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European Hospital and Healthcare Federation

GROUPINGS IN THE HEALTHCARE SECTOR

HOPE SURVEY

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INTRODUCTION

With the growing pressure to deliver higher quality of care at lower cost, while reducing clinical activity levels in hospitals, European countries are testing and using various methods. Hospital and healthcare groupings are one of them.

They could aim at reducing operation expenses, increasing revenue or re-configuring service delivery. Quality improvement and acquisition of new skills and technologies are also rationales that led to the hospital and healthcare groupings.

HOPE has been collecting with its members the information available on this complex topic. This report provides then a summary on the most recent information available as groupings in the healthcare sector in Europe.

CATEGORIES OF GROUPING

The categories of grouping described in this report are the following:

a. Hospital grouping: hospitals working together but keeping their autonomy;
b. Network of professionals: healthcare professionals with different backgrounds working together, being self-employed or employees of various kind of institutions;
c. Network of healthcare and social care institutions: hospitals and/or other health and social care institutions working together;
d. Public institutions providing services to healthcare institutions.

COUNTRY PROFILES

The information provided in the paragraphs below has been gathered on the literature produced by various sources: OECD, WHO, European Observatory on Health Systems and Policies, studies and reports of consulting companies, universities and the European Commission.

In some cases, such information has been integrated with feedbacks received from HOPE liaison officers, who contributed in providing a more complete overview of the situation in their countries (Austria, Cyprus, Denmark, Estonia, Finland, Germany, Italy, Malta, Poland, Portugal, Spain, Sweden and United Kingdom).

For some countries, it was not possible to find information available on the topic (Czech Republic, Latvia, Lithuania, Luxembourg, Romania, Slovakia, Slovenia, Serbia, Switzerland).

Austria

Categories of groupings identified:	*Hospital grouping (a);* *Network of professionals (b);* *Networks of healthcare and social care institutions (c);* *Public institutions providing services to healthcare providers (d).*

In Austria, *hospital grouping (a*) has recently taken place. The rationale behind is a growing need to contain costs and to cope with an increasing shortage of health professionals especially in rural areas while ensuring a high level of quality of service. During the last 15 years, the merging of hospitals reduced the number of hospital by 20%, according to the respondents' opinion, while the number of the actual hospital sites remained more or less constant. Hospitals with more than one address operate either in form of a main hospital with satellites where all sites are served by a central personnel pool, or each of the sites is specialised and provides a certain range of services. The degree of autonomy of merged hospitals varies subject to different regional policies or business plans. The process of hospital grouping started with public hospitals but has been adopted meanwhile also by the private (mainly not-for-profit) hospital sector.

While hospital grouping in most cases is part of public hospital development strategies, *networks of professionals (b)* are, apart from the necessary multidisciplinary teamwork in various treatment areas

(e.g. oncology), more or less a voluntary option and mostly subject to individual preferences. For instance, there are groups of doctors or of doctors and other health professionals. Also, voluntary but most common is the cooperation of doctors at the national level in scientific societies within each medical speciality and the cooperation within interest groups of other healthcare professions.

Networks of healthcare and social care institutions (c) usually may easily reach their limits due to different competence areas and financing schemes. But, particular mention should be made of two areas where such networks are fostered and supported on the national level by public policy and through State action, namely primary care and hospice and palliative care:

Recently, a new concept of units providing primary healthcare (either in form of primary care centres and/or networks) has been launched by health policy makers which includes a mandatory requirement for networks of different professions (at least several GPs and nurses and, according to the demand, also specialists and other healthcare and social care professionals). Beyond that, cooperation with other healthcare facilities and with social services is strongly recommended. The establishment of such primary care facilities started in 2016 and currently about 20 of them are providing health services complying with the national concept's guidelines. The target is to reach 75 facilities until the year 2021.

Regarding hospice and palliative care, national policy makers foster and support the development and expansion of services within healthcare as well as within social care since almost 20 years. Though, it has been achieved a quite successful enhancement in the field of palliative care services. The implementation of hospice care services within the social sector has just recently taken up some dynamics, due to political action, which determines that a certain amount of regional budgets has to be dedicated to the development of the hospice and palliative care sector. However, interaction and cooperation between the healthcare and the social sector is still impeded by competence and financing issues (see *(c)*). Whereas obstacles still have to be removed on the large scale, there is already a successful cooperation of various health and social care professionals in palliative and hospice services. For instance, there are almost 60 multidisciplinary mobile palliative teams, partly working out of hospitals that provide palliative care services to patients in their home or long-term facilities.

