

The Changing National Role in Health System Governance

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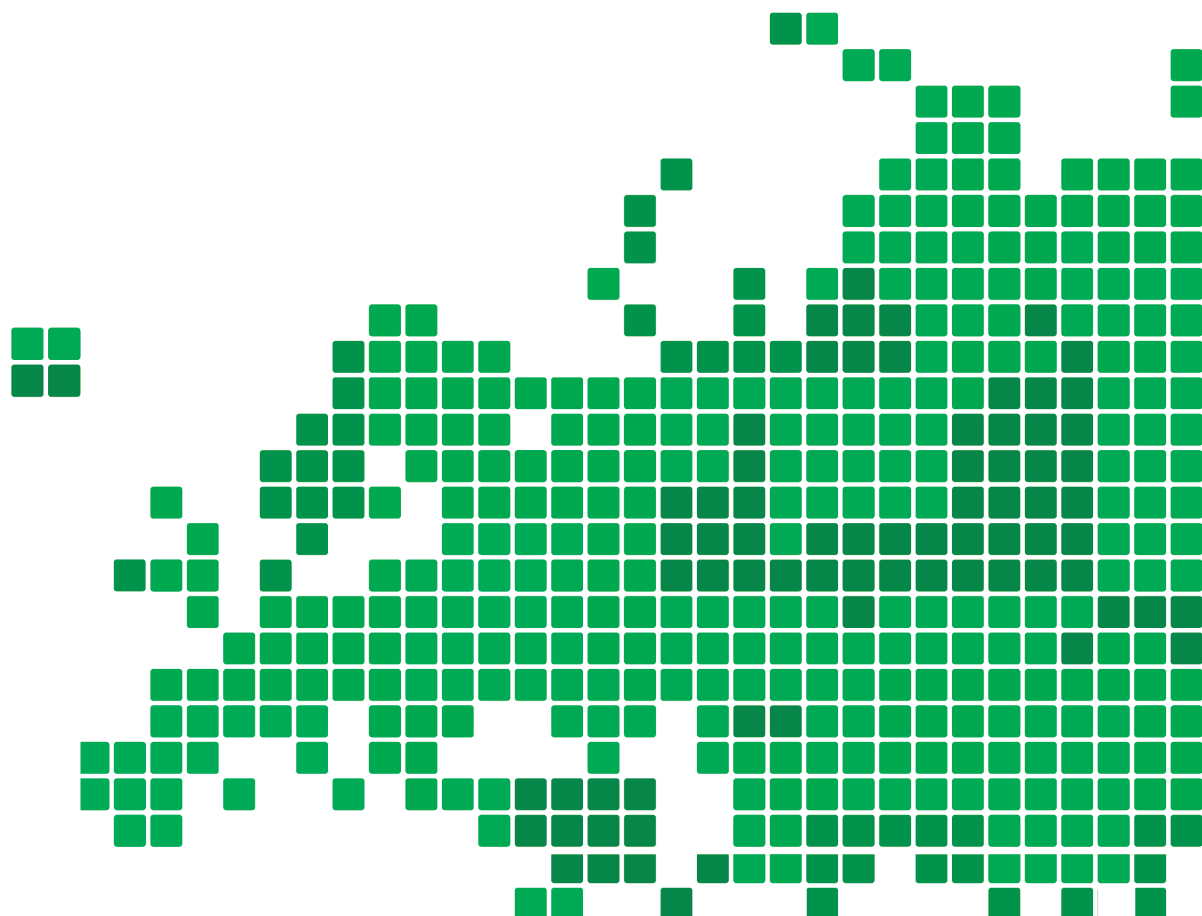
Observatory
Studies Series

A case-based study of
11 European countries and Australia

Edited by

Elke Jakubowski

Richard B. Saltman



The Changing National Role in Health System Governance



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The Changing National Role in Health System Governance

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**Elke Jakubowski
Richard B. Saltman**

Keywords

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Foreword

The Observatory wrote the first version of this report for the Swedish Governmental Inquiry on Health Care and Social Services. That report was an important contribution to our work.

The Inquiry's remit was to suggest a reformed role and structure for the national government in health care and social services, without changing the basic balance between national, regional and local levels.

In the Inquiry's first report, October 2011, we summarized that Swedish healthcare and social services are facing serious challenges and also important new opportunities. Growing needs and new medical possibilities have to be handled within restricted finances; empowered citizens demand more information and influence, and do not automatically accept regional differences; and knowledge is becoming more international and much more mobile through new forms of information technology. While talking to stakeholders throughout the system of health care and social services, we found a broad consensus that many of these challenges and opportunities have to be handled on the national level, often in an international context.

This report by the Observatory gives a both broad and specific picture of recent international/European issues and initiatives; successes as well as difficulties and shortcomings. Together with other international outlooks, it leads us to the conclusion that Sweden shares many fundamental challenges with other countries. There are strong implicit forces for improved central coordination in fields like knowledge management and IT. At the same time, there are strong forces for decentralizing information and decision-making to individual patients and users of social services. Public health, as well as integrated care for people with multiple needs, are issues that largely have to be locally implemented. These aspects of centralization and decentralization seem to be relatively independent of political structures.

Aside from these fundamental similarities, we have seen important differences in context and practical solutions. Many countries have created interesting mechanisms and structures for resource allocation, hospital reform, quality improvement and control, knowledge management, integrated care etc.

In most cases, governmental bodies and agencies are important agents behind these reforms, but also professional organizations, unions, insurers, enterprises, patient-organizations and others contribute with initiatives, practical development, opinion and sometimes even financing. On a very general level, we concluded that national governments are always important players, but they cannot take their influence for granted and they have to look at themselves as parts of complex systems.

The Swedish case is that professionals, politicians and civil servants on regional level are taking numbers of initiatives to strengthen coordination from beneath. Similar initiatives are taken from local level, although the demand for national coordination is not yet as strong in the social sector as in healthcare. The national government is promoting this increasing coordination in important areas including waiting-times, access and quality. Negotiations and contracting between national, regional and local levels have got more frequent, and transferring national money to the regional and local levels has been an important incentive.

The proposals in the Inquiry's final report, delivered in May 2012, were based on the firm belief that Swedish healthcare and social services need stronger national coordination in many areas. Given our present structure, important parts of this coordination can be built by cooperation between regional and local authorities. However, the national government and national agencies have to be more efficient in supporting and leading these processes.

In order to make it more efficient, we suggested a clarified role and simplified structure for the national government. This was done by focusing the national responsibility on four basic functions: Knowledge-management, Inspection, ICT-infrastructure and Strategic leadership. These functions should be managed by four new agencies, replacing twelve present agencies and organizations. We underlined knowledge-management as a key issue, as it – if it is well organized – can combine the advantages of standardized guidelines with local professional decision-making and continuous learning. Healthcare and social services are complex by nature, and we think that such a complexity is best handled in a structure that is as logical, as simple and as adapted as possible to the needs of the end-users eg. professionals, patients and users of social services.

Our ideas and proposals have met support from many regional and local bodies and national professional groups, but the present national agencies turned out to be more skeptical. Some parts of our suggestions are now influencing practical policy. A decision has already been taken for a new Inspectorate, the present Institute of Public Health is suggested to be merged with the Institute for Communicable Disease Control, and there are plans for a new agency for

IT-infrastructure. The new Inspectorate will be in place by June 2013 and the suggested agencies for public health and IT are planned to be in business by January 2014. Radical restructuring and reducing the number of agencies is however not yet (as to January 2013) on the agenda.

We would like to thank the Observatory for writing its report and for giving us other valuable comments. We hope that the report in this updated version will be useful also for other purposes, as a contribution to the important international exchange of experience and knowledge.

January 2013

Stefan Carlsson, Anders Åhlund, Sören Berg, Hanna André
Swedish Governmental Inquiry on Health Care and Social Services

Acknowledgements

This study was undertaken to provide information on governance arrangements in selected European countries as background material for the Swedish Governmental Inquiry on Health Care and Social Services. The information was collected between autumn 2011 and spring 2012.

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Australia: Judith Healy (Australian National University); Denmark: Karsten Vranbæk (University of Copenhagen); England: Martin Roland (University of Cambridge) and Nigel Edwards (King's Fund, London); Finland: Kimmo Leppo (Ministry of Social Affairs and Health of Finland, emeritus); France: Zeynep Or (Institute for Research and Information in Health Economics, Paris); Germany: Jürgen Wasem (University of Duisburg-Essen); Israel: Avi Israeli (Ministry of Health of Israel); Italy: Giovanni Fattore (Bocconi University Milan); Netherlands: Tom van der Grinten (Erasmus University, Rotterdam); and Aad de Roo (Tiburg University); Norway: Jon Magnusson (University of Science and Technology, Trondheim); Spain: Antonio Durán (Técnicas de Salud) and Lluís Bohigas (Roche Diagnostics); Sweden: Anders Anell (Lund University) and Sören Berg (Ministry of Social Affairs of Sweden); Switzerland: Thomas Zeltner (Science et Cité Foundation, Bern).

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Abbreviations

AC	autonomous community (Spain)
AZBW	Exceptional Medical Expenses Act (Netherlands)
CISNS	Interterritorial Council of the Spanish National Health System
CMU	universal health coverage (France)
DMP	disease management programme
DRG	diagnosis-related group
EU	European Union
G-BA	Federal Joint Committee (Germany)
GDP	gross domestic product
GKV-FinG	Social Health Insurance Financing Act (Germany)
GP	general practitioner
HPST	Hospital, Patients, Health and Territories Act (France)
HTA	health technology assessment
IT	information technology
LAMal	Swiss Federal Law on Compulsory Health Care
NHS	National Health Service (England)
NICE	National Institute for Health and Clinical Excellence (England)
OECD	Organisation for Economic Co-operation and Development
SALAR	Swedish Association of Local Authorities and Regions
SNS	Spanish National Health System

Executive summary

This study provides an overview of recent changes in the national government's role in the governance of the health systems in 12 countries. Country assessments focus on recent efforts to reconfigure responsibilities for health policy, regulation and management; the resultant policy priorities; and the initial impact. The assessment also reflects current debate in order to provide a perspective for potential changes in future governance arrangements. A short review of common trends is based on the country cases.

The study was conducted by the European Observatory on Health Systems and Policies at the request of the Swedish Ministry of Health and Social Affairs. The methodology facilitated a rapid response to this request – conducted through a combination of reviews of recent Observatory publications followed by telephone interviews with key experts in each survey country. However, the study should be interpreted as only an initial assessment of ongoing and wide-ranging changes in health sector governance arrangements in Europe and beyond.

The changes in governance arrangements in the countries studied involve a wide range of measures but show no clear uniform direction for the resulting shifts in responsibilities. In a number of countries, recent reforms have centralized certain areas of decision-making or regulation but decentralized others – although the former has been more prevalent. Central governments have been seeking greater control of decision-making in countries with traditionally decentralized decision-making structures (including Australia, Denmark, Finland, Germany, Italy, Norway and Sweden). One core objective for the extension of central government authority is better alignment of subnational health administrations and other health actors towards common strategies, visions and national objectives. These new approaches often seek better targeting of increasingly constrained human and financial resources. Arguably, a smaller number of the reviewed countries have been pursuing a more collaborative approach. Spain (until summer 2012) has relied on various cooperative mechanisms to tackle problems in the level, and the uneven distribution, of health care financing and provision that reflect the strong role of its 17 regions. France has increased the regions' remit for strategic health

services planning. Switzerland is reinforcing the role of the cantons in some policy areas related to insurance and care provision and is re-emphasizing market conditions amongst insurers. However, the central government is also strengthening both the monitoring of private insurers and the coordination of standards for quality of care and disease prevention. Some countries also have sought to simplify their governance structures by merging health insurers (Germany) or regional and local governmental structures (Denmark, England, Finland). The Netherlands has placed health insurers in the driving seat for many decisions related to the financing and provision of care.

Introduction

Elke Jakubowski and Richard B. Saltman

Scope of the study

This study reviews how 11 European countries (Denmark, England, Finland, France, Germany, Italy, the Netherlands, Norway, Spain, Sweden, Switzerland) and Australia currently view national government responsibilities for steering their health care systems. It explores recent changes in these responsibilities, and whether and why national governments are increasing or decreasing their national role in both the design and supervision of particular governance activities. The purpose of the study was to explore shifts in the balance of responsibilities and decision-making powers between national, regional and local governmental (or delegate/subordinate) bodies and the degree to which these changes may indicate new national strategies with regard to those relationships. The underlying research also sought to identify the driving forces, objectives and values behind these changes and, whenever possible, their effects. In addition, topics of particular interest to the Swedish Ministry of Health and Social Affairs (which requested the study) have been reviewed. These include accountability for the quality and safety of medical services; changing approaches in evidence-based medicine and health technology assessment (HTA) activities; experiences in priority setting; and the interface between social and health care.

The selection of survey countries was based on a number of practical considerations. We have focused on European countries, as well as Australia, for which the Observatory has up-to-date country profiles available. Countries with recent (within the last two decades) changes in governance arrangements have been of particular interest. We have also focused on countries with comparable per capita income and health system development status.

Structure of this volume

This book is structured as an Introduction followed by Parts I and II. The Introduction describes the scope of the study, as well as the main elements of the research methodology employed. Part I examines the changing patterns that

can be observed in the national role in health system governance, concentrating on overall changes in policy priorities, practical tools and impacts. Part II contains the country reviews.

Research methods

The study utilizes a mixture of research methods. It is based on a literature review of the Observatory's Health Systems in Transition profiles and of its published and ongoing analytical studies, in combination with information collected through structured telephone interviews with country health system experts.

Several relevant criteria were used to identify the experts. These included ensuring that they were not currently employed by government or any other governing actors, in an effort to reflect real developments in the system as well as official governmental positions. One expert does hold a parallel academic and government position and two informants have retired from government positions. The majority of experts are affiliated with universities and have contributed to this review in their academic capacity. In addition, some interviewees also reviewed the respective country section to enhance the validity of the cases.

Country	Name of expert	Expert's affiliation	Date of interview
Australia	Judith Healy	Adjunct Associate Professor, Regulatory Institutions Network, Research School of Pacific and Asian Studies, Australian National University	28.9.2011
Denmark	Karsten Vrangbæk	Director of Research, Danish Institute of Governmental Research	18.10.2011
England	Martin Roland	Professor of Health Services Research, University of Cambridge	30.9.2011
Finland	Kimmo Leppo	Director-General emeritus, Ministry of Social Affairs and Health	27.9.2011
France	Zeynep Or	Research Director, Institute for Research and Information in Health Economics	28.9.2011
Germany	Jürgen Wasem	Professor of Business Studies, University of Duisburg-Essen, Germany	30.9.2011
Italy	Giovanni Fattore	Associate Professor of Health Management, Bocconi University, Milan	4.10.2011

Country	Name of expert	Expert's affiliation	Date of interview
Netherlands	Tom van der Grinten	Professor of Sociology, Erasmus University Rotterdam; and adviser to the Ministry of Health	26.9.2011
	Aad de Roo	Professor of Management, Tilburg University	30.9.2011
Norway	Jon Magnussen	Professor of Economics, Norwegian University of Science and Technology, Trondheim	28.9.2011
Spain	Antonio Durán	Director General, Técnicas de Salud	21.9.2011
	Lluís Bohigas	Director, International Relations, Roche Diagnostics	26.9.2011
Sweden	Sören Berg	Ministry of Social Affairs of Sweden, Government Inquiry on the National Health System of Sweden	7.6.2012
	Anders Anell	Professor, Institute of Economic Research, School of Economics and Management, Lund University	26.6.2012
Switzerland	Thomas Zeltner	President, Science et Cité Foundation; former Director General, Federal Office of Public Health	29.9.2011

Interview guidelines

The telephone interviews were based on a simple questionnaire to help guide the experts' interview preparation. The request for a telephone interview was e-mailed together with this questionnaire, which included the following questions.

1. Has the central government's governance role changed in the last few years? How? Why? Who won/who lost as a result of these changes?
2. What tools/instruments were adopted/changed to implement this change? Did they work well? Why or why not?
3. What policy priorities were they intended to address? Did they create perverse consequences?
4. Was this change implemented as planned? If not, what hindered or is hindering implementation? Were/are there open opposition or hidden dynamics working against this change? What were the real effects? How do these compare to the planned effects? Did you experience any unforeseen effects?

5. How happy is the government with the current outcome? Are additional changes likely? If yes, in what direction?
6. Can you recommend any references for further reading on the subject?

Practical frame

The review of case experiences on changing governance arrangements followed a practical framework that guided the collection, analysis and reporting of information on the selected countries. This framework was developed to facilitate comparisons in governance arrangements, their objectives and impacts across countries. The framework has three parts: policy priorities, tools and impacts.

Within policy priorities the emphasis was on the two or three real objectives that senior national analysts consider to have driven recent changes, not necessarily on official government statements of reform objectives. The study has also tried to take account of who has shaped these policy priorities and whether these priorities are governmental, political or clinical; those of the administrative apparatus; or of providers, purchasers, patients and/or citizens, respectively. Where possible, the review includes a short discussion on whether and how this change in governance arrangements has affected the fundamental values of the health systems of the selected countries.

Tools include legislation and other regulatory means, measures and procedures newly introduced to implement changes in governance arrangements. Often these tools comprise legal means to change the scope of responsibilities of a certain administrative or governmental decision-making tier, or the establishment of new institutions.

The impact section seeks to assess whether the changing government arrangements have yielded the intended effects. It also considers unforeseen effects of the reforms as well as constraints on their implementation.

Each country section begins with a short introductory paragraph on the basic governance model and a description of the recent changes, concluding with the outlook for possible future options and likely directions in governing the health system.

Part I

Comparative governance themes and issues

Richard B. Saltman and Elke Jakubowski

1.1 Governance overview

Health sector governance involves a complicated mix of activities that run concurrently and at multiple different levels of the funding and service delivery system. These activities can stretch from strategic (legislation) to mechanical (reporting financial or clinical data), and may involve a variety of institutions and/or health system levels in any one particular process (e.g. regulating physician behaviour). Further, these activities typically have political, financial, clinical, institutional, professional, legal and economic dimensions, often at the same time. Traditionally, governance has been an intra-health system activity but in the last several decades a variety of outside actors – most notably patients and citizens – have also been drawn in. In essence then, health sector governance is a complex area of responsibility that requires a complex analytic perspective (Saltman, Durán & DuBois, 2011).

