

**The management of health systems in
the EU Member States - The role of
local and regional authorities**

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1. Summary

Health systems across the European Union (EU) are managed in very different ways. This report focuses on the role of local and regional authorities (LRAs) within these systems in terms of power and responsibility, from the issuing of legislation to policy development, implementation and funding.

LRAs play a significant role with regard to health issues. This role often reflects the constitutional structure of the country in question. However, there are several factors which complicate this simple relationship, such as the prevailing type of hospital governance or the LRA's competence for raising the financial resources to be invested in health locally.

The study has three aims: (i) compiling an inventory outlining the type of prevailing management within health systems across the EU; (ii) proposing a typology of health management systems on the basis of some key competences held by LRAs within the systems; and (iii) highlighting, on the grounds of the evidence gathered, those health-related policy areas where local and regional inputs may potentially add value to EU policy development processes.

Chapter 2 includes the health management system profiles of 27 EU Member States (MS). The profiles outline the structure of the health systems, main actors and responsibilities; modalities for the delivery of health care services; financing mechanisms; and main types of expenditure. Although focussing on the role of LRAs, setting the institutional scene upstream (national level) and briefly describing the recipient catchment downstream (beneficiaries of the services and types of services) were necessary steps for understanding the framework in which LRAs intervene. The profiles are the result of the desk review of existing and publicly available literature and of information made available online by the relevant national authorities. Therefore, there may be gaps in the information provided and it is not possible to present the same information systematically for all countries, although efforts are being made in this direction.

Some major sources deserve a special mention as being among the most important and comprehensive references: these are the health system profiles prepared by the European Observatory on Health Systems and Policies and

published by the World Health Organization, in particular with regard to countries recently reviewed.

A number of health systems are undergoing reform. Reforms often address funding mechanisms and the purchaser/provider relationship. Some of these reform processes started some time ago and face evident difficulties in being implemented; others are a direct consequence of increasing health expenditure, driven, among other things, by the economic downturn and related occupational crisis (several systems have an occupation-based mechanism for contributing to statutory health insurance) as well as by important demographic changes (ageing population). In other cases, the constitutional structure of countries could allow for a deeper participation of LRAs in health management but this is not the case yet, largely due to financial constraints. All these situations make the inventory a snapshot that will change in the near future.

In *Chapter 3*, a typology of existing health management systems across the EU is outlined. Classifications of health care systems have traditionally been articulated around the types of funding mechanism for health care or on the basis of the prevailing contractual relationships between health care service providers and payers. These elements allow an analysis of the financial sustainability of the systems, and corresponding classifications are aimed at supporting decisions on the efficiency and effectiveness of expenditure. However, in the last Joint EPC/EC Report on health systems it was highlighted how the understanding of drivers of health expenditure and of overall performance also requires an understanding of the organisational features of the systems. Research efforts in this area are acknowledged to be limited, with the survey undertaken by the OECD in 2008 among its member countries representing the most systematic and recent effort in this sense.

The dimensions to be considered for a classification are determined by the scope of the classification. In this study, the proposed typology was therefore built on a number of dimensions directly or indirectly correlated to the traditional classifications but all characterised by a clearly distinguishable regional and/or local contribution. In addition, as the types of hospital governance were found to be significantly related to the level of decentralisation of health management

systems, ownership and management of health care facilities were also considered in the clustering process.

The proposed typology was outlined with respect to the following criteria: (i) presence/absence of LRA responsibility in health funding and level of health funding at the sub-national level, as a percentage of total sub-national public sector expenditure; (ii) presence/absence of power/responsibility of LRAs with regard to the following functions: health-related legislation, planning of health care services, and delivery (implementation) of health care services; and (iii) ownership and/or management of health care facilities, in particular hospitals, by LRAs.

The clustering process has outlined five main types of health management systems across Europe with respect to the role played by local and regional actors. **Type 1 (decentralised systems)** includes *de facto* ‘regional health management systems’, i.e. management systems whose regulation, operation and also co-funding are delegated to regional authorities (Italy and Spain) or States (Austria). Within this type, funding through sub-national budgets is well above the EU27 average of 12.9% of sub-national budget contributed to health¹ and sub-national authorities also own and manage health care facilities. **Type 2** includes those health management systems where local and regional governments are responsible for several planning and implementation functions, besides co-funding; in this type LRAs also own and manage health care facilities. A further distinction of the type into sub-types is possible on the basis of the level of co-funding from sub-national budgets (above or below the EU average). Type 2 may be referred to as **partially decentralised systems**.

Type 3 refers to health management systems where local and regional authorities have operational (implementation) functions, including as a consequence of owning health care facilities; co-funding from sub-national budgets is limited. There are two unusual situations in type 3: the Netherlands and the United Kingdom. In the Netherlands, hospital governance is centralised but LRAs have a role in planning and implementation, and provide a limited funding contribution from the sub-national budget. As the ‘operative’ function

¹ Council of European Municipalities and Regions & Dexia (2009)

of Dutch local authorities is evident, their health management system has been categorised within this type (**operatively decentralised systems**). In the UK, each of the four constituent countries (England, Scotland, Wales, and Northern Ireland) has its own ‘National Health Service’ managed at the level of constituent country and thus falling into type 3, even if within each constituency a ‘centralised but structured at the territorial level’ system applies.

Types 4 and 5 are characterised by health management systems that are **centralised** (type 5) or **centralised but structured at the territorial level** (type 4); in type 4, most of the responsibilities lie with the central government even if implementation is at the territorial level through bodies or agencies representing the central administration; additionally, with the exception of Portugal, LRAs of type 4 systems may also manage health care facilities.

In the light of the important role played by LRAs in health care development and delivery of services across the EU, additional input from the local and regional level within relevant EU committees, working parties or expert groups would be beneficial to discussions feeding health policy development, as it would bring policy-making closer to real needs and make it more demand-driven.

