

POLICY BRIEF 28

What is the experience of decentralized hospital governance in Europe?

10 case studies from Western Europe on institutional and accountability arrangements

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This policy brief is one of a new series to meet the needs of policy-makers and health system managers. The aim is to develop key messages to support evidence-informed policy-making and the editors will continue to strengthen the series by working with authors to improve the consideration given to policy options and implementation.

What is a Policy Brief?

A policy brief is a short publication specifically designed to provide policy makers with evidence on a policy question or priority. Policy briefs

- Bring together existing evidence and present it in an accessible format
- Use systematic methods and make these transparent so that users can have confidence in the material
- Tailor the way evidence is identified and synthesised to reflect the nature of the policy question and the evidence available
- Are underpinned by a formal and rigorous open peer review process to ensure the independence of the evidence presented.

Each brief has a one page key messages section; a two page executive summary giving a succinct overview of the findings; and a 20 page review setting out the evidence. The idea is to provide instant access to key information and additional detail for those involved in drafting, informing or advising on the policy issue.

Policy briefs provide evidence for policy-makers not policy advice. They do not seek to explain or advocate a policy position but to set out clearly what is known about it. They may outline the evidence on different prospective policy options and on implementation issues, but they do not promote a particular option or act as a manual for implementation.

What is the experience of decentralized hospital governance in Europe?

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Acronyms

AO	<i>aziende ospedaliere</i>
ARH	<i>agences régionales d'hospitalisation</i>
ARS	regional health agency
ASL	<i>azienda sanitaria locale</i>
CA	<i>comunidades autónomas</i>
CMA	Competition and Markets Authority
DDKM	Danish Healthcare Quality Programme
DRG	diagnosis-related group
ESPIC	<i>établissements de santé privés d'intérêt collectif</i>
EU	European Union
GDP	gross domestic product
GHT	<i>groupements hospitalier de territoire</i>
GP	general practitioner
HAS	<i>Haute Autorité de Santé</i>
NHS	National Health Service
OECD	Organisation for Economic Co-operation and Development
PFI	Private Finance Initiative
UNCAM	<i>Union Nationale des Caisses d'Assurance Maladie</i>

Boxes and tables

Box 1: The three levels of hospital governance

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How do Policy Briefs bring the evidence together?

There is no one single way of collecting evidence to inform policy-making. Different approaches are appropriate for different policy issues, so the Observatory briefs draw on a mix of methodologies (see Figure A) and explain transparently the different methods used and how these have been combined. This allows users to understand the nature and limits of the evidence.

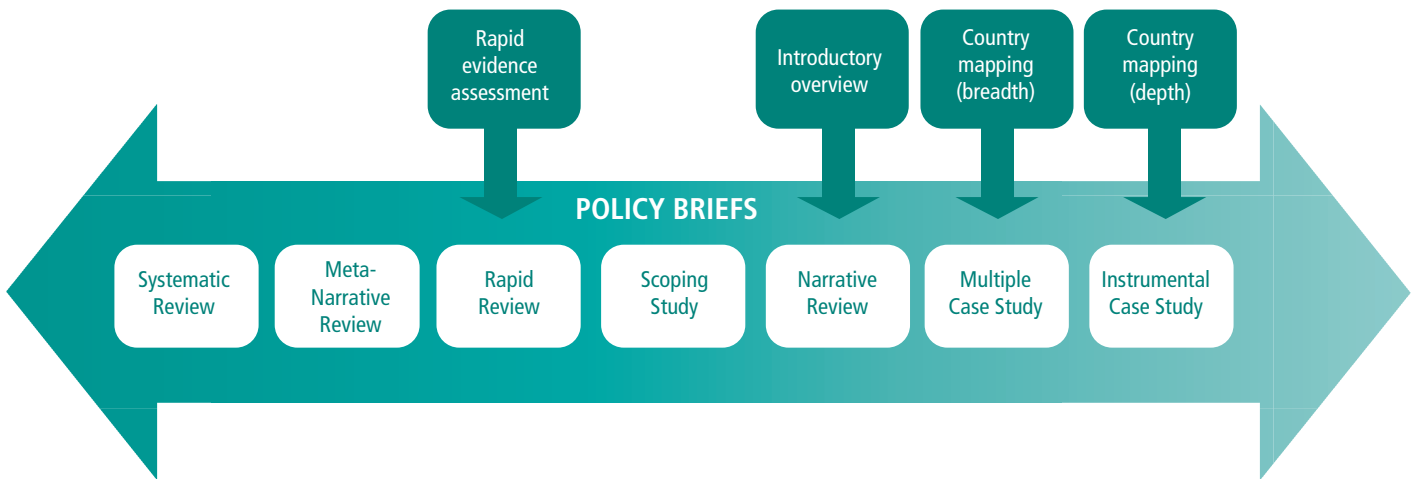
There are two main ‘categories’ of briefs that can be distinguished by method and further ‘sub-sets’ of briefs that can be mapped along a spectrum:

- **A rapid evidence assessment:** This is a targeted review of the available literature and requires authors to define key terms, set out explicit search strategies and be clear about what is excluded.

- **Comparative country mapping:** These use a case study approach and combine document reviews and consultation with appropriate technical and country experts. These fall into two groups depending on whether they prioritize depth or breadth.
- **Introductory overview:** These briefs have a different objective to the rapid evidence assessments but use a similar methodological approach. Literature is targeted and reviewed with the aim of explaining a subject to ‘beginners’.

Most briefs, however, will draw upon a mix of methods and it is for this reason that a ‘methods’ box is included in the introduction to each brief, signalling transparently that methods are explicit, robust and replicable and showing how they are appropriate to the policy question.

Figure A: The policy brief spectrum



Source: Erica Richardson

Key terms

- **Governance** in the health sector refers to a wide range of steering and rule-making related functions carried out by governments or other decision-makers as they seek to achieve health policy objectives. It is a political process that involves balancing competing influences and demands.
- **Decentralization** is the transfer of formal responsibility and power to make decisions regarding the management, production, distribution and/or financing of health services, to geographically or organizationally separate actors. The reverse trend is **centralization** or **recentralization** depending on historical context.
- **Hospital autonomy** is when hospitals in the public or private sectors have the authority to make planning and investment decisions (which are often more typically government functions) are made independently.

Key messages

- The political pressure to change how hospital governance is currently organized comes from a mix of sources, including increasing costs, technological advances, changing patterns of disease, and growing patient expectations.
- This pressure to reform has prompted a review of hospital ownership and a drive, in many countries, to decentralize hospital governance.
- The key trends in decentralizing hospital governance, which may not be compatible with each other, include increasing hospital autonomy and more direct managerial control of hospitals; and decentralization to newly created administrative layers in the health system:
 - Hospitals with greater autonomy are perceived to be more flexible in meeting the needs of the local population and, thanks to active purchasing, more efficient performers.
 - Decentralizing hospital governance to allow decision making at the local level is seen as a way of promoting responsiveness to communities and to changing patterns of disease; it is also a means of moving responsibility for funding or adopting technological advances away from central government.
- Despite these apparent merits of decentralized hospital governance, there is an explicit need to:
 - acknowledge the tension between potential efficiency gains from centralization and the potential to improve responsiveness and flexibility with greater decentralization.
 - address investment decisions (e.g. strategic planning of hospital infrastructure) to ensure geographical equity and efficiency and to balance this with the 'narrower focus' decision making in a locally run system.
- There are good examples of authorities in systems with decentralized hospital governance collaborating to overcome equity and efficiency concerns, but the specific institutional and political contexts make it difficult to transfer successful models from one country to another.
- More broadly, unless this is supported by the existing country context, policy-makers will struggle to achieve the desired degree of decentralization in hospital governance.

Executive summary

Hospitals face many challenges in adapting to their changing environment. Hospitals are operating under greater cost pressures as technological changes push up the cost of providing care, while the shifting disease burden in Europe pushes up demand; this has also been accompanied by growing patient expectations. Public authorities have faced political pressure to restructure traditional governance models in hospitals so that they can adapt to the changing environment and better meet the needs of patients.

A response to these challenges has been decentralizing hospital governance and giving hospitals greater autonomy. In centralized systems, the nominal key drivers of decentralization policies are to improve health system performance and/or strengthen local democracy. The theory is that autonomous hospitals are more flexible in meeting the needs of the local population and become more efficient performers, because it allows for active purchasing. The public/private ownership and legal form of the hospitals determines which policy options may be available.

England and the Netherlands have abolished centralized planning bodies for capital investments in hospitals without embracing devolved forms of hospital governance, instead shifting the responsibility for planning to the level of individual hospitals by making them autonomous. Both have embraced the concept of regulated competition, but at the same time have intervened where necessary to prevent hospitals from going bankrupt, highlighting a continued need for government involvement.

Another response has been to create new intermediate administrative layers for planning and capital investment. The involvement of local or regional governments is generally related to the broader governance framework for the health system and the country as a whole, with intermediate actors emerging on the basis of exiting decentralized administrative levels, such as in Germany, France and Spain. However, in Italy and Finland, there has been a consolidation across territories, with local or regional bodies collaborating to coordinate investment and planning for services.

