Application of European accounting standards to the public healthcare sector

A comparative study on the application of the European System of Accounts ESA-95 to healthcare centres in the United Kingdom, France and Germany

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A comparative study on the application of the European System of Accounts ESA-95 to healthcare centres in the United Kingdom, France and Germany

Commissioned by: Consortium for Healthcare and Social Services of Catalonia*

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** Professor Ana Belén Macho has conducted the sections realting to "Application of ESA-95 to healthcare centres in the United Kingdom and Germany". On the other hand, Professor Ester Marco has carried out paragraphs "General criteria for the classification of healthcare centres under ESA-95" and "Application of ESA-95 to healthcare centres in France and Spain". The remaining sections of this work have been conducted jointly by both authors.

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Table of contents

Preface

The Consortium for Healthcare and Social Services of Catalonia commissioned the Pompeu Fabra University School of Law (Department of Finance and Tax Law) to compile this report as supplementary information to a CSC Document of Recommendations as to how the health system and providers are governed, entitled Governance in healthcare institutions, which has been published and made available to the sector.

The Document of Recommendations is the result of work carried out by a group of experts, as well as a debate and discussion session with the heads of government bodies and entities with links to the CSC, in order to establish and agree on the key factors for good institutional governance and the requirements of the system to promote this, as well as formulating a series of practical proposals that can be implemented in our organisations in the short and middle term.

The aim of this work by the CSC is to ensure that healthcare organisations are able to obtain the best possible results, making good use of the resources society provides them with, and that the healthcare bodies and system be passed down, stronger than ever, to coming generations.

The CSC's report "Governance in healthcare institutions" covers the concepts of governance, governability and government, as well as the principals and tools of good governance, both with regard to the healthcare system and the service providers. Special emphasis is put on the need for professionalisation and for the administrators/members of the governing body at institutions to take on a personal risk, as neither the public nature of the entity, nor its non-profit nature nor the fact that the position is un-paid exempt them from or attenuate their responsibility, which is governed by general and specific regulations derived from the public nature of the funds they manage.

The conclusions of the debate posed by the CSC as to the measures needed to ensure the good governance of the healthcare system and institutions, taking into account the diagnosis and SWOT analysis of the current situation, can be summed up in the following proposals:

Proposals for good governance of the health system

1. We must ensure **coherent global planning** with an overall view of the system, reinforcing the integrated use of **planning tools**, as a **key element** of governance of the system.
2. The system must be governed by **establishing clear objectives and results regarding health** (ensuring both access and service), and answering to the citizen's needs in terms of health rather than through the planning of the existing resources. Also by **boosting network coverage** and alliances among providers, and by facilitating **territorial and local participation** through pacts and consensus.
3. We must **delve deeper into the topic of separation of functions as a characteristic trait of the Catalan healthcare model**, reformulating the system's governing bodies to ensure this separation of roles. Likewise, in cases in which the Government of Catalonia holds ownership rights over the body, we must clearly differentiate between the owner and the partner or associate.
4. **The system must be governed jointly by the Government of Catalonia and the local authorities**[1], each within their own and shared purview. Local entities (city councils, provincial councils and county councils) are **key stakeholders** that must be heard and with whom a consensus must be reached as to the system's objectives. They must be fully informed of the systems operation and results, **both in their own right and as representatives of the people.**
5. We need a new **social and political agreement on the public health system**, regaining the **spirit of consensus** that led to the creation and development of the present model.
6. The law governing the public health system (LOSC) must be revised and modified, in order to provide **full legal coverage for the separation of the functions**, assigned to each of the stakeholders: planning, purchasing and providing.
7. **Contracts are the key tool through which the relationship between purchasers and providers** is established, and they must be a tool for assigning the resources necessary to meet society's health-related needs. This ensures governability, both of the system as a whole and of the health provider organisations themselves, and **must be geared towards achieving the desired results**, fostering cooperation and networking amongst providers.

1. It is very likely that new legislation currently being discussed by the Spanish Parliament (Law for the rationalization and sustainability of the local administrations) will introduce changes regarding the scope of the local administration's purview in most matters.

8. **Contracts** must be **public, transparent and homogeneous** regardless of whether the chartered provider belongs to the public or private sector. They must include an explicit definition of the consequences of compliance (rewards/incentives) or breach (sanctions/penalties) of terms.
9. Healthcare and economic **results must be transparent and made public,** fostering assessment and **accountability as tools for decision-making.**
10. **Assessment, control and supervision** of the provider organisations must focus mainly **on results, not in the assessment of procedures.**

Proposals for good governance in provider institutions

1. **The owner of an entity proposes and appoints** the members of the governing bodies, delegating responsibility on them upon appointment. Members of the governing bodies shouldn't have an esclusively political profile but also a business profile; with experience in healthcare management and planning, as well as knowledge of the local arena, understanding and **assuming the responsibilities implicit in this position**. Likewise, it is important to **define the role of the members of the governing bodies**, and for them to defend the best interests of the institution when exercising their functions (**duty of institutional loyalty**).
2. Each governing body must establish **internal, transparent, agreed-upon criteria of good governance**, which include terms of implication, dedication and compensation for the governors.
3. **Mutual trust between the governing body and the management team** is essencial, to make sure of their alignment, and so is a clear definition of the functions and duties of each of them.
4. **Ensuring internal and external transparency** is a criterion that must be made explicit in the entity's Code of good governance. Transparency is the purview of the governing body, but management is in charge of executing it and managers must make sure that **efficient channels** exist for the internal and external communication of the institution's results.
5. Improved use of healthcare expenditure in the public sector requires **tools that vary greatly from those required for administrative control** in order to **combine the regulatory requirements of the public sector with the autonomous management of the chartered centres and their necessary efficiency.** We need new regulations that provide a greater degree of management autonomy for bodies in the public sector, adapting the legal and statutory structure of the entities in order to consolidate their autonomous management and defend it against any possible interference.

6. One of the main points of **value added** from the **public business sector** is that its **efficiency and flexibility go alongside its non-profit nature**. The privatisation of this public sector would lead to the loss of this value added.
7. The non-profit character of any given organization should not prevent it from generating the necessary surplus as to properly address the obsolescence and depreciation of structures and equipment.
8. We must strengthen the role of the **contract (between the administration and the providers) as a key tool for managing the public business sector.** Contracts must include a system of payment against the purchase of services (based on transparent, homogenous market rates for both the private and public sectors), as well as new views on issues such as time limits and territorial coverage.
9. We must generate mechanisms to **identify and make public any potential conflicts of interest** that may arise in an entity. The entity's Code of Good Governance must clearly define the **procedures to resolve** any such type of conflict.
10. The governing bodies must promote **professional commitment**, posing this strategic goal to the management teams. Professionals must be involved in the governability of the institution, **not its governance**, except when they take on a financial risk at a personal level.

Executive summary

Aim: This report aims to analyse how European accounting standards (European System of Accounts ESA-95) are interpreted and applied to the public healthcare sector, from the standpoint of comparative law. Specifically, the study focuses on the application of ESA–95 to healthcare centres in the United Kingdom, France and Germany, with the aim of reaching useful conclusions for the Public Companies and Consortia (EPIC, for their initials in Catalan) in the Catalan Public Healthcare System.

Context: Currently, in terms of ESA–95, EPIC are classified as non-financial public-sector bodies, within the "General government" sector, and, as such, their debt must be consolidated with that of the Government of Catalonia for compliance with European Union (EU) budgetary discipline goals. Based on the experience of applying ESA–95 in the three aforementioned Member States (United Kingdom, France and Germany), this report analyses the requirements set by European institutions for exclusion of healthcare centres –and public hospitals in particular- from the "General government" sector under ESA–95, despite being public bodies with mainly public funding.

Contents and structure: The main issues posed in the study are as follows: 1) how ESA–95 is interpreted and applied to healthcare centres in the United Kingdom, France and Germany; 2) the characteristics healthcare centres must have in order to be excluded from classification within the "General government" sector under ESA–95; and 3) the extent to which application of ESA–95 conditions the autonomous management of these centres. To provide background for the comparative legal study, one section of the report is devoted to general criteria for the sector classification of healthcare centres under ESA–95. Likewise, comparative tables with other European Union Member States are provided at the end of the report.

General criteria: In order to know the public deficit and debt levels for compliance with limits established in European regulations (Treaty on the Functioning of the EU and the EU Stability and Growth Pact), Member States must submit their accounts in accordance with the Regulation approving the European System of Accounts (currently, ESA–95, and as of 1 September 2014, ESA–2010). The criteria to interpret and apply these complex standards are set by Eurostat (European Community Office of Statistics), both in its "ESA–95 Manual on government deficit and debt" (latest edition, 2013), and in its

Decisions. For the purposes of this report, we are interested in establishing the configuration of the "General government" sector under the European accounting standards (it must be noted that Spanish budget regulations define the concept of the "public sector" by referring to the definition in the European accounting standards). The general criteria for sector classification of bodies, as part of the general government sector or not, is particularly difficult to establish for public hospitals, which is why the ESA–95 Manual includes a special section addressing this topic.

Application in the United Kingdom, France and Germany

There are significant differences in how ESA–95 is applied to health centres in the three Member States analysed (United Kingdom, France and Germany). In the United Kingdom, public hospitals (NHS Trusts and NHS Foundation Trusts) are currently classified as part of the general government sector (S. 13), central government subsector (S. 1311), but authorities are working to implement a government payment system that would allow them to be excluded from this sector.

In France, although they seem to comply with the Eurostat criteria to be excluded from the general government sector (given their payment system), French public hospitals are currently classified under the general government sector (S. 13), specifically in the social security funds subsector (S. 1314), and French statistical authorities don't seem to have any desire to change this classification, for reasons explained in this report.

However, the situation is quite different in Germany. In terms of national accounting, German hospitals, both public and private, are not classified as general government sector, but under the "Non-financial corporations" sector (S. 11). German statistical authorities classify public hospitals as "market" public-sector entities, given their funding system. Another element analysed in this report is the fact that public hospitals in Germany have a high level of financial independence and, in some cases, may even pay dividends to the general government, circumstances that Eurostat takes into account, due to the nature of capital injections these entities receive from the government.

Comparative analysis and conclusions

f we compare the previous results with the sector classification of public hospitals in Spain, we see that these are classified under the general government sector (S. 13), and the vast majority –91%– in the state government subsector (S. 1312), for various reasons. Some Spanish public hospitals can't be considered

"institutional units", but entities dependent on the government. Those hospitals classified as "public" institutional units are always considered by Spanish statistical authorities to be "non-market" entities, given their payment system. The high level of financial dependence on the government seen in Spanish public hospitals must also be noted.

Nevertheless, as analysed in this report, the fact that a specific entity is included in the general government sector does not entail specific obligations from national legislature in terms of internal control. This is an issue left up to the States, by virtue of the principle of institutional and procedural autonomy. And, to the contrary, the fact that a specific entity is excluded from the general government sector doesn't preclude possible control by European institutions in compliance with transparency obligations.

If we take into account Eurostat's latest interpretations of the sector classification of healthcare centres, as well as the recent approval of the new European System of Accounts ESA–2010, we see that the criteria allowing for classification outside the general government sector of public institutional units funded mainly by the government is being interpreted more and more restrictively. However it is also true that, as established in ESA–2010, each institutional unit must be judged individually (and not as a block) in terms of sector classification. Thus, it is possible to find that a specific hospital does meet the ESA–2010 criteria to be classified outside of the general government sector. Both the need to assess sector classification on an individual basis and the fact that, 17 years later, the new European System of Accounts has been approved, should motivate Spanish statistical authorities to analyse hospitals one by one in order to see if they meet the requirements established in the new ESA–2010.

Introduction

The aim of this report is to carry out a comparative legal study analysing how ESA–95 (European System of Accounts, approved by Council Regulation no. 2223/1996 on 25 June[2]) is applied to healthcare centres in three European Union Member States: the United Kingdom, France and Germany. This analysis is completed with comparative tables with the main aspects taken into consideration by European institutions for the sector classification of hospitals in Member States. As shown in this study, healthcare systems in the European Union vary widely and, as a result, the results obtained cannot always be completely extrapolated; however significant conclusions may be extracted for application in Public Companies and Consortia (EPIC, for their initials in Catalan) in the Catalan Public Healthcare System[3].

The parameters established in ESA-95 (which will be analysed in the general section of this study) allow Member States a certain margin in drawing up the limits of their "General government" sector. Logically, configuration of the

2. Throughout this report, on many occasions, we refer to sections of ESA–95 in order to define concepts of European budgetary discipline. In these cases, we refer to sections in Annex A of Regulation (EC) number 2333/1996, of 25 June 1996, regarding the European System of National and Regional Accounts (hereto forth, ESA–95). However, we must point out that on 26 June 2013 European Parliament and Council Regulation (EU) number 549/2013 regarding the European System of National and Regional Accounts (hereto forth ESA–2010) was published in the Official Journal of the EU. ESA–2010 will go into effect for data submitted after 1 September 2014. In our explanation, which is based on ESA–95, we will highlight any significant changes introduced in ESA–2010. Specifically, related to this study, we must point out two new issues introduced in ESA–2010. First of all, ESA–2010 introduces certain changes to the criteria for the sector classification of a body. As we will analyse in further detail, it establishes stricter restrictions for classifying a public body outside of the general government sector. Secondly, in a new section on "accounting issues related to the general government", ESA–2010 includes, among other issues, regulations related to the classification of capital injections from the general government to bodies outside the general government sector and rules on accounting for public-private partnerships. These regulations are not new in and of themselves, as they had appeared previously in the same format in the ESA–95 Manual and other specific pronouncements from Eurostat. However there is now increased binding force for these criteria as they are included in the text of the Regulation approving ESA–2010.

3. In fact, we mustn't forget that the funding models for healthcare systems in these countries vary widely. That of the United Kingdom (like Spain) is based on the National Health System or Beveridge model, in which funding comes from the country's general budget, mainly through taxes. Nevertheless, there have recently been important changes in this area (notably measures introduced through the Health and Social Care Act of 27 March 2012 in the United Kingdom; and in Spain through approval of the Royal Decree-Act 16/2012 of 20 April, on urgent measures to ensure the sustainability of the National Health System and to improve the quality and safety of its benefits, which establishes the figure of the "insuree" in terms of receiving healthcare services). The National Health System model is also seen in Sweden, Finland, Norway, Denmark, Ireland, Italy and Portugal. However, in France and Germany (as well as Austria, Belgium, the Netherlands and Luxembourg) the healthcare system has traditionally been funded through the Bismarck model, which is mainly based on the payment of obligatory insurance policies to mutual organisations and contributions are determined by each insuree's income level. Although there are different models, it must be noted that, on one hand, European countries nowadays tend towards a mixed model with elements from both systems; and, on the other, that the application of ESA-95 (which is the object of this study), as we will see, is not directly conditioned by the use of one model or the other.

"General government" sector (with a more or less inclusive interpretation) has an impact on public deficit and debt levels in the State in question. In this sense, the situation must be studied to see the extent to which public hospitals are excluded from the "General government" sector in some States as a national accounting strategy to reduce public deficit and debt or whether is it for efficacy.

As we will see, hospitals may be excluded from the "General government" sector even though they are public in nature (controlled by the government) and have mainly public funding. This can significantly reduce public deficit and debt levels. This is an alternative to other mechanisms that also allow for the reduction of public deficit and debt levels, like several formulas for public-private partnership (PPP) for infrastructures and the provision of public services, whether exclusively contractual (contractual PPP) or through mixed-capital public-private entities (institutional PPP)[4 and 5].