Chapter 4 focuses on highlighting specific areas where local and regional input could add value in terms of policy development. These highlights are based on the evidence gathered through the inventory compiled in Chapter 2 and through other recent investigations by the Committee of the Regions, and do not enter into the merit of feasibility of, or modalities for, a higher degree of participation by LRAs in EU processes. However, since the topics are usually relevant for more than one type of health management system, a structured representation of LRAs by means of existing bodies, such as the Committee of the Regions or associations of regions, is recommended.

There is scope for input by LRAs through their representing bodies in the following policy domains:

- (i) Nutrition and Physical Activity, in particular with regard to: the enrichment of the knowledge base with experiences from the local and

regional level; the proposal of new policy ideas; the acceleration of the creation of PPP through direct involvement of LRAs with the private sector.

- (ii) Social Determinants of Health and Health Inequalities, in particular with regard to: monitoring the impact of the crisis at the local and regional level, including indicator development and modalities for streamlining data and indicator-based evidence into the policy-making process; developing integrated regional strategies to reduce health inequalities or ‘local care approaches’; promoting telemedicine; partnering across border regions to reduce access inequalities by making facilities and personnel available across borders; determining the requirements for the enhancement of public health capacity at the local and regional levels through training on equity in health approaches across policy sectors.
- (iii) Cross-border Health Care, in particular with regard to: monitoring respect of the subsidiarity principle and of the social, economic and financial impact of the EU Directive on patients’ rights in cross-border health care on health systems at the local and regional level, including the effect on patient inflows and outflows and reduction of health inequalities.
- (iv) Implementation of the European Health Strategy as well as the shaping of Europe 2020 health objectives and making health a thematic priority for investment, along with better use of EU cohesion policy and structural funds.
- (v) Data Protection, in particular by providing input on specificities related to health data on the basis of experiences made by LRAs.

2. Inventory

2.1 Introduction

This chapter includes the health management system profiles of 27 EU Member States. Profiles outline the structure of the health systems, main actors and responsibilities; modalities for the delivery of health care services; financing mechanisms; and main types of expenditure. This inventory is intended to provide a snapshot of the main features of health management systems across Europe. Even though the focus of the report is on the role of local and regional authorities (LRAs) with regard to health matters, from policy and regulation to planning, implementation and funding of health care, it was nevertheless necessary to set the institutional scene upstream (national level) and briefly describe the recipient catchment downstream (beneficiaries of the services and types of services) in order to understand the framework in which LRAs intervene.

Profiles have been developed on the basis of desk research. The most important sources of information are the health system reviews prepared by the European Observatory on Health Systems and Policies and published by the World Health Organization.² Other good references, mainly for gathering an indication of latest developments, are the 2009 or 2010 annual national reports on pensions, health and long-term care prepared by the Analytical Support on the Socio-Economic Impact of Social Protection Reforms (ASISP).³ Hospital governance-related information was gathered through the European Hospital and Healthcare Federation (HOPE) country profiles, available on-line and related to information updated to 2007, and through the 2009 report by HOPE and Dexia on hospitals in the EU.^{4,5}

² All profiles are available at: <http://www.euro.who.int/en/home/projects/observatory/publications/health-system-profiles-hits/full-list-of-hits>

³ The Analytical Support on the Socio-Economic Impact of Social Protection Reforms (ASISP) is a network of independent experts established by the European Commission. The network prepares annually 34 country reports on pensions, health, and long-term care evaluating latest developments and reforms undertaken in these policy areas.

⁴ Hospital country profiles by HOPE are available at: <http://www.hope.be>

⁵ Hope & Dexia (2009)

In a number of cases, reference was directly to the website of relevant ministries dealing with health within individual countries and to the information made publicly available there. Finally, another significant literature source was the OECD Health Working Paper reporting on the results of a survey launched in 2008 to collect information from 29 countries on their health systems.⁶ The survey, based on 81 questions, also gathered information on governance and decentralisation in decision-making with regard to resource allocation and financing responsibilities; replies related to the latter aspects have been included in the profile of those EU Member States that are also OECD member countries, as a complementary element to the narrative description of their health system.⁷

A number of health systems are undergoing reform, especially with regard to funding mechanisms and revision of purchaser/provider relationship. This is a direct consequence of increasing health expenditure driven, among other things, by the economic downturn and related occupational crisis (several systems have an occupation-based mechanism for contributing to statutory health insurance) and important demographic changes (ageing population). Whenever possible, the occurrence of these changes was noted.

The inventory is by nature a descriptive text but efforts have been made to provide visually immediate information to the reader on important features such as prevalence of a decentralised or centralised management structure, types of health facilities owned by LRAs, and types of power/responsibility exercised by LRAs. Table 1 provides the ‘legend’ of such visual information.

⁶ Paris, V., M. Devaux and L. Wei (2010)

⁷ Reference is to Table 30 in Paris, Devaux, Wei (2010), pages 69-70.

Table 1 – Icons for visualising main information



decentralised

health management system or tendency of the system towards decentralisation



centralised

health management system or tendency of the system towards centralisation



ownership by LRAs of major health facilities

Regions	<ul style="list-style-type: none"> • implementation of hospital care • funding • delivery of services
Local governments	<ul style="list-style-type: none"> • funding • delivery of services

LRAs functions within the health management system

The information gathered in this inventory supports the outlining of a typology of health care systems in terms of decentralisation of tasks and responsibilities from the central to the local and/or regional level. Aggregated conclusions and synthesis of the information included in chapter 2 are presented in chapter 3 where the cluster analysis is also supported by other relevant statistics and indicators.

The main findings of the inventory in terms of functions are summarised in Table 2.

