mechanisms.

The concept of governance puts the emphasis on qualitatively new dimensions of policy-making that attempt to connect regulation (“institutional governance”) and management (“operational governance”). “Hospital governance” conceptually encompasses three increasingly blurred levels of hospital-related decision-making, in the context of each health system:

- a) “Macro” level: government decisions that determine the basic structure, organization and finance of the entire health system, and of the hospital sector within it. The decision to maintain publicly operated, tax-funded hospitals, for example, is just such a “macro governance” decision. The macro level of hospital governance is the part of traditional national, regional or sub-regional policy-making that establishes the structural, organizational and operational architecture of the hospital sector.
- b) “Meso” level: Decision-making at the institutional level of the hospital. It is at this meso level of organizational policy where decisions that the hospital is allowed to make (e.g. that are not restricted by macro-level regulatory constraints) are taken. This includes, for example decisions on the service mix.
- c) “Micro” level: The day-to-day operational management of staff and services inside the units of the hospital as an organization and with the specific scope of maximizing outputs. This level of “governance” includes what is traditionally known as “hospital management” and incorporates such subsets as personnel management, clinical quality assurance, clinic-level financial management, patient services and hotel services (cleaning services, catering, etc.).

The main "entry point" for this policy review is the macro-level, mostly government-based, aspect of governance.

This review explores the macro-level structures and processes that govern the hospital sector at the sub-regional, regional and national level in nine selected European countries (Denmark, England, Finland, France, Italy, Netherlands, Scotland, Spain, Sweden). It describes and assesses institutional and accountability arrangements, as well as processes for financing capital investment.

2.2 Dimensions to be assessed

Institutional arrangements:

- Ownership and legal form of hospitals (private or public, organized as trusts, for-profit or not-for-profit, etc.)
- Strategic planning of hospital infrastructure and capital investment at the national, regional or sub-regional level;
- Division of tasks between different types of hospitals;

Accountability arrangements:

- Degree of decentralization of hospital governance (hospital governance layers between the Ministry of Health and the hospitals proper; political representation versus administrative responsibility)
- Extent to which geographically defined responsibilities for specialized health care at the regional level exist.

- Supervisory board (role, size, composition in terms of stakeholders, appointments, citizen and patient involvement and participation);
- Reporting obligations (completeness, transparency and timing).

Financial arrangements for capital investment:

- Capital investment in buildings, medical equipment and ICT systems (sources, constraints, conditions);
- Adjusting capital and operational expenses (additional sources, loans);
- Ability to retain surpluses and incur debt.

This policy review examines macro-level structures in the context of evolving forms of decentralization.

3 Sources of information

This review draws on previous Observatory studies on hospital ownership, governance and capital investment, its HiT series of detailed assessments of health systems and policies in the countries of the WHO European region, and a review of published and grey literature.

4 Selection of countries

Experiences in the following countries have been explored:

- Denmark
- England
- Finland
- France
- Italy
- Netherlands
- Scotland
- Spain
- Sweden

The list includes those tax-funded countries in Europe that are closest to Norway in critical elements of health system structure and function (although significant differences exist and will be recognized in the study). Furthermore, France and Italy have been included, as they have regional-level governance structures for the hospital sector. The experience of Netherlands is relevant, as it has gone further than most in devolving hospital governance and responsibility for capital investment.

5 Country examples

5.1 Denmark

Institutional Arrangements

In Denmark, as of 2007, hospitals are owned and operated by five regional governments. These regional governments are elected; however, they cannot levy taxes and all regional funding is allocated from the national government.

Most secondary and tertiary care takes place in general hospitals owned and operated by the regions. Doctors and other health professionals are employed at hospitals on a salaried basis. Hospitals have both inpatient and outpatient clinics, as well as 24-hour emergency wards. Outpatient clinics are often used for pre- or post-hospitalization diagnosis and treatments (Oleyaz et al, 2012).

The 2007 hospital restructuring also involved creation of acute hospitals with a 24-hour acute service by a range of specialists. The idea was to weight quality higher than geographical closeness to the

nearest hospital (Christensen, 2012). A subsequent reform gave a portion of hospital budgets to municipal governments, who now pay hospitals for certain services to municipal inhabitants. The incentive is for municipalities to provide a higher standard of nursing home or home care to chronically ill or elderly inhabitants, enabling the municipality to keep a portion of these funds for itself rather than paying hospitals for unnecessary emergency and inpatient services. Concurrent reforms included economic incentives to increase hospital production as measured by DRGs; quality programmes to secure high quality and patient safety; and electronic patient records and increased use of IT systems (Christensen, 2012).

The municipal level was consolidated in the 2007 reform from 273 into 98 municipalities. The municipalities are responsible for environment and technology, schools, social services, prevention and health promotion, as well as certain health care services. The regions and the municipalities have separate responsibilities and, in comparison with the state, the regions do not have any governing or regulatory role with regard to the municipalities (Olejaz et al, 2012).

Since the 1990s, a number of private for-profit hospitals have been established. According to the Association of Private Hospitals and Clinics, private hospitals experienced a rise in demand in 2005-2009. In 2010, private hospitals had a capacity of approximately 500 beds, corresponding to 2.5% of all hospital beds (Association of Private Hospitals and Clinics, 2010). Measured in production value, private hospitals constituted 2.2% of total hospital activity in 2010, compared with 1.1% in 2006. In the same period, the number of private hospitals and clinics rose from 175 to 249, a 42% increase (National Board of Health, 2011c). While some political actors believe the existence of private hospitals threatens the equity principles of the Danish health system, others contend that these hospitals offer a necessary increase to the public system and provide an innovative element (Andreasen et al., 2009). Some academics have argued that the use of private hospitals was necessary as a means to fulfil a waiting time guarantee of offering treatment within 1-2 months of referral (Christensen, 2012).

Accountability arrangements

The role of the state is mainly to regulate and contain expenditure and to provide some general guidelines for the health sector. There is no national health plan for the development of the health sector. In terms of organization, the five regions are responsible for providing hospital, somatic and psychiatric care, and for financing private practitioners (such as GPs, practising specialists, dentists, physiotherapists and chiropractors) for their public sector work (Olejaz et al, 2012).

Transparency of the health system has increasingly been a political priority during recent decades. Initiatives for improving this transparency have included quality indicators on clinical performance of individual hospital departments, which are gradually becoming available on the Internet. Information for the public on actual waiting times for admission to public hospitals has also been provided on the Internet in order to facilitate the use of the right to free choice by patients (Olejaz et al, 2012).

A number of quality standards for accreditation pertain to physical structure. Health care facilities are supervised and increasingly governed by the Danish Health Authority (*Sundhedsstyrelsen*). This body is part of the Ministry of Health and its Director General is appointed by the Minister of Health.

Most public hospitals are general hospitals with different specialization levels. There is no official classification of hospitals according to the level of specialization, technological equipment or performance. There are very few hospitals treating only one medical specialty. Contracting is used to a limited extent by the regions. Contracts are entered into either with public hospitals, in the region or in another region, or with private hospitals. There are usually contracts for a number of specific interventions, such as elective surgery. Since Denmark is a small country with good transportation links, the location of very specialized services in just a few hospitals does not present a major problem.

The quality of secondary and tertiary care is monitored in the Danish Healthcare Quality Programme, where accreditation of Danish hospitals is under way. The Danish Institute for Quality and Accreditation in Healthcare (IKAS) was created in 2005 to develop, plan and run the Danish

Healthcare Quality Programme. It was established as an independent institution headed by a board of directors, from the Ministry of Health, the Danish Health Authority and the regions as representatives of the hospital owners.

Furthermore, a national effort to modernize the hospital sector is being carried out. This includes capital investments as well as centralized national specialty planning.

Capital Investment

The regions in Denmark are making substantial investments in hospitals, building new or renovating and expanding existing institutions. This process is being triggered by the local government reform, the planning of specialization (with fewer, larger and more specialized hospitals) and the planning of emergency functions (Henriksen, 2014).

The overall financing for the regions is established in annual negotiations with the government. In the agreement for 2008, the government and the regions agreed that there is a need for structural changes in hospitals and consequent investment in buildings, new technology and equipment. The total investment of DKK 40 billion is being financed by a state grant (DKK 25 billion), the regions' ordinary budgets (DKK 10 billion) and loans (DKK 5 billion). The conditions laid down by the state are the following:

- the budget for each project is fixed,
- the regions are not allowed to loan to finance cost-effective investments, environmental and energy-saving investments and
- the state requires yearly productivity gains (Welfare-Tech Business Innovation).

The central government has appointed an expert panel to assess regional projects in relation to a set of principles regarding structure, efficiency and quality. After recommendation of the panel, the government decides on which projects to finance. In January 2009, the government gave a preliminary commitment to 11 projects for a total amount of DKK 25 billion (including all types of financing outlined above). In the further process the regions were required to submit detailed project descriptions to get a final commitment. A similar process applied for the remaining DKK 15 billion that was implemented a year later, in 2010.

The first 11 projects vary in both scale (two of the projects are new university hospitals in Aarhus and Odense with budgets of more than DKK 6 billion), clinical areas (somatic/psychiatric) and character (building new hospitals on greenfield sites or renovating and expanding existing hospital facilities). Common to the five regions is that they are all busy planning future hospitals.

The overall hospital reform has thus been facilitated by large-scale capital investment, 62.5% of which was funded by central government. This capital investment was used alongside an expanded role for the Danish Health and Medicines Authority (now the Danish Health Authority, *Sundhedsstyrelsen*) to determine whether the nominated specialized hospital services ought to occur at one or a small number of hospitals for the whole country or at one or a small number of hospitals in each of the five regions. By prescribing which services could be delivered where, the central government's decisions had flow-on implications for the health and capital planning of individual regions. Regions' capital plans were submitted to the central government, along with bids for investment to modernize services that often included closing or scaling down smaller hospitals. Currently, capital investments are being rolled out as part of a decade-long investment programme that is anticipated to amount to the equivalent of an additional 2.5% of health spending per year (OECD, 2013).

The restructuring of specialist hospital care is being led by both quality and efficiency concerns. Many of the small hospitals that have been closed down had up to 100 beds at most, well below thresholds regarded internationally as desirable to deliver safe and appropriate services (OECD, 2013).

The goals for the year 2020 include 16 new hospitals which are hoped to be the backbone of patient-centred health care. The focus will be on increased specialization and centralization, combined with a stronger pre-hospital effort and stronger local health services. The goals are:

- Increase of outpatient treatment by 50%
- Reduction in the number of hospital beds by 20%
- Reduction in the average length of stay in acute hospitals by approximately 3 days
- A coordinated boost of patient treatment and technology in the health sector
- New patterns and possibilities for cooperation and task-sharing
- Large-scale adoption of new technologies
- Within the buildings: improved logistics and tracking systems
- Outside the buildings: increased use of telemedicine, personal devices, home monitoring etc.

By 2020 more than one third of Denmark's hospital capacity is anticipated to consist of newly built hospitals. The bulk of hospital construction expenditure is planned to be utilized in 2015-2020 (Healthcare Denmark 2015).

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Welfare-Tech Business Innovation

<http://en.welfaretech.dk/business-opportunities/new-hospital-structure-%E2%80%93-investments-in-new-hospitals/>

5.2 England

Institutional arrangements

The National Health Service (NHS) in England, established in 1948, is the country's publicly funded health system. It is mainly funded through taxation and, for those who are "ordinarily resident",

mostly free at the point of use. The Department of Health is the main government body responsible for controlling the NHS. It is setting policy and preparing legislation and regulation. The department has three core roles: (i) it is a department of state, run by the Secretary of State for Health (an elected member of parliament) and a civil servant, the Permanent Secretary; (ii) the national headquarters of the NHS, run by the NHS Chief Executive; and (iii) the agency responsible for setting health policy, run by the Chief Medical Officer (Boyle 2011).

Until 2013, Primary Care Trusts were responsible for commissioning primary, community and secondary health services. Starting in April 2013, Primary Care Trusts were replaced with GP-led NHS organizations called Clinical Commissioning Groups. Most of the NHS commissioning budget is now managed by 211 Clinical Commissioning Groups. They are overseen by NHS England (formed in 2013), an executive body of the Department of Health that oversees the commissioning side of the NHS.

National estimates suggest a proportion of private beds of 6.5% in 2007 in the whole of the United Kingdom (Boyle 2011). In 2013 there were 465 private acute hospitals in the United Kingdom. However, only 201 of them had overnight beds enabling them to offer surgery requiring inpatient stays. Their size tended to be small when compared to NHS hospitals. While in central London there were eight private hospitals with an average of 137 beds, private hospitals in other parts of the United Kingdom only had 30-50 beds. Private hospitals focus on elective treatments and do not provide accident and emergency services, intensive care or high dependency units (CHPI 2014, CMA 2014).

In addition, private services are being offered by public hospitals, either in dedicated private patient units (PPUs) or in private beds in NHS hospitals. In the financial year 2012/13, NHS England generated approximately £500 million in revenue from the provision of privately-funded health services (CMA 2014). The NHS, in turn, also purchases services from private hospitals, contributing 27.5% of funding of private acute hospitals in 2012, a more than four-fold increase in real terms since 2004 (CMA 2014).