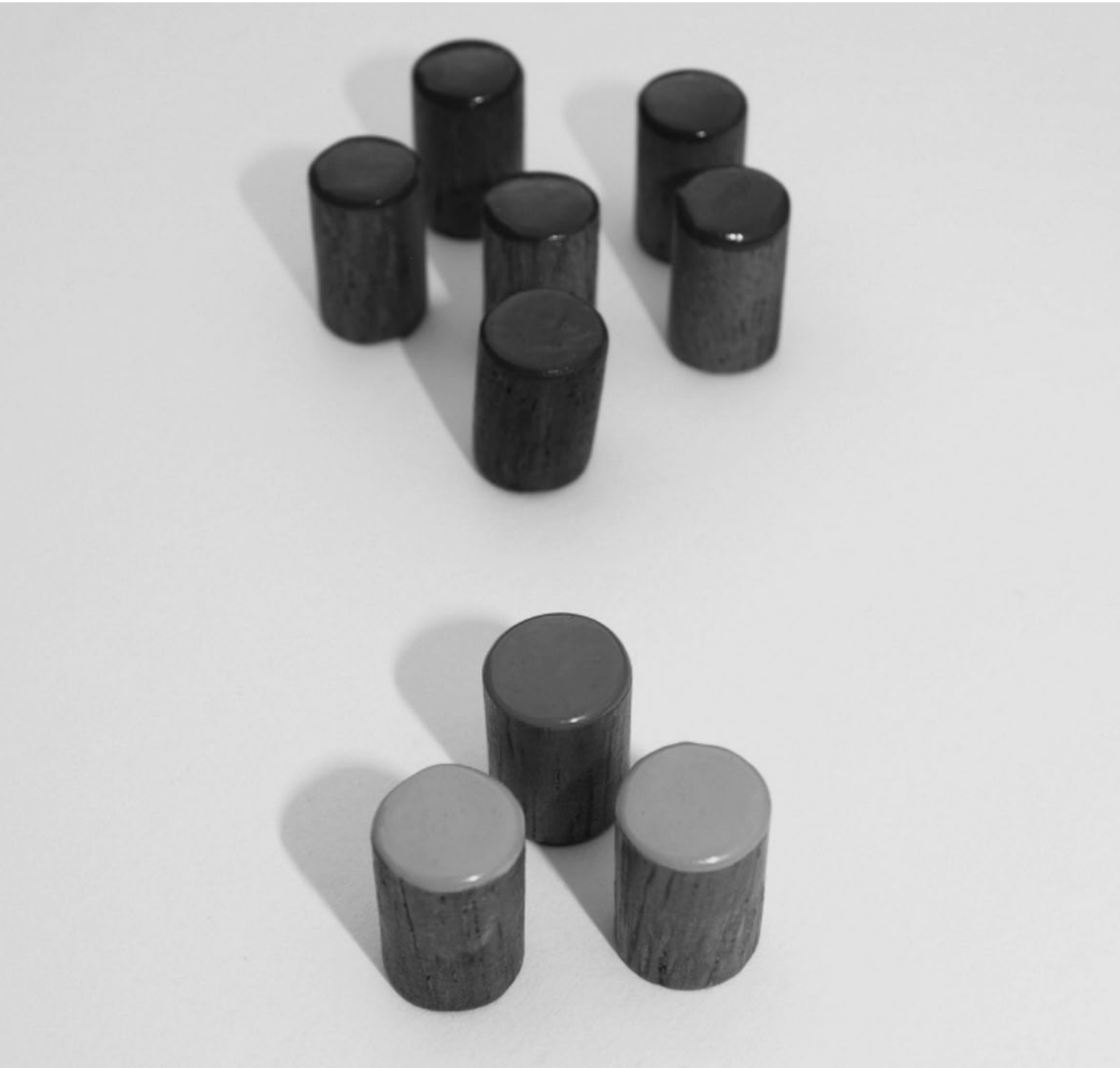
Regarding structure, this study will cover the following issues: 1) how ESA–95 is interpreted and applied to healthcare centres in the United Kingdom, France and Germany; 2) the characteristics healthcare centres must have in order to be excluded from classification under the "General government" sector according to ESA–95; and 3) the extent to which application of ESA–95 conditions autonomous management of these centres. As mentioned before, the aim is to reach valid conclusions that can be applied to Public Companies and Consortia (EPIC) in the Catalan Healthcare System, which are currently classified as public non-financial corporations and, as such, their debt must be consolidated with that of the Government of Catalonia for compliance with European Union (EU) budgetary discipline goals. The final aim is to find out which requirements a healthcare centre or establishment must meet in order for their debt to not be accounted for and controlled for compliance with the budgetary discipline goals.

4. EUROPEAN COMMISSION (2004): Green Paper on public-private partnerships and Community law on public contracts and concessions. COM (2004), 327 final, of 30 April 2004, paragraph 1.

5. In Spain and Catalonia there is a long tradition of PPP under the concession model (mainly for transport infrastructures). Nonetheless, in recent years the use of PPP has also been spreading to public services (healthcare, education, etc.)

General criteria for the classification of healthcare centres under ESA-95

A comparative study on the application of the European System of Accounts ESA-95



General criteria for the classification of healthcare centres under ESA-95

Context: European public deficit and debt restrictions

Under the framework of the provisions of article 104 C of the 1992 Treaty of the European Union (TEU)[6] - currently article 126.1 of the Treaty on the Functioning of the European Union (TFEU) – a European and national process was begun that tends towards the containment of public deficit and debt by Member States. In accordance with this European regulation, States aiming to become members of the Economic and Monetary Union (EMU) had to meet four convergence criteria (art. 109 J section 1 of TEU), one of which required a sufficient level of fiscal responsibility. This criterion is understood to be met when the public deficit and debt levels in the Member State are below the limits established in article 104 C of the TEU, cited above. The benchmark values to this effect are specified in article 1 of Protocol 12 on Excessive Deficit Procedure, according to which deficit shall be no more than 3% of the GDP and public debt no more than 60% of the GDP. These budget discipline criteria are not merely a formality for entering the EU; Member States must continue to comply with them after joining.

The directives of the Treaty on this issue were developed through approval in 1997 of the European Union Stability and Growth Pact (SGP)[7] and the surveillance regulations[8] and the Excessive Deficit Procedure[9].

6. Article 104 C of the Treaty on European Union (TEU), in the Treaty of Maastricht version of 7 July 1992, states: *"Member States shall avoid excessive government deficits"*. This precept is included in the same terms in article 104.1 of the Treaty establishing the European Community (TCE), in the Treaty of Amsterdam version of 2 October 1997, and, currently, in article 126.1 of the Treaty on the Functioning of the European Union (TFEU), in the Treaty of Lisbon version signed on 13 December 2007, which went into force on 1 December 2009.

7. The European Union Stability and Growth Pact (SGP) is made up of two parts: a preventative arm (aiming to strengthen permanent budgetary positions and coordination of economic policy –Regulation number 1466/1997) and a corrective arm (which seeks to speed up and clarify procedures to be implemented in the case of excessive deficit –Regulation number 1467/1997).

8. Council Regulation number 1466/1997 of 7 July 1997 on the strengthening of the surveillance of budgetary positions and the surveillance and coordination of economic policies, which was amended by Council Regulation number 1055/2005 of 27 June 2005, and again recently by European Parliament and Council Regulation number 1175/2011 of 16 November 2011.

9. Council Regulation number 1467/1997 of 7 July 1997 on speeding up and clarifying the implementation of excessive deficit procedure, which has been amended twice by Council Regulation number 1056/2005 of 27 June 2005, and more recently by Council Regulation number 1177/2011 of 8 November 2011.

Faced with these budget restrictions, Member States (both those who are already members of the EMU and those who aspire to be) have seen a generalised move away from credit that is counted as public debt, in order to comply with the parameters established in the Treaty and the SGP, specified through the European System of Accounts (ESA–95, Council Regulation no. 2223/96 of 25 June 1996). In this context, as we have mentioned previously, in terms of the European System of Accounts (ESA–95), if a healthcare centre is classified under the "General government" sector, its debt must be consolidated with the public debt of the corresponding government, impacting compliance with the criteria established in article 126 of the TFEU and recently amended article 135 of the Spanish Constitution[10].

In order to know the deficit and debt levels for the purpose of the limits established in the Stability and Growth Pact of 1997 (SGP), Member States must submit their accounts in line with ESA–95[11].

Given the complexity of these standards, of a notably accounting nature, Eurostat (European Community Office of Statistics) approved an interpretative document, the "ESA–95 Manual on government deficit and debt" (in its five editions, 2000, 2002, 2010, 2012 and 2013), hereto forth ESA–95 Manual.
How national authorities interpret the ESA–95 rules as applied to various entities can be problematic at times. There are entities for which inclusion or exclusion in the "General government" sector for public accounts is ambiguous. In order to carry out this analysis, we will follow the ESA–95 methodology applied by Eurostat in its Decisions.

Contents of the general government sector

The configuration of the "General government" sector constitutes one of the key elements in establishing the scope of public debt, insofar as, through the concept of the "General government sector", it gives content to this subjective area. For this reason, we will focus on how the "General government" sector

10. These precepts are laid out in articles 11 and 13 of Act 2/2012 of 27 April on Budgetary Stability and Financial Sustainability (LOEPSF).

11. The European System of National and Regional Accounts (ESA–95) was approved by Council Regulation number 2223/96 of 25 June 1996 on the European system of national and regional accounts in the Community, published in Official Journal L 310 on 30 November 1996. Member States must use the European System of Accounts (ESA–95) to compile and submit all previsions and documentation required by European institutions regarding budgetary discipline. However, it must be noted that the new European System of National and Regional Accounts (ESA-2010), approved by Regulation (EU) number 549/2013 and published in the Official Journal of the EU on 26 June 2013 will go into force on 1 September 2014 (see above footnote 3, page 5).

is configured for the purposes of ESA–95 ("public sector", by the way, doesn't have a clear definition on a European or national level). Specifically, this report must determine which healthcare entities and centres belong in the "General government" sector and compare this with the experience of other States.

In order to determine the limits of the "General government" sector, in theory, we must take under consideration both EU regulations (specifically ESA–95) and national and state-level regulations regarding budgets. However, it must be said that we will focus on the regulations in the European System of Accounts (ESA–95), because internal budget laws define the concept of the "public sector" by referring to the definition in ESA–95[12].

Taking into account the European System of Accounts (ESA–95), we can first of all point out that the economy of a State is made up of five sectors: "General government", "Non-financial corporations"; "Financial corporations"; "Households", and "Non-profit institutions (NPI) serving households". In terms of the entities that belong to the "General government" sector, ESA–95 establishes that they are: "*all institutional units which are other nonmarket producers whose output is intended for individual and collective consumption, and mainly financed by compulsory payments made by units belonging to other sectors, and/or all institutional units principally engaged in the redistribution of national income and wealth*" (section 2.68 ESA–95)[13]. How the configuration of the concept of the "General government sector" is extracted from this definition hinges on another autonomous concept of national accounts: the institutional unit. Specifically, all public non-market institutional units will belong to the "General government" sector. Thus, we must study three elements, which are those Eurostat analyses in determining whether to include or exclude these entities in the general government's debt: 1) if it is an institutional unit or, to the contrary,

12. This reference to European regulations can clearly be seen both in article 135 of the Spanish Constitution, recently amended (BOE 27-9-2011), and in article 2 of Act 2/2012 of 27 April on Budgetary Stability and Financial Sustainability (LOEPSF), which contains a direct reference to ESA–95 in defining the contents of the "General government" sector.
Likewise, in order to analyse how the government sector is defined in internal legal structure, the way internal and external control bodies (the General State Comptroller and the Court of Auditors, respectively) have delimited the shape of this sector must be taken into account. In Spain, for example, for internal purposes the Comptroller takes the two characteristics set by Eurostat and the Governmental Accounting Standards Board as a reference: - *"The general government exercises its main function without seeking profit, producing collective goods or services that are not for sale, as well as being able to carry out operations to redistribute national income or wealth. – The main resources come from direct or indirect compulsory payments from units belonging to other sectors, without any proportionate or measurable compensation."*

13. The definition of the "General government" sector (S. 13) is found in section 2.111 of the new ESA-2010 and, in practical terms, is identical to the previous standards, establishing that it: "consists of institutional units which are non-market producers whose output is intended for individual and collective consumption, and are financed by compulsory payments made by units belonging to other sectors, and institutional units principally engaged in the redistribution of national income and wealth."

a body dependent on the government; 2) if the institutional unit is public or private in nature; and 3) if the institutional unit is market or non-market.

It must be noted that, if an entity were to be excluded from the general government sector and classified in the "Non-financial corporation" sector or "Non-profit institutions (NPI) serving households" sector, the nature of the transactions between this entity and those in the general government sector must be analysed.

Below we will examine the three issues that must be resolved consecutively in order to determine sector classification of a body in terms of national accounting.

Determine if the entity is an institutional unit

An institutional unit is considered to be one that: 1) has decision-making autonomy in exercising its main function; and 2) either keeps a complete set of accounts or it would be possible and meaningful to do so from both an economic and legal standpoint. Of these two requirements, the most complex to tie down is decision-making autonomy. Thus, the ESA–95 Manual sets the requirements for considering that an institutional unit has autonomy of decision (section 2.12 of ESA-95[14] and Part I, section 3 of the ESA-95 Manual). According to this precept, an institutional unit is said to have decision-making autonomy in exercising its main function when it is entitled to own goods or assets in its own right and can therefore exchange ownership of goods or assets in transactions with other institutional units. Likewise, the entity must be able to take economic decisions and engage in economic activities for which it is held directly[15] responsible and accountable by law. And, finally, it must be able to incur liabilities on its own behalf, take on other obligations or further commitments and enter into contracts[16].

In the event that the general government controls the exercise of the main function of the entity, in accordance with the terms described above, this entity would not be considered an institutional unit but a dependent unit of the general government and, as a result, must be included in the "General government" sector.

14. Section 2.12 of the new ESA–2010 is very similar, although there are a few differences like the removal of the reference to the fact that it would be "meaningful, from both an economic and legal viewpoint, to compile a complete set of accounts".

15. The new ESA–2010 (section 2.12) has removed the adverb "directly" and simply states "engage in economic activities for which it is responsible and accountable at law".

16. None of these requirements have changed in the new ESA–2010 (section 2.12).

It must be taken into account, as we will see later, that some Spanish public hospitals aren't considered institutional units. Therefore, as they don't meet the requirements to be considered an institutional unit, it is unnecessary to further analyse the other two issues to determine sector classification (public or private nature of the entity and market or non-market character), given that the entity must already be included in the "General government" sector.

Determine whether the institutional unit is private or public

The public or private nature of an institutional unit is defined by the nature of the institutional unit that controls it, with control understood to mean the ability to determine its general policy. In the case of non-profit institutions (NPI), these are public producers if they are controlled and funded mainly by the general government.

Thus, if the general government controls the general policy of an entity, it will be considered to be public. On this point, it would be conflictive to determine whether control is limited to general policy or affects the exercise of its main function. The consequences are diametrically opposed. If the general government controls the exercise of its main function, the entity cannot be considered an institutional unit but must be classified as a dependent unit of the general government and be included in this sector. However, if the general government only controls general policy, the entity will be a public institutional unit but whether this unit has a market or non-market character must still be assessed in order to determine its exclusion or inclusion, respectively, from the general government sector.

After defining control as an essential element in establishing the public or private nature of a unit, the ESA–95 Manual clarifies the position of public and private producers. Public producers may be classified either in the "Non-financial corporations" sector (if they are market) or in the "General government" sector (if they are non-market).

Determine whether a public institutional unit is market or non-market

Finally, for an institutional unit to be considered non-market, the ESA–95 Manual establishes that its main function must be to redistribute national income and wealth. To the contrary, an institutional unit is considered market when its products are sold at economically significant prices. Production by non-market units is supplied free of charge or at prices that are not economically significant. As it is difficult to determine whether or not a price is economically significant, the ESA–95 Manual sets some criteria: an economically significant price has a

clear influence on the amounts the producers are willing to supply and on the amounts purchasers wish to buy. However, it is also complicated to determine when price influences the amounts supplied or demanded, so the ESA–95 Manual establishes a second, objective criterion. Economically significant prices are those in which more than 50% of production costs are covered by sales. As a result, if sales cover more than 50% of production costs, we are looking at a market producer. And, if the price doesn't cover 50% of costs, we are looking at: 1) a non-profit producer; or, 2) the general government, a public producer. Practical application of the distinction between market and non-market producers to units in the general government sector isn't exempt from controversy, as the 50% criterion for production costs can be unfeasible to determine in some cases, given the difficulty of attributing cost to some types of production.

Application of the market or non-market rule

In short, in order to assess the nature of an entity, it must pass a triple screening: determine whether or not it is an institutional unit (existence); if it is public or private (nature); and if it is market or non-market (purpose).

From what we have seen before, we know that the decisive element in excluding a public entity from the "General government" sector, for the purposes of public deficit and debt accounting, is whether or not it can be considered a "market" producer; and it can be considered such if its "sales" cover more than 50% of its production costs (ESA-95 paragraph 3.32[17]).

Based on these general criteria, institutional units that are mainly funded through payments from the general government that are not directly linked to production volume, or receive important amounts to cover activity deficit, and don't obtain their resources mainly through market sales, must consolidate their accounts in the "General government" sector. This will be true regardless of their legal nature or budget regime. On the contrary, entities that truly have market activity and are not mainly funded through public resources will not be included in the "General government" sector, but in the "Non-financial corporations" sector, specifically in the "Public non-financial corporations" subsector, or in the "Financial corporations" sector.

In conclusion, application of the 50% criterion is one of the decisive issues for final classification of an entity as not belonging to the "General government"

17. See section 3.19 and sections 20.19 and following of the new ESA–2010; as well as the latest interpretations of the criteria to determine whether a unit is market or non-market (penultimate section of this report).

sector. In order for payments from the government to the entity to be considered "sales" they must qualify as significant. A payment shall be considered significant if the general government carries out equivalent payments to private bodies for the same services. If there is no equivalence with the same type of activity in the private sector, payments shall be considered significant if they are made exactly for services rendered.

To the contrary, if payments are made to ensure the entity's costs are covered or with the aim of influencing its activity, orientating it towards services of general benefit, these payments shall not be considered sales.

The payment mechanism, its scope and the existence of complementary payments in case of deficit that ensure the survival of a private body are key elements in determining the relationship between two institutional units and, thus, the market or non-market character of the unit providing service to the general government.

This criterion delimiting the public sector is markedly economic, as it basically takes into account how the entity is funded. As we will see throughout this study, from a comparative standpoint, this European regulation has marked the internal regulations delimiting the general government sector, which have progressively adopted similar parameters to those established in ESA–95. This report aims to precisely analyse how the general criteria examined (the triple screening mentioned above) are applied to healthcare centres in the United Kingdom, France and Germany, and finally in Spain and Catalonia.

Eurostat pronouncements

Eurostat has made pronouncements on how to account for some entities held or funded mainly by the general government. Eurostat's pronouncements can shed light on the nature of the Catalan Healthcare System's EPIC in terms of national accounting and the possibility of excluding them from the general government sector, under specific requirements.

The Austrian Bundesimmobiliengesellschaft

Among the relevant cases analysed by Eurostat on how ESA-95 deals with entities outside the general government sector, we highlight that of the Austrian

Bundesimmobiliengesellschaft, commonly known as the Austrian BIG[18]. BIG exemplifies the case of a public institutional unit that, although it carries out functions that are essentially public and obtains funding mainly from the general government, is excluded from the general government sector as it is considered a market public institutional unit. Through this unit, the Austrian government has been able to shed a significant amount of their public debt.

What the Austrian government has done is relatively simple. In 1992, a company held 100% by the Austrian government was created, to which the majority of public buildings was transferred (mainly schools and universities –71% of the assets- and other government buildings –27%). This transfer of assets from the general government sector to the BIG was funded by the latter emitting debt or taking on loans. Afterwards, the majority of the buildings transferred to the BIG were leased back to government units that were previously housed in these buildings, through lease agreements based on market estimations.