Table 2 – Overview of functions delegated to local or regional authorities, by country

	legislative	planning	implementatio	funding		legislative	planning	implementatio	funding		legislative	planning	implementatio	funding
AT	●	●	●	●	FI	⊘	●	●	●	MT	⊘	⊘	⊘	⊘
BE	⊘	●	●	●	FR	⊘	●	●	●	NL	⊘	●	●	●
BG	⊘	⊘	●	●	GR	⊘	⊘	●	⊘	PL	⊘	●	●	●
CY	⊘	⊘	⊘	⊘	HU	⊘	⊘	●	●	PT	⊘	⊘	●	⊘
CZ	⊘	●	●	●	IE	⊘	⊘	⊘	⊘	RO	⊘	⊘	●	●
DE	⊘	●	●	●	IT	●	●	●	●	SE	⊘	●	●	●
DK	⊘	●	●	●	LT	⊘	●	●	●	SK	⊘	⊘	●	●
EE	⊘	●	●	●	LU	⊘	⊘	●	⊘	SL	⊘	●	⊘	●
ES	●	●	●	●	LV	⊘	⊘	●	⊘	UK	⊘	●	⊘	⊘

2.2 Country profiles

AUSTRIA

Main characteristics of the Austrian health care system

- ▶ Decentralised, with several competencies delegated to provincial and local authorities or social security institutions
- ▶ Providing almost universal coverage (98.8%) through statutory insurance
- ▶ Health expenditure is mostly funded through public funds – out of social insurance contributions and taxation - and complemented by private payments
- ▶ Mixed service provision – public and private

Structure of the system

The Federal Government is responsible for health policy and legislation.



Overall, it plays a supervisory and facilitating role among the numerous actors involved in health care, with **several functions being**

shared with, or delegated to, the nine States/Provinces (*Bundesländer*) and/or social security institutions. In general, cooperation within the health sector is regulated by law. The Federal government bears responsibility for: regulations regarding pharmaceuticals, pharmacies and medical devices; health professions (for example education of physicians) and structural policy; and legislation for outpatient care (physicians in individual practices). Main institutional actors include: (i) at the federal level, the Federal Health Agency and its executive body (the Federal Health Commission), managed by the Federal Ministry of Health and composed of representatives from all government levels, as well as from social security institutions, the Austrian Medical Chamber, church-owned hospitals, and patient representatives; (ii) at the provincial level, the Regional Health Funds and their executive bodies (the Regional Health Platforms) that include representatives of the respective provinces, of the Federal Government, of the Main Association of Austrian Social Security Institutions⁸, of the Austrian Medical Chamber, of local governments and hospital organisations. The Regional Health Funds are the implementation branches of the Federal Health Agency and distribute funds to public, private and non-profit hospitals.

As self-governing bodies, the social security institutions have regulatory functions with respect to outpatient health services. The social insurance system is based on statutory insurance that is thus compulsory and regulated by law. There is no insurance market, as people may not choose their social security institution. Affiliation to an insurance fund depends on the profession of the insured person, on the place of work, or on the place of residence.

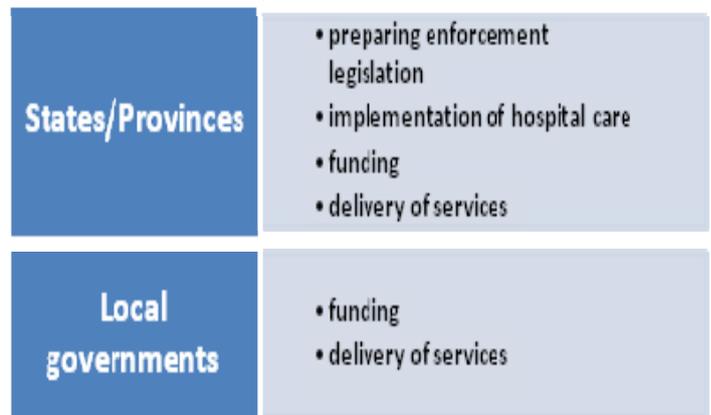
Planning of resources across all levels is through a national Health Care Structure Plan (ÖSG) and Regional Health Care Structure Plans (RSG).

All levels of government, from the federal to the local, are jointly involved in the provision of public health services and administration. The responsibility for in-patient care (provided in hospitals) is shared between the federal and the provincial authorities, with the former laying down the legislative framework and the latter preparing enforcement legislation.

⁸ The Main Association of Austrian Social Security Institutions (HVB) is the umbrella organisation of 22 social security institutions, covering pension, health and accident insurance.

Delivery of services

Insurance provides free access to a package of services; services not included in this package may require upfront payments by patients, or co-payments. Direct payments are also made when using benefits that are not covered by the package or that are delivered through physicians not employed by the respective social health insurance fund. Exemptions from co-payment exist for specific categories of patients (chronically ill, below a certain income level, etc.)



Provincial authorities are specifically responsible for the implementation of hospital care, the maintenance of hospital infrastructure, health promotion and prevention services; social welfare benefits and services are the responsibility of local governments (districts, statutory cities and municipalities).

Access to health services is not regulated, in that patients are not obliged to enrol with one specific physician and physicians do not play a gate-keeping role. Patients may thus also access outpatient departments of hospitals without referral. Outpatient care is provided through physicians (some self-employed), outpatient clinics, privately owned or belonging to the social health insurance funds, other specialists and outpatient departments of hospitals. Physicians usually have a contract with the social health insurance funds.

In 2008, a total of 267 hospitals were available for inpatient care, with some 130 hospitals (about 48,600 beds) funded by provincial health funds (*Landesgesundheitsfonds*) and some 44 hospitals (about 4,000 beds) by the private hospital-financing fund (*Privat-krankenanstalten-Finanzierungsfonds*). The ownership of hospitals is 58% public (States/Provinces, local authorities, or social insurance institutions, directly or



through companies) and for the remaining share, private (religious orders, associations).⁹

Licensing and monitoring of medicines market is at the federal level by the Austrian Medicines Agency, AGES PharmMed. Drugs are delivered through privately owned pharmacies or, in rural areas, through family physicians.