Given this broad perspective, the national government should be viewed as a key, but not exclusive, actor in the design and implementation of governance measures. Some areas of governance (e.g. certain regulatory and reporting requirements) naturally fall within the purview of national government. Other regulatory roles (e.g. professional behaviour) and institutional responsibilities (e.g. within semi-autonomous public and/or privately operated hospitals) may properly fall to non-national government and indeed to completely nongovernmental agencies, depending upon the construction of the health system and its operating mandate.

This complicated mosaic of responsibilities and actors suggests that strategies and measures to change national government's role in the behaviour and performance of specific subsectors of the health system (e.g. highly specialized hospital services) should not be conceived or introduced in isolation. Rather,

these measures need to be understood in the broader context within which they take place and which can accelerate or retard their ability to achieve their stated objectives. As experienced national regulators know well, medical professionals believe (not always inappropriately) substantial clinical autonomy (e.g. separation from political and politician-based decision-making) to be essential for providing and maintaining a high standard of medical care (Mechanic, 2000). Further, as organizational sociologists have long documented (Barnard, 1938; Roethlisberger, 1941; Simon, 1947; Crozier, 1964), efforts to impose external authority on technically based employees can lead to a variety of unexpected and sometimes perverse organizational outcomes.

A further factor in this governance mix is the complex character of national governments' regulatory interventions in health systems in which operational decision-making is decentralized to regional bodies (as in Sweden) or delegated to private non-profit-making and/or profit-making actors (e.g. as in the Netherlands). Regulation in these multi-actor contexts is considerably more difficult than in a top-down command and control state-run mode of service funding and delivery (Kettl, 1993). Moreover, this becomes increasingly complex if a contract-based, market competitive model is adopted – regulation is subdivided into measures that promote forms of competitive behaviour seen to be positive to achieving political objectives (e.g. raising quality of care), as against regulatory measures that restrain competitive behaviour seen to be negative to achieving political objectives (e.g. adverse selection of insurees or patients) (Saltman, Busse & Mossialos, 2002). Thus, it becomes a key task of national government to design regulation to encourage “good” competition and restrain “bad” competition – vital for the redesign and modernization of health sector governance.

1.2 Summarizing key themes

The brief country reviews in Part II were undertaken to examine recent changes in the mix or balance of decision-making authority between national government; regional and/or local government; and private non-profit-making or (in the Netherlands) private profit-making actors. The types of measures adopted can include formal transfer of responsibility between levels of government – involving major structural changes in how government deals with health care. They can also include a growing variety of nonstructural efforts to create either better coordination among regional governments (Italy, Switzerland); better information flows between regional and national governmental levels to allow national government a better view of ongoing activities in the health sector (Spain, also Italy); or broader institutional cooperation between public sector

and non-profit-making private sector health actors (Switzerland for HTA). The results from these country reviews provide a useful snapshot of the types and character of changes under way in a variety of different countries and a sense of the types of governance measures being introduced in the face of a relatively well-defined set of common health sector challenges.

The central theme that emerges from these country reviews is the extent of national governments' recent and/or ongoing efforts to increase their decision-making leverage over important financial and/or clinical aspects of the health system (Saltman, 2008). Whether structural (e.g. changing the formal institutional responsibilities of national and regional and/or municipal government) or nonstructural (e.g. based on regulation and/or negotiation) in character, these centralizing efforts reflect pressures on central government to achieve better financial (efficiency) and clinical outcomes. The diffuse sources of these pressures include higher patient expectations for care quality – tied to Internet-driven awareness of different treatment options; the impact of information technology (IT) based collection of financial and clinical data; and what has been called the “blame factor”, by which citizens hold national politicians responsible if health sector performance appears sluggish, bureaucratic and/or clinically inadequate.

The country studies in Part II document the degree to which this broad centralizing trend continues to be observed in systems based on social health insurance (France, Germany, Switzerland, also the Netherlands) and those that are tax-funded (Australia, Denmark, England, Norway). These efforts take a number of different and often overlapping forms including direct recentralization of decision-making authority; establishment of new national agencies that centralize previously uncoordinated areas of authority (e.g. dealing with quality of care measures); new regulatory interventions that mandate certain changes from non-state actors (e.g. regional health administrations, private sector insurers and/or providers); and negotiated agreements with these regional governments and/or non-profit-making private actors (e.g. national medical associations).

National legislation has been used to apply formal structural measures to increase national government's authority, including the following examples.

- Legal authority over health system fund-raising and fund distribution is transferred to national government from regional governments in tax-funded systems (Denmark) or from private non-profit-making, but statutorily responsible, sickness funds in a social health insurance system (France, Germany).

- Legal ownership of major provider institutions (e.g. hospitals) is transferred to national control but with a new regional form of day-to-day operational responsibility (Denmark, Norway).
- Establishment of new national agencies with mandatory authority over emerging areas of health system importance such as quality of care (Australia, England, France) also primary and/or preventive services (Australia, France).
- Consolidation of the number and/or responsibilities of regional/municipal government bodies (Denmark, England, Finland, France, Norway).

Although this has been the predominant trend, it should be noted that not all structural reforms have aimed to centralize more authority in national government. Several structural (legislative) measures have shifted elements of health care decision-making downwards, to either regional (France established regional authorities in 2010) or municipal governments (Denmark delegated approximately 20% of health resources to municipal governments, partly for use in contracting with private primary care physicians for preventive health services). Thus, there has been a mix of structural measures in some countries – shifting some types of authority upwards but certain types of authority (often tied to prevention and/or public health) to lower level and/or municipal governments. Similar strengthening of non-state actors – in this case private non-profit-making and profit-making (Netherlands) and/or corporatist (Germany) bodies – can be seen in the continuing consolidation of health insurers in social health insurance countries.

Nonstructural measures to increase national government's authority in the health sector have been both regulatory and intergovernmentally negotiated in character. In both instances, there were no changes in legal boundaries and no formal restructuring of intergovernmental relationships. Thus the role of national government was strengthened by adopting strategies that could be implemented inside the existing structure of formal institutions and the official allocation of ownership and operating roles of national, regional and local governments. This has the political advantage of not only being less cumbersome and time-consuming to implement, but also raising fewer (but certainly not eliminating) political complaints from other levels of government.

The following are examples of new regulatory measures that have strengthened central government's role in the financing and production of health services.

- France introduced a programme of 100 priorities in 4 areas (access, prevention, quality, efficiency) as part of the 2004 Public Health Act.
- France promoted competition between public and private hospitals (through 2009 Act).

- Australia established a new system for monitoring professional boards.
- Italy adopted a broad series of new regulatory measures including “external commissioners” to monitor the financial performance of regional governments.
- Italy proposed the imposition of one national set of prices for all regionally delivered hospital, community and public health services.
- The Netherlands established a strong regime of four national agencies to regulate non-public health insurance and health provider markets.
- England proposed strengthening of Monitor in order to expand regulatory activities beyond hospital trusts to include private hospitals and primary care practices.

Negotiated compacts between national and regional governments and/or other private non-profit actors have a mixed record – such intergovernmental arrangements working out largely as anticipated in some countries (e.g. Switzerland) but more often disregarded in others. Some examples of negotiated contracts are described briefly below.

- In collaboration with the cantons and nongovernmental organizations, the Swiss federal government is to establish national goals on disease prevention.
- Swiss cantons have agreed to common planning of highly specialized health services.
- Organized by the Health Directors Conference (Gesundheitsdirektorenkonferenz, the association of Swiss physicians) and the Swiss Academy of Medical Sciences, establishment of a Medical Board will be an initial step towards a private HTA institute in Switzerland.
- Set up by the 2003 Cohesion and Quality Act, the Interterritorial Council of the Spanish National Health System (Consejo Interterritorial del Sistema Nacional de Salud, CISNS) was established with the aim (unrealized) of encouraging the 17 autonomous communities (ACs) to provide the national government with quality and safety related data to enable monitoring and evaluation of regionally delivered health care services.
- Italy’s national solidarity fund was intended to ensure equity of access by providing cross-subsidies between well-off and less-well-off regions (but never generated actual transfers).
- Italy’s national health plan was agreed between the national and regional governments.

- England's proposed local planning processes are to be negotiated between national and local commissioning boards.
- Australia has introduced Medicare Locals – integrated local planning units intended to foster better collaboration among 100 to 300 medical professionals of different disciplines.

1.3 Additional issues

Several additional issues emerge from close reading of recent country experiences presented in Part II. These reflect broader questions about the overall focus and direction of current efforts to strengthen the role of national governance in European health systems. They remain questions without any clear answers at this stage in the reform process.

- a) Are new national agencies a cost-effective solution? A number of countries have chosen to build new national government infrastructures as part of their solution to regulatory gaps in their health care systems. In some instances (England, Netherlands), the new infrastructure has replaced previous national agencies but often incorporates elements from them. In other instances (e.g. France), these new agencies are being built in addition to existing, sometimes overlapping, national and/or regional government authorities. When and under what institutional circumstances are new national agencies a good idea? When are they likely to be ineffective and/or counter-productive?
- b) How successful are new national efforts to align subnational actors likely to be? In several countries with strong regional responsibility in the health sector (Italy, Spain, Switzerland) recent experience has shown it to be quite laborious to shift the existing balance of decision-making control more towards national goals and objectives for their health care systems. Similarly strong resistance can also be observed in various professional, labour-union and other staff organizations. Even when these national governments have full authority over the financing of their health sectors, some (Italy, Spain) have not always been able to affect health sector outcomes as they would like. What mix of structural and non-structural tools is most likely to produce the types of organizational and behavioural change that national governments are seeking to create?
- c) How can national governments streamline the decision-making procedures in regional and municipal governments? In a number of countries with decentralized responsibility for the health sector's day-to-day operating decisions, the subnational governments are bureaucratic and politicized.

National government goals to improve the quality, safety and cost effectiveness of service delivery may be difficult to achieve if regional governments are not managerially efficient. However, central imposition of new governance standards is fraught politically and unlikely to be considered by any but the strongest of national governments. It is also likely to alienate key professional and patient groups who continue to rely upon their ability to influence local government decision-making. What strategy can ensure that new national regulatory initiatives are not dissipated by more traditionally organized lower-level governments?

- d) How will the emerging fiscal realities of austerity shape these new national governance strategies? Most European national governments will be dealing with large national debt obligations for at least the next decade. Facing substantial economic competition with Asian countries, these European governments will have little option but to limit taxes and to reduce overall spending, including for health care (Saltman, Calltorp & de Roo, 2011). How will this long-term shrinkage of revenues affect national governments' new strategies to increase their role in their health sectors? Will this ongoing revenue scarcity favour a differing mix of structural and non-structural initiatives than might otherwise be preferred?

These additional questions raise issues for which the evidence presented here does not allow an answer, nonetheless they are very much a part of the current policy-making environment. Finding responses to them will necessarily be part of the process of reform if national governments are to achieve their central objectives.

Country governance profiles

Elke Jakubowski, Richard B. Saltman and Antonio Durán

2.1 Australia

2.1.1 Governance model and recent changes

Responsibilities for funding and managing health care services in Australia have traditionally been divided between the national government, and the six states and two mainland territories. Thus, the power of individual actors to plan and regulate is usually limited and the Australian Commonwealth Government and the states and mainland territories must agree on all major health reform steps. Recent reforms in 2004 and 2011 have reflected the government's continuous attempts to assume a higher level of control in some areas. This has usually worked through intergovernmental agreements and funding mechanisms and, more recently, by creating national regulatory, planning and oversight agencies.

2.1.2 Policy priorities and tools

Health professional regulation has traditionally been a responsibility of the eight states and territories, mainly through their separate health professional registration boards. However, in 2010, legislation restructured health professional regulation into ten national boards for each group of legally recognized health professionals (while retaining state and territory committees). The Australian Health Practitioner Regulation Agency was set up as a national oversight agency to ensure accountability of the national boards. Health Workforce Australia is a new agency created to provide national-level advice, coordination and consultation on health professional recruitment and retention. The purpose is to tackle the progressive shortage of health professionals in Australia and work towards a nationally coherent approach to health professional staffing in hospitals.

Primary care has become subject to a nationwide policy of setting up local planning units funded by the Commonwealth Government. Currently about

30 Medicare Locals have been funded, each comprising around 100 to 300 health professionals of different disciplines. The intention is to roll these out to most general practitioners (GPs). Medicare Locals are expected to encourage collaboration amongst GPs and other health professionals; foster integration and continuity of care; and enhance continued training. Although financial incentives are available for signing up with Medicare Locals, GPs will continue to operate as private practitioners. In addition to general practice, a small number of polyclinics will be established as community health centres employing an interdisciplinary approach to care provision. Some GPs who fear losing patients have not supported the establishment of these polyclinics but opposition has not been very fierce – overall the demand for health care exceeds supply in Australia and therefore polyclinics are unlikely to challenge significantly the market share of GPs in private practice.

A national agency for disease prevention, the Australian National Preventive Health Agency, was established in 2011 as a partnership of the Commonwealth Government, state governments and the private sector. This will focus on strengthening individual responsibility for prevention and provide recommendations. Critics of the agency have argued that it will not have the leverage to influence the health environment towards a collective and community approach to disease prevention.

Recent reform (August 2011) influences funding and governance arrangements for public hospitals – the Commonwealth Government will assume a stronger role but the administration and provision of public hospital care remains in the hands of the states. Additional funding covering block grants for public hospitals is provided nationally and performance targets will be developed nationally, starting with waiting-time targets for elective surgery and emergency care. In addition, local hospital networks are being established to group together up to four hospitals in order to improve management. These groups will be paid according to a national pricing system – 60% of “the efficient price” of the respective diagnosis-related group (DRG) for each patient provided with hospital services under the public scheme. The new Hospital Pricing Authority will determine hospital prices for the local hospital networks (see below). The scheme is expected to improve efficiency and level out the substantial variation in hospital prices.

Three new national agencies are being established to increase leverage of the national government on hospital funding and performance management: (i) the independent Hospital Pricing Authority will establish a national pricing scheme for hospital services; (ii) the National Health Funding Pool will make payments to hospitals; and (iii) the National Health Performance Authority will monitor and publicly report on hospital performance. In addition, the

Australian Commission on Safety and Quality in Health Care has become a statutory national entity, setting out standards for safety and quality of care.

The Commonwealth Government also has increased funding and policy responsibility for care of the elderly, including long-term home and community care (except in Victoria and Western Australia, where they will continue as joint ventures). Care of the elderly, in particular long-term care in residential homes, is provided under the Aged Care Act 1997. Care for people in their own homes in the community, and support for their carers, is provided under an intergovernmental agreement through the Commonwealth Home and Community Care (HACC) Program.

2.1.3 Conclusion and outlook

The health care system in Australia is characterized by the division of governance responsibilities between the states and the Commonwealth Government. Major changes have to be negotiated jointly through bodies such as the Council of Australian Governments (COAG) and the Australian Health Ministers' Conference. The trend has been growing coordination of strategies and policies such as those for funding and provision of care to ensure more equal access to care; level out differences in the prices of health services; constrain the growth in health care costs; increase nationwide performance on quality, transparency and public accountability of health care providers; and increase the continuity of care between the different health care sectors. The recent trend to coordinate policies at national level has arguably diminished the autonomy of states and territories. In addition, health care providers are being offered incentives to sign up to certain care groupings with the goal of aligning care providers with common strategies and policies in order to create better health care outcomes. However, the scope of services provided has not been revisited fundamentally and rationing takes place by waiting lists only. The shortage of health professionals in Australia will likely be one factor that restrains fundamental changes, at least until the graduates of expanded training courses enter the market.

2.2 Denmark

2.2.1 Governance model and recent changes

In 2007 the Danish administrative system underwent major structural reform that shifted responsibilities and affected relationships between the national, county/regional and local levels (Table 2.1). This reduced the number of regional units (from 15 counties to 5 regions) and local units (from 275 to

Table 2.1 *Government reforms in Denmark: changes in responsibilities*

1973–2006	2007–2011
State	
Legislative power	Legislative power
Partition of tax money in negotiation with municipalities and counties about general grants	Partition of tax money in negotiation with municipalities
Counties	
Fifteen counties	Five regions
Power to levy taxes	No power to levy taxes
Hospital steering/treatment	Hospital steering/treatment (somatic and psychological)
Chronic diseases	Plan hospital structure and function
Health promotion and prevention activities	Receive payments for hospital treatment from the municipalities
Ambulatory treatment	
Secondary education	
Rehabilitation	
Municipalities	
Less power	More power
Small geographical areas (275 municipalities)	Bigger geographical areas (98 municipalities)
Responsible for all social services (e.g. elderly care), welfare services (e.g. unemployment benefits) and education services (e.g. primary schools), except health care	Same responsibilities in addition to secondary education (e.g. high schools)
	<i>Responsibilities inherited from counties</i>
	Extended health promotion and disease prevention
	Rehabilitation
	<i>New responsibilities</i>
	Establish health agreements between municipality and region about cooperation/coordination within health sector
	Patient education

Source: Andersen et al., 2010.

98) and transferred responsibilities for prevention, rehabilitation and social care from the regional to the local level. The reform also created larger regions and municipalities and redistributed responsibilities among them. In hospital and highly specialized care this meant a more central form of administration, supervision and provision of care with fewer and larger hospitals and more centralized provision of highly specialized care. In addition, the National Board of Health was given more power to plan and provide guidelines for highly specialized services. In contrast, responsibility for prevention, rehabilitation and social care was shifted to a lower level of administration – from counties

to the municipalities. The new responsibility levels for administering and providing the different types of care mean greater division of responsibility and accountability for overall care provision. To enhance coordination between the different levels of care, the 2007 reform enforced mandatory regional health agreements between the regions and municipalities.

The reform also included a change in fund redistribution – a new system of earmarked taxation was introduced at national level with approximately 80% redistributed to regions through block grants and 20% redistributed to municipalities to co-finance hospital services. Regions' right to levy tax income was removed and, at the same time, central-level influence over their capital investments was increased – since 2007, regions have required Ministry of Health approval for capital investments above a certain level.

2.2.2 Policy priorities and tactics

Priorities of the 2007 reform may be divided into official policy priorities and political priorities. An often stated policy objective of the concentrating element of the reform was to secure economies of scale in service provision according to the perception that larger catchment areas would guide more efficient specialization and structural adjustments. This was expected eventually to yield economic savings in specialized care and to improve the quality of highly specialized services. In addition, more direct state control of hospital care provision was expected to enforce more uniform quality standards; equalize waiting times; and improve the availability of medical technology and the provision of diagnostic and curative care across the country.