Eurostat analysed various issues relating to this case. First of all, Eurostat classifies BIG as an institutional unit because it "keeps a complete set of accounts in compliance with business guidelines and legal obligations required of all companies"; and because, although 100% of the capital of the BIG is held by the government, the government doesn't control the exercise of its main function, but "merely sets the general strategy for the unit without interfering with current management."

After establishing that it is an institutional unit, Eurostat qualifies the Austrian BIG as public, as 100% of its capital is held by the general government. According to the ESA-95 Manual, the fact that the government owns more than half of the shares of an entity is a sufficient (but not necessary) condition to understand that the general government controls general policy and the institutional unit can therefore be considered public[19].

Then, Eurostat analyses classification of the BIG either in the "Central government" subsector of the "General government" sector or within the "Non-financial corporations" sector. The study carried out by Eurostat

18. EUROSTAT, *Treatment of the transfer of Government real estate to a publicly-owned corporation in Austria,* Press Release number 15/2002, Luxembourg, 31 January 2002.

19. EUROSTAT, Manual on Government Deficit and Debt. Implementation of ESA95, Luxembourg, ed. 2013, page 12.

resulted in classification of the Austrian BIG as a "Non-financial corporation". This classification is based on two aspects. First, that the money paid by the government to lease the buildings is determined "according to market-based valuation methods". Second, that the BIG covers more than 50% of its production costs with the rents paid; and, thus, according to the criteria in the ESA-95 Manual, the BIG charges "economically significant prices".

In order to determine whether or not a price is economically significant, the price of service and the extent to which costs are covered by the price must be taken into account. This operation is complex in the case of the BIG. The specific nature of some of the assets held by the BIG mean that there isn't a market for them in Austria, which makes it difficult to affirm whether or not the prices are market or non-market (this is the case of rents on buildings for schools, universities, etc.). Despite this difficulty, Eurostat considers that the BIG charges the general government economically significant prices, equivalent to sales, and qualifies it as a market public institutional unit, classified in the "Non-financial corporations" sector.

Given the prevalence of this type of body found outside the general government sector, but which can eventually have a significant impact on public deficit and debt levels (given their public nature), in later pronouncements Eurostat has been stricter in excluding an entity from the general government sector. This higher level of stringency can be seen in two points. First, Eurostat is stricter in assessing the scope of "control" by the general government, and considers that this affects the exercise of the main function of the entity and, thus, it isn't an institutional unit. One example can be seen in Eurostat's classification of the *Fund for Orderly Bank Restructuring* (hereto forth, FROB for its initials in Spanish)[20].

Secondly, Eurostat is also stricter is assessing the funding system and its classification of a public institutional unit as "market". One example can be seen in the case of *Madrid Infraestructuras de Transporte* (hereto forth, MINTRA), an entity created in 1999 to execute, manage and maintain collective transport

20. See also EUROSTAT, *Information note on the impact of the Spanish bank rescue package on Spanish government deficit and debt*, Luxembourg, 12 June 2012. This is not the case of the *Company for the Management of Assets proceeding from Restructuring of the Banking System* (SAREB), which Eurostat has classified under the "Financial institutions" sector (S.12), as a private institutional unit (54% of which is held by private capital and 46% by public capital). EUROSTAT, *Formal ex ante consultation on the classification of the Sociedad de activos de Reestructuración (SAREB)*, Luxembourg, 26 March 2013. It must be taken into account, as Eurostat indicated in its decision, that this is a provisional classification and is subject to possible review in the future based on new data. Likewise, it must be said that the differences between FROB and SAREB stem not only from control of the body, but also from other aspects like, for example, the origins of their capital.

infrastructures in the Community of Madrid. In this case, Eurostat, after analysing the nature of payments made by the general government to MINTRA, qualified it as a *non-market* public institutional unit (included in the general government sector) based on the following arguments[21]: i) the majority of MINTRA's revenue is obtained through a rental contract with Metro de Madrid, S.A. (a corporation included in the general government sector) for use by the latter of the infrastructure; ii) the majority of revenue is fixed beforehand and doesn't correspond to objective parameters, related to the use of the infrastructure by Metro de Madrid, S.A.; iii) the price of services MINTRA provides to Metro de Madrid, S.A. can be revised in order to re-establish "economic balance" between the two parties; iv) in 2003, increased operating costs didn't result in increased ticket prices but in an increase in the subsidies Metro de Madrid S.A. receives from the Madrid Regional Transport Consortium; v) finally, Eurostat concluded that the price of the services MINTRA provides to Metro de Madrid S.A. is not economically significant, which is a requirement to be classified as an institutional unit outside of the general government sector in terms of national accounting.

This last example shows how the modification of specific aspects of the payment method from the general government to public institutional units (like the introduction of pre-established payments, covering losses, or that the general government doesn't obtain a sufficient return on the investment made) can lead to the unit in question being re-classified in the general government sector. In the case of MINTRA, unlike the Austrian BIG, Eurostat didn't go on to assess whether or not prices were at market level (compared to those that would be paid by other companies for use of similar infrastructures) because the previous conditions were already enough to classify the entity as a non-market public institutional unit.

The case of ADIF

Once an entity has been classified into a sector, and it has been excluded from the general government sector, a second element to take into account is the nature of the relationship between this entity and the general government. On this point there is a significant pronouncement from Eurostat regarding capital injections the general government made to the entity *Administrador de Infraestructuras Ferroviarias* (ADIF).

21. Initially, in 2003, Eurostat qualified MINTRA as a market public institutional unit (excluded from the general government sector) based on data provided by the National Statistics Institute (INE) regarding a theoretical operations model (given that the infrastructure had not yet gone into operation). Despite this initial decision, in 2005 Eurostat requested more information from the INE and, after analysing this additional information, officially declared the reclassification of MINTRA as a non-market public institutional unit belonging to the general government sector (letter from Eurostat dated 3 February 2005). This reclassification shows that the sector classification of an entity is subject to change if Eurostat believes the control or funding of the entity to have changed.

Regarding classification, following the criteria of ESA-95, ADIF is an institutional unit as it meets the two criteria analysed by Eurostat: decision-making autonomy in exercising its main function and keeping a complete set of accounts.

Secondly, as we have seen, for an institutional unit to be classified as public, the entity controlling it must be taken into account, understanding control to be the ability to determine its general policy. In the case of ADIF, control is exercised by the State.

Finally, the function of ADIF must be determined in order to classify it as either a market or non-market public institutional unit. As we have seen, the criterion to be followed is whether or not the public institutional unit covers at least 50% of its production costs (market producer) or, to the contrary, doesn't reach this amount (non-market). Likewise, whether or not the price of the service provided can be considered "sales" must be taken into account. Given that ADIF meets these criteria, INE and Eurostat agree on excluding ADIF from the general government sector. We can thus distinguish between public corporations that charge economically significant prices for rental of infrastructures and are not subsidised (as is the case of the prices charged by ADIF to RENFE, as well as AENA to IBERIA) and others, as is the case of MINTRA, that are considered non-market producers because they obtain subsidised prices.Once ADIF has been determined to be a market public institutional unit (excluded from the general government sector), we must analyse how to account for the transactions between this entity and the general government under ESA-95. The ESA–95 Manual establishes that if the general government acts with public policy in mind, providing funds to a corporation without receiving financial assets and without expecting property income, the capital injection must be registered as a capital transfer[22]. If, on the other hand, the general government's expenditure is made under contractual conditions, with the government providing funds through the purchase of bonds emitted by the corporation, the transaction shall be classified as "other flows" under ESA-95, a transaction that doesn't impact public deficit and debt levels. The Spanish government had classified the capital injections made by the government to ADIF as the acquisition of financial assets, but Eurostat considered that these didn't offer sufficient return on investment and thus classified them as capital transfers, which add to public deficit and debt[23].

22. EUROSTAT, Manual on Government Deficit and Debt. Implementation of ESA95, ed. 2013, pages 111 and following.

23. EUROSTAT, Methodological treatment of the capital injections into ADIF, Luxembourg, 26 July 2007.

The case of ADIF shows that, in order for the activity of a public corporation not to impact public deficit and debt levels, not only must the institutional unit be excluded from the "General government" sector, but payments made by the government to this entity must also not be considered capital transfers, as these must be included in public deficit and debt. On this point, the payment of dividends by a public corporation to the general government is considered a key element in considering that the capital injection isn't a capital transfer but the acquisition of financial assets[24].

Payment methods from the general government to public hospitals

The "50% rule" established in ESA-95 to determine whether a public institutional unit is "market" or "non-market" (whether or not more than 50% of production costs are covered by sales) can be difficult to determine in some cases; especially regarding schools and hospitals. For this reason, at the end of the 1990s, Eurostat created a work group on the "delimitation of the general government sector"[25]. Specifically, the group studied whether payments made by the general government to hospitals should be considered "sales" for application of the 50% test. They carried out a "Survey on the sector classification of public hospitals and homes for the elderly in ESA-95" (Eurostat, 1999), which showed the differences in the way healthcare organisations are structured in the various Member States. As a result of this study, regulations were agreed on by a majority and included in the ESA-95 Manual from its first edition in 2000, and have been maintained in later editions[26].

The ESA-95 Manual points out that, among the various Member States that submit accounts to Eurostat, there are significant differences in the way general governments make payments to public hospitals[27]. Given that there is no single payment mechanism, Eurostat created a classification of the various payment systems in order to determine whether public hospitals should be included

24. EUROSTAT, Manual on Government Deficit and Debt. Implementation of ESA95, ed. 2013, page 120.

25. This work group is mentioned in: Public Sector Classification Committee (PSCC) of the Office for National Statistics (ONS) decisions – PSCC case 2002/22. "National Accounts Sector Classifications of NHS Foundation Trusts and NHS Trusts", 2 July 2003, section 23.

26. In fact, these regulations on the application of the market/non-market rule to public hospitals haven't varied in the various editions of the ESA-95 Manual, from 2000, 2002, 2010, 2012 and 2013.

27. The 2000 and 2002 editions of the ESA-95 Manual cite results from a 1999 Eurostat survey as one of its sources (Eurostat 1999 "Survey on the sector classification of public hospitals and homes for elderly in ESA95"). There is a later Eurostat survey on the classification of public hospitals, from 2009, which is not mentioned in any of the later editions of the ESA-95 Manual (2010, 2012 and 2013).

or excluded from the "General government" sector. Eurostat identified the following forms of payment from general government to public hospitals (ESA-95 Manual, Part I, section I.2.4.4[28]):

1. according to their costs;
2. according to a negotiation (global budget) between general government and each hospital, focusing on several factors (final output, maintenance of building, investment in technical equipment, payments for compensation of employees, etc.)
3. according to a system of pricing applied only to public hospitals;
4. according to a system of pricing applied to both public and private hospitals.

According to Eurostat, only payments made under iv) can be considered sales. In the 2010, 2012 and 2013 editions of the ESA-95 Manual, a final remark was added pointing out that this is due to the fact that "the other methods are just ways to ensure the government's payments cover each hospital's costs".

Given what we have seen so far, it is essential to analyse how the general government funds the healthcare entities in question. Following is an examination of this problem in three European Union Member States: the United Kingdom, France and Germany. As we have already pointed out, the healthcare systems in the European Union vary widely and, thus, the results cannot be extrapolated[29].

The analysis of these aspects and their practical application by Eurostat will allow us to determine the feasibility of excluding the Catalan Healthcare System's EPIC from the "General government" sector under specific parameters.

28. EUROSTAT, Manual on Government Deficit and Debt. Implementation of ESA95, ed. 2013, page 15.

29. There are also significant differences between the health accounts systems. To this end, we must mention the tool provided by the 2011 System of Health Accounts (SHA), a manual co-published by the Organisation for Economic Co-operation and Development (OECD), Eurostat and the World Health Organisation (WHO): OECD, EUROSTAT, WHO. *A System of Health Accounts*, OECD Publishing, 2011.

L'aplicació del SEC-95 als centres sanitaris del Regne Unit

A comparative study on the application of the European System of Accounts ESA-95

Application of ESA-95 to healthcare centres in the United Kingdom

Structure and funding of the healthcare system in the United Kingdom. The National Health Service (NHS)

First of all, we must examine how the healthcare sector is structured in the United Kingdom in order to briefly describe the context in which our later analysis takes place.

The National Health Service (NHS) was created on 5 July 1948. It belongs to the Department of Health and is classified in the National Accounting Standards as part of the central government. It must be noted that NHS services are free of charge (meaning there is no direct cost for the user, although society as a whole pays for these services indirectly through taxes), so people are treated according to their need and not their ability to pay. Nevertheless, users must pay for some services, like, for example, prescriptions, dentistry and optical services[30].

In 1990, the NHS and Community Care Act created an "internal market", in which hospitals and healthcare centres are the "providers" and the general government and some general practitioners are the "buyers". In order to be a "provider", healthcare centres must become NHS Trusts. The creation of the NHS Trusts came about mainly between 1991 and 1996. The NHS Trusts were created as "quasi-independent" entities, belonging to the central government (which exercises control) but with management autonomy. These Trusts were created in order to promote competitiveness among them and boost efficiency through "market discipline". The vast majority of their "buyers" are from the general government.

In 1999/2000, the British government undertook a significant reform of the healthcare system (NHS Plan). Specifically, it was agreed to "abolish the internal market", to reduce the number of public authorities designated as

30. On the origin and evolution of the NHS in the United Kingdom, see: Public Sector Classification Committee (PSCC) of the Office for National Statistics (ONS) decisions – PSCC case 2002/22. "National Accounts Sector Classifications of NHS Foundation Trusts and NHS Trusts", 2 July 2003, sections 15 and following. However, it must be noted that the British NHS has been profoundly restructured under the Health and Social Care Act of 27 March 2012, to which we will refer later.

"purchasers" of healthcare services, and the NHS Trusts were instructed to cooperate instead of competing.

In 2003/2004, the NHS Foundation Trusts (FTS) were created as part of the United Kingdom's NHS (Health and Social Care Act, 2003). Compared to the NHS Hospital Trusts, the FTS have greater management and financial autonomy (decentralising state control and management)[31]. The FTS continue to be part of the public sector, and are structured as "non-profit public-benefit corporations".

The structure and organisation of the NHS Foundation Trusts is similar to that of cooperatives (general society, patients and healthcare personnel can be members and participate in their governing). One of the aims of the 2003 reform was to incentivise "providers" of healthcare services to offer higher quality services more efficiently[32]. In order for an NHS Hospital Trust to become an NHS Foundation Trust, it must meet a series of requirements (be well-governed, financially sustainable and locally representative). These requirements are assessed by the Monitor, an independent regulatory authority of the NHS Foundation Trusts[33]. There are currently 147 NHS Foundation Trusts in the United Kingdom[34].

31. GODDARD, VERZULLI and JACOBS (2011) point out that other countries have also carried out similar reforms in the past two decades, in the sense of decentralising hospital management, delegating decision-making from the central government to local healthcare providers. For example, in Scandinavian countries, and Norway in particular, many public hospitals have been restructured as quasi-independent public corporations (MAGNUSSEN, J., VRANBAEK, K., SALTMAN, R., *Nordic Health Care Systems. Recent reforms and current policy challenges*. Open University Press: Maidenhead and New York, 2009). In Italy, the main hospitals (called *Aziende Ospedaliere*) have been given greater financial and decision-making autonomy, and have been given the status of semi-independent hospital corporations (FRANCE, G., TARONI, F., DONATINI, A., "The Italian health-care system", *Health Economics,* 14, 2005). New methods of autonomic management have also been implemented in hospitals in Spain and Portugal (SALTMAN R., BANKAUSKAITE V., VRANGBAEK K., *Decentralization in health care: strategies and outcomes*. Open University Press/McGraw-Hill Education, London, 2003). See also GODDARD, M.; VERZULLI, R.; JACOBS, R., Do Hospitals Respond to Greater Autonomy? Evidence from the English NHS. Centre for Health Economics, University of York, United Kingdom, July 2011.

32. On the impact of the FTS policy on hospital performance, measured in terms of finance, quality of care and satisfaction of personnel, see the independent study: Goddard, Maria; Verzulli, Rossella; Jacobs, Rowena, Do Hospitals Respond to Greater Autonomy? Evidence from the English NHS. Centre for Health Economics, University of York, United Kingdom, July 2011. The results of this empirical evaluation suggest that, overall, the better results seen in FTS versus non-FTS aren't strictly the result of achieving FTS status, but are due to other pre-existing factors (we cannot forget that only the best-governed and most financially viable NHS Trusts can become FTS). Regarding the financial performance of the FTS, the results confirm that the FT policy in itself hasn't resulted in any change versus non-FTS, measured in terms of increased surplus. Nor is there solid evidence to show that the FTS perform better in terms of serving their local community (Bojke C, Goddard M, *Foundation Trusts: A retrospective review*, CHE research paper 58, University of York, 2010).

33. http://www.monitor-nhsft.gov.uk/about-monitor/what-we-do-0#1

34. The list is available on: http://www.monitor-nhsft.gov.uk/about-nhs-foundation-trusts/nhs-foundation-trust-directory (last seen: 15 July 2013).

The latest changes in this evolution of the NHS came through the Health and Social Care Act 2012 passed by the Parliament of the United Kingdom on 27 March 2012. This legal reform entailed a very significant restructuring of the NHS[35]. First of all, it abolished the 150 NHS Primary Care trusts (PCTs) and Strategic Health Authorities (SHAs) –healthcare authorities classified under the general government sector– and created a new agency called Public Health England, which is planned to be established on 1 April 2013. All of the NHS Trusts will have to obtain authorisation to become Foundation Trusts, or be amalgamated into a Foundation Trust, before April 2014. A very important aspect of this reform is that it abolished the existing cap on trusts' income from non-NHS sources (previously this limit was, for approximately 75% of the Foundation Trusts, 1.5% or less of their business volume).