OECD survey

Setting the level of taxes to be earmarked for health care		Financing new hospital building	R
Setting the basis and level of social contributions for health	C	Financing new high-cost equipment	R
Setting the total budget for public funds allocated to health	C,R,L	Financing the maintenance of existing hospitals	R
Deciding resource allocation between sectors of care	C,R,L	Financing primary care services Setting public health objectives	
Determining resource allocation between regions	C,R,L	Financing specialists in outpatient care	
Setting remuneration methods for physicians		Financing hospital current spending	C,R,L
Defining payment methods for hospitals	C,R,L	Setting public health objectives	C,R

Source: Paris, Devaux, Wei (2010)

Note: C (central/federal government); R (regional/state government); L (local/municipal government)

Finance and health care expenditure

In 2007, 76% of total health expenditure was from public sources and the remaining 24% from private sources; in particular, social insurance contributions covered about 50% of total health expenditure (ÖBIG, 2010a).

The health care system is thus primarily financed through public funds, the main sources of revenue for which are social insurance contributions (about 60%) and

⁹ HOPE online country profile – Austria: latest information from 2007

taxation (40%). Public funds come from the Federal Government, the provincial and the local governments. Private payments are in the form of both direct and indirect co-payments.

‘The organisation and financing of the healthcare system are governed by intra-state agreements between the national and provincial governments in accordance with Article 15a B-VG (Austrian Constitutional Law)’...such funds ‘are distributed to the individual provinces and the provincial health funds in those provinces on the basis of set proportional allocations’ (ÖBIG, 2010b).

References:

- Federal Ministry of Health [website](#)
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- Fink M. (2010), Annual National Report 2010 – Pensions, Health and Long-term Care: Austria. [ASISP](#): Analytical support on the Socio-Economic Impact of Social Protection Reforms

BELGIUM

Main characteristics of the Belgian health care system

- ▶ Decentralised, with main responsibilities shared between the federal government and the federated authorities (communities, regions), reflecting the institutional setting and devolution of the country
- ▶ Providing nearly universal coverage (99.6% of the population) through compulsory insurance
- ▶ Health expenditure is mostly funded through public funds – out of social security contributions and taxation from the federal government and, to a lesser extent, from the local level
- ▶ Mixed service provision – public and private

Structure of the system

Health care is determined by three levels of government: the federal government, the federated authorities (three regions and three communities) and, to a minor extent, the local governments (provinces and municipalities). The division of responsibilities for health care



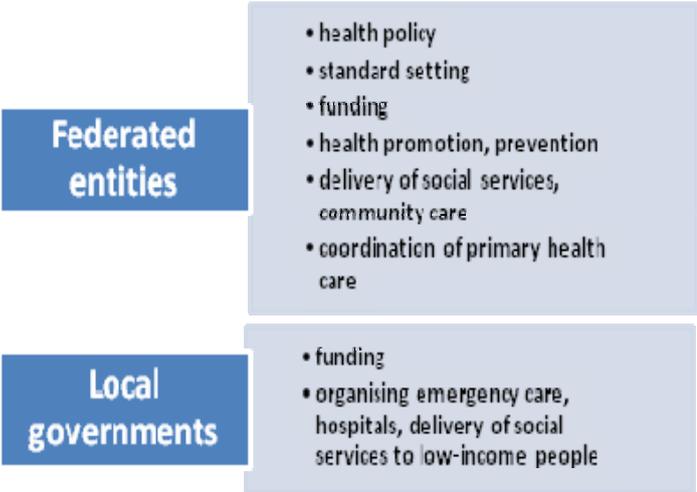
reflects the structure of the country as, since the 1980s, some responsibilities have been devolved to the three communities (Flemish, French, and German). The federal level, through the Ministry of Social Affairs and Public Health, is responsible for the regulation and financing of compulsory health insurance, pharmaceutical policy and hospital legislation. The health legislative framework and the drawing up of the annual budget of the health system are determined at the federal level. Both the federal level and the federated entities are responsible for health policy. The three communities define their own objectives for health promotion and preventive health care policies and their internal governance structures. Responsibilities of the federated authorities are mainly on *‘health promotion and prevention; maternity and child health care and social services; different aspects of community care; coordination and collaboration in primary health care and palliative care; the implementation of accreditation standards and the determination of additional accreditation criteria; and the financing of hospital investment.’* (Gerkens and Merkur, 2010).

- ⇒ As an example of responsibility-sharing and of the level of interaction with regard to hospital planning, hospital capacity is planned at the federal level, along with the requirement for hospitals to obtain accreditation from the regional ministries of public health; the communities are responsible for authorising hospital construction; capital subsidies for hospital buildings are provided by both the communities and the federal government.

Cooperation between the different levels is through inter-ministerial conferences, composed of ministers responsible for health policy from the federal and federated governments. These conferences may produce protocol agreements on specific policy areas such as long-term and elderly care, vaccination programmes, and cancer screening, but decisions are not binding and, above all, are a consultation forum.

Provinces and municipalities have limited responsibilities in health care. Provincial commissions deal with responses in cases of contagious diseases, the checking of professional qualifications and the supervision of the practice of medicine, nursing and paramedics. Municipalities are responsible for organising social support for those on low incomes, as well as emergency care and public hospitals.

The health insurance scheme is compulsory. Membership is based on current or previous professional activity. There are two main schemes, one for all but the self-employed, and one for the self-employed (since 2008). Compulsory health insurance is managed by the National Institute for Health and Disability Insurance, a public institution accountable to the Minister for Social Affairs and Public Health. All individuals entitled to health insurance must register with one of the existing sickness funds that are private, non-profit-making organisations. Voluntary health insurance accounts for a small share of the market.