Looking at the political motives, central government officials were keen to stop being held accountable for problems occurring at county level and over which they effectively had no control. In this way, the reform ended a power struggle between the counties and central government. By simultaneously empowering municipalities and creating locally accountable planning structures for welfare, public health and health care services, central government communicated its objective to improve coordination of care by eliminating duplications and insufficient or poorly handled (grey zone) health care and welfare services (Ministry of the Interior and Health, 2004). Thereby, central government formed an effective coalition with the municipal level to allay any potential opposition from the counties (possibly the main losers of the 2007 reform in terms of decision-making and planning power).

Some commentators have argued that the 2007 reform paved the way towards more market-oriented reforms by breaking the power of the regions and further encouraging outsourcing and contracting out of services to the private sector.

Outsourcing has become more popular since the introduction of the waiting time guarantee in 2002 that allows patients waiting for treatment for more than one month to seek care from any provider.

2.2.3 Tools

National frameworks and indicators are important national-level tools for coordinating policy and planning for health services. This applies not only to the 2007 reform but also to the whole of the last decade, albeit national guidance for services planning and for integrated care models was re-emphasized with the 2007 reform.

Obligatory health agreements are important contractual commitments conducted between each municipality and its respective region to secure health care provision in line with national guidelines. Health agreements include arrangements regarding hospital discharges for weak and elderly patients; for the social service available for people with mental disorders; and for prevention and rehabilitation. They were introduced in 2007 to foster coherence between the different levels of care. The National Board of Health became responsible for issuing national indicators for patient pathways and integrated models of care that were to be included in health agreements.

Development of a model to improve quality of care builds on regional initiatives but has moved progressively towards a nationally applied system. In 2002, national and regional authorities agreed to integrate a number of national and regional models into a comprehensive national scheme comprising standards (including process-related standards for care; diagnosis-related standards for care; and organizational standards). A national quality database allows quality comparison in a number of clinical areas (including diabetes care, lung cancer, schizophrenia, heart failure, hip fracture, stroke, surgery for acute gastrointestinal bleeding) and national measures of patient satisfaction. A national system for monitoring adverse incidents was introduced in 2004 and all hospitals were included in the national quality scheme in 2007.

2.2.4 Implementation and impact

Strong support from central government and the municipalities has been an important factor in the implementation of the reform and watered down counties' resistance to giving up their remits. In turn, this has affected hospitals' compliance with the reform as hospital managers of public hospitals are civil servants directly employed by the regions (formerly by the counties). Hence, they seldom operate as independent policy actors and do not form a strong representative interest group. Overall most health professionals were indifferent

about the reforms but some have promoted them as they saw professional merits in a higher degree of specialization.

Implementation of the reform was a complex process since it drastically changed responsibilities for planning, managing and administering health and welfare services across the different organizational tiers. Administrative changes resulting from merging counties into regions, and municipalities into larger units, took place at a relatively quick pace. Regional plans have helped to implement new provisions for capital investments in hospital infrastructure according to national guidelines. A number of smaller health care facilities closed, as they no longer complied with national requirements for service infrastructure and for the required volumes of interventions. These closures may have influenced geographical access to acute care in some remote areas of Denmark but so far this has not been a subject of major public concern. Recorded waiting times reduced substantially following the introduction of the maximum one-month waiting time guarantee in 2002, but have not yet changed substantially since the 2007 reform. This suggests that the reform is likely to have had little measurable impact on waiting times to date.

Implementation of the new prevention, rehabilitation and social services planning responsibilities at municipal level has been more varied, partly owing to the large differences in the size and capacities of the municipalities. Many of the larger municipalities have been proactive in developing health agreements with providers. Some of the smaller municipalities have found it more difficult to deliver highly specialized rehabilitation and long-term care services (e.g. for patients with complex disabilities). This has triggered debate in the new government about revisiting the functional remits of the municipalities.

2.2.5 Conclusion and outlook

The 2007 reform has shifted responsibilities for health services planning to the municipal level and increased national government's role in setting out national frameworks for local and regional health services plans, specialty planning and performance on quality and efficiency. Considering the large scale of the reform, opposition was not very fierce – partly owing to the highly integrated nature of the policy-making and provider institutions – and implementation has been complex but generally smooth. Early observations suggest that so far the more centralized form of planning clinical specialties has increased efficiency without fundamental compromises in access to care, as measured by waiting times. The results of the reform in planning and provision of long-term, rehabilitative and social care are more heterogeneous due to the large differences in size, capacities and health and social structure of the different municipalities.

Health care figured as one of the major campaign themes in the run-up to the national election in September 2011. The liberal-conservative coalition had launched plans to abolish the regional health administrations. However, a left-of-centre government was elected and is less likely (compared to the previous government) to introduce fundamental changes in the division of responsibilities.

The new government took office only recently (September 2011) and it is too early to determine exactly how this will influence current health care governance arrangements. Overall, it is unlikely that there will be a fundamental change in the current delegation of responsibilities. Some immediate decisions have been taken, including the removal of regulation introduced by the previous government to encourage the uptake of voluntary health insurance schemes by making private health insurance contributions tax deductible. These plans have already started to show an effect, with substantial losses in the private health insurance sector. In contrast to private funding schemes, the new government is not expected to deter private providers from offering services under the public waiting time guarantee scheme. Likely, it will continue to encourage regions to embark on outsourcing agreements with private providers where there are shortages of public providers and where there are cost-effective alternative private providers (e.g. in auxiliary services).

The government is currently considering the scope of municipal responsibilities and whether environmental health regulation should revert to either a regional or a national responsibility as some municipalities have found it difficult to regulate the industrial behaviour of industries on which they rely. Municipalities' responsibilities for complex long-term care are also at stake.

2.3 England

2.3.1 Governance model and recent changes

England has a centralized health system administered through the publicly funded National Health Service (NHS). The NHS is a pioneer in providing national guidance for clinical interventions through the National Institute for Health and Clinical Excellence (NICE); quality assurance through the Care Quality Commission; and financial sustainability through Monitor, which supervises foundation trusts. The NHS also has a long track record of national clinical policy development inscribed into national service frameworks, as well as targets that guide priorities and resource allocations at regional and local levels. Strategic health authorities were created in 2002 to manage the NHS at regional level and to make sure that local health service plans integrate national

health priorities. The original number of 28 strategic health authorities was reduced to 10 in 2006 and to 4 in 2011.

Since 1989, England has been on a quest to find the right balance between strong national-level guidance and market approaches. The introduction of GP fundholding in 1991 was designed to stimulate entrepreneurial provider behaviour by giving GPs limited responsibility to manage budgets and purchase secondary care for their registered patients. In 1998, the GP fundholding and purchasing system was replaced by a system of commissioning primary, secondary and tertiary care services through managerial units called primary care trusts. In 2001 around 152 primary care trusts managed about 80% of the budget of public hospitals and GPs. Thus, by 2010, the NHS operated three prevailing governance models in parallel (Greer, 2011): (i) model consisting of direct management by nationally defined targets delivered through local managerial arrangements; (ii) model characterized by specialist regulation and guidance provided through national institutions; and (iii) model determined by market mechanisms designed to stimulate competition and promote patient choice.

In early 2011, the Conservative-Liberal Democrat coalition government launched plans to fundamentally alter the arrangements for commissioning services. The Health and Social Care Act passed in 2012 provides for the introduction of local clinical commissioning groups (to replace primary care trusts, dominated by GPs but also including representatives of specialist physicians and other health professional groups. Their role will be to purchase hospital and specialist care for their registered populations, negotiating with regulated autonomous hospitals. They will be free to purchase care from the public, private, and charitable sectors. The territorial commissioners (primary care trusts and strategic health authorities) will be abolished and the government would devolve responsibility for vertical performance management to the new NHS Commissioning Board. This will be responsible for regulating local commissioning groups and, together with NICE, play a leading role in defining standards for the quality of care. The NHS Commissioning Board will hold local commissioning groups responsible for their contributions to achieving a set of NHS outcomes. The *NHS Outcomes Framework 2012/13* published in March 2011 confirms plans to move away from performance management by targets and replace them with local planning processes whereby locally expected results will be negotiated between national actors (representatives of the NHS Commissioning Board) and local actors (local commissioning groups). The local plans are also expected to emphasize a more integrated approach to social and health care for adults (in the domain of long-term care).

2.3.2 Policy priorities

The most consistent driving force for the changes in governance arrangements across different governments in the past three decades has been the desire to control costs without compromising quality in a system that aims to provide universal access to care (Greer, 2011). This priority has also driven the current government's agenda, which officials maintain is one of decentralization. It is argued that the introduction of local commissioning groups will empower local clinicians to take a leading role in deciding how care will be delivered whilst the role of the NHS Commissioning Board will be limited to overseeing and supervising their operations. An alternative view holds that this Board will increase central influence, imposing a rigid regulatory framework for the commissioning groups who would consequently become agents of the state.

In addition, the coalition government has officially argued for a need to produce more cost-effective care by bringing services closer to patients' homes. It also stresses the need to move away from reliance on a management driven commissioning agenda towards a clinical outcome agenda.

The reform plans' parallel objectives are to increase efficiency – by reducing management in the NHS by about 2% over four years – and increase savings. Abolition of the primary care trusts and the strategic health authorities is expected to release approximately 24 000 jobs (mostly in management) and will effectively eliminate the regional and managerial tier of the current health services commissioning process, albeit replaced in part by clinical commissioning groups.

Another agenda is a reversion to a more contestable environment for health services provision because NHS and private health care providers are expected to compete for contracts with clinical commissioning groups. In essence, the current government is also keen to see their electorates benefit from increased choice of provider together with a greater variety of provider organizations.

2.3.3 Tools

As mentioned, the Health and Social Care Bill 2012 provides for an independent NHS Commissioning Board to allocate resources and provide commissioning guidance; making GPs responsible for commissioning services on behalf of their patients; strengthening the role of the Care Quality Commission; changing Monitor's remit; and abolishing primary care trusts and strategic health authorities. Thus, local clinical commissioning groups will be the most important tools for implementing reforms at local level, taking control of about 80% of the NHS budget.

Monitor and the new NHS Commissioning Board will be the national regulatory and oversight bodies for the new commissioning and care arrangements. Originally a national agency responsible for regulating NHS trusts, it is planned that Monitor will become the main economic regulator in the NHS that will promote and regulate competition based on quality and pricing and promote coordinated integrated care approaches. With responsibility for all primary care contracts, specialist commissioning, commissioning of services not covered by the clinical commissioning groups and some aspects of education – Monitor will become a huge and potentially centralized government agency. The NHS Commissioning Board will set guidelines and regulate and oversee the commissioning process.

NHS hospitals will continue to be allowed to take on treatment of private patients (privately insured or paying out-of-pocket). Caps on the income generated through private patients of NHS trusts were introduced by the previous government but they will be removed.

2.3.4 Impact, opposition and outlook

The discussions about reforms are ongoing and therefore cannot yet be assessed with respect to their likely impact. Early signs of the reform indicate that health administration and trust staff are already leaving, and that more than 150 commissioning groups have been formed to date (October 2011).

The draft bill created a lot of controversy and therefore was withdrawn from the House of Commons (lower parliament) after its second reading in January 2011 as it risked failing to pass through the House of Lords (upper parliament). This was due to strong opposition from the Liberal Democrats who had fundamental concerns about the provisions on competition and the promotion of private sector services. In the first half of 2011, the bill underwent a series of consultations and listening exercises which resulted in a number of amendments. One of the most important amendments revises Monitor's duties to include the promotion of integrated care, not just competition. This takes account of concerns over allowing competition to produce radical change in the health service.

During 2011, proposals have faced (and still face) significant opposition from a range of actors, including the representative bodies of the medical professionals, hospital boards and trade unions. It is feared that the contestable environment for hospitals and a zero nominal budget growth up to the year 2015 will lead some hospitals into bankruptcy or force them to reduce services; and that the market orientation will eventually erode principal NHS values such as universalism, equal access and public accountability. There are also concerns

that provisions in the bill change the responsibility of the Secretary of Health and may essentially reduce central government accountability to provide a comprehensive and universally accessible NHS.

Fierce opposition from the trade unions is focused on changes to pensions and a potential reduction of labour. There are also fears that the reform plans, the speed and the scale of changes will tie up considerable staff and capital resources, thereby destabilizing health services and making it impossible to maintain the level of care. Some commentators have expressed concerns about the possible fragmentation and duplication of services through the emergence of parallel public, private and charitable providers and, consequently, inflationary volumes of health services and expenditures.

Even amongst GPs who have called for more clinical orientation of the commissioning process within the NHS, there is widespread concern that they might not be qualified for the financial and administrative responsibilities of commissioning services. Some fear losing popularity with their patients by having to take on NHS management roles.

In the second hearing in the House of Lords on 12 October 2011, some critics focused on the lack of attention provided in the bill to ensure the means for proper public participation and democratic legitimation of the new structures such as the clinical commissioning groups, the NHS Commissioning Board and Monitor. Others argued that the bill's main concern was tackling costs – a comparatively well-performing domain of the English NHS – and did not propose measures designed to improve variations in health outcomes.

It seems that two main scenarios may lie ahead for the commissioning reforms. One would lead to a more heavy-handed governance set-up through a strong regulatory NHS Commissioning Board. The other would require local commissioning groups to take up entrepreneurial and leadership roles, in some ways reverting to GP fundholding's attempts to engage clinicians in helping to manage the services.

2.4 Finland

2.4.1 Governance model and recent changes

The Finnish government's central role is legislating, guiding and providing block grants to municipalities. Decision-making related to the organization, provision and funding of health and social care is delegated to the 336 municipalities, which have a strong tradition of local democracy (Koivusalo, 1999). Their competencies have increased progressively as central government has shifted from a steering role towards a guiding role. For example, in 1993,

municipalities were given the authority to decide upon the provision and financing of services whilst central government was responsible for defining the general conditions (e.g. for contracting out and patients' cost sharing) (Koivusalo, 1999). Financing was changed from earmarked state funding for health towards a system whereby the state provides municipalities with block funds to cover health and social care. Municipalities were empowered to raise additional funding. Since then, Finland has operated a multichannel financing system funded mainly by municipalities through a combination of municipal taxes, state subsidies and user charges; and a rapidly growing occupational health care system that provides additional coverage for the employed population, giving easier access to primary care and outpatient specialist services.

2.4.2 Policy challenges and priorities

Finland was hit heavily by a steep economic depression in 1991. This led to a marked decline of total health expenditures in real terms and in public expenditures as a share of total health expenditures. Total expenditures as a share of gross domestic product (GDP) remained relatively stable until 1995 but started to decline substantially thereafter. The decline in state funding was compensated for by an increase in private funding through user charges and the abolition of tax deductions on medical expenses. The low per capita spending on health care in the mid 1990s and early 2000s (in comparison to other Nordic health care systems) has thus been subject to ongoing policy debate, especially during the past decade. Overall per capita spending has increased markedly over the past five years, but there are substantial differences between municipalities.

The small size of numerous municipalities and the small funding pools available to cover costly interventions are also problematic, leading to the creation of municipal federations and governmental equalization processes such as cross subsidies. The small size of the municipal population covered and major differences in catchment areas and geographical access have also led to concerns about equitable access and efficiency. The quality of health and social services has caused particular concern since municipalities have progressively opted to introduce user charges to cover health care expenditures. Large differences in purchasing power and municipalities' capacity to purchase care from the 21 hospital districts and private health and social services providers – and the fact that smaller and remote municipalities simply lack choice (e.g. for accessible hospitals) – further exacerbate the differences between municipalities.

Finland has also seen the emergence of parallel coverage and provider structures. For example, employees have double coverage – as recipients of entitlements due from occupational health and those due to residents of municipalities.

These duplications have been exacerbated by problems in aligning the new municipalities' competences with the country's fundamental values of equity and universalism.

The public/private mix in health care has seen no major shift in policy priorities. Regarding financing, the mechanisms around multichannel financing have progressively led to an increased share of private funding sources over time. Private provision of primary care has been subsidized by the state with the objective of increasing consumer choice of care providers. Municipalities have experimented increasingly with outsourcing provision in primary care and it is increasingly common for them to contract specific services segments from the private sector (e.g. for certain low-risk operations such as cataract surgery). Voucher systems are common, enabling patients to purchase care from the providers of their choice, and choice of a private provider is likely to yield higher user charges. Within the Finnish health care system, private care models have evolved incrementally and somewhat experimentally as an alternative way towards public integrated provider structures. This is partly to tackle shortages in public sector staff and partly to test out efficiency savings. To date, they have not been developed as an explicit strategic priority of the Finnish health care system.

A transgovernmental "productivity programme" in 2006 and 2007 had an explicit objective to reduce administrative costs of the governmental apparatus by reducing the number of staff simply by freezing posts that became vacant due to retirement. The reform was implemented across all governmental legislative and executive services.

It should be noted that, in general, decentralization of health care responsibilities is widely accepted in Finland. The population is dispersed and therefore values local decision-making and accountability structures – any reversal of this is politically difficult to implement.

2.4.3 Tools

Major changes in Finland are usually achieved through law.

One of the most visible tools to address concerns related to unequal access, waiting times, the availability of human resources and differences in care standards was the 2001 government-initiated project to ensure the future of health care. This resulted in an agreement by which national government would increase the level of state subsidies to municipalities and municipalities would work towards a number of structural changes and a set of new care standards (Vuorenkoski, Mladovsky & Mossialos, 2008). The agreement also resulted

in waiting time limits on 270 diagnostic categories, with unified nationwide criteria in hospital and primary care.

The government has also been able to tackle fast-growing expenditures within the pharmaceutical sector by introducing a reference price system to regulate prescriptions of generics – in the face of fierce opposition from pharmaceutical companies.

Reconfiguration of municipalities has been a major instrument for counteracting the negative consequences of decentralization. In 2008, many municipalities were too small to secure sufficient skill mix, resources and infrastructure for providing services – more than 75% of municipalities had fewer than 10 000 inhabitants; 20% had fewer than 2000. The previous government substantially reduced the number of municipalities from 415 in 2008 to 336 in 2011, covering a minimum of about 20 000 people. This process has been fairly smooth, partly due to the support of the Finnish Centre Party that is particularly strong at rural municipal levels. The current broad coalition is striving for a much more radical change.

The recent Health Care Act of 2011 introduces patient choice on the primary care centre, the family physician and nurse, and on public hospital for treatment.