There are many forms of decentralized hospital governance. In this brief, we examine institutional and accountability arrangements in 10 European countries: Denmark, England, Finland, France, Germany, Italy, Netherlands, Scotland, Spain and Sweden. There are two basic types of decentralized system. Many countries in Europe already have decentralized health systems where hospital governance is the responsibility of subnational bodies. This is the result of long-standing historical processes rather than explicit policy-making. In other countries, health systems have been actively decentralized, either as part of wider political changes or as part of a specific package of reforms.

The amount of leverage policy-makers have depends on both the institutional and accountability arrangements. In reality, there is very little room for manoeuvre in health systems, as the degree of decentralization is essentially context specific. Pressure comes from wanting to be responsive to local needs and to increased marketization of the system etc., but decentralization alone will not resolve these tensions. There is an inherent tension between having a locally run, person-centred system and ensuring equity between subnational units. There is also a trade-off between the potential efficiency gains from matching local preference and achieving greater efficiency through economies of scale.

It is simply not possible to transfer the experience of one country to another because the context is crucial. The different institutional arrangements in different countries, as well as the values which underpin them, inevitably shape the outcomes that can be achieved from decentralization policies.

Policy brief

Introduction

Context: Why is decentralized hospital governance important for policy-makers?

Hospitals in Europe face many challenges, including cost pressures, technological changes, an evolving burden of disease, growing patient expectations, political pressure on public authorities to restructure traditional governance models and, in some countries, increasing competition from the private sector [1]. Hospital governance has received particular attention, reflecting the growing number of political, financial and technical, as well as social and professional, factors that affect decision-making in the hospital sector. Reforms have introduced different models of hospital governance in different European countries [2].

This policy brief provides an overview of 10 case studies from Western Europe on macro-level arrangements in hospital governance – the structural, organizational and operational architecture of the health system. The aim is to compare the experience of decentralized hospital governance to inform policy-making as there have been concerns about the trade-offs involved.

The concept of **hospital governance** represents a relatively new approach to hospital-related policy and health policy analysis. Its emergence since the early 2000s reflects the growing number of political, financial and technical, as well as social and professional, factors that affect hospital sector decision-making. Reforms have introduced different models of hospital governance in different European countries [3]. Hospital governance conceptually encompasses three increasingly blurred levels of hospital-related decision-making, in the context of each health system (Box 1). The main "entry point" for this policy brief is the macro-level, mostly government-based, aspect of governance rather than the day-to-day operational management of the micro-level or institutional decision-making at the meso-level (Box 1). One of the key processes has been an increasing decentralization of the macro-governance of public hospitals, and the role of the private sector has also increased in many countries. Among public hospitals, there has been a move away from centralized political control towards the introduction of greater institutional autonomy and the use of market incentives [3]. There has also been a trend towards hospital consolidation, driven by concerns over efficiency and quality of care, with the closure of smaller facilities and implications for the ways in which hospitals are being governed [4].

Box 1: The three levels of hospital governance

1) **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.).

- 2) **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.
- 3) **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 subregional policy-making that establishes the structural, organizational and operational architecture of the hospital sector.

Source: [3]

Many countries in Europe have decentralized health systems, where hospital governance is the responsibility of subnational bodies. Some of these systems have evolved in a decentralized way, so this is the result of long-standing historical processes rather than explicit policy-making. In other countries, health systems have been actively decentralized, either as part of wider political changes or as part of a specific package of reforms (Box 2).

Box 2: What is decentralization?

Decentralization is the transfer of formal responsibility and power to make decisions regarding the management, production, distribution and/or financing of health services, usually from a smaller to a larger number of geographically or organizationally separate actors [5]. The reverse trend is centralization or recentralization, depending on historical context.

There are four basic types of decentralization:

Deconcentration: passing some administrative authority from central government offices to the local offices of central government ministries.

Devolution: passing accountability and a degree of independence to regional or local government, with or without financial responsibility (i.e. the ability to raise and spend revenues).

Delegation: passing responsibilities to local offices or organizations outside the structure of central government, such as arm's-length bodies, but with central government retaining indirect control.

Autonomization: transfer of government functions to independent organizations in the public or private sectors.

Source: adapted from [5,6].

Subnational bodies can be responsible for hospitals serving millions of people or just a few hundred and these bodies can be almost independent decision-makers or there simply to administer paper processes from the national level [5]. Such subnational bodies can also be public, private not-for-profit or profit-making companies, and they can be political entities (run according to democratic rules), administrative entities (run according to managerial precepts) or fiscal entities (run primarily as financial bodies) [5].

Decentralization has had a lot of intuitive appeal to policy-makers as an answer to many of the most pressing policy issues they face in the health sector. In centralized systems,

the three key drivers of decentralization policies are: performance-related (i.e. refining a malleable system to improve efficiency); legitimacy-related (i.e. strengthening local democracy by reducing central bureaucracy); self-interest related (i.e. creating the opportunity for individuals to build their powerbase in the system) [5].

However, the available evidence on whether subnational bodies are more or less efficient, or more flexible in meeting the specific needs of local populations, is equivocal at best [5]. The diversity of decentralization in European health systems means there is no agreed definition that could be used to measure it, so the evidence on outcomes is “messy” [5]. Context matters, where the “context” is the different institutional arrangements and values that underpin them. This inevitably shapes the outcomes that can be achieved. There is an inherent tension between having a locally run system and ensuring equity between subnational units. There is also a trade-off between the potential efficiency gains from matching local preference and achieving greater efficiency economies of scale. This tension between responsiveness and economies of scale means that many decentralized countries are now in the process of recentralizing aspects of their health system in response to rising costs of new health technologies and to address inequities between regions. Governance mechanisms also confront numerous challenges in decentralized systems [5].

Hospital governance in Europe is thus characterized by the simultaneous involvement of different actors and levels, including the national government, regional authorities and the hospitals themselves, and involves both the public and private sectors [7].

The brief: What does this policy brief address?

This policy brief explores the experience with decentralized forms of hospital governance in Europe. It is based on 10 case studies of institutional and accountability arrangements in Western European countries (see Appendix 2) – Denmark, England, Finland, France, Germany, Italy, Netherlands, Scotland, Spain and Sweden (Box 3). This brief provides an overview, which pulls together the themes that emerged from these case studies.

Specifically, the brief explores:

- ownership and legal form of hospitals (private or public, organized as a trust, for-profit or not-for-profit, etc.)
- strategic planning of hospital infrastructure and capital investment at the national, regional or subregional government level
- degree of decentralization of hospital governance (hospital governance layers between the Ministry of Health and the hospitals; political representation versus administrative responsibility; extent of direct managerial control by higher administrative structures).

Box 3: Methods

This policy brief is a rapid review of the evidence on decentralized hospital governance in 10 European countries: Denmark, England, Finland, France, Germany, Italy, Netherlands, Scotland, Spain and Sweden. Seven of the countries (Denmark, Finland, France, Germany, Italy, Spain, Sweden) were selected on the basis of having some forms of devolved hospital governance, and the remaining three countries (England, Netherlands, Scotland) were selected as comparators to ensure a broad spectrum of hospital governance models was included.

The policy brief is based on a review of published academic and grey literature, as well as government and Ministry of Health websites. We reviewed relevant country profiles of the Observatory's Health Systems in Transition (HiT) series, and searched Medline and Google using the search term “hospital governance” in combination with the names of the countries. We also consulted official websites in the respective countries, where our language skills allowed us to do so (England, France, Germany, Scotland, Spain). Finally, we reviewed OECD statistics on hospital ownership

Limitations

This review covered the experience of decentralized hospital governance in 10 countries of Europe, but a wider sample including other countries in Europe might have identified other trends more specific to the circumstances in these countries. The information was also compiled as part of a rapid response in 2016 and, as such, may not cover every detail of hospital governance in the 10 countries selected.

The evidence

Overview

All of the countries reviewed here have a similar commitment to providing universal and reasonably equitable access to health care for their populations, but do so in different ways. They differ markedly in the way their health systems are set up, governed and financed, including countries where the health systems are primarily financed through taxation (Denmark, England, Finland, Italy, Scotland, Spain, Sweden) and countries that primarily finance their health systems through statutory social health insurance (France, Germany, Netherlands). The countries also vary with regard to health system governance structures, with England and France tending to concentrate governance functions at the central (national) level, while delegating some functions to bodies at arm's length from government.

In the other countries, administrative and political responsibility for health care provision is partly or fully devolved to local or regional authorities (Denmark, Finland, Italy, Spain, Sweden) or federal states (Germany). In Germany and the Netherlands, corporate actors (e.g. health insurance bodies or health care providers) also play an important role. From the countries reviewed, there is no clear link between the way in which a health system is funded or organized and the way in which hospitals are governed.

Countries differ also in terms of their geography, population size and political context, all of which may be conducive to more centralized or decentralized forms of health system

and hospital governance. Not surprisingly, the countries' hospital systems also differ vastly in terms of their size, number of hospitals and hospital beds, and the financing of capital investment and recurrent expenditure. The principal features of the hospital systems in the 10 countries are described in Appendix 1.