Classification of healthcare centres in the United Kingdom in terms of ESA-95

In terms of national accounting, when the NHS Trusts were created in the 1990s, they were classified as "public corporations", meaning public entities with market activity (just like, for example, Royal Mail and BNFL). With the adoption of ESA-95 as the basis for national accounting in the United Kingdom, in 1998, the NHS Trusts maintained this classification, as they were considered market units controlled by the government. Specifically, the situation in the United Kingdom was established in compliance with type iv) on the Eurostat list of payment methods to public hospitals (ESA-95 Manual, Part I, section 5.5), because the general government was considered to pay public hospitals according to a system of pricing applied to both public and private hospitals. As a result, when the British Office for National Statistics (hereto forth ONS) compiled their National Accounts based on ESA-95 for the first time, in 1998, the NHS Trusts continued to be classified as public corporations.

Although the aforementioned legal reform of 2000 didn't constitute a formal reclassification of the NHS Trusts in the national accounting, it did lead the ONS to reconsider their classification, as a step prior to the creation of the

35. This legal reform has been called the biggest revolution in the British National Health System in the past 60 years (Daily Telegraph, 9 July 2010). Although the British Government has said that none of the key principles that have always characterised the NHS will be changed (universal service free of charge, based on need and not ability to pay), it is true that many critical voices have come out against this reform. See: Pollock, A M, Godden, S, Macfarlane, A. *Dismantling the signposts to public health? NHS data under the Health and Social Care Act 2012, BMJ* 2012; 344. The basis of this reform can be seen in the white paper entitled *Equity and excellence: Liberating the NHS,* British Department of Health, 12 July 2010 (available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353).

NHS Foundation Trusts. General government "purchasers" had various types of contracts with the "providers" of healthcare services, but the predominant contract with the NHS Trusts was a block contract, through which "service availability" was purchased instead of acquiring specific treatments. There were also "cost and volume contracts", which covered service availability to a certain extent and, beyond that limit, established additional charges according to the volume of patients treated. However, contracts with healthcare providers in the private sector were more detailed and prescriptive, and referred to the purchase of specific treatments.

So, given the former, in 2003 the United Kingdom's Public Sector Classification Committee of the Office for National Statistics (PSCC of the ONS) came to the conclusion that type iv) in the Eurostat regulations (on payments made by the general government to public hospitals) wasn't applicable to the situation in the United Kingdom. And this is because the aforementioned "block contracts" contain elements of types i) and ii) on the Eurostat list: i) according to their costs; and ii) according to a negotiation (global budget) focusing on several factors; although they cannot clearly be classified in either of the two cases. What is true, in any case, is that the "block contracts" between the general government and the public hospitals in the United Kingdom aren't the type of precise, detailed contracts used for purchasing healthcare services in the private sector. Meaning that they don't use the pricing system required in case iv), which is the only case in which payments may be considered sales.

Although in the United Kingdom there is a "market" mechanism ("purchaser" bodies have limited budgets and discretion in deciding how to spend them), this market is insufficient to qualify the payments made by the general government as "sales" (it is an internal market or a "shadow" market). For this reason, the ONS, after several conversations with Eurostat, understood that the situation in the United Kingdom isn't the same as that in other countries on continental Europe, where payments made by the government to hospitals can be considered sales[36]. Thus, the ONS handed down its decision on 2 July 2003[37], establishing that the NHS Trusts must qualify, in accordance with ESA-95 section 3.32, as "non-market" producers and, as a result, decided

36. The ONS points out that public hospitals in Belgium, the Netherlands, Austria (autonomous), Germany (except for Bavaria) and the Basque Country are classified as public corporations ("Non-financial corporations" sector). Public Sector Classification Committee (PSCC) of the Office for National Statistics (ONS) decisions – PSCC case 2002/22. "National Accounts Sector Classifications of NHS Foundation Trusts and NHS Trusts", 2 July 2003, section 27.

37. Public Sector Classification Committee (PSCC) of the Office for National Statistics (ONS) decisions – PSCC case 2002/22. "National Accounts Sector Classifications of NHS Foundation Trusts and NHS Trusts", 2 July 2003.

to reclassify them in the "Central government" subsector of the "General government" sector. This reclassification was applied retroactively from the creation of the first wave of NHS Trusts, in April 1991.

In this decision of 2 July 2003, the ONS pointed out that the general government of the United Kingdom had a project to change to a new system of "National Rates" (similar to that used in European countries where public hospitals are classified as public corporations), with the aim of applying them to their healthcare "purchases" both for public and private hospitals. According to the ONS, after this system of "National Rates" was put in place, all NHS Trusts and NHS Foundation Trusts in the United Kingdom would be classified as market producers and, thus, as public corporations (excluded from the general government sector) from that time onwards[38].

In fact, in 2000, along with the creation of the NHS Foundation Trusts (FTS), another key element of the NHS reform was the introduction of Payment by results (PbR).

In 2004, the Audit Commission[39] drafted a report on Payment by Results[40], which laid out the basic rules of this new NHS funding system and contained some recommendations. As we have seen, before the PbR system payment to the NHS was based on "block contracts" negotiated locally. These contracts were based on a compromise between provider costs and what government authorities could pay, and established prices that had little connection to the outputs of the service provided. However, with the PbR system, payment to providers depends on the number and type of patients treated, according to national regulations and national rates. According to the Audit Commission, the PbR system creates a clear link between volume, the complexity of the activity carried out, and payment. This allows providers and the government more clarity in terms of funding.

38. Public Sector Classification Committee (PSCC) of the Office for National Statistics (ONS) decisions – PSCC case 2002/22. "National Accounts Sector Classifications of NHS Foundation Trusts and NHS Trusts", 2 July 2003, section 31, page 4, and section 90, page 12.

39. The Audit Commission is an independently controlled public body in the United Kingdom, created in 1983, that is charged with ensuring that public funds are spent efficiently and that there is a good price-quality balance in local and national public services. Their purview covers local government, housing, health, fire and rescue, and criminal law. The Audit Commission drafts publications with information, practical recommendations and good practices in these areas.

40. AUDIT COMMISSION, Introducing Payment by Results: getting the balance right for the NHS and taxpayers, London, 2004. Available at: www.audit-commission.gov.uk/health/paymentbyresults/reportsandstudies/Pages/introducingpbr_copy.aspx

However, the Audit Commission's 2004 report pointed out that, although the PbR system is geared towards increased efficiency, budgetary discipline and financial responsibility in "provider" centres, it also entails significant risk that, if not managed properly, could lead to financial instability and poor patient care. As the Audit Commission points out in its report, Payment by Results requires high-quality data on costs and clinical activity, and in 2004 significant improvements were still needed in the information and management systems, both for the NHS ("providers") and the public "purchasing" authorities.

In 2008, a new report from the Audit Commission[41] analysed the evolution of the Payment by Results system, since its introduction in 2003/2004. This 2008 report shows that the PbR system had brought greater funding transparency to the NHS and had helped it work more efficiently, as the new system establishes a clear link between payment and the activity carried out. This has led many NHS Trusts to review which activities they carry out and how they are being funded.

Recently (August 2012), the Audit Commission drafted its Annual report on the Payment by Results system (PbR)[42], analysing audited data and reviewing advances in the recommendations for NHS Trusts expressed in previous reports. The aim is to ensure the quality of the data on which PbR is based, as a system of rates governing payments made to hospitals by local NHS authorities[43].

In any case, it seems that this system of "National Rates" hasn't been successful in reclassifying the NHS Trusts and NHS Foundation Trusts as "market" public institutional units (excluded from the general government sector). This can be seen in the ONS statistics for the United Kingdom, which continue classifying all of the NHS Trusts and NHS Foundation Trusts in the "Central government" subsector of the "General government" sector[44] (S. 1311). In contrast, we must

41. AUDIT COMMISSION, *Is the treatment working? Progress with the NHS system reform programme*, Audit Commission and Healthcare Commission, London, 2008. Available at: http://www.audit-commission.gov.uk/nationalstudies/health/financialmanagement/Pages/isthetreatmentworking.aspx

42. AUDIT COMMISSION, Right data, right payment. Annual report on the Payment by Results data assurance programme 2011/12, London, 2012. Available at: http://www.audit-commission.gov.uk/health/paymentbyresults/reportsandstudies/Pages/rightdatapbr2012.aspx

43. In its 2012 report, the Audit Commission continued by pointing out that the aim of the PbR system is to ensure fair funding for hospitals for the work they do; as well as incentivising greater efficiency, good practices, more patient choice, and competition among suppliers. However, it also indicates that there are still aspects that must be improved and notes that compliance with recommendations from the Audit Commission in the NHS Trusts is disappointing.

44. OFFICE FOR NATIONAL STATISTICS (ONS). Public Sector Classification Guide, June 2013 (available at http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-316145).

note the special cases of NHS Blood and Transplant, which is classified as a non-financial public corporation (S. 11001)[45], and NHS Professionals Limited, also classified as a non-financial public corporation (S. 11001), excluded from the "Central government" subsector of the "General government" sector effective 1 April 2004.

45. NHS Blood and Transplant was created by merging the National Blood Authority and UK Transplant on 1 October 2005. The National Blood Authority had already been excluded from the general government sector and classified as a non-financial public corporation since 1 April 1993.

Application of ESA-95 to healthcare centres in France

A comparative study on the application of the European System of Accounts ESA-95

Application of ESA-95 to healthcare centres in France

Structure and funding of the healthcare system in France

The French healthcare system is mainly based on a national health insurance known as Social Security or "Sécu". Originally the French social protection model was based on the Bismarck model (principle of solidarity)[46]. All workers in industry and commerce were obliged to pay health insurance. Nevertheless, in the mid-nineties, it was decided that the burden of health insurance costs should not fall exclusively on social funds from work (given the effects social contributions have on employment levels, forcing up the cost of labour), and a "tax" was created, called Generalised Social Contribution (*Contribution sociale généralisée, CSG*) applied to both income from employment and capital income.

The system is divided into three large regimes[47], the first of which is the "National Health Insurance Fund for Salaried Workers" (*Caisse nationale d'assurance maladie des travailleurs salariés du commerce et de l'industrie, CNAMTS*). This body is managed by the general Social Security system. This regime covers 84% of the population, including salaried workers, retirees, the unemployed and their dependents. This regime is pyramidal in nature, with a national fund, regional funds and local or primary funds. The latter are charged with registering insurance holders and reimbursing them for care. The second regime is the "Agricultural Social Mutual Fund" (*Mutualité sociale agricole, MSA*), which covers farmers and farm employees, making up 7% of the population. Finally, the third regime is the "Insurance Fund for Non-salaried Workers in Non-agricultural Professions" (*Caisse d'assurance des travailleurs indépendants non agricoles, CANAM*), covering 5% of the population.

In terms of structure, the system clearly distinguishes between consultations and hospital care. Consultations are done by general practitioners and

46. See footnote 1 above.

47. Alongside the three general regimes, there are also special regimes, some of which are administered by the general regime, like that for civil servants or students. While other special regimes are managed independently, like that for miners or rail employees.

specialists, through "private liberal" practice[48]. Doctors' fees are established through negotiations between medical trade unions and health insurance funds, under State supervision. Doctors must sign an agreement with the health insurance carriers, which pay them for the services rendered in the act, according to nationally established rates (called the Common classification of medical procedures, *Classification commune des actes médicaux, CCAM*). Doctors that belong to this remuneration system are part of what is called Sector I; however, since 1980, as a result of pressure from some doctors, the government created Sector II, for those who want some freedom with regard to the agreement with the insurance funds. Doctors in this second sector can set higher fees, up to 50% on average, than those agreed-upon with the insurance funds. The surcharge on the insurance-fund prices is paid for by patients or through complementary insurance policies.

Regarding hospital care, in France there are two main categories of hospitals, public hospitals and private hospitals. Within the second category, there are two types of hospitals: for-profit private hospitals (known as "clíniques") and non-profit private hospitals, owned by foundations, mutual organisations and religious congregations. Some of these non-profit private hospitals are integrated into the public hospital service, and are known are PSPH hospitals (*Hôpitaux participant au service public hospitalier*). Through 2004, these hospitals were funded through donations from the general State budget, just like public hospitals, which is why they have been classified together.

The functional distribution of these two main types of hospitals, public hospitals and for-profit private hospitals, is as follows: Private hospitals, which make up one-third of all hospital centres in France and have one-fourth of all hospital beds, focus on minor surgical procedures. Despite the fact that they make up a smaller percentage, in some areas their weight is very significant, as is the case of surgery or consultations, which make up 50% of their activity. And in some operations, like cataract surgery or digestive-tract surgeries, the percentages are even higher, 80% and 60%, respectively. On the other hand, public hospitals focus on emergency treatment, research and psychiatry. Moreover, they take care of more serious surgeries and life-threatening procedures as

48. Access to both was direct before but, as of 2004, with the reform of health insurance carried out under the Act of 13 August 2004, in order to see a specialist patients must first visit their "primary physician" (this process is referred to as *"parcours des soins coordonnés"*). This doctor, who is normally a general practitioner, can refer patients to specialists. This system is required for all patients over 16 that don't suffer from chronic illness. Some specialists (like ophthalmology, gynaecology, psychiatry, etc.) are excluded from the *"parcours donis soins coordonnés"* system. If patients don't respect the *"parcours donis soins coordonnés"* system, the visitation fee is higher and the specialist is authorised to charge 17.5% more for the visit. These surcharges aren't covered by the reimbursement from health insurance, nor by complementary insurance policies.

a result, for example, of accidents in public spaces.As a result, the French hospital system is a combination of the public and private sectors. This in some cases leads to private clinics choosing which patients to treat, to the extent that they transfer more serious cases to public hospital centres. This situation means that the French market is segmented more based on type of care than price competitiveness[49].

Each year, since 1996, under the framework of the Social Security Funding Act (*Loi de financement de la sécurité sociale*), Parliament passes the yearly increase in spending for the insurance funds (known as the "National Health Insurance Spending Objective", *Objectif national de dépenses d'assurance maladie, ONDAM*) for the following year.

In recent years there have been significant changes to French hospital policy. First of all, it must be noted that the "Plan Hôpital 2007" was approved in 2002. This plan entailed a restructuring of the French healthcare system with the aim of reactivating investment in hospital centres through the proliferation of public-private partnerships (*Partenariats public privé*), basically to build and renovate facilities.

Secondly, an activity-based fee system, or case-mix funding, was introduced in 2004. Before 2003, hospital entities had two types of funding. Public hospitals and PSPH hospitals, since 1983, were assigned a limited yearly operating budget (*called donation global or DG*). This budget was calculated based on the number of overnight patient stays and was later modified each year based on the previous year's results, at the rate of increase in hospital expenditure.

On the other hand, for-profit private hospitals invoiced insurance funds directly for the cost of services rendered (structural remuneration) and for the cost of procedures (remuneration of healthcare professionals). The amounts were determined based on previous fees, taking into consideration geographic variables. This funding was included, as of 1992, in the "National Quantified Objective" (Objectif quantifie national, OQN), which determined the amount health insurance must transfer to private clinics. After 1996, this amount was added to the ONDAM.

This way, for-profit private hospitals, unlike public hospitals, were funded through activity-based payments, on top of the regionally variable base fees, and not based on a single national schedule of fees, as seen in public hospitals. This

49. See BELLANGER, M. M., "Francia: la racionalización del sistema de salud. El control del gasto sanitario y el mito de Sísifo", *Ars Medica. Revista de Humanidades*, issue 4, 2005, page 263.

situation created a disparity between public and private hospitals. Moreover, this system had two disadvantages: on one hand, it made it difficult to control private hospitals and, on the other, complicated cost comparisons between the two sectors.

On 1 January 2000, tests were started to introduce pathology-based fee schedules in both public and private hospitals. These projects were laid out in the "Plan Hôpital 2007"; which established the implementation of the *Tarification à l'Activité* (T2A). The *Tarification à l'Activité* establishes Groupes Homogènes de Séjour (GHS)[50], in which patients are classified based on their type and the procedure needed. As of 2004, the *Tarification à l'Activité* is the way resources are assigned to both public and private healthcare centres by the insurance funds. The price of each activity is fixed annually by the Ministry of Health.

Given that funding for private hospitals and public hospitals was based on different systems, their adaptation to the new pricing method was also different. Public hospitals, through 2008, maintained part of their annual global allocation of funds. Thus, from 2004 to 2008, activity-based payments co-existed with the residual general allocation in public hospital centres. However, in private hospitals, the move to the new system was ensured by a transition coefficient. Thus, during the transition period, the national fee was multiplied by a transition coefficient[51]. After this transition period (2004-2008), government funding for public and private hospitals, as we mentioned above, has been through *Tarification à l'Activité*.

Classification of healthcare centres in France under ESA – 95

In France, social security bodies are independent institutional units, which are organised and managed separately from the rest of the general government. These bodies are characterised by: i) covering the whole or a significant part of the population; ii) being established, controlled and funded by the general government.

In French national accounting –as well as under ESA–95– Social Security falls under a subsector of the general government sector: Social security funds

50. These are the equivalent of the DRG (Diagnostic Related Groups) we mentioned before in the section on the National Health Service (NHS) in national accounts, when we discussed the PbR system and national fees in the United Kingdom.

51. The transition process between the two systems of funding was analysed by the Ministère de la Santé de la Jeunesse et des sports: Point d'étape T2A a l'occasion du passage à 100 de la part tarifée à l'activité dans le secteur public en 2008, Mission tarification à l'activité.

