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Lessons from Europe: provider governance

Key points

- Provider governance is not an end in itself, rather the means to drive value in service delivery.
- Reorganising care delivery structures will not on its own be enough to improve outcomes.
- In systems with autonomous providers, a regulatory framework is needed to maintain quality, including equal access to care.
- Focus should be placed on developing a framework that balances provider freedom in decision-making with accountability for outcomes.

Successive UK and European governments have believed that granting a hospital or healthcare provider the ability to make its own strategic or financial decisions will secure the quality, innovation and productivity required to improve healthcare delivery.

In England, the NHS foundation trust model has become the preferred form of provider governance. Originally designated as an 'elite' model offering earned autonomy to reward high-performing trusts, the Government now expects most providers operating in the NHS to achieve foundation trust status by 2014.

This *Briefing* outlines key insights from a *Lessons from Europe* seminar that examined the impact of recent reforms in hospital governance in Spain and the Netherlands. It identifies lessons for NHS managers and policymakers in England on how to approach the challenge of effective provider governance as the present NHS reforms are implemented.

Background: the move towards institutional autonomy

European health systems display a range of approaches to provider governance, with varying degrees of autonomy (see Figure 1 on page 2). Recent reforms show how countries across Europe have sought to combine the advantages (and mitigate the disadvantages) of state-hierarchical 'command and control' at one end of the provider governance spectrum and delivery by fully independent private organisations at the other. They have done this by giving publicly-owned hospitals varying degrees of semi-autonomy.

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Legal status

There is considerable variation in the formal designation of public hospitals in Europe, which generates differing degrees of formal autonomy. When hospitals are not directly managed by the ministry of health, hospital staff and public involvement may be formalised through board membership, regular consultation or informal dialogue. However, traditional political, employee, trade union and physician players with a historically strong influence often lose much of their authority in these new decision-making models.

Financing

Publicly-owned hospitals in Europe typically cannot make capital investment decisions or bear financial risks without political approval. However, reforms in some countries have given hospitals greater autonomy over capital investment (sources, constraints, conditions) and permission to retain surpluses for future investments to enable public hospitals to respond to changing patient needs, technological advances in medicine, increasing cost pressures and the concerns of professionals and other stakeholders.

Accountability

The role and influence of political authorities within new hospital governance models can be complex. Although more autonomous models have been designed to restrain the influence of local and national political actors, most countries with publicly-owned hospitals view some form of political scrutiny as being essential.

Decision-making capacity

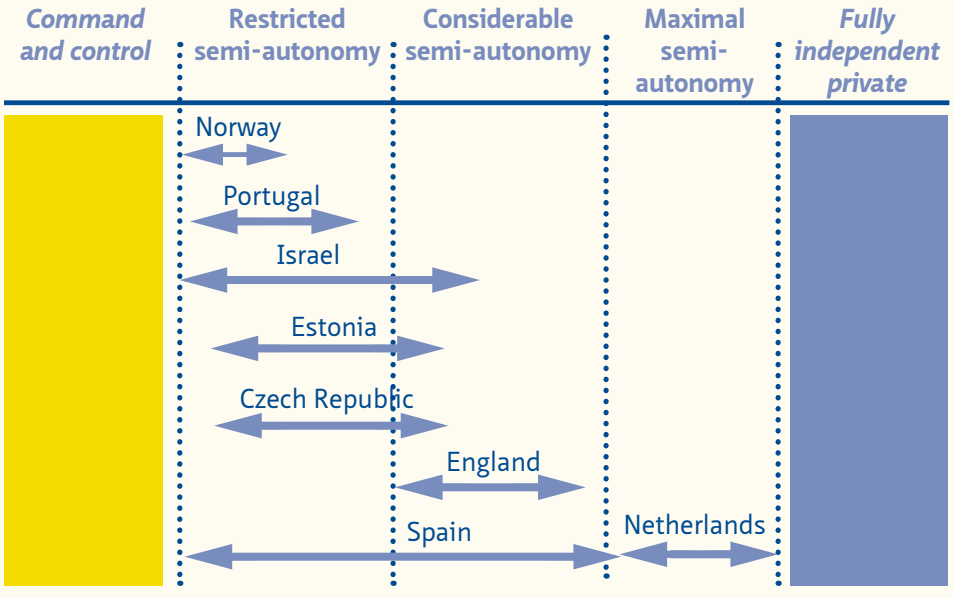
The ability to take decisions is the acid test of hospital autonomy. A dilemma exists in where to draw the line between high-level government stewardship of the system and enabling hospitals to adjust to unexpected trends in practice by entrusting them with decisions that – for reasons of efficiency, effectiveness, quality and responsiveness – ought to be separated from direct political control.

Lessons from Europe seminars

Organised by LSE Health, the Health Services Research Network and the NHS European Office, the *Lessons from Europe* seminar series gives service leaders and policymakers across the NHS the opportunity to discover how policy experience and lessons from Europe can be applied to health policy organisation in England. The seminars feature experts from one or more European countries.