Ownership and legal form of hospitals

Two crucial issues for (decentralized) hospital governance are the predominant forms of hospital ownership and, where hospitals are mainly in the public sector, how much autonomy public hospitals have. In eight of the 10 countries covered in this brief, most hospitals and hospital beds remain in the public sector. The exceptions are the Netherlands, where all hospitals are by law private,

not-for-profit entities (although the Ministry of Health can take them over if it believes this to be necessary), and Germany, where private for-profit and private not-for-profit hospitals each account for about 30% of acute hospital beds [8]. In the other eight countries, a higher share of non-public hospitals (either for-profit or not-for-profit) can be found in France (accounting for about 28% of hospital beds), while in Denmark, England, Finland, Scotland and Sweden almost all hospitals are in the public sector [8]. Table 1 presents recent data on the percentage of hospital beds in hospitals that are publicly owned, private not-for-profit or private for-profit. Although bed numbers are a poor indicator of hospital capacity [9] these data nevertheless provide some approximation of hospital ownership.

Table 1: Percentage of beds in publicly owned hospitals, private not-for-profit hospitals and private for-profit hospitals (latest available year)

	Publicly owned hospitals (%)	Private not-for-profit hospitals (%)	Private for-profit hospitals (%)
Denmark (2016)	93.6	4.2	2.2
Finland (2015)	94.5	0.0	5.5
France (2015)	62.0	14.1	23.9
Germany (2015)	40.8	29.1	30.1
Italy (2015)	67.6	3.9	28.5
Netherlands (2013)	0	100	0
Spain (2015)	68.7	12.1	19.2

Source: Authors' calculation, based on [8].

Note: No data available in OECD Health Statistics for hospital beds by sector in England, Scotland and Sweden.

In those countries for which public ownership remains the predominant model, the public bodies that own the hospitals vary in the degree of autonomy they are afforded. Among the 10 countries, England is at one end of the continuum, with most hospitals having taken the form of self-governing foundation trusts (see Appendix 2: Country reports). Italy and Spain have also introduced public hospital enterprises or foundations, but with less autonomy. In the other countries (Denmark, Finland, France, Germany,

Scotland, Sweden), it is either the local, regional or national administration that owns public hospitals, with varying degrees of direct political control in hospital management boards (Table 2). The ownership and legal form of hospitals shapes the degree and nature of decentralized hospital governance and this determines which policy options may be available.

Table 2: Ownership, management and planning of public hospitals in 10 countries

	Ownership	Management	Responsibility for planning and capital investment
Denmark	Regional governments	Hospital boards, consisting of medical, nursing and administrative directors	5 regional governments
England	Hospital trusts	Independent hospital trusts managed by a board of directors	No formal agency for planning hospital infrastructure and capital investment
Finland	Municipalities	Executive board elected by the respective hospital district council	20 hospital districts, consisting of federations of municipalities
France	Local or national administration	Hospital boards, mostly consisting of selected experts	17 regional health agencies
Germany	Municipalities, states, districts or regions have a majority of shares or board members	Hospital boards, consisting of professionals and elected representatives	Governments of 16 federal states, with participation of regional health insurance funds and hospital providers
Italy	Local health authorities or independent public hospital enterprises	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 are quasi-independent public agencies	20 regional governments
Netherlands	Private not-for-profit	Hospital board and Chief Executive Officer	No formal agency for planning hospital infrastructure and capital investment
Scotland	Mostly Scottish national health service (NHS)	NHS boards, comprising a non-executive chair, non-executive directors, and around six executive directors	14 geographically based NHS boards and 7 non-geographically based National Special Health Boards
Spain	a) regional governments b) not-for-profit foundations c) consortia d) administrative concessions	a) and b) Hospital board, composed of officials especially from the health sector and policy-makers from the region c) Governing body, with equal representation of public and private entities forming the consortium d) Board of directors, composed of company representatives, plus a representative of the health administration (with voice but without vote)	17 regional governments
Sweden	Mostly county councils	Hospital boards are appointed by the respective county council and under their direct political control	17 county councils and 4 regional bodies

Strategic planning of hospital infrastructure and capital investment

The strategic planning of hospital infrastructure and capital investment is a crucial lever in most European countries for ensuring an appropriate number and capacity of hospitals. Most countries have arrangements in place to plan the number and kind of hospitals that provide publicly funded care, be it in the public or private sector. This applies in particular to capital investment in new hospital facilities. However, arrangements for planning hospital infrastructure and capital investment differ widely. Depending on the administrative organization of the health system, the planning of hospital infrastructure happens at the central, federal, regional or local government levels (Table 2).

In Denmark, Germany, 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 (Table 2). In Italy, some regions have started to organize their local health authorities and hospital trusts (as well as the private providers that are commissioned) across subregional zones. In Finland, 20 hospital districts, consisting of 6–58 municipalities, organize and provide hospital services to their member municipalities. In France, the country's 17 regional health agencies are independent of regional governments. They collaborate with the central level in planning and overseeing major new investment projects in the hospital sector (Box 4).

Box 4: Capital investment and hospital planning in France

The regional health agencies in France are responsible for planning services, authorizing hospitals and for changes to the existing hospital infrastructure, including through restructuring and mergers. They also oversee capital investment and the purchase of major medical equipment in public hospitals. However, the construction of new hospitals (either public or private) has to be authorized by the Ministry of Health [10].

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. The 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 selected projects proposed by public and private hospitals. The plan was entirely funded by statutory health insurance, but involved public–private partnerships. The 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 [10].

Box 5: Hospital districts in Finland

Most hospital care in Finland is provided by public hospitals operated by hospital districts. Currently, the country is divided into 20 hospital districts (excluding the Åland Islands). Each one of the 311 municipalities must be a member of one hospital district and the number of municipalities per hospital district varies from 6 to 58.

The hospital districts organize and provide specialist medical services for the population of their member municipalities. 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 50 000 to 1.2 million inhabitants.

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 resident population and a corresponding voting share, although one municipality cannot control more than one fifth of all votes.

Although this devolved system means local communities have a strong say in decision-making about their health and social care services, there are concerns about fragmentation and duplication in the system. Reforms proposed in 2016 and 2017 sought to establish a new administrative tier of 18 autonomous counties responsible for a wide range of public services in addition to health and social care. This would include the transfer of personnel and resources from the municipal organizations to the autonomous counties and the centralization of financing for public health and social services from the municipalities to the state [11, 12].

The involvement of the subnational level is generally related to the broader governance framework for the health system and the country as a whole, with federal or decentralized governance structures in the majority of these countries, coupled in the Nordic countries with strong traditions of local democracy (Box 5). 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 of making decisions, with a varying degree of involvement at the national level. However, in some European countries, the responsibility for capital investment and hospital capacity has – at least theoretically – been shifted to the level of individual hospitals. This has been the case in England and the Netherlands. In line with these countries' emphasis on an internal market and managed competition, both have abandoned an explicit centralized planning process for the distribution of hospital facilities. Hospitals in these countries are now (in theory) free to make their own investment decisions as they are not explicitly planned, although in practice the governments still intervene in case of major difficulties (Box 6). Furthermore, in England, by setting budgets and the regulatory framework for investment, the central government still determines to a large extent the overall levels and pattern of investment, while in the Netherlands new hospital developments still require government approval. In both countries, hospitals also operate within a national framework of accreditation and quality control, which all hospitals

have to meet. Although there is a growing emphasis on and regulation of the quality of care, as well as a trend towards the public reporting of quality indicators, in most of the countries covered, it is clear that with autonomization the government still needs to lead on the regulation of hospitals.

Box 6: The limits on hospital autonomy in the Netherlands

In the Netherlands, the Dutch Health Care Authority 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 Dutch Health Care Authority sets the prices for 30% of diagnosis–treatment combinations (the Diagnosis Treatment Combination Maintenance Organization, or *DBC-Onderhoud*, responsible for independently designing, constructing and maintaining the diagnosis–treatment combination system, was integrated into it in May 2015). 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 the macro-budget. In 2008, for example, the Minister overruled the Authority's decision that a certain hospital did not qualify for financial support, arguing that the "bankruptcy of the hospital would jeopardize continuity of care". Since then, however, the Minister has argued that such requests should be handled by insurers and the Authority, and has displayed more restraint regarding financial support [13].

Degree of decentralization of hospital governance

In addition to planning hospital infrastructure and capital investment, public authorities in most European countries also play a role in the broader management of hospitals, steering hospital activities and volumes. This includes direct managerial control in some of the health systems where hospitals are publicly owned and managed, as well as the negotiation of contracts and volumes with private or public hospitals in countries where there is a clear split between providers and purchasers.