Most hospital care in England is provided by publicly owned hospitals known as “trusts”. There are NHS trusts and NHS foundation trusts. NHS foundation trusts were introduced in 1997 and a process of transforming trusts into foundation trusts was set in motion. Foundation trusts are not-for-profit public benefit corporations. They have greater autonomy from the Department of Health than NHS trusts. Foundation trusts are publicly owned semi-autonomous organizational units within the English NHS that provide over half of all NHS hospital, mental health and ambulance services (UK Government 2016). They remain subject to a system of external audit and inspection that has been developed and extended since 1999 and are overseen by Monitor against their licence conditions (Boyle 2011). Furthermore, foundation trusts are accountable to their members through the Council of Governors and to commissioners (such as the Clinical Commissioning Groups) for the delivery of NHS services through legally binding contracts. Specialized services (such as blood and marrow transplantation or rare cancers) are provided in a few specialist centres that are commissioned by 10 Specialised Commissioning Groups, coordinated by the National Specialised Commissioning Group.

Although there is no centralized planning process for capital investment or the distribution of hospital facilities in the NHS, by setting budgets, priorities and targets for investment, the central government determines to a large extent the overall levels and pattern of investment (Boyle 2011). When still in existence, strategic health authorities (abolished in March 2013) had the responsibility to consider any significant changes to the distribution of hospital services in the region for which they were responsible. This function has now been assumed by NHS England which, as mentioned above, is overseeing the commissioning side of the NHS. However, there is no longer a formal prioritization process for large capital schemes (Cylus et al. 2015).

In 2000, the NHS Plan promised to replace or update 100 hospitals by 2010, a goal that was achieved in October 2008 (Boyle 2011). The promise of “100 new hospitals” was largely a political one by the then Labour government, and, while much of the hospital infrastructure of the country was outdated, it was difficult to ascertain exactly how many new hospitals would be needed.

Local providers are now responsible for initiating local investments, with their decisions subject to a regulatory framework specified by the Treasury and developed further by the English Department of Health. This indicates when NHS bodies may initiate capital investment without reference to higher authorities, and provides rules for ensuring good business practice. There are different rules for foundation trusts, which are not subject to delegated limits and can invest within their prudential borrowing limits. NHS trusts, when initiating capital investments, are expected to produce a strategic outline case, an outline business case and a full business case for large schemes that are referred to the Department of Health (Boyle 2011).

Accountability arrangements

Until the early 1990s, NHS hospitals and other providers were managed by health authorities, which were under the direct supervision of the central government (Edwards 2011). The NHS in England was based on an integrated model, with no separation between the purchasing role and the provision of hospital services (Boyle 2011). In the 1990s internal market and competition were introduced, based on a split between purchasers and providers. District health authorities in England (and Wales) became purchasers that contracted with NHS providers. Their role in governing providers was replaced with contractual arrangements, and providers became more autonomous NHS trusts (Bevan et al. 2014).

Following the election of the Labour government in 1997, the model of governance changed once more. In England, the separation of purchasers and providers was retained, but the rhetoric of competition abandoned. Purchasers became commissioners and the aim were collaborative arrangements with providers. This changed again in the years in 2000-2005, when a performance management system of targets and ratings was introduced. Between 2005-2006 and 2008-2009, the regime of star ratings was replaced with an annual Health Check and the reintroduction of a revised internal market. Following the election of the Coalition government of Conservatives and Liberals in 2010, publication of annual Health Checks was discontinued and the model of governance returned to one of choice and competition. In contrast to Scotland, Wales and Northern Ireland, in England there is now again a competition between public and private providers (Bevan et al. 2014).

As mentioned above, hospital-based care in England is now mainly provided through NHS trusts and NHS foundation trusts. NHS trusts are publicly owned and directly accountable to the Secretary of State for Health. Foundation trusts are no longer subject to financial and management control from the Department of Health, and thus represent an explicit devolution of responsibility for hospital management and governance from the centre (Boyle 2011). The 2011 Health and Social Care Bill proposed that all NHS Trusts become NHS Foundation Trusts or part of an existing NHS Foundation Trust by April 2014. However, at the time of writing (January 2016), there were still NHS trusts that had not been transformed. The remaining NHS trusts are now managed by the NHS Trust Development Authority, a body of the Department of Health that was established in 2012 to manage the transition of NHS trusts into foundation trusts and to manage the performance of those that remain directly accountable to the NHS, of which there were 99 in April 2013.

NHS trusts have a board consisting of a non-executive chairman and at least five non-executive members, all appointed by the Appointments Commission, and up to five executive members, including the chief executive, the finance director and the medical director (Boyle 2011). Foundation trusts are also managed by a board of directors. However, they have a board of governors, the majority of whom are elected by members – a member can be anyone who lives in the local area, works for the foundation trust or has been a patient or service user. External control is exercised by Monitor, purchasers, local government and a number of external regulators, such as the Care Quality Commission (Edwards 2011).

Foundation trusts are regulated by the Independent Regulator of NHS Foundation Trusts, commonly known as Monitor (Boyle 2011). Monitor, was set up in 2004 to authorize and regulate foundation trusts with the aim of ensuring that they are financially strong and well-managed. It is an executive, non-departmental public body appointed to oversee foundation trusts and consists of up to five members appointed by the Secretary of State for Health (Boyle 2011). Monitor is responsible for

authorizing the creation of foundation trusts. This is a form of licence, setting out the conditions under which the foundation trust will operate which include governance arrangements for the trust, such as the constitution of membership, the board of governors and the board of directors (Boyle 2011).

Arrangements for capital investment

The Public Finance Initiative (PFI) has played a major role in financing capital investment in England in the 2000s. It is a public-private partnership model that started under a Conservative government, but was considerably extended under the Labour administration that came into power in 1997 (Dewulf et al. 2009), soon to become “the only game in town” (Blanken et al. 2009) for large-scale hospital rebuilding and replacement, despite a formal process of ascertaining “value for money”. The initiative helped to finance the largest hospital building programme in the history of the English NHS. Between 2000 and June 2009, 104 hospitals were replaced or updated, with PFI accounting for 77 of these projects (Boyle 2011). By December 2012, 120 PFI hospital projects had been implemented, with a combined capital value of approximately £15 billion, making it the largest hospital building programme worldwide (Hellowell 2013). By 2008–2009 PFI was the source of over 25% of capital investment in the English NHS (Boyle 2011).

In the PFI model, the private sector agrees to finance, design, build and maintain a hospital for an NHS trust, in return for a periodic fee paid by a public authority. Providers formed for this purpose legal entities known as Special Purpose Vehicles. The private partner finances the project and is responsible for operation and maintenance, while the English National Health Service (NHS) is responsible for the provision of clinical services. Usually, PFI projects involved 10% equity and 90% of debt. However, crucially, the debt did not appear on public balance sheets and did not affect government borrowing requirements. Contracts were typically over 30-40 years.

The PFI scheme has given rise to substantial controversy. While some argue that the major capital investment programme in England in the 2000s would not have taken place without it, others contend that costs were not lower than when financed through public sources and that the long duration of contracts results in lacking flexibility, in terms of the design of hospitals, the services provided from them and their financing (Blanken et al. 2009). Substantial costs seem to be transferred to future generations, with considerable uncertainty over which services and volumes will be needed in 30-40 years. Partly due to payments for costly and inflexible PFI deals, hospital trusts in England have come under major financial pressure (Limb 2013, Torjesen 2012). The proportion of NHS and foundation trusts in deficit rose from 10% in 2012-13 to 26% in 2013-14 (Hellowell 2013). In 2012, the UK government itself admitted that the PFI scheme had “become tarnished by its waste, inflexibility and lack of transparency” (HM Treasury 2012).

The consequences of the economic crisis included an increase in the cost of PFI capital and an increasing scarcity of funds, leading to the “death of PFI” (Hellowell 2013). In December 2012, the UK government introduced ‘Private Finance 2’ (PF2) (HM Treasury 2012). In this new approach, the capital structure includes a higher share of equity (25% instead of the previous 10%) and a lower share of debt; the public sector contributes part (25-49%) of the equity; the public sector assumes risks associated with utility costs, insurance, construction sites and changes to employment law; and a control is introduced for all commitments arising from off-balance sheet PF2 contracts (HM Treasury 2013). These changes are likely to increase the cost of capital, while transferring fewer risks to the private sector, raising questions about the value for money the new approach to PFI brings (Hellowell 2013). The UK Department of Health aimed in 2013 to pilot PF2 on a £370 million project for the Sandwell and West Birmingham Hospitals NHS Trust (Hellowell 2013).

The role of NHS trusts in capital investment also changed tremendously in recent years with the introduction of foundation trusts. When NHS trusts were established during the 1990s, they were given responsibility for the capital assets that were required for their long-term operation. Since 1999–2000, all NHS trusts have had a statutory duty to report on the condition of the estate and facilities for which they are responsible. They were also required to make a capital-related payment (capital charges) each year to the Treasury based on the value of their existing capital assets, known

as public dividend capital (Boyle 2011). NHS trusts can apply for capital loans from the Department of Health, but those loans must be affordable over an agreed time period with principal repayments made from operating surpluses and improvements in working capital (Boyle 2011).

Foundation trusts have the freedom to invest and disinvest and are, therefore, separate from the capital regime of the NHS. They can also sell assets, within the overall regulatory framework, and retain surpluses with the aim to improve services instead of these going back to central government (Boyle 2011; UK Government 2016). Capital investment by foundation trusts is financed locally, either through the reinvestment of cash generated (the primary source of capital funding) or through interest-bearing loans. These loans may come from the private sector (commercial banks) or from the government through the Foundation Trust Financing Facility. Monitor, the independent regulator, allocates a “prudential borrowing limit” to each foundation trust based on the trust’s ability to pay back the money it borrows. Loans drawn from the Foundation Trust Financing Facility are on commercial terms (Cylus et al. 2015). A similar system of so-called prudential-based capital allocations has operated for all NHS trusts since 2007–2008 (Boyle 2011). Foundation trusts pay for their use of capital through interest on any loans which they take out or through PFI payments. In addition, they pay interest on their public dividend capital in the same way as other NHS trusts (Boyle 2011).

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5.3 Finland

Institutional arrangements

Specialized care funded by municipalities is provided mostly by public hospitals operated by public hospital districts and regulated by the Act on Specialized Medical Care. Currently, the Act divides the country into 20 hospital districts (excluding Åland Islands). Each municipality must be a member of one hospital district (the number of member municipalities varies from 6 to 58). The hospital districts organize and provide specialist medical services for the population of their member municipalities.

The hospital districts are federations of municipalities. These federations are separate from federations maintaining health centres. However, recently there have been local reforms to integrate these two organizations. Each hospital district has a central hospital, five of which are university-level teaching hospitals. Hospital districts are managed and funded by the member municipalities. The catchment population of hospital districts varies from 65 000 to 1.4 million inhabitants (Vuorenkoski, 2008). Hospital districts are governed by a hospital district council. Each municipality has one to six seats in the council depending on the size of their population. Each municipality's share of votes is the same as its share of total population within the district (but it cannot be more than one fifth of all votes).

Practical administration is directed by the executive board elected by the council. Usually members of both the council and the executive board are local politicians and the composition of representatives of political parties reflects the support received by the political parties in municipal elections. The council adopts the annual budget, approves financial statements and makes decisions on major investments.

There are a small but growing number of private hospitals. Mehelainen in Helsinki performs over 5000 surgical operations per year (Merivaara, 2015).

The highly specialized hospital, Coxa, was founded in Tampere in 2002 to carry out endoprosthetic operations. Coxa works as a limited company, and it was founded by Pirkanmaa hospital district (and three other hospital districts), four cities, one Finnish foundation (Invalidisäätiö) and a German private hospital company, Wittgensteiner Kliniken AG, which originally had 20% ownership. All elective endoprosthetic operations of Pirkanmaa hospital district are carried out in Coxa hospital. (Vuorinkoski, 2008). In addition, it provides these services for patients from other hospital districts as well as private patients.

Recently a large Finnish banking and insurance company, OP-Pohjola, opened a new private hospital in Helsinki and has announced plans to open several private hospitals elsewhere in the country (Saltman and Teperi, 2016).

In 2013, reform proposals in a government draft bill focused on establishing larger public provider districts called SOTE (social services and health) which would combine municipal level social and primary care services into an unspecified number of public regions. Subsequently, in March 2014, Finland's parliamentary parties agreed a compromise structural reform that would organize health and social care into 5 regions, which – much like both the Norwegian and Danish reforms - would be built around existing university hospital catchment areas. Moreover, these regions would have administrative responsibility for primary and social care as well as hospital services, combining all three levels of care within the same administrative unit. These 5 SOTE regions, serving as

administrative bodies, were meant to then contract for actual services from a maximum of 19 service production units, which would have consisted of existing public hospital, primary care, and social care facilities organized into one authority within a discrete geographical area. These 19 proposed service production units would probably have followed closely the lines of Finland's current 20 hospital federations, and would likely have had the ability to contract out some services to private providers. In theory, each of the 5 SOTE could then decide which of the 19 care production units to contract with for specific services, creating the possibility of contestability between these provider organizations (Saltman and Teperi, 2016).

