

**Decision-making in health care:  
Roles and responsibilities at local, regional and  
national level**

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## Summary

### *Introduction*

This report reviews the role and responsibilities of local and regional authorities<sup>1</sup> in health system governance in six countries: Denmark, Finland, France, Italy, New Zealand and Spain. This is set against the broader context of decision-making at the national level, which the report maps for the six countries plus Germany, focusing on five core functions.

We begin by describing the scope of decision-making of local and regional authorities in health system governance. Using the lens of 'accountability', we analyse the mechanisms through which a local or regional authority can be held responsible for its activities and decisions in relation to the organisation and delivery of health services. We examine two 'directions' of accountability: (1) 'downward' accountability, typically referring to mechanisms to involve a local population in governance to varying degrees, and (2) 'upward' accountability to the next higher administrative level and/or to central government.

We also examine trends and recent developments as they relate to the overall health system and administrative reforms, and whether and how these affect mechanisms of accountability. We then explore the relationship between the centre and local/regional authorities and describe several recurring sources of tensions. We conclude with an overview 'map' of decision-making responsibilities at the national level, focusing on core functions: collecting funds; national budget setting; resource allocation; defining the publicly-funded basket of services; and pricing.

The report has been informed by a review of published and 'grey' literature, including government reports and governmental websites, and information provided by country informants co-operating with the On-call Facility for International Healthcare Comparisons at the London School of Hygiene & Tropical Medicine.

It is important to note that countries reviewed here vary considerably in both their political systems and health systems. This includes differences in the degree of political and administrative decentralisation (e.g. federalism, quasi-federalism and centralism), as reflected, for example, in the ability of regional governments to levy regional taxes and to develop binding legislation autonomously from central government.

Partly as a consequence of differences in political structures, the organisation and financing of health systems vary considerably, with, for example, resources generated through a varying degree of taxation, social health insurance and private sources. Health services are typically provided through a combination of public and private providers, although the mix of public and private provision varies among countries.

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<sup>1</sup> We use 'local and regional authorities' as an approximation of a term that covers local and regional organisations responsible for certain governance functions in relation to health care as diverse as 'regional governments' in Spain, 'hospital districts' in Finland and 'local health authorities' in Italy.

## ***Administrative structures and decision-making at sub-national level***

A given country's approach to sub-national decision-making through local and regional authorities is in many ways shaped by its past, and its administrative and political traditions. Denmark and Finland, for example, share a history of decentralised governance, with traditionally strong systems of local representation and local administration. More recently, however, local administration in Denmark has undergone substantial change involving the creation of a more centralised administrative layer at the regional level, following extensive debate about the effectiveness and efficiency of local government. A similar debate has been observed in Finland.

The administrative system of France is based on a strong centralist tradition, with central government in control of almost all aspects of public administration. Although health system governance has become somewhat more decentralised and responsibility for hospital care was transferred to regional hospital agencies during the 1990s, central government has retained substantial control over regional activities and its steering role vis-à-vis regional agencies has remained strong.

In contrast, both Italy and Spain have experienced a period of extensive centralisation associated with the building of a nation state, but at the same time are also characterised by strong historical and contemporary regional identities and diversity. Both countries have recently undergone a process of devolution involving the strengthening of regional governments and the transfer of legislative and administrative powers from the centre to the regions.

Roles and responsibilities of local and regional authorities vary considerably. Municipal councils in Finland, and municipal and regional councils in Denmark are democratically elected bodies, representing small local communities, and are responsible for organising a range of public services, including health services. In Italy and Spain, responsibility for overseeing regional health systems falls within the remit of elected regional governments as one of many functions. However, in contrast to the local authority structure in Finland and Denmark, regional governments in quasi-federalist Italy and Spain also have extensive legislative powers and responsibilities beyond the realm of public services.

France and New Zealand are very different as both have created separate regional structures for the sole purpose of organising health care. These are regional hospital agencies in France (at present responsible for hospital care only) and district health boards in New Zealand. Regional hospital agencies are managed by an appointed director, while district health boards are composed of both elected and appointed members, with the majority elected. Table 1 briefly demonstrates decision-making structures at sub-national level.

**Table 1 Decision-making at local and regional level in six countries**

	<i>Denmark</i>	<i>Finland</i>	<i>France</i>	<i>Italy</i>	<i>New Zealand</i>	<i>Spain</i>
<b>Local level</b>	Municipal councils	Municipal councils	<i>None</i>	Local health authorities	<i>None</i>	Health area boards
<b>Regional level</b>	Regional councils	Hospital district boards	Regional hospital agencies	Regional governments	District health boards	Regional governments (Autonomous Communities)

*Note:* Local health authorities in Italy, health area boards in Spain and district health boards in New Zealand are responsible for organising health services. Hospital district boards in Finland and regional hospital agencies in France oversee hospital services only. All other local and regional authorities oversee a larger portfolio of responsibilities.

### ***Accountability of local and regional authorities***

Schedler (1999) defined ‘accountability’ as a relationship between two parties in which A is required to inform B about A’s actions and decisions (both past and future), to justify these and to be penalised if they fail to meet B’s expectations.<sup>1</sup> Thus, mechanisms to ensure accountability of local and regional authorities always involve a second party, which is responsible for satisfying the function of holding the authorities to account.

As mentioned above, we examine two ‘directions’ of accountability: (1) ‘downward’ accountability, typically to a local population and/or electorate, and (2) ‘upward’ accountability involving, for example, reporting duties to central government or the next higher administrative level.

We focus here on two forms of accountability: ‘political’ accountability (e.g. through local or regional elections) and ‘administrative’ accountability (e.g. through norms and procedures within the civil service or between an agency and its funder). Other forms of accountability, particularly ‘legal’ accountability exercised through the judicial system, may also play an important role in some countries. Several case studies touch on the role of the courts; however, this form of accountability is not the main focus of this report.

With the possible exception of district health boards in New Zealand, local and regional authorities seem to be primarily, although not exclusively, accountable in one direction only, that is, either ‘downward’ or ‘upward’ (Table 2). Also, ‘downward’ accountability tends to be mostly political, although it may also involve administrative components, such as a requirement to undertake local population health needs assessments. The nature of ‘upward’ accountability is mainly administrative.

New Zealand is a notable exception as district health boards have dual accountability both to the Ministry of Health (in legislation) and to the local population (‘felt’ accountability on a day-to-day basis and more formally through periodic elections of board members). The overall accountability framework is defined by the Ministry and boards have to meet extensive reporting duties. ‘Downward’ accountability is secured as the majority of the members of district health boards are locally elected.

**Table 2 ‘Downward’ and ‘upward’ accountability of local and regional authorities in six countries**

	<i>Denmark</i>	<i>Finland</i>	<i>France</i>	<i>Italy</i>	<i>New Zealand</i>	<i>Spain</i>
<b>Local/ regional authority</b>	1. Municip. councils  2. Region. councils	1. Municipal councils  2. Hospital district boards	Regional hospital agencies	1. Local health authorities  2. Regional governments	District health boards	1. Local health areas  2. Regional governments
<b>‘Downward’ accountability</b>	1. Political  2. Political (local population)	1. Political  2. None (local population)/ administrative (municipalities)	<i>none</i>	1. <i>None</i>  2. Political	Political/ administrative (elections/ consultations)	1. <i>None</i>  2. Political
<b>‘Upward’ accountability</b>	1. Very restricted  2. Very restricted	1. Very restricted  2. Only through municipalities	Administrative	1. Admin.  2. <i>None</i>	Administrative	1. Admin.  2. <i>None</i>

*Note: Numbers indicate different levels of administration, with ‘1’ referring to a local authority and ‘2’ to a regional authority.*

Members are elected as individuals, since the main political parties have chosen not to put forward candidates or campaign in board elections.

Further research may be needed to explore the nature of the relationship between different types and ‘directions’ of accountability.

### **‘Downward’ accountability**

‘Downward’ accountability refers to procedures through which a local population can hold a local or regional authority to account for its actions on its behalf.

Accountability mechanisms in place largely reflect the nature and position in the administrative hierarchy of a local or regional authority. In countries where the executive board of local or regional authorities is determined through local or regional elections, accountability is largely ‘political’. Voting procedures may vary, for example, individuals may be directly elected or through party lists. Members of municipal councils in Denmark, for example, are elected through party lists. As parties may compete on a wider set of issues, accountability for decisions on health services may potentially be weak. As in all democratic systems, electoral cycles affect the ability of elected bodies to make difficult and potentially unpopular strategic decisions.

Where the executives of authorities are appointed and/or recruited through the civil service, making them administratively accountable to central government, direct accountability to the local population may not be a priority. In France, for example, regional hospital agencies are not formally accountable to the local population, although they are required to assess the health needs of the population they serve. Formal

complaint procedures (if in place) or legal action may be required if citizens want to challenge a decision of a regional hospital agency.

In three of the six countries reviewed here 'downward' accountability of local/regional authorities includes a responsibility for resource generation through local/regional taxation (Table 3). Municipal councils in Denmark and Finland can levy local taxes to finance public health services, as can regional governments in Italy. In Spain, in contrast, health services organised by the regions are almost entirely funded through a centrally allocated budget. In France and New Zealand, regional authorities are funded entirely through centrally allocated resources (with health services in France being covered through social health insurance, while the operating costs of agencies are covered through a centrally allocated budget). Thus, lines of accountability do not correlated with the source of funding.

**Table 3 Generation of health care funding and local accountability**

	<i>Denmark</i>	<i>Finland</i>	<i>France</i>	<i>Italy</i>	<i>New Zealand</i>	<i>Spain</i>
<b>Authority</b>	1. Municipal councils  2. Regional councils	1. Municipal councils  2. Hospital district boards	Regional hospital agencies	1. Local health authority  2. Regional govts.	District health boards	1. Local health areas  2. Regional governments
<b>Source of funding</b>	1. Central/local taxation  2. Central/local taxation through municipalities	1. Central/local taxation  2. Central/local taxation (through municipalities)	Central allocation through SHI	1. Allocated by regional govts. 2. Mainly regional taxation (plus some central)	Central taxation	1. Allocated by regional governments  2. Central taxation (plus some regional taxes)
<b>Downward accountability</b>	1. Local elections  2. Regional elections	1. Local elections  2. To municipalities only	<i>None</i>	1. <i>None</i>  2. Regional elections	DHB elections	1. <i>None</i>  2. Regional elections

*Note: Numbers indicate different levels of administration, with '1' referring to a local authority and '2' to a regional authority.*

### ***'Upward' accountability***

Accountability requirements of local/regional agencies towards central governments vary considerably. Similar to 'downward' accountability, 'upward' accountability largely reflects the position in the administrative hierarchy of the local or regional authority and whether its executive board is elected or appointed.