The role of public authorities also varies in line with the degree of administrative decentralization. Where public hospitals are owned by regional (Denmark) or local (Italy) levels of administration, they are under direct managerial control of the respective health authorities and levels of government. At the same time, 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 subregional zones, which are intermediate levels between the region and the local health authority (Box 7). In Finland, hospital districts do not correspond to regional-level administrations; they are governed by a hospital district council. However, examples of intermediary levels of hospital governance between the national level and the hospitals can also be found in countries with more centralized governance structures, such as France and Scotland.

Box 7: Subregional zones in Italy

The subregional zones in Italy (area vasta, or wide area) are intermediate levels between the region and the local health authority, created to achieve greater economies of scale [14]. They have subsequently become the territorial level for all regional strategic planning, including waste management, public transport and natural resources [15]. In Tuscany, for example, three zones were created that were deemed to be the minimum operational units for the effective planning of health services. Most health care needs of patients should be met in their respective zone. Zones within a region are linked through networks [15]. Many large local health authorities that manage several hospitals have also introduced clinical directorates across hospitals to regroup units and professionals as required [14].

Two key dimensions of decentralized hospital governance can be distinguished: the administrative level involved (which can be the national, regional, municipal or facility level) and the degree of decision-making autonomy at the institutional level (which can range from being in the public sector with little institutional autonomy to being in the private sector with full institutional autonomy). Governance mechanisms and the degree of influence of public authorities will vary according to both dimensions.

Three main levels of institutional autonomy can be distinguished as ideal types:

- **Restricted autonomy:** In this model, providers tend to be firmly in the public sector and have little scope for decision-making over which services to offer. They cannot generate revenues or reinvest them into their organization.
- **Moderate autonomy:** In this model, hospitals in the public sector have taken on an independent legal form, can make decisions on the scope of services offered and may be able to generate and reinvest surpluses.
- **Maximum autonomy:** In this model, hospitals are either fully privately owned or are still in the public sector, but without direct accountability to or management by higher levels of the public administration. Hospitals are free to generate profit and to make decisions on capital investment, within certain regulatory boundaries.

Among the countries reviewed here, these arrangements differ not only between but also within countries. In Spain, for example, four different types of hospital can be distinguished, which vary according to ownership and institutional autonomy (Box 8). In the country's public health care companies, the hospital's Board of Supervisors includes a representative of the regional government's Ministry of Health and of its Ministry of Finance, each with veto power, restricting the decision-making autonomy of the hospital. In Spain's consortia model, however, hospitals are allowed, within limits, to generate revenues and reinvest surpluses. This model corresponds to the ideal type of moderate autonomy [16]. The same applies to 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. 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, not-for-profit hospitals in the Netherlands.

Box 8: Hospital types in Spain

Beginning in the 1980s, there have been changes to the ownership of public hospitals in Spain to facilitate prospective contracting for services by creating a purchaser–provider split. This has enhanced flexibility in the system and enabled performance assessment to become central to the efficient running of the system. After adjustments, four types of hospital with increased autonomy 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 not-for-profit foundations, then consortia and finally administrative concessions [17]:

- a. Public health care companies (*empresas públicas sanitarias, EPS*) are publicly owned 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 a salary).
- b. Not-for-profit foundations (*fundaciones*) are not-for-profit entities under private law, explicitly created to meet a particular social need with public, private or mixed funding capital. They are staffed with non-statutory health professionals, have great capacity to define 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 legal entities resulting from merging resources from more than one public authority, plus sometimes private not-for-profit entities with non-statutory employees/civil servants as staff. Managers typically enjoy autonomy to rent or buy equipment and to decide on the basket of services to offer.
- d. In administrative concessions (*concesiones administrativas*), a private concession (often a joint-venture type of trading company between private health insurers, health groups, building societies or banks) wins the tender to build and manage a hospital, including the provision of clinical and non-clinical services, usually with non-statutory staff, such as the Hospital de la Ribera in Alzira, Valencia.

There is a desire in some countries to decentralize hospital governance in order to address different policy pressures, but it is not necessarily an adequate solution. In reality, there is very little room for manoeuvre in health systems as the degree of decentralization is essentially context specific. Pressure comes from wanting to be responsive to local needs and to increased marketization of the system etc., but decentralization alone will not resolve these tensions.

Countries decentralize hospital governance to [5]:

- improve technical efficiency through the introduction of a purchaser–provider split
- improve allocative efficiency through greater responsiveness to local needs
- drive innovation through local experimentation
- empower local government by giving it more to do
- improve quality through better access and greater integration
- increase equity through the redistribution of resources.

However, the absolute and relative size of government units shapes decentralization, along with the size and density of population, country size and homogeneity of population [5]. Therefore, in population catchment area terms, what might be considered to be decentralized in one country might be viewed as centralized in another. There is no correlation between country size and the average size of its administrative subunits.

In those countries in which public hospitals are owned by regional (Denmark) or local (Italy) levels of administration, they are under the direct managerial control of the respective health authorities and levels of government. Where the private sector plays a more important role, or where public hospitals have a greater degree of autonomy, hospital governance is more indirect and takes the form of hospital plans, accreditation of providers and quality improvement programmes. In both contexts, there is scope for decentralized forms of hospital governance to emerge. However, so far, devolved forms of hospital governance have only emerged in those countries where hospitals in both the public and private sectors do not have full institutional autonomy. This indicates that the degree of decision-making autonomy at the institutional level is of major relevance to the forms of hospital governance that are being pursued.

Policy implications

The administrative level responsible for governance and strategic planning of hospital activities, capacity and investment, as well as the degree of decision-making autonomy and ownership at the institutional level, determine the available options for decentralized hospital governance. The national, regional, municipal or facility level may be responsible, and institutional autonomy can range from being in the public sector and limited to being comprehensive in the private sector. Governance mechanisms available to policy-makers and the degree of influence they have will vary in line with both dimensions. This means that, while there are in theory a range of policy options, not all of these will be available in a given context.

Two crucial issues at the macro-level are the predominant forms of hospital ownership and, where hospitals are mainly in the public sector, how much autonomy public hospitals have. Overall, the governance of hospitals tends to be more straightforward when they are located in the public sector, with higher (local, regional or central) administrative levels having direct managerial control in some countries. However, this mostly applies where public hospitals do not have full autonomy. Where the private sector plays a more important role, or where public hospitals have greater autonomy, macro-level hospital governance tends to be more indirect. This highlights the de facto limits to autonomy.

A balance needs to be struck between ideological pressures to decentralize in order to increase marketization in the system or to democratize decision-making and the pressure to centralize or recentralize hospital governance in order to achieve greater economies of scale. A chief concern in decentralized systems is the need to ensure equity between subnational units of access to services of suitable quality. Such redistribution is necessary, but it also runs counter to strict autonomization and marketization policies. When decentralizing systems which were previously centralized, it is also necessary to consider scaling issues so that care is provided efficiently and yet there is sufficient capacity where new administrative or managerial roles are shifted to a different level of government [5].

To a certain extent, decentralization is a statement of fact as much as a policy solution and challenges need to be defined in the context of the existing system. For this reason, countries will need to be cautious in copying others when pursuing reforms, as different forms of decentralization in hospital governance need to be tailored to the country-specific challenges and institutional characteristics.

Conclusions

This brief has explored the experience of decentralized forms of hospital governance in 10 European countries. It found that devolved forms of hospital governance have most often emerged on the basis of existing decentralized administrative levels (such as in Germany, Italy or Spain). However, there are also new subnational structures for hospital governance (such as in Finland or Italy). Governance models for hospitals are to a large degree embedded in countries' administrative and political systems, but there may also be scope in some countries to go beyond existing administrative structures and establish new subnational layers of hospital governance. In all countries, the national or regional governments are bound to continue playing a crucial steering role for the hospital sector, even in those countries that have formally abolished centralized systems for planning capital investments in hospitals.

Appendix 1: Principal features of the hospital sector in the 10 countries

	Total number of hospitals (average number of beds per hospital – where available)	Total number of hospital beds (and rate per 100 000 population)	Average bed occupancy rate for curative care Average length of stay (all hospitals)	Financing of capital investment	Financing of recurrent hospital expenditure
Denmark	72 hospital sites, with bed numbers ranging from 20 to 1500 (2009)	14 871 hospital beds <i>(261 per 100 000) (2016)</i>	84% (2001) <i>5.4 days (2016)</i>	New hospital projects are financed through state grants, the regular budgets of regional governments and loans.	Hospital budgets are distributed by regions on the basis of a combination of global budgets and case-based diagnosis-related group (DRG) financing.
England	In 2015 there were 155 acute National Health Service (NHS) trusts and 56 mental health trusts in England, most of which consist of several hospital sites	169 995 hospital beds <i>(261 per 100 000) (2015), United Kingdom</i>	84% (2010), United Kingdom <i>7.0 days (2015), United Kingdom</i>	The Private Finance Initiative (PFI) played a major role in financing capital investment in England in the 2000s. By December 2012, 120 PFI hospital projects had been implemented, with a combined capital value of approximately £15 billion. In December 2012, the UK government introduced Private Finance 2 (PF2). 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, and the public sector contributes part (25–49%) of the equity.	Since 2003, the Payment by Results tariff system has been used to pay for hospital services, covering about 60% of activities in an average hospital. The system is based on Healthcare Resource Group codes that are, with some adjustments, based on national average costs. Additional payment schemes were introduced in 2009 with the Pay for Performance scheme and in 2010 with the best practice tariffs, both aiming to reward improvements in quality of care.
Finland	268 hospitals <i>(89 hospital beds per hospital) (2015)</i>	23 854 hospital beds <i>(435 per 100 000) (2015)</i>	74% (1995) <i>9.4 days (2015)</i>	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 for 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.	Payment mechanisms for hospital services vary between the country's 20 hospital districts. Funding by municipalities is mainly on the basis of services provided, using global budgets and case-based financing.