As *public institutions providing services to healthcare providers (d)* may be classified the legally defined network of federal and regional (Länder) healthcare administrations and the social security institutions at the national level. The network develops standards and provides advices on organisation, planning, coordination and quality of healthcare services. The regional health funds support the regional healthcare system, mainly composed of public healthcare providers. Another example is the national public procurement agency which supports procurement of public hospitals if they wish so.

Belgium

Categories of groupings identified:	*Network of professionals (b);* *Network of healthcare and social care institutions (c).*

There are *networks of professionals* (b) and *healthcare and social care institutions* (c). Several initiatives have been implemented to foster collaboration within primary healthcare professionals and institutions, such as the Impulseo and Impulseo II funds, which financially supported the GPs in the management of their daily practices.

Networks of healthcare and social care institutions (c) include mainly outpatient centres, residential institutions, and primary care settings.

A Network of Clinical Pathways, has been created, gathering 106 organisations among acute hospital trusts, rehabilitation centres and home care organisations. Within the network, several multi-disciplinary teams are involved in the provision of care to a specific patient population.

Networks of professionals are developed in the field of palliative care on all Belgian territory. Their activities consist in raising awareness and coordinating palliative care at the local level. Palliative care networks are composed by multi-disciplinary teams operating in different settings such as home and hospitals. The hospital palliative care units are members of the networks. There are 379 palliative care units in 5 hospitals in Brussels, 29 hospitals in Flanders and 17 hospitals in Wallonia.

In the field of mental care, efforts have been made to implement networks of professionals and institutions aimed at defining new pathways of care for young people.

Bulgaria

Categories of groupings identified:	*Network of professionals (b);* *Network of healthcare and social care institutions (c).*

There are *networks of professionals* (b) and *networks of healthcare and social care institutions* (c) in the field of rehabilitation and mental care.

One of the actions planned is the enlargement of the *network of long-term care institutions and rehabilitation hospitals*.

Regarding mental care, the Government and the municipalities are supporting the development of *networks of State or municipal social institutions* (c), including several institutions. Such social institutions have multi-disciplinary teams involving physicians, nurses, social workers and paramedics. The number of institutions and places available can be found in the table below.

Table 1 Network of state or municipalities: number of settings and places (Year 2008). Source: WHO Observatory on Health Systems and Policies.

Setting	*N° of centres*	*N° of places*
Centres for social rehabilitation and integration	241	6.927
Day-care centres for children and young people	82	2.583
Day- care centres for adults with cognitive impairment	31	806
Homes for children and youngsters with cognitive impairment	26	1.612
Homes for adults with cognitive impairment	58	4.689

A network for palliative care has been established as well. The clinical pathway is performed in *inpatient care facilities, including hospitals for long-term treatment, multi-profile hospitals for active treatment with palliative care units and comprehensive cancer centres with inpatients beds*[1].

Croatia

Categories of groupings identified: *Public institutions providing services to healthcare institutions (d).*

Croatia implemented in 2012 the Act of Sanation of Public Administration with the aim of reducing the inpatient expenditure, that was heavily affecting public finances. This initiative transferred the management of hospitals to the Ministry of Health.

A "*joint procurement programme*" for public hospitals was implemented as well, by which some hospitals were assigned to procure goods for all participating hospitals (d).

[1] European Observatory on Health System and Policies website, section dedicated to compare mental healthcare in several countries: http://www.hspm.org/searchandcompare.aspx

Cyprus

Categories of groupings identified: *Network of professionals (b).*

In Cyprus, there are *networks of professionals* (b) corresponding to teams of nurses providing long-term care to patients at home.

Long-term care services are provided mainly to people with a high level of dependency, often elderly people, those with chronic diseases and people with physical, learning and mental disabilities. The nursing services of the Ministry of Health facilitates the long-term care provided by a network of community nurses (General Community Nurses and Mental Health Community Nurses) through home visits to mentally ill patients, disabled people, artificially ventilated patients at home and elderly people who live alone and encounter severe health problems.