Where local and/or regional authorities are elected, i.e. are politically accountable, accountability requirements towards the next higher level and/or central government may be comparatively 'soft' (without the option of enforcement or sanctions), limited in scope or absent. This is the case in Italy and Spain, where regional governments organise health services almost entirely autonomously, with few controls exercised by central government. Regional governments in Italy are expected to implement a national health plan, but central government has very few instruments to enforce its implementation. Its main tool is the provision of additional central funding for particular activities.

In Denmark and Finland, activities of municipalities and regions (Denmark only) in relation to health services are guided by a framework of national legislation and nationally set standards. Yet, in both countries, local and regional bodies have few responsibilities for which they are held accountable by central government, which also has little direct control over the organisation of health care at local and regional level. However, central government has retained significant indirect power, including the ability to alter the structure of the local/regional administrative system (which would not easily be possible in a federalist country). Also, the recent local government reform in Denmark has strengthened the role of central agencies, namely the National Board of Health, which is now responsible for reviewing and approving regional health plans.

In contrast, in France and New Zealand lines of 'upward' accountability are much more explicit. The regional hospital agencies in France, composed of representatives of central government and the administration of the social security system, are largely centrally co-ordinated and guided by a complex set of norms and regulations. These mechanisms of administrative accountability have recently been made more explicit through the introduction of formal agreements between regional hospital agencies and the Ministry of Health. The agreements take the form of contracts and specify targets and indicators against which to measure the performance of regional hospital agencies. As yet these agreements do not involve any sanctions for underperformance.

District health boards in New Zealand are directly accountable in statute to central government (specifically, the Minister of Health). Accountability requirements are defined in an annual operational policy framework, detailing, for example, the reporting duties of district health boards towards the Ministry of Health and its agencies. Central government has retained the authority to directly intervene if it finds district health boards failing and it can do so by scaling up reporting requirements and oversight, and, in serious cases, by replacing board members or the entire board. Since the district health board system was established in 2001, central government has taken a relatively restrained approach towards exploiting its options of central intervention because in the early years of the system, it has preferred to emphasise the local role of the boards in order to raise their profile.

## ***Relationship between central government and local and/or regional authorities***

All six countries reviewed here have recently or are currently experiencing tensions between central government and local and/or regional authorities over issues related to health care governance. The case study approach, while examining each country individually, does not easily lend itself to a systematic analysis of the nature of these tensions. However, the approach has helped to identify several recurring sources of potential conflict, including the following:

- *Allocation of central funding:* Tensions appear to be arising over issues related to health care resources. These include the appropriateness of centrally allocated budgets; perceived fairness of central allocation among regions; financial deficits of regions with demands from regions to be 'bailed out' by central government; and the mix of central and regional funding.
- *Satisfying national standards:* All countries have introduced some form of national standards that local and regional authorities are required to meet to reduce regional diversity. These include centrally determined 'packages of services', but may also involve, for instance, the implementation of national plans and standards of care. In some countries, central government uses its financial 'lever' (or the threat of it) to exert pressure on local and regional authorities to improve standards; in other countries this option is rather restricted. However, it is unclear whether and under which conditions use of financial levers is effective to improve performance.
- *Efficiency of local authorities:* Tensions may also arise over issues of (perceived) ineffectiveness, inefficiency or variability in service delivery of local and/or regional authorities. This has been a particular issue for debate in Denmark and Finland, where the efficiency of public service provision has been questioned in view of the often-small population size of municipalities. The recent local government reform in Denmark has addressed this problem by merging counties into regions, by creating larger municipalities and by strengthening the role of the National Board of Health. Approaches to improve the efficiency of local administration have also been experimented with in Finland.
- *The system context:* Tensions between central government and local and/or regional authorities may also be influenced by factors not directly related to health system governance. While not impacting directly on the decision-making power in health care at local level *per se*, contextual factors may affect the ability of both the centre and local/regional bodies to organise health services. These include tensions over the division of tasks, the effect of political representation at different administrative levels (e.g. through different political parties represented at municipality/regional and central level) and the extent of representation of regional interests at national level (e.g. in Spain).

## **Decision-making at national level**

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This section maps the roles and responsibilities of decision-making at national level, focusing on key actors in five core functions: collecting funds, national budget setting, resource allocation, defining the publicly-funded basket of services, and the pricing of publicly funded hospital services in seven countries: Denmark, Finland, France, Germany, Italy, New Zealand and Spain.

**Table 4 Collecting funds**

	<b>Denmark</b>	<b>Finland</b>	<b>France</b>	<b>Germany</b>	<b>Italy</b>	<b>New Zealand</b>	<b>Spain</b>
<b>Main mechanism of health care financing (proportion of total expenditure on health)</b>	Central and local (municipal) taxes (84.1%)	Central and local (municipal) taxes plus national health insurance contributions* (78%)	Compulsory contributions* levied on earnings and income (74.9%)	Compulsory social health insurance contributions* levied on earnings (67.4%)	Central and regional taxes (76.4%)	General budget for health care: Central taxes (78.1%); Accident Compensation Scheme (ACC): Contributions plus central taxes*	Central and regional taxes (66.5%)
<b>Decision-making bodies</b>	Central taxes: Several ministries led by the Ministry of Finance Municipal taxes: Ministry of Finance, National Association of Local Authorities	Government, municipal councils and Social Insurance Institute (under the authority of the Parliament)	Ministries of Public Accounts & Civil Service, of Finance, of Health	Contribution rate: Individual sickness funds Risk equalisation scheme: Federal Insurance Office	Ministries of Health and Finance, regional governments	Parliament, several ministries led by Ministry of Finance	National Council on Financial and Fiscal Policy, national and regional governments
<b>Role of Ministry of Health</b>	Pools central government health budget	Pools central government health budget	Advisory	Contribution rate: none Risk equalisation scheme: not directly involved	Pools central government health budget	General budget: Pools central government health budget ACC: Sets contribution rates with relevant ministries	Pools central government health budget

(cont.)

**Table 4 Collecting funds (cont.)**

	<b>Denmark</b>	<b>Finland</b>	<b>France</b>	<b>Germany</b>	<b>Italy</b>	<b>New Zealand</b>	<b>Spain</b>
<b>Role of legislature</b>	Approves central and local tax rates (annual Finance Act)	Parliament approves annual state budget	Parliament approves rates for payroll and general taxes earmarked for statutory health insurance funding	Social Code Book V defines role of stakeholders and framework for contribution rates	Parliament approves annual budget; tax rates are set by central and regional governments	Parliament approves annual budget negotiated by relevant ministries	Act 21/2001 specifies taxation responsibilities between centre and regions
<b>Decision-making process</b>	Annual stakeholder negotiations	Negotiation between Ministries; parliamentary approval; local taxes decided in municipality councils	Negotiation between ministries; parliamentary approval	Determined at individual fund level	Annual negotiation Ministry of Health and regional health departments	Negotiation between ministries; parliamentary approval	Parliamentary approval
<b>Who acts as final arbiter?</b>	Parliament	Parliament; municipality councils	Parliament	Social courts	Parliament	Parliament	Parliament

Notes: \*Employers and employees contributions; source for national expenditure data: OECD Health Data, 2007

**Table 5 National budget setting**

	<b>Denmark</b>	<b>Finland</b>	<b>France</b>	<b>Germany</b>	<b>Italy</b>	<b>New Zealand</b>	<b>Spain</b>
<b>Nature of budget</b>	Annual national health budget	Annual national health budget	Annual budget ceiling for spending through public health insurance	Provider budgets (ambulatory & hospital care) with legally set limits	Annual national health budget	Annual national health budget	Annual national health budget
<b>Decision-making bodies</b>	Ministry of Finance, Ministry of Health, Danish Regions, National Association of Local Authorities	Parliament, government and municipalities	Parliament, Ministries of Economy & Finances and of Public Accounts & Civil Service, 'Alert' Committee, National Health Conference (advisory)	Associations of sickness funds, association of SHI physicians, German Hospital Association	Ministries of Health and Finance, regional health departments, Standing Conference of the State and Regions	Ministry of Finance, Ministry of Health	Ministry of Finance, Ministry of Health, regional governments
<b>Role of Ministry of Health</b>	Directly involved in budget negotiations	Directly involved in budget negotiations	Advisory	Not involved	Sets budget with Ministry of Finance following negotiations with the regional governments	Negotiates with Ministry of Finance	Drafts the annual budget for health services
<b>Role of legislature</b>	Parliament approves annual budget	Parliament approves national annual budget	Parliament approves budget ceiling	Social Code Book V defines roles of shareholders	Parliament approves annual health budget	Parliament approves annual budget	Act 21/2001 stipulates minimum health care expenditure level for regions

(cont.)

**Table 5 National budget setting (cont.)**

	<i>Denmark</i>	<i>Finland</i>	<i>France</i>	<i>Germany</i>	<i>Italy</i>	<i>New Zealand</i>	<i>Spain</i>
<b><i>Decision-making process</i></b>	Negotiations between stakeholders	Negotiations between stakeholders; Parliamentary vote	Negotiations between ministries; Parliamentary vote	Negotiations between shareholders	Negotiations between stakeholders; parliamentary vote	Negotiation	Negotiations between stakeholders; parliamentary vote
<b><i>Who acts as final arbiter?</i></b>	Parliament	Parliament	Parliament	<i>None</i>	Parliament	Parliament	Parliament

**Table 6 Resource allocation**

	<b>Denmark</b>	<b>Finland</b>	<b>France</b>	<b>Germany</b>	<b>Italy</b>	<b>New Zealand</b>	<b>Spain</b>
<b>Nature of resource allocation process</b>	<i>Centre to regions/ municipalities:</i> transfer of state subsidies for public services to regions; redistribution of municipality tax income	Municipal taxes, supplemented by state subsidies according to calculated needs estimate	No allocation mechanism but definition of expected budget ceiling for each sector; redistribution among health insurance schemes <i>Centre to regions:</i> allocation of funds for hospital care	<i>Ambulatory care:</i> regional budgets based on capitation <i>Hospitals:</i> regional budgets	<i>Centre to regions:</i> weighted capitation, by mortality rate, covering core basket of services <i>Regions to local units:</i> capitation	Ministry of Health to District Health Boards (DHBs) and to Pharmaceutical Agency (Pharmac)	<i>Centre to regions:</i> based on allocation model <i>Allocation per sector:</i> varies among regions
<b>Decision-making bodies</b>	Ministries of Health and Finance, Danish Regions, National Association of Local Authorities	Ministries of Health and Finance, municipal councils, Hospital district councils	Ministry of Health	Regional sickness funds, regional associations of SHI-physicians*, regional hospital associations	Ministry of Health, regional governments and the Standing Conference of the State	Ministry of Health	Ministries of Health and Finance, regional governments
<b>Role of Ministry of Health</b>	Allocates central government health budget	Allocates state subsidies	Defines budget ceiling for the different sectors	Not involved	Allocates central government health budget according to capitation to regions	Allocates resources to District Health Boards	<i>Centre to regions:</i> Negotiates with regional governments; <i>Allocation per sector:</i> no involvement

(cont.)