In March 2015, the soon-to-leave government abandoned its proposal based on five SOTE regions, officially due to constitutional problems. However, the new coalition government, formed in May 2015, continues to express strong interest in provider-side reform. According to the most recent reform proposal, 18 SOTE regions will be created which will combine within themselves both administrative and service production responsibilities. These meso-level administrative districts are to have governing bodies directly elected by the area population (previous hospital districts had governing boards made up of representatives chosen by the member municipalities), and will make both strategic policy decisions as well as owning public provider facilities and contracting out for private services as necessary.

In an innovative effort to simultaneously consolidate service areas while still maintaining a traditional distribution of local control, the current proposal calls for only 12 of the 18 SOTE to be full-service 24/7 providers, while 3 of the SOTE will have to rely on the 12 for full services, and the final 3 SOTE will not be allowed to provide services themselves but will be required to do so in cooperation with one or more of the other 15 regions. In the initial phase, at least, the SOTE regions will not levy their own taxes, but rather will get their funding directly from the state. At present there continues to be pressure from one of the governing coalition's members (the Center Party) to allow these new administrative districts to incorporate other regional level functions in addition to health and social care. Another unresolved issue concerns whether patients will be allowed to take public funding with them if they see private providers. Substantial new legislation would be required to implement this ambitious new plan, with these and other specifics about the re-structuring process yet to be finalized (Saltman and Teperi, 2016).

Accountability arrangements

Tax financing for health care comes from two different taxation systems: state taxation and municipal taxation. State level financing of health care is largely in the form of state subsidies. On average, 16% of municipal revenue came from state subsidies which represented on average 24% of municipal budgets for health and social care in 2005. State subsidies to municipal social and health care services are calculated according to factors such as number of inhabitants, age structure, unemployment rate, remoteness and morbidity in the municipality. The amount transferred in the state subsidy is also in part determined by the potential of the municipality to raise tax revenue. (Vuoronkoski, 2008).

Several bodies established at the national level have some direct regulatory functions. The two most important of these in regard to health services in general are the health and social departments in the provincial administration and the NAMLA (National Authority for Medico-legal Affairs). In 2006, national level supervision was reinforced by expanding the functions of the NAMLA from supervising individual professionals to supervision of health care organizations, municipal health centres and hospital districts.

Municipalities have a significant degree of freedom to plan and steer health care services. National legislation provides only a framework for the provision of health services at the municipal level. There are two main acts which set this framework, (the Primary Health Care Act, 1972 and the Act on Specialized Medical Care, 1991). The other main tools for steering municipal health services from the national level are information and local development programmes (Vuorenkoski, 2008).

In the capital, Helsinki, a new hospital district (known as 'HUS') was formed in 2000 by merging two hospital districts in the capital area (Helsinki and Uusimaa) and the Helsinki University Central

Hospital. The new HUS covers a population of 1.4 million which is about 27% of the Finnish population. The member municipalities vary from the capital to the small rural municipalities. The goal was to merge two geographically proximate hospital districts and the Central University Hospital of Helsinki in order to achieve more effective organization and to avoid the duplication of services. However, it has been found that old structures are hard to change rapidly in an organization of this size (Vuorenkoski, 2008).

Capital financing arrangements

From the 1970s until the 1980s there was a special state subsidy system to support capital investments. From 1993 the state almost totally withdrew from funding capital investments. Currently, capital investment in health care is controlled by the providers: municipalities, hospital districts and private providers. The state level administration may only intervene in special situations, for example if an important building is removed from active use due to health and safety reasons. The municipalities and hospital federations are free to invest in technologies. Municipalities and hospital districts normally fund the investments from the annual budget. Usually the hospital and health centre buildings are owned by the municipal service providers. Many of the hospital buildings were built in the 1950s–1960s, and health centre buildings were built about 20 years later. Both hospitals and health centre facilities are increasingly requiring renovations (Vuorenkoski, 2008).

In Helsinki, the Foundation for the New Children's Hospital 2017 is responsible for fundraising and coordinating project finances, planning and construction with a budget of 175 million euros (hospital 170 mill. and parking level 5 mill.) - donations were 35 million euros (FINPRO, 2015).

In the Helsinki region, building work is commencing on a cancer hospital with a cost estimate of about EUR 250 million. Tampere has ongoing hospital projects worth EUR 200 million. Hospital construction projects starting in Northern Ostrobothnia amount to more than EUR 500 million and reach as far as 2030 (Invest in Finland, 2014).

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5.4 France

Institutional arrangements:

For decades health care in France has been mostly funded with public funds (mainly statutory health insurance plus taxes); all the French population is covered by three health insurance funds under the *Caisse Nationale d'Assurance Maladie* (NHIF). In contrast, and at the same time, services are delivered by both public and private providers (primary care by self-employed general practitioners; specialized care in ambulatory and in-patient institutions, including hospitals). Acute hospitals are

either public, not-for-profit or for-profit, and each category is represented by a national federation which actively defends the interests of its members:

- *Public hospitals* are owned by a local or national administration and mandated to provide universal access to all services, with governance linked to rules and its structure defined by law (e.g. director's nominations are ratified by the Ministry of Health or the Prime Minister). This category accounts for 75% of acute medical care capacity, performs 75% of full-time acute episodes, and includes general (CH) as well as teaching hospitals -single or groups-linked to medical schools (CHU). In 2014, 32 university hospital groups held a reputation of excellence and comprised over 200 hospitals, 3,000 hospital departments and about 90,000 beds.
- *Private not-for-profit hospitals* (*Etablissements de santé privés d'intérêt collectif*; ESPIC), owned and run by a private association, religious organisation or foundation. ESPIC share with public hospitals accessibility and continuity of care as core values and have a special role in teaching and research in the field of cancer.
- *For-profit hospitals*, often called "hospital chains", run by private companies with commercial objectives but without teaching or research mission. They focus on certain types of procedures and treatment (e.g. day surgery), account for 10% of beds and provide 15% of episodes of care in France. Currently there are about 50 private groups, which started to develop from the mid-1980s in single regions. There are a small number of physician-owned facilities, but also larger groups that provide services across the country. In 2013 one of these groups accounted for 60% of private hospitals (and 30% of bed capacity) in the private for-profit sector (Nolte et al., 2014).

Being historically a health insurance-based system (with the separation of purchasing and provision functions already embedded), service providers in France always had room for planning and delivering services that the social insurance (Assurance Maladie) would later on pay for. Geographically defined public responsibility for specialized health care at the regional level exists only in an indirect way; service providers act under supervision of the government (first central and now regionalised, as the regions have some responsibility to take care of the population in an area), but never under their direct control. Key decisions regarding hospital investments (or closures) in France are decided by the hospital boards, mostly consisting of what could be described as non-elected experts (bureaucrats or CEOs), but with a substantial amount of influence (in fact, amounting to veto rights) of politicians.

Table 1 Key characteristics of the hospital sector in France in 2011

	Number of hospitals	Total number of hospital beds	Average number of beds per hospital	Average bed occupancy rate	Average length of stay
All hospitals	2,086	221,713 inpatient beds (350 per 100,000 population)	106	74.8%	5.1 days
Public	35%	62%	176	79.2%	
Not-for-profit	29%	19%	26	72.4%	
For-profit	39%	24%	101	63.9%	

Source: (Nolte et al., 2014)

The trend towards hospital consolidation observed in France since the 1990s is said to have typically French features: a series of health reforms each with its 'new' Law and frustrations regarding implementation, yet the 'next' reform often aiming to fulfill some of the objectives of the previous one, although under a different name; the problem analysis is based on microeconomic analyses and there is a clear analysis of weaknesses, but little or no evaluation (Rochaix and Xerry, 2009).

The planning of beds and expensive equipment in France has since 1975 been linked to the *Carte Sanitaire* (Laroque, 1983). In 1982 concern over very high figures of hospital utilization (constituting 54.7% of health care utilization) led to a change in the traditional French concentration of governance at the national level, which was replaced by a gradual de-centralization of functions to regional agencies. Regional hospital agencies (*Agences Régionales d'Hospitalisation*, ARH, until 2010 predecessors to the ARSs) were created, and the open-ended retrospective payment system was replaced with prospective overall financial targets. Global budgets were established in 1983 for public hospitals and global caps for *cliniques privées* in 1992.

Regional hospital agencies were public agencies, but not part of the Ministry of Health. They were created by the 1996 reform and took over the remit of hospital capacity planning from the state (DRASS) and from the regional health insurance funds (CRAM), which previously shared management of this sector. Regional hospital agencies were also given the responsibility of financing hospitals (public and private) within the framework of the regional hospital subtarget of the ceiling for SHI expenditure (ONDAM). Directors of regional hospital agencies were appointed by the Council of Ministers and were directly responsible to the Minister of Health. Regional hospital agencies were replaced by ARS in 2010 (Chevreul et al. 2010).

Looking for a fiscal base that should be larger than social insurance contributions, a new tax ('*Contribution Sociale Généralisée*', CSG) was levied in 1991, originally for family benefits but increasingly used for health financing reform. Since 1996, the national government is accountable to the French Parliament for increases in national health insurance expenditure, with a vote taking place on the target budget growth for national health insurance (*Objectif National des Dépenses d'Assurance Maladie*, ONDAM). Patients and citizens are also increasingly important for health policy decisions through national and regional *Conférences de santé* (health committees).

In August 2004, the High Authority for Health (*Haute Autorité de Santé*, HAS) was set up in order to bring together activities designed to improve quality of care and guarantee equity. HAS is not part of government but rather an independent public body with financial autonomy, mandated by law to carry out specific missions on which it reports; its activities range from assessment of drugs, medical devices and procedures to the issuance of guidelines, accreditation of health care organisations, certification of doctors, training in quality issues, and providing information to or liaising with government health agencies, national health insurance funds, research organizations, professional unions and patients' representatives. While its recommendations are advisory, the Ministry of Health or the National Union of Health Insurance Funds (representing the statutory health insurance funds in negotiations with the state and health care providers) in most cases accept its findings.

The National Union of Health Insurance Funds is separate from the Ministry of Health. It was created by combining the three main schemes (the scheme for salaried workers, the agricultural scheme and the independent workers scheme) in a new body called National Union of Health Insurance Funds (Union Nationale des Caisses d'Assurance Maladie, UNCAM), as the single representative of the insured that negotiates with the state and with health care providers.

The general director of UNCAM (who is also the director of the sickness fund for salaried workers) is nominated by the government. The board of directors includes representatives of the unions of employers and employees. The board focusses on strategic orientations, and has no day-to-day management responsibility. The operational management is in the hands of the general director, who nominates the directors of the offices of local and regional funds (Polton et al. 2004).

Convergence of financing rules between public, not-for-profit and private for-profit hospitals is expected to occur around activity-based financing (*Tarification de l'Activité*, T2A), with productivity scores (*Indice Synthétique d'Activité*, ISA) derived from DRG-type information systems (Ettelt et al,

2006). Tariffs for private for-profit providers (as explained above, typically for easier, elective procedures) do not include salaries and are lower than public hospital equivalents. Since 2005, reimbursement claims processed by public health insurance funds are centralized in a data warehouse, allowing for each patient to identify the treatment received, and the hospital and health professionals that provided the services. In 2008 the Finance Law for Social Security opened the way for new payment systems that would promote hospital modernization.

Accountability arrangements

Quality of hospital care is regulated by the High Authority for Health and overseen by the Ministry of Health. DRG-based financing requires hospitals to undergo accreditation, introduced in 1996 as voluntary for private hospitals, but since then evolved into a mandatory process for all hospitals. 'Hospital Certification' every four years comprises an assessment of the quality of care and of hospital processes to sustain quality improvement and includes (i) a self-evaluation performed against a set of criteria and quality indicators on efficiency and quality of care, including patient experience, and (ii) a certification visit by independent experts trained by the HAS (Haute Autorité de Santé, 2015). In monitoring cancer care, the National Cancer Institute, INCa, has some responsibility and, for all hospital care, the National Agency for Safety of Drugs and Medical Devices (*Agence Nationale de Sécurité du Médicament et des Produits de Santé*, ANSM) also sets standards.

All these agencies work closely with the ARSs. In 2009 the Law on Hôpital, Patient, Santé, Territoire, HPST) created 26 Regional Health Authorities (ARSs, merging ARH and regional health insurance funds, URCAM). They replaced regional and departmental institutions in charge of the provision and funding for public health and health care. The directors of ARSs are appointed by the Ministry of Health, but they are not the "owners" of the hospitals. ARSs are a subsidiary of the state under the supervision of the ministers in charge of health, social security, the elderly and disabled. However, they are autonomous bodies, and their directors have extended autonomy with regards to SHI and CNSA budget management and capacity planning in the region (Chevreul et al. 2015).