Delivery of services

Insurance coverage provides access to a range of some 8,000 services. Outpatient care is usually delivered upon upfront payment by patients that will be later reimbursed through their sickness fund. For in-patient care and medicines, patients only pay user charges, as the sickness funds pay the providers directly (third party payer system).

General practitioners do not function as gate-keepers and generally operate from their premises as independent professionals. Patients thus have free choice and can directly access both specialists and hospitals. In general, emergencies are handled through 24-hour primary health care hospital emergency departments.

Secondary care comprises in-patient care in hospitals and in day care. Hospitals are private or public non-profit organisations, classified into acute, psychiatric, geriatric and specialised hospitals. Specialist health care is provided by professionals, generally organised as self-employed professionals (except nurses and midwives). The majority (60%) of hospitals are non-profit private, mostly owned by religious orders or, to a lesser extent (5%), by sickness funds (Van



Gyes, 2009); most of the public hospitals are owned by municipalities, provinces, a community or an inter-municipal association.¹⁰

The pharmaceutical sector is regulated at the federal level. Pharmaceuticals are exclusively distributed through community or hospital pharmacies and prescribed by physicians or, limited to their professional services, dentists and midwives.

OECD survey

Setting the level of taxes to be earmarked for health care	C	Financing new hospital building	C,R
Setting the basis and level of social contributions for health	C	Financing new high-cost equipment	C
Setting the total budget for public funds allocated to health	C	Financing the maintenance of existing hospitals	C
Deciding resource allocation between sectors of care	C	Financing primary care services Setting public health objectives	
Determining resource allocation between regions	C	Financing specialists in outpatient care	
Setting remuneration methods for physicians		Financing hospital current spending	C
Defining payment methods for hospitals	C	Setting public health objectives	C,R

Source: Paris, Devaux, Wei (2010)

Note: C (central/federal government); R (regional/state government); L (local/municipal government)

*Finance and health care expenditure*¹¹

Health care expenditure is mainly publicly funded (71.3% in 2006), main sources being social security contributions and taxation at the federal, regional and local level. Federated and local government revenues (1.5% and 2.0% of the total health expenditure, respectively, in 2006) are mainly for prevention and health promotion activities.

¹⁰ HOPE online country profile – Belgium: latest information from 2007

¹¹ Gerkens and Merkur, 2010

In 2006, the private share of total health care expenditure was 28.4%, out of which 23.3% came from upfront payments and 5.1% from voluntary health insurance.

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BULGARIA

Main characteristics of the Bulgarian health care system

- ▶ Partially decentralised, with some implementation and funding responsibilities delegated to local authorities (municipalities)
- ▶ Providing coverage to some 92% of the population through statutory insurance; Roma and permanently unemployed individuals are excluded from the scheme
- ▶ Mixed funding of health expenditure: through public revenues out of statutory health insurance contributions and taxation, and private sources through out-of-pocket payments
- ▶ Mixed service provision – public and private

Structure of the system



At the central level, the Ministry of Health is responsible for health policy development, drafting of legislation, sectoral planning and priority setting, organisation of emergency care and of public health activities. It is operational at the regional level through 28 centrally-funded regional health centres and 28 independently functioning emergency health care centres. The Ministry of Health also has direct control of several national hospitals and defines the ‘guaranteed medical services package’ to which each insured person has free access.

The National Health Insurance Fund (NHIF), under the Ministry of Health, is a public non-profit-making organisation administering the compulsory health insurance: it has branches at the regional level (28 regional health insurance funds - RHIFs) and offices at the municipal level. The NHIF is responsible for financing health care and for guaranteeing access to it by the insured; in particular, it finances all outpatient and in-patient care provided by those institutions with which it has a contract. Provision of services within the statutory system is, in fact, subject to the conclusion of contracts between physicians and institutions on the one hand and the NHIF/RHIFs on the other. Contractual conditions are set within the National Framework Contract, agreed on an annual basis and also determine the benefits package.

Since 1992, **municipalities have had ownership of local hospitals, outpatient clinics, and other health care facilities, a circumstance that also implies financing responsibilities.**

Municipalities may also have a share in the ownership of inter-regional and regional hospitals, organised into joint-stock companies.



The health insurance system is based on compulsory insurance. It is regulated by the Health Insurance Act and is designed as a state monopoly: *‘The choice of one fund for social health insurance brings into balance the interrelations with the health service providers who are also associated and represented by the professional organizations of doctors and dentists. The Law does not provide for a re-distribution mechanism to level the risks, which would have been necessary in the process of functioning of more than one independent fund’* (NHIF website). Insurance is based on citizenship and residence; it guarantees insured persons free access to a benefits package, as well as free choice of any service provider who has concluded a contract with the RHIFs. Some services require co-payments or user charges. Certain categories of the population are exempted from the payment of contributions: that is covered by state and municipal budgets (for example, pensioners, individuals receiving unemployment benefit, high school students up to the age of 26, or individuals below the age of 18). The undertaking of voluntary health insurance is possible.

Delivery of services

Primary and outpatient health care has been mostly privatised and is provided through individual and group practices. General practitioners function as gate-keepers to specialised and secondary care.

In-patient care is provided by general and specialised health care facilities. Hospitals may be public (owned by the state or by municipalities) or private. In the latter case, if they do not have a contract with the NHIF, patients have to pay in full for the services or be covered by a voluntary insurance scheme. In 1991, private practice was legalised and since then privatisation of health care facilities has progressed significantly; in 2009, there were 103 privately owned hospitals (ASISP, 2010) compared to 40 in 2004.



The Pharmaceuticals and Human Medicine Pharmacies Act of 1995 regulates the licensing, manufacturing, marketing, wholesale and retailing of drugs. It set the basis for the restructuring and privatisation of the sector, according to which most pharmacies are now private.