**Table 6 Resource allocation (cont.)**

<b>Role of legislature</b>	None	<i>Centre to municipalities:</i> 1993 Act on subsidies	Parliamentary vote	Roles, procedures and regulations defined in Social Code Book	<i>Centre to regions:</i> Capitation rate approved by parliament (latest: 2005) <i>Regions to local units:</i> Regional decree	Decisions monitored by parliamentary committees (e.g. for health and expenditure)	Rules for regional allocation defined in national legislation (Act 21/2001)
<b>Decision-making process</b>	<i>Centre to regions/ municipalities:</i> Negotiations between national ministries and associations of the regions/ municipalities	<i>Centre to municipalities:</i> Negotiations between government and municipalities <i>Local:</i> Municipal councils approve resources allocated for health	Ministry of Health decides allocation per sector within a ceiling set by parliament	Negotiations between regional sickness funds and physician associations (ambulatory); negotiations between sickness funds and hospital associations (hospital)	Negotiations between the Ministry of Health and the regions in the Standing Conference	Minister of Health makes decision	<i>Centre to regions:</i> Negotiation between national ministries and regional governments; Ministry of Finance approves Ministry of Health <i>Proposal Allocation per sector:</i> regional governments decide
<b>Who acts as final arbiter?</b>	Ministries of Health and Finance	Parliament; municipal council	Parliament	None	Ministry of Health	Ministry of Health	Ministry of Finance

**Table 7 Defining the publicly-funded basket of services<sup>2</sup>**

	<i>Denmark</i>	<i>Finland</i>	<i>France</i>	<i>Germany</i>	<i>Italy</i>	<i>New Zealand</i>	<i>Spain</i>
<b>Nature of the basket of services</b>	Not explicitly defined beyond broad legal entitlements	Not explicitly defined beyond broad constitutional and legal entitlements	Explicitly defined by positive lists of goods and services	Not explicitly defined beyond broad legal entitlements with a few explicit exclusions	Defined by a positive and a negative list	Mostly implicit within national priorities	Broadly defined core benefits to be provided by regional health systems; regional additions possible
<b>Decision-making bodies</b>	Ministry of Health, National Board of Health, Medicines Agency, Danish Regions, National Association of Local Authorities & provider organisations	Ministry of Health, municipal councils and committees, Hospital district councils	National Union of Health Insurance Funds (UNCAM); High Health Authority (advisory), Voluntary Health Insurers Union; Ministry of Health	Joint Federal Committee (G-BA), provider organisations, Valuation Committee	Standing conference of the State and Regions, Ministry of Health	Ministry of Health, Pharmac, 21 District Health Boards	Co-ordination of regional additions through Interregional Council of the NHS (CISNS)
<b>Role of Ministry of Health</b>	Minister is empowered by law to issue notices and circulars which are binding to the bodies they are imposed on	Develops guidelines and laws defining the types of services provided; monitors and comments on inequalities	May refuse UNCAM's decisions, especially where public health issues are concerned; decisions have to be vetoed within one month	May veto decisions made by G-BA (within a period of 2 months)	Defines core benefit package ('Essential Levels of Care', LEA)	Sets objectives & priorities; sets operational frameworks and expectations based on guidelines developed by NZ Guideline Group (independent)	Advice to parliament on core services; Participates & co-ordinates negotiations between regional governments within CISNS

*(cont.)*

<sup>2</sup> The information presented in this table mainly relates to publicly-funded ambulatory and hospital care services.

**Table 7 Defining the publicly-funded basket of services (cont.)**

	<b>Denmark</b>	<b>Finland</b>	<b>France</b>	<b>Germany</b>	<b>Italy</b>	<b>New Zealand</b>	<b>Spain</b>
<b>Role of legislature</b>	Defines in/exclusions; defines eligibility criteria/co-payments for specific services		The Social Security Code (SSC) defines the range of goods and services reimbursed by the statutory scheme	Social Code Book V defines patient entitlements as they relate to broad service areas funded under the public system	2001 Governmental decree, called 'the LEA decree'; Standing Conference of the State and Regions agreement	Little direct involvement – definition of services not embodied in legislation	2003 Cohesion & Quality act defines residents' entitlements & specifies areas to be agreed upon by CISNS
<b>Decision-making process</b>	Negotiations, agreements and contracts	Municipalities, hospital districts define service basket	Consultation and negotiation	Consultation and negotiation; decisions must be submitted to Ministry of Health	Standing Conference negotiations followed by legislation introduced by central government, Ministry of Health specifies service basket	National policy and local purchasers' decisions, but national level predominant	Negotiation and agreement, approved by 2006 Royal Decree
<b>Who acts as final arbiter?</b>	Ministry of Health review and complaints function	Municipal councils and hospital district councils	Ministry of Health may overrule decision	Ministry of Health can veto G-BA decisions in legal grounds; social courts	Ministry of Health	Ministry of Health	Regional governments

**Table 8 Pricing of publicly funded hospital services**

	<b>Denmark</b>	<b>Finland</b>	<b>France</b>	<b>Germany</b>	<b>Italy</b>	<b>New Zealand</b>	<b>Spain</b>
<b>Nature of 'pricing'</b>	Diagnosis related groups (DRGs); budgets	Prospective budgets; DRGs in most of 20 Hospital Districts	DRGs; grants	DRGs; grants	DRGs; budgets	Global budgets; DRGs for inter-district compensation	Global budgets
<b>Decision-making bodies</b>	<i>Public hospitals:</i> National Board of Health, Medical Specialties Association <i>Private hospitals:</i> Danish regions, individual hospital	<i>Public hospitals:</i> Municipal councils; hospital districts councils, public hospitals <i>Private hospitals:</i> individual hospital	<i>DRGs:</i> Ministry of Health <i>Budgets:</i> Ministry of Health, Regional Hospital Agencies (ARHs), National Union of Health Insurance Funds (UNCAM)	<i>DRGs:</i> Regional associations of sickness funds and private health insurers, regional hospital associations <i>Grants:</i> local payers (sickness funds), hospitals	<i>DRGs:</i> Ministry of Health and regional health departments, physicians <i>Budgets:</i> Hospital trusts and regional health departments	<i>DRGs:</i> association of district health boards in co-operation with the Ministry of Health <i>Budgets:</i> DHBs, hospitals	Regional Ministries of Health, regional Health Services Management Organisations (HSMOs), hospitals Private hospitals: HSMO, private provider associations
<b>Role of Ministry of Health</b>	Determines, through National Board of Health, prices for DRGs (20% of hospital budgets)	None	<i>DRGs:</i> updates algorithm and tariffs annually	None – hospital care is responsibility of the federal states	Determines and updates DRG tariffs	Defines benchmark prices	None – except that central government covers deficits incurred by public hospitals/regions

(cont.)

**Table 8 Pricing of publicly funded hospital services (cont.)**

	<b>Denmark</b>	<b>Finland</b>	<b>France</b>	<b>Germany</b>	<b>Italy</b>	<b>New Zealand</b>	<b>Spain</b>
<b>Role of legislature</b>	DRGs: legislation at the national level	None	Social Security Code defines roles of stakeholders	Social Code Book V defines roles of stakeholders	Nationally determined framework	NZ Public Health and Disability Act 2000 defines roles of stakeholders	Procedure defined by regional legislation
<b>Decision-making process</b>	Stakeholder negotiations; contracts	Stakeholders negotiations; agreements	Stakeholder negotiations	Stakeholder negotiations; contracts	<i>Central level:</i> defines national DRG catalogue <i>Regional level:</i> specifies DRG catalogue and tariffs	Stakeholder negotiations; contracts (service agreements)	Stakeholder negotiations
<b>Who acts as final arbiter?</b>	Ministries of Health (approval of DRGs)	Hospital District Councils	Ministry of Health	Social courts	Ministry of Health and regions	Ministry of Health	Regional governments

## **Country case studies**

## Denmark

Health care in Denmark is largely funded through national and local taxation with a modest share of co-payment, mostly for pharmaceuticals and dental services. Health care provision is mainly through practitioners (primary care and specialists) in private practices and public hospitals, owned by the regions.<sup>2</sup>

The Danish health system is characterised by a high degree of decentralisation, reflecting the decentralised nature of the political system. The five regions and 98 municipalities are mainly responsible for organising health care. They are regulated by national legislation and, to some extent, overseen by central bodies.

The five regions were created in January 2007 as part of the local government reform and replaced the previous 14 counties.<sup>3</sup> The number of municipalities was reduced from 275 to 98. The reform constitutes the most recent development in a longer history of decentralisation that has seen a gradual transfer of tasks and responsibilities from the centre to counties/regions and/or municipalities. Before 1970, Denmark was divided into even smaller units, including 25 counties, 86 boroughs and nearly 1300 parishes.

The local government reform had three main purposes: (1) to strengthen local decision-making and democracy; (2) to clarify responsibilities for tasks for which responsibility was shared by counties and municipalities; and (3) to create units large enough to accomplish public service tasks (more) efficiently and at a high(er) standard,<sup>3</sup> a key motive behind organising health care through regions. The reform was intended to be 'expenditure-neutral' for citizens, i.e. it should not result in increased public expenditure and/or higher taxes. However, it was anticipated that the reallocation of tasks and the merger of numerous public administration bodies would involve the transfer of thousands of employees to new employers (equalling an estimated 170,000 full-time equivalents). The costs of the merger were born by the municipalities, which have been considered the main drivers and beneficiaries of the reform. Some municipalities had already prepared for mergers with neighbouring municipalities prior to the reform; Bornholm, Langeland and Ærø held local referendums to support mergers. Given that the public administration is still adjusting to the changes introduced by the reform, it is still too early to draw conclusions about its effects.

Some researchers have argued that the timing of the reform, if not its contents, was at least partly coincidental. Bundgaard and Vrangbæk (2007) suggest that there was no urgent or obvious need for a reform, but it offered a political opportunity to foster a pro-reform coalition across the spectrum of political parties.<sup>4</sup> They also note that public participation in the decision was very limited.