The ARS director is in charge of and authorizes the various types of care of the hospital(s) in the region, based on the plans for the organization of care at the regional level (regional health schemes, *Plan Regional de Santé*, PRS), while also controlling the functioning of public or private hospital groups, in particular the decisions made by different committees. ARSs are responsible for social care, public health, care for the elderly and for ensuring that health care provision, including hospital care, meets population needs while respecting national health expenditure objectives.

The ARSs are responsible for the control of capital investment and purchasing major medical equipment; they are also responsible for planning services and for the authorization of hospitals; they oversee any change to the existing hospital infrastructure, including restructurings and mergers (although, as mentioned above, this does not amount to direct control and restructurings or mergers are ultimately decided by hospital boards). The only exception is the construction of (new) hospitals (private and public) and comprehensive emergency centres, which have to be authorized by the Ministry of Health (Chevreul et al. 2015).

On the basis of the regional health schemes, each Regional Health Authority establishes target agreements with hospitals defining services, volumes (such as the number of procedures or hospital stays) and responsibilities for each hospital in the region (rather than bed/population ratios) in order to avoid oversupply. Regional health schemes are expected to increase service efficiency by promoting best practices and reducing systemic misuse. In achieving this objective, Regional Health Authorities and hospitals are supported by the National Performance Support Agency for Health and Other Medico-Social Organisations (*Agence Nationale d'Appui à la Performance des Établissements de Santé et Médico-Sociaux*, ANAP) (*Agence Regional de Santé*, 2015).

Financial arrangements for capital investment

The share of hospital care in health care utilization stabilized at around 46% in 2002 and has remained stable since then, yet one of the main challenges French hospitals are facing today is the limited availability of financial resources, simultaneous to an increase in the volume of inpatient

cases. The key drivers behind these changes include a combination of factors (Nolte et al, 2014 is the main source of the analysis below):

First, resources available to the statutory health insurance and Regional Health Authorities through the target budget growth for national health insurance have remained rather scarce, increasing by less than 3% each year in the 2000s. This translated into almost frozen activity tariffs, triggering a decline in the average length of hospital stay. The daily tariff to cover accommodation expenses set up in 1983, despite regular increases, amounts to only around 15 Euros today and did not offer much economic room either. Initiatives tried at other levels reduced the margins for traditional savings (in 2012, for example, savings for the statutory health insurance from replacing branded medicines with generics were much smaller than foreseen, despite the National Health Insurance Fund spending some Euro 250 million at the national level.

These financial pressures triggered a considerable decline in the number of hospitals (although this decline slowed from the early to mid-2000s), as well as structural changes related to hospital ownership and legal status. Obstetrics provides a good example; there were 1,370 facilities in 1975, but new technical requirements led to the closure and mergers of smaller facilities, while increasing the market share of the larger maternity hospitals. In 1998, a decree created three categories (type 1 facilities providing obstetrics services only; type 2 facilities providing obstetrics and neonatology services; and type 3 facilities providing obstetrics, neonatology and neonatal reanimation services) and facilities performing fewer than 300 deliveries per year were required to close or merge. Between 2001 and 2010 the number of maternity hospitals and wards decreased from 679 to 535. However, while the number of type 1 hospitals and wards fell by one third, the number of type 2 and type 3 maternity hospitals slightly increased. Type 3 maternity hospitals performed in 2010 about one quarter of all deliveries compared with one fifth in 2001.

The 2009 health reform sought to promote efficiency by enhancing collaboration among hospitals. Activity tariffs may have further encouraged high volumes of activity, complicating the financial sustainability of smaller hospitals. Within a hospital group, however, small hospitals could benefit from the expertise of large teaching hospitals, and the group structure would allow to share some logistical difficulties while streamlining some processes. Groups of public hospitals linked to medical schools have in fact benefited from the introduction of activity-based funding, increasing their market share with the number of patients growing faster than the population (between 2005 and 2009, the number of patients treated grew by 1.1%, while the general population increased by 0.54%). Many also felt the need to transform acute facilities into long-term care centres, or evolve within profit-making mergers; most mergers in the public sector led to a decrease in the number of beds available. Assistance Publique-Hôpitaux de Paris is an example of this pattern of development.

At the same time, hospital consolidation has typically involved privatization. An increase in private for-profit hospitals and increasing financial participation of investment funds in private hospital groups replaced to some extent physicians as main shareholders. In the private sector mergers have often translated into increased bed capacity and some chains even launched a regional or national strategy, shifting from acute care to rehabilitation services. Recently there has been a trend towards the closure of private hospitals and greater service concentration in larger centres to improve quality and safety. Most small independent private hospitals are losing money. Financial pressures played a role as tariffs stagnated or decreased. Overall, profitability has remained low (1.3% in 2012 for acute care activities, the least profitable activity for the private for-profit sector). An example of this pattern of development is Générale de Santé, created in 1987, with international expansion in the 1990s. This private hospital chain has been listed on the stock market since 2001 and recently bought by a big Australian hospital chain (Ramsay).

The ARSs, as mentioned above, are responsible for planning services and for the authorization of hospitals as well as for changes to the existing hospital infrastructure, including restructuring and mergers (although these are ultimately decided by hospital boards). They are also tasked with overseeing capital investment and purchasing major medical equipment in public hospitals. The construction of new hospitals (either public or private) has to be authorized by the Ministry of Health (Chevreul et al. 2015).

Capital investments in the health sector are either covered by payments for service delivery or funded by specific national or regional programmes. Two nationwide capital investment programmes have been set in motion since the early 2000s with the aim of improving quality and safety. Hospital Plan 2007 was launched in 2003 as part of an ambitious reform of the hospital sector; €6 billion was invested over five years for select projects proposed by public and private hospitals. The plan was entirely funded by statutory health insurance, but involved public-private partnerships. Hospital Plan 2012 was introduced in 2007 to extend the previous investment cycle. This plan involved an initial endowment of €7 billion, again financed by statutory health insurance through direct funding (€5 billion) and through access to public lending at preferential interest rates (€2 billion). Regional schemes for investment in health (*schémas régionaux de l'investissement en santé*) were put into place in 2013, with the objective of ensuring coherence of investments at the regional level. In December 2013 the government signed an agreement with the European Investment Bank to finance the construction and renovation of private and public hospitals under the Hospital of the Future Programme (*programme Hôpital Avenir*), totaling €1.5 billion over three years (Chevreul et al. 2015).

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5.5 Italy

Institutional arrangements

In Italy, the organization and provision of health services is a responsibility of the regions, including decisions on which services should be provided by which hospitals. Within each region, local health authorities (Azienda sanitaria locale, ASL) are in charge of the organization and delivery of hospital (and other health) services. Hospital care is provided by three main actors: local health authorities,

free-standing public hospital trusts and private providers accredited by the regions. In 2013, there were about 145 local health authorities and 80 hospital trusts. Most local health authorities manage more than one public hospital, with an average of three (Angeli et al. 2013).

The majority (68.5%) of hospital beds in 2012 were in publicly owned hospitals, 3.9% were in private not-for-profit hospitals and 27.6% were in private for-profit hospitals (OECD 2016). The proportion of private hospital beds is particularly high in the regions of Lazio, Campania and Lombardy (Ferré et al. 2014).

Public sector hospitals comprise hospitals owned by local health authorities, such as *Presidi Ospedalieri* (District General Hospitals), which are directly managed by ASLs, and public hospital enterprises, the AOs (*Aziende Ospedaliere*, hospital trust). The regions have used their increasing autonomy from the central government in different ways. Some, such as Tuscany, have kept most hospitals under ASL control and only very few became AOs. Lombardy (the largest and most prosperous region), in contrast, transformed all its publicly owned hospitals into AOs and now purchases all hospital services from AOs and private hospitals. (Ferré et al. 2014). In Veneto region in 2010, there were 59 public hospitals (including 2 AOs) and 31 private hospitals accredited by the region (Toniolo et al. 2012).

Accountability arrangements

Public hospitals owned by local health authorities are under direct managerial control of the local health authorities and the respective regional government. Public hospital enterprises provide services on the basis of a purchaser-provider split in a quasi-market system with defined tariffs (DRGs), with the ASLs as purchasers of services. They are quasi-independent public agencies that are accountable to the regions, although the organization of AOs is subject to national-level regulations (Toniolo et al. 2012).

Private hospitals are accredited by the regions, which set the accreditation criteria and enter into contracts with them (Ferré et al. 2014). Since the end of the 1990s, however, virtually all regions have reduced the extent of quasi-markets through the introduction of a variety of measures that limit market forces, such as the use of targets and ceilings, to directly govern the volume and revenues of both public and private providers (Ferré et al. 2014). Most regions rely largely on the public sector, although some have introduced some internal market mechanisms, such as separating the responsibility of buying health care from the provision of services within the regional health service. Among the 21 regional health systems, only Lazio, Campania, Molise and Lombardy have a higher share of private acute care, with 30% of total hospitalizations supplied by private providers in 2009 (Ferré et al. 2014).

Some regions have started to organize their local health authorities and hospital trusts (as well as the private providers that are being commissioned) across sub-regional zones to achieve higher scale economies. These sub-regional zones (*area vasta*, or wide area) are intermediate levels between the region and the local health authority (Angeli et al. 2013). They have subsequently become the territorial level for all regional strategic planning, including waste management, public transport and natural resources (Erskine et al. 2009). In Tuscany, for example, three wide areas were created that were deemed to be the minimum operational units for the effective planning of health services. Most health care needs of patients are expected to be met in their respective wide area. Wide areas within a region are linked through networks (Erskine et al. 2009). Many large local health authorities that manage several hospitals have also introduced clinical directorates across different hospitals to regroup units and professionals as required (Angeli et al. 2013).

Arrangements for capital investment

Regions have the main responsibility for planning capital investment and they have dedicated units and strategies for this purpose. The Veneto Region, for example, has a comprehensive and coordinated financing strategy for capital projects based on its capital fund, which pools various sources, including those from the central government. A 10-year financing plan for the period 2004-

2013 is in place to ensure that existing health care facilities meet accreditation requirements and to implement new investments (Toniolo et al. 2012).

Funding for capital investment comes from both national and regional sources, as well as EU funds, self-financing by health enterprises and project finance (Toniolo et al. 2012). A proportion of the National Health Fund is earmarked for capital investment in the health sector (including new buildings, renovations, purchasing of technologies), with a central committee approving which projects to fund. In 2008 the most recent national investment plan was adopted, amounting to nearly €20 billion. An independent national assessment body coordinates the capital investment plan and monitors its implementation across the country. The regions mobilise additional sources of funding. However, since the onset of the financial crisis capital investment has decreased and some capital investment projects have been halted. In 2012 the central government approved a reduction in capital investment of €1 billion (Ferré et al. 2014).

Local health authorities and AOs have the autonomy to generate their own additional funds for capital projects. The Veneto Region was one of the first Italian regions to promote and use project finance for the building and management of facilities, with new hospital premises in the city of Mestre, co-financed by the European Investment Bank (Toniolo et al. 2012). The national Centre for Evaluation and Verification of Public Investments under the Ministry of Health advises on proposed investments, monitors data and supports projects that face difficulties.

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5.6 Netherlands

Institutional arrangements:

Major recent changes introduced in the Netherlands somehow culminate a journey marked by dissatisfaction with the historical dual (public and private) coverage system. In 1987 the Dekker Report favoured a basic health package available to all, funded through social insurance and with all financing channelled through a single central fund. Greater demand- and supply-side competition between purchaser organisations, plus a strong regulatory framework, would make public sickness funds and private insurers compete for enrolees without risk selection; consumers with the right to choose would push insurers and providers to increase service quality and efficiency; an outcome-driven approach would then control costs through provider payment reforms and the use of performance indicators (Westert et al., 2009).

By 2000 a number of changes had already occurred: (i) sickness funds became risk-bearing enterprises able to extend their operations nation-wide; (ii) sickness funds were re-organized (administration-oriented chief executives were replaced by entrepreneurial managers); and (iii) more

price competition between funds emerged (in 2000, the lowest flat rate premium was about 30% less than the highest premium). The 2006 Health Insurance Act further fostered market forces and changing governance structures; the role of government was re-formulated as (i) monitoring access, quality, and costs for a population of slightly over 17 million people and setting priorities for health care as necessary (through legislation if need be): (ii) ensuring financing of the social and compulsory health insurance (basic benefit package of short-term personal care and a scheme for long-term care, with long-term disability protection organized separately from health insurance); (iii) ensuring general taxation financing for prevention and social support. The role of the Ministry of Health was shifted from directly steering the process to safeguarding it from a distance, becoming responsible for the preconditions pertaining to access, quality, and cost of the health system plus an overall responsibility over priority-setting (Van de Ven and Schut, 2008).

Hospitals in the Netherlands are now by law private, non-profit entities. Since 1986 the country has moved towards an even bigger separation of functions and all planning or goal-setting by the Ministry of Health is only indicative. Providers produce services in negotiation with payers; there is no geographically defined responsibility for specialized health care at the regional level in the governance structure of the Netherlands.