Finance and health care expenditure

Health care expenditure is characterised by a high level of private funding. In 2005, upfront payments for user charges and co-payments for medical services accounted for 41.6% of total health expenditure. Private revenues from voluntary health insurance play a minor role. Public funding accounted for 57.5% of total health expenditure, mostly out of compulsory health insurance contributions, which are payroll-based, and state and municipal budgets that provide cover for those unable to contribute.¹²

The central budget revenue comes from general taxation (VAT, income tax, corporate tax) while the municipal budget revenue comes from local levies such as waste charges and building tax (Georgieva *et al.*, 2007).

¹² Thomson S. *et al.* (2009)

References:

- European Commission (2008): [The socio-economic impact of the Hospital Information System in National Heart Hospital-Sofia, Bulgaria](#)
- Georgieva L. *et al.* (2007), Health Systems in Transition, Vol.9 No.1, [Bulgaria: Health system review](#), European Observatory on Health Systems and Policies
- NHIF [website](#)

CYPRUS

Main characteristics of the Cypriot health care system

- ▶ Currently highly centralised, although an ongoing reform process is expected to move towards decentralisation
- ▶ Not yet providing universal coverage
- ▶ Public health care financing is through general taxation
- ▶ There is a high share of private expenditure
- ▶ Mixed service provision – public and private

Structure of the system



Cyprus is in the midst of a reform process of its national health system that has been planned since 2001 but that remains unimplemented. Factors currently slowing down the reform process include, , the downturn caused by the financial crisis with consequent budgetary constraints, and a debate on the need to restructure public hospitals as independent units. The reform is considered necessary to address major deficiencies and inequalities that characterise the existing system. Established by Law 89(I)/2001, the Health Insurance Organisation (HIO) is the public legal entity in charge of implementing the new National Health System (NHS).

Overall responsibility for social protection and health care lies with the Council of Ministers. The provision of care is regulated by the Government Medical Institutions and Services General Regulations of 2000 and 2007. The Ministry of Health, through the Department of Medical and Public Health Services, governs the Government Medical Institutions and is responsible for the organisation and the provision of health care services.

Services are provided by the Government Medical Services, made available through Government Medical Institutions, or by the private sector. Private health facilities are, in fact, flourishing, although there is a lack of effective control and coordination with public care. Some 70% of the population is covered by public health care.

Delivery of the services

Delivery of public services is via a network of hospitals, health centres, sub-centres and dispensaries. Namely, public primary health care is provided ‘*at 4 hospital outpatient departments, 7 suburban outpatient departments, 5 urban and 23 rural health centres and 274 sub-centres*’ (WHO, 2004). Lower administrative levels cooperate in implementation and promotion activities but the organisation, administration and regulation functions remain at the central level. Secondary and tertiary health care is provided through four main district hospitals and specialist centres, in addition to three small rural hospitals. The private provision of services is through practising physicians, and supporting structures such as surgeries, pharmacies, laboratories and polyclinics. Limited to urban areas, there are 105 small private clinics for in-patient care, some of which offer highly specialised services. Patients are free to choose the service provider; there is no gate-keeping system in place.

The forthcoming reform is expected to unify service provision by both private and public suppliers on a competitive basis, thus the need to make hospitals independently managed units. Once implemented, the reform is expected to generate a certain degree of decentralisation.

Pharmaceutical care is provided according to an approved list of pharmaceuticals; medicines are dispensed through community pharmacies (430 private and 35 public in 2006) and public hospital pharmacies (8 in 2006).

Finance and health care expenditure

Public health services are financed by general taxation through the budget. The contribution of charges imposed on some services is limited.

Some categories of patients are exempted from the payment of public care service provision : state officials and civil servants (active or retired) and their

dependants, families with four or more children, university students, and people belonging to vulnerable categories because of illness (chronic disease, for example) or income. However, co-payments may also be requested from some of the above categories for the delivery of certain services.

Those persons deciding to refer to the private sector pay upfront fees; they may be fully or partially covered by medical funds operated by trade unions or employers. There is a high level of private expenditure for health (about 60% of total expenditure).

As a result of the reform process, the public health system will be funded through compulsory health insurance contributions.

References:

- Ministry of Health of the Republic of Cyprus [website](#)
- Cyprus Health Insurance Organisation [website](#)
- Golna C. *et al.* (2004), [Health care systems in transition: Cyprus](#). Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies
- Petmesidou M. (2010), Annual National Report 2010 – Pensions, Health and Long-term Care: Cyprus. [ASISP](#): Analytical support on the Socio-Economic Impact of Social Protection Reforms

CZECH REPUBLIC

Main characteristics of the Czech health care system

- ▶ Decentralised, with responsibilities held by regional authorities (self-governing regions)
- ▶ Providing universal coverage through a mandatory health insurance system
- ▶ Mainly public financing of health care – contributions from the insurance system
- ▶ Mixed service provision – public and private

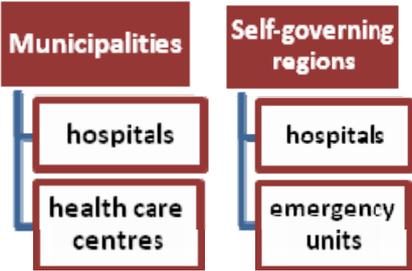
Structure of the system



At the central level, the Ministry of Health is responsible for health policy and legislation. It has also a supervisory role and the direct administration of some care institutions and bodies, the latter

including the Regional Public Health Authorities, the National Institute of Public Health and the Regional Institutes of Public Health, responsible for science, research, epidemiological and immunisation activities. Together with the Ministry of Finance, the Ministry of Health supervises the health insurance funds.