## ***Decision-making at sub-national level***

### ***Municipal councils***

Municipalities are governed by councils; all members of a council board are elected for four years. Municipal councils are responsible for a range of public services and their scope has been further extended with the 2007 local government reform. Prior to the reform, municipalities had already been involved in providing some services in the health and social care sector, including care for the elderly, child care and primary schools. From 2007, however, municipalities have been responsible for additional new tasks in health care and other public sector services, including employment; social services; special education; business services; collective transport and road; nature, environment and planning; culture and administrative citizen services.

In the health sector, municipal councils are responsible for disease prevention and health promotion, rehabilitation outside hospital, and treatment of alcohol and drug abuse. Municipal councils organise services delivered through nursing homes, home nursing services, health visitors, municipal dentists, prevention and health promotion services, and facilities for people with special needs. Most of these services had previously been organised by counties, and there were 'grey' areas where responsibility for municipalities and counties overlapped. Services are financed through taxation, mainly levied at local level. Municipal councils form sub-committees responsible for specific health or social care services.

The increase in responsibilities has strengthened the position of municipalities vis-à-vis central government. Municipalities are represented at national level through the National Association of Local Authorities. They are involved in a range of activities, including negotiation of the national budget for health (with the Ministry of Finance, the Ministry of Health and the 'Danish Regions'). These negotiations establish the level of central government subsidies to the regions and municipalities. As the regions and municipalities are responsible for different sectors, the process partly determines how much is spent on health care versus social care. The negotiations also establish the level of redistribution between municipalities (to account for differences in local tax revenues) and the size of one-off or ongoing grants for specific nationally determined programmes and initiatives.

### ***Regional councils***

Denmark's five regions are governed by regional councils. Councils are elected for four years and comprise 41 members.<sup>3</sup> Unlike the previous counties, regions do not levy taxes but receive funding from the State and the municipalities; health service provision and regional development constitute their main tasks.

Regions own and run general and psychiatric hospitals and pre-natal care clinics and fund general practitioners, specialists, physiotherapists, dentists and pharmaceuticals. They are also responsible for district psychiatric care.

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<sup>3</sup> Elections for regional (and municipal) councils can only be held every four years and not in between. Electoral results tend to be stable throughout each election period, forcing political parties to co-operate rather than to seek political confrontation over controversial topics.

Legislation clearly defines the responsibilities of regions, stipulating that regions are not permitted to carry out tasks beyond their legal remit. Municipalities and regions are required to form binding agreements to support the required coherence between treatment, prevention and care.<sup>2</sup> The health care agreements are expected to comply with centrally defined requirements, and service goals for the joint effort should be published. Agreements cover, for example, arrangements on discharge from the hospital for elderly patients, agreements on the social services for people with mental disorders or on prevention and rehabilitation.<sup>5</sup> Health care agreements are overseen by regional consultative committees, consisting of representatives from the regions, the municipalities in the region and private practices. They also provide a forum for dispute resolution and for a continuous dialogue about service planning.

At the national level, the regions are jointly represented as the 'Danish Regions'. They are, for example, involved in negotiating salaries for employed health professionals and reimbursements for private practitioners with the different professional organisations. These negotiations are also attended by the Ministry of Health, the Ministry of Finance and the National Association of Local Authorities. The regions are also involved in annual budget negotiations with the Ministry of the Finance and the Ministry of Health.

## ***Accountability***

### ***Downward accountability***

One of the aims of the local government reform of 2007 was to strengthen local democracy and participation of citizens in decision-making at local level.<sup>3</sup> There is an expectation that transferring responsibility for a wide range of public services to municipalities will improve transparency and local accountability for service delivery. As members of municipal (and regional) councils are locally elected, councils can be held directly politically accountable by their constituency.

In a country of 5.5 million people, political representation is characterised by a high degree of proximity (although the reform reduced the number of local politicians), and the 'distance' between local politicians and citizens is comparatively 'short'. One of the effects of local elections is (as in any political system based on elected representation) that more difficult and perhaps unpopular decisions tend to be made shortly after elections, but they also may be delayed in view of upcoming elections.

Also, following the 2002 legislation establishing a guarantee for patients to be treated at a public hospital within two months (one month since 2007) of referral or else to be referred to a private facility or to a hospital abroad, citizens can to some extent be expected to 'vote with their feet' if they are dissatisfied with a local service.

### ***Upward accountability***

The relationship between regions/municipalities and the State is generally defined through national legislation. Legislation also sets out the expectations of central government with regard to the standard of service delivery. Central government has the power to take legal action against a municipality or region in case of underperformance. Although performance issues are mostly dealt with in dialogue/follow-up on general agreements, there is an implicit threat of legal intervention, which could potentially involve stricter

supervision and withholding block grants. Indeed, local government reform itself can be regarded as an example of such an intervention.

Many observers see the current period as a 'testing phase' for the regions. If the regions fail to deliver on the general targets, the state is likely to take control. The potential threat of legal action and the perception that central government is in a position to change the administrative architecture again (namely to abolish the regions) implicitly strengthens the authority of central government, although, in practice, this dimension of (legal) accountability is rarely utilised.

Another way to enforce expectations by central government is through annual budget negotiations as regions are fully funded through national taxation supplemented by a smaller 'co-payment' from municipalities. Regions and the Government eventually enter into a formal agreement that sets out the core principles, priorities and targets for health care delivery. These include, for example, spending priorities (e.g. for cancer treatment, psychiatric services, heart surgery); minimum levels for growth in productivity and service volumes; targets for waiting times and volumes; target level of expenditure; and the level of central subsidy.

The overall level of direct control that the Ministry of Health exerts over the provision of health services by regions and municipalities appears to be comparatively low. However, the centre has retained the authority for direct intervention if a specific issue is regarded as politically sensitive. The Government, for example, has set limits on waiting times in response to public demands. Politically, however, central intervention tends to come at a price, as central government is likely to be held responsible once a topic is given priority at national level.<sup>6</sup>

Also, central government has strengthened the role of central arm's-length bodies vis-à-vis regions and municipalities. Following the local government reform, central government has authorised the National Board of Health to centrally approve regional and municipal health plans, which had previously been submitted only for the purpose of monitoring and non-binding feedback.

In 2005, the Danish Institute for the Evaluation of Municipalities and Regions (KREVI) was established as an independent institution under the Ministry of Social Welfare (until November 2007 under the Ministry of Interior and Health). KREVI was established to analyse and evaluate the performance of municipalities and regions in providing and managing public services. Its mandate includes, but is not restricted to, health care. KREVI has the following key functions:

- to evaluate and provide comparative analyses of local and regional public administration with the aim of promoting the quality and efficiency of public services and controlling the financial performance of public authorities.
- to provide information for the development of strategies to improve the performance of public authorities.
- to collect information on international experiences of strategies that enhance public administration performance and develop tools for evaluation, quality improvement and financial control.

As yet, KREVI does not have the mandate to enforce standards. However, it provides the information for benchmarking the quality of public services provided by municipalities and regions. The establishment of KREVI is more likely to reflect, and respond to, increased demands for more transparency and better management in the public sector, rather than to provide a tool to enforce national policies. This again may reflect the extent of decentralisation of power in the Danish system.

### ***Tensions between the centre and the regions/municipalities***

Given that local government reform is a very recent process, experience of its effects is as yet limited. It is expected, however, that the formation of regions and larger municipalities redefines the relationships between municipalities, regions and the State. There is an expectation that more effective municipalities and clarification of roles and responsibilities of each level of administration will allow the central government to focus on its core objectives, namely, defining goals and framework setting, while leaving the day-to-day tasks of organising and managing public services to municipalities and regions.<sup>3</sup>

Whether or not these expectations will be met is difficult to assess. However, emerging evidence suggests that while the reform has addressed some 'grey areas' of responsibilities, such as the boundaries between the regional and municipal responsibilities in relation to primary prevention, it has simultaneously created new areas in which responsibilities remain unclear, for example the definition of boundaries between treatment (regions) and rehabilitation (municipalities). These tensions are likely to have financial implications in the long run.

Another example for potential tensions is the new mode of financing of hospital services, which receive 80% of their funding from the central government and 20% from municipalities. The funding mechanism was changed to encourage municipalities to prevent hospitalisation by improving care of the elderly and by integrating preventive treatment and health promotion in other local tasks and establishing alternatives to hospital services such as health care for patients with chronic illness. This may potentially lead to a duplication of services, provided by both municipalities and regions.<sup>7</sup>

## Finland

Finland's highly decentralised health system is mainly funded through local and national taxation. Delivery of health care is mainly public, with municipal taxes accounting for almost half of all funding, supplemented by state subsidies, national health insurance contributions and some co-payments.<sup>8</sup> Health system governance is shared by the centre and the municipalities, with municipalities being responsible for organising primary care and, through participation in hospital districts, secondary and tertiary care.<sup>9</sup> Municipalities provide health and social services independently or in co-operation with neighbouring municipalities; they can purchase services from other municipalities, non-governmental organisations or for-profit providers.

The transfer of decision-making powers from the centre to municipalities has been a gradual process over several decades. Until 1993, central government was more directly involved in regulating the organisation of health services. Municipalities had to provide rolling five-year health plans, which had to be approved by regional health authorities, overseen by the National Board of Health; approved health plans formed the basis for disbursement of state subsidies. The National Board of Health and the approval process were abolished in 1993.<sup>9</sup>

Municipalities now have substantial autonomy in decision-making (guaranteed through the Constitution), within the legislative framework set by the central government. Central government, through the Ministry of Social Affairs and Health, also develops targets and guidelines and allocates subsidies for health care to the municipalities.<sup>10</sup> Aside from these responsibilities, the role of central government is largely restricted to monitoring and disseminating comparative information about the performance of municipalities in relation to public service provision, an approach that has been termed 'steering by information'.

From 2002, central government has made available additional funding for local development projects in the field of social and health care. Between 2003 and 2007 the Ministry of Social Affairs and Health has allocated over €200 million for about 1100 local development projects, with the aim to support municipal service provision in line with nationally set objectives. However, an evaluation by the National Audit Office in 2007 found that this approach had not been as efficient as intended and had proved to be a rather weak tool of central steering.<sup>11</sup> Overall, central government has few levers to directly control health service provision at local level.

### ***Decision-making at sub-national level***

Finland is divided into six provinces, 20 regions, 74 sub-regions and 416 municipalities (as of January 2007). The main levels of government are the State and the municipalities,<sup>12</sup> while the regional structures are generally weak; they do not levy taxes and are not represented through democratically elected bodies.

The following sections focus on municipalities and hospital districts (formed by municipalities) as the most important sub-national bodies involved in health care decision-making.