(S.1314). Likewise, this is further divided into two subsectors: Social security regimes (S.13141) and Agencies dependent on social security funds (S.13142), known by the initials ODASS. Social security regimes are funded through compulsory social contributions. On the other hand, the ODASS are institutional units that participate in the public social protection system –that are not part of the Social Security regimes– and have close ties to and are funded by Social Security agencies. The ODASS are essentially public units that belong to the public healthcare system and their main characteristic is that they are non-market units (and thus classified under the general government sector).

In essence, ODASS includes public hospitals and non-profit private hospitals that participate in public hospital service (PSPH), at which both the services provided and the way they are funded do not adhere to market criteria[52]. However, for-profit private hospitals are classified as non-financial corporations (S. 11).

At the same time, the ODASS include social works incorporated into social security agencies, but which have a different management (like the social works of *Caisse nationale d'allocations familiales CNAF* and the *Conservatoire national des arts et métiers CNAM*), as well as the Technical Agency for Hospital Information (ATIH) created in 2002 to launch the medicalisation of information systems. Nevertheless, the French Blood Agency isn't considered a unit of the general government for the purposes of national accounting.

Thus, the ODASS (S. 13142) have the following sub-classification:
- S. 131421: Public hospitals
- S. 131422: Social works incorporated into social security agencies.
- S. 131423: Technical Agency for Hospital Information

This is the classification used for national accounting, and the same parameters are followed in applying ESA–95 criteria. The *Institut National de la Statistique et des Études Économiques* has expressed the difficulties in classifying public hospitals, and has thus received specific indications regarding this operation[53]. As the *Institut National de la Statistique et des Études Économiques* points out, following the general criteria established in the ESA–95 Manual, the classification of a unit in the national accounts is done through a decision tree. This is made up of three questions: 1) Is the unit an institutional unit with decision-making

52. Nursing schools in hospitals don't constitute a market unit; they are included in the public hospitals classified as ODASS.

53. INSTITUT NATIONAL DE LA STATISTIQUE ET DES ÉTUDES ÉCONOMIQUES, *Les Administrations de la Sécurité Sociale*, Base 2000, issue 4, 2007, page 16 (box 3).

autonomy?; 2) Is the institutional unit public, meaning controlled by the general government?; 3) Is it market or non-market according to ESA–95?

For the *Institut National de la Statistique et des Études Économiques*, the response to the first two questions is yes for French public hospitals and the PSPH. The most difficult question, thus, is the third, which is also directly related to another question: funding. Here it must be determined whether the services rendered by hospitals is for sale –or available on the market- at an economically significant price, which allows them to cover a majority of their costs in a lasting manner; or if, to the contrary, the services are mainly covered through public funding that has little impact on supply and demand.

The crucial issue in the way services rendered are funded is whether or not economically significant prices are paid. From this premise, it can be determined whether the public entity is a market unit. In France, the *Institut National de la Statistique et des Études Économiques* is analysing both the ESA-95 criteria and the criteria of the 1993 National System of Accounts approved by the UN (hereto forth, NSA-93).

Based on the criteria of NSA-93, which are equivalent on this point to those of ESA-95, an economically significant price is one that has a significant influence on the amount producers are willing to supply and on the amounts purchasers will buy (NSA 6.45). On the other hand, non-market producers are Non-Profit Institutions (NPI) or general government that provide individual or collective goods or services free of charge or at prices that aren't considered economically significant to other institutional units or to general society. The main reason non-market producers exist is to reach specific goals of general benefit (national cohesion, social solidarity, public health, etc.). The most common examples are those related to education and healthcare (NSA 6.49).

In France, funding for public hospitals and PSPH is, in general, considered non-market according to the aforementioned criteria. There was no doubt about this in the period between the early eighties and 2004. During this period, as we have mentioned, hospital centres were funded through a global hospital allotment of funds (*Dotation Globale Hospitalière, DGH*), calculated by the *Direction de l'hospitalisation et de l'offre de soins* (part of the Ministry of Health) and paid for by the National Health Insurance Fund (*Caisse Nationale d'Assurance Maladie, CNAM*). Under this funding system, it was clear that hospital centres had to be considered non-market and thus part of the Agencies dependent on social security funds (ODASS, S. 13142), under the general government sector.

As we have pointed out, in 2004 a new system was introduced to quantify short-term hospital services in medicine, surgery and obstetrics (*médecine, chirurgie, obstétrique -MCO*). This has led, on one hand to the implementation of a joint classification of medical procedures (CCAM) to establish the fees of medical professionals (who don't belong to the general government sector); and, on the other, to an activity-based fee schedule (T2A) that pays for patient stays in hospital centres and the use of the corresponding body's facilities. Again, as we have mentioned, T2A doesn't focus as much on the period of hospitalisation but prioritises the activity.

Healthcare authorities highlight that the aim of introducing T2A is to properly distribute resources in a fairer, more effective way. Pathologies are treated with the same "professional quality", with the aim of avoiding the risk of over-endowment or under-endowment of some hospitals. By introducing this system (T2A), France joined some twenty other countries that have introduced similar activity-based fee systems[54].

In terms of national accounts, the payments made under T2A by the National Health Insurance Fund to hospital centres are the same as those made from the general hospital endowment (DGH): internal transfer of funds to a subsector of the general government (D. 732).

Despite the introduction of the new fee system, the *Institut National de la Statistique et des Études Économiques* maintains its views on keeping hospital centres in the general government sector. Their reasoning is twofold: first, the introduction of the activity-based fee system was carried out to rationalise distribution of public funding and not to carry out an overhaul of supply and demand through market pricing; and second, public hospitals continue providing "the community as a whole" with a service that is universal in nature, not for profit, meeting the criteria of non-market and under public control. Moreover, in the views of the *Institut National de la Statistique et des Études Économiques* the establishment of this fee system hasn't led to a situation in which public hospitals truly compete with private clinics[55].

Regarding the possible modification of accounting for the ODASS outside the general government sector, there is a clear hurdle in the deficiencies detected

54. These countries include Germany, Austria and Belgium, which can be seen on the comparative tables at the end of this study, specifically in the question in block "C. Funding I": "*How is payment made from general government to hospitals*?".

55. INSTITUT NATIONAL DE LA STATISTIQUE ET DES ÉTUDES ÉCONOMIQUES, *Les Administrations publiques dans les comptes nationaux*, Base 2005, 2012, page 20.

in the application of the activity-based fee system (T2A). The French Court of Auditors (*Cour des Comptes*) has analysed the introduction of this system[56]. In 2011, three-quarters of all hospital resources depended on these fees. For proper application of T2A, exhaustive information must be collected on production. This process is carried out through the program to medicalise information systems (*Programme de médicalisation des systèmes d'information, PMSI*), which provides hospital centres with standardised, quantifiable information regarding their activity, through which they can measure their medical production. Nevertheless, although the PMSI was approved in 2004 as an essential measure to improve operations of T2A, various dates have been proposed for it to go into effect. The reason lies in the difficulty of transmitting information from healthcare centres to health insurance centres. The PMSI project was re-launched in 2010 and hopes to be operational in 2013.

These deficiencies have complicated the proper application of the T2A system. The main criticisms of its application are: the existence of an inadequate distribution of resources, as the public sector believes that funding obtained through this system is excessive, while the private sector believes it is insufficient; the pauperisation of hospitals and, paradoxically, this method's inflationary nature in terms of budget; the trend towards shorter hospital stays, as if the price is reduced 50% in the case of a new hospitalisation, this leads to the new hospitalisation occurring in the three days following the previous one, linking one stay to the next[57]. In short, as the *Cour des Comptes* has noted[58], T2A "disconnects fees from costs without facilitating control of hospital expenditure".

The aforementioned situation leads us to say that, in the French case, the introduction of an activity-based fee system, applied to all hospital centres – both public and private- allows payments made by the general government to hospital centres to be considered under case iv) established by Eurostat ("according to a system of pricing applied to both public and private hospitals", ESA–95 Manual, Part I, section 5.5). As we have pointed out in analysing the general criteria, Eurostat considers payments made according to this fourth method to be the only ones that can be qualified as "sales".

56. COUR DES COMPTES, *La Sécurité sociale - Septembre 2011*, Chapitre VII. Tarification à l'activité et convergence tarifaire, pages 199 and following.

57. *Comptes rendus a la mission d'évaluation et contrôle de la sécurité sociale*, Senat, 7 February 2012. Available at: http://www.senat.fr/compte-rendu-commissions/20120206/mecss.html (last seen November 2012).

58. See previous footnote.

Insofar as the amounts hospital centres obtain through their "sales" cover more than 50% of their costs (although payment for these sales comes mainly from the general government), these centres may be classified as "market public institutional units", and as a result be excluded from the general government sector.

Thus, although French hospital centres seem to meet Eurostat's criteria to be excluded form the general government sector, both the fee difficulties and the French government's lack of desire to remove healthcare bodies from the general government sector, for the aforementioned reasons, have led the *Institut National de la Statistique et des Études Économiques*[59], in its latest report, to include public hospitals and PSPH in the social security subsector of the general government sector.

59. INSTITUT NATIONAL DE LA STATISTIQUE ET DES ÉTUDES ÉCONOMIQUES, *Les Administrations publiques dans les comptes nationaux*, Base 2005, 2012, page 20.

Application of ESA-95 to healthcare centres in Germany

A comparative study on the application of the European System of Accounts ESA-95

Application of ESA-95 to healthcare centres in Germany

Structure and funding of the healthcare system in Germany

The national healthcare system in the Federal Republic of Germany follows the Bismarck model, which involves the payment of obligatory health insurance policies[60]. These payments are made to the "*Krankenkassen*", obligatory healthcare insurers[61], regulated by Book V of the *Sozialgesetzbuch* (SGB)[62]. Specifically, article 3, regarding funding, states: "*Benefits and other expenditure of the healthcare insurers shall be funded through contributions (Beiträge). These contributions are paid by insurees and businesspeople, generally based on the insurees' income. The insurees' family members are not required to contribute*"[63].

Regarding hospital centres, in Germany there is a "double funding" system, as they receive income from two different sources: infrastructure investment is covered directly under the State budget based on taxes, while operating costs are paid for mainly through private insurers and healthcare funds.

Since 1 January 2009 (through the modification of Book V of the Sozialgesetzbuch under the Act of 2007), this funding system through obligatory insurance policies has been redesigned with the introduction of Social Funds (*Gesundheitsfonds*)[64]. The creation of these funds is a change

60. According to data from the Federal Ministry of Health (*Bundesministerium für Gesundheit*), in 2010 there were 51.4 million insurees in Germany (including their relatives, 70 million insurees), of a total of 80 million inhabitants.

61. The *Krankenkasse* are autonomous statutory corporations (*Körperschaften des öffentlichen Rechts mit Selbstverwaltung*). Their governing boards (*Verwaltungsrat*) are made up of businesspeople and workers in equal parts.

62. The *SGB* is from 1969, but Book V was approved by the Act of 20 December 1988 and has been in force since 1 January 1989 (the latest modification was through the Act of 21 July 2012).

63. § 3 SGB V Solidarische Finanzierung: "Die Leistungen und sonstigen Ausgaben der Krankenkassen werden durch Beiträge finanziert. Dazu entrichten die Mitglieder und die Arbeitgeber Beiträge, die sich in der Regel nach den beitragspflichtigen Einnahmen der Mitglieder richten. Für versicherte Familienangehörige werden Beiträge nicht erhoben" (the translation in the text is ours).

64. The Health Funds (Gesundheitsfonds) were created by the "Act to enhance competition in statutory health insurance" - *Gesetz zur Stärkung des Wettbewerbs in der gesetzlichen Krankenversicherung* (*GKV-WSG*) – and went into force on 1 January 2009.

in the funding model for the system, given that insurees don't contribute directly to each insurer (*Krankenkasse*), as contributions are paid to one body (*Gesundheitsfond*), which then distributes funds to the various insurers.

The Krankenassen receive a rate per insuree from the *Gesundheitsfons*, depending on their age, gender, risk factors, etc.

Classification of healthcare centres in Germany under ESA – 95

In Germany, according to data from German statistical authorities in the "Survey on sector classification of hospitals" created by Eurostat in 2009[65], there are 677 public hospitals and 1,410 private hospitals, 790 of which are non-profit institutions and 620 private for-profit entities.

In terms of national accounting, in Germany both public and private hospitals are classified in the "Non-financial corporations" sector.

Following is an analysis of how the German entities answer the three questions on the test to classify entities by sector, according to Regulation number 2223/1996 (ESA-95) and developed in the ESA-95 Manual[66]. In fact, the 25 questions in the "Survey on sector classification of hospitals" that Eurostat put to the EU Member States (plus Iceland and Switzerland) indirectly attempt to answer these three issues on the test to classify entities by sector[67].

The first of the three issues on the test to classify entities by sector is to determine whether or not they are institutional units, and in this sense they must meet two requirements: 1) either keep a complete set of accounts or it would be possible and meaningful to do so; and 2) have decision-making autonomy in exercising their main function.

So, in the case of Germany, as the German statistical authorities notified Eurostat in answering the 2009 Survey, all of the hospitals (public and private) keep a complete set of accounts.

65. EUROSTAT, Survey on the sector classification of public hospitals and homes for elderly in ESA95, 2009.

66. EUROSTAT, Manual on Government Deficit and Debt. Implementation of ESA95, Luxembourg, ed. 2013, pages 11 and following.

67. It must be noted that the United Kingdom and France didn't answer the Eurostat 2009 "Survey on the sector classification of public hospitals".

Regarding the second requirement under this first issue (whether or not they have decision-making autonomy in exercising their main function), Eurostat poses three questions: 1) Who names the hospital managers?; 2) Who decides salaries for hospital workers?; and 3) Who determines the hospitals' pricing policy? For public hospitals in Germany, the general government doesn't decide salaries or pricing policy; it only names the hospital managers. Thus, it can be said that German public hospitals have decision-making autonomy and can thus be considered institutional units. The naming of hospital managers is also key in analysing the following issue regarding the nature of the hospitals.
The second issue on the test to classify entities by sector is to determine whether the institutional unit is public or private. In this sense, we must see whether the general government controls the general policy of the entity (this is the ability to name, if necessary, appropriate management). In the case of German public hospitals, according to the data provided to Eurostat in 2009, we can see that the general government names the hospital managers. This element allows us to confirm the public nature of control of the entity.

The third issue for classifying an entity into a sector is whether it is market or non-market. National statistical authorities consider German public hospitals to be market public institutional units. Various issues are relevant to this qualification. To analyse them we will focus on the answers given by German statistical authorities on the 2009 Eurostat Survey.

First of all, funding for German public hospitals is varied, coming not only from the general government (the Länder budgets and local corporations, as well as Social Security funds), but also from non-Social Security insurances, from the patients themselves and from donations. Despite the varied nature of funding, it can be said that the majority comes from the general governmentAnother question that is relevant to this issue is how the government makes payments to German public hospitals. These payments are decided during the fiscal year and made depending on the activity carried out by the hospital (and not depending on its expenses). The same is true of payments made by the government to private hospitals.

In Germany there is a unified list of prices for treatments in all hospitals, public and private. This system of prices for hospital services is the *Diagnosis-Related-Groups, DRG*[68].

68. The origins of the DRG system can be found in the United States (it began to be used in the early eighties) and it has become the main payment method for hospitals in the majority of the OECD countries. QUENTIN W., GEISSLER A., SCHELLER-KREINSEN D., BUSSE R.: DRG-type hospital payment in Germany: The G-DRG system. Euro Observer, 2010.

In Germany, with the legal reform on compulsory insurance of 2000 and the DRG-system Act of May 2001[69], this payment system was introduced in hospitals (*Krankenhäuser*) and is obligatory in nature; this mandate is currently planned in § 301 SGB. The system has been applied in Germany since 1 January 2004[70].

This system aimed to introduce funding for hospital operating costs that was more focused on the activity carried out, in order to promote efficiency, quality and transparency.

Nearly all hospitals in Germany dealing with serious cases (both public and private) use this official pricing system in their billing and it is a system that must be applied to all patients[71].

In addition to these aspects regarding the hospital funding system, and regarding their economic management, the following questions posed in the Eurostat Survey allow us to determine the level of financial independence of the hospitals. German public hospitals have a significant level of financial independence from the general government. This is demonstrated by the fact that they don't need authorisation from the government to go into debt; and that the general government doesn't establish any sort of limit on debt or capital investment in hospitals.

Another example of the financial independence of German public hospitals is that in some cases they even pay dividends to the general government. Although the Eurostat Survey doesn't include specific data on the dividends paid by German public hospitals to the government, this fact in itself is relevant. According to the ESA-95 Manual, payment of dividends is an element that can lead some capital injections made by the general government to public hospitals to be qualified not as government expenditure (capital transfers), but as investment (acquisition of financial assets); as the general government is acting as a private investor that provides funds and obtains profit in return[72]. These capital injections, as we saw in the case of ADIF, don't impact public

69. *DRG-Systems-Gesetz* (BGBl. I, Nr. 19 vom 04.05.2001, S. 772).

70. For their technical management, the Institute for the Hospital Payment System (*Institut für das Entgeltsystem im Krankenhaus, InEK*) was created as a corporation in 2007.

71. In Germany there are nearly 2,100 hospitals that provide care for roughly 17 million cases of hospitalisation per year. It must be noted that psychiatric services are not included in the DGR payment system as it is not considered appropriate at this time.

72. EUROSTAT, *Manual on Government Deficit and Debt. Implementation of ESA95*, Luxembourg, ed. 2013, pages 113 and 116 (Part III.2, regarding capital injections for public corporations).

deficit and debt under ESA-95. This fact is highly significant given that Germany is the only State that said its public hospitals have paid dividends to the general government in the past four years on the 2009 Eurostat Survey. Finally, it must be noted that German private hospitals also pay dividends to the government. In conclusion, according to the criteria analysed previously, in Germany all public hospitals (as well as private hospitals) are excluded from the general government sector, given that they are considered market producers and are classified as “Non-financial corporations” (S. 11). The decisive criteria to this effect are those of control and the fact that the payments made by the general government to public hospitals are based on the same pricing system applied in private hospitals.