Key decisions regarding hospital investments (or closures) are taken by the hospital board and the CEOs, in principle on their own. However, in 2008 the Minister of Health overruled the Health Authority's decision that a certain hospital did not qualify for financial support (see below).

Practically all 82 general, 8 university, and 4 specialty hospitals are not for-profit, funded by public money mobilized through private health care insurers. Average Dutch hospitals are relatively large in size. Their number has declined from about 200 immediately after the Second World War and a further 25% decrease in the number of hospitals took place from 2009 to 2014, mostly at the expense of hospitals smaller than 125 beds. Further streamlining is likely. Consolidation has been paralleled by an increase (from about 30 in 2000 to 280 in 2010) in "independent treatment centres" for non-acute, elective care covered by statutory health insurance and dealing with diagnostics, surgery, orthopedics, ophthalmology and dermatology. Some of these independent treatment centres are (co)-owned by hospitals and most are tied to hospitals in different ways. More than 170 are independent private and non-profit treatment centres with services limited to same-day admissions; at least 80 are private clinics that specialize in care outside the benefit package and there is an unknown number of self-employed specialists with their own private practice. The prices in the independent sector are on average 15-20% lower than those of the hospitals, yet their overall market share is only 3–4% of total hospital revenues. Hospitals (including outpatients) are funded based on diagnosis treatment combinations, DBC, the Dutch version of DRGs, reduced in 2012 from 30,000 to 4,400 (Maarse et al, 2015).

Medical specialists are "self-employed hospital doctors", somehow separate from the facilities hosting them; 40-45% of all specialists work in group practice and are paid under fee-for-service arrangements; university clinics are exceptionally paid on salary. Specialists (except for emergency care) are accessible only upon GP referral; only 4% of appointments with a GP result in a referral to secondary care, after which patients are free to choose a provider. In addition to referral from regular care, patients can visit an emergency department by ambulance. Between 5 p.m. and 8 a.m. health care is provided by centralized "posts for after-hours primary care" organized by a nearby hospital at municipal level with trained phone assistants and triage. Most hospitals have emergency departments and all have a GP post (Schäfer et al., 2010).

Given the redefined role of the state, a number of arm's-length agencies responsible for setting operational priorities have been established as governance layers between the Ministry of Health and the hospitals:

- the Dutch Health Care Authority, which acts as an advisory body to the Minister of Health and provides regulation, organizes oversight, safeguards public values, develops policy initiatives and gives general direction to health care (while the Dutch Competition Authority enforces antitrust laws among both insurers and providers). The Authority sets the prices for 30% of diagnosis-treatment combinations (the

Diagnosis Treatment Combination Maintenance Organization (DBC), responsible for independently designing, constructing and maintaining the diagnosis treatment combination system will soon be integrated in it); it also decides whether hospitals with budgetary problems qualify for financial support, which makes institutional links with the Ministry complex; the Authority is in charge of issuing specific instructions on hospital reimbursement but the Minister decides on its macro-budget. In 2008, for example, the latter overruled the Authority's decision that a certain hospital did not qualify for financial support, arguing that "bankruptcy of the hospital would jeopardize continuity of care" (since then, however, he has argued that such requests should be handled by insurers and the Authority and has displayed more restraint regarding financial support).

- the Health Council (Gezondheidsraad) is a statutory advisory body to the government, including the Ministry of Health, Welfare and Sport. The Council brings together experts on specific topics, on request of the government, or undertakes studies on its own initiative. The Council is presided over by a president and two vice-presidents and consists of nearly 200 members, selected from scientific and health care societies. gives the government non-binding evidence-based advice on health care, public health, and environmental protection, and performs health technology assessment, including cost-effectiveness analysis. However, decisions about the benefits package rest with the Minister;
- the National Health Care Institute (formerly Health Care Insurance Board) integrates knowledge on quality management from various agencies as insurers showed dissatisfaction with "the slow progress in objective and comparable quality measurement" and started collecting their own quality data as well as introducing their own volume norms (Maarse et al., 2013). Since 2014 it has various tasks relating to professions, training and the insurance system (risk adjustment) and encourages evidence-based practice through HTA. Its core role as central body is advising on services covered in the statutory benefits package, which should cover medical care provided by GPs, midwives, specialists and hospitals; dental care; medical aids and devices; prescription drugs; maternity care; ambulance and patient transport; paramedical care; basic ambulatory and specialized outpatient and inpatient mental healthcare and some effective health promotion programs (such as smoking cessation, diet advice, etc.). The members of the National Health Care Institute are appointed by the Minister of Health, Welfare and Sport.
- the Dutch Health Care Inspectorate is an advisory body, independent from the Ministry of Health, Welfare and Sport. It is responsible for monitoring quality and safety. Among others, it enforces statutory regulations on public health; it investigates complaints and accidents in health care; and it takes appropriate measures.
- the Medicines Evaluation Board oversees the efficacy, safety, and quality of medicines. Its members are appointed by the Minister of Health.
- the Centre for Needs Assessment deals with eligibility assessments for long-term care under the Exceptional Medical Expenses Act and therefore is only marginally if at all related to hospitals – although, together, care under the Exceptional Medical Expenses Act and the Social Support Act accounts for 44% of the government's total health care budget (Maarse et al, 2015).

Accountability arrangements:

Hospital governance was essentially fostered as a private initiative. Most Dutch health care organizations were foundations for whose administration the Civil Code indicated that the Executive Board was responsible (no supervisory Board was required). As a result of the increase in scale and professionalism of hospitals it was felt that the classical foundation model ceased to be adequate (an Executive Board consisting of volunteers was no longer capable of administering a large, professional

enterprise of this kind). In 1983 the Netherlands Association of Hospital Directors (NVZD) submitted proposals for a new administrative structure for foundations: an Executive Board would take over the management functions and a Supervisory Board would be created, following the model of statutory rules as in the case of two-tier companies. In 1999 the 30 “Recommendations for good administration, good supervision and proper accountability in the Dutch health system” produced by a commission consisting of administrators and managers, academics and consultants triggered a new vision: the executive board would be in charge of managing the foundation while the supervisory board would ensure the functioning of management and approve its strategic decisions; the composition, appointment mechanisms and remuneration would be left to each organization. The Commission recommended that the government should introduce the role of supervisory boards in legislation and other additional provisions (Smith et al., 2012).

As providers contracted by health insurance funds, hospitals are expected to provide the best value, in terms of quality and cost. Beyond internal control, they render account to relevant bodies fulfilling a public function. Responsibility for financial and clinical outcomes has led hospitals to operate much more efficiently; hospitals have also improved client services, so that waiting times for first-outpatient visits and non-emergency treatments are shorter and below the maximum acceptable waiting time standard; outpatient clinics have been opened and evening consultation hours introduced, together with facilities for one-stop provision of care, care pathways, on-line consultation reservations and many other innovations. Reporting obligations are clear: since the 1980s new legislation has been passed on medical guidelines and a Healthcare Inspectorate set up to measure quality by outcome indicators. Furthermore, hospitals (and other provider organizations) are required to submit and publish to the public on the internet data on patient outcomes, patient satisfaction and standardized mortality (Van den Bovenkamp et al., 2014).

At present, all patients have a unique identification number for issues related to electronic lab results, prescriptions, etc. and all hospitals use electronic health records, but they are neither standardized nor interoperable between domains of care yet. Patient experiences are systematically assessed and, since 2007, a national centre has been working with validated measurements; publicly available information on waiting lists, patient satisfaction and a few quality indicators are also generated that are later on reported on a website. The patient movement includes organizations of different types (some are broad while others deal with specific diseases); all offer support, provide information and increasingly look after patients’ interests by participating in quality-of-care projects (Peeters et al, 2014).

Strategies to ensure quality of care were strengthened after the Dutch Health Care Performance Report 2010 showed that the quality and price of services varied substantially among providers. Quality at the system level is now ensured through legislation governing professional performance (especially regarding the chronically ill), and promotion of quality registries, patient rights and health technologies. Most of it is carried out by providers, sometimes in cooperation with patient and consumer organizations and insurers. The main methods used to ensure quality in health care institutions include accreditation and certification; compulsory and voluntary performance assessment; and national quality improvement programs (Westert et al., 2010).

Financial arrangements for capital investment:

All Dutch hospitals are not only allowed but also requested to retain surpluses and manage debt. Hospital budgets are determined through price and volume negotiations between insurers and hospitals, with most payments taking place through the above-mentioned case-based diagnosis treatment combination system. 70% of hospital service rates are freely negotiable between hospital and insurer since 2012. There are ongoing experiments with pay-for-performance and population management to improve quality in hospital (as well as primary) care. Some hospitals participate in bundled-payment approaches to integrated chronic care, applied nationwide for diabetes, chronic obstructive pulmonary disease and cardiovascular risk management (insurers pay a single fee for a full range of chronic disease services for a fixed period to a principal contracting entity -the legal entity “care group” formed by multiple health care providers that assumes clinical and financial responsibility for all assigned patients and either delivers services itself or subcontracts with other

providers). To patients, hospitals are not allowed to charge above the fee schedule; some costs of hospital admission are included in an annual deductible for health care costs that everybody above 18 years must pay (€360). Given their peculiar relationship with hospitals, specialist care is at the same time separated and integrated in the hospital organization; specialist fees (also by “diagnosis–treatment combinations”) are since 2015 freely negotiable as a part of hospital payment, after years of being set nationally. Ambulatory surgery centre specialists are paid fee-for-service, and the fee schedule is negotiated with insurers.

The central planning of capital investments was abolished in 2006. Since 2008, the government has limited ability to steer investments (Schäfer et al. 2010). Hospitals are now free to make their own investment decisions and bear the financial risk themselves; the government abolished in 2008 the state certificate of the need for major construction works which guaranteed during a 40-year period full reimbursement of the costs of rent and depreciation, thus increasing risk-based funding for capital. Professional business plans have nowadays become indispensable to attract external capital resources, since banks have become aware of their increased exposure to financial risks. Strategic planning of infrastructure is more inclined towards mergers; more information on quality of care and active purchasing by health insurance funds is forcing hospitals to specialize and let go of some of their treatment spectrum. Increased attention has to be paid also to operational expenses. In 2014 the Lower Chamber approved legislation permitting hospitals to pay investors a return on investment (withdrawn in the Upper Chamber), but in fact some hospitals are now allowed to operate for profit under very strict conditions and a few are already owned and exploited by commercial companies. Capital investment in buildings, medical equipment and ICT systems amounted to 12% of total health expenditure, which was one of the highest shares across the OECD and double the OECD average (Wammes et al, 2014).

In view of the problems and political controversies of regulated competition, policy-makers and regulators in the Netherlands need to decide on whether to use regulation and central negotiations or market interventions and increased transparency, accompanied with an anti-trust approach for certain high-cost and low volume medical services (Thomson et al., 2013). Managerialism, overpaid executives, money-driven health insurers, fraud and excess power are often presented as excrescences of the new system and generate public discontent; insurers are viewed as too powerful and as money-driven agents restricting patient choice. Hospitals and health professionals experience their contract as a dictate and perceive insurers’ interference with quality issues as imposing norms. A range of differing opinions are emerging as to how to assess results so far and on how to direct the future course of the reform, and interpretations change in the course of reforms (Schut and Van de Ven, 2011).

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5.7 Scotland

Institutional arrangements

Almost all hospitals in Scotland are owned and run by the NHS. In contrast to England, there are neither NHS trusts nor foundation trusts. As a result of the PFI initiative (see the case study on England), there are a number of hospitals, including four major acute hospitals, that are owned privately and leased to the NHS (Steel et al. 2012). There is a relatively small private sector, including in 2010 (Steel et al. 2012):

- 7 acute medical and surgical hospitals (306 beds) offering inpatient, outpatient and day-care services ranging from routine investigations to complex surgery;
- 10 mental health hospitals and clinics (342 beds and 50 day-case places), providing assessment, treatment and rehabilitation for children and young people with eating disorders, people with learning disabilities, people requiring intensive psychiatric care, and people with drug and alcohol problems;
- 15 voluntary hospices (286 beds and 160 day-case places) providing specialist palliative care on an inpatient, outpatient and day-care basis;
- 2 specialist clinics providing cosmetic and laser treatment.

With the exception of hospice care, this sector is funded mainly by voluntary health insurance or paid directly by patients. Hospices have charitable status and do not charge for their services; they receive a substantial part of their funding from the NHS. The NHS also contracts to a very limited extent with the private sector for the provision of certain services to NHS patients (Steel et al. 2012).

Accountability arrangements

In the 1990s, Scotland, alongside the rest of the United Kingdom, introduced an internal market and competition, based on a split between purchasers and providers. However, the government of Scotland abandoned the internal market and the purchaser/provider split in 2004 and created health boards similar to those that existed in the 1980s (Bevan et al. 2014).