The long-term care provided by the Mental Health Services, is being ensured by monitoring chronic patients in the community (at their homes or at rehabilitation units, such as *day centres* and *occupational rehabilitation units*). These services are provided by multi-disciplinary teams of health professionals (psychiatrists, clinical psychologists, ergo therapists, nursing officers).

Denmark

Categories of groupings identified: *Hospital grouping (a);*
Network of professionals (b);
Network of healthcare and social care institutions (c);
Public institutions providing services to healthcare institutions (d).

Denmark is divided into five Regions, which manage the hospitals. During the last decade they have continued the process of merging smaller hospitals into fewer, larger and more specialised hospitals. Some hospitals today are formally merged while retaining two or more addresses.

Hospitals work together extensively while keeping various degrees of autonomy (a). The hospitals have limited economic autonomy where they are free to prioritise within the economic limits that the Regions assign to them. The regions are economically constrained by the result of an annual negotiation between Danish Regions and the Government. They are also constrained by the budget law which punishes the Regions economically if they exceed the budget.

It is also coordinated at the national level what diseases the individual hospitals treat and what procedures they conduct (the so-called *speciality plan*). The reason for this is to ensure that each hospital is able to uphold the best clinical quality.

Patients are free to choose where they want to be treated which also means that the hospitals have to cooperate. Patients can choose both public and private hospitals.

In Denmark, there are also *networks of professionals* (b). Various healthcare professionals are generally involved in the treatment of patients. For example, there are multi-disciplinary teams providing palliative care to oncological patients.

General practitioners often employ other healthcare professionals to take part in the treatment of their patients. Doctors also cooperate on a national level in scientific societies within each medical speciality.

It is an ongoing effort in the Danish healthcare sector to increase cooperation between the hospitals and the municipalities, which run the social care institutions (c). For example, efforts are being taken to ensure that elderly patients who are discharged from the hospitals experience a smooth transition to social care. Likewise, the hospitals and the social care sector often cooperate on preventing hospital admissions.

Hospitals, municipalities and general practice also cooperate to create coherent treatment for patients with chronic diseases.

The Regions provide general services to the hospitals (d) for example concerning central administration, planning and procurement.

Estonia

Categories of groupings identified:	*Network of professionals (b);* *Network of healthcare and social care institutions (c).*

Estonian Governments have been focusing for a long time on the creation and optimisation of inpatient healthcare services. A reform started during early 90s to improve the provision of inpatient care in terms of acute care bed capacity, bed occupation rate and average length of stay. From late 90s there was a reduction of the number of acute care beds due to the merger of hospitals.

The Cooperation Agreement in Healthcare of 2013 defined an Hospital Master Plan promoting the *network of institutions* (c) in order to ease specialist care in small hospitals, through the coordinated use of human[2] and technological resources.

For example, North Estonian Medical Centre and Tartu University Hospital received 2 million Euro from the Government to buy shares of public hospitals and to invest in hospital infrastructures. Moreover,

[2] In this context, the coordinated use of human resources is intended as a network of professionals.

the cooperation between hospitals, primary care and ambulance care providers is also promoted. So far, 5 out on 19 general hospitals have become part of Estonian Medical Centre and Tartu University Hospital, that are regional hospitals.

To promote cooperation between primary and inpatient care, the Estonian Government has financially supported the construction of healthcare centres, with the objective of merging family practitioners and also to create medical centres inside or close to hospitals. This choice is led by the necessity of providing to patients primary and inpatient care in one place.

Several innovations have been introduced to improve the provision of mental care services. One of them regards the creation of a *network of professionals* (b) and *institutions* (c) aimed at ensuring a more integrated approach to patients.

Finland

Categories of groupings identified:	*Network of healthcare and social care institutions (c);* *Public institutions providing services to healthcare institutions (d).*

Administrative units of social and healthcare sectors have been merged in most municipalities. In several areas, administrative units of different healthcare providers (*hospitals and healthcare centres*) have been merged to provide a more efficient service both in the primary and secondary care field. The oldest examples are South Karelia Social and Healthcare District (Eksote) and Kainuu Social and Healthcare.

Siikalatva Health Service District is an example of merging the administrative functions of several healthcare centres in a single unit.

Other initiatives have been implemented to facilitate the cooperation within different healthcare providers such as the provision of laboratory and radiological services and emergency services in five special areas of healthcare. A regional system of patient data management has been introduced in Pirkanmaa and Satakunta hospital districts, and others are in development.