### ***Municipal councils***

Municipalities typically cover large geographic areas, but are small in terms of population size (11,000 inhabitants on average; median size 5,000 inhabitants).<sup>13</sup> At national level, municipalities jointly form the Finnish Federation of Municipalities, which represents local government interests in negotiations with the central government, including negotiations about the allocation of state subsidies for health care and other public services.<sup>14</sup>

Municipalities levy income taxes on their residents. Following the 1993 state subsidy reform, municipalities receive a lump sum from central government for health care and other public services. However, municipalities may use this subsidy for purposes other than health care, such as education or the development of local business. This move initially gave cause for concern as it was felt that this flexibility could potentially increase regional variation in access to health care services. However, there is little indication that existing inequalities have been exacerbated following the reform.<sup>9</sup>

As mentioned previously, municipalities have become increasingly autonomous with regard to organising health care. They provide and purchase health services from different providers, including secondary care from hospital districts.

### ***Hospital districts***

The 20 hospital districts are formed by municipalities. Hospital districts cover populations of between 100,000 and 1.2 million residents and are responsible for organising and providing all inpatient and outpatient specialised health care within a region. They do not levy taxes and receive all their funding from constituent municipalities.

Decision-making by hospital districts is strongly influenced by the municipalities, as hospital districts are governed by local politicians representing the municipalities. For example, planning of secondary care is the result of annual negotiations and agreements between the hospital districts and individual municipalities. The process of decision-making and planning also varies, reflecting differences in geography, population size, the number of facilities, and other factors.

During the last ten years, several local reforms have been implemented, merging primary and secondary care providers into a single organisation.<sup>15</sup> These reforms aim at improving the co-ordination of services, typically organised separately by municipalities and hospital districts, and at reducing inefficiencies of care provision, especially of smaller municipalities.

## ***Accountability***

### ***Downward accountability***

#### ***Municipalities***

Municipalities are directly accountable to their residents through local elections. The main decision body of municipalities is the council, which is led by a chairman. The council appoints a municipal executive board, which is accountable to the council.<sup>13</sup> The council also appoints members of various municipal committees such as for health care and other social services. The composition of committees usually reflects the proportional

representation of political parties elected into the council. Committees are appointed for four years.<sup>13</sup>

Members of municipal councils are elected for a four-year term. The Finnish Local Government Act 1995 provides the legal framework for residents' involvement in municipal activities. This includes electing representatives to municipal bodies, organising referendums and public consultations, and introducing measures to encourage citizens to launch local initiatives.<sup>16</sup>

### Hospital districts

Each hospital district is governed by a council and an executive board, whose members are appointed by the participating municipal councils, in proportion to the size of each municipality. District councils are thus directly accountable to the municipalities.

The role of local politicians in decision-making in relation to health care can be problematic. Local politicians may lack the expertise needed to oversee the management of facilities and to assess the actual delivery of health services. Decisions by councils may also be exposed to the influence of the health care profession claiming this expertise. This was demonstrated, for example, by the extensive industrial action of the medical profession during the 1990s. It has been suggested that responsibility for unpopular decisions thus can be conveniently shifted between politicians and professionals.<sup>17</sup>

### **Upward accountability**

#### Municipalities

As municipal councils are locally elected, their relationship to central government is not straightforward. The 1993 reform abolished a number of legal and administrative norms, thus decreasing the influence of central government on municipalities and health care providers. As outlined above, the main tools of central steering are information, project funding and legislation. Projects funded by central government usually involve a contract between the municipal councils and the government. In theory, the government could claim back funding if a municipality does not comply with the terms of the contract. This however has not happened yet. Project implementation is also monitored by the provincial offices of the state administration, although their capacity to follow up on individual projects is limited.

Municipalities are required to implement and comply with national legislation and they do so under the supervision of the provincial state offices and the Ministry of Health. Recent years have seen cases of municipalities being charged with a penalty by provincial state offices for not fulfilling nationally set standards, e.g. addressing quality of health care.

#### Hospital districts

Hospital districts are not directly accountable to the central government, although they are directly affected by national legislation and monitoring (through the Ministry of Health and provincial state office). Accountability requirements of hospital districts are principally directed at municipalities.

## ***Tensions between the centre and the municipalities***

Tensions between central government and municipalities tend to arise around matters of financing and the allocation of funding, including financial deficits incurred by municipalities and hospital districts, and questions about the future sustainability of health care funding.

Decentralisation has gradually shifted responsibility for health care to municipalities, while maintaining the system of central subsidy allocation. This leaves central government with little control over the performance of municipalities. There was an expectation that decentralisation would lead to an increase in accountability towards the local population. However, local politicians tend to blame central government for not allocating sufficient resources when a municipality runs into deficit. Equally, central government officials tend to emphasise local responsibility and may question the effectiveness of local governments in running the health service.<sup>14</sup> Tension may further arise with respect to hospital districts. When a given hospital district incurs financial deficits, the relevant municipalities are expected to cover these. Since municipalities are often small and economically less powerful than hospital districts, they tend to be in a weaker position (e.g. when it comes to negotiating prices for hospital services).

In 2005, the Government launched a project aimed at examining options for restructuring local administration to create 'a sound structural and financial basis [...] for the services that municipalities are currently responsible for in order to secure the organisation and provision of such service in the future with due regard to the required standard of quality, effectiveness, availability, efficiency, and technological advancement'.<sup>18</sup> (p.5). The project comes in response to a perception of increasing financial difficulties of some municipalities and the growing need for improving the sustainability of service provision in view of an ageing population.<sup>19</sup> The project was led by the Minister of Regional and Municipal Affairs, but also involved representatives of government parties, the opposition parties in Parliament and the Association of Finnish Local and Regional Authorities.

Of the proposed three models for administrative restructuring, one was subsequently selected for further development, looking at the possibility of voluntary mergers of municipalities to increase the population size to an average of 20,000-30,000, thereby reducing the current number of municipalities by 25%.<sup>12</sup>

In 2006, central government submitted a proposal for a new legislative Act to Parliament. This Act gives the Government the authority to continue the project and would require municipalities to participate in the process.<sup>12</sup> Following national elections in 2007, the new Government decided to continue the project. Progress of the project, reflecting its voluntary nature, has however been slow

## France

Health care in France is funded through a combination of social health insurance (SHI) contributions, tax revenues and patients' co-payments, mostly through supplementary private insurance. Health care is delivered through a mix of public and private providers, with generalist and specialist physicians largely working in private practice. Hospitals are public or private (for profit and not-for-profit), with public hospitals being general, regional or local community level, depending on size and level of specialisation.<sup>20</sup> Social health insurance covers all residents; patients receive publicly funded care in any facility, independent of its status of ownership.

Governance of the health system has traditionally been centralised with the Ministry of Health (and other ministries depending on the division of tasks in the Government of the day), playing a major role in steering and directing the funding and delivery of health care. Parliament also plays an important role in regulating the health system, specifically since a parliamentary vote on an annual maximum SHI expenditure was introduced in 1996.

There have been efforts to gradually decentralise some of the health system governance functions, particularly in the hospital sector. Several organisational designs have been experimented with, including extending the tasks of regional directorates of health and social affairs (DRASs), established in 1977. Some of the responsibilities of the DRASs were subsequently transferred to regional hospital agencies (*Agences régionales d'hospitalisation*, ARHs, established in April 1996).<sup>20</sup>

### ***Decision-making at sub-national level***

The establishment of ARHs has increased health care decision-making power of regions. ARHs are responsible for the planning of hospital care (private and public hospitals), resource allocation to public hospitals and for adjusting tariffs for private for-profit hospitals.<sup>4</sup> These tasks are undertaken within a regulatory framework set by the Ministry of Health.

ARHs are also responsible for developing regional strategic health plans (*Schéma régional d'organisation sanitaire*). These plans are prepared in consultation with the Ministry of Health and regional actors, such as the health professions, public and private hospital federations, patient organisations and local politicians.<sup>9</sup> Regional plans are guided by national health priorities, mainly defined by the Ministry, and take regional health priorities into account, determined through regional health conferences. Regional strategic health plans also set out the implementation of the strategy; this includes defining service volumes for hospitals and maintaining and developing the hospital infrastructure. Regional plans are approved by the Ministry of Health.

ARHs are bodies under public law, placed between central government and the social health insurance system.<sup>21</sup> They bring together, at the regional level, the representatives of the State and the health insurance funds, which previously shared management of the hospital sector.

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<sup>4</sup> Financing of hospital care provided in public and private facilities will be gradually harmonised through the introduction of diagnosis-related groups (DRGs). This process is expected to be completed in 2012.

ARH are governed by a director, who is appointed by the Cabinet of Ministers and who chairs the executive committee (*Commission exécutive*). The committee is composed of representatives of the central government and of representatives of the social health insurance system (Social Security), in equal shares.

The organisational structure of ARHs is slim. The number of staff typically ranges between 10 and 20 (excluding the executive committee), operating on a budget of a few million Euros (i.e. for administration and personnel). Planning and other decisions made by ARHs have immediate financial implications for social health insurance funds, affecting budgets ranging between 5 and 12 billion Euros per region.<sup>5</sup> Thus implications of ARH decision-making extend far beyond their own budget.

At present, ARHs have responsibility for hospital care only. There are, however, plans to transform ARHs into regional health authorities and to expand their remit to ambulatory care, long-term care and public health. This extended role is currently being piloted.

## **Accountability**

### **Downward accountability**

ARHs are not accountable to the local population. To perform their planning function, ARHs are required to assess the health care needs in their region and do so, mainly, by using information on regional health care utilisation and data on mortality and morbidity trends.<sup>9</sup>

### **Upward accountability**

ARHs are directly accountable to the Minister of Health. Their financial performance is overseen by the audit court (*Cour des Comptes*), responsible for controlling the financial conduct of all bodies of public administration. The audit court assesses whether an ARH meets its objectives and whether it has accomplished its tasks efficiently. The court provides annual reports, which are usually confidential.

ARHs can also be assessed by the General Inspection of Social Affairs (*Inspection générale des Affaires Sociales*, IGAS). Assessments are commissioned by the Ministry of Health and typically investigate specific problems that have caused concern. A case for investigation would be, for example, if there are reports of patients who do not have access to necessary care as a result of a hospital merger mandated by an ARH.

Accountability requirements for ARHs were amended further in 2007. For the first time, ARHs were required to enter into a formal agreement/contract with the Ministry of Health. This contract specifies a number of special objectives (or 'missions') that ARHs are required to achieve on behalf of the Government. These objectives are further specified into measurable indicators so as to provide targets ARHs can be assessed against. Examples include: to increase the number of day surgery cases, to decrease financial deficits of hospitals (indicated by the number of relevant agreements between ARHs and hospitals) and to develop appropriate information systems on the use of emergency hospital services. Contracts do not yet contemplate penalties or rewards, although there

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<sup>5</sup> These funds, however, are not channelled through ARHs but are directly transferred from social health insurance funds (Social Security) to the hospitals.

might be professional implications for ARH directors (who are career civil servants) if they are unable to reach the agreed targets. It is possible that the performance of ARHs against these contracts will be subject to public reporting in the future.