Responsibility for planning and managing hospital services now lies again with NHS boards (Steel et al. 2012). There are 14 geographically based NHS boards and 7 non-geographically based National Special Health Boards. The 14 geographically based NHS boards are responsible for planning and delivering services to meet the health care needs of their respective populations. Each board

comprises a non-executive chair, appointed by ministers after open competition, varying numbers (currently between 9 and 23) of non-executive directors (some lay, appointed by ministers after open competition; others, also appointed by ministers, but as representatives of particular stakeholder interests such as the board's employees, the area clinical forum, and each of the local authorities in the board's area), and normally around six executive directors appointed by virtue of their position (e.g. Chief Executive, Medical Director, Nursing Director, Finance Director, Director of Public Health) (Steel et al. 2012).

Within each board, responsibility for day-to-day delivery is delegated to operating divisions for acute services. These divisions are headed by a Chief Operating Officer leading a multiprofessional management team in each NHS board. They have authority to act without constant reference to the board, backed by formal schemes of accountability (Steel et al. 2012). The composition and accountability of the nine national specialist health boards are broadly the same as for the geographically based boards (Steel et al. 2012).

The private sector was regulated from 2000 until 2011 by the Scottish Commission for the Regulation of Care (known as the Care Commission) and is now regulated by Healthcare Improvement Scotland (HIS).

Arrangements for capital investment

In contrast to England (discussed above) capital investment for large infrastructure projects remains centralized in Scotland (as well as in Wales and Northern Ireland) (Cylus et al. 2015).

In 1999, the Scottish Executive embarked on the largest programme of hospital building in the history of the NHS in Scotland, amounting to £0.5 billion over the following eight years, including three major new hospitals in the Central Belt (the part of Scotland stretching from Glasgow in the west to Edinburgh in the east). This programme has been continued by the new Scottish National Party (SNP) government since 2007, which has prioritized infrastructure investment both as a lever of economic recovery and to modernize public services (Steel et al. 2012).

Most investment in the NHS in Scotland has been funded through public sector capital, but, similar to developments in the English NHS, schemes to introduce private finance were adopted since the 1990s, accounting for just over one-third of capital spending in Scotland in 2010/2011 (Steel et al. 2012). Until the 1990s all capital investment was funded through allocations of public funds to the NHS. This changed with the PFI scheme and, more recently, non-profit distributing funding, although ultimately the government remains responsible for providing the funds in the long term (Steel et al. 2012). Under PFI the private sector agreed to finance, design, build a hospital and operate non-clinical services under a contract, often lasting 30-40 years, and the private finance is repaid through "unitary charges" out of current spending. For any new hospital project, the NHS was required to test the value for money of a PFI option.

Although PFI enabled more investment than would have been possible by the public sector alone, it has proved controversial (see the case study on England). Critics argued that payments were high over the life of the contract and that the private sector was able to make large "windfall" profits, including through refinancing existing contracts (Steel et al. 2012). In 2012, the UK government itself admitted that the PFI scheme had "become tarnished by its waste, inflexibility and lack of transparency" (HM Treasury 2012).

In Scotland, the SNP government announced in 2008 a new financing scheme, called the Non-Profit Distributing Model, to deliver revenue-financed investment. This approach seeks to transfer risk and exert private sector discipline both during the construction phase of a project and throughout its lifetime, but with smaller profits to the private sector and reduced financing costs to the public sector in comparison with past PFI projects (Steel et al. 2012).

In 2011/2012 there were 29 PPP/PFI/non-profit distributing projects in the health sector in Scotland for which the estimated unitary charges to the private sector were £198 million. The two largest PPP/PFI projects are the Royal Infirmary of Edinburgh (completed in 2003 with over 900 beds) and Forth Valley Royal Hospital (completed in 2011, with 860 beds/day-care spaces) (Steel et al. 2012). In

April 2015, Scotland's largest hospital, the £842m Queen Elizabeth University Hospital in South Glasgow (1677 beds), was opened. The hospital was built with Scottish government funding.

NHS boards are responsible for initiating local capital schemes in accordance with guidance provided by the Scottish Government health directorates in the Scottish capital investment manual. Depending on the size of the project, they are required to produce different levels of documentation. For projects not concerned with information management and technology and under £5 million (£10 million for the two largest boards), territorial boards approve their own business cases. Above these delegated limits, they have to be submitted to the health directorates' Capital Investment Group for approval (Steel et al. 2012).

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5.8 Spain

Institutional arrangements

In just a decade Spain was transformed from an authoritarian, centralist regime to a soon-to-be member of the EU; devolution to 17 regions (*Comunidades Autónomas*, CAs) was critical in that regard. In health (the protection of which was recognized as a constitutional right) competencies for CAs to exercise legislative and executive authority were transferred between 1979 and 1981. Shared institutional responsibilities mean that the Ministry of Health, Social Services and Equality, MSSI, provides a common framework (to ensure equity, cohesion and common quality standards) while the Ministries of Health of the CAs, each with a regional health department and health minister plus a health service delivery executive, are responsible for health policy and service delivery. Coordination happens in an Inter-Territorial Council/ Commission (*Consejo Interterritorial*) without executive power, which provides "consensus recommendations to promote cooperation and exchange of information". The Spanish National Health System (SNS) Cohesion and Quality Act (2003) ratified the design; its last update, from December 2006, allows ACs to include additional services if they finance them through their own budget. Some ACs have enacted their own Regional Health Laws while others used lower range legislative tools for developing their own legal framework. A parallel transition from a contributions-based, *Bismarck-type* social security system to a general taxation-funded, NHS *Beveridge-type* model in the public sector sanctioned by the General Health Act (1986) completed the reform (Durán et al, 2006).

CAs are funded by the state through funds transferred as "non-earmarked budget" and health represents around 30% of each CA's total budget (which also includes education, unemployment benefits, etc.) (García-Armesto S et al. 2010). Transfer of funds from the centre is negotiated annually between central and regional governments, and then it is up to each CA how to fund hospitals in terms of both overall figures, as well as the distribution of capital investment and running costs. On average, in 2012 88% of total public expenditure on health was spent on services provided by public facilities, and 12% was used in agreements with private entities (Ministerio de Sanidad, Servicios Sociales e Igualdad 2012).

Hospitals in the new, CA-led public sector kept the inherited schemes, with staff being quasi civil-servants and some 67.4% of all available hospital beds in the hands of the public sector in 2014, including 74% of acute care beds, 34% of long-term care beds and 27% of psychiatric beds (Ministerio de Sanidad, Servicios Sociales e Igualdad 2015). Politicians (directly or through appointed managers) set objectives, establish operational boundaries and staffing requirements, negotiate and regulate payment levels, and make final decisions about hospital finances; managers typically decide on internal professional structures, carrying out data collection and monitoring day-to-day activity, hiring and firing as well as setting incentives and performance indicators (irrespective of whether or not they are later published).

In the 1990s some not-too-big hospitals around virtually all of Spain were granted variable autonomy, initially within the existing legal framework (BOE 1997), adjusted later on in each region. Changes affected a number of essential areas and the corresponding tools to govern the facility:

- (a) institutional arrangements, e.g. legal, social, financial and political status of the hospital, including role, freedom from political interference in making decisions (on services, incentives / sanctions), size and composition of different boards, etc. and relationships with stakeholders (authorities, professional organizations, unions);
- (b) accountability arrangements related to supervision (reporting obligations in terms of transparency, content and timing) and patient involvement;
- (c) constraints in running operations, e.g. setting contracts, terms and conditions of hiring and firing staff; service adjustment (e.g. waiting time management);
- (d) financial arrangements, including decisions on capital investments, operating expenses (budgets and capacity to find additional sources of revenue), ability to incur debt, arrange loans and retain surpluses.

From the point of view of working hours, dedication and accountability, however, the new arrangements were more demanding than the old statutory regime.

After adjustments, four increased autonomy offshoots were promoted in different parts of the country, with an implicit agreement of future cross-fertilization in a continuum from less to more autonomy, from public health care companies to non-profit foundations, then consortia and finally administrative concessions (Alvarez and Duran, 2011):

- a. Public health care companies (*Empresas Públicas Sanitarias, EPS*) were introduced in 1992. They are owned by the public sector but subject to private law in matters not governed by specific legislation, or by the founding statutes, with non-statutory staff instead of civil servants (and clinicians under a performance-related payment scheme as opposed to under a salary).
- b. Non-profit foundations (*Fundaciones*) were promoted in 1994. They are non-profit entities under private law, explicitly created to meet a particular social need with public, private or mixed funding capital; staffed with non-statutory health professionals, have great capacity to decide their basket of services and autonomy to choose where to invest and whether to rent or buy equipment and are free to manage their own cash-flows and pay their providers directly.
- c. Consortia (*consorcio*) are a formula used since the 1980s. They are legal entities resulting from merging resources from more than one public authority, plus sometimes private non-profit entities with non-statutory employees/civil servants as staff. Managers typically enjoy autonomy to rent or buy equipment and decide on the basket of services to offer.
- d. Administrative concessions (*Concesiones Administrativas*) were launched in 1999. In these, a private concessionary (often a joint-venture type of trading company between private health insurers, health groups, building societies, or banks) receives the tender to build and manage a hospital, including (in contrast with the Private Finance Initiative, PFI, in England) the

provision of clinical and non-clinical services, usually with non-statutory staff, such as the *Hospital de la Ribera* in Alzira, Valencia.

However, Spain has maintained a direct involvement of the authorities in the planning and priority-setting of services. Geographically defined responsibility for specialized health care is crucial in the health governance structure and gets expressed at the regional level ("Autonomous Communities") in health plans and similar documents. The key decisions regarding hospital investments (or closures) are taken by the political authorities of each region. While investment plans are thus decided by the regional government, a variable component of the services eventually provided is decided at the facility level, by clinicians and the hospital director.

Accountability arrangements

Accountability enhances legitimacy through periodically reported information tracking the goals in the fields of hospital activity, accessibility and performance of care. This is done in Spain using measurement tools, such as the Compulsory Minimum Data Sets (Ministerio de Sanidad, Servicios Sociales e Igualdad, 2011). The topics covered, the frequency of reports and their comprehensiveness varies, according to the mechanisms in the direct public administration of each CA. Most are using a Program Contract Arrangement (*Contrato Programa*) as preferred funding/accountability mechanism, which then generates numerous relational documents in terms of accountability that have to be sent to the Regional Health Service Executive. In the case of the Andalusian CA the most important ones are:

- Between primary health care centres and hospitals:
 - Continuity of Care Agreement.
 - Annual Report by the Commission on Continuity of Care
- Between hospitals and the Regional Health Service Executive:
 - Financial monthly reports (COAN-hyd)
 - SIGLO Information System for management of logistics
 - Patient Satisfaction Improvement Plan reports
 - Biannual analysis of claims and complaints
 - Basket of services (diagnostics, medical, surgery...)
 - Epidemiological Alerts report
 - Annual report on care provided to immigrants
 - COHEASIST Information System to manage surgery waiting lists
 - INFHOS Information System to register diagnostic procedures (weekly reports)
 - Agreements of the Clinical Network Units (*Unidades de Gestión Clínica*)
 - Report on Integrated Care Processes (*Procesos Asistenciales Integrados*)
 - Annual Report by the Committee for Improving Referrals
 - Annual Report by the Committee on Staff Training

Explicit accountability is more marked in hospitals with increased autonomy. For example, in administrative concessions to private trading companies the owner companies receive specific requests by the Health Authorities in the tender document and have to use well-structured dashboards with indicators for monitoring. Public health care companies and foundations engage in reporting for payment purposes, after Management/ Executive Boards evaluate the achievements, with an important role for department heads. Public health care companies, foundations and consortia use some mid-way economic indicators based on company statements of income and

expenditures, but with a strong simultaneous role of budget monitoring. Consortia have been using monthly reporting on waiting lists and three-monthly reports on their financial situation. In concessions to a private trading company, full business reporting is used, with common indicators in the clinical part.

Quality has been in general a common priority in most regions; in virtually all hospitals Quality Committees were set up and Continuous Quality Improvement initiatives incorporated, although unwarranted variability remains in access, quality, safety and efficiency, across regions, health care areas and hospitals (García Armesto et al, 2010). Hospitals somehow care also about their brand identity and cultivate a line of activity trying to gain political and media attention with their own communication structures.

One problematic aspect of decentralization is an information deficit and limited connectivity across the country and between regions: regional health systems have developed a variety of sophisticated information systems (including electronic prescriptions, etc) not necessarily fully compatible with each other, which adds to the traditional reluctance to disclose information about costs and quality and an arguable transparency in clinical information to patients. In many cases it is more an issue of political risk aversion against possibly malicious uses of the information provided than an organizational or technological problem. Yet despite millions of Euros of financial investment, no homogeneous assessment of the performance of the entire SNS seems to be currently feasible. Similarly, the relative success of the different forms of hospital autonomy and their clinical and cost-effectiveness remain nebulous.

Financial arrangements for capital investment

Notably, the decentralized health system in Spain was developed in a favourable financing context, with gross domestic product (GDP) growth above the corresponding European Union (EU) average, fiscal surpluses and declining unemployment. National and regional administrations felt stimulated to increase public spending and highly qualified professional teams tended to develop service portfolios above their strict needs in relation to the health care networks of each CA. Autonomous hospitals had some additional flexibility in financial management, as well as agility in updating technology and equipment, as per the arrangements shown in Table 2.