Details on the series, together with presentations, can be found at **www.nhsconfed.org/LessonsFromEurope**

Figure 1. European hospital governance strategies



Source: Saltman, Durán and Dubois, 2011[1]

The Netherlands: governing hospitals in a regulated market

Background

Since the 1980s, market-oriented reforms have radically changed the context in which Dutch hospitals operate. As a result, hospitals now operate as private, not-for-profit entities, owned by a domestically-chartered foundation, and are:

- responsible for operational expenses and capital investments

Key lessons for boards and policymakers to consider

- Innovative care models and financing arrangements need to address the complexity of assessing population health needs.
- The governance of providers is not an end in itself, but a means to support good governance of the services required to meet population health needs.
- Reorganising healthcare delivery structures will not necessarily be sufficient to improve processes and outcomes – there is a need for better comparative information and outcome standards.
- In a system with autonomous providers, a regulatory framework will be needed to maintain equal access to care across regions. Annual performance checks at hospital level do not appear to be a sufficient regulatory response to tackling regional variations in care.
- The challenge will be to define and implement a framework that gives providers freedom to make decisions, but also holds them accountable for outcomes through appropriate reporting requirements and incentives.

- funded through a mark-up on tariff
- allowed to retain surpluses.

Hospital performance is measured using a range of indicators. Increasingly, this data is being made available to the public. The influence of insurers is growing, particularly through selective contracting, and price competition has increased.

Despite their private sector status, hospitals view themselves as 'enterprises with a public purpose'.

Regulatory framework

In the absence of a formal hierarchical relationship with government, self-regulation plays an important role. The hospital governance code signed by various provider associations (including the Dutch Hospitals Association, NVZ) provides a voluntary regulatory framework that sets out the function and role of hospital executive and supervisory boards. Despite the lack of legal enforcement, the impact of the voluntary code should not be underestimated as hospitals are required to justify any deviance.

Members of the executive board are appointed and discharged by the supervisory board; medical staff are usually involved in the appointment procedure; and employee/patient councils have a legal right to express their opinion.

The supervisory board oversees the executive board and approves specific decisions such as budget estimates, annual reports, strategic plans, property transactions and consolidations. Required to operate 'at a distance', the supervisory board is not in charge of hospital management.

State intervention

Despite their formal private status, hospitals are viewed as part of the public sector and the ministry of health may intervene if patient access to care is perceived to be at risk. For example, a hospital recently turned to the ministry to avoid impending bankruptcy. The ministry provided the necessary funds (based on its responsibility to provide service coverage) and appointed a government representative with full power of veto on major decisions to the hospital's supervisory board.

Ensuring accountability

Concerns over the poor functioning of supervisory boards in general – especially around their weak countervailing power and dependence on the executive management for information on performance – has resulted in a drive to increase the public accountability and professionalisation of board members.

To this end, the hospital governance code is currently under revision and supervisory boards are to undergo self-assessment. There is also a move to increase the professionalisation of supervisory boards as, in the past, recruitment has been traditionally based on cooptation by social position (mayors or local business representatives) rather than expertise. However, the problem of who supervises the supervisory board remains.

To resolve the issue of the overly generous remuneration of executive board members ("golden handshakes") the ministry of health has intervened in hospital self-governance. Taking the stance that chief executives are paid using public funds and that the government has to offset cost overruns on the global budget for hospital care, it now sets a maximum remuneration level for chief executives.

Competition or cooperation?

Market competition is embedded in a regulatory framework to preserve solidarity within the system, and hospitals are considered as public enterprises guided by the principle of community orientation rather than shareholder value. Recent proposals exist to allow for-profit hospitals, subject to many restrictions. But the extent to which more competition in healthcare can help improve quality and efficiency in the system continues to stir controversy in public debates. Concerns exist that, should the market-led reforms continue, this will result in less coherent public policymaking to the detriment of patients.

Spain: does more autonomy improve performance?

Background

The delivery of health services is decentralised to 17 autonomous communities that operate five different models of self-governing hospital. These range from a slight deviation from the publicly-owned and managed hospital to a more commercial model of administrative concession, as in Alzira in Valencia.[2]

Public healthcare companies, characterised by 'restricted semi-autonomy,' are chaired by the regional minister, and health service portfolios are largely decided by the regional government.

At the other end of the spectrum, the administrative concession involves a contract with a private company consisting of private health insurers and provider groups. Together they decide on the portfolio, which may also involve the vertical integration of primary and community care services.

The administrative concession can freely choose sources of capital and is not subject to public procurement law. Funding is via capitation and surpluses can be retained, subject to annual profit caps. Unlike other innovative hospital governance models, however, there is no involvement of local citizens or patients.