Application of ESA-95 to healthcare centres in Spain

A comparative study on the application of the European System of Accounts ESA-95

Application of ESA-95 to healthcare centres in Spain

Structure and funding of the healthcare system in Spain

Although this is not meant as an exhaustive study but simply to provide context for the analysis, we must start by noting that the current Spanish healthcare system is primarily based on the principles of universality, accessibility and decentralisation of healthcare to the Autonomous Communities, although it has undergone a series of changes. In order to understand the situation, we must first take a look at its antecedents.

The most relevant dates back to 1908, a time when insurance was voluntary, when the Act to create the National Insurance Institute (INP for its initials in Spanish) was passed, aiming to "spread and instil social prevision, especially that in the form of retirement pensions". This body was the first and most influential step in our country in social prevision policy, and was the body in charge of managing social insurance with the longest history (from 1908 to 1978).

The INP was laid out as a body to group together all of the existing insurance systems, so the system moved from the voluntary nature of funds towards the obligatory nature of compulsory payments to the equalitarian regime. Thus, the first compulsory social insurance in Spain was created in 1919: the Obligatory Workers Retirement insurance. This was followed by others, like the approval of maternity insurance in 1929, and making work accident insurance obligatory for all activities in 1932, although it had existed since 1900.

After the Civil War, under the INP social protection system, the Obligatory Old-Age and Disability Insurance (SOVI for its initials in Spanish) was created in 1942; and at the same time Social Security continued to expand through voluntary insurance, like various mutual organisations. The aim of SOVI was to provide healthcare for "economically weak producers in industry and commerce". Thus, we are looking at a system that followed the Bismarck model, just as in Germany and France. Under this model, funding for Social Security benefits came solely from contributions from businesspeople and workers, which is what gave them the right to access these benefits.

It was in late 1963 that Spain broke with this model, supressing classical social prevision and insurance schemes and moving towards a Social Security system. The main change was that the new system required the General National Budget to permanently include subsidies for Social Security, which, as it had expanded its target audience, could no longer be funded solely by businesspeople and workers. From this time on, the foundations of the Social Security system were laid. Later, in May 1974, the revised text of the General Act on Social Security was approved, modifying and expanding healthcare coverage under the Social Security system.

However, the basis of the current Social Security system can be found in the Spanish Constitution of 1978, which establishes the right of all citizens to health protection and healthcare in article 43. Moreover, article 41 of the Constitution definitively marks the end of the Bismarck system and the move towards a new universal system: expressing that public authorities shall maintain a public social security system for all citizens, guaranteeing sufficient support and social benefits in situations of need, regardless of their economic or employment status. The State promises to ensure this right by managing and funding the system through the national general budget.

In November 1978, Royal Decree-Act 36/1978 was published, eliminating the INP and dividing it into three institutes: the National Social Security Institute (INSS), the National Social Services Institute (INSERSO) and the National Health Institute (INSALUD). INSALUD is charged with managing and administrating healthcare services under the Social Security system.

Regarding organisation, it must be noted that the Constitution establishes a new territorial distribution of the country into Autonomous Communities, to which it also expects to transfer healthcare competences. The main weight of managing and administrating public services and interests thus falls to the state-level governments. This was formalised in General Health Act 14/1986 of 25 April (LGS), creating the National Health System, which is defined in the statement of intent as “the properly coordinated group of national and state-level healthcare services”.

Thus, each Autonomous Community had to create a Healthcare Service, made up of all the centres, services and establishments in that Autonomous Community (AC) as well as any territorial government within the AC (provincial, county or town councils, etc.), respecting their respective purview. In January 2002 (with Act 21/2001), the healthcare-management transfer process was completed in all Autonomous Communities.

With regard to funding, articles 78-83 of General Health Act 14/1986 of 25 April indicate that the budgets of the Nation, the Autonomous Communities, Local Corporations and Social Security must have the necessary items to cover healthcare needs. This is done through social contributions, State transfers, fees for specific services, contributions from the Autonomous Communities and Local Corporations, and tax revenue.

Therefore, funding for healthcare basically comes from taxes and is included in the general funding of each Autonomous Community, in addition to two other funds: the Healthcare Cohesion Fund managed by the Ministry of Health and the Savings Program for Temporary Disability.

However, it must be noted that in 2012 the Spanish National Health System underwent a significant modification with the approval of Royal Decree-Act 16/2012 of 20 April on urgent measures to ensure the sustainability of the National Health System and improve quality and safety of the benefits it provides. Among other issues, this Decree-Act establishes the figure of the "insuree" for the provision of healthcare services, which is a significant change in the system. These changes to the National Health System (as well as those seen in the United Kingdom in 2012 in effect since April 2013), although not the focus of this report, deserve to be addressed.

Finally, regarding the structure of the Spanish healthcare system, there are two different levels: Primary Care and Specialised Care. Both are public. This is an important difference compared to other countries, like France, where we saw that, while public hospitals are classified in the general government sector, primary healthcare is governed by market criteria and is part of the financial corporations sector.

Classification of healthcare centres in Spain under ESA-95 and a brief comparative analysis

Regarding hospital care, we can see from the data provided in response to the 2009 Eurostat "Survey on sector classification of hospitals" that Spain has two types of hospitals: public and private. Regarding the former, the general government has a total of 475 public hospitals, most of which fall under the subsector "State government" (431), while only a minority are classified as "Central government" (6), "Local government" (16) and "Social security funds" (22).

According to the data from the aforementioned 2009 Eurostat Survey, Spain has 446 private hospitals, which are divided into non-profit and for-profit institutions. There are 320 for-profit institutions and they are classified under the "Non-financial corporations" sector. There are 124 non-profit private hospitals, 116 of which are classified as "Non-financial corporations" and 8 in the "Non-profit institutions" sector.

On the 2009 Eurostat Survey, Spanish statistical authorities classified Spanish public hospitals under the "General government" sector. Following is an analysis of the answers Spain gave to questions posed by Eurostat that give context to the three issues on the test for classifying entities by sector under ESA-95. The first of the three issues on this test is to determine whether or not the hospitals are institutional units. As we saw in analysing the general criteria, in order for a unit to be considered an institutional unit, it must meet two requirements: 1) has decision-making autonomy in exercising its main function; and 2) either keeps a complete set of accounts or it would be possible and meaningful to do so. In order to avoid deceptive behaviour, ESA–95, approved in Regulation number 2223/1996 (section 2.12), establishes that the complete set of accounts must be meaningful from both an economic and legal standpoint[73]. In fact, this second requirement may be considered more formal in nature, and secondary to the first requirement, decision-making autonomy in the exercise of the main function, which is truly decisive.

In response to the question regarding the second requirement, Spanish statistical authorities notified Eurostat that some of the Spanish public hospitals do not keep a complete set of accounts.

Regarding decision-making autonomy in the exercise of the main function, Eurostat poses the following three questions to national statistical authorities: 1) Who names the hospital managers?; 2) Who decides salaries for hospital workers?; and 3) Who determines the hospitals' pricing policy? In Spanish public hospitals, the answer to all three questions is the general government. We believe this aspect is key to understanding why the requirement of decision-making autonomy is not met. The government doesn't decide these three issues in countries in which hospitals are excluded from the "General government" sector. In Germany, for example (where all public hospitals, a total of 677, belong to the "Non-financial corporations" sector), as we have seen,

73. It must be noted that in section 2.12 of the new ESA–2010, approved by Regulation (EU) number 549/2013 of 21 May 2013, published in the Official Journal of the European Union on 26 June 2013 (applicable as of 1 September 2014), the requirement that it be "meaningful, from both an economic and legal viewpoint, to compile a complete set of accounts" has been removed.

the general government only names hospital managers but doesn't decide salaries or pricing policy for the hospitals.

In short, given that some Spanish public hospitals don't keep a complete set of accounts and/or don't have decision-making autonomy in exercising their main function, Spanish statistical authorities consider that they are not institutional units but units dependent on the general government and it is therefore not necessary to analyse the other issues on the test to classify entities by sector, which are those regarding control and funding.

In our opinion, in order to exclude a healthcare entity from the general government sector under ESA-95, it is very important to verify that the entity in question meets the two initial requirements: that it keeps a complete set of accounts and that, although its managers may be named by the general government, it has decision-making autonomy.

The second issue on the test for sector classification of entities is to determine whether the entity is public or private.

In the case of (public) Spanish hospitals, the general government always controls general policy, thus they are public in nature. In fact, as we saw in resolving the first issue, the scope of the government's control in some cases even extends to decision-making in exercising their main function, excluding them from classification as institutional units.

In general, as seen in the results from the Eurostat Survey, in most European Union Member States the general government controls general policy in hospitals (understood as the ability to name, if necessary, the appropriate management). This fact means that in most European Union Member States hospitals are public in nature.

Only in the Netherlands do we see that there are no public hospitals; all hospitals are for-profit private hospitals, as their management is not controlled by the general government (second issue for sector classification of entities). Their private nature means that they are not included in the general government sector but classified under non-financial corporations, despite the fact that most of their funding comes from the general government (central government and social security funds) and payments are made based on hospital expenditure[74].

74. EUROSTAT, Survey on the sector classification of public hospitals and homes for elderly in ESA95, 2009.

Thus, in our mind, the option employed in the Netherlands is another possibility for excluding hospitals from the general government sector, in spite of being funded mainly by the government and receiving payment based on hospital expenditure (and not activity) with budgets fixed before the beginning of the economic year.

The third issue on the test for classification by sector of entities is whether they are market or non-market. With regard to Spanish public hospitals, these are mainly considered by national statistical authorities as non-market. Two of the questions on the Eurostat Survey are key in determining that public hospitals are non-market. The first question is related to their source of funding. Spanish public hospitals are funded mainly through three sources: the central government, the Autonomous Communities and Social Security. Thus, funding is mainly public. And the second question is in regard to the nature of payments made by the general government to hospitals.

In the case of Spain, payments are made according to a general budget fixed through a bilateral agreement between the general government and the hospital. This answer confirms the fact that payments cover hospital costs. To the contrary, in countries where the general government makes payments to their hospitals based on activity, payments are determined by other variables like the number of beds, procedures carried out or number of patients.

From the analysis of the data provided by Eurostat on its 2009 Survey, we can say that the answer to this question is decisive in excluding public hospitals from the general government sector. Countries in which hospitals are classified under the non-financial corporations sector indicate in response to this question that payments from the general government to hospitals are made according to the activity carried out by the hospital and not costs. This is the case of Germany, Slovakia, Hungary (which has some hospitals excluded from the general government sector and others that are included), Austria, Belgium, and, outside of the EU, Switzerland.

However, as we saw in analysing the classification of hospitals by sector in France, the existence of activity-based payments to hospitals doesn't necessarily mean that hospitals may be excluded from the general government sector. This way, payments by activity are a necessary requirement for exclusion from the general government sector but it is possible that, despite this fact, national statistical authorities may decide to maintain hospitals within the general government sector, or at least some of them (as is the case of Hungary).

Another complementary question to determine the nature of payments is whether there is a unified price list for all hospitals. This question confirms whether or not the general government pays public and private hospitals in the same manner. As we saw in the section on general criteria, as established in the ESA–95 Manual, payments made by the government to an institutional unit will be considered sales when the prices paid, for goods or services provided, are also applied to similar goods and services (of the same quality) provided by private producers; which is why Eurostat asks about the existence of a unified list of prices per procedure. Unlike Spain, in countries that apply an activity-based fee system and payments to hospitals are considered sales, there is a unified list of prices the government uses to pay both public and private hospitals (as we see, for example, in Germany and Austria).

These aspects we have analysed regarding the funding of Spanish public hospitals determine that they must be classified as non-market public institutional units. This classification is further ratified by the level of financial dependence hospitals have on the general government. Spanish public hospitals need authorisation from the general government to go into debt and, moreover, the government establishes limits regarding both debt and capital investments in hospitals.

With all of this in mind, Spanish public hospitals are part of the “General government” sector, which means that their deficit and debt must be consolidated with that of the corresponding level of government.

Obligations derived from application of ESA-95 to the general government

A comparative study on the application of the European System of Accounts ESA-95

Obligations derived from application of ESA-95 to the general government

In European regulations, the only express mention of the measures Member States are required to adopt regarding budgetary discipline are found in article 3 of Protocol 12 on the excessive deficit procedure annexed to the Treaty of the European Union (TEU) and the Treaty on the Functioning of the EU (TFEU).

This precept establishes various obligations. First of all, it states that "*In order to ensure the effectiveness of the excessive deficit procedure, the governments of the Member States shall be responsible under this procedure for the deficits of general government as 26.10.2012 EN Official Journal of the European Union C 326/279 defined in the first indent of Article 2*". The first indent of article 2 of the aforementioned Protocol encompasses in the concept "Public" all issues pertaining to the "General government"; and, under this concept: central, regional and local government and social security funds, excluding commercial operations, as defined in the European System of Integrated Economic Accounts.

Secondly, article 3 of the aforementioned Protocol determines the following mandate: that "*The Member States shall ensure that national procedures in the budgetary area enable them to meet their obligations in this area deriving from these Treaties*".

This precept of the Protocol defines the principle of sincere cooperation and the principle of institutional and procedural autonomy on the subject of budgetary discipline. The principle of sincere cooperation laid out in article 4.3 (second paragraph) of the TEU establishes that "*Member States shall take any appropriate measure, general or particular, to ensure fulfilment of the obligations arising out of the Treaties or resulting from the acts of the institutions of the Union*". And the principle of *institutional and procedural autonomy*, which is very important to the subject of this report, establishes that European Union Law shall not distinguish among the internal structures of the Member States and the way in which these States meet the aforementioned requirements.

In short, the specific obligations of Member States as derived from ESA-95

established in European regulations are related to the way the information is submitted to the European Union (accounting and financial transparency obligations), but do not condition internal budgetary procedures, nor are they binding regarding the internal management or controls undertaken by the government of each State. These obligations are established in Council Directive 2011/85/EU of 8 November 2011 on requirements for budgetary frameworks of the Member States.

Regarding accounting obligations, article 3 of the aforementioned Council Directive 2011/85/EU establishes that: "*As concerns national systems of public accounting, Member States shall have in place public accounting systems comprehensively and consistently covering all sub-sectors of general government and containing the information needed to generate accrual data with a view to preparing data based on the ESA-95 standard*".

As we can see, European institutions assume that the government of each State bases this information on other accounts, like for example budgetary accounts, according to cash-based fiscal data (see article 3, section 2, letter a) of Directive 2011/85/EU) to compile the data that must later be submitted. This entails the need to carry out the necessary adjustments, which must be included in a "reconciliation table" between the two accounting systems (see article 3, section 2, letter b) of Directive 2011/85/EU)[75].

Concerning obligations with regard to the transparency of public finances, section 1 of article 14 of the aforementioned Directive 2011/85/EU, establishes that: "*Within the framework of the annual budgetary process, Member States shall identify and present all general government bodies and funds which do not form part of the regular budgets at sub-sector level, together with other relevant information. The combined impact on general government balances and debts of those general government bodies and funds shall be presented in the framework of the annual budgetary processes and the medium-term budgetary plans*".

75. Article 3, section 2, of Directive 2011/85/EU states:
"Member States shall ensure timely and regular public availability of fiscal data for all sub-sectors of general government as defined by Regulation (EC) No 2223/96. In particular Member States shall publish:

a. cash-based fiscal data (or the equivalent figures from public accounting if cash-based data are not available) at the following frequencies:
- monthly for central government, state government and social security sub-sectors, before the end of the following month, and
- quarterly, for the local government sub-sector, before the end of the following quarter;

b. a detailed reconciliation table showing the methodology of transition between cash-based data (or the equivalent figures from public accounting if cash-based data are not available) and data based on the ESA 95 standard."

And, most importantly, section 3 of article 14 of Directive 2011/85/EU establishes that: "*For all sub-sectors of general government, Member States shall publish relevant information on contingent liabilities with potentially large impacts on public budgets, including government guarantees, non-performing loans, and liabilities stemming from the operation of public corporations, including the extent thereof. Member States shall also publish information on the participation of general government in the capital of private and public corporations in respect of economically significant amounts*".