2.4.4 Impact

The governmental productivity programme mentioned above has substantially reduced administrative costs at both national and regional level but, in turn, municipalities have had to strengthen their administrations. In addition, simultaneous downsizing of legislative and executive capacity at central government level was accompanied by substantial upheavals in capacity at the level of institutions operating at arm's length of government. For instance, in 2005 the Ministry of Social Affairs had a small team of about 70 core staff for health but the merger of the National Public Health Institute and the National Institute for Health and Welfare created a core staff of around 1000. Institutional changes over time also created upheavals in institutional governance arrangements at national level. For instance, the remit of a national institute responsible for professional regulation was first extended to social services and then to certain areas of public health, before being shifted back to the level of the provinces. The Finnish Medicines Agency is a national institution that is struggling with an explicit decision for it to be relocated away from the centre – the decision to move its headquarters from Helsinki to Kuopio in three stages up to 2014 makes it more complicated for the institution to operate at arm's length from government and, more importantly, to recruit qualified professional staff.

The current system leaves municipalities in charge with a high degree of autonomy. Finns show high satisfaction with their services which are still associated with low costs in comparison to other European countries within a similar income spectrum. However, municipalities' stronger remit has created tensions concerning the limitations on central subsidies for the municipalities and the centrally defined obligations. Municipal authorities have repeatedly called for higher levels of subsidies in order to fulfil these obligations in the past. In effect, this has increased the Ministry of Finance's role in steering the system. The weakening of the Ministry of Health's steering role has also left a gap in strategic national leadership role for health policy. Overall municipal investments, human resources recruitments and expenditures have focused heavily on the secondary and tertiary care sectors and on the occupational health sector which has tended to promote private providers and more specialist care settings. The municipalities' autonomy in steering the provision of care meant that the state was unable to intervene effectively in this development. For instance, central government's 2005 initiative to introduce regulations for providing specific maternal and child care services within the municipal primary health centres took more than three years of negotiation between central government and the municipalities and doctors. Overall, the heavy focus on specialist care has compromised Finland's reputation as a leader of primary care in Europe.

The waiting time limit is considered a major achievement that has substantially reduced both lists and times in hospital and outpatient specialist care. The policy has been less successful in primary care owing to substantial challenges remaining in recruitment of the primary care workforce.

2.4.5 Conclusion and outlook

Arguably, the health care system in Finland has seen a higher degree of decentralization than in most other European countries. Some commentators have pointed out that the resulting problems (e.g. inequalities in financing, access and quality of care) may have outweighed the advantages associated with local responsiveness of policies covering the health and social needs and preferences of the people, accountability and local participation. Yet, following the pendulum principle, the trend toward decentralization is currently reversed. This is partly to address some of the challenges of decentralized administration. For instance, the governmental programme for the restructuring of municipalities and services decreased the number of municipalities. The national government has also fostered increased cooperation between municipalities; reduced the number of central hospital districts from 22 to 18; and introduced national criteria for waiting time limits. Further central-level regulation is expected to

focus on legislation on care of the elderly and primary care, which so far has been rather piecemeal.

The April 2011 election changed the political landscape in Finland, with the National Coalition Party and the Social Democratic Party becoming main players in the six-party coalition government. This government has proposed a substantial further merger of municipalities towards an average population size of 100 000, thereby reducing the number of municipalities from 336 to about 53. It is not yet clear how this reform would be implemented and whether it would be accompanied by further principal changes in governance arrangements. For now, the strongest opposition party (the Centre Party) has presented great resistance to this reform.

2.5 France

2.5.1 Governance model and recent changes

The French system is characterized by strong state regulation. Traditionally, planning and regulation involved negotiations between the representatives of providers, social health insurance and the state but the latter's role in planning has increased over the past two decades. The system remained fairly stable until the 1990s. Reforms in the last two decades have attempted to devolve planning responsibilities to the regions. The 1996 reform (called the Juppé reform after the Prime Minister at the time) empowered the 26 regions to undertake hospital planning. As a consequence, several regional institutions were created to represent the main stakeholders. These included representative bodies of the social health insurance funds, representatives of health professionals and public health actors. This resulted in regional planning work becoming somewhat dominated by the partial interests of individual actors. The 2009 Hospital, Patients, Health and Territories Act (*Loi hôpital, patients, santé et territoires*, HPST) tried to tackle this by merging the majority of these actors into 26 regional health authorities (*agences régionales de santé*) leading to more integrated institutions cutting across the boundaries of health care, public health and social care.

2.5.2 Policy priorities

As in many other European countries, a lack of coordination of care and system inefficiencies have contributed to escalating costs and made it rather difficult to deliver on the principal objectives of the French system listed in the 2004 Health Insurance Reform Act. These include: universal and equal coverage; equitable access to care; fairness in finance; and continuity, coordination and

effectiveness of care (Chevreul et al., 2010). France's health system is among the top five in the world in terms of per capita expenditure and health expenditure as a share of GDP. However, this level of expenditure becomes problematic in times of troubled economic performance and growing public deficits.

Important priorities justifying strong central-level stewardship include fairness in financial contributions to care and minimizing the risk of financially grounded exclusion from care (e.g. by granting free access to voluntary health insurance or providing low-income patients with vouchers to cover user charges). Regional health authorities were introduced based on policy objectives of simplifying and improving regional governance; ensuring policy coherence and better tailoring services portfolios to population health needs; facilitating continuity between different sectors of care, especially to meet the increasing demand for long-term care; and increasing regions' power to tackle inequalities in health care access in their catchment areas.

The 2004 Public Health Act was introduced with similar intentions to improve coordination and consistency in public health policies, but at national level. This put forward 100 health priorities which were translated into targets and indicators for each social security branch in the so-called quality and efficiency programmes. Programmes in the health insurance branch aim to balance access to health insurance benefits, ensure adequacy of health insurance coverage to meet population health needs, provide efficiency in the provision of insurance benefits and work towards financial sustainability (Chevreul et al., 2010). They include four programmes, on: (i) equal access to care with targets to reduce physicians' extra billings; (ii) five preventive health targets; (iii) enhancing quality of care with targets for improving GP referrals, reducing waiting times, improving availability of primary care on a 24-hour basis, reducing hospital-acquired infections, increasing the number of accredited health care institutions and enhancing professional appraisal; and (iv) improving efficiency and control expenditure with targets on, for instance, drug prescriptions and use, sick leave compensation, and elective procedures performed in outpatient settings.

Policy priorities in hospital care in recent years have aimed mostly at increasing productivity and efficiency in hospital care. The 2009 HPST Act aimed to introduce a DRG-based payment system in hospitals and allow more flexibility in the management of public hospitals. In practice, the DRG system is more a budget distribution instrument with opaque tariff-setting mechanisms and public hospitals do not have sufficient autonomy to plan their staff, for instance. Competition amongst public and private hospitals is to be promoted by introducing a common funding structure by adopting similar DRG tariffs, originally by 2012 but recently postponed to 2016. There is much ongoing debate about whether this will improve efficiency, especially since the DRG

system has so far led mainly to an increase in hospital activity with little change in medical and resource management (Or & Bellanger, 2011).

2.5.3 Tools and debates around them

In spite of regions' stronger role in previous years, the Ministry of Health, the government and parliament remain the most powerful regulatory and policy-making institutions. This role has further strengthened in recent years. Following the 1996 reform, the parliament was mandated to approve the national ceiling on annual health insurance expenditures and the revenue side of the budget.

The 1999 Universal Health Coverage (*Couverture maladie universelle*, CMU) Act is another central-level steering device that has regulated basically free access to voluntary health insurance for low-income groups by providing either free voluntary insurance or a voucher system that removes the need for out-of-pocket payments.

The 2000 Social Security Finance Act transferred responsibility for hospital policy from social health insurance to the state. The Health Insurance Reform Act and the Public Health Act (both 2004) furthermore changed the governance of the system by increasing parliament's role in setting the above-mentioned health priorities and establishing national management of social health insurance. Parliament also acquired a new role – the Alert Committee is activated when the social security deficit reaches a predefined threshold. Stricter control on tariffs was enforced – although these are negotiated between providers and social health insurance representatives, the Ministry of Health grants final approval. Furthermore, the reform formalized a gatekeeping system imposing financial disincentives for accessing services directly without prior consultation with a preferred doctor.

Quality of care is another area increasingly determined by national policy, using a plethora of tools. A national policy requires hospitals to undergo certification every four years and all health professionals must provide proof of regular continuous training. National agencies have been developing mandatory practice guidelines and good practice commitments have emerged between collective representatives of health professionals and social health insurance. Sanction fines for non-compliers initially accompanied these commitments but there is now a trend towards establishing a pay-for-performance scheme based on good practice targets for individual doctors. Individual practice contracts for practice improvements were introduced in April 2009. The contract uses a voluntary pay-for-performance incentive to achieve efficiency targets in primary care, in which the prescription of generics and of low-cost statins received much

public attention (Chevreul et al., 2010). GPs who sign the contract can increase their annual income by a maximum of €6000 annually. Over 50% of all free practising doctors are eligible for additional payments for achieving targets but, so far, there appear to be no major behavioural differences between the GPs practising under the new contracts and those who are not (Or, 2010).

In recent years the government's strong health policy role has triggered the establishment of high-level advisory bodies such as the High Council for the Future of Health Insurance, the High Council of Public Health and the National Health Conference. In 2004, the National Authority for Health was established to support quality and equal access to care, independent of government. Reporting to government and parliament, this organization provides assessments on drugs, devices and procedures, accredits health care institutions, certifies professionals and publishes clinical practice guidelines.

The 2009 HPST enacted the merger of health care, public health and social health insurance funds at regional level with the objective of identifying health needs and establishing priorities at local level with the major stakeholders including hospitals, self-employed health professionals, public health decision-makers, patients' representatives and representatives of the state and social health insurance (Chevreul et al., 2010). The law was implemented in 2010 by establishing 26 regional health authorities with the mandate to coordinate outpatient ambulatory care, hospital care and long-term care for elderly and disabled people within their catchment area. They are responsible for developing strategic regional health plans that spell out criteria and targets for the provision of care. The strategic health plans are based on epidemiological and demographic profiles of the catchment population and indicators for the utilization of care. They are designed to provide the framework for any services planning and tendering conducted at regional level. Regional health authorities can rationalize and, for instance, now have the power to close or merge hospitals. As part of their mandate, regional health authorities also have more influence on workforce planning and distribution – for instance, setting legal provisions for the transfer of tasks between health professionals and providing recommendations for the *numerus clausus* for medical school admission in accordance with current and projected regional health needs. In theory they can also optimize the distribution of health professionals by providing financial incentives for professionals to serve in under-supplied areas. In practice this happens rarely since the regional health authorities lack the necessary budgetary resources. Thus, although the reform aimed to increase regional health authorities' autonomy in service-related planning, in practice there are still limitations on capacity and the budgetary resources required to act on this in health services planning.

The degree of power given to the new regional health authorities, and especially their directors, in the 2009 HPST was the subject of some debate between the Ministry of Health and the social health insurance funds. The Senate's Social Affairs Committee consequently advised the government to limit the remit of regional health authorities towards implementing "nationally defined priorities". These proposals were rejected but the original plans were amended to concretize the terms of reference covering regional health authorities and their directors – increasing the mechanisms of accountability and allowing non civil servants to apply for the position of regional health director (Or, 2009). One key concern of those who remain sceptical of the reform is that appointment of a regional health director or a public hospital director requires the prior approval of the Ministry of Health and that these directors are accountable to the state. In practice, this means that regional autonomy may be limited and any regional decision-making can potentially be overruled or undermined by the central authorities (Or, 2009).

2.5.4 Impact

The French population enjoys good health with high life expectancy and longevity, low infant mortality and comparatively low prevalence of cardiovascular diseases and obesity. Most are relatively satisfied with the system.

Several factors explain why the introduction of the gatekeeping system did not result in major changes. One is that gatekeeping reflected existing patterns of utilization of transferral through a preferred doctor. In addition, incentives for doctors to act as effective gatekeepers have produced inconclusive results – for instance, gatekeeping is not addressed systematically in medical education and the financial incentives for acting as gatekeepers remain weak. Some essential specialties were excluded from the transferral scheme (dermatology, gynaecology, paediatrics, ophthalmology and psychiatry). In reality, access outside the referral scheme has been granted, basically without sanctioning the consequences (Chevreul et al., 2010).

The CMU scheme has not yet entirely achieved its objectives to remove financial barriers to access of care. Some physicians refuse patients under this scheme, partly because they have no possibility for extra billing beyond the tariffs reimbursed by the insurance companies. There is also concern that the deductibles on medical consultation, ancillary care, transportation and drug problems will increase access problems. Overall, the reforms aimed at tackling inequality in access to care do not appear to have yielded the expected results as yet. For instance – in 2006, 14% of the population aged 18–64 years was reported to have forgone health care in the last 12 months for financial reasons;

this share amounted to 16.5% in 2008 (Allonier, Dourgnon & Rochereau 2008, 2010).

The setting up of the Alert Committee in 2004 and new statistical monitoring procedures for the health insurance expenditure budget have started to show an effect as the size of the budget overrun has started to decrease up to 2007.

2.5.5 Conclusion and outlook

The system has undergone a fair amount of governance reforms in recent years but the Ministry of Health has retained substantial control over the health system. The national health priorities first adopted for the period 2005–2009, the succeeding priorities for 2010–2014 and the new provisions for the governance and surveillance of social health insurance at national level have re-emphasized the central-level governance model based on central government leading and setting directions for the health care system. But ongoing reforms at regional and national level may challenge this traditional role in future. In particular, the 2009 HPST empowered the regions to take a more integrated approach towards health financing and the delivery of care. The regional health authorities have now become more important actors in governing ambulatory care, hospital care and the so-called third sector – the health and social sector (Chevreul et al., 2010). There are still very high numbers of administrative stakeholders at national and local level and it is not yet apparent what effect the new arrangements will have on the traditional challenges of the French health care system (e.g. how to coordinate care effectively between the different health care sectors and numerous players; how to sustain the level of care given the high level of expenditures).

The big question is how the regional health authorities will interpret their new role. Will they micromanage? Will they have sufficient authority and leverage for action? Much will depend on the leader of each health care region.

2.6 Germany

2.6.1 Governance model and recent changes

In Germany, responsibility for the health system is divided between central government, the federal states and self-governing bodies. The latter are corporatist health care providers and social health insurers, usually legitimized through social elections held every six years – members of the health insurance funds elect representatives on the decision-making boards of the health insurance funds. The subnational players have traditionally held a powerful policy-making role but central government has gradually enhanced central-

level control over social health insurance financing and the provision of services. A national social health insurance fund (*Gesundheitsfond*) was established in 2009 and has centralized the collection of all social health insurance contributions. At the same time, the level of social health insurance contributions was fixed nationally and applied uniformly to all social health insurers for the first time.

Under a new law on health care provision, some planning of highly specialized ambulatory health care services will be moved from the association of ambulatory care physicians working under social health insurance conditions and shifted to new planning agencies at *Länder* level. This is intended to influence the establishment of specialized medical practices towards geographically remote areas (in essence, rural areas and the eastern *Länder*). Public health emergency planning is also seeing a gradual shift of traditional responsibilities from regional to central level. Within the corporatist actors, the trend is towards progressive merging and centralizing of administrative units.

2.6.2 Policy priorities

Overall, policy priorities of the German social health insurance system are determined by the need to balance the insured's choice of insurers and health care providers and macroeconomic concerns over social health insurance expenditures. The objective to ensure consumer choice has contributed to the promotion of market competition between insurers in the past and has also provided the basis – albeit less explicitly – for the modest promotion of competition amongst providers in both hospital and ambulatory care. The Christian Democrat and Liberal coalition government intended to reinforce competition in 2009 by setting contribution rates centrally but introducing the option for funds to levy and collect a surcharge to health insurance contributions in order to cover their excess expenses. This surcharge was limited to a maximum of 1% of the contribution-relevant income from 2009 until 2011 when the limit was removed. In addition, a special exit condition was granted for members wishing to change funds so that the additional surcharge has not become subject to price competition between funds. Individuals whose average surcharges exceed 2% of their gross income are granted lower contribution rates, covered by general taxes. Additional surcharges levied by sickness funds were expected to promote efficiency of the funds since it was expected that surcharges would become an important criterion leading members towards the more efficiently operating funds. In addition, the Social Health Insurance Financing Act (*GKV-Finanzierungsgesetz*, GKV-FinG) aimed to separate labour costs from health expenditures by capping health insurance contributions at 15.5% and increasing employees' share (Bäumler, Sundmacher & Zander, 2010). The introduction of the social health insurance fund in 2009

was motivated by the intention to increase government influence on health insurance finance, by enabling tax subsidies.

The progressive merger of health insurance funds and the creation of a single lead organization (*Spitzenverband*) of sickness funds is motivated by the objective to increase transparency, reduce fragmentation in decision-making and make collective contracting more efficient. Improvement of the coordination of care was another key objective that drove the introduction of disease management programmes (DMPs) in 2002.

2.6.3 Tools

Created in 2009, the national social health insurance fund has been one of the most fundamental financing reforms of the German social health insurance system in the past decade. The fund has centralized the pooling of social health insurance contributions of all social health insured members (88% of the population) which were previously collected and pooled by individual health insurance funds. The social health insurers continue to collect contributions from their members and pass these on to the national fund. Funds are reallocated to the social health insurers based on a standard average cost (€15 per month per insured) and the age, gender, employment status and morbidity patterns of the insured. The risk compensation scheme for the morbidity structure relates to 80 well-defined chronic cost-intensive diseases and is identified through hospital discharge data and diagnostic data of ambulatory care physicians. In addition, data on prescribed medicines are reviewed in order to differentiate the severity of diseases. A standard contribution rate (15.5% of gross income, up to an income ceiling) was set initially. The second economic stimulus plan contained a further tax-based injection of funding which lowered the contribution rate to 14.9% during the financial crisis in 2009 but the contribution rate was returned to 15.5% in 2010. The share of the insured amounts to 8.2%; the employer share is 7.3% and fixed. The government loan subsidy to the social health insurance scheme fluctuated between €15 billion and €14 billion from 2009 to 2012. Establishment of the new national fund facilitates more centralized monitoring of social health insurance revenues and increases the opportunities to effect transfers from taxed sources.