As this development is very recent there has been no evaluation yet and experiences are limited.

## Italy

Public health care in Italy is delivered through a national health service (*Servizio Sanitario Nazionale*) and largely funded through national and regional taxation, supplemented by co-payments. The organisation of health care falls into the remit of the 19 regions and two autonomous provinces.<sup>8</sup> Following a lengthy process of decentralisation, regions have obtained substantial legislative, administrative and regulatory powers, which also involved the gradual devolution of responsibilities for taxation, provision and regulation of health services. This evolving system of 'fiscal federalism' was substantially strengthened by the 2001 constitutional reform.

Regions exercise their autonomy very differently, with northern regions being more successful in establishing effective structures of health care delivery, management and monitoring, compared to the regions in the south. This regional variation in health care reflects (and exacerbates) differences of contextual, i.e. political, economic and cultural factors, as well as differences between regional health systems (see below).<sup>9</sup>

Central government provides the legislative framework for health care and defines the basic principles and objectives within which the National Health Service operates. Central government also has a constitutional obligation to guarantee access to health care in each of the regions, to reduce health inequalities and to ensure that the health system operates efficiently and transparently. It defines, through the Ministry of Health, the basic benefits package and standard of health services to be provided by the regions (*Livelli Essenziali di Assistenza*, Essential Levels of Care). The Ministry also develops a three-year national health plan (see below).<sup>9</sup> As a consequence of decentralisation, central government has gradually become less involved in directly regulating health care, and responsibility for overseeing providers has been shifted to regional governments.

### ***Decision-making at sub-national level***

Regions vary substantially in size, population and economic development. The regions are subdivided into 94 provinces, with around 1,000 municipalities forming the lowest level of local government. Regions are led by a president and a council, both directly elected for a five-year term. Each province has a prefect, who is appointed by the central government as a representative of the State. Municipalities are governed by a mayor and a council, both elected for a period of four years. The following sections focus on regions and local health authorities as the most important units for regional/local decision-making in relation to health services.

Regional councils raise revenue for health care through regional taxation (up to a centrally defined ceiling). A fiscal equalisation mechanism, the National Solidarity Fund, was established in 2000 to support those regions unable to raise sufficient resources to provide the centrally defined package of essential services. This allocation of central funds is negotiated annually between the regions and the centre. Regional councils, through regional health departments, also set the level of co-payments that patients are required to make for certain (centrally defined) health services.

Regional health departments oversee and regulate the delivery of health services within their territory almost autonomously and develop regional legislation to this effect. Regional health departments set the legislative framework for providers and monitor their

performance in relation to quality, appropriateness and efficacy of services. They are responsible for managing the financial resources allocated by the central Ministry of Health (through the National Solidarity Fund) and generated through regional taxation, and for assessing local health needs.

Within the National Health Service, health care is delivered through local health authorities (*Aziende Sanitarie Locali*), public hospital trusts and private accredited hospitals; there are around 200 local health authorities and 100 independent hospital trusts (comparable to foundation trusts in the NHS). Local health authorities are responsible for organising the majority of health services provided through public acute care and rehabilitation hospitals, 'health districts' responsible for primary care and through health promotion divisions responsible for health promotion, community care and disease prevention.<sup>22</sup> The number of local health authorities was gradually reduced from 659 (1978) to 195 (2007).<sup>6</sup>

At national level, regional councils are also represented at the Standing Conference of the State, the regions and the autonomous provinces. The conference brings together the 21 presidents of the regions and provinces and representatives of the State, and provides a platform for negotiation of strategies (e.g. in relation to national and regional health plans), objectives and budgets between the centre and the regions.<sup>6</sup>

## ***Accountability***

### ***Downward accountability***

#### *Regions*

Regions are governed by an elected regional council and a regional government.<sup>22</sup> The regional council is chaired by a president, who forms the regional government. Councils are elected through regional party lists. As elected bodies they are politically accountable to the regional constituency.

The 2001 constitutional reform aimed to increase the control of regions over revenues for publicly funded health services, which corresponded to a reduction of discretionary funding from the centre. The intention was to increase the sense of ownership of local governments for publicly funded health services and to enhance accountability of local governments towards taxpayers.<sup>23</sup>

Regions are advised to promote consultations with voluntary and patients' associations in health policy planning and evaluation and to develop formal channels for involvement.

#### *Local health authorities*

There is no explicit mechanism of accountability of local health authorities towards the local population. However, local health authorities, as well as independent hospital trusts, have to establish an explicit list of services and a formal complaints procedure for patients (in co-operation with patient associations). Local health authorities, regions and hospital trusts also organise training for health professionals aimed at improving patient experience.

## ***Upward accountability***

### **Regions**

Regions have extensive legislative power and develop binding regional legislation. The boundaries between central and regional legislation are defined in the Constitution, stipulating that the centre is responsible for, for example, foreign policy, defence and the justice and penal system, but also the protection of civil and social rights. Some responsibilities are shared by the centre and the regions, e.g. the maintenance of infrastructure, welfare, labour policies and urban and territorial planning.<sup>24</sup> However, central government has little influence on regional affairs as they relate to legislation and administration, although it can appeal to the Constitutional Court if it wishes to challenge a regional law.

With respect to health care, regions have to develop a three-year health plan, in line with the national health plan. The national plan mainly provides a framework for regional health plans, giving regions the freedom to organise care according to their own objectives and priorities, provided they meet national targets. The setting and implementation of health targets is, however, a major challenge in a largely decentralised system and involves considerable negotiation and bargaining between the centre and the regions.<sup>9</sup>

Regional health plans are also discussed at the Standing Conference of the State, the regions and the autonomous provinces. The Standing Conference, however, does not hold regions accountable for achieving the objectives of the national health plan or for staying within budget.

The Ministry of Health is responsible for supporting, monitoring and assessing the regional implementation of the national health plan. An observatory has been established at the Ministry of Health mandated with monitoring the health system and supervising that regional health departments work towards the implementation of the plan. Regions have to report on an annual basis about the progress towards achieving the objectives of the plan. If a region fails to provide the basic package of essential services defined by the Ministry of Health, the Ministry can take measures to ensure that these services are offered by allocating additional funds.

Until recently, regional health spending deficits were retrospectively covered by the national budget, i.e. regional health budgets were 'soft'.<sup>23</sup> Since 2006, central government has made increasing efforts to impose sanctions against regional governments/administrations if these overspent their health care budget. Possible sanctions include requiring regions to increase the rate of regional taxation.

### **Local health authorities**

Local health authorities are mainly accountable to regional health departments. As noted earlier, they are responsible for providing health services within an allocated budget. They are required to develop a local plan, consistent with the health plan of the respective region. Local plans are aimed at ensuring access to services for citizens; they outline how services will be provided effectively and efficiently. The local plan has to be approved by the regional health department.

The organisation of local health authorities in terms of size and structure is determined by the regional health department, which also appoints general managers, based on their qualifications and technical expertise.<sup>25</sup> General managers are responsible for ensuring that health services are provided according to the local plan and within the allocated budget. General managers have substantial decision-making power with regard to managing human, financial and technological resources at the local level.<sup>26</sup> They are appointed for a term of five years, typically employed on a renewable rolling contract,<sup>27</sup> and are assessed annually according to rules and criteria developed at the regional level. General managers who fail to achieve the performance targets set by the regions may be replaced by the regional health department.

Local health authorities were previously governed by an elected body. Through the introduction of legislation to professionalise the management of local health authorities, central government intended to reduce the influence of political party politics on local decision-making in relation to health care, which tended to make local health authorities vulnerable to cronyism and corruption before 1992. This process is still ongoing, unevenly implemented and thus as yet not entirely successful.<sup>28</sup>

### ***Tensions between the centre and the regions***

Tensions between the centre and the regions tend to arise over issues related to health care expenditure and regional (in)equalities in access to health care.<sup>28</sup>

Deficits in public spending have been a long-standing concern in Italy, and public health care expenditure has increased steadily over time.<sup>6</sup> The Government has sought to control expenditure by introducing Health Pacts with the regions, which are agreed on for a period of three years. However, as health care spending continued to exceed the target set in Health Pacts by almost 1% each year, central government intervened by (temporarily) restricting the autonomy of regions over determining the level of regional taxes and co-payments (2002–2005). This move was, however, objected to by the regions, arguing that national standards for essential levels of services were set too high. The regions went before the Constitutional Court, which decided in 2006 that regions were to receive ex-post transfers from the central government.

The current Health Pact for 2007–2009 has been incorporated by the central government into the 2007 Budget Act. The 2007–2009 Pact re-establishes full regional autonomy to determine the level of regional taxes, requiring/permitting regions with financial deficits to increase regional taxes even beyond the maximum ceiling. It imposes a structural deficit plan on regions in deficit, which is agreed with and monitored by the Ministries of Health and of Economics. These plans may involve provisions for service reconfiguration such as the number of hospital beds. Additional public funding may be made available by central government to support structural changes in the regions affected.<sup>23</sup>

A related issue is the way in which the Italian health care system is funded. Fiscal federalism and regional differences in terms of economic development create potential disparities in resource allocation for health care among the Italian regions. As wealthier regions in the north generate more revenue through regional taxation, the central

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<sup>6</sup> Spending for publicly funded health care (6.7% of GDP in 2006) continues to grow rapidly and is projected to double between 2005 and 2050 (to 13.25%).<sup>24</sup>

government has introduced the National Solidarity Fund (see above) to enable the poorer regions to provide the nationally defined level of essential care. However, it has been estimated that only a small number of regions (i.e. seven out of 20<sup>29</sup>) are in fact capable to autonomously raise sufficient resources, and thus contribute to the Fund.

While this is likely to create tensions not only between the centre and the regions, but also among regions themselves, the situation is further complicated by the requirements on deficit control set out in the 2007–2009 Health Pact. Thus, in order to reduce the deficit, low-income regions will have to raise tax rates to a greater level than high-income regions. This creates negative incentives for local industry and business and might therefore obstruct further economic development.<sup>29</sup> It may be for this reason that geographic disparities in access to and quality of care continue to persist and, in some cases, increase further. This is further exacerbated as central government policy only provides for essential services, while services outside the nationally defined package are to be financed by the regions.<sup>30</sup>

## **New Zealand**

Health care in New Zealand is largely financed through general national taxation and private payments supplemented by statutory insurance for accidents and injuries.