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	Total number of hospitals (average number of beds per hospital – where available)	Total number of hospital beds (and rate per 100 000 population)	Average bed occupancy rate for curative care Average length of stay (all hospitals)	Financing of capital investment	Financing of recurrent hospital expenditure
France	3089 hospitals <i>(132 hospital beds per hospital) (2015)</i>	408 245 hospital beds <i>(613 per 100 000) (2015)</i>	75% (2014) <i>10.1 days (2014)</i>	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.	Since 2004, hospital care is funded through activity tariffs, based on DRGs; DRG-based financing includes public, private not-for-profit and private for-profit hospitals, as long as they are formally accredited by the national health authority (HAS). The tariff for private for-profit providers does not include salaries.
Germany	3108 hospitals <i>(214 hospital beds per hospital) (2015)</i>	664 364 hospital beds <i>(813 per 100 000) (2015)</i>	80% (2015) <i>9.0 days (2015)</i>	Since 1972, hospitals are financed through “dual financing”, with financing of capital investments (based on hospital requirement plans) through the federal states and financing of running costs through the sickness funds and, to a lesser degree, through private health insurers and self-paying patients.	Since 2004, all hospitals are required to document their activity through DRGs, and their recurrent expenditure is almost entirely paid through this mechanism. All hospitals listed in a hospital requirement plan in one of the 16 federal states are reimbursed through this system (public, private not-for-profit and private for-profit).
Italy	1115 hospitals <i>(174 hospital beds per hospital) (2015)</i>	194 065 hospital beds <i>(320 per 100 000) (2015)</i>	79% (2015) <i>7.8 days (2015)</i>	Funding for capital investment comes from both national and regional sources, as well as EU funds, self-financing by health enterprises and project finance. A proportion of the National Health Fund is earmarked for capital investment in the health sector (including new buildings, renovations, “big ticket” purchasing), with a central committee approving which projects to fund.	There is a purchaser–provider split in a quasi-market system with defined tariffs (DRGs), with the azienda sanitaria locale (ASLs) as purchasers of services from public hospital enterprises

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	Total number of hospitals (average number of beds per hospital – where available)	Total number of hospital beds (and rate per 100 000 population)	Average bed occupancy rate for curative care Average length of stay (all hospitals)	Financing of capital investment	Financing of recurrent hospital expenditure
Netherlands	505 hospitals (2014) (139 hospital beds per hospital) (2013)	70 310 hospital beds (418 per 100 000) (2013)	46% (2012) 10.8 days (2006)	The central planning of capital investments was abolished in 2006. Hospitals are now free to make their own investment decisions and bear the financial risk themselves. Finance is raised privately, based on professional business plans.	Hospital services (including outpatient services) are funded using diagnosis–treatment combinations (DBC), the Dutch version of DRGs, which were reduced in 2012 from 30 000 to 4400. Hospital budgets are determined through price and volume negotiations between insurers and hospitals, with most payments taking place through the DBC system; 70% of hospital service rates have been freely negotiable between hospitals and insurers since 2012.
Scotland	252 hospitals (2010)	169 995 hospital beds (261 per 100 000) (2015), United Kingdom	81% (2010) 5.5 days (2010), acute care hospitals	Most investment in the NHS in Scotland has been funded through public sector capital, but private finance schemes have been adopted since the 1990s, accounting for just over one third of capital spending in Scotland in 2010/2011. In April 2015, Scotland's largest hospital, the £842 million Queen Elizabeth University Hospital in South Glasgow (1677 beds), was opened. The hospital was built with Scottish government funding.	Since the abolition of the internal market in 2004, there is no purchaser–provider separation and no formal contracting for clinical services. A Scottish National Tariff Project was launched in 2005 to develop a list of national average estimated Healthcare Resource Group costs, similar to the case-based system that is being used in England.
Spain	765 hospitals (181 hospital beds per hospital) (2015)	138 368 hospital beds (298 per 100 000) (2015)	76% (2015) 7.3 days (2015)	Investment plans are decided by regional governments. There are four different models of hospital and the private sector plays an important role, including for capital investment.	Public funding by regional governments, generally on the basis of global budgets and case-based financing.
Sweden	81 hospitals (2003) (337 hospital beds per hospital) (2003)	23 885 hospital beds (244 per 100 000) (2015)	78% (1996) 5.9 days (2015)	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. The largest ongoing investment is the building of a new Karolinska hospital in Stockholm, estimated at SEK14.5 billion, which was 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.	Hospital payment mechanisms vary across county councils. There tends to be a combination of global budgets, per diem rates and case-based payments, complemented by price or volume ceilings and quality components. Some county councils have also introduced pay-for-performance programmes.

Sources [8,10,18,24,28,32,41,47,54,55,56,63]

Appendix 2: Country reports

Denmark

Institutional arrangements

The Danish health system is tax-based, with taxes collected at national and municipal levels. In 2014, taxation accounted for 84.2% of total health expenditure, complemented by out-of-pocket payments (13.8%) and a small element of voluntary health insurance [8]. More than 80% of the health budget is financed by the state through a combination of block grants and activity-based funding [18]. The municipalities are financed through centrally collected, locally set income taxes and block grants from the state; they co-finance regional hospital services for their respective populations.

A major structural reform implemented in 2007 changed the administrative landscape of Denmark through the creation of larger municipalities and regions. In conjunction with the 2005 Health Act, it reallocated responsibilities in the health care sector to five newly established regions (replacing the previous 14 county councils) and 98 municipalities (created from the former 275) [18]. The five regions are governed by democratically elected councils. They are responsible for the planning and delivery of specialized services, with additional tasks related to specialized social care and coordination. They own, operate and finance hospitals and the majority of services delivered by general practitioners (GPs), office-based specialists and other health professionals in independent practice [19]. The municipalities are responsible for financing and delivering nursing home care, home nurses and home help, among other tasks, as well as for general prevention and rehabilitation. Importantly, the reform introduced municipal co-financing of 20% of the budget. The motivation behind municipal co-financing was to encourage municipalities to expand preventative services in order to reduce hospitalization rates [20].

The 2007 administrative reform also involved a restructuring of the hospital landscape, with the newly formed regions tasked with redesigning the hospital structure based on national guidelines [18]. It further involved the development of regional plans for capital investment in new and improved hospitals, which was to be financed by a state grant of DKK25 billion (complemented by regional sources). A government-appointed commission reviewed the plans and made recommendations on granting the resources, based on whether regional plans would facilitate the further concentration of infrastructure and the closure of smaller and older facilities to ensure the consolidation of treatment facilities within regions [8]. Overall, these changes have led to a reduction in the number of acute hospitals from over 40 to around 20, along with the establishment of a joint acute ward with specialists available 24/7 at each acute hospital. The renovation and construction of university hospitals and other hospitals are ongoing [21].

Concurrent reforms included economic incentives to increase hospital productivity using DRGs; quality programmes to ensure high quality and patient safety (see below); and

electronic patient records and increased use of IT systems [22]. Most (around 95% in 2014) hospital beds in Denmark are publicly owned [8]. Although a number of private for-profit hospitals have been established since the 1990s, the private hospital sector has remained small.

Accountability arrangements

The Danish health system is governed by a combination of national institutions, regions and municipalities. The Ministry of Health provides the overall regulatory framework for the health sector as it relates to organizing and financing health care, with the Danish Health Authority (in operation since January 2016), the (re-)established Danish Medicines Agency and the newly formed Danish Patient Safety Authority taking on important roles in the planning of specialist services location, approving regional hospital plans, and the approval of mandatory health agreements between regions and municipalities to coordinate service delivery [19,23].

The five regions are responsible for organizing and operating hospital services and supervising and paying GPs and specialists. Regions have considerable budgetary autonomy in operational issues, while larger investment decisions and highly specialized services are subject to central government approval [7].

Mandatory health agreements between municipalities and regions were introduced as part of the 2007 health reform to promote coordination across municipal care services, primary care and hospital care [19]. Agreements include a number of mandatory areas related to admission and discharge from hospitals, rehabilitation, prevention, psychiatric care and IT support systems; they are formalized at least once in each four-year election term for municipal and regional councils.

There has been some debate about the future role of the regions as a consequence of the new hospital infrastructure with much fewer and larger units, with some political voices arguing that regions may become redundant. In response to this, as well as to the perceived centralization and level of control exercised by the central government, the associations of the regions in Denmark and the Danish municipalities are considering merging by 2018 to strengthen their mutual influence on local government and decentralization efforts more broadly [21].