In Helsinki, two hospital districts and the Helsinki University Central Hospital have been merged in a new hospital district already in 2000. There are municipal enterprises taking care of laboratory services and X-ray services in some hospital districts (d). There are municipally owned private enterprises like Coxa in Tampere, which is the largest hospital in the Nordic countries and one of the leading ones in Europe specialised in joint replacement surgery.

Health, social services and regional-Government reform is one of the biggest administrative and operational overhauls in Finland. The aim is to transfer the organisation of healthcare and social services and other regional services to 18 counties as of 1 January 2020. The reform impacts the jobs of hundreds of thousands of people and affects the services of every citizen in the country. It affects also

the financial resources, steering and taxation of healthcare and social services. There is ongoing establishment of regional solutions to integrate social care, primary and secondary healthcare services under one roof, like SiunSote, Essote, Soite and Päijät-Häme, all over the country.

France

Categories of groupings identified: *Hospital grouping (a);*
Network of professionals (b).

Territorial Hospital Groups (GHTs) have been established by Law on January 2016 reforming the hospital care system in the country. It sets the rules to formally constituting the GHTs, the features of the shared medical project as well as the activities managed by the "support" facilities. GHTs are set by the regional agencies (ARSs), that define the composition of the groups in the geographic area of their competence. GHTs are mandatory for public facilities but could include also private ones (for profit or not for profit). So far, few private hospitals and nursing homes joined GHTs.

With the GHTs, public health facilities outline a strategy defining the organisation of care for patients by medical specialty on a territorial basis. They share units managing cross functions such as hospital ICT system management, purchasing procedures, training of professionals. The modalities of formalising GHTs differ according to the strategy put in place by the ARS in that specific territory. Thus, some GHTs could correspond to *hospital grouping* (a) while others to shared administrative departments managing *cross functions*. There will also be medical teams shared by hospitals (corresponding to *network of professionals*) and joint investments in tele-medicine.

1.100 hospitals will be re-organised in 150 GHTs. By July 2016, 135 GHTs have been set up. The extent of GHTs is varying, ranging from 2 to 20 facilities covering from 50.000 to 2 million inhabitants.

In the palliative care sector, *networks of professionals* (b) have been created to assist patients at hospital or home. These networks are local associations bringing together several professionals in a unique multi-disciplinary mobile team, providing care while collaborating with GPs. Information on the background (degree in palliative care) and composition of palliative team (physicians, nurses, psychologists and paramedical staff) is available. When palliative care is provided in hospitals, patients could receive care by professionals employed by the hospital itself or by mobile multi-disciplinary teams. There are 6.500 hospital beds for palliative care, 420 palliative care teams and 110 active palliative networks.

Germany[3]

Categories of groupings identified: *Hospital grouping (a).*

The number of hospital mergers (creating or enlarging hospital groups) increased in the last 15 years. Germany adopted an Act against Restraints of Competition (GWB – *Gesetz gegen Wettbewerbsbeschränkungen*) and the main principles behind competition policy in the country namely the protection of economic freedom.

Indeed, mergers could bring to the creation of dominant players that could limit the competition in any sector. Information is available also on the criteria that shall be taken into consideration to assess the market position of a player, including the financial power.

The document analysed lists also the procedure that the appointed authority, the Federal Cartel Office (BKA – *Bundeskartellamt*), put in place when receiving the proposal of merger.

The increased number of mergers was due to the fact that several public hospitals have been sold to private players, given budget difficulties faced by public authorities. The BKA applied the GWB to the hospital sector in order not to compromise the competition and, for this reason, some mergers proposals have been rejected. Information is available on the cases of mergers rejected or accepted but also on the approach to defining geographic hospital markets. Such analysis is addressed to verify if the patient would have faced difficulties in accessing care after the merger.

In general, the competition law enforcement on hospital market is addressed to preserve the competition and as a consequence, to ensure a proper quality of healthcare services delivered. In 2016, BKA launched a market analysis by interviewing 500 representatively selected hospitals. This analysis aims at mapping the competition between hospitals but also at further developing the criterion for the merger control procedures.

Greece

Categories of groupings identified: *Network of professionals (b);*
Network of healthcare and social care institutions (c);
Public institutions providing services for healthcare institutions (d).