The majority of self-governing actors have moved towards more concentrated governance structures over the past decade. One of the most prominent national decision-making institutions for the social health insurance scheme is the Federal Joint Committee (*Gemeinsamer Bundessausschuss*, G-BA) (Smith et al., 2012). Established in 2004, this is the highest decision-making authority of the self-governing physicians, dentists, psychotherapists, hospitals and sickness funds in Germany. The G-BA comprises 13 members – an independent chair;

5 representatives of providers; 5 representatives of insurers; and 2 independent members who are meant to serve as mechanisms to solve conflicts between the participating representative parties. Patient representatives participate without voting rights. The G-BA is responsible for defining the benefit package for social health insurance on the basis of systematic reviews – partly provided by the Institute for Quality and Efficiency in Health Care – on the costs, benefits and cost-effectiveness ratios of pharmaceuticals and medical interventions. There have been a number of recent considerations to increase the democratic legitimacy of the G-BA – one current parliamentary debate focuses on the proposal for political nomination of representatives.

The notable merger of sickness funds – reducing their number from more than 960 in 1995 to 153 in 2011 – is a development explicitly intended by the government. The majority of sickness funds are now organized at national level with central decision-making processes; subnational units have mostly administrative roles. The *Spitzenverband* of sickness funds was created through a merger of several lead organizations and started operating in 2008. It now operates as the central governance institution representing all 153 sickness funds and thus the interests of close to 70 million German people covered by social health insurance. The organization has advisory functions for federal and state parliaments and federal governments, is a member with voting rights of the G-BA, and a key negotiator for both collective and individual contracts under social health insurance. Mergers of funds are ongoing to date. For instance, the German Sickness Fund for Employees (DAK) and a company based sickness fund (BKK Gesundheit) merged in January 2012 to form DAK Health. Insuring about 6.6 million people (5.1 million members and their dependents), this is now the third largest fund, following the BEK (8.5 million insured) and the TK (7.7 million insured). DAK Health has recently launched plans to eliminate the €8 surcharges in order to retain existing members and attract new members.

The 2011 GKV-FinG liberalized the per capita surcharge to cover health insurers' additional expenses as mentioned above. In addition, it eased the switching to private substitutionary health insurance by allowing individuals earning above €48 500 per year to opt out of social health insurance. Previously, individuals had to earn more than €48 500 in three consecutive years in order to be eligible for opting out.

In 2002, DMPs were enforced on the basis of selective contracting, initially for type 2 diabetes, breast cancer, coronary heart disease and chronic obstructive lung disease. This was later extended to type 1 diabetes, asthma and heart failure. Health insurance funds can contract providers selectively for the integrated management of the diseases following a protocol of

minimum requirements on treatment guidelines and referrals to specialists, quality assurance, documentation, provision of training and information to providers and patients, and evaluation three years post accreditation. DMP contracts are conducted selectively between sickness funds and GPs; patients are required to sign up for a specific provider in order to enroll on a DMP. Until the introduction of DMPs, sickness funds' incomes were redistributed based on insurers' average spending by age and sex. At the time the risk structure compensation mechanism did not take account of patients with chronic diseases so insurers concentrated on attracting the healthy. Following the introduction of the DMP, insured people received a higher payment under the risk structure compensation scheme and insurers were provided with a strong incentive to roll out DMPs to their patients. Until 2008, sickness funds received a higher share from patients enrolled in the DMP. As of November 2010, 5.9 million patients – around 7% of the members of the social health insurance scheme – were enrolled in DMPs and more than 60 000 providers were participating.

2.6.4 Debates and expected impact

Introduction of the national health insurance fund has been one of the most important changes in the governance structure for social health insurance. The fund emerged as a compromise between two different fundamental reform models for health insurance in the national election campaign of 2005. The Christian Democrats' concept is a capitation-based uniform scheme for all social health insured citizens. It includes a tax-funded insurance scheme for children and tax subsidies for low-income individuals but retains substitutionary private health insurance. The Social Democrats favour an income-based model of the whole population (see Section 2.6.5).

Some experts have argued that the fund works against transparency by making it more difficult to track the flow of funds from sickness funds to the national fund and from the national fund to individual insurers. In addition, some have claimed that the morbidity structure compensation mechanism might lead to sickness funds positively selecting health risks eligible for compensation payments. However, a scientific evaluation of the risk structure mechanism launched in September 2011 concluded that the morbidity structure compensation mechanism has not led to a disproportional allocation of funds according to the morbidity risk structure of the insured (Drösler et al., 2011). There was also concern that the solidarity fund would establish an additional administrative layer, thereby leading to higher administrative expenditures and more bureaucracy.

The introduction of the fund coincided with the financial crisis of 2009 and the German government's two consecutive economic stimulus plans. The first stimulus package contained a lowering of the contribution rate to 14.9% in order to lighten employers' social insurance costs and to stimulate consumer consumption. Thus, the financial crisis became the first successful test case for the solidarity fund, making governmental authority to interfere in funding of social health insurance contributions more acceptable to previous critics (mostly representatives of the health insurance funds).

A relatively small number of health insurance funds claimed surcharges from patients or reimbursed part of the paid contributions but this has led to a substantial shift of insurance membership. For instance, DAK Health lost 460 000 insured during 2010 following the introduction of an €8 surcharge. The winners were those funds without surcharges such as the GEK, TK and the IKK.

Since the introduction of the national health insurance fund in 2009, one sickness fund has been closed – City BKK had recorded ongoing financial difficulties over several years and raising the surcharge of €15 per month resulted in substantial membership exits. The Federal Insurance Agency announced the closure of a second fund – the company based insurer BKK insuring health professions – by the end of 2011.

The GKV-FinG has been highly controversial. Opponents such as the opposition parties, unions, social associations and the media have raised concerns that the surcharges in social health insurance and the strengthening of private health insurance may foster inequalities in financing, access to care and the provision of services. The latter is an anticipated effect of strengthening the private insurance sector which might provide incentives for providers to prioritize their services for the privately insured, as these are subject to higher reimbursement rates than services provided under social health insurance conditions. The political opposition has argued that the GKV-FinG will place more emphasis on competition by price rather than quality. The latter was the intention behind the introduction of equalized contribution rates in 2009.

Defenders of the reform claim that the new compensation scheme that applies to individuals paying more than 2% of their gross wages or salaries is more equitable since the tax subsidy to compensate for their lower contribution rates is funded out of general taxation, not from social health insurance contributions alone. Some health economists have pointed out that the combination of income-dependent and flat-rate fees will promote fragmentation in the sources of funds and pooling and make health insurance funding more regressive.

Overall, most commentators agree that the GKV-FinG is unlikely to influence the sustainability of health insurance financing in the longer run.

2.6.5 Conclusion and outlook

The German social health insurance system has moved gradually towards more central governance approaches, deploying two main strategies. The first is to centralize and further empower the corporatist governance arrangements of the self-governing actors. Prominent examples of this strategy include increasing the G-BA's decision-making power for coverage decisions in the social health insurance benefit basket through the G-BA; centralization of lead organizations of health insurance funds; and the progressive merger of insurers to create more powerful negotiators vis-à-vis providers. The second strategy is to strengthen national-level regulation of certain aspects of health insurance funding – for example, through the national health insurance fund and the standardization of the contribution rate. Notably, the objective to sustain consumers' choice of insurer and providers has so far accompanied most reforms. This will likely continue since choice in health insurance and health care has been a German citizen's consistent privilege throughout different governments and seems politically difficult to remove.

It is likely that the debate around a more universal form of statutory insurance will be revitalized in the near future. The Social Democrats are currently developing plans for a citizen insurance that would apply to the whole population and restore the 50:50 contribution rate between employers and employees. Likely, this would lead to an exodus from substitutionary private health insurance since well-paid Germans (earning above €48 550 per year), civil servants and/or the self employed (except those already enrolled in private health insurance) would no longer have a choice between the private and the statutory schemes. In addition, private health insurers would be obliged to offer a basic scheme with regulated premiums. In this model, contributions would continue to be income-related but employees' total incomes – salaries and any extra incomes excluding capital incomes and rents – would contribute to the scheme. The model would also reinforce the competitiveness of the social health insurance market by removing the uniform contribution rate. The morbidity-related risk structure compensation mechanism would be extended to cover many more diagnoses.

The Christian Democrats continue to defend their more liberal model, allowing private health insurers to provide substitutionary insurance as before but introducing capitation-based contribution rates with state subsidies for low-income families.

2.7 Italy

2.7.1 Governance model and recent reforms

Italy has a tax-funded health system with a predominantly publicly owned and operated hospital system. In the early 1990s, the 19 regions and autonomous provinces assumed the principal role in funding and delivering health care in Italy. Regional health departments are responsible for providing the delivery of a nationally set standard basic benefit package through a network of outpatient facilities (local health enterprises) and private and public hospitals. The national government sets out the objectives and basic principles of the system and is responsible for regulating the pharmaceutical market and monitoring the consumption of pharmaceuticals. Since the 1990s, reforms have aimed at enforcing balanced regional budgets; standardizing clinical practice through a national clinical guidelines programme and electronic patient records; and delegating managerial autonomy to hospitals and local health enterprises (Lo Scalzo et al., 2009).

2.7.2 Policy priorities and tools

A major shift of responsibilities occurred in 1997 when regions were empowered to set their own reimbursement rates; allocate and withhold public funds; and set quality standards in addition to those set at national level. The downward shift of fiscal and decision-making responsibility took place in a broader context of political devolution in most social policy domains. At the subnational level, powers have been concentrated in the regional health departments whilst the power of provinces and municipalities is negligible. At the same time, hospitals and local health enterprises have gained more decision-making autonomy in their management, finance and administration through the creation of NHS foundation trusts in the 1990s. This was motivated by the intention to introduce some market competition between public and private providers aimed at increasing efficiency in management and the quality of services. However, these expectations were not fully achieved owing to the different pace of implementation in different regions and fragmentation in the internal market (Lo Scalzo et al., 2009). This has been somewhat reversed recently by creating single management and administrative boards covering several providers.

The national government introduced a national solidarity fund with the aim of subsidizing regions that were unable to cover the basic benefit package (the southern regions). Essentially this contained an equalization scheme to redistribute financing to regions on the basis of geographical criteria and population size; the population's health care needs; and fiscal capacity to rectify the ongoing differences in the provision of services between the centre-north

regions and the south. However, this was not implemented as planned owing to disagreement over the redistribution formula (Lo Scalzo et al., 2009).

There is still a notable trend for national government to assume an increasing steering role and control of regional financial performance on cost containment. This is illustrated by two recent developments. First, since 2009 the central government has had the mandate to appoint an external commissioner responsible for working with regions that are overspending their budget targets or break the nationally defined financial rules. These regions are required to develop and adopt regional recovery plans that spell out the activities planned to recover their regional budget deficits and improve their financial situation. The commissioner is required to monitor progress towards implementation of a region's recovery plan, influence this process as necessary and provide technical support. Thus this process sets out a new collaborative agenda between national government and the respective regions, with disciplinary consequences for non-compliance. It has enabled increased governmental interference in regions' autonomy to fund and plan health care services. Since 2009, several of the regions have had to adopt recovery plans and collaborate with the commissioner.

A second emerging, albeit not yet implemented, issue is a new scheme to set the prices of health services of hospital, community and public health services according to the best performing regions at national level. According to the scheme, standard costs will be set at the level of the average services costs of the regions performing best on health care expenditure targets. The introduction of this scheme is highly controversial, not only because it will further dilute the regions' powers to set their own prices but also because it will inevitably give fewer resources to the under-funded regions.

Agreed between the national and regional governments in 2009, the National Health Plan 2010–2012 puts forward a monitoring process and introduces a set of new standards to monitor regional performance on topics such as clinical costs, personnel and hospital admission rates.

There is a strong role for pharmaceutical regulation and coverage decisions on pharmaceuticals on a national scale but HTA and priority setting for interventions are not taking place on a national scale. Some northern regions (including Piedmont, Veneto, Lombardy and Emilia Romagna) are more active in using HTA to plan services and for reimbursement decisions. Only recently there has been a call for more interregional collaboration.

Care of elderly people and of people with disabilities is a major issue for the ageing Italian population. Coordination and integration is still underdeveloped, partly owing to a backlog on the policy commitment to provide a strategic frame for service provision of long-term and palliative care by a wide range of

providers with different institutional arrangements including residential, partly residential and community home care. The National Health Plan 2010–2012 introduces a commitment towards a programme to develop new regulations for elderly people and home care.

So far there is very limited interregional collaboration in service provision. Yet the autonomy of the regions has made it difficult for central government to steer towards more uniform levels of quality, volumes of care and health care funding.

2.7.3 Impact

Empowerment of the regions was accompanied by the separation of responsibilities for health care funding and for spending powers. This has caused continued disputes between central government and the regions. Whilst the national government determines the scope and depth of the basic benefit package and (re)allocates funds to the regions, the regions are responsible for ensuring that their financial resources are sufficient to provide the standard package. However, funding from national government favours regions with strong industrial and income bases and less economically productive regions are left with difficulties in covering the basic benefit catalogue. These regions at higher risk of budget overspends or of failure to deliver the basic benefit package may need to levy additional taxes which in turn have negative consequences for business location. In addition, some regions have levied additional co-payments, increasing the regressivity of some regional fiscal regimes. Overall, northern regions have tended to achieve a better balance of their health expenditure accounts than southern regions.

In addition to the funding divide, north and south show substantial differences between facilities concerning the volume and quality of health services provided. These may have been exacerbated by the funding divide and led to substantial increases in cross-regional patient flows, particularly amongst patients seeking complex medical care in tertiary care hospitals in the past decade (Lo Scalzo et al., 2009). Patient satisfaction with hospital services has not fundamentally changed.

2.7.4 Conclusion and outlook

The high level of devolution of governance responsibilities in Italy and centralization of regional health departments' decision-making go hand in hand with large differences in expenditures, care availability, access, satisfaction and the quality of health care services between regions and lead to substantial

patient flows. These require cross-regional or national approaches but the willingness for interregional collaboration has been very limited so far.

There appear to be two possible options for the way ahead. The first would be to tighten national governance through (for instance) rationing and services exclusion, including the use of new fiscal equalization and transfer mechanisms or the introduction of incentives for regional alignments. The second would be further strengthening of regional governance arrangements by increasing interregional collaboration on health services, human resources or high technology planning; and interregional benchmarking. The recent trend towards more central-level control of regional health care expenditures through regional recovery plans seems to indicate the former direction. Early data show some cost control effects in 2011. In light of the national deficit budget and the financial crisis, these effects may substantiate further efforts to align regional financial performance such as setting reimbursement rates nationally, orientated on the financially best-performing regions. Yet, this also revitalizes the ongoing debate about the level of compensation for economically disadvantaged regions.

2.8 Netherlands

2.8.1 Governance model and recent changes

Formerly a traditional compulsory social health insurance model with private substitutionary insurance for high-income families, the Dutch health system governance structure has moved towards a system of competing insurers with a mandatory basic benefit package offered to the whole population (Smith et al., 2012). The reform has led to fundamental changes in the roles of government, patients, providers and insurers. The government retains a strong role but this has shifted from direct steering of the system towards regulation, oversight of competition and safeguarding standards in care. It took about 20 years for the Dekker Committee's proposal to introduce regulated competition to be translated into new health insurance legislation in 2006.

The new system is characterized by a competitive environment for both insurers and providers. Some commentators argue that insurers are the principal winners of the reform as they have substantially increased their potential for driving care. The reform has also affected consumers' choices (e.g. on supplementary insurance arrangements) but as yet there have been no substantial changes in consumer behaviour.

The emphasis on new market conditions has brought new requirements for regulation. Four national institutions at arm's length from government have

the most important regulatory role for the functioning of the Dutch health care market. The Dutch Healthcare Authority controls activities and costs and ensures the functioning of the insurance market by setting payment rates; imposing obligations on dominant actors with substantial market shares in both the insurer and provider markets; and ensuring transparency of the markets to patients and payers. The Health Care Inspectorate is the national institution responsible for supervising minimum standards for the quality of care. It also performs institutional accreditation as a contractual precondition for providers entering and remaining in the insurance market. The Netherlands Competition Authority ensures fair competition between insurers and between providers on the basis of the Dutch Competition Act of 1998. The Health Care Insurance Board advises the government on coverage decisions in the basic benefit package of the compulsory scheme on the basis of evidence on the cost effectiveness of interventions.

In addition, a number of intermediate agents – for instance, employers who obtain group contracts for their employees – have an impact on the governance roles and relationships between the different actors and the direction in which the current market model will evolve.

2.8.2 Policy priorities and tensions amongst different objectives

Many of the objectives concerning improved efficiency, consumer choice and patient quality and safety are consistent with a liberal governmental agenda. These are supported by both the liberals and the conservatives in the last government.

One of the fundamental objectives of the 2006 reform was to slow the trend in rising health care expenditures. There is a ceiling for public health care expenditure – floating around 10% of GDP. The insurance market was designed on the assumption that consumers would select their insurers on the basis of the premiums in combination with potential additional flat fees, the scope of supplementary insurance services provided and the nature of the contracted providers. It was assumed that this would translate into pressures on insurers to ensure that providers deliver efficient services at lower costs, thereby leading to a reduction in total health care expenditures. The decision to transfer responsibility to fund and manage long-term care services from the national to the local level is a very clear form of decentralization, grounded on expectations that local government can achieve greater efficiencies than insurers and thereby reduce pressures on the national health care budget.

In reality, the reform has created a tension between different policy objectives. Competition may have increased the institutional efficiency of individual

insurers but this has not translated into measurable cost savings at system level. For instance, the introduction of case-based payment schemes in the absence of volume caps has led to an overall increase in the volume of services. This has accelerated a substantial growth of health care expenditure as a share of GDP, an effect that had been underestimated with the introduction of the reform. Rival objectives may have also triggered some institutional tensions between the Health Care Inspectorate, the Dutch Healthcare Authority and the Netherlands Competition Authority. The former has argued in favour of concentration of medical care – for example, by merging hospitals to stimulate enhanced quality of care. This is opposed by the latter authorities who suggest that it might be anti-competitive.

Another tension that is difficult to disentangle concerns the desire to reduce bureaucracy while enabling more liberal administration of the market actors. This appears to conflict with the need to closely regulate, control and inspect the fairness of the market and to monitor the effects of any problems.

2.8.3 Tools

The Dutch *Health System in Transition* profile describes three markets emerging through the 2006 reform: (i) insurer; (ii) purchasing; and (iii) provider. In the insurer market, patients choose an insurance company which in turn has an obligation to offer a basic insurance package to its members and to accept any applicant for insurance. In this way insurers play a double agency role – as the agent of their members in providing individual insurance plans, and as the agent of the government in offering a nationally guaranteed basic package of benefits and coverage entitlements.

