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

Ettelt S, Nolte E, Nikolentzos A, Mays N

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Summary

Introduction

This report reviews the role and responsibilities of local and regional authorities[1] 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.

[1] 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.

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.

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

	Denmark	***Finland***	***France***	***Italy***	***New Zealand***	***Spain***
Local level	Municipal councils	Municipal councils	*None*	Local health authorities	*None*	Health area boards
Regional level	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.[1] 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

	Denmark	***Finland***	***France***	***Italy***	***New Zealand***	***Spain***
Local/ regional authority	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
'Downward' accountability	1. Political 2. Political (local population)	1. Political 2. None (local population)/ administrative (municipalities)	*none*	1. *None* 2. Political	Political/ administrative (elections/ consultations)	1. *None* 2. Political
'Upward' accountability	1. Very restricted 2. Very restricted	1. Very restricted 2. Only through municipalities	Administrative	1. Admin. 2. *None*	Administrative	1. Admin. 2. *None*

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 though 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

	Denmark	***Finland***	***France***	***Italy***	***New Zealand***	***Spain***
Authority	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
Source of funding	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)
Downward accountability	1. Local elections 2. Regional elections	1. Local elections 2. To municipalities only	*None*	1. *None* 2. Regional elections	DHB elections	1. *None* 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).