[3] Varkevisser M. and T. Schut F. T. Hospital merger control – an international comparison, 2009.

Greece experience a reduction or merger of existing health units as well as the transfer of National Healthcare Service (ESY) departments or the establishment or relocation of university clinics from one hospital to another. Following the Law 3235/2004 on primary care, *networks of primary healthcare institutions* (c) and *professionals* (b), mainly GPs, have been promoted.

In 2007, the procurement procedures of the public hospitals have been centralised at the Central Committee of Health Supplies (EPY) (*public institutions providing services to healthcare providers*).

Rehabilitation care is provided through two *networks of institutions* (c), the first comprising 24 centres and the second one 17 centres.

Hungary

Categories of groupings identified:	*Network of professionals (b);* *Network of healthcare and social care institutions (c).*

Four hospitals were merged in a single State central hospital.

There are *networks of professionals* (b) and *networks of healthcare and social care institutions (*c). The latest gathers primary care doctors, outpatient specialist clinics and hospitals.

Ireland

Categories of groupings identified:	*Network of professionals (b);* *Network of healthcare and social care institutions (c);* *Public institutions providing services to healthcare institutions (d).*

There are nine Communities Health Organisations (CHOs), structures gathering primary care and mental health providers as well as health and well-being settings, as *network of professionals* (b) *and institutions* (c).

In the hospital sector, the National Hospitals Office (NHO) is carrying out management functions for 51 national hospitals, including advisory, organisation, planning and coordination. This is one of the case where a *public institution providing services to healthcare institutions* (d). In the same category (d) could

be included entities that carry out support services such as: Finance Directorate (financial management), Human Resources Directorate (human resources management), ICT division and Office for Procurement.

There are *networks of professionals* (b) established in the health sector in general, and in palliative care in particular. The first of those is dated back to 1985 at Our Lady's Hospice in Dublin. 550 multi-disciplinary teams have been established also in primary care to foster the cooperation within general practitioners also to provide out-of-hours services.

10 *networks of hospitals* (c) have been initially settled after the reform of 2005, which contributed to re-configuring the organisation of the health sector as well as to allocating the acute hospitals management to Health Service Executive NHO.

Italy

Categories of groupings identified:	*Hospital grouping (a);* *Network of professionals (b);* *Network of healthcare and social care institutions (c).*

The categories of groupings identified in Italy are *networks of hospitals (a), networks of professionals* (b) and *networks of healthcare and social care institutions* (c).

The *network of professionals* is typical of the primary care sector, where GPs are merged into groups of practices, jointly providing healthcare services to their patients and acting as gate-keepers to other levels of care. Such networks, have been promoted by the Local Health Authorities to cope with the consequences of the financial crisis and to employ in a more efficient way the human resources available on the territory.

As regards *hospital grouping (a)* and *healthcare and social care institutions* (c), the Italian National Legislation (D.M. 70/2015) states the development in each Region of the following clinical networks: *Oncological Network, Pain Therapy Network, Rare Disease Network, Myocardial Infarction Network, Stroke Network, Neonatology & Delivery Network, Transplants Network, Traumatology Network, Paediatrician Network* and *specialist medicine*. A National Working Group was settled for facilitating the development of these networks with the aim of creating guidelines and recommendations. It is composed by experts from Health Ministry, Regions, AGENAS (National Agency for Regional Health Services). The common aim of these networks is working in a coordinate way involving hospitals, outpatient care, home care services, inpatient care and residential facilities. The most frequent regional clinical networks are Emergency Networks, Diabetes Networks, Alzheimer's Networks. The delivery of palliative and mental care is organised around *networks of healthcare institutions* (c).

The mental healthcare *network of professionals* (b) *and institutions* (c) operates at the primary care level through the Departments of Mental Health, representing a means for the local health authorities to guarantee the promotion and coordination of mental healthcare services.

The creation of clinical networks is an important opportunity to create synergies and coordination between the different levels of care (acute hospitals, intermediate care, homes, residential). However, a critical point to be faced today and more in the future is how to manage in a coordinated way a patient belonging to different clinical networks. In fact, many patients are affected by multi-morbidity and are included in more networks. Primary care will be very important, as above said, acting as house keeper to the other levels of care. The development of ICT will be very important for the managing of the networks.