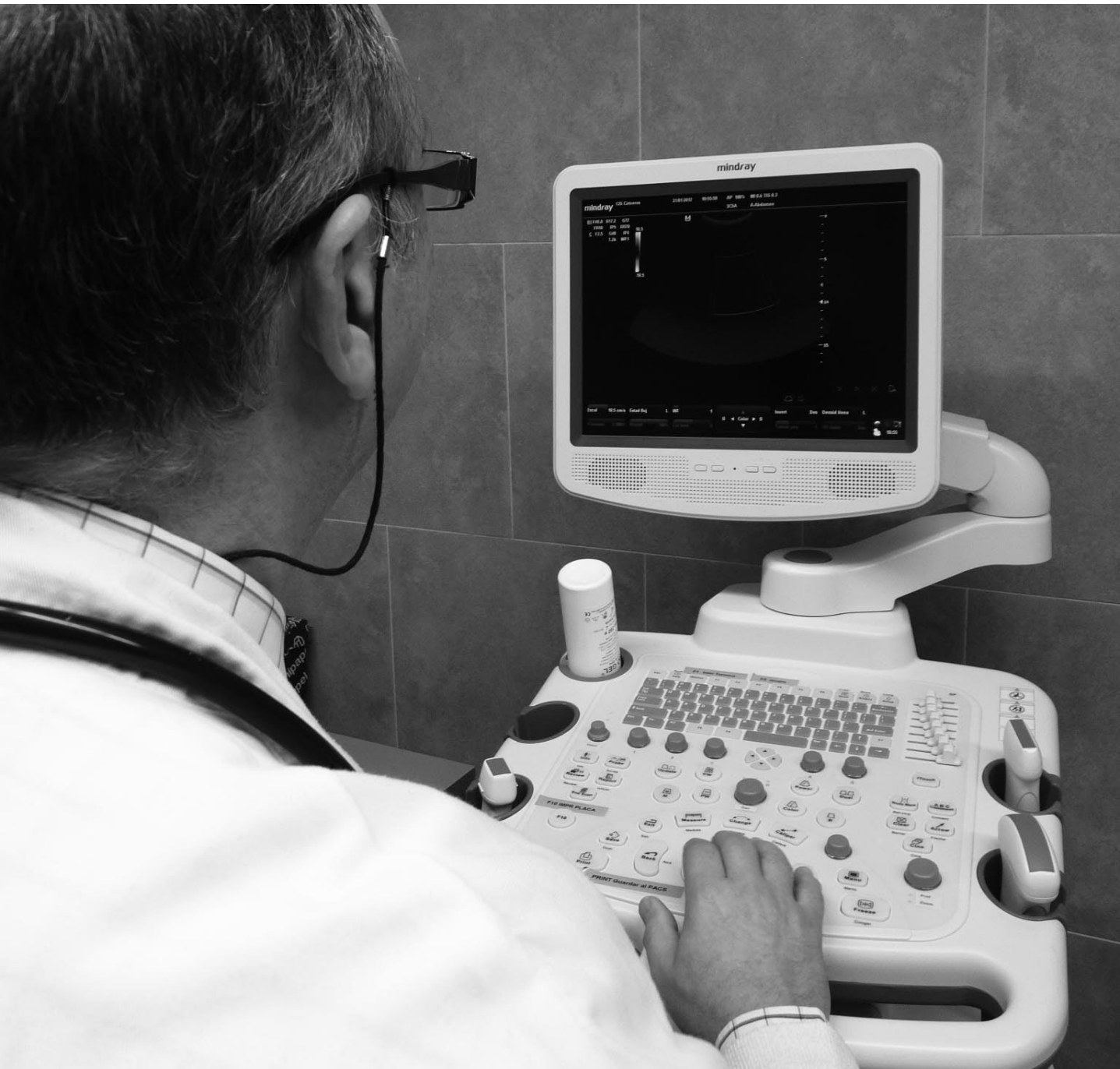
From these mandates, we can extract that European regulations don't restrict the requirement for transparency only to bodies classified within the general government sector under ESA–95. As a result, it is a viable option (taking into consideration the demands stemming from European regulations in terms of transparency) for national lawmakers to establish control mechanisms also applying to market public institutional units[76]. Transparency must also be implemented regarding two other aspects that directly affect the sustainability of public finances: first of all, any possible contingent liabilities taken on by the general government (especially through guarantees); and, secondly, the government's participation in public and private corporations, if in economically significant amounts.

In short, we can conclude that the obligations stemming from European regulations are regarding transparency, but they do not determine a specific type of budgetary procedure or control that must be introduced by national lawmakers, which have the freedom to establish the mechanisms they consider necessary in order to ensure compliance with the transparency obligations.

76. Council Regulation (EU) number 679/2010 of 26 July 2010 amending Regulation (EC) number 479/2009 as regards the quality of statistical data in the context of the excessive deficit procedure, in consideration 7, establishes that under the framework for methodological visits to a Member State to ensure statistical compliance with the former, Eurostat must be given access not only to the accounts of institutional units in the general government sector, but also to the accounts of any public units classified outside of the general government sector.

Eurostat's latest interpretations of the classification of healthcare centres (2013). Perspectives

A comparative study on the application of the European System of Accounts ESA-95



Eurostat's latest interpretations of the classification of healthcare centres (2013). Perspectives

Although the analysis we have carried out on the sector classification of healthcare centres in various EU States is currently valid, in 2013 Eurostat has made some specifications regarding the criteria for classifying hospitals as a result of the classification of Austrian hospitals. Specifically, within the framework of the Final findings of the Excessive Deficit Procedure Dialogue to Austria[77], Eurostat indicated that there are various aspects that necessitate revision of the classification of Austrian hospitals in the "Non-financial corporations" sector.

First of all, in general, Eurostat has already announced that the future ESA–2010 will modify the criteria for determining whether a unit is market or non-market. ESA–2010 establishes, as a prerequisite for application of the 50% rule, that the relationship between the general government and the entities must be taken into account, especially if the former is the main or only purchaser of the services rendered by the entity[78].

Precisely, according to the recently approved ESA–2010[79], in section 1.37, an activity will be considered market if the corresponding goods and services are traded under the following conditions: "*1) sellers act to maximise their profits in the long term, and do so by selling goods and services freely on the market to whoever is prepared to pay the asking price; 2) buyers act to maximise their utility given their limited resources, by buying according to which products best*

77. EUROSTAT, *Final findings*, *EDP dialogue to Austria*, *25 - 26 June 2012*, Luxembourg, 8 January 2013, pages 2-3 and pages 23-25.

78. According to Eurostat, taking into account existing relationships between the government and the body is a "qualitative" criterion that must be applied before the 50% rule. See EUROSTAT, *Final findings, EDP dialogue to Austria*, 25 - 26 *June* 2012, Luxembourg, 8 January 2013, pages 2 and 24.

79. European Parliament and Council Regulation (EU) number 549/2013 of 21 May 2013 on the European system of national and regional accounts in the European Union (ESA–2010), published in the Official Journal of the EU on 26 June 2013. ESA–2010 will be applicable for the first time for data submitted after 1 September 2014.

meet their needs at the offered price; 3) effective markets exist where sellers and buyers have access to, and information on, the market. An effective market can operate even if these conditions are not met perfectly".

Under these new parameters it may be more difficult for there to be public institutional units funded mainly by the general government but excluded from the general government sector.

Secondly, Eurostat points to some specific aspects regarding funding and the classification of hospitals in Austria, which could be extrapolated to other States. Notably the need to apply the 50% test not to the system of hospitals as a whole but to each individually[80]. In order to meet this requirement, Eurostat asks that Austrian statistical authorities apply the 50% rule specifically to the most representative hospitals. This way, it will be easier to judge compliance with the 50% rule, as in some cases it is difficult to determine when transfers from the general government (Austrian social security funds) to hospitals are to cover sales and when they are subsidies. This makes it difficult to determine whether or not they comply with the rule requiring at least 51% of costs to be covered by activity-based payments.

As we can see in the responses to the Eurostat survey[81], Austria is one of the countries that analyses sector classification of the body not hospital by hospital but by group of hospitals. This is also what is done in Germany. As we have mentioned, Eurostat has changed its criteria (as reflected in the new ESA–2010) and is now against joint analyses and requires obligatory individualised analysis of each institutional unit. Spanish statistical authorities, in principle, as understood from their responses to the survey, already carry out this individualised analysis for their hospitals.

In short, although the general criteria for sector classification of hospitals (and of the body in general) haven't changed in the latest versions of the ESA–95 Manual[82], they have come to be interpreted more strictly by Eurostat.

80. Eurostat's requirement that Austria apply the 50% rule individually to each of its hospitals is included in ESA–2010 with general application. EUROSTAT, *Final findings, EDP dialogue to Austria, 25 – 26 June 2012*, Luxemburg, 8 January 2013, page 24. Section 20.20 of the new ESA-2010 states: "Whereas the assessment of whether a price is economically significant is carried out at the level of each individual output, the criterion determining the market/non-market character of a unit is applied at the level of the unit".

81. EUROSTAT, *Survey on the sector classification of public hospitals and homes for elderly in ESA95*, 2009. See the table at the end of this report (*D. Sector classification of hospitals III*).

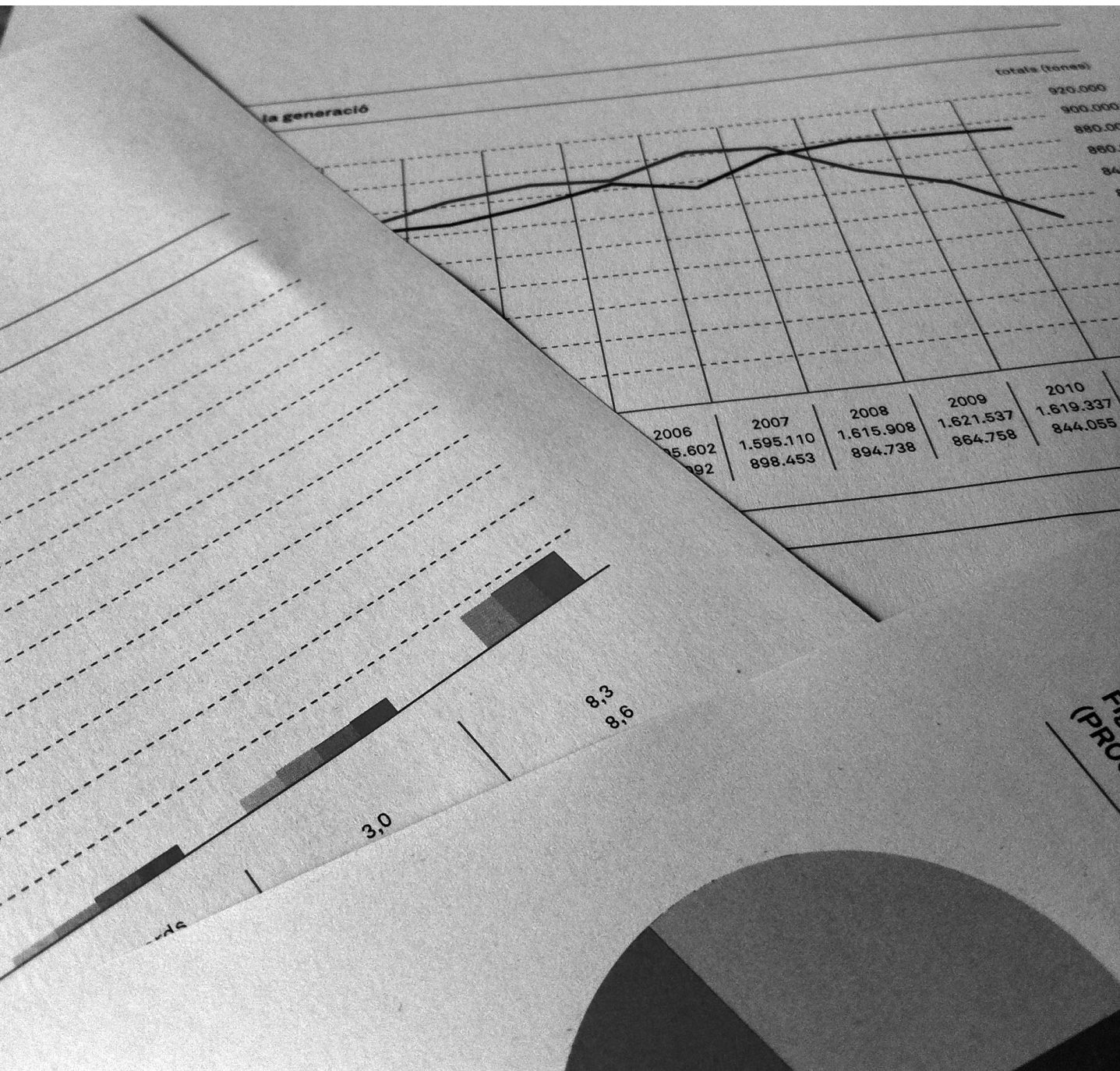
82. Eurostat recognises the need for additional information on methodological treatment of hospitals (on sector classification of healthcare providers) in the ESA–95 Manual. This task is expected to be carried out in the upcoming editions of the ESA–95 Manual. EUROSTAT, *Final findings, EDP dialogue to Austria*, 25 - 26 June 2012, Luxemburg, 8 January 2013, page 3.

Furthermore, with the recent approval of ESA–2010, it is possible that many States will have to revise their classification of public hospitals in the "Non-financial corporations" sector[83].

83. Regarding the periodicity with which the classification of hospitals in the various Member States is reviewed, in the table at the end of this report (*D. Sector classification of hospitals III*) it can be seen that Spain is the only State that reviews sector classification of a hospital when it begins and ends activity. This was the response provided by national statistical authorities on the Eurostat survey (*Survey on the sector classification of public hospitals and homes for elderly in ESA95,* 2009). However, in practice there have been modifications to sector classifications of hospitals in other moments. Thus, taking into account the greater periodicity, in general, with which other States review the classification of their hospitals (annually, every two years, when funding changes, etc.), as well as changes to accounting standards (new ESA-2010), we believe it is necessary to review the classification of Spanish hospital centres, or at least those that expressly request it.

Comparative tables with other European Union Member States

La governança en les institucions de salut



Comparative tables with other European Union Member States

To complement the explanation provided in the previous sections of this report, on the United Kingdom, France, Germany and Spain, we believe it advisable to include a comparative table partially reproducing information from the "Survey on sector classification of hospitals" complied by Eurostat in 2009. These tables show the sector classification of public and private hospitals in some European Union Member States other than those previously analysed in this report. The answers to some questions are not included on these tables and this is due to the fact that the Member State in question didn't provide the corresponding data.

To analyse the comparative tables, the following classification may be taken into account:

(*) Institutional sectors according to the European System of Accounts (ESA-95):

Sector 11: Non-financial corporations
Sector 12: Financial corporations
Sector 13: General government
- Subsector 1311: Central government
- Subsector 1312: State government
- Subsector 1313: Local government.
- Subsector 1314: Social security funds

Sector 14: Households.
Sector 15: Non-profit institutions (NPI) serving households

A. Types of hospitals and sector classification

State	Type of hospitals	Number of hospitals	Sector classification of hospitals (*)
GERMANY	Public	677	- Non-financial corporations
	Private NPI	790	- Non-financial corporations
	Private	620	- Non-financial corporations
AUSTRIA	Public	157	- Non-financial corporations: 157 – x - General government: x
	Private NPI	43	- Non-financial corporations
	Private	64	- Non-financial corporations
BELGIUM	Public	57	- Non-financial corporations - Except Hôpital Militaire: Central government
	Private NPI		
	Private	147	- Non-financial corporations
CZECH REPUBLIC	Public	105	- Non-financial corporations
	Private NPI	2	- NPI
	Private	49	- Non-financial corporations: 47 - Other: 7
SLOVAKIA	Public	93	- Non-financial corporations: 89 - General government: - Central government: 1 - Local government: 3
	Private NPI	31	- NPI
	Private	31	- Non-financial corporations
FINLAND	Public	Nearly all	- General government: - Central government: 2 - Local government: all except 2 previous
	Private NPI	Aprox. 20	- NPI
	Private		- Non-financial corporations
NETHERLANDS	Public		
	Private NPI		
	Private	100	- Non-financial corporations
ITALY	Public	566	- Local government
	Private NPI		
	Private	633	- Non-financial corporations
PORTUGAL	Public	73	- Non-financial corporations: 44 - Administració central: 29
	Private NPI	58	- NPI
	Private	56	- Non-financial corporations: 55 - NPI: 1
SPAIN	Public	475	- General government: - Central government: 6 - State government: 431 - Local government: 16 - Social security funds: 22
	Private NPI	124	-Non-financial corporations: 116 -NPI: 8
	Private	320	-Non-financial corporations

B. Control

State	Type	Do they keep a full set of accounts?	Who appoints director of hospital?	Who sets personnel salaries?	Who sets pricing policy?
GERMANY	Public	Yes	- Government	- Other	- Other
	Private NPI	Yes	- Owner	- Other	- Other
	Private	Yes	- Owner	- Other	- Other
AUSTRIA	Public	Yes	- Government	- Government - Other	- Government - Other
	Private NPI	Yes	- Other	- Other	- Government - Other
	Private	Yes	- Other	- Other	- Other
BELGIUM	Public	Yes	- Government, indirectly through public funding - Other	- Government, only for civil servants, by grade - Other, labour contracts	- Government, with unified list of prices by procedure - Other
	Private NPI				
	Private	Yes	- Government, indirectly through public funding - Other	- Government, only for civil servants, by grade - Other, labour contracts	- Government, with unified list of prices by procedure - Other
CZECH REPUBLIC	Public	Yes	- Government - Other	- Government - Other	- Government - Other
	Private NPI	Yes	- Other	- Other	- Government - Other
	Private	Yes	- Other	- Other	- Government - Other
SLOVAKIA	Public	Yes	- Government	- Government	- Government
	Private NPI	Yes	- Other	- Other	- Government - Other
	Private	Yes	- Other	- Other	- Government - Other
FINLAND	Public		- Government		- Government
	Private NPI	Yes	- Hospitals		- Hospitals
	Private		- Hospitals		- Hospitals
NETHERLANDS	Public				
	Private NPI				
	Private	Yes	- Hospitals	- Hospitals	- Government (majority) - Minority through agreements between insurance companies and hospitals

ITALY	Public	Yes	- Government	- Government	- Government
	Private NPI				
	Private	Yes	- Other	- Other	- Other
PORTUGAL	Public	Yes	- Government	- Other	- Through agreements and pacts with the government
	Private NPI		- Institutions' board of directors	- Unit administration	- Hospital, through agreements and negotiations with government - Hospital, but price of products and services provided to patients from private insurance is negotiated through agreements and pacts
	Private	Yes	- Partners/ shareholders	- Unit administration	- Ídem
SPAIN	Public	Yes/No	- Government	- Government	- Government
	Private NPI	Yes	- Other	- Other	- Other
	Private	Yes	- Other	- Other	- Other