Transparency of the health system has become a political priority, with a number of initiatives launched. For example, in 2009, the Danish Healthcare Quality Programme (DDKM) was introduced. This is developed, planned and managed by the Danish Institute for Quality and Accreditation in Healthcare (IKAS), which 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 hospital owners. DDKM is based on the principle of accreditation and standards (organizational standards, standards related to care coordination and disease-specific standards, such as treatment guidelines); it further includes monitoring of quality of care in primary and secondary care [18]. The system was in operation at the hospital level until 2015 but is currently being replaced by a

new programme with fewer standards and more emphasis on clinical and local dimensions [19]. The DDKM continues to be rolled out in primary and municipal health care.

The national authorities also undertake comparative effectiveness (productivity) studies, which are published on a regular basis, allowing regions and hospital managers to benchmark the performance of individual hospital departments [19].

Most public hospitals are general hospitals with different specialization levels. There is no official classification of hospitals by level of specialization, technological equipment or performance. There is only a small number of single-specialty hospitals. 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 only a small number of hospitals is not generally perceived to pose a major challenge.

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 [24].

Until 2013, Primary Care Trusts were responsible for commissioning primary, community and secondary health services. Starting in April 2013 (following adoption of the Health and Social Care Act in 2012), 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. These 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 [24]. 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 [25,26].

Private services are also offered by public hospitals, either in dedicated private patient units (PPUs) or in private beds in NHS hospitals, although the income hospitals can generate from this is capped. In the financial year 2012/13, NHS England generated approximately £500 million in revenue from the provision of privately funded health services [26]. 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 [26]. This is the result of the Any Qualified Provider plan introduced in 2012, which sought to give patients more choice of service providers for routine elective care.

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 [27]. They remain subject to a system of external audit and inspection that has been developed and extended since 1999. 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 for 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 longer a centralized planning process for capital investment or the regional distribution of hospital facilities in the NHS, by setting budgets and the regulatory framework for investment, the central government to a large extent determines the overall levels and pattern of investment. When still in existence, strategic health authorities (abolished in March 2013) had 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, but there is no longer a formal prioritization process for large capital schemes [28].

In 2000, the NHS Plan promised to replace or update 100 hospitals by 2010, a goal that was achieved in October 2008 with the help of the Private Finance Initiative (PFI), a public-private partnership model, in which 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 [24]. 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 Department of Health [28]. 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, but loans for capital investment by foundation trusts are interest-bearing even if they are from the Department of Health.

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 [29]. The NHS in England was based on an integrated model, with no separation between the purchasing role and the provision of hospital services [24]. In the 1990s, an 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 [30].

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 was to achieve collaborative arrangements with providers. This changed again in the years 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 the annual Health Checks was discontinued and the model of governance returned to one of patient choice and competition between providers. In contrast to Scotland, Wales and Northern Ireland, in England there is now competition between public and private providers once again [30].

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 [24]. The 2012 Health and Social Care Act states that all NHS trusts should become NHS foundation trusts or part of an existing NHS foundation trust by April 2014. However, there are still NHS trusts that were not 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.

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, finance director and medical director [24]. 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 [29].

Monitor was established in 2004 to authorize and regulate foundation trusts, but as of 2013 it is also the economic sector regulator for all providers, including private and not-for-profit groups that provide NHS-funded care. It ensures that if a provider runs into serious financial problems, essential services are maintained for patients. Monitor works with the Care Quality Commission, NHS England and other bodies to make sure that the procurement, choice and competition elements of provision work in the best interests of patients. Monitor is one of the agencies involved in setting prices.

Monitor assists in preparing hospital trusts to transition to become a foundation trust. Foundation trusts must meet the licensing rules set by Monitor, which include how they are governed, what services they provide, the amount of money the trust is permitted to borrow from private sources and the number of assets the trust is allowed to sell. Monitor works with the Competition and Markets Authority (CMA) to make sure foundation trust mergers and acquisitions are not anti-competitive, in keeping with the regulations passed following the Health and Social Care Act, 2012, although this means Monitor is responsible for both mergers and competition [28]. From 1 April 2016, Monitor and the NHS Trust Development Agency have been pulled together under one umbrella – NHS Improvement.

The Care Quality Commission registers, monitors, inspects and regulates both NHS and private services in England to ensure they meet fundamental standards of quality and safety. Its findings are published, including performance ratings, which are designed to help patients make choices about providers. The Care Quality Commission sets the minimum standards of care, as well as determining what constitutes good and outstanding care. If services fall below the minimum standards, the Care Quality Commission has the power to define what providers need to do in order to improve the quality of care or, if necessary, can limit a provider’s activities until the necessary changes have been made. Its regulatory powers include issuing cautions and fines; and where patients have been harmed or put at risk, they can also prosecute.

Finland

Institutional arrangements

Specialized care funded by municipalities is provided mostly by public hospitals operated by public hospital districts (Box 5). The practical administration of hospitals 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 the municipal elections. The council adopts the annual budget, approves financial statements and makes decisions on major investments.

There is a small but growing number of private hospitals. Mehelainen in Helsinki performs more than 5000 surgical operations per year [31]. A highly specialized hospital, Coxa,

was founded in Tampere in 2002 to carry out endoprosthetic operations. Coxa works as a limited company and was founded by Pirkanmaa hospital district (plus three other hospital districts), four cities, one Finnish foundation (Invalidis-äätiö) and a German private hospital company, Wittgensteiner Kliniken AG, which originally had 20% ownership. All elective endoprosthetic operations in the Pirkanmaa hospital district are carried out in Coxa hospital [32].

In 2013, reform proposals in a government draft bill focused on establishing larger public provider districts called SOTE (social services and health; Sosiaali- ja terveystoimiala), 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 five regions, which 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 five 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 five SOTE could then decide which of the 19 care production units to contract with for specific services, introducing the possibility of competition between these provider organizations [33].

In March 2015, the outgoing government abandoned its proposal for 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, combining both administrative and care production responsibilities. These meso-level administrative districts will have governing bodies directly elected by the area population (previous hospital districts had governing boards comprising representatives chosen by the member municipalities), and will make both strategic policy decisions as well as owning public facilities and contracting for private services as necessary.

In an innovative attempt 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 three of the SOTE will have to rely on these 12 for full services and the other three 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 will obtain their funding directly from the state. There continues to be pressure from one of the governing coalition's member parties (the Centre 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 a private provider. Substantial new legislation would be required to implement this ambitious new plan, with these and other specifics about the restructuring process yet to be finalized [33].

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. Several bodies established at the national level have some direct regulatory functions. The two most important of these for health services in general are the health and social departments in the provincial administration and the National Authority for Medico-legal Affairs. In 2006, national-level supervision was reinforced by expanding the functions of the National Authority for Medico-legal Affairs 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 1972 Primary Health Care Act and the 1991 Act on Specialized Medical Care. The other main tools for steering municipal health services from the national level are information and local development programmes [32].

In the capital, Helsinki, a 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. HUS covers a population of 1.4 million, which is about 27% of the Finnish population. The member municipalities range from the capital to small rural municipalities. The goal was to merge two geographically proximate hospital districts and the Central University Hospital of Helsinki to achieve more effective organization and to avoid duplication of services. However, it was found that structures are hard to change rapidly in an organization of this size [32].

France

Institutional arrangements

Health care in France is mostly funded from public funds (mainly statutory health insurance plus taxes); the whole French population is covered by three health insurance funds under the *Caisse Nationale d'Assurance Maladie*. Services are delivered by both public and private providers (primary care by self-employed GPs; specialized care in ambulatory and inpatient institutions, including hospitals). Acute hospitals are either public, not-for-profit or for-profit (Table 3), and each category is represented by a national federation that actively defends the interests of its members:

- *Public hospitals* are owned by the national administration and mandated to provide universal access to all services, with governance linked to rules and the structure defined by law (e.g. directors' nominations are ratified by the

Ministry of Health or the President). This category accounts for 68% of acute medical care capacity, performs 65% of full-time acute episodes and includes general as well as regional teaching hospitals in a contractual relationship with universities. In 2014, 32 university hospital groups had a reputation of excellence and comprised over 3000 hospital departments and about 90 000 beds.

- *Private not-for-profit hospitals (établissements de santé privés d'intérêt collectif, ESPIC)* are owned and run by a private association, religious organization or foundation. ESPIC share with public hospitals accessibility and continuity of care as core values. A specific group of comprehensive cancer centres have a special role in teaching and research in the field of cancer.
- *For-profit hospitals* are run by private companies with commercial objectives, but limited teaching and no research missions. These focus on certain types of procedures and treatment (e.g. surgery), account for 10% of beds and provide 15% of episodes of care in France. There are currently about 50 private groups, which started to develop from the mid-1980s in single regions. There is a small number of physician-owned facilities and also some 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 [34].

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 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 regionalized), but never under its 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 (physician representatives or CEOs), but with substantial influence for politicians.