The 14 self-governing regions have been delegated a number of responsibilities in health care including the registering of in-patient health care facilities and of ambulatory care providers in private practice and polyclinics; in



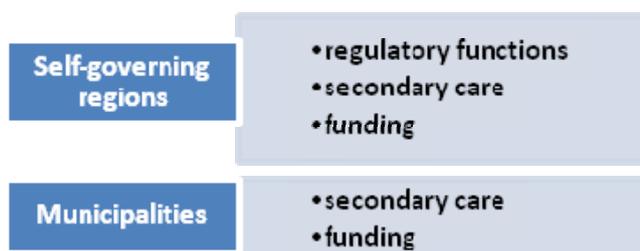
addition to this regulatory role, in 2003, the ownership of several of the hospitals and health care facilities (emergency units and long-term care institutions) owned by the state was transferred to them. Several of these hospitals were transformed into joint stock companies owned by the regions,

the others remaining as public non-profit-making organisations. As part of this decentralisation process of care facilities, some small hospitals were also transferred to municipalities.

Other key actors in the system include the health insurance funds, quasi-public, self-governing bodies in charge of contracting health care providers. The purchasing process and related negotiations are supervised by the Ministry of Health. The health system is based on mandatory social health insurance through membership in one of the 10 (as at 2009) health insurance funds. The funds function as payer and purchaser of care services; they are obliged to accept all applicants, regardless of the risk, and therefore a risk-adjustment scheme applies when funds pooled by the social health insurance are redistributed among them; additionally, these funds are not allowed to make profit, any surplus they may have is used for health care funding. Responsibility for the regulation of primary care is shared between the central level, the regions, and the health insurance funds, since regions, as members of dedicated committees, contribute to the issuing of recommendations on the contracting of providers. Although these recommendations are not binding, they are usually followed by the health insurance funds.

Delivery of the services

Insurance provides access to a wide range of services, from in-patient to outpatient care, medicines (upon prescription), rehabilitation, spa treatment and some dental care. Individuals are



free to choose the fund and the doctor to register with. There is no gate-keeping system, thus specialist care may also be accessed freely. Most (95%) of the services provided at primary care level are from professionals working in private practice, although they occasionally rent facilities in health centres or polyclinics. Secondary care is provided through health care centres (generally owned by municipalities), polyclinics, hospitals, specialised centres or private professionals. The ownership and management of hospitals is undertaken by a different range of actors, from the state to regions and municipalities, private entities and churches. Public hospitals account for more than two thirds of the total number of hospitals (in 2008, out of 192 acute hospitals, 25 were owned by the state, 66 by the regions, and 28 by the municipalities).

Pharmacies are almost entirely (99%) privately owned and run, apart from those belonging to publicly owned hospitals. The State Institute for Drug Control, under the Ministry of Health, is responsible for pricing and reimbursement of registered medicines.

OECD survey

Setting the level of taxes to be earmarked for health care	C	Financing new hospital building	C,R,L
Setting the basis and level of social contributions for health	C	Financing new high-cost equipment	C,R,L
Setting the total budget for public funds allocated to health		Financing the maintenance of existing hospitals	C,R,L
Deciding resource allocation between sectors of care	C	Financing primary care services Setting public health objectives	C

Determining resource allocation between regions		Financing specialists in outpatient care	C
Setting remuneration methods for physicians		Financing hospital current spending	C
Defining payment methods for hospitals		Setting public health objectives	C,R,L

Source: Paris, Devaux, Wei (2010)

Note: C (central/federal government); R (regional/state government); L (local/municipal government)

Finance and health care expenditure

Public expenditure contributes the major part of total health expenditure (85.8% in 2007). Its main sources are social health insurance contributions, comprising mandatory contributions from payroll tax (split between employees and employers) and from the self-employed (on the basis of their profit); and state contributions on behalf of the economically inactive. Other sources of public expenditure, accounting for 7.4% of total health expenditure in 2007, are from state, regional and municipal budgets. These budgets are financed through general taxation (VAT, income and wealth taxes, and excise duties), mainly for capital investments in facilities or subsidies.

In 2007, private expenditure accounted for 14.2% of total health expenditure. Its main sources include upfront payments for co-payments on services and medicines or for the purchasing of over-the-counter pharmaceuticals. Voluntary health insurance has a small market.

Reference:

Bryndová L. *et al.* (2009), [Czech Republic: Health System Review](#). Health System in Transition, European Observatory on Health Systems and Policies

DENMARK

Main characteristics of the Danish health care system

- ▶ Decentralised, with a significant role played by regional and local (municipal) authorities, the latter also in financial terms
- ▶ Providing universal coverage free of charge at the point of service
- ▶ Mainly public financing of health care – out of national and local taxation
- ▶ Mostly public service provision

Structure of the system



At the central level, the Ministry of Health and Prevention is responsible for health policy and legislation. It also develops national guidelines for health care provision, monitors and facilitates exchange of experience and information, and administers economic incentives and activity-based payments.

The 5 regions are responsible for the running of hospitals and the administration of primary health care, with the possibility of arranging service provision according to regional requirements and facilities, although always within an overall, centrally-set framework. **The 98 municipalities have several responsibilities in the field of health**, from public health care, with the local administration of the primary health care service, to home nursing, prevention and rehabilitation, as well as financing. They are also responsible for most social services, including support to the elderly.

Delivery of services

General practitioners act as gate-keepers to secondary care, so a referral is necessary for hospital treatment and treatment



by specialists, but not for emergency care. Any person above the age of 16 has the right to decide to belong to either ‘Group 1’ or ‘Group 2’ patients. The default group, to which most of the population belong (98.5% in 2007), is ‘Group 1’; people are free to choose a GP working within 10 km of their house; they have free access to general preventive, diagnostic and curative services. Belonging to Group 2 enables the person to consult any GP and any specialist

without referral; incurred expenses will be subsidised by the public system up to the equivalent cost of a Group 1 patient, the rest being at the expense of the Group 2 individual. Most health professionals are self-employed and paid by the regions according to collective agreements between the regions and the unions of professionals.