Unwarranted regional variations

Despite good overall population health status in Spain – average life expectancy at birth ranks fourth worldwide, and mortality in major causes of death, including cancer and cardiovascular and respiratory diseases, is among the lowest in Europe – there is significant geographic variation in health outcomes and access to healthcare is unequally distributed across the country. For example, in 2010 there was a variation of over 40 per cent in levels of public health expenditure per person and a gap of three years in life expectancy at birth across regions, as well as variation in the rate of many elective surgical interventions, such as prostatectomy. For other conditions, such as caesarean sections, variability between hospitals is declining but only due to the convergence of all providers towards higher rates of provision.

Measuring comparative performance

There has been limited evaluation of the comparative performance of the different models of hospital governance in Spain. Research suggests that the administrative concession in Valencia performs better than traditional models in a number of activity parameters including external consultation delays, length of stay, patient satisfaction, outpatient surgery rates and emergency waiting times. Overall costs also appear lower – the annual fee paid to the contractor per inhabitant is about 26 per cent lower than the cost per inhabitant in the rest of Valencia (€825 versus €607 in 2010).

However, much uncertainty remains with regard to the outcomes of care. Health information systems in Spain are focused on resources and activity data, to the detriment of outcomes data. The lack of a comprehensive and robust evaluation of the different hospital governance models represents a serious gap in knowledge.

Nevertheless, the administrative concession is viewed as a promising model of provider governance. The Valencia regional government has announced plans to extend this model to all general services of public hospitals, and other regions have also started to convert public hospitals into administrative concessions.

What can the NHS in England learn from international experience?

Right for whom?

Governing healthcare delivery in the interest of populations rather than in the interest of providers requires better coordination across the entire spectrum of generalist, specialist and preventive care. However, innovative care models and financing arrangements – such as the bundled payments strategy used in the Netherlands to cover the costs of a defined patient group across care settings – have to overcome the complexity of assessing population health needs. In a supply-oriented system, efforts to determine the appropriate mix of services and structures required to meet those needs are often met with inertia.

A key challenge for the future will be to ensure that provider governance is not an end in itself, but a means to support good governance of the services required to meet health population needs.

Does more autonomy produce better outcomes?

Policymakers might too easily conclude that changes in institutional structure lead to higher quality at lower cost. Experience from England and elsewhere suggests that reorganising healthcare delivery structures will not necessarily be sufficient to improve processes and outcomes – there is a need for better comparative information and outcome standards. In England the situation is complicated by the fact that early foundation trusts were, by definition, high performers in the first place.

Who is accountable for regional variations in care?

Even when the outcomes of some hospitals are excellent, increasing institutional autonomy raises questions over who is responsible for unwarranted geographic variations in access to and quality of care.

In a system with autonomous providers, a regulatory framework will be needed to maintain equal access to care across regions. Annual performance checks at hospital level, as introduced in Spain some years ago, do not appear to be a sufficient regulatory response to tackling regional variations in care.

When should regulators intervene?

An ongoing issue is how to deal with failing hospitals that do not meet defined performance standards. Furthermore, defining what is 'appropriate access' is often closely linked to questions of efficiency. For example, in the Netherlands there is an ongoing debate on whether a hospital in every town is needed, given that travelling times for patients are usually five to ten minutes at most.

The capacity to reinvest any surpluses over a longer timeframe, as in England where providers must break even over three years, illustrates the potential importance of a regulatory framework that enables long-term investment decisions.

The challenge will be to define and implement a framework that creates the freedom for providers to undertake decision-making, but which also holds them accountable for outcomes through appropriate reporting requirements and incentive systems.

Viewpoint

In many European countries, 'command and control' is no longer seen as an effective option for governing public hospitals, but pure private markets are not considered an appropriate alternative for achieving equal and affordable access to high-quality and efficient care.

The 'right' level of semi-autonomy is not easy to find. Much uncertainty remains about what really works in provider governance. More entrepreneurial freedom can help address some of the shortcomings associated with hierarchical governance. Nevertheless, more autonomous structures do not automatically lead to improved performance and may raise new governance issues relating to accountability arrangements and how to best meet population health needs.

For more information on the issues covered in this *Briefing*, contact Michael Wood, European Policy Manager at michael.wood@nhsconfed.org

Further information

To view the presentations from *Lessons from Europe*: *The right form of provider governance in healthcare?*:
www.nhsconfed.org/ProviderGovernance

References

1. Saltman RB, Durán A and Dubois FW (editors) (2011) *Governing public hospitals: reform strategies and the movement towards institutional autonomy*. WHO on behalf of the European Observatory on Health Systems and Policies.
2. NHS European Office (2011) *The search for low-cost integrated healthcare: the Alzira model*.

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This *Briefing* was written by Laura Schang.

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NHS European Office

Rue Marie Thérèse, 21 B 1000 Brussels
Tel 0032 (0)2 227 6440 Fax 0032 (0)2 227 6441
Email european.office@nhsconfed.org
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