Since 1975, the planning of beds and expensive equipment in France has been linked to the *Carte Sanitaire* [35]. In 1982, concern over very high hospital utilization figures (54.7% of total health care utilization) led to a change in the traditional French concentration of governance at the national level, which was replaced by a gradual decentralization of functions to regional agencies. Regional hospital agencies (*agences régionales d'hospitalisation*, ARH, until 2010 predecessors to the regional health agencies [*agences régionales de santé*, 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 and from the regional health insurance funds, which previously shared management of this sector. Regional hospital agencies were also given the responsibility of financing hospitals (both public and private) within the framework of the regional hospital subtarget of the ceiling for social health insurance expenditure. 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 regional health agencies (ARSs, merging ARH and regional health insurance funds, UNCAM) in 2010 [36] following the 2009 *Hôpital, Patient, Santé, Territoire* Law. There were initially 26 regional health agencies, but this was later reduced to 17, in line with the merger of regions.

Looking for a fiscal base that would 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 has been 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. Patients and citizens are also increasingly involved in health policy decisions through national and regional health committees (*conférences de santé*).

Table 3: Key characteristics of the hospital sector in France in 2011

	Proportion of hospitals	Proportion of hospital beds	Average number of beds per hospital
Public	35%	62%	176
Not-for-profit	29%	19%	26
For-profit	39%	24%	101

Source: [34].

In August 2004, the High Authority for Health (*Haute Autorité de Santé*, HAS) was set up to bring together activities designed to improve quality of care and guarantee equity. HAS is not part of the government but 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 organizations, 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 patient 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) accept its findings in most cases.

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 the National Union of Health Insurance Funds (*Union Nationale des Caisses d'Assurance Maladie*, UNCAM), as the single representative of the insured, which 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 focuses 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 [37].

Tariffs for private for-profit providers (typically for easier, elective procedures) are lower than public hospital equivalents because they do not include salaries, as doctors are usually self-employed and paid on a fee-for-service basis. Since 2005, reimbursement claims processed by public health insurance funds have been centralized in a data warehouse, allowing the treatment received, as well as the hospital and health professionals that provided those services, to be identified for each patient. 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, but since then evolving 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 [38]. 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. The directors of the ARSs are appointed by the Ministry of Health, but they are not the "owners" of the hospitals. The ARSs are a subsidiary of the state under the supervision of the ministers in charge of health, social security, older people and people with disabilities. However, they are autonomous bodies and their directors have extended autonomy with regards to social health insurance budget management and capacity planning in the region [10].

The ARS director manages and authorizes the various types of care provided by the hospital(s) in the region, based on the plans for the organization of care at the regional level (regional health schemes, *Plan Régional de Santé*, PRS), while also monitoring 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 older people and for ensuring that health care provision, including hospital care, meets population needs while also 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 (both private and public) and comprehensive emergency centres, which have to be authorized by the Ministry of Health [10].

On the basis of the regional health schemes, each regional health authority establishes target agreements with hospitals to define 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 Organizations (*Agence Nationale d'Appui à la Performance des Établissements de Santé et Médico-Sociaux*, ANAP) [39].

In line with the Law of 26 January 2016 on the modernization of the health system, 150 territorial hospital groups (*groupements hospitalier de territoire*, GHTs) are to be set up to improve hospital efficiency. The GHTs will formalize the partnerships between hospitals, with implications for hospital functions and markets. By the end of July 2016, 135 GHTs had been set up [40].

Germany

Institutional arrangements

Germany has a mix of public hospitals (usually owned by local governments), private not-for-profit hospitals (often owned by religious organizations) and private for-profit hospitals. Since 1991, the share of acute care hospital beds in private hospitals has increased substantially, mainly as a result of takeovers of hospitals that used to be publicly owned, particularly in the eastern part of Germany. In 2012, 48% of hospital beds were in publicly owned hospitals, 34% in private not-for-profit and 18% in private for-profit hospitals [41].

Since the Hospital Financing Act (*Krankenhausfinanzierungsgesetz*) of 1972, hospitals are financed through “dual financing”, with financing of capital investments (based on hospital requirement plans) through the federal states and financing of running costs through the sickness funds, and, to a lesser degree, private health insurers and self-paying patients. Financing of running costs is negotiated between individual hospitals and associations of sickness funds at the federal state level; it is primarily based on DRGs [41].

In order to be eligible for investment funds, hospitals have to be listed in the hospital requirement plans set out by the country's 16 federal states. The vast majority of hospitals, including most private for-profit hospitals, are included in these hospital requirement plans. They may treat patients covered by social health insurance, are subject to uniform regulations and are entitled to investments from the federal states, irrespective of hospital ownership [41].

Hospital planning became a public responsibility with the 1972 Hospital Financing Act. With this law, the federal states became responsible for hospital planning and hospital infrastructure policy. Hospital governance at federal state level is based on hospital requirement plans and infrastructure programmes. Hospital requirement plans define the territorial distribution of hospitals [42].

Planning and the regulation of treatment facilities for inpatients are undertaken by the ministries of health (ministries of science for university hospitals) at federal state level, but based on the federal legal framework of the 1972 Hospital Financing Act. Sickness funds and providers have a say through hospital committees at federal state level, but in the end decisions are taken at the politico-administrative level [41].

Approaches to hospital requirement plans, capacities and investment vary widely among the federal states. Some (e.g. Rhineland-Palatine) still rely on the number of beds per specialty as the primary planning unit, while others (e.g. Saxony-Anhalt) leave decisions concerning hospital capacity to market actors, with a major role for health insurers and provider associations. A third model (e.g. in North-Rhine Westphalia) aims for involvement of all key actors in regional health conferences [42]. However, in most federal states, hospital planning is still based on inputs (rather than service volumes), in particular the number of beds. The hospital requirement plans set by the federal states list the specialties that are necessary, and even the number of beds per

specialty for every hospital. The number of hospitals and beds is usually planned at a trilateral committee, consisting of representatives from the federal state government, hospitals and sickness funds [41].

Hospital planning focuses on input; however, changes at the federal level of hospital governance have introduced DRGs as the provider payment mechanism. DRGs have an inherent focus on outputs and emphasize quality improvements [42]. Dual financing in the hospital sector released the federal states from the necessity of taking into account the follow-up costs of investments, thus favouring overprovision of capacities and major items of equipment. As a result of the DRG remuneration system, hospitals are now under pressure to close departments producing deficits, something that is frequently in conflict with the goals of hospital planning. There are therefore calls for greater participation in the planning process by those financing the operating costs [41].

The federal Law on Hospital Structures (*Krankenhausstrukturgesetz*), which came into force in January 2016, not only further emphasized quality improvements, but introduced them as one of the criteria for hospital planning. It charged the Federal Joint Committee with developing quality criteria relevant to hospital planning by the end of 2016. These criteria are to be the basis of hospital planning at the federal state level. Hospitals that do not meet the required quality criteria have to be removed from the hospital plan. The law also set up a Structural Fund of €500 million to support capital investment for hospitals at the level of the federal states, to be matched by financing from the federal state governments [43].

Accountability arrangements

Hospitals are licensed according to federal state law. They contract individually with representatives of the sickness funds at the regional level, such as the regional associations of sickness funds, although final decisions are taken by state governments [41].

German corporations are required to have separate management boards (*Vorstand*) and supervisory boards (*Aufsichtsrat*); this is also the case for publicly owned hospitals [44]. Some federal states have detailed provisions for the composition of management boards for public hospitals, but management and supervisory functions are normally devolved to municipal-level authorities. The public hospitals' supervisory boards usually consist of representatives for health affairs from the local authorities, local councils, and members of the professional groups of the individual hospitals. In the case of most German public hospitals, elected politicians are members of the supervisory boards. The supervisory board has full discretion over the appointment of the members of the management board, including approval of the elected medical director [44].

Since 2005, all German hospitals approved to provide care to statutory health insurance members are obliged to publish structured quality reports every two years [45]. This includes a set of roughly 300 quality measures. For selected interventions (e.g. appendectomies), hospital treatment is documented for each patient based on a set of quality

indicators. These performance data are transmitted to a central external agency (AQUA Institute for Applied Quality Improvement and Research in Health Care), as well as to the corresponding state offices for quality assurance, where the data are evaluated. Performance results are then fed back to the hospitals [46].

Italy

Institutional arrangements

In Italy, the organization and provision of health services is the 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 [14].

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 [8]. The proportion of private hospital beds is particularly high in the regions of Lazio, Campania and Emilia-Romagna [47].

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 AO (*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 have become 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 [47]. In the Veneto region in 2010, there were 59 public hospitals (including two AOs) and 31 private hospitals accredited by the region [48].

The regions have the main responsibility for planning capital investment and have dedicated units and strategies for this purpose. Within 150 days of the introduction of the triennial national health plan, every region has to adopt regional health plans for the planning of capital investments, expensive health technologies and bed capacity. The regional health plan typically covers aspects such as: the distribution of beds in secondary, emergency and long-term care; the size and location of hospitals; and the integration between health and social care. Regional planning usually involves all providers of health care, both public and private (for-profit and not-for-profit).