The New Zealand health system serves a population of 4.2 million people. Responsibilities in the public health system are defined through a number of laws, most recently through the New Zealand Public Health and Disability Act 2000 (NZPHDA). The NZPHDA established the current structure of the public health system by delegating the organisation of health services to 21 newly created district health boards. The provision of health services is, largely, through publicly owned hospitals and 81 primary health organisations, which co-ordinate primary health services on behalf of the enrolled population.

### ***Decision-making at sub-national level***

District health boards (DHBs) are responsible for providing and purchasing publicly funded health and disability services for the population in their area.<sup>31</sup> The role of DHBs is defined as: (1) to improve, promote and protect the health of their respective community; (2) to promote the integration of health services, especially primary and secondary care services; and (3) to promote support of those in need of personal health- or disability-related services.<sup>32</sup> Other DHB objectives include reducing health inequalities and fostering community participation.

DHBs are statutory corporations owned by the Crown ('Crown entities') and do not levy taxes. Instead, funding for health care is allocated by central government based on a formula adjusting for demography, unmet need, internal and external migration and population density (i.e. rurality). DHBs have some control over user co-payments outside the hospital sector, as they can negotiate with local primary health organisations (PHOs) and their practitioners the charges that patients pay out-of-pocket for primary medical services.

While DHBs are responsible for organising health care at the local level, the overall scope of their decision-making is limited through a number of national policies, including the NZPHDA, several other national strategies (e.g. to improve health outcomes of the Maori population) and a framework for accountability that regulates the relationship between DHBs and the Ministry of Health. It has been suggested, however, that while these various policies and frameworks aim to explicate central and local responsibilities, the precise boundaries are not always clear and ministerial interference may have been perceived as colliding with local preferences by some DHBs.<sup>33</sup> On the other hand, from the perspective of the Ministry of Health, charged with ensuring that the whole population has access to good health and disability support services, issues arise periodically in relation to the co-ordination of decisions by individual DHBs that may have major implications either for neighbouring DHBs or the system as a whole.

In many ways, the establishment of DHBs can be interpreted as a return to the pre-1991 organisational model when publicly funded health care in New Zealand was organised through 14 area health boards, which were responsible for the funding and provision of public hospital services and public health services (but not primary health care) in their areas.<sup>33</sup>

Area health boards were abolished in 1991 following the introduction of the purchaser-provider split, which subsequently also led to a centralisation of the purchasing function, eventually exercised by a single funding authority. Similar to DHBs, area health boards were centrally funded via a population-based formula and were governed by locally elected boards. They were integrative in their involvement of key stakeholders and geared towards a strategic, target-led approach towards health service delivery.<sup>33</sup>

## ***Accountability***

### ***Downward accountability***

DHBs are governed by a board, comprising up to 11 board members, of whom seven are elected by the local community. DHBs are thus electorally accountable to their local constituencies. The number of Maori representatives has to be proportional to the resident Maori population, but should not be less than two. Elected members serve for three years and can be re-elected. Appointed members can serve a maximum of three consecutive terms.

Concerns that elections may result in high turnover of board members because of the highly technical nature of the issues that board members are expected to address have not materialised. Between 2001 and 2004 only 35% of board members were first-time members; most chairs appointed in 2001 were reappointed by the Ministry in 2004.<sup>34</sup> Participation rates in DHB elections are, however, relatively low and fell from 50% in 2001 (first election) to 43% in 2007. However, the lower turnout may also be a response to changes in the election procedure, involving a move from first-past-the-post to single transferable voting. As candidate numbers are high (although numbers of candidates fell by 50% between 2001 and 2007), board members are typically elected by a small number of votes.<sup>34</sup>

Conflicts of interest could potentially compromise the performance of DHB boards. Legislation stipulates that any member of a community may stand for election, including health professionals employed by DHBs and individuals working in the private sector or as contractors. In 2004, 12% of elected board members were employed by the same DHB.<sup>34</sup> The DHBs in Auckland were criticised in 2007 for not managing potential conflicts of interest sufficiently rigorously in relation to the retendering of a major contract for medical laboratory services.

### ***Upward accountability***

While being electorally accountable to the local population every three years, legislatively DHBs are primarily accountable to the Minister of Health for their performance and use of public funds. This is reflected in the fact that up to four board members are appointed by the Minister of Health, including the chair (who may be either an elected or appointed board member). Technically, the relationship between DHBs and the Ministry of Health is strictly hierarchical. Legislation amending both the State Sector Act 1988 and the Crown Entities Act 2004 has clarified the role of DHBs as 'agents' of the Ministry, and as such DHBs are required to implement government policy and to act upon ministerial instruction.<sup>35</sup> However, the relatively devolved history of hospital ownership and management in New Zealand, added to the decision to reintroduce elected boards, has

encouraged some DHBs to assert their decision-making autonomy and reluctance to be bound by collective decisions of other DHBs.

Accountability requirements are specified through a national operational policy framework and involve strategic five-year health plans, annual statements of intent, annual operational plans and regular monthly and quarterly reports.<sup>36</sup> DHBs are also expected to comply with the Service Coverage Schedule, which defines the nature and minimum standard of services to be provided, and the Indicators of DHB Performance, which measure DHBs' performance in key areas.

The Operational Policy Framework forms part of the 'Policy Component of the District Health Board Planning Package', with individual requirements for each DHB further specified in Crown funding agreements between the Minister and the respective DHB. The Operational Policy Framework defines two sets of accountability requirements: the first is mandatory and reflects government policy or statutory provisions; the second involves 'trigger reports', i.e. DHBs are required to obtain the Ministry's consent and/or certain mechanisms are 'triggered' by specific events.<sup>36</sup>

Accountability requirements set out in the Operational Policy Framework fall into six categories:

- (1) Financial operating rules: for example, DHBs must: comply with generally accepted accounting rules and applicable legislation; operate in a financially responsible manner; provide appropriate financial information; and require ministerial consent to borrow from the Crown Health Funding Agency or registered banks and to enter into leasing arrangements from other sources.
- (2) Monitoring and reporting requirements: for example, DHBs are required to: submit annual reports and audited financial statements, quarterly hospital benchmarking information and monthly financial reports to the Ministry; provide specified data to the National Systems of the New Zealand Health Information Service; and fulfil reporting requirements towards HealthPAC relating, for example, to data quality, costs associated with provision of data and health benefits.
- (3) Regulation of the relationship with the Maori population: that is, to provide for the specific needs of the Maori population and to ensure that Maori participate at both governance and operational level.
- (4) Requirements relating to funding and quality: for example, DHBs are required to: maintain a robust and documented prioritisation process; meet requirements regulating relationships with providers; comply with legislative requirements and are providers of last resort. Ministerial consent is to be obtained if DHBs intend to change agreements with nationwide operating service providers, plan to outsource services or to provide services previously provided by a non-governmental provider. Consent is also required for proposals for any involvement of DHBs in privately funded services.
- (5) Requirements relating to changes in service provision: for example, DHBs have to engage the Ministry early in the process of service change and use a checklist provided to guide service change proposals. Ministerial consent is required prior to any change of service if the change involves a breach of the Service Coverage

Schedule or any of the mandatory components of the Operational Policy Framework.

- (6) Management of inter-district flows: rules for the provision of public hospital services across DHBs (e.g. specialised services that are not available in all DHBs or where it is more convenient for patients to be treated in another DHB), including the administrative and financial management of inter-district flows.

### ***Tensions between the centre and regional authorities***

Given that DHBs are simultaneously accountable both 'upwards' and 'downwards', the relationship between DHBs and the Ministry of Health is not without tensions. It has been suggested that the Government has 'designed tensions into the system' and it has done so 'in the expectation that it will be productive rather than destructive' (p. 19).<sup>34</sup>

As implementers of government policies, DHBs are first and foremost accountable to the Minister, and the Ministry of Health has thus retained authority to intervene on behalf of the Minister in DHBs' operations in case of underperformance or failure. Interventions may involve the appointment of a Crown monitor to report to the Minister on the performance of the board, the replacement of the board with a commissioner, the dismissal of board members and the replacement of the chair or deputy chair of the board.<sup>9,37</sup> Replacements of boards are rare, and there was no case of board replacement in the first four years following the 2001 reform.<sup>34</sup> However, the financial environment of DHBs was relatively benign in this period. When finances are tighter, more conflict between the centre and Boards might be expected.

Tensions between DHBs and the Ministry (and among DHBs) tend to arise over the allocation of public funding. As described earlier, public funding is centrally allocated to DHBs using a population-based formula, and there is concern about differences in cost and efficiency of service provision between DHBs and the appropriateness of inter-district flows, which compensate for the cost of services provided to people from outside the districts.

It has been noted that DHBs have become more accustomed to the complexity of their tasks so that performance has improved over time. They may have also gained more experience in navigating between local demands and central requirements and have learned how to meet their multiple roles. DHBs, for example, can be requested to appear before Parliamentary Select Committees (since 2004), and while this process was initially fraught with mutual misconceptions, these seem to have diminished.

A 2007 survey of board members found that the majority of chairs interviewed rated the relationship between their DHB and the Ministry as very positive, with the quality of the relationship having improved over time.<sup>38</sup> Yet, case studies of five DHBs provided a somewhat more ambivalent picture, with some informants perceiving the Ministry as being overbearing and overly involved in DHB operations.

Several examples of government interventions have been explored in the IHC report A review of the role and responsibilities of national ministries of health in five countries. The role of the Ministry of Health is illustrated by its responses to particular cases (Box 1).

**Box 1** Excerpt (amended) from the case study on government intervention<sup>6</sup>

At present, the Government aims to avoid intervening in areas that fall within the remit of DHBs or for which decisions are taken by a Crown entity. These include wage disputes, decisions to subsidise particular drugs and quality and safety issues arising from the treatment of individual patients. Although the Ministry of Health has retained the authority to intervene directly in many of these areas (for example, by replacing a DHB), it tends to take a restrained approach to using this power. Much depends on the political position of the Government and the personality and authority of the Minister. Instead, the Ministry of Health has tended to support DHBs to put in place effective processes and to strengthen their management capacity. The Ministry may also decide to intensify the monitoring of the performance of a DHB, which usually involves a scaling-up of the Board's accountability and reporting duties towards the Ministry (the Ministry has a sliding scale of monitoring depending on the performance of DHBs). [...]