The purchasing market allows insurers some degree of negotiation on providers' volumes, prices and quality of services. Although selective contracting is a typical tool in this market, it has been introduced only gradually since negotiation on prices and quality has been fairly regulated and free negotiation applies to only a very limited number of services (Schäfer et al., 2010). However, from 2012, free pricing applies to about 70% of hospital expenditures. Selective contracts are unpopular with consumers as they constrain their choice of providers; insurers have therefore not made excessive use of them. A risk equalization scheme was introduced as a tool to tackle demand and supply side differences in health insurers' expenditures. For instance, insurers in Amsterdam bear higher costs due to higher numbers of people who are drug dependent and a more highly specialized provider portfolio than remote areas of the Netherlands where utilization of health care services is substantially lower.

In the provider market, providers offer services to patients on competitive grounds. Tools supporting insurance and patients' choice of providers are mostly associated with information. For instance, the Ministry of Health regularly publishes information on quality of care including survey information on patient experiences, prices and waiting lists. Providers compete for contracts with insurers through attractive care arrangements; and with patients on the basis of quality standards, competence and reputation, geographical accessibility and comfort factors.

Responsibility for certain types of home care – mainly long-term care of elderly people, people with disabilities and patients with chronic diseases requiring long-term care – was delegated to the municipalities in 2007 through the Social Support Act (Schäfer et al., 2010). This has increased the municipalities' role in governing long-term care. Most long-term care is covered through income-dependent contributions and regulated by the Exceptional Medical Expenses Act (AZBW). In future, funding and administration of the AZBW scheme will be implemented by the insurers on behalf of their insured members and formal legal rights to long-term insurance will be removed. Patient-bound budgets have enabled patients to manage their own long-term care supplies through either a personal budget or benefits-in-kind but these will be removed. Within the terms of the Social Support Act, municipalities are free to organize their services as required. Most municipalities have created special information and entry facilities to implement the Act's requirements but this has led to considerable variations in practice. Health insurers are responsible for purchasing long-term inpatient care but have delegated this task to special care offices.

Priority setting and rationing in the pharmaceutical sector is effected through the Medicines Evaluation Board that is responsible for assessing and ensuring the efficacy, safety and quality of medicinal products for market approval and reimbursement. The independent Health Care Insurance Board advises the government on insurance coverage decisions for medical interventions. Parliament must approve ministry of health proposals on changes to the basic benefit package. Decisions are guided by the "Dunning funnel" which defines four criteria (services have to be medically necessary or essential; effective; cost effective; and not affordable for individual citizens). Overall, the government has been trying to cut back more rigorously on entitlements in the basic insurance package and the AZBW. However, these decisions are unpopular and therefore political scope is very small and somewhat focused on preventive interventions applying to a small segment of the population. For example, medically assisted smoking cessation had become subject to a new co-payment but was removed from the basic package in January 2012.

2.8.4 Reform implementation, flaws and early impacts

The 2006 reform was implemented as planned, on the basis of concepts launched by the Dekker Committee proposals about 20 years ago. There was relatively minor resistance from providers and insurers, possibly due in part to the government's reliance on existing institutions to implement the reform. Anticipation of the reform, and a need for scale economies, had already produced some trends towards merging institutions to create larger organizations. Even before 2000, for instance, private and social health insurers merged into larger corporations to strengthen competitiveness and become more powerful negotiators in the system (van der Lee, 2000). As a result, the number of insurance companies decreased from 118 in 1990 to 32 in 2008 (Schäfer et al., 2010). Mergers have also driven provider structures as hospitals move towards larger organizational units with integrated multidisciplinary health professional teams, offering not only specialist care but also increasingly integrated primary care physicians and teams. Also, some 200 independent treatment centres now offer various forms of specialized care in addition to about 100 hospitals providing specialized care.

GPs can opt out of hospital organizations to work in polyclinics. They too are exposed to the need to organize in larger corporations which effectively means that single-handed practices have disappeared. In part, provider organization mergers have followed pressures on the financial position of health care providers that have borne increasing liability for capital costs and experienced higher financial risks. This indicates one effect of the more competitive requirements facing providers. Quality concerns have also been a factor leading to higher concentration of services in hospitals as they try to ensure that volumes are high enough to meet certain minimum standards. Progressive upscaling of provider organizations is beginning to take a toll on the functioning of the market as some organizations have started to take on monopoly positions. For example, a large provider organization in Zealand disputed the Netherlands Competition Authority's intention to intervene although the merger was eventually approved under strict conditions. This case exemplifies a fundamental challenge between market rules and the optimization of service capacities and infrastructures in the reformed governance arrangements in the Dutch health care market.

One underestimated effect of the reform has been the emergence of collective or group contracts between insurers and employees or special interest groups. Employers have emerged as intermediate agents between their employees and the health insurance companies. Insurers are attracted to employers who can ensure membership of a whole group of employees (usually with relatively good health risks), offering group contracts with premium discounts of up to 10%. In 2011, around 60% of those insured were members of a group contract.

Collective contracting may have constrained patients' free choice of insurer. This is supported by the observation that the number of persons changing insurers reduced from an initial 18% in 2006 to 3.6% in 2008 (Schäfer et al., 2010). Often younger people, the proportion changing insurers was around 5.5% per year in 2010 and 8% in 2011 (Brabers et al., 2012).

There is some indication that the uptake of entrepreneurial behaviour amongst insurers is slower than anticipated. For instance, since 2006 all insurers have operated under private law and are allowed to make profits and pay dividends to shareholders, but almost all still operate under non-profit-making conditions (Schäfer et al., 2010). Since 2006, insurers have frequently had to raise the flat-rate premium levels set in addition to the government-set contribution rates in the compulsory acute care insurance segment. This may have contributed to an increasing number of people (about 300 000 in 2011) who cannot afford to pay their premiums.

Expenditures have been affected in different ways. Total health expenditures increased by 16% between 2002 and 2005 but by 19.4% between 2006 and 2009 (Maarse, 2011). A higher public share (64.8% in 2005; 81.5% in 2007) can be explained by the abolition of substitutionary private health insurance since the entire population is now required to take out publicly financed health insurance (Schäfer et al., 2010). Growth in hospital expenditures is estimated to amount to 5% between 2005 and 2007, mainly due to the introduction of a diagnosis-related payment scheme in which tariffs were set too high. Expenditure for GP care was estimated to have increased to 17% in 2006 due to a change of payment system and an increase in the volume of care. There are also signs that the 2006 reform led to a profit decrease among providers, leading to a lack of solvency that exacerbated providers' financial risks. This may well be linked to the more contestable environment for hospital performance. Initially, insurers also suffered a loss on both basic and complementary insurance, partly owing to the efforts to minimize premiums with the expectation that many consumers would change insurers. Insurers have also experienced some financial uncertainties due to additional changes introduced in 2008, such as extension of the basic benefit package to include coverage of mental health, and a higher number of freely negotiable services. Overall, competition has put considerable pressures on the profit margins of insurers.

2.8.5 Conclusion and outlook

The current governance arrangements in the Dutch health care system are the result of a longer term strategy towards introducing managed competition in the health insurance and provider markets with consistency over different governments of distinct political composition. The 2006 reform fundamentally

changed the governance role of the health system actors. Central government's role in steering the system has been changed by transforming some bureaucratic state functions into more of a regulatory role, using quasi-independent regulatory agencies for various government functions. The health insurance companies, the Dutch Healthcare Authority and the Netherlands Competition Authority have taken greater control of acute hospital and primary care. Responsibilities for long-term care have been transferred to the local level. Long-term care is currently still financed out of the former AZBW scheme but there are plans to transfer negotiation of contracts with providers of long-term care from the regional agencies to health insurers. It has not been decided whether or not these contracts will be accompanied by financial risks.

Challenges have been increasing variations in quality of care indicators between the different providers. In response to this variation, a national quality institute is currently being established to integrate knowledge and issue best practice guidelines.

Another modification under consideration is the retrospective roll back of the risk equalization scheme between insurers. Yet, overall, the government seems determined to continue along the lines of managed competition. Continuation of the market reform was announced recently but the government is also likely to maintain expenditure control through fixed budgets. The way ahead will likely be a quest towards a compromise between free markets on one hand and central control on the other (Maarse, 2011).

2.9 Norway

2.9.1 Governance model and recent changes

Traditionally, Norway has been one of the Nordic health care models with a heavy focus on subnational governance structures – mostly publicly owned integrated health care providers – and a strong focus on equity (Magnusson, 2011). Primary care and long-term care are the responsibility of the 430 municipalities. Specialist health care was the responsibility of the counties until 2002 when the reform of responsibility and leadership substantially changed the governance arrangements (Magnusson, 2011). Before the reform, the 19 counties were responsible for managing specialist care, running hospitals and covering expenses out of unconditional block grants. Highly specialist health care was coordinated at the level of five regions, so that each region had a university or teaching-level hospital. In 2002, the state took ownership of hospitals. These were administered through five regional health authorities, organized as trusts and governed by an appointed board of professional trustees. Regional health

authorities were also empowered to undertake capital investments in hospitals within their regional budgets allocated by national government.

2.9.2 Policy priorities and debates

The 2002 reform was preceded by a number of problems in coordinating care with duplication of services at county and regional levels; budget deficits in the less affluent counties; and major geographical variations in access to care and utilization of services (Magnusson, 2011). Hence, one important policy objective of the reform was to improve geographical access to care and equity in utilization.

The multiple responsibilities of counties meant that health care was sometimes prioritized differently, resulting in major intercounty differences in infrastructure and spending. Many hospitals experienced budget deficits and therefore turned to their owners – the counties. The counties were bound to their priorities and so, in turn, looked to the state for help. This resulted in a so-called “blame game” chain from hospitals to counties to the state (Magnusson, 2011). It was concluded that the separation between ownership and managerial responsibility (i.e. counties on one side, central funding on the other) was a reason for the difficulties in addressing deficits. This substantiated the decision to return hospitals to state ownership as it was expected that greater coherency in ownership and funding responsibilities would reduce deficit budgeting.

Some years after the introduction of the reform, a debate focused on whether boards of trustees of regional health authorities and local health boards created a democratic deficit as they were not subject to political appointment. In 2006, these boards were reorganized with government-appointed politicians acting as representatives and political representation following the strength of the party. This reorganization followed the logic that party politicians, even those who had not necessarily been elected, would be more sensitive to local needs.

The coordination reform being introduced in 2012 is driven by economic concerns rather than considerations of efficiency or quality, particularly as expenditures in hospital care have doubled since the 2002 reform (Romøren, Torjesen & Landmark 2011). The reform aims at reducing hospitalization (especially of elderly patients) by introducing low threshold units in primary care as an alternative to hospital treatment. Such wards have existed in some city municipalities to facilitate rehabilitation of elderly patients after acute hospital treatment and are considered successful in improving the quality of care for these patients. This measure may therefore lead to some rationing of hospital resources for elderly patients.

As Magnusson pointed out, reforms so far have not yet tackled explicitly any of the fundamental policy issues to make health care more sustainable for a progressively ageing population such as for instance the criteria, processes and responsibility for deciding public coverage of services, rationing of care and priority setting. These are considered contentious questions and are often played down in the political debates due to concerns about electoral preferences which usually are more local in nature and often drive political interests (Magnusson, 2011).

2.9.3 Tools

The 2002 reform was implemented by replacing unconditional grants with earmarked funding and by integrating hospital ownership and funding into one administrative layer. Hospital merger has been a principal tool to enable more centralized administration of hospital providers at regional level. The number of local health authorities (essentially hospitals) was reduced substantially (from 55 in 1999 to 21 in 2011) and now is close to the number of counties. Mostly, single hospitals were merged into larger enterprises – for instance, four smaller hospitals in Oslo became one hospital trust. The reform and (especially) hospital mergers have not been uncontroversial, especially amongst trade unions. However, hospital managers and hospital staff have not raised substantial resistance to implementation of the reform as they form part of the public system with relatively limited autonomy.

New arrangements for promoting the coordination of care will be implemented in 2012. Adopted in 2011 by the Storting, the Norwegian Parliament, the “coordination reform” aims to promote primary care treatment settings over hospital care (especially for elderly people) and incentivize earlier hospital discharges. The plan is to use financial incentives to encourage municipalities (responsible for primary and long-term care and rehabilitation) to retain treatment in the primary care setting. From 2012, half of the activity-related funding for hospital care – overall about 40% of funding, 60% of funding is through a fixed budget – will be allocated to municipalities to co-fund general hospital admissions. Hospital budgets will be reduced accordingly. Low threshold pre-hospital wards will be established in primary care settings by 2016 and primary care institutions will be charged a penalty for not receiving patients ready for hospital discharge and in need of long-term care or rehabilitation.

2.9.4 Impact

Debate about the distribution of funds amongst the five regional health authorities was initially one of the major factors constraining implementation of

the 2002 hospital reform. This was due to lack of consensus on the methods for distributing funding and on the redistribution effect of the different methods. A government-appointed commission recommended an initial capitation-based model but failed to obtain agreement from the Ministry of Health and Care Services due to concerns over favouring certain county models. A second committee finally led to agreement on another capitation-based distribution model in 2009 (Magnusson, 2011).

The reform did not lead to the expected reductions in deficit budgeting during the initial aftermath – four of the five regional health authorities ran substantial deficits. It was not until 2009 that the regional health authorities managed to secure small budget surpluses (Magnusson, 2011). In addition, the reform has not yielded any economic savings. On the contrary, subsequent hospital expenditure is said to have doubled (Romøren, Torjesen & Landmark 2011).

2.9.5 Conclusion and outlook

The governance model for hospitals is subject to considerable controversy after ten years of implementation of hospital reform. Only one of three parties (Labour Party) in the government coalition defends this model. Recent surveys show that equity may not have substantially improved and that waiting times have increased. Hence, it is not unlikely that the system will experience some further changes in the near future (Magnusson, 2011). Reversion to the pre-2002 decentralized model with counties in charge of specialist care is very unlikely. One of the more probable options seems to be abolition of the regional health administrations to further strengthen the national-level policy capacity – for instance, giving the Ministry/Directorate of Health a direct governance role in the 22 local health authorities/hospitals. Hospital mergers have led to a substantially lower number of hospital actors, making delegation of responsibility from state to local level more feasible than in 2002 (Magnusson, 2011).

Another argument in favour of a more centralized governance form holds that the abolition of the regional health administrations would not change the resource allocation model as local authorities receive their funds on the same capitation basis (Magnusson, 2011). A related option is adoption of a national health plan as a more detailed policy tool guiding priorities, resources and expected outcomes for health and health care. It is also likely that municipalities will merge to create economy-of-scale benefits in delivering primary and long-term care to a larger catchment population. Municipalities' principal responsibilities for primary health care and long-term care are unlikely to be centralized at state level since this would trigger strong resistance and might be too dramatic a shift

from Norway's traditionally decentralized health system culture (Romøren, Torjesen & Landmark 2011).

2.10 Spain

Antonio Durán

2.10.1 Governance model and recent changes

The current configuration of the Spanish national health system (*Sistema Nacional de Salud*, SNS) emerged during the transition to democracy that began in the mid 1970s. Over the brief time span of a decade, Spain transformed from an authoritarian, centralist regime to a democratic, decentralized state. The 1978 Constitution substantially devolved political power to 17 autonomous communities (ACs) and two autonomous cities in northern Africa, but with wide-ranging asymmetric autonomy as some ACs have more powers than others.

The institutional agreement outlined a two-chamber parliament, elected by direct vote, with a national government at the centre of a "federal-like system without federation". Central government would control certain policy areas (e.g. defence and foreign affairs). Through their own elected regional parliaments and governments, ACs would exercise legislative and executive authority over an increasing number of policy fields, including health (the protection of which was recognized as a constitutional right). Outlined by the national constitution and the regional charters, ACs have constitutional responsibility over health in the "*España de las Autonomías*".

Public health and health care planning competencies were transferred to ACs between 1979 and 1981 by common law. The General Health Act (1986) coincided with entry into the European Union (EU) and effected the formal transition from a system of social security (Bismarck-type model) into a national health service (Beveridge-type model), with a progressive transition from payroll contributions to general taxation as the main source of financing. The exception was three publicly funded mutual funds which cater exclusively for different sets of civil servants in government departments and the armed forces. These occupy a unique quasi-public position (civil servants are free to choose between public provision within the social security health care facilities' network and fully private provision).

In summary, in the last few decades central state competencies in Spain have been transferred upwards to Brussels and downwards to regions. The transfer of supra-national sovereignty to the EU has been the same for all EU Members

and is not covered here. Decentralization to regions has had a far deeper impact than Europeanization, and health system decentralization has resulted in a complex balance (Durán, 2011). Public opinion (e.g. media reports, experts' opinions) is in no doubt that central government is now much weaker and ACs are much stronger.

2.10.2 Tools

The main tool of reorganization was the law, supported by financial instruments. In health, the stewardship mandate is shared between the centre (Ministry of Health, Social Services and Equality) and the regions (health departments of the ACs). Professional organizations also contribute through official bodies such as ethical committees. The designated division of responsibilities in health care is detailed below.

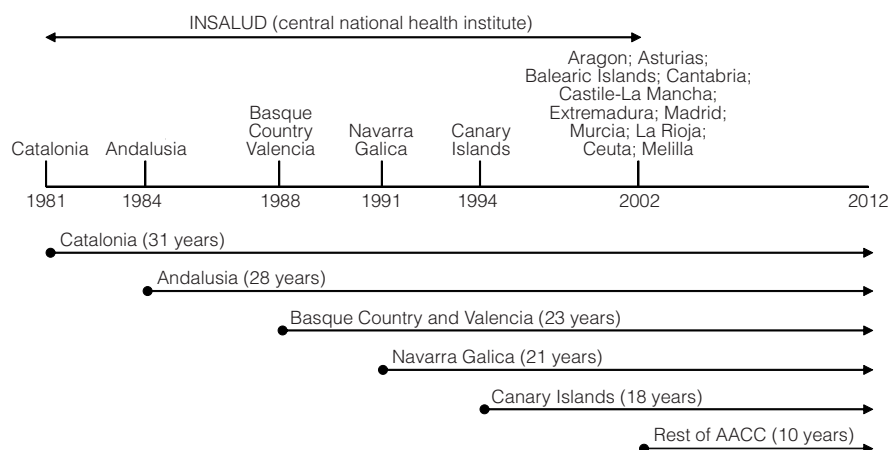
- Central government is responsible for providing a common framework for health and health care in order to ensure equity, cohesion and common quality standards.
- ACs are responsible for implementation and service provision. Each AC has a regional health department and health minister responsible for health policy plus a health service which manages service delivery.
- The Interterritorial Council of the Spanish National Health System (CISNS) is responsible for coordinating health policy between central government and ACs. This has no executive power, providing only “consensus recommendations to promote cooperation and exchange of information towards equity”. This comprises representatives from the central level, the health ministry and each regional health department.