Malta

Categories of groupings identified:	*Hospital grouping (a);* *Network of professionals (b);* *Network of healthcare and social care institutions (c).*

In Malta three categories of groupings have been identified. The first one refers to *hospital grouping* (a), including Gozo hospital and rehabilitation hospital run by Vitals Group.

Besides it, several examples of *networks of professionals* (b) have been reported and are listed as follows:

- The cancer Care Pathways Directorate (CCP), established to improve the cancer patient pathway, is responsible for providing vision and direction across the whole patient pathway, including coordination and continuity of care. Some of the initiatives undertaken include:
  - Fast-tracking of e-referral system for suspected colorectal cancer which has been developed in liaison with the directorate, GPs, consultants, health policy and the IT department.
  - Collaboration with the primary healthcare department, whereby primary healthcare nurses have been trained to extend Port-a-cath maintenance for cancer patients.
  - The Tailored Information in Cancer Care (TICC) working group, set to develop a number of site-specific patient information booklets including oncology information.

- Multidisciplinary meetings bringing together different healthcare professionals from the National Screening Unit, Imaging Department, Pathology Department, Surgery Department and Oncology Department regularly organised at the main acute hospital. These multi-disciplinary fora allow discussion of clinical cases with breast conditions, upper and lower gastrointestinal

tract conditions, and hepatic disease. The expertise derived from the various healthcare professionals coming from different sectors provide a more holistic approach to care and better continuity of care.

- The Mental Health Act enacted in 2012, emphasises the need of multi-disciplinary care with the patient participation. Mental Health Services are provided by the main mental hospital, the psychiatric unit within the main acute hospital and by primary care – health centres and community settings including a Government scheme to incentivise private GPs to review psychiatric patients.

There is cooperation between the main hospital, the rehabilitation hospital and homes for the elderly which fall under the remit of the Ministry of the family and social solidarity including community services(c).

Poland

Categories of groupings identified:	*Network of professionals (b)* *Network of healthcare and social care institutions (c).*

There is a large number of hospitals (more than 1,000 including public and private ones) existing in Poland, being "heritage" of the past healthcare system. The Government, Ministry of Health and local governments made efforts to reduce this number mainly by merging them (a).
The strategy of merging was promoted for the past 5 years to acquire higher levels of reference (both for specific departments and hospitals) and higher level of resources through contracts with National Health Fund, the only payer institution in Poland.

There are *networks of professionals* (b) and *healthcare institutions* (c) in primary care (primary care centres, GPs and other professionals – pediatricians, internists). The *network of professionals* is typical of the primary care sector, where GPs are merged into groups of practices, jointly providing healthcare services to their patients and acting as gate-keepers to other levels of care.

The delivery of palliative care is organized around the *networks of healthcare institutions* (c). The palliative care network includes outpatient care (in palliative care clinics), home care services, inpatient care (in a stationary hospice or a palliative care unit) and residential facilities.

The need of promoting integrated care led to the creation of *clinical pathways* gathering acute hospitals, rehabilitation centres and outpatient clinics (e.g. for patients after myocardial infarctions). Within the network, several multi-disciplinary teams are involved in the provision of care (intervention cardiologists, cardiologists, physiotherapists, internists).

The integration of healthcare service provision is also reflected in the creation of networks of healthcare institutions (c) – mainly hospitals - and professionals for cancer care.

In January 2015, the Polish Government introduced a "waiting time and oncology treatment package". The package aims at improving early diagnosis of cancers and shortening waiting times for oncology treatment. The package introduced *oncology diagnosis and treatment cards* enabling quick diagnosis, confirmation of cancer and preferential access to treatment for each patient with suspected or diagnosed cancer. The card should contain all the information on the progresses of treatment.

One of the most important aims of oncology package is introducing a waiting time limit of 7 weeks from the diagnosis to treatment. Lists of patients waiting for treatment are electronically recorded and updated every week.

Portugal

Categories of groupings identified: *Network of healthcare and social care institutions (c).*

Networks of healthcare institutions are typical of mental care, where the healthcare services are provided through community care network. At the primary care level, the ACES (groups of primary care centres) have been established to provide better care to diabetic patients.

An additional example of this kind is represented by the Diabetes Coordinating Units (UCFD), which integrate diabetes healthcare facilities, primary care and tertiary care. Networks of providers relate also to long term and palliative care.