C. Funding I

State	Type	How are hospitals funded?	How is payment made from general government to hospitals?
GERMANY	Public	- Budgets from regions and local corporations - Social security funds - Other insurances, not SS - Patients - Charitable donations	- According to activities carried out by hospital
	Private NPI	- Budgets from regions and local corporations - Social security funds - Other insurances, not SS - Patients - Charitable donations	- According to activities carried out by hospital
	Private	- Budgets from regions and local corporations - Social security funds - Other insurances, not SS - Patients - Charitable donations	- According to activities carried out by hospital
AUSTRIA	Public	- Central government - Budgets from regions and local corporations - Social security funds - Other insurances, not SS - Patients	- According to activities carried out by hospital
	Private NPI	- Central government - Budgets from regions and local corporations - Social security funds - Other insurances, not SS - Patients	- According to activities carried out by hospital
	Private	- Social security funds - Other insurances, not SS - Patients	- According to activities carried out by hospital
BELGIUM	Public	- Central government (funds 25% of daily hospitalisation) - Budgets from regions and local corporations - Social security funds - Patients	- According to activities carried out by hospital
	Private NPI		
	Private	- Central government (funds 25% of daily hospitalisation) - Budgets from regions and local corporations - Social security funds - Patients	- According to activities carried out by hospital

CZECH REPUBLIC	Public	- Central government - Budgets from regions and local corporations - Social security funds - Patients - Other	- Other
	Private NPI	- Social security funds - Patients - Other	- Other
	Private	- Social security funds - Patients - Other	- Other
SLOVAKIA	Public	- Central government: 1 hospital - Budgets from regions and local corporations: 2 hospitals - Social security funds	- According to activities carried out by hospital
	Private NPI	- Social security funds - Patients	- According to activities carried out by hospital
	Private	- Social security funds - Patients	- According to activities carried out by hospital
FINLAND	Public	- Central government - Budgets from regions and local corporations	
	Private NPI	- Social security funds - Other insurances, not SS - Patients	
	Private	- Social security funds - Other insurances, not SS - Patients	
NETHERLANDS	Public		
	Private NPI		
	Private	- Central government - Social security funds - Other insurances, not SS - Patients	- Depending on hospital costs
ITALY	Public	- Budgets from regions and local corporations - Patients	- Depending on hospital costs - According to activities carried out by hospital
	Private NPI		
	Private	- Budgets from regions and local corporations - Other insurances, not SS - Patients - Other	- According to activities carried out by hospital

PORTUGAL	Public	- Central government - Budgets from regions and local corporations - Other insurances, not SS - Patients	- Depending on hospital costs (central government) - According to activities carried out by hospital (non-financial corporations)
	Private NPI	- Central government - Budgets from regions and local corporations - Social security funds - Other insurances, not SS - Patients	- According to activities carried out by hospital
	Private	- Central government - Budgets from regions and local corporations - Social security funds - Other insurances, not SS - Patients	- According to activities carried out by hospital
SPAIN	Public	- Central government - Budgets from regions and local corporations - Social security funds - Other insurances, not SS - Patients	- Depending on hospital costs
	Private NPI	- Budgets from regions and local corporations - Social security funds - Other insurances, not SS - Patients	- According to activities carried out by hospital
	Private	- Budgets from regions and local corporations - Social security funds - Other insurances, not SS - Patients	- According to activities carried out by hospital

C. Funding II

State	Type	Government funding is tied to…
GERMANY	Public	Other
	Private NPI	Other
	Private	Other
AUSTRIA	Public	- Number of medical procedures
	Private NPI	- Number of medical procedures
	Private	- Number of medical procedures - Bilateral budget agreements between government and hospital
BELGIUM	Public	- Number of beds - Number of medical procedures - Number of patients
	Private NPI	
	Private	- Number of beds - Number of medical procedures - Number of patients
CZECH REPUBLIC	Public	- Other
	Private NPI	- Other
	Private	- Other
SLOVAKIA	Public	- Number of beds - Number of medical procedures - Number of patients - Bilateral budget agreements between government and hospital
	Private NPI	- Number of beds - Number of medical procedures - Number of patients
	Private	- Number of beds - Number of medical procedures - Number of patients
FINLAND	Public	
	Private NPI	
	Private	
NETHERLANDS	Public	
	Private NPI	
	Private	- Number of beds - Number of medical procedures - Number of patients
ITALY	Public	- Number of medical procedures - Bilateral budget agreements between government and hospital - Other
	Private NPI	
	Private	- Number of medical procedures - Bilateral budget agreements between government and hospital

PORTUGAL	Public	- Number of medical procedures - Other
	Private NPI	- Number of medical procedures - Number of patients (some hospitals have agreements with the government to provide services to National Health Service beneficiaries by number of patients)
	Private	- Number of medical procedures - Number of patients (some hospitals have agreements with the government to provide services to National Health Service beneficiaries by number of patients)
SPAIN	Public	- Bilateral budget agreements between government and hospital - Hospital costs
	Private NPI	- Number of medical procedures
	Private	- Number of medical procedures

C. Funding III

State	Type	Is there a unified price list for procedures in all hospitals?	How are hospitals paid for services rendered?
GERMANY	Public	Yes	- By the Social Security system, other insurance systems and patient co-payment, among others
	Private NPI	Yes	- By the Social Security system, other insurance systems and patient co-payment, among others
	Private	Yes	- By the Social Security system, other insurance systems and patient co-payment, among others
AUSTRIA	Public	Yes	- Other
	Private NPI	Yes	- Other
	Private	Yes	- Patient co-payment and insurance system
BELGIUM	Public	Yes, generally. However there are specific prices for each hospital for hospitalisation	- 85% by Social Security, 10% by patients and 5% other
	Private NPI		
	Private	Yes, generally. However there are specific prices for each hospital for hospitalisation	- 85% by Social Security, 10% by patients and 5% other
CZECH REPUBLIC	Public		- Patient co-payment and insurance system
	Private NPI		- Patient co-payment and insurance system
	Private		- Patient co-payment and insurance system
SLOVAKIA	Public	Yes	- By the Social Security system
	Private NPI	Yes	- By the Social Security system, partial patient co-payment
	Private	Yes	- By the Social Security system, partial patient co-payment
FINLAND	Public		- Patients pay hypothetical amount
	Private NPI		- Patient co-payment and insurance system
	Private		- Patient co-payment and insurance system

NETHERLANDS	Public		
	Private NPI		
	Private	Yes, mainly	- By the Social Security system and other insurance systems
ITALY	Public	No	- Other
	Private NPI		
	Private	No	- Non-Social Security insurance systems, among others
PORTUGAL	Public	Yes	- Other
	Private NPI	No, except for services contracted by the National Health System and public and private insurance funds	- Directly by patients (in the case of Social Security funds, reimbursement is less than 100%) - By the Social Security system - Per other insurance systems - Patient co-payment. The percentage is variable and depends on agreements with supplier, type of insurance and service rendered.
	Private	No, except for services contracted by the National Health System and public and private insurance funds	- Directly by patients (in the case of Social Security funds, reimbursement is less than 100%) - By the Social Security system - Per other insurance systems - Patient co-payment. The percentage is variable and depends on agreements with supplier, type of insurance and service rendered.
SPAIN	Public	No	- By the Social Security system and other sources
	Private NPI	No	- By other, non-Social Security insurance systems, with partial co-payment from patients, among others
	Private	No	- By other, non-Social Security insurance systems, with partial co-payment from patients, among others

C. Funding IV

State	Type	What sort of financial aid have hospitals received from the government in the last 4 years?	When are the terms of government funding for hospitals set?
GERMANY	Public	- Subsidies - Government investment grants - Payment for services - Injections of capital - Loans - Guarantees	During fiscal year
	Private NPI	- Subsidies - Government investment grants - Payment for services - Loans	During fiscal year
	Private	- Subsidies - Government investment grants - Payment for services - Loans	During fiscal year
AUSTRIA	Public	- Subsidies - Government investment grants - Payment for services	Before beginning of fiscal year, by contract
	Private NPI	- Subsidies - Government investment grants - Payment for services	Before beginning of fiscal year, by contract
	Private	- Payment for services	Before beginning of fiscal year, by contract
BELGIUM	Public	- Subsidies: hospitals are legally required to accept all patients, even those without funds (in which case the local government must cover their deficit). - Government investment grants - Payment for services	Before beginning of fiscal year, by contract (budget set by government)
	Private NPI		
	Private	- Government investment grants - Payment for services	Before beginning of fiscal year, by contract (budget set by government)
CZECH REPUBLIC	Public	- Subsidies - Government investment grants - Payment for services - Guarantees	Before beginning of fiscal year, by contract (budget set by government)
	Private NPI	- Payment for services	During fiscal year
	Private	- Payment for services	During fiscal year
SLOVAKIA	Public	- Debt assumption	Before beginning of fiscal year, by contract
	Private NPI		Before beginning of fiscal year, by contract
	Private		Before beginning of fiscal year, by contract

FINLAND	Public		
	Private NPI		
	Private		
NETHERLANDS	Public	- Subsidies - Government investment grants - Payment for services	
	Private NPI		
	Private		Before beginning of fiscal year, by contract
ITALY	Public	- Government investment grants - Payment for services - Debt assumption	
	Private NPI		
	Private	- Payment for services	
PORTUGAL	Public	- Subsidies and government investment grants in hospitals run by the government - Payment for services to non-financial corporations - Capital injections and loans	Before beginning of fiscal year, by contract
	Private NPI	- Payment for services	Before beginning of fiscal year, by contract
	Private	- Payment for services	Before beginning of fiscal year, by contract
SPAIN	Public	- Payment for services	Before beginning of fiscal year, by contract
	Private NPI	- Payment for services	Before beginning of fiscal year, by contract
	Private	- Payment for services - Other: according to hospital expenditure	Before beginning of fiscal year, by contract

C. Funding V

State	Type	Do hospitals need government authorisation for loans?	If yes, is there a limit set by the government?	Does the government provide guarantees for loans to hospitals?
GERMANY	Public	No		
	Private NPI	No		
	Private	No		
AUSTRIA	Public	In some cases yes, in others no	Yes, for all types of loans	Yes
	Private NPI	No		
	Private	No		
BELGIUM	Public	No		Not generally but "intercommunale" hospitals can receive them from the local government
	Private NPI			
	Private	No		No
CZECH REPUBLIC	Public	In some cases yes, in others no	In some cases yes, in others no	
	Private NPI	No	No	
	Private	No	No	
SLOVAKIA	Public	No		No
	Private NPI	No		No
	Private	No		No
FINLAND	Public			
	Private NPI	No		No
	Private	No		No
PAÏSOS BAIXOS	Public			Yes
	Private NPI			
	Private	No		
ITALY	Public	Yes	Yes, for all types of loans	Yes
	Private NPI			
	Private	No		No
PORTUGAL	Public	Yes when general government, no when non-financial corporations	Yes, for all types of loans when general government	No
	Private NPI			No
	Private			No
SPAIN	Public	Yes	Yes, for all types of loans	No
	Private NPI	No		No
	Private	No		No

C. Funding VI

State	Type	Is there an economic limit (fixed by the government) on capital investment in hospitals?	Are there any public hospitals that have paid dividends to the government in the last 4 years?	If a hospital is closed or eliminated, who receives the value of the liquidation?
GERMANY	Public	No	Yes	The regional or local government that owns the hospital
	Private NPI	No	Yes	Owner
	Private	No	Yes	Owner
AUSTRIA	Public	No	No	
	Private NPI			
	Private			
BELGIUM	Public	Sometimes yes, but only on the party receiving public funding	No	The procedure of reactivation or mergers between hospitals
	Private NPI			
	Private	Sometimes yes, but only on the party receiving public funding	No	The procedure of reactivation or mergers between hospitals
CZECH REPUBLIC	Public	No	No	The central, regional or local government
	Private NPI	No	No	Other
	Private	No	No	Other
SLOVAKIA	Public	No		The central, regional or local government
	Private NPI	No		Other
	Private	No		Other
FINLAND	Public			The central, regional or local government
	Private NPI	No		Owner
	Private	No		Owner
NETHER-LANDS	Public			
	Private NPI			
	Private	No	No	Divided up among creditors

ITALY	Public	Yes	No	The regional or local government
	Private NPI			
	Private	No		Other
PORTUGAL	Public	No	No	The central, regional or local government
	Private NPI	No		Creditors > owner institutions
	Private	No		Creditors > shareholders
SPAIN	Public	Yes	No	The central, regional or local government
	Private NPI	No	No	Owner
	Private	No	No	Owner

D. Sector classification of hospitals I

State	Type	Which criteria are used to decide the sector?	What is taken into account when applying the market unit test?
GERMANY	Public	Control and 50% test	Only 50% criterion for sales and costs
	Private NPI	Control and 50% test	Only 50% criterion for sales and costs
	Private	Control	Only 50% criterion for sales and costs
AUSTRIA	Public	50% test	Only 50% criterion for sales and costs
	Private NPI	50% test	Only 50% criterion for sales and costs
	Private	50% test	Only 50% criterion for sales and costs
BELGIUM	Public	Funding and 50% test	Whether or not services are sold at economically significant prices that have a relevant influence on the volume of services patients want to receive, and the 50% criterion
	Private NPI		
	Private	Funding and 50% test	Whether or not services are sold at economically significant prices that have a relevant influence on the volume of services patients want to receive, and the 50% criterion
CZECH REPUBLIC	Public	Combination of legal status and 50% test	Only 50% criterion for sales and costs
	Private NPI	Combination of legal status and 50% test	
	Private	Combination of legal status and 50% test	
SLOVAKIA	Public	Funding, control and 50% test	Only 50% criterion for sales and costs
	Private NPI	Funding, control and 50% test	Only 50% criterion for sales and costs
	Private	Funding, control and 50% test	Only 50% criterion for sales and costs
FINLAND	Public	Funding, control and 50% test	Whether or not services are sold at economically significant prices that have a relevant influence on the volume of services patients want to receive
	Private NPI	Funding, control and 50% test	
	Private	Funding, control and 50% test	

NETHERLANDS	Public		
	Private NPI		
	Private	Control and 50% test	Only 50% criterion for sales and costs
ITALY	Public	Control and 50% test	Only 50% criterion for sales and costs
	Private NPI		
	Private	Control and 50% test	Only 50% criterion for sales and costs
PORTUGAL	Public	Legal status, funding, control and 50% test	Whether or not services are sold at economically significant prices that have a relevant influence on the volume of services patients want to receive, and the 50% criterion
	Private NPI	Legal status, funding and control	
	Private	Legal status, funding and control	
SPAIN	Public	Funding, control and 50% test	Whether or not services are sold at economically significant prices that have a relevant influence on the volume of services patients want to receive
	Private NPI	Funding, control and 50% test	Only 50% criterion for sales and costs
	Private	Funding, control and 50% test	Only 50% criterion for sales and costs

D. Sector classification of hospitals II

State	Type	What income (from financial balance of units) is considered sales in applying 50% criterion?
GERMANY	Public	Income derived from goods and services rendered, payments for healthcare from medical insurance and revenue from patients for healthcare received.
	Private NPI	Income derived from goods and services rendered, payments for healthcare from medical insurance and revenue from patients for healthcare received
	Private	
AUSTRIA	Public	
	Private NPI	
	Private	
BELGIUM	Public	Prices per day of hospitalisation (from the central government and Social Security funds), fees (from Social Security funds) and patient co-payment.
	Private NPI	
	Private	Prices per day of hospitalisation (from the central government and Social Security funds), fees (from Social Security funds) and patient co-payment.
CZECH REPUBLIC	Public	
	Private NPI	
	Private	
SLOVAKIA	Public	Income derived from goods and services rendered, and from the sale of goods
	Private NPI	Income derived from goods and services rendered, and from the sale of goods
	Private	Income derived from goods and services rendered, and from the sale of goods
FINLAND	Public	
	Private NPI	
	Private	
NETHERLANDS	Public	
	Private NPI	
	Private	Income derived from goods and services rendered and payments for healthcare from medical insurance.
ITALY	Public	
	Private NPI	
	Private	

PORTUGAL	Public	Income derived from goods and services rendered (regardless of who pays for these goods and services)
	Private NPI	Income derived from goods and services rendered (regardless of who pays for these goods and services)
	Private	Income derived from goods and services rendered (regardless of who pays for these goods and services)
SPAIN	Public	Income derived from goods and services rendered
	Private NPI	Income derived from goods and services rendered
	Private	Income derived from goods and services rendered

D. Sector classification of hospitals III

State	Type	Decision regarding classification made by:	How often is classification of hospitals reviewed?
GERMANY	Public	By group of hospitals	No set time. In special situations (e.g. new funding system for hospitals).
	Private NPI	By group of hospitals	
	Private	By group of hospitals	
AUSTRIA	Public	By group of hospitals	Every 2 years
	Private NPI	By group of hospitals	
	Private	By group of hospitals	
BELGIUM	Public	By group of hospitals	
	Private NPI		
	Private	By group of hospitals	
CZECH REPUBLIC	Public	Hospital by hospital	
	Private NPI	Hospital by hospital	
	Private	Hospital by hospital	
SLOVAKIA	Public	Hospital by hospital	Every 3 years
	Private NPI	Hospital by hospital	
	Private	Hospital by hospital	
FINLAND	Public	By group of hospitals	Annually
	Private NPI		
	Private		
NETHERLANDS	Public		Each time there are changes to the health system. Classification is examined in benchmark reviews.
	Private NPI		
	Private	By group of hospitals	
ITALY	Public	Hospital by hospital	Annually
	Private NPI		
	Private	Hospital by hospital	
PORTUGAL	Public	Hospital by hospital	When benchmark year changes, or when a new hospital is created or changes legal status
	Private NPI	Hospital by hospital, as well as by group of hospitals	
	Private	By group of hospitals	
SPAIN	Public	Hospital by hospital	When hospitals begin or end activity
	Private NPI	Hospital by hospital	
	Private	Hospital by hospital