The role of the Ministry may be illustrated by its responses to the following cases:

*Failure of individual providers:* Over the past months/years several incidents of poor clinical quality were reported to have occurred in the hospital at Wanganui, a small provincial hospital in the north of New Zealand. A patient died in 2004 after being discharged from the emergency department three times because of miscommunication between the referring general practitioner and (inexperienced) hospital staff.<sup>39</sup> In November 2006, it became known that more than 600 patients at the same hospital had missed out on specialist treatment because referral letters were lost.<sup>40</sup> Another case involved a gynaecologist who had performed several failed sterilisation operations.<sup>41</sup>

Following this sequence of failures the Minister of Health was pressurised by the opposition National Party to replace some members of the Wanganui DHB.<sup>42</sup> In response, the Government launched several investigations into the performance of the hospital management and the DHB. The Ministry also placed the DHB on an intensive monitoring regime and appointed a senior adviser to assist the Board in making the necessary changes.<sup>42</sup> The Health and Disability Commissioner, who can be called upon under the Code of Health and Disability Services Consumer Rights (1996), has initiated an inquiry into the conduct of the gynaecologist.

A recently published external review of clinical quality in Wanganui Hospital and an associated joint review of Wanganui District Health Board commissioned by Wanganui DHB and the Ministry of Health, concluded that clinical practice at the hospital was safe and quality systems in place were comparable to other hospitals in New Zealand.<sup>43</sup> However, the reviews were strongly criticised by several commentators, including the Royal Australian & New Zealand College of Obstetrics and Gynaecology, for being superficial and not going far enough.<sup>44</sup> The findings of the review by the Health and Disability Commissioner have not yet been released.

*Closure of hospital departments:* In the case of Kaitia Hospital, a 28-bed hospital in a rural community in Northland, the Ministry was asked to resolve a dispute between the DHB, the local community and the hospital staff following the DHB's decision to suspend all caesarean sections and after-hours surgery because of specialist staff shortage.<sup>45,46</sup> The Ministry required the DHB to ensure that local communities and staff were adequately consulted and commissioned a review of the safety and quality implications of the decision the DHB had taken. This case in part reflected a wider problem with recruiting and retaining specialist staff in small rural hospitals.

*Failure of a DHB to secure services:* The Ministry intervened in a recent dispute over a diagnostic contract between two private firms after it became apparent that a DHB had not adequately addressed a conflict of interest on the part of one of its board members.<sup>42,47</sup> The DHB had to retender, while the serving provider remained contracted in the interim.

## Spain

The Spanish national health system (*Sistema Nacional de Salud*, SNS) was established in 1986 under the General Health Act. The system offers universal coverage for all residents and provides publicly funded and delivered health services, mainly financed through national taxation.

Responsibility for organising publicly funded health care largely rests with the 17 regions (autonomous communities).<sup>8</sup> Regions have substantial autonomy in administering the health system, largely reflecting the decentralised nature of the quasi-federalist political system.<sup>48</sup> Regions have their own basic law (Statute of Autonomy), parliaments and governments, and develop regional legislation.<sup>49</sup> However, the degree of decision-making power varies substantially among regions, reflecting what has been described as 'asymmetric federalism'.<sup>50</sup>

National legislation sets out the principles of the SNS, such as the principles of universal coverage (including equal access to care) and of solidarity of public financing. Most funding for publicly financed health care is centrally allocated, through the central tax agency (*Agencia Tributaria*). Following the Act on the Financing System of the Autonomous Communities 2001, regions are now permitted to levy additional regional taxes for health care on citizens, for example through a regional 'health cent' on petrol. However, their contribution to public health care financing is small. There is an ongoing discussion about regional taxation, with regions such as Catalonia demanding more extensive rights to levy taxes.<sup>7</sup>

The Act on the Financing System of the Autonomous Communities 2001 has strengthened the position of the regions vis-à-vis the centre. It redefined the rules for financial transfers from the centre to the regions with the aim to enhance transparency and distributive equity of central funding. Geographic inequalities have been addressed through the Cohesion and Quality of the SNS Act 2003, which requires regions to enhance the co-ordination of the regional health systems at federal level by strengthening the role of the Interregional Council of the SNS (see below).<sup>49</sup>

### ***Decision-making at sub-national level***

#### ***Regions***

The structure of the SNS within the regions is largely hierarchical. As mentioned above, regional governments are responsible for organising and planning services provided within their territory, and they mostly do so through regional health authorities/regional ministries of health (*Consejerías*).

Organisational arrangements vary from region to region. Regional authorities oversee health services management organisations (*Servicios Regionales de Salud*, HSMOs), which are responsible for organising regional health services within the regional health care budget allocated by the regional ministry of health.

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<sup>7</sup> Catalonia's recent demand for the right to establish a regional tax office has been approved by the central government.

At national level, regional governments are represented at the Interregional Council of the SNS (*Consejo Interterritorial del Sistema Nacional de Salud*), which coordinates regional health policies (see Box 1).<sup>8</sup> Although the role of the Interregional Council has been strengthened, its role remains mainly advisory and decisions taken by the Council are not binding for individual regions (i.e. they do not substitute for legislation).

**Box 2** The Interregional Council of the SNS

The Interregional Council of the SNS (*Consejo Interterritorial del Sistema Nacional de Salud*, CISNS) co-ordinates regional health policies. The CISNS is mainly formed by representatives from the regions with members of the central government participating as appropriate. The CISNS provides a forum for discussion and negotiation of health policies between the regions and central government. The negotiation mechanism involves several tiers of regional health administration. For example, topics of national relevance are discussed at the ministerial level, while issues relating to the actual management of health services are normally discussed at the level of management organisations. The formal status of most agreements reached by the CISNS is that of recommendations, although some are binding covenants.

***Sub-regional level***

Regions are further subdivided into 50 provinces and almost 8000 municipalities. Their role in publicly funded health care has undergone numerous changes since the late 1970s, progressively transferring their responsibilities to regional governments, including responsibility for policy development and delivery of primary care and secondary care.

An important change involved the General Health Act 1986, which established two parallel health-specific structures within each region: health areas and basic health zones. Health areas are responsible for managing health care facilities, run benefits programmes and organise primary and secondary care for populations between 200,000 and 250,000 people. Basic health zones are responsible for the provision of primary care and are typically organised around a single primary care team. This team also co-ordinates activities associated with prevention, health promotion and community care.<sup>49</sup>

Local governments (municipalities) are responsible for basic public health functions, including environmental health, industrial health, housing and cemeteries, while provinces (*Diputaciones Provinciales*) have lost their influence on health care following several administrative reforms; they have, however, retained responsibility for some functions related to social care.

The extent to which these structures were established varies widely among regions.<sup>51</sup> Many regions have developed two separate organisational structures with overlapping and sometimes contradictory responsibilities. In Valencia, for example, primary and secondary care services are integrated in health areas. Andalusia established only a few health areas, while Catalonia is experimenting with new management strategies several health

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<sup>8</sup> A more detailed account of the role of different bodies is available in the recent IHC report on the role of ministries.<sup>7</sup>

system levels. In other regions, primary and secondary care services are mainly integrated through general hospitals, with hospital managers in charge of decisions on primary care delivery.

The duplication of organisational structures in some regions has been criticised as being inefficient, in terms of both the use of human resources and service provision. It creates tensions between health professionals working in different arrangements and also undermines efforts to improve continuity of care and to contain costs. The diversity of structures among and within regions has given rise to the perception that Spain has many regional health systems instead of one national health system.

## ***Accountability***

Given the diverse organisational structure of the Spanish health system, lines of accountability between different levels are complex, diverse and sometimes unclear. This section focuses on accountability as it relates to regional governments.

### ***Downward accountability***

Regional governments are mainly held accountable through elections (general and regional), i.e. they receive a general mandate that includes governing the regional health system. Elections are through party lists, but not individual candidates. Thus, politicians cannot, in theory, be held individually accountable to the local population.

Public opinion, usually amplified through mass media, tends to play an important role in articulating discontent with the organisation of health care. With increasing decentralisation this effect has become stronger, as issues that had previously been dealt with at the national level have now become matters of concern for regional governments.

There have been efforts to strengthen the involvement of patient organisations in health policy decision-making at both regional and national level. Thus, following the Cohesion and Quality of the SMS Act 2003, a national patient forum has been created.<sup>49</sup> However, the influence of patient organisations on regional and national health policy is perceived as rather small.

Citizens may challenge funding decisions of a regional or central government in court. However, court decisions tend to be in favour of the respective government.<sup>6</sup>

### ***Upward accountability***

Regional governments are primarily accountable to their respective regional parliaments. They are not accountable to central government, reflecting the quasi-federalist nature of the political system.

The extent to which regional parliaments hold governments accountable in relation to health care varies among regions. Political debates – for example, about the effectiveness of the health system – tend to develop along the lines of party-political controversies. Thus, the actual contribution of regional parliaments to improving the performance of regional health systems is limited.

This may be illustrated by the example of regional health plans. Most regional governments develop health plans. Although plans may specify objectives, targets and indicators in view of future evaluations, the implementation of regional plans is rarely systematically assessed and regional parliaments usually do not pressurise regional governments to provide an evaluation.

There are few issues in which central government may choose to get involved at regional level, and it mainly does so by mediating negotiations and co-ordinating activities through the CISNS (for examples, see Box 2).

**Box 3** Issues in which central government may get involved

*Regional overspending:* In theory, the central government could hold a regional government to account if it overruns its budget. In practice, however, facing strong regional autonomy in matters of finance public services, the central government usually covers the financial deficits of the regions to avoid political confrontation.

*Public health crises of national importance:* Examples of public health issues with a national dimension have been numerous in recent years and have included heat waves, environmental disasters (e.g. the *Prestige* ship oil spill), health concerns associated with mobile-phone masts and potential epidemic outbreaks (Severe Acute Respiratory Syndrome, avian influenza). In these cases, the central government has mainly assumed the role of a co-ordinator of regional activities and it appears to have fulfilled this role 'reasonably well'.<sup>6</sup>

### ***Tensions between the centre and the regions***

Tensions between the centre and regional governments are deeply entrenched in Spain's political architecture and history. Tensions chiefly arise in relation to two issues: the allocation of central funds and the political influence of the regions on national policies.

Regional health systems largely depend on centrally allocated funding, generated through national taxation. Central government, however, has little control over how this money is spent by the regions. Tensions also arise between regions, questioning the fairness and appropriateness of the allocation of central funds. The Act on the Financing System of the Autonomous Communities 2001 addressed this issue and has aimed to reduce inconsistencies in the process of central funding (previously relying more strongly on individual negotiations) by introducing a more transparent allocation mechanism and distribution formula. For central government, however, the question remains how to guarantee universal access to publicly funded health care across regions in the absence of central steering mechanisms.

Tensions between the centre and the regions are further exacerbated by the electoral system, which allows regional parties to strongly represent their interests at central level.

Catalan and Basque 'nationalist' parties, for example, have frequently been decisive in supporting specific government policies, laws or presidents. The strong representation of regional interest at central level creates a major barrier to developing policies that would strengthen the role of the centre vis-à-vis the regions.

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