Table 2 Governance and capital investment arrangements in different types of hospitals in Spain

	Variants in Hospital Supervisory Boards	Flexible use of capital investments	Ability to (1) generate revenue and (2) reinvest surpluses
Public health care companies	Board of Governors, composed by high rank officers especially from the health sector and policy-makers from the region	With major restrictions	(1) Allowed; in practice, however, retrospective funding and rather scarce extra income (2) Limited (Treasury gets any surpluses)
Non-profit foundations	Board of Patrons, composed by high rank officers especially from the health sector and policy-makers from the region	With major restrictions	(1) Allowed; in practice, however, not great extra income (2) Limited (Treasury gets any surpluses)
Consortia	Governing Body, with equal representation of public and private entities forming the consortium. Annual turnover to chair the Council.	Certain restrictions	(1) Allowed; in practice, however, subject to political issues because of the risk of generating inequities (2) A key in the model; nevertheless limitations imposed by

			Finance Department
Administrative concessions	Board of Directors, composed of company representatives, plus a representative of the health administration (with voice but without vote)	Variable, according to the terms of the concession agreement	(1) As per the terms of reference of the concession; in practice, however, subject to political issues because of the risk of generating inequities (2) Allowed; surpluses are reinvested via profits

This coalition of expectations has contributed to make regions over-spend their allocated budgets while parliament and central government had little control over such expenditure. The 2001 Act on the Financing System of the Autonomous Communities (not explicitly a health law) established, after numerous disputes, an overall framework for the financing function of the Spanish NHS, after its approval through the high-level National Council of Financial and Fiscal Policy. In 2003 (and then in 2009) the SNS Cohesion and Quality Law established another regional financial system, with a Guarantee Fund for Fundamental Public Services, integrating the National Cohesion Fund which holds 80% of the resources for key public services such as education, social services and health care.

Decentralization has also kept per capita health expenditure uneven across regions, with even greater variation in publicly funded (budgeted) health expenditure. Changes in population-protected volume failed to explain this variability in the period 1992–2009 (García Armesto et al, 2010). In 2013 publicly funded (budgeted) expenditure per person differed by €420 (ie. 35% of the average of €1.208) between Valencia at the bottom (€1.109, i.e. 92% of the average) and the Basque Country at the top (€1.529, or 127% of the average) (Ministerio de Sanidad, Servicios Sociales e Igualdad (2015). According to the Health Barometer 2013, only 40.2% of respondents believed that the same health services are offered across all regions, while 87.9% believed treatment to be equal for men and women and 69.4% believed treatment to be the same despite a patient's social class and wealth (Ministerio de Sanidad, Servicios Sociales e Igualdad, 2013); in other words, regional devolution is seen as being adverse to equity.

A mistaken handling of the situation by the government of the day when the economy started to crumble in 2008 threw Spain into severe economic recession. Arguing that the very foundations of the health system were challenged in unprecedented ways (Price Waterhouse Coopers, 2012), the government that emerged from the 2011 elections claimed that it was forced to introduce drastic cuts, including: (a) a refusal to give assistance to undocumented migrants from September 2012 onwards (although this measure was not applied by all regions and was reversed in April 2015); (b) an increase of the cost-sharing of medicines (senior citizens who did not pay before the reform now pay 10%, up to €8, €18 or €60/month depending on their income; workers now pay 40%, 50% or 60%, depending on their income (Royal Decree Law 16, 2012).

The ensuing political polarization of the country has changed the policy environment, with the absence of impartial evaluation efforts as one notable manifestation. A deepening of the pro-privatization movement in the conservative camp, placing new hospitals under private law in several regions, sometimes in rather obscure ways, led to a response in the socialist camp of stepping back towards traditional forms of management and presenting virtually any alternative arrangement as hidden privatization (Alvarez and Duran, 2013). Experiences are being vehemently discussed almost without any available study to assess the performance of the new centres (Cortès-Franch I and González López-Valcárcel B, 2014). A periodic report on differences and inequalities among the way Spanish citizens are cared for in different parts of the country concluded that data on access to the publicly funded health system are unavailable not only for the population and researchers, but also for international institutions such as the OECD (FADSP, 2015). The regional and general elections of 2014 and 2015 have resulted in new turbulences in the political landscape of Spain, which are bound to have repercussions for the hospital sector and the degree of autonomy afforded to hospitals.

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5.9 Sweden

Institutional arrangements

There is a mix of publicly and privately owned health care facilities in Sweden, but they are generally publicly funded. There are 7 regional/university hospitals and about 70 hospitals at the county council level. Highly specialized care, requiring the most advanced technical equipment, is

concentrated in seven (public) university hospitals located in Malmö/Lund, Gothenburg, Linköping, Stockholm (Huddinge), Uppsala, Umeå and Örebro.

County council hospitals can be divided into acute care hospitals and local hospitals. About two-thirds of the county council hospitals are acute care hospitals. In acute care hospitals, care is offered 24 hours a day and a larger number of clinical expert competences are represented than in local hospitals.

There are six private hospitals in Sweden, of which three are non-profit-making (Sophiahemmet, Ersta and Red Cross (Röda Korset) hospital in Stockholm), and three are profit-making (St Goran hospital located in Stockholm, Lundby hospital located in Gothenburg and Simrishamn hospital located in the south of Sweden). The three former are privately owned and operated but have contracts with the county council of Stockholm and provide care to a certain number of patients each year paid for by the county council. The three latter are privately owned but fully financed by the county councils, based on contracts. St Goran hospital is the only private acute care hospital in Sweden (Anell et. al., 2012).

In 2003, the Parliamentary Committee on Public Sector Responsibilities (Ansvarsutredningen) was formed. One of its key missions was to investigate whether the local government structure, with 21 county councils (including the two regions formed in 1999), was suitable for future demands concerning health care services. One alternative was to merge additional county councils into regions with at least 1 million inhabitants, who then would become similar to the three largest county councils already in place (Stockholm county council, Region Skåne and Västra Götalandsregionen). Another option, indeed one supported by many physicians (Anell, 2004), was to hand over responsibility for all hospitals or at least university hospitals to the state, similar to the reform introduced in Norway.

In the final report from the Committee (SOU, 2007:10), it was concluded that developing towards 6–10 larger regions and maintaining decentralization of health care services were the preferred options. Each of these regions should ideally have between 1 million and 2 million inhabitants, and include a research-based university and a university hospital. The Committee was careful not to propose actual new geographical borders of the larger regions. The argument was that the formation of the new regions should develop from the bottom up rather than by national government decision (Anell et. al., 2012).

No additional larger regions have been formed apart from the by now permanent regions initiated in 1999. In 2015, the Swedish government initiated a new investigation into forming regional governments, which will present its report in 2016.

Accountability arrangements

During the latter part of the 1990s and throughout the 2000s there have been efforts towards strengthening national influence, partly driven by the need to better coordinate care and to reduce regional differences. One example is the strengthened role of government agencies. The National Board of Health and Welfare is commissioned by the government to provide evidence-based guidelines for the care and treatment of patients with serious chronic illness.

The guidelines include recommendations for decisions on priority-setting, and provide national support to assist health care decision-makers (county councils and municipalities) and providers in establishing health care programmes and setting priorities. Another example is the development of national “action plans”, supported by additional government grants that have been implemented to strengthen available resources and to encourage coordination between the care for older people, psychiatric care and primary care (Anell et. al., 2012).

Since the late 1990s, there has also been a tendency towards regional concentration or centralization through mergers of hospitals and county councils and increased cooperation between different levels of care and between hospitals. Two regions – Skåne and Västra Götaland – were formed in 1999. Previous national policies of decentralization have been replaced by the reverse trend of centralization and regionalization in the delivery of care during the 2000s. In a report from the

Committee on Public Sector Responsibilities (SOU, 2007:10), it was proposed that the 21 county councils should be replaced by between 6 and 9 regional authorities, with responsibility for the provision of health care but also with increased responsibility for other regional matters. Two other examples of centralization include the establishment of the Committee for National Specialized Medical Care (*Rikssjukvårdsnämnden*) in 2007 and the development of regional cancer centres (Anell et al, 2012).

One reason for concentrating highly specialized care in seven hospitals is to maintain high levels of clinical competence. This is achieved by gathering a large number of patients with rare and or severe conditions or diseases in a few hospitals, instead of treating a small number of these patients at several hospitals. Each region serves a population averaging more than 1 million people. There is currently a tendency towards concentrating highly specialized services even further, that is, in national centres.

The trend towards increased specialization and concentration of services has continued in the 2000s, supported by both county councils and the national government. From an organizational perspective, the focus has shifted from reorientation of small hospitals to mergers and collaborations between large university hospitals. In the Gothenburg area, the Sahlgrenska university hospital was formed in 1997 through the merger of three hospitals. In Stockholm, the

Karolinska and Huddinge hospitals were merged into the Karolinska university hospital in 2003. Finally, the Malmö university hospital and Lund university hospital were merged into the university hospital of Skåne in 2010.

Important objectives in all three cases have been to contain costs through increased collaboration. Additional objectives concern improvements in the quality of services and in conditions for clinical research. In all three cases, the mergers have initiated debate and significant criticism of centralization and regarding the disadvantages of large-scale organizations from senior specialists affected by the changes. More generally, concentration of services is far from always supported by outcome data available in the national quality registers (Anell et al., 2012). The problems with implementing the changes associated with the merger of the Karolinska and Huddinge hospitals have been documented in research (Choi, 2011).

The trends toward specialization and the concentration of specialist services have been supported by several national initiatives in more recent years. In 2007, the Committee for National Specialized Medical Care (*Rikssjukvårdsnämnden*) was established with the objective of concentrating highly specialized services in national centres. A further important national initiative was the creation of Regional Cancer Centres (RCCs) in 2011. An impetus for the latter initiative was forecasts of the doubled incidence of cancers by 2030 following demographic changes. Another important motive behind regionalization of services concerns regional differences in waiting times for diagnosis and treatment. Further objectives are to concentrate curative treatment for cancer patients with more unusual diseases or patients requiring specialized resources, and to improve conditions for clinical cancer research (SOU, 2009:11).

Arrangements for capital investment

Capital investments are generally decided upon and funded by the local county councils. County councils have the ability to borrow funds if they cannot provide the necessary capital themselves through the current fixed rate county income tax.

With a few exceptions, there were no investments in new hospital buildings since 1980 until recently, when several new hospital buildings have been planned and built. The rapid pace of capital investments in health care during the 1960s and 1970s declined in the 1980s. One explanation for this decline was that the expansion phase up to the 1970s led to mature health care infrastructure in the 1980s. Then, in the 1990s, the psychiatric and the ÄDEL reforms transferred the responsibility and provision of care for a large proportion of patients from the inpatient hospital setting to the outpatient care setting and the municipalities (Anell et al, 2012).

Facilities are generally well maintained although the buildings in many cases are more than 20 years old. Currently, instead of fixing poorly maintained buildings, hospital buildings are being planned and built to meet changes in health care demands and structures in the provision of health care, such as more outpatient care and day care. In several cases, it would be more expensive to keep rebuilding and renovating existing buildings to meet the demands for new forms of care than to build new ones (Lövtrup, 2011).

In order to fund this new round of hospital construction, some regional and county level governments have turned to innovative funding arrangements that involve structured collaboration with several different types of non-public sector actors.

The largest ongoing investment is the building of a new Karolinska hospital in Stockholm, estimated at SEK 14.5 billion, which is scheduled to begin providing services in 2016. The project is financed through a public–private partnership between the Stockholm county council and the company Swedish Hospital Partners AB, owned by the Swedish construction company Skanska Infrastructure Development and the British investment fund Innisfree (Anell et. al. 2012). The project includes 800 beds, as well as a 100 bed patient hotel (Wikipedia, 2016).

A new children’s hospital is to be built in Goteborg, as part of the Queen Silvia’s Children’s Hospital which itself is part of Sahlgrenska University Hospital. The new facility will cost SEK 850 million, some of which has been raised from private foundations. The facility will be owned and operated by Vastfastigher, a separate publicly owned property management company, and is scheduled to open in 2020.

A third large hospital capital project is planned in Angelholm in Skane Region, for SEK 515 million provided by the Nordic Investment bank. Construction and ownership will be by a publicly owned property company Hälsostaden Ängelholm AB, established in 2010 as a joint venture between Sweden’s Region Skåne, the construction company PEAB and the real estate management company Wihlborgs Fastigheter AB. PEAB and Wihlborgs are Swedish publicly listed companies. All three partners have an equal share in the company. The company’s purpose is to develop and maintain healthcare facilities in cooperation with Region Skåne, the municipality of Ängelholm and other stakeholders (Nordic Investment Bank, 2015).