The first case corresponds to the so called "long term network" (RNCCI), composed of 268 facilities and 5.916 beds in 2012. The second case corresponds to the creation of the National Network of Palliative Care (RNCP) which complements the existing structures.

Spain

Categories of groupings identified:	*Network of professionals (b);* *Network of healthcare and social care institutions (c);* *Public institutions providing services to healthcare institutions (d).*

In Spain, there are Primary Healthcare Centre Networks throughout the country, composed by multi-disciplinary teams of family doctors, paediatricians, nurses and social workers (b). Some can include physiotherapists and dentists, and are linked to laboratories and diagnostic centres, either in the same facilities or centralised and serving several centres in the surroundings. The existing healthcare networks may frequently assume responsibility for the provision of palliative care, in coordination with hospitals.

In terms of innovative initiatives put in place, in some Autonomous Regions, more than one management model may coexist. Further examples of this kind are developed not only in primary care centres but also in hospitals, where multiple clinical services are provided in an integrated way (Institutes or Clinical Areas), sharing protocols and guidelines (c). Examples of clinical institutes are the Cardiovascular Institute of the Hospital Ramón y Cajal in Madrid, the Oncology Institute of the Hospital Virgen de la Arrixaca in Murcia and the Heart Institute of Hospital Juan Canalejo in Galicia.

Integrated healthcare areas managed by a unique team is a further example of innovative model. Regional healthcare services are increasingly creating single area management frameworks, integrating primary care and specialist care, sharing administrative structures and/or organisation care process.

One of the functions of the Carlos III Health Institute is establishing partnerships with other National Health System research centres for cooperative investigation networks.

Reference Centers, Services and Units (CSUR) of the Spanish National Health System (NHS) are being accredited by the central Government to improve equity in access to highly specialised services for all citizens when needed. CSUR concentrate the experience with a high level of specialisation ensuring quality, safety and efficient healthcare and improving low prevalence pathologies care and procedures. These Reference Centres, where care is provided by multi-disciplinary teams, act as support for diagnostic confirmation and as consultancy for clinical units as well as define therapeutic and monitoring strategies.

Finally, the National Health System Centralised Procurement Platform (d) allows to unify technical criteria and improve transparency in contracts and to establish single drug and medical devices price, the same for all Autonomous Regions, that want to adhere to this platform. It also represents a guarantee for the providers companies, because it favours market stability through a common contracting scenario, especially when time of payment arrives.

Sweden

Categories of groupings identified:	*Hospital grouping (a);* *Network of professionals (b);* *Networks of healthcare and social care institutions (c).*

In Sweden, most hospital services are provided by the 21 county councils/regions. Since most of them run several hospitals, these belong to the same group (a). Additionally, the county councils/regions are grouped into six medical care regions to facilitate cooperation concerning highly specialised healthcare. In the last decades, we have seen several mergers of hospitals.

Karolinska University Hospital was formed by merging Karolinska Hospital and Huddinge Hospital. Sahlgrenska University Hospital in Gothenburg was created by merging several hospitals. Skåne University Hospital was created by merging the university hospitals in Malmö and Lund. But there have also been several mergers of smaller and medium-sized hospitals.

Professional teamwork is very common in Swedish healthcare, but these professionals often have the same employer.

One example of healthcare workers having different employers is the provision of medical services at nursing homes. Municipal nursing homes employ nurses but cannot employ doctors. These services are instead provided by the county council/region or a private provider contracted by the county council/region (b).

A lot of initiatives have been taken to improve cooperation between healthcare and social care. One example is “TioHundra” in Norrtälje municipality (north of Stockholm), where the municipality (Norrtälje) and the county council (Stockholm county council) has created a joint company (TioHundra) being responsible of providing both health and social care (c).

The Netherlands[4]

Categories of groupings identified:	*Hospital grouping (a);* *Network of professionals (b);* *Network of healthcare and social care institutions (c).*

The process of *hospital grouping* (a) is ongoing since 60s. This tendency was due to the necessity of balancing the power between inpatients settings and health insurers. The information available reports the historical reasons behind this choice.

There are *networks of healthcare and social care institutions* (c) in the palliative care sector, including 606 outpatient settings. The largest group, is formed by 247 home care organisations and 190 volunteer organisations. Palliative care could be provided also in hospices or to inpatients.