In the field of *service production*, for decades multiple public health care networks (mostly municipal and provincial) had covered the charity-based system; monitoring and treatment of infectious diseases; a network of rural primary care; most health promotion and prevention activities; psychiatric care; and some community care programmes (a total of about 15% of total public expenditure on health care). Between 1948 and 1985 these coexisted with a social health insurance system financed by compulsory contributions from workers and later extended to their families (representing some 80% of total public expenditure in health care). As indicated, in 1986 the country merged all health resources into the tax-funded SNS offering universal coverage to all residents, including immigrants (only 0.5% of the population, consisting of high-income, non-salaried individuals, refuse to be registered). Health services in primary health care are provided by publicly salaried professionals (one doctor and nurse for every 1500 inhabitants, with numerous prevention

programmes) and the public sector provides 71.2% of all available hospital beds – including 80% of acute care beds, 36% of psychiatric beds and 30% of long-term care beds. Overall, 40% of beds are directly state-owned, the remainder are subcontracted from the private sector.

While traditional public health care networks resources were transferred to the regions in the late 1970s, social security institutions were transferred on a step-by-step basis. This was due to prudence and to disagreements between central government and regional governments concerning costing and related financing issues. The process was far from problem free. Until 2001, central government devolved responsibility for the health care network to Andalusia, Basque Country, Canary Islands, Catalonia, Galicia, Navarra and Valencia. Together, these cover approximately two thirds of the Spanish population. A central institution inherited from social health insurance, the National Institute of Health (INSALUD) in Madrid managed services in the other ten regions. The decentralization reform was completed in 2002 and, after almost 20 years, resulted in governance being transferred to all 17 ACs. The chronology of this decentralization (devolution) of health care competencies is illustrated in Fig. 2.1.

Fig. 2.1 Chronology of the decentralization of health care competencies in Spain, 2012



Source: Adapted from Durán, Lara & van Waveren, 2006.

The Constitution, the regional autonomy charters (*Estatutos de Autonomía*) and the General Health Act comprise the core laws of health care. In addition, the minimum benefits package offered by all regions has traditionally been set at the national level, stipulating a number of areas where services must be agreed with the CISNS. In December 2006, the mechanisms for inclusion of new common benefits were established. Regions are allowed to include additional

services if they are prepared to finance them through their own budgets, thus expressing the tensions between the principles of regional diversity/decision-making and of universal and equitable access to health services. Some regional governments have enacted their own regional health laws; others have used lower range legislative tools to develop their own legal frameworks. However, in the midst of the most severe economic recession, Royal Decree Law 16/2012 on Urgent Measures to Guarantee the Sustainability of the SNS has decreed the reform of the common basket of services. It has established three levels of services: (i) a common basket of care services (including preventive, diagnostics, treatment and rehabilitation services, plus urgent health care transport services); (ii) a “common supplementary” basket (including ambulatory drugs subject to co-payment, prosthetics, dietary products and non-urgent health care transport); and (iii) a common basket of accessory services (activities, services and techniques that are considered necessary or adjuvant for the treatment of selected pathologies, such as cosmetics support treatments for patients with rare diseases). ACs are allowed to develop their own basket of services, but these should include at least the national basket in the three dimensions described.

Following approval from the high-level Fiscal and Financial Policy Council, the new overall framework regarding the financing function of the SNS was set in Act 7/2001 on the Financing System of the Autonomous Communities (not explicitly a health law). Transfer of funds from the centre to the regions is negotiated annually between central government (Ministry of Health, Social Services and Equality) and the regional governments (regional health ministries). Within the percentage of revenue by source, public expenses represent 71% of total health funding (of which taxation is 94.07%, professional mutual schemes 2.53% and civil servants’ mutual funds 3.4%), out-of pocket direct expenses (mostly for pharmaceuticals) represent 22.5% and private insurance 5.5%.

On average, the health departments (responsible for health policy) and the health services (managing service delivery) of the ACs jointly spend 89.81% of total public funds for health; as explained, these are mostly not earmarked budget transfers from the state. The health budget represents around 30% of each AC’s total budget (which also includes education, unemployment benefits, etc). Within the public funds spent on health, specialist care represents roughly 55% of the total; pharmaceuticals almost 20%; primary health care accounts for slightly more than 15%; and prevention and public health some 1.5%. The remaining 9% is classified as ‘other’ (García-Armesto et al., 2010).

As the last cornerstone of the health decentralization process, the 2003 SNS Cohesion and Quality Act ratified the principles of universal provision, equity in access to services, system integration and decentralization as founding principles of the Spanish (now regionalized) health system.

2.10.3 Policy priorities and impact of decentralization

The policy priorities of health service decentralization were explicitly political – there was consensus that this process would have positive effects in Spain. Since it was considered that all regions should enjoy the opportunity to offer services “closer to where people live”, there was a need for them to be, first, involved (inclusiveness) and then coordinated (supervision). Coinciding with a period of sustained economic growth before the beginning of the financial crisis in 2008, the changes encouraged flexibility and innovation in health services delivery, fostered approaches attuned to local preferences and stimulated investment in health care (Borkan et al., 2010).

Decentralization has certainly coincided with (and most likely contributed to) positive effects, including improvements in health outcomes. For example, Spain now enjoys a high position in most world rankings for health outcomes – occupying fourth place in average life expectancy at birth (third for females); fourth place in life expectancy at age 65; and fourth place in rankings for female potential years of life lost. From 1970 to 2008 average life expectancy at birth rose from 72.88 to 81.24 years and infant mortality fell substantially from 20.78 per 1000 live births to 3.35 (WHO Regional Office for Europe, 2011).

Since 1970, Spain has been among the countries with the lowest mortality rates for top causes (cardiovascular diseases, cancer and respiratory diseases) in Europe. The only area in which Spain shows clearly worse outcomes is in diabetes-related lower-limb amputations – 26.5 amputations per 100 000 in 2006, compared with the Organisation for Economic Co-operation and Development (OECD) average of 14.9 amputations. Reductions in avoidable mortality during the period 1991–2005 suggest substantial access to health care and to quality and safe services (García-Armesto et al., 2010). A similar picture of improvement emerges for the five-year relative survival rates for selected cancers (breast, colorectal and lung) from 1990 to 2002. These are comparable to the advances made in France, Germany, Italy and the United Kingdom (Kantar Health, 2010).

Importantly, such results have been achieved with what appears to be an efficient level of expenditure in terms of international comparisons – in 2007, spending on health care as a percentage of GDP was 8.5% in Spain (US\$ 2671 per person) and 16% in the United States of America (OECD, 2009). National surveys also show generally high levels of user satisfaction and system legitimacy – for example, usually more than two thirds of respondents consider that “the SNS works quite well” and “works well yet needs changes” (Agencia de Calidad del SNS, 2010). Another positive product of the Spanish decentralization in health has been an unexpected explosion of semi-autonomous public hospital

models – see the case-study on Spain in the recent Observatory book (Alvarez & Durán, 2011).

On the minus side, geographical differences in health outcomes and financing as well as intra-region inequities have, to a large extent, remained unchanged: “Healthcare decentralization in Spain seems to show no positive effect on convergence in health, as measured by life expectancy at birth and infant mortality between provinces ... Some provinces improved their situation overtaking others but the final result is one of greater dispersion than at the start” (Montero-Granados, de Dios Jiménez & Martin, 2007). By region, average life expectancy at birth for both sexes ranges from 82.5 years in Navarra to 79.8 in Andalusia; infant mortality in Navarra is reported to be less than half that in almost neighbouring Asturias (FADSP, 2011). No doubt, differences in health status also reflect differences in income and wealth so it would be unfair to blame (only or entirely) the health system decentralization process – the issue is mentioned here mostly in terms of “unfulfilled expectation”.

Decentralization appears to have kept per capita health expenditure uneven. Overall, the variation coefficient of expenses among regions in the period 1992–2009 increased – and changes in population-protected volume fail to explain such variability (García-Armesto et al., 2010). Publicly funded health care expenses (budgeted) per person in 2010 still differed by €557 (i.e. 41.47% of the average of €1343) between the Balearic Islands (at 79.37% of the average) and the Basque Country (at 120.84%); and in 2011 were reported to be almost 50% bigger in Navarra and the Basque Country than in the Balearics and Valencia (FADSP, 2011).

In past years, different funds were set up to compensate for differences in health needs and minimize inequities in Spain. In particular, in 2003 a “compensating” mechanism was designed, comprising three funds.

- Two general funds: (i) Interterritorial Compensation Fund (*Fondo de Compensación Interterritorial*) designed to finance investment projects to remedy economic imbalances among regions; and (ii) Sufficiency Fund (*Fondo de Suficiencia*) intended to provide regions with the resources necessary to cover their needs fully, covering the gap between funds required and funds obtained from tax revenues.
- One health-specific fund: (i) Health Cohesion Fund (*Fondo de Cohesión Sanitaria*) aimed at guaranteeing equitable access to services for individuals who receive health care outside their region of residence; come from other EU countries; or come from non-EU countries that have signed reciprocal public health care agreements with Spain.

In practice, those monies clearly failed to promote national cohesion and reduce inequality by addressing geographical inequalities. In December 2009, further legislation was passed to create a new regional financial system around a Guarantee Fund for Fundamental Public Services (*Fondo de Garantía de Servicios Públicos Fundamentales*). This integrated the national Cohesion Fund created by the SNS Cohesion and Quality Act and holds 80% of the resources for key public services such as education, social services and health care. Monies are collected centrally from tax revenues and then dispersed. However, critics argue that this fund was created in the context of electoral politics, and that allocation arrangements disproportionately served the demands of some regions (namely Cataluña).

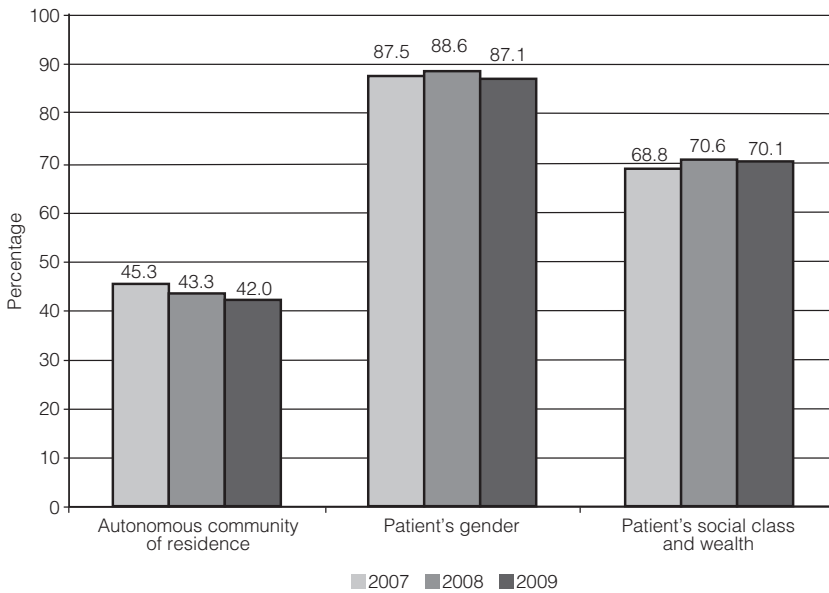
In light of the above, there should be little wonder that the Spanish health care system shows marked variability in access, quality, safety and efficiency, across regions, health care areas and hospitals. This includes the following examples:

- 5-fold variation in the use of percutaneous transluminal coronary angioplasty (PTCA) between areas and 2-fold variation in mortality after PTCA (hospitals);
- 7.7-fold variation in prostatectomy rates across health care areas;
- variation between health areas of 28 times more frequent admissions to acute care hospitals due to affective psychosis;
- 26% of hospitals with 501–1000 beds are at least 15% more inefficient than the average;
- 12% of hospitals with 201–500 beds are at least 25% less efficient than the standard for treating similar patients (Durán, 2011).

The population does seem to be aware of the lack of geographical equity in financing – only 42% of respondents in the *Health Barometer* survey (Agencia de Calidad del SNS, 2010) believe that the same health services are offered to citizens despite region of residence, compared with around 87% who assess that treatment is equal despite patient's gender and around 70% who assess that treatment is equal despite a patient's social class and wealth. In other words, regional devolution is rather clearly perceived as equity-adverse, as shown in Fig. 2.2.

Paradoxically, devolution has not given SNS staff and patients/citizens any greater voice in how health services are managed. Decision-making at the national level has clearly been decentralized but processes at regional level have copied the old over-centralization, with plenty of duplication of the delegation and accountability chain. In addition, it is remarkable that “[ACs] ... have

Fig. 2.2 Respondents who believe that the same health services are offered to all citizens despite ...



Source: Agencia de Calidad del SNS, 2010.

been belligerent against municipal powers ... and have tried to grab their competences” (Flores Juberias, 2003).

Wrong patterns of decentralization have also been quoted as the cause of the complex relationships between regional administrations and the medical profession:

Health services management in Spain was born in an unfavourable context: obsolete public administration, bureaucratic inheritance, lack of qualified human resources ... In spite of it all, a modernizing wave gave birth to a spectacular improvement ... But while this generation of enthusiastic managers improved facility and service management, they did so at the expense of enforcing a centralist model tainted with enlightened despotism, side-lining away from power even the influential medical leaders who rather informally but effectively had led life in the big public institutions for decades – especially in big hospitals (Belenes, 2003).

Other problematic aspects of decentralization include an information deficit and very limited connectivity across the country and between regions – regional health systems have developed an enormous variety of sophisticated information systems (including electronic prescriptions, etc) but they are not

necessarily compatible with each other. Therefore, despite millions of euros of financial investment, no assessment of the entire SNS performance is currently feasible – whatever the level of disaggregation.

2.10.4 Implementation

In short, there are multiple signs that the Spanish devolution process lacked careful planning and was rather a sequence of unsolved clashes between the centre and the periphery (regions) on claims of historical rights, conflicting financing figures and political gambling. By design, as indicated, the Ministry of Health, Social Services and Equality held responsibility for setting what is known as the bases and the general coordination of the health system as well as the competences of foreign relationships (with e.g. EU, WHO, OECD) in health and pharmaceutical legislation (public reimbursement and price setting of drugs). In turn, regions had competences on health policy formulation and implementation as well as planning and management of personal and population health services. However, in practice it was more difficult than anticipated to determine the scope of the respective competences and frequent clarifications (including Constitutional Court consultations) have been required since 1983 (Beltrán Aguirre, 2007).

2.10.5 Conclusion and outlook

The Ministry of Health, Social Policy and Equality has been repeatedly criticized for its lack of leadership. Given this failure, and the absence of efforts to align policies between regions, ACs have assumed increasing responsibilities for health over the years. Examples of this lack of leadership include the failure to forge a broad agreement around health; the political tensions within the CISNS; and the delays in passing key legislation such as the public health law (*Ley 33/2011, de 4 de octubre, General de Salud Pública*) or secondary legislation for developing key articles of the 2006 Law of Guarantees and Rational Use of Drugs (*Ley 29/2006, de 26 de julio, de Garantías y Uso Racional de Medicamentos*).

Another good example of the Ministry of Health, Social Policy and Equality's lack of leadership is provided by the progress of the idea for a national health care agreement (*Pacto por la Sanidad*). The Health Pact was intended to find common solutions to critical pending issues involving all regions and political parties. Floated at the beginning of the 2008–2011 parliamentary period and originally proposed by the then Minister Soria, the appeal included as pending issues not less than “human resources policy, common services, budget sustainability, common health policies, quality and innovation and prevention of drug addiction”. Successive health ministers of the previous Socialist

government embraced this initiative and created working committees, whose membership included other stakeholders, including patient groups, to work on these areas. However, although the draft pact was prepared in 2009, it has not materialized – neither under the previous Socialist government, nor under the new government of the Popular Party elected in November 2011 (despite the latter enjoying an absolute majority in parliament). At the time of reviewing this chapter (October 2012), the Health Pact has still not been signed but a new window of opportunity may open following its mention in the recent Royal Decree Law 16/2012 as a tool to achieve savings of €600 million by enhancing regional coordination.

Previously hidden tensions and challenges have become increasingly visible as a result of the economic and political crisis – raising clashes between parties and between regions in a context of polarization bordering on filibusterism. For example, mass refusals to attend meetings of the CISNS have sadly been a common tactic used by regional ministers of both the Socialist Party and the Popular Party when they were in opposition at national level. The CISNS was summoned only twice in 2011. As a result, the coordinating ability of the CISNS has been extremely poor over recent years.

Beyond taking a position in the political debate in the context of the economic crisis (nationalists versus centralizers and socialists versus conservatives), there are calls for the suppression of central departments (including the ministries of health and education) now considered redundant as their functions are being covered at the regional level. In response, others are calling for a substantial reduction in the degree of autonomy that regional governments should have in the future.

2.11 Sweden

2.11.1 Governance model and recent changes

Decision-making in the Swedish health care system is shared between the national government, county councils and the municipalities. However, Sweden is not a federal state since the decentralized power of regions and local authorities depends on decisions taken by the national parliament. Health care is the main responsibility of the 21 regions/county councils – most with a few hundred thousand inhabitants, some with very small populations. Among the three larger counties (Stockholm, West Sweden, Scania) Stockholm alone comprises approximately one fifth of the national population. Fundamental reform decisions are made through consensus building between the national government and the Swedish Association of Local Authorities and Regions (SALAR) which represents the 290 municipalities and 21 regions.

The Swedish health care system has a particular governance structure characterized by a horizontal, rather than a downward, hierarchical relationship between the national government and the county councils. Hence, most nationwide policies are agreed between SALAR and the national government. This model has emerged from several decentralization phases in the past decades, starting from the late 1960s when initially responsibilities were devolved from the national level to the county councils. The process to create SALAR started at the turn of the millennium, resulted in the merging of the municipal and regional organizations of civil servants in 2005 and was finally formalized in 2007. SALAR now represents all county councils and local authorities as well as all the largest employers in Sweden.