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6 Cross-country comparison

Institutional arrangements:

In eight of the nine countries covered in this review, most hospitals remain in the public sector. The exception is the Netherlands, where now all hospitals are by law private, non-profit entities (although the Ministry of Health can take them over if it believes it necessary). In the other countries, a higher share of non-public hospitals (either for-profit or not-for-profit) can be found in France and Germany, while in Denmark, England, Finland, Scotland and Sweden almost all hospitals are in the public sector.

This finding is in line with data captured in OECD Health Statistics on the percentage of hospital beds in hospitals that are publicly owned, private not-for-profit or private for-profit (Tables 3, 4 and 5). Keeping in mind that bed numbers are a poor indicator of hospital capacity (Rechel et al. 2010), the OECD data provide some approximation of hospital capacity by sector. In most OECD countries, most hospital beds are in the public sector, but there are major exceptions, such as Korea, Mexico and the United States.

Table 3 Percentage of beds in publicly owned hospitals, selected OECD countries, 2011-2014

	2011	2012	2013	2014
Australia	69.2%	68.4%		
Austria	70.4%	69.7%	69.5%	
Canada	99.1%	99.1%		
Chile	72.5%	76.2%	75.4%	
Czech Republic		82.2%	81.9%	
Denmark	94.0%		94.6%	
Estonia	89.3%	88.0%	91.5%	
Finland	95.1%	95.4%	95.8%	
France	62.4%	62.3%	62.2%	
Germany	40.6%	40.4%	40.7%	
Greece	68.5%			
Hungary	96.9%			
Iceland	100.0%	100.0%	100.0%	100.0%
Israel	71.0%	71.0%	70.6%	70.8%
Italy	68.4%	68.5%		
Japan	26.3%	26.3%	26.2%	
Korea	12.4%	11.7%	10.8%	
Mexico	76.0%	76.2%	76.8%	
New Zealand	83.7%	83.9%	83.7%	84.6%
Norway	79.0%	78.6%	77.6%	
Poland	73.2%			
Portugal	72.5%	72.0%	70.5%	
Slovenia	98.9%	98.9%	98.9%	
Spain	68.6%	69.1%	68.7%	
Turkey	81.6%	80.6%	79.6%	
United States	23.6%	23.1%		
Latvia	91.3%	91.1%	90.8%	
Lithuania	99.5%	99.0%	98.4%	

Source: Authors' calculation, based on: OECD 2016

Table 4 Percentage of beds in private not-for-profit hospitals, selected OECD countries, 2011-2014

	2011	2012	2013	2014
Australia	14.2%	14.4%		
Austria	17.8%	17.6%	17.5%	
Belgium	0.0%	0.0%	0.0%	0.0%
Canada	0.0%	0.0%		
Chile	0.0%	0.0%	0.0%	
Czech Republic		0.5%	0.4%	
Denmark	3.2%		3.3%	
Estonia	5.7%	7.0%	2.8%	
Finland	0.0%	0.0%	0.0%	
France	13.9%	13.6%	14.1%	
Germany	29.6%	29.6%	29.6%	
Greece	2.5%			
Hungary	2.9%			
Iceland	0.0%	0.0%	0.0%	0.0%
Israel	17.2%	17.3%	17.9%	17.8%
Italy	3.6%	3.9%		
Japan	0.0%	0.0%	0.0%	
Korea	87.6%	88.3%	89.2%	
Mexico	0.0%	0.0%	0.0%	
New Zealand	3.9%	4.1%	3.9%	3.6%
Norway	0.0%	0.0%	0.0%	
Poland	0.0%			
Portugal	19.9%	19.6%	19.8%	
Slovenia	0.0%	0.0%	0.0%	
Spain	13.0%	12.3%	12.5%	
Turkey	0.0%	0.0%	0.0%	
United States	60.7%	60.5%		
Latvia	0.0%	0.0%	0.0%	
Lithuania	0.0%	0.0%	0.0%	

Source: Authors' calculation, based on: OECD 2016

Table 5 Percentage of beds in private for-profit hospitals, selected OECD countries, 2011-2014

	2011	2012	2013	2014
Australia	16.6%	17.1%		
Austria	11.8%	12.6%	13.1%	
Canada	0.9%	0.9%		
Chile	27.5%	23.8%	24.6%	
Czech Republic		17.4%	17.7%	
Denmark	2.8%		2.1%	
Estonia	5.0%	5.1%	5.7%	
Finland	4.9%	4.6%	4.2%	
France	23.7%	24.1%	23.7%	
Germany	29.8%	30.0%	29.8%	
Greece	29.0%			
Hungary	0.3%			
Iceland	0.0%	0.0%	0.0%	0.0%
Israel	11.8%	11.7%	11.6%	11.4%
Italy	28.0%	27.6%		
Japan	0.0%	0.0%	0.0%	
Korea	0.0%	0.0%	0.0%	
Mexico	24.0%	23.8%	23.2%	
New Zealand	12.4%	12.1%	12.4%	11.7%

Norway	0.0%	0.0%	0.0%	
Poland	26.8%			
Portugal	7.6%	8.4%	9.7%	
Slovenia	1.1%	1.1%	1.1%	
Spain	18.4%	18.6%	18.8%	
Turkey	18.4%	19.4%	20.4%	
United States	15.8%	16.5%		
Latvia	8.7%	8.9%	9.2%	
Lithuania	0.5%	1.0%	1.6%	

Source: Authors' calculation, based on: OECD 2016

For those countries for which public ownership remains the predominant mode of hospital ownership, the public bodies that own public hospitals differ. At one end of the continuum is England, where most hospitals have taken on the form of self-governing foundation trusts. Italy and Spain have also introduced public hospital enterprises or foundations, but with a lesser degree of autonomy. In the other countries, it is either the local, regional or national administration that is the owner of public hospitals.

Table 6 Responsibility for capital investment and funding methods

Country	Level of investment responsibility	Investment method
Austria	Federal	Separate
Belgium	Federal/Regional	Separate
Bulgaria	Central	Separate
Cyprus	Central	separate
Czech Republic	Central	Mix (subsidies & service delivery funding)
Denmark	Regional	Separate
Estonia	Central	Service delivery funding
Finland	Local	Separate
France	Provider	Service delivery funding + programmes
Germany	Federal	Separate
Greece	Central	Separate
Hungary	Local	Separate
Ireland	Central	Separate
Italy	Regional	Separate
Latvia	Central or local	Separate
Lithuania	Local	Separate
Netherlands	Provider	Service delivery funding
Poland	Provider	Separate
Portugal	Central	Separate
Romania	Central	Separate
Slovakia	Regional	Service delivery funding
Slovenia	Central or local	Separate
Spain	Regional	Separate
Sweden	County or regional	Separate
Switzerland	Federal	Separate
England	Devolved to hospital trusts	Government spending and PFI

Source: adapted from (van Ginecken 2016)

Depending on the administrative organization of the health system, capital investment and the planning of hospital infrastructure can be a responsibility of the central, federal, regional or local

governments (Table 6). However, in some cases the responsibility has been shifted to the level of individual hospitals. In the countries covered by this review, the latter has been the case in England and the Netherlands. Both, in line with their emphasis on an internal market and managed competition, have abandoned a centralized planning process for capital investment or the distribution of hospital facilities. Hospitals in these countries are now (in theory) free to make their own investment decisions, although in practice the governments would still step in, in case of major difficulties. The situation is very different in Scotland, which has retained centralized planning of capital investment for large infrastructure projects.

In Denmark, France, Italy and Spain, responsibility for the planning of hospital infrastructure and for capital investment rests with the regional governments, while in Sweden the county councils are responsible for capital investments. In Finland, 20 hospital districts have been set up, consisting of 6-58 municipalities; hospital districts are charged with organizing and providing hospital services to their member municipalities. This means that in a number of European countries the sub-national or regional level has a substantial role in overseeing or shaping capital investment, often due to broader processes of administrative decentralization or (in the Nordic countries) traditions of local democracy. However, the parallel trend of increasing the autonomy of public hospitals or even outright privatisation, and the increasing use of internal markets run counter to this oversight function.

In those countries where key decisions regarding investments are still taken by public bodies, it is usually the elected political authorities at the relevant administrative level that are ultimately in charge, with varying involvement of the national level.

Accountability arrangements:

In most of the countries covered by this review (except England and the Netherlands), intermediary levels of hospital governance are in place, between the national level and the public hospitals (Table 7). Where public hospitals are owned by regional (Denmark, France) or local (Italy) levels of administration, they are under direct managerial control of the respective health authorities and levels of government. In Finland, hospital districts do not correspond to regional-level administrations; they are governed by a hospital district council. In Italy, some regions have started to organize their local health authorities and hospital trusts (as well as the private providers that are being commissioned) across sub-regional zones, which are intermediate levels between the region and the local health authority. In Scotland, public hospitals are overseen by territorial and non-territorial NHS boards.

Table 7 Intermediary hospital governance levels

	Intermediary hospital governance level
Denmark	5 regional hospital administrations
England	n.a., instead self-governing foundation trusts
Finland	20 hospital districts (each comprising 6-58 municipalities)
France	Regional health agency (agence régionale de santé)
Italy	Local health authorities (Aziende Sanitarie Locali) within each region; there are also sub-regional zones (area vasta or wide area) in some regions
Netherlands	n.a., instead private, not-for-profit hospitals
Scotland	14 territorial NHS boards
Spain	17 regional health ministries
Sweden	17 county councils and 4 regional bodies

The accountability arrangements for hospitals in the countries covered in this review differ according to the institutional arrangements in place, in particular the degree of decision-making autonomy at institutional level and whether there has been a move towards an internal market and managed competition. Examples for public hospitals that only have “restricted autonomy” include several of Spain’s four models, in particular the public healthcare company, in which the hospital Board of Supervisors includes a representative of the regional government’s Ministry of Health and of its Ministry of Finance, each with veto power. Spain’s Consortia model, however, falls under the category of “considerable autonomy”, as do the hospital trusts in England. Similarly, in Italy public hospital enterprises provide services on the basis of a purchaser-provider split in a quasi-market system with defined tariffs (DRGs), with the ASLs as purchasers of services. Private hospitals are accredited by the regions, which set the accreditation criteria and enter into contracts with them. Models that have “maximum autonomy” include the Foundation Trusts in England and the private, non-profit making hospitals in the Netherlands. Where public hospitals have a greater degree of autonomy, such as in England or the Netherlands, there is an increasing role for governance through accreditation, contracts and public reporting of patient outcomes and satisfaction. Notwithstanding these differences, in most countries there is growing emphasis and regulation of the quality of care, as well as a trend towards the public reporting of quality indicators.

Financial arrangements for capital investment:

As ownership of hospitals remains mostly public, government at some level usually also holds responsibility for the financing of capital investments. Funding for capital investment is covered either as part of the remuneration for service delivery or, more commonly in Europe, through a separate stream of funding (Table 6).

In several countries covered in this review, funding from national or regional governments remains the main source of capital investment. This applies to Denmark, Finland, France, Italy, Scotland and Sweden. There has also been an increasing use of project finance in public-private partnerships. The pioneer in this was England with its Private Finance Initiative, in which the private sector agrees to finance, design, build and maintain a hospital, in return for a periodic fee paid by a public authority. This model, although not uncontroversial, has been exported to several other European countries, including Italy, Spain and Sweden (most importantly, in the new Karolinska hospital). In the Netherlands, the hospitals need to attract external capital resources too.

There has been a noticeable impact of the economic crisis on both levels and approaches to capital investment. In Italy, capital investment has decreased and some capital investment projects have been halted. In 2012 the central government approved a reduction in capital investment of €1 billion. In England, on the other hand, limitations of traditional PFI finance have led to the launch of “PF2”, with greater involvement of the public sector.

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7 Key lessons

This review of institutional and accountability arrangements, as well as processes for financing capital investment, has shown the major variety in approaches that exist across Europe, as well some common trends. There is a growing importance of the private sector in the provision of hospital care in a number of countries, but overall, the public sector remains the predominant owner of hospitals in the countries covered, with the notable exception of the Netherlands.

Various forms of decentralized hospital governance have emerged, sometimes on the basis of existing administrative levels and process of decentralization (such as in Italy or Spain), but sometimes giving rise to new sub-national structures that go beyond existing structures (such as in Finland or Italy). England and the Netherlands have gone further than others in abolishing centralized systems for planning capital investments in hospitals, but have so far refrained from letting hospitals go bankrupt.

A growing emphasis on quality improvement programmes, the accreditation of providers and the public reporting of patient outcomes and satisfaction is a common trend across countries, which can be expected to become even more important in the future. This is particularly salient in the context of regulated competition in some countries, giving rise to ongoing political controversies.

A key question will be whether new models of governing public hospitals will be sustainable or whether they will slide back into more direct political or public sector control. This partly depends on how well policy-makers can define the organizational dimensions and boundaries of new public hospitals or quasi-markets. Yet, the advantages or disadvantages of different governance models in terms of clinical, managerial or financial outcomes and performance are still far from clear and will require more in-depth research. What can be concluded is that countries should be cautious in copying others when pursuing reforms, as these will need to be tailored to the country-specific challenges and institutional characteristics.

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