Professionals involved in palliative care are grouped into multi-disciplinary teams composed of professionals working in different settings such as primary or specialist care and nursing homes. This has been encouraged with the implementation of a national integrated strategy, focused on creating patient pathways for specific diseases. Such networks are organised at the primary care level and are based on the so called primary care groups, involving from 4 to 150 GPs and other providers.

Rehabilitation care is provided in out-patients settings and is based on multi-disciplinary teams (*network of "allied" professionals*) composed of physical and occupational therapists, speech therapists and social workers. Also in the field of long term care the presence of multi-disciplinary teams has been reported. These have been created by municipalities to assist citizens through an informal network.

The Netherlands Competition Authority promoted the competition since 2004, year in which it has investigated more than 150 cases of care concentration.

The Netherlands is one of the country where information on mergers is fully available. Studies have been developed to investigate further on the effect produced by hospital mergers in a liberalised context such as the one in the country[5]. A clear description on the reasons that led to the introduction of policies on merger control has been reported, together with the description of the Dutch Competition Act and the Netherlands Competition Authority. Furthermore, information is available on the criteria applies by such authority to refuse/accept merger proposals. In general, the feedback is negative when they foster the creation of a dominant economic position. It is available also a table of proposed mergers with the year and the final feedback of the authority.

[4] Varkevisser M. and T. Schut F. T. Hospital merger control – an international comparison, 2009.
[5] Canoy M. and Sauter W. Hospital mergers and the public interest: recent developments in The Netherlands, September 2009.

United Kingdom

Categories of groupings identified: *Network of professionals* (b);
Network of healthcare and social care institutions (c).

In Scotland and Northern Ireland, the integration of health and social care departments in a unique unit is planned. This unit enhances the sharing of information and resources (c).

In Northern Ireland, the creation of seventeen care partnerships is forecasted to include several professionals such as: doctors, nurses, pharmacists, social workers and carers. Furthermore, it has been announced in 2015 that smaller hospitals will be closed (b).

NHS England has a new models of care programme which encourages groupings of hospitals, both with primary care providers and social care. In particular, some of the Vanguards mentioned below focus particularly on acute services and have encouraged hospitals to group around provision of certain services (a).

NHS organisations and local councils are developing shared proposals to improve health and care. Working in 44 geographical areas covering all of England (called *footprints*), the plans are led by senior figures from different parts of the local health and care system. The proposals are designed around the needs of whole areas, not just individual organisations, following discussion with staff, patients and others in the communities they serve.

Through the new care models programme the NHS is looking at complete redesign of whole health and care systems. This means fewer trips to hospitals with cancer and dementia specialists holding clinics in local surgeries, having one point of call for family doctors, community nurses, social and mental health services, or access to blood tests, dialysis or even chemotherapy closer to home.

Integrated Care Pioneers act as exemplars, demonstrating the use of ambitious and innovative approaches to efficiently deliver integrated care. Following an independent selection process, 14 pioneer sites across England were announced in November 2013. The selection process was repeated in the autumn of 2014, and a further 11 pioneer sites joined the programme in January 2015. These 25 integrated care pioneer sites (the pioneers) are developing and testing new and different ways of joining up health and social care services across England, utilising the expertise of the voluntary and community sector, with the aim of improving care, quality and effectiveness of services being provided (c).

ANNEX

As follows, it is provided a table resuming the kinds of hospitals grouping in the European Member States plus Switzerland and Serbia. Information refers to solutions already implemented or future developments.

Country	Hospital grouping (a)	Network of professionals (b)	Network of healthcare and social care institutions (c)	Public institutions providing services to healthcare institutions (d)
Austria	X	X	X	X
Belgium		X	X	
Bulgaria		X	X	
Croatia				X
Cyprus		X		
Czech Republic			n.a.	
Denmark	X	X	X	X
Estonia		X	X	
Finland			X	X
France	X	X		
Germany	X			
Greece		X	X	X
Hungary		X	X	
Ireland		X	X	X
Italy	X	X	X	
Latvia			n.a.	
Lithuania			n.a.	
Luxembourg			n.a.	
Malta	X	X	X	
Poland		X	X	
Portugal			X	
Romania			n.a.	
Serbia			n.a.	
Slovakia			n.a.	
Slovenia			n.a.	
Spain		X	X	X
Sweden	X	X	X	
Switzerland			n.a.	
The Netherlands	X	X	X	
United Kingdom		X	X	

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