A key decentralization phase took place in the early 1980s, culminating in the national Health and Medical Service Act passed in 1982. This defines and regulates county councils' (and municipalities') responsibilities, essentially making them the central players in terms of the financing and provision of health care services. Social care, long-term care (since 1992) and some public health services are the responsibility of the municipalities (the local authorities). The grey zone between health care and social services generates ongoing discussion on the division of responsibilities and cooperation. Municipalities are not subordinate to the regions/county councils, therefore these discussions must be based on mutual agreements and/or national government decisions.

Local government has a strong tradition in Sweden. Many reforms stem from initiatives of county councils and municipalities and hence patterns of reforms vary across local and regional government (Anell, Glenngård & Merkur, 2012). Many county councils introduced global district budgets to the municipalities to contain municipal costs for health care. Some counties initiated further reforms in the 1990s, seeking to enhance consumer choice on health care providers, splitting purchasers from providers and introducing case-based and performance-based payment schemes. During the past ten years, there has been a considerable focus on developing primary care and enhanced coordination of care for elderly people and patients with chronic diseases.

In the late 1990s, the regionalization trend gradually started to reverse as problems with equity and coordination of care emerged. These difficulties have triggered a debate about whether some counties are too small to manage health services effectively (Anell, Glenngård & Merkur, 2012). Over the past ten years, central stewardship elements have gradually been strengthened in the Swedish health system governance model. The number of counties has decreased from 26 to 21, following the voluntary merger of three counties in Scania and four in West Sweden. For tertiary care, counties are grouped into six health care regions in order to improve coordination and planning of tertiary care services.

The national government also has increased its role by setting evidence-based guidelines for quality of care.

Public health policy has also been promoted at national level. A national health policy adopted in 2003 sets out 11 focus areas for improving the overall health of the Swedish population. Adopted in 2005, the national health services waiting time guarantee is another national policy with substantial impact at local and regional level. This will be discussed further below.

Eight national agencies have assumed considerable influence on national health policy-making in the past two decades. The National Institute of Public Health is responsible for following up on intersectoral policies and the assessment of national public health policies (Anell, Glenngård & Merkur, 2012). The National Board of Health and Welfare is responsible for issuing evidence-based treatment guidelines for health care professions. The Medical Responsibility Board is in charge of disciplinary measures concerning patient complaints and suspected malpractice. The Swedish Council on Health Technology Assessment (SBU) is responsible for assessing medical interventions and technologies related to medical, social, ethical and economic aspects and setting standards. SBU also contributes to evidence-based clinical practice guidelines. The Medical Products Agency is the drug regulatory and surveillance authority with responsibility for the registration, regulation and surveillance of research and development, production and sales of all drugs in Sweden. The Dental and Pharmaceutical Benefits Agency decides upon drug coverage and subsidies. The Swedish Agency for Health and Care Services Analysis was set up in 2011 as a research institute to analyse and evaluate health policies from a patient and citizen perspective. The Swedish Social Insurance Agency administers social insurance and benefits.

The evolution of these central agencies over the past ten years has reflected the intention to exert more central-level influence over health policy in Sweden. It has also been the subject of criticism by SALAR and individual county councils that have found it difficult to coordinate their interests between so many national institutions.

2.11.2 Policy priorities

In the past ten years, the policy priorities of health reforms have been strengthening the role of the patient and increasing patient choice; patient safety; efficiency; access to care; and increased population health equity through setting national priorities, directions and targets for population health efforts at regional and local levels.

Patient choice of providers has gradually been strengthened. Since 2010, patients have been able to choose freely between primary care providers in primary care. This now includes the choice between public health centres and private practice providers. The number of private practitioners in primary care has increased substantially, albeit the bulk of primary care centres are still working under county ownership. Choice has gradually become more important as a health policy objective although it is unlikely to challenge the more important fundamental underlying values of the Swedish health system, such as equity in health.

Patient safety has received more attention in recent years, and individuals in various institutions (including SALAR, the county councils and the national organizations) have played an important role. Efforts currently focus on medical errors and infections acquired in medical institutions. More attention is being paid to public comparisons of indicators of quality and efficiency and responsiveness to patients' and citizens' expectations (Anell, Glenngård & Merkur, 2012).

Efficiency concerns in health care provision have been triggered by different symptoms. One has been long waiting times for elective specialized care, caused partly by a low level of specialist services supply in comparison to other European countries. Another set of problems has been substantial intercounty variations in access and quality of care as well as duplication of services between neighbouring counties. These have become more visible in recent years, requiring more interregional coordination and benchmarking of performance on policy objectives and targets across regions.

A government inquiry commission was established in 2011 to provide recommendations for revisiting the governance arrangements in place for central government. Recommendations have focused on a clearer distribution of responsibilities and greater efficiency between the different elements of central government and, in particular, the national agencies (Swedish Government Commission Inquiry Report, 2012). Although the terms of the inquiry emphasized responsibilities within the central elements of government, the commission also sought to address central government's concerns that public health and social policy priorities set out at national level are not sufficiently followed through at county and local levels. Concerns about central government's lack of possibilities to require counties and local communities to align with national measures of performance related to access to care, equity and efficiency were also highlighted. At the same time, the inquiry commission's terms did not allow for a fundamental departure from the current division of responsibilities between the different levels of government.

The inquiry commission identified fragmentation of knowledge support; weak supervision of quality of care, drug supply and management; insufficient balance and demarcation between guidance, advice and audit; insufficient impact of guidelines; inadequate intrasectoral cooperation; lack of coordination of the IT structure and communication channels; and lack of strategic management to be key problems in the current governance arrangements at central government level.

In contrast to some other countries reviewed in this study, cost containment is currently not a main driver for governance reforms in the Swedish health care system. County councils and municipalities have the authority to levy proportional income taxes and to raise taxation levels. County politicians have been reluctant to raise taxes that are unpopular among their electorates, thereby creating fairly strong incentives for more effective cost-containment policies at county level. In turn, this has created problems in terms of more restrictive human resources policies, and underinvestment-related productivity losses at institutional level in the municipalities. At the same time – with the exception of pharmaceuticals – cost-containment efforts at national scale have been rather weak (Smith et al., 2012).

2.11.3 Tools

Several measures have been introduced to address one central concern in the Swedish health care system – timely access to specialist care. In 2005, the counties introduced a health care guarantee requiring the provision of immediate (same day) consultations; a GP consultation within 7 days and a specialist consultation within 90 days; and then a maximum of 90 days to receive treatment following a diagnosis. Since July 2010, the guarantee has been regulated by law and includes all elective care in the county councils (Anell, Glenngård & Merkur, 2012). Between 2010 and 2012, the central government has allocated overall an extra 1 billion Swedish crowns annually to county councils that provide care within 90 days to at least 80% of their patients. The current incentive scheme has introduced new ways of working towards waiting time targets but there is a prevailing concern that the current scheme rewards regions for meeting these targets while de-emphasizing allocation decisions based on need. Additionally the waiting time guarantee scheme has focused on acute and single visit care – so far it has not been developed sufficiently to be applied to continued and integrated care for chronic diseases.

To increase patient choice and to facilitate the waiting time guarantee, many county councils have increased public contracting of private primary care as well as private specialist services. The possibility for county councils to purchase specialist services is not new. There has been a slow increase in volume over

recent years but the issue has now become politically more sensitive, with different views even inside the Social Democratic Party. Currently, about 10% of county councils' health care funding pays for privately provided health services.

Other reforms have targeted the pharmaceutical market. This has been diversified since 2009 when the Swedish pharmacy monopoly was abolished and new owners and chains were allowed to operate (Anell, Glenngård & Merkur, 2012). Re-regulation of competition has resulted in an increase in private pharmacies and pharmacy operators (previously a single operator but 13 by 2011) and the introduction of over-the-counter products within pharmacies (Anell, Glenngård & Merkur, 2012).

The concentration of specialist services initiated in the mid 1990s has continued. The Committee for National Specialized Medical Care was established to coordinate highly specialized care between six health care regions. However, the preferences of county politicians, hospitals and physicians for local provision and access to services can be an obstacle to further centralization. An important obstacle is the preference for local production across county councils, local hospitals and, not least, specialists themselves (Anell, Glenngård & Merkur, 2012).

There is a renewed effort to improve health information and statistics on a national scale in order to increase transparency about geographical variations in health care performance on, for example, waiting times, indicators for quality of care and population health status (including lifestyle factors). This process was launched also to provide better benchmarking and alignment of county councils; increase the transparency of public information on the performance of counties, municipalities and health care providers; and provide a platform to enhance political decision-making and priority setting at county, municipal and national levels. A health target-setting framework is currently being developed as a monitoring tool.

2.11.4 Impact

Overall, there have been few assessments of the effects of the reforms and it is difficult to attribute effects to single reforms since numerous changes have taken place over a longer period of time (Anell, Glenngård & Merkur, 2012). In addition, in Sweden (as elsewhere), concepts in health information and evidence for policy decision-making are in constant evolution – current concepts might enable measurements of today but their results cannot necessarily be compared to past situations. For instance, problems in terms of equity of access to care across counties and socioeconomic groups have become visible in recent years,

but it is uncertain how the governance structure has contributed to this visibility given that public comparisons on quality and efficiency have been introduced gradually since 2005 (Anell, Glenngård & Merkur, 2012).

It is hoped that further improvements will result from the newly emerging national paradigm structured on health care performance, health system performance and health policy performance, alongside a more systematic agenda towards policy monitoring and auditing (Anell, Glenngård & Merkur, 2012).

2.11.5 Conclusion and outlook

In Sweden, important changes occurred in the 1960s and 1970s when regions were given full responsibility for health care provision, including all hospitals. Municipalities were given wider responsibility for health care connected to care for the elderly and long-term psychiatry in the 1980s and 1990s. The former aimed to integrate all medical care; the latter aimed to integrate different kinds of support for people with multiple needs.

While many reforms in the past two decades have focused on structural changes and changes of decision-making structures, more recently the emphasis has been on enhancing performance management and benchmarking approaches. In this context, current discussions focus on tools such as national quality registers; public comparisons of local authorities and providers based on quality and efficiency of care and comparative health outcomes; and experience with care from the perspective of the patient (Anell, Glenngård & Merkur, 2012).

The report of the government inquiry on health and social care in Sweden was delivered in May 2012. This proposes that national government agencies focus on four functions: (i) knowledge support for progressive health improvement; (ii) regulation and supervision; (iii) infrastructure for information technology and communications; and (iv) long-term strategic management. It is recommended that knowledge support be better coordinated and adapted to the needs of users, and local and regional authorities be given more responsibilities on national priority setting processes. The commission also recommends a stronger regulatory and supervisory role (especially regarding health care providers) at national level and better coordination of IT and communications. Strategic management should be enhanced through a new monitoring and auditing function that allows for policy assessments and forms the basis for future priority setting.

Based on the four core functions, the inquiry proposes more cooperation between counties, the national government, local authorities and providers. It also suggests a new government agency structure with fewer central agencies

and revised agency functions: (i) a knowledge agency for all health and social policy and care knowledge support; (ii) an inspection agency in charge of licensing of providers, drug approval and supervision of care and the pharmacy market; (iii) an IT and communications solutions agency; and (iv) an agency responsible for monitoring, auditing and long-term strategic management for health and social care.

The inquiry report received substantial public and media attention and formal replies will be handed to government in late 2012. Whilst it is too early to know whether the recommendations of the report will be followed, there is considerable consensus among various actors in the Swedish health care system that there is a growing need for stronger national-level coordination in health and social care – particularly regarding knowledge, priorities and infrastructure – and that this coordination will not threaten local and regional democracy but may open new opportunities for local and regional involvement.

2.12 Switzerland

2.12.1 Governance model and recent changes

Governance arrangements in the Swiss health care system are based on three traditional constitutional features. The first is a federal structure with a strong focus on decision-making by cantons and a complex organization of powers and responsibilities between the cantons and the national government. The second feature is a tradition of direct democracy through popular votes and referendums and governance through consensus. The third is growing reliance on a regulated market of competing private health insurers and providers that limits the role of the government authorities to one that sets the financial and regulatory rules to ensure market performance (OECD/WHO, 2011). At the same time, a number of new laws have strengthened the role of the confederation – for example, the *Loi fédérale du 18 mars 1994 sur l'assurance-maladie* (LAMal), the basic health insurance legislation that made health insurance mandatory. The draft law on disease prevention and the national health project are prominent and more recent national developments in this direction. Yet a number of strategically underdeveloped areas remain and, overall, the federal policy-making institutions have yet to meet the new requirements and build capacity for their new leadership roles. The different parallel principles have given rise to a constant tension between defenders of market approaches and those calling for more state regulation (OECD/WHO, 2011).

Cantons are under pressure to meet expectations and results for national objectives on cost containment, efficiency and quality of care. They are increasingly leaning towards working for national targets such as those on the

package of nationally set indicators for hospital care which were elaborated and adopted in 2011. The Federal Office of Public Health is making increasing efforts to assume more regulatory and policy-making control in some areas and these have also triggered improvements in collaboration between cantons. For instance, cantons contributed to the planning of hospital investments in 2012 by providing a joint list of funding requests.

2.12.2 Policy priorities

The most important policy priorities behind the recent dynamics in governance changes are those related to the traditional design of the system such as re-emphasis on the instruments for direct democratic control, accountability and responsiveness to local needs. Enhancing consumer choice of insurers and health care providers and increasing their participation in health care provision is one of the main objectives behind enhancement of patients' rights – for instance, to seek care outside their cantons. Policy motives behind the “renaissance of cantons” are based on the view that the strong focus on cantons as the most important tier of regulatory, fiscal and managerial authority over health care has enabled a fair amount of experimentation and innovation in policy decision-making in Switzerland. For instance, fastest progress has been experienced in areas that have been piloted in one or few cantons, such as drug substitution or alcohol policy. Yet, at the same time, the need for more policy coherency has driven consensus-based processes, such as agreement within the Swiss Conference of Cantonal Health Directors concerning common planning of highly specialized health services. The call for enhanced quality of care and a more uniform strategic frame has also substantiated the development of national-level standards for health promotion and disease prevention.

2.12.3 Tools

At institutional level there is a renewed emphasis on instruments for a regulated market, including managed and integrated care models and drivers for competition between health insurers and between health care providers. The recent leadership crisis in the leading health insurers' organization has weakened the monopoly of health insurers; reorganization of some major insurers is likely. A new law for hospital financing includes payment-per-case schemes. This has been adopted with the aim of improving the transparency of pricing negotiations and reducing inefficiencies and potential conflicts between insurers and providers. A draft legislation on health insurance surveillance is currently under consideration, aiming to protect the insured through increased state control over insurers' practices (for example) to ensure coverage with potential sanctions.

The new draft legislation permits national goals on disease prevention to be formulated by the federal government in collaboration with the cantons and nongovernmental organizations. Some concern has been expressed regarding the ability to meet national targets given the wide differences in cantonal capacity and infrastructure (OECD/WHO, 2011).

Priority setting and HTA is not well established at central level and leaves scope for improvement. Only a fraction of services covered under health insurance are evaluated in some form (OECD/WHO, 2011). Medical doctors have so far shown little interest in a stronger central governance role over HTA but one recent development is the Medical Board, established by the Health Directors Conference and the Swiss Academy of Medical Sciences. This provides assessments and policy recommendations for pharmaceutical and medical interventions and is seen as an initial step towards the permanent institution of a privately operated national HTA institute. Such an institute most probably would be a joint venture of public and private actors but the likely role of the national government remains uncertain.

2.12.4 Impact

The strong focus on cantons in combination with direct democracy instruments has enabled immediate democratic control, given cantons the flexibility to respond to local needs and ensured an innovative environment by providing scope for experimentation. Enhanced consumer choice of insurers in recent years has started to show an effect – about 15% of those insured (albeit mostly young and healthy individuals) have changed their insurer in recent years (OECD/WHO, 2011).

The challenges associated with the high degree of decentralization have been policy incoherency between cantons; conflicting incentives for cantons (e.g. for cost control as the regulator and owner of hospitals); a heavy focus on curative care with a backlog of disease prevention patterns; a lack of strategic oversight; and poor national-level information on quality and performance (OECD/WHO, 2011). In addition, the pace of reform may have been slowed by the presence of direct democracy elements that contest legislation and by strong parliamentary lobbying by doctors, insurers and the pharmaceutical industry that can influence legislation.

2.12.5 Outlook and conclusion

Governance arrangements in Switzerland have followed a complicated division of powers and responsibilities between national government and the cantons, the traditional decision-making tier. Three major developments are influencing

changes in the governance arrangements of the Swiss health care system. Firstly, cantons are experiencing a renaissance as the strongest policy decision-making tier, with the state assuming a subsidiary supporting role when cantons fail to resolve issues that are critical to the fundamental economic or welfare concerns of the country. The development towards collective intercantonal strategy and policy development, dialogues and platforms are showcased in the areas of planning highly specialist health care services and a joint list of hospital investments for cantons' investment planning in 2012. Secondly, and at the same time, a stronger central governance role is emerging in the domains of regulating and policy-making for quality of care standards, health insurance surveillance and disease prevention. Thirdly, there is also a notable re-emphasis of governance arrangements for managing, organizing, commissioning and providing care through the self-governing actors of the regulated market. In part, this builds on the objective to enhance patient and consumer choice and maintain the liberal environment for health insurance and health care provision with a view to position the health care sector as one of the most efficient, productive and innovative sectors of the economy. In comparison to previous years, the overall speed of dynamics in governing care arrangements accelerated in 2010 and 2011. Yet, recent changes in governance arrangements suggest not so much a total shift of responsibilities but rather a flexible collaboration between the various stakeholders and different levels of governance.

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How do national governments currently view their responsibilities for directing health care systems? Are governments increasing or decreasing their role in both the design and supervision of particular governance activities?

This volume seeks to answer these questions and to provide an overview of recent changes in the role that national governments play in governing their health systems. Assessments from 12 countries focus on efforts to reconfigure responsibilities for health policy, regulation and management; the resultant policy priorities; and the initial impact. One core objective for the extension of central government authority has been better alignment of sub-national health administrations and other health actors towards common strategies, visions and national objectives. These new approaches also seek better targeting of increasingly constrained human and financial resources.

The changes in governance arrangements identified show little uniform direction regarding the shift in responsibilities. In a number of countries, recent reforms have centralized certain areas of decision-making or regulation but decentralized others (although greater centralization has been more prevalent).

This important study looks closely at the evolution of the role of central government in the development of health care systems and reviews common trends and potential future developments.

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