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 (AOs) provide services in a quasi-market system with a purchaser–provider split and 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 [48].

Private hospitals are accredited by the regions, which set the accreditation criteria and enter into contracts with them [47]. 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 [47]. Most regions rely largely on the public sector, although some have introduced limited 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 [47].

Netherlands

Institutional arrangements

Major recent changes introduced in the Netherlands are somehow the culmination of 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 organizations, plus a strong regulatory framework, would make public sickness funds and private insurers compete for enrollees 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 [49].

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 reorganized (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 reformulated 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 for priority-setting [50].

Hospitals in the Netherlands are by law private, not-for-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 boards and 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 (Box 6).

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, orthopaedics, 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 not-for-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 practices. 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 outpatient services) are funded based on diagnosis–treatment combinations (*diagnose-behandelcombinatie*, DBC), the Dutch version of DRGs, which reduced in number from 30 000 to 4400 in 2012 [13].

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 [13]:

- The Dutch Health Care Authority provides regulation, organizes oversight, safeguards public values, develops policy initiatives and gives general direction to health care (Box 6).
- 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, at the 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. It 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 the Health Care Insurance Board) integrates knowledge on quality management from various agencies as insurers had expressed dissatisfaction with the "slow progress in objective and comparable quality measurement" and started to collect their own quality data as well as introduce their own volume norms [13]. Its core role as the central body is advising on services covered in the statutory benefits package.
- 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 other responsibilities, it enforces statutory regulations on public health; investigates complaints and accidents in health care; and takes appropriate measures.
- The Medicines Evaluation Board oversees the efficacy, safety and quality of medicines. Its members are appointed by the Minister of Health.

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 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 (*Nederlandse Vereniging van Ziekenhuisdirecteuren*) 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 [51].

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 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; plus there have been many other innovations including new facilities for one-stop provision of care, care pathways and online consultation reservations. However, efficiency gains have been offset by increases in volume and, since 2011, the government has stepped in to make broad sectoral agreements (so-called covenants) with hospitals, insurers and physicians to keep spending within a certain agreed budget (because of large overspending in previous years).

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 [52].

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 those with chronic conditions) 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 programmes [53].

Scotland

Institutional arrangements

Almost all hospitals in Scotland are owned and run by their respective NHS boards. In contrast to England, Scotland does not have NHS trusts or foundation trusts, following the 2004 NHS Reform (Scotland) Act. 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 [54]. There is a relatively small private sector, including in 2010 [54]:

- 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, services provided in this sector are funded mainly by voluntary health insurance or paid for directly by patients. To a limited extent, the NHS in Scotland also contracts with the private sector for the provision of certain services to NHS patients [54].

For large infrastructure projects, capital investment is centralized. As part of the annual spending round, the NHS in Scotland is allocated a capital budget, part of which is distributed to boards by formulae, and the rest is allocated to specific large projects whose value is in excess of board-delegated limits [28].

Accountability arrangements

In the 1990s, Scotland, along with the rest of the United Kingdom, introduced an internal market and competition, based on a split between purchasers and providers. However, since political devolution in 1997, responsibility for the organization and financing of health services has been devolved from the United Kingdom to the national level in Scotland and the government of Scotland abandoned the internal market and purchaser/provider split in 2004, creating health boards similar to those that existed in the 1980s [30].

Responsibility for financing, planning and managing hospital services now lies once again with NHS boards [54]. There are 14 geographically based NHS boards and seven 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; and others, also appointed by ministers, to represent particular stakeholder interests such as the board's employees, the area clinical forum and each of the local authorities in the board's area); 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) [54].

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 [54]. The composition and accountability of the seven national specialist health boards are broadly the same as for the geographically based boards [54].

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. Healthcare Improvement Scotland was formed in 2011 to oversee the quality of care provided in both the NHS in Scotland and the private sector [28].

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*) was critical in that regard. In health, the protection of which was recognized as a constitutional right, competencies for regions 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 (MSSSI) provides a common framework (to ensure equity, cohesion and common quality standards), while the Ministries of Health of the regions, 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 regions to include additional services if they finance them through their own budgets [55].

Regions are funded by the state through funds transferred as "non-earmarked budget" and health represents around 30% of each region's total budget (which also includes education, unemployment benefits, etc.) [56]. Transfer of funds from the centre is negotiated annually between central and regional governments, and then it is up to each region 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 [57].

Hospitals in the new regional public sector kept the inherited schemes, with staff being quasi civil servants. Some 67.4% of all available hospital beds were 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 [58]. 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 these are later published).

In the 1990s, some smaller hospitals across virtually all of Spain were granted variable autonomy, initially within the existing legal framework and later adjusted in each region. Changes affected a number of essential areas and the corresponding tools to govern the facility:

- (a) institutional arrangements, e.g. the 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. For working hours, dedication and accountability, however, the new arrangements were more demanding than the old statutory regime.

Spain has maintained a direct involvement of the authorities in the planning and priority-setting for services. Geographically defined responsibility for specialized health care is crucial in the health governance structure and gets expressed at the regional level 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 using measurement tools, such as the Compulsory Minimum Data Sets [59]. The topics covered, frequency of reports and their comprehensiveness varies, according to the mechanisms in the direct public administration of each region. Most are using a program contract arrangement (*Contrato Programa*) as the 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.

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 from 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 for 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 in general been 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 [56]. Hospitals also care 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 in Spain is the 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 limits transparency in clinical information for patients. In many cases it is more an issue of political risk aversion against possible 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 health system in Spain seems currently feasible. Similarly, the

relative success of the different forms of hospital autonomy and their clinical and cost-effectiveness remain nebulous.

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 region. Autonomous hospitals had some additional flexibility in financial management, as well as agility in updating technology and equipment (Table 4).

In recent years, Spain has experienced a political polarization. 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 [60]. Experiences are being vehemently discussed in the virtual absence of any available study to assess the performance of the new centres [60]. A periodic report on differences and inequalities between 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 [61]. The regional and general elections of 2014 and 2015 have resulted in new turbulence in the political landscape of Spain, which is bound to have repercussions for the hospital sector and the degree of autonomy afforded to hospitals.

Table 4: Governance arrangements in different types of hospital in Spain

	Number of hospitals
Public health care companies	(1) Allowed; in practice, however, retrospective funding and rather scarce extra income (2) Limited (Treasury gets any surpluses)
Not-for-profit foundations	(1) Allowed; in practice, however, not great extra income (2) Limited (Treasury gets any surpluses)
Consortia	(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	(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

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 seven regional/university hospitals and about 70 hospitals at the county council level. Highly specialized care, requiring the most advanced technical equipment, is concentrated in the seven (public) university hospitals located in Malmö/Lund, Gothenburg, Linköping, Stockholm (Huddinge), Uppsala, Umeå and Örebro. One reason for this concentration 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 in lots of hospitals. Each region serves a population averaging more than 1 million people.

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 specializations is represented than in local hospitals.

There are six private hospitals in Sweden, of which three are not-for-profit (Sophiahemmet, Ersta and Red Cross (*Röda Korset*), all in Stockholm) and three are profit-making (St Goran in Stockholm, Lundby in Gothenburg and Simrishamn in the south of Sweden). The three not-for-profit hospitals 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 profit-making hospitals 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 [63].

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 relating to health care services. One alternative was to merge additional county councils into regions with at least 1 million inhabitants, which would then 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 [64], was to hand over responsibility for all hospitals, or at least the university hospitals, to the state.

In the final report from the Committee [65], it was concluded that developing towards 6 to 10 larger regions and maintaining the 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 university hospital. The Committee was careful not to propose actual new geographical borders for 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 [63].

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

Accountability arrangements

During the latter part of the 1990s, and throughout the 2000s, there were efforts to strengthen national influence, partly driven by the need to better coordinate care and reduce regional differences; for example, by strengthening the role of government agencies. The National Board of Health and Welfare was 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 [63].

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 large regions (Region Skåne and Västra Götalandsregionen) were formed in 1999. Previous national decentralization policies were replaced by centralization and regionalization in the delivery of care during the 2000s. In a report from the Committee on Public Sector Responsibilities [65], it was proposed that the 21 county councils should be replaced by between six and nine regional authorities, with responsibility for the provision of health care but also with increased responsibility for other regional matters.

The trend towards increased specialization and concentration of services 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 include improvements in the quality of services and in the conditions for clinical research. In all three cases, the mergers have sparked debate and significant criticism of centralization and the disadvantages of large-scale organizations from senior specialists affected by the

changes. More generally, concentration of services is rarely supported by outcome data available in the national quality registers [63]. The problems arising from implementing the changes associated with the merger of the Karolinska and Huddinge hospitals have been documented in research [66].

The trends toward specialization and the concentration of specialist services have been supported by several national initiatives [63]. In 2007, the Committee for National Specialized Medical Care was established to concentrate 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 concerned regional differences in waiting times for diagnosis and treatment. Further objectives were to concentrate curative care for cancer patients with more unusual diseases or patients requiring specialized resources and to improve conditions for clinical cancer research [67].

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