Secondary care is delivered through hospitals, most of which are owned and operated by the regions. Hospitals with highly specialised departments may be used by patients of other regions, on the basis of inter-regional agreements whose aim is to make specialised hospital treatment available to all. Regions may also refer patients to treatment abroad and pay for it. If the waiting time for treatment exceeds one month, patients have the right to be treated in a private hospital or abroad. Private hospitals, especially specialised ones, are used through the public system on the basis of agreements with the regions.



OECD survey

Setting the level of taxes to be earmarked for health care		Financing new hospital building	C,L
Setting the basis and level of social contributions for health		Financing new high-cost equipment	C,L
Setting the total budget for public funds allocated to health	L	Financing the maintenance of existing hospitals	C,L
Deciding resource allocation between sectors of care	C,R,L	Financing primary care services Setting public health objectives	C,L
Determining resource allocation between regions		Financing specialists in outpatient care	C,L
Setting remuneration methods for physicians	C,R	Financing hospital current spending	C,L
Defining payment methods for hospitals	C,R	Setting public health objectives	C

Source: Paris, Devaux, Wei (2010)

Note: C (central/federal government); R (regional/state government); L (local/municipal government)

Finance and health care expenditure

Public health services are financed through a health care contribution tax that corresponds to 8% of taxable income. At the regional level, funding from the central level is complemented by resources raised locally. Most of the finance is from a State Block Grant (some 77% of the total); the central level contributes also with a State Activity-related Subsidy (3% of the total) intended to incentivise activities within hospitals. The remaining 20% of the total financing of health care is raised locally through a basic contribution (8%) and an activity-related contribution (12%) (Kvist, 2010). The basic contribution is a lump sum charged to each citizen and determined by the region; the activity-related contribution depends on the level of use by citizens of the regional health services, and is thus related to hospitals and general practice. Some 50% of the activity-related contribution is re-distributed by regions to hospitals.

Public health expenditure represents 84% of total health expenditure, the rest being private expenditure as upfront payments for medicines and dental care.

References:

- Ministry of Health and Prevention (2008), [Health Care in Denmark](#).
- Kvist J. (2010), Annual National Report 2010 – Pensions, Health and Long-term Care: Denmark. [ASISP](#): Analytical support on the Socio-Economic Impact of Social Protection Reforms.

ESTONIA

Main characteristics of the Estonian health care system

- ▶ Central responsibility, with provision of services devolved to private entities that may be partially or wholly owned by the public administration (state or municipalities)
 - ▶ Wide coverage (95%) through a mandatory, solidarity-based insurance
 - ▶ Mainly public financing – out of earmarked taxation through mandatory health insurance contributions
 - ▶ Service provision has been mostly privatised, i.e. delegated to autonomous individuals or private legal entities such as limited liability (profit-making) companies or (no-profit) foundations
-

Structure of the system



The health care system is administered by the Ministry of Social Affairs. The organisational structure of the system consists of several bodies including, among others: various agencies under the Ministry for Social Affairs; the Estonian Health Insurance Fund (EHIF), as an independent, public legal entity; private primary care units and hospitals established as limited companies or foundations, but mostly owned or controlled through supervisory boards by local governments; and various non-governmental organisations and professional associations.

Responsibilities for the financing and management of public health services are at the central level. The Ministry for Social Affairs, structured into four main departments (Health Care, Public Health, Health Information and Analysis and eHealth), is responsible for health and health care policy formulation, regulation, planning, and monitoring, as well as regulation and funding of ambulance services and emergency care services for uninsured people. The EHIF (*Haigekassa*) is accountable to the Ministry of Social Affairs through the chair of its Supervisory Board. The Board is the governing body of the Fund, including 15 representatives of state, employer and insured individuals' organisations: it approves 4-year development plans, annual budgets, reports and criteria for the selection of health service providers. EHIF has implementation responsibilities as it collects and distributes funds, contracts the health service providers (as the main purchaser), pays for health services, reimburses pharmaceutical expenditure, checks the quality of the services provided and pays out benefits. At county level, county governments, representing the state regionally, are responsible for the planning, supervision and administration of primary care within the county.

The role of local authorities (municipalities) in the organisation and financing of health services is mostly on a voluntary basis as from 2001 they are no longer obliged to fund or provide health care services but, for example, some municipalities continue providing partial reimbursement of medicines and nursing care to low income households and the elderly.



Health care provision has been almost entirely privatised and delegated to autonomous providers, whether these be individuals or private legal entities such as limited liability (profit-making) companies or (non-profit) foundations. Both the state and municipalities may own and manage these entities that are, in this case, considered to be public institutions. Additionally, since 2008, an amendment to the Health Services Organisation Act allows municipalities to establish or own family practices. Family doctors are private entrepreneurs or employees of private companies providing primary care services.

The health insurance system is mandatory for all residents; it covers some 95% of the population. Insured people receive cash and in-kind benefits from EHIF, such as maternity and sickness benefits, other allowances or partial lump sum reimbursements for dental care (cash benefits); or preventive and curative health services (in-kind benefits) that may, however, be subject to co-payments.

Delivery of services

Primary care is delivered through family doctors, who are required to work together with at least one nurse; the service area of each family doctor is determined at the county level. Citizens are free to choose the family doctor to register with; family doctors function as entry points to secondary care even if some specialist care can be accessed without referral.



Specialist and hospital care (both secondary and tertiary care) are legally separated from primary care. The hospital network is organised at different levels or types of hospitals. At the end of 2006 there were 55 hospitals, including: 18 local and general small hospitals, usually at least one per county, providing ordinary treatment care; 4 central hospitals with up to 200,000 catchment inhabitants; 3 regional hospitals with up to 500,000 catchment population; 7 small specialised hospitals; 3 rehabilitation hospitals; and 20 nursing care hospitals located in major towns or county centres. Most of the hospitals are managed or owned by public authorities (the State or local authorities).

Emergency medical care is provided through ambulance services countrywide. Medicines may only be distributed through privately-owned pharmacies, most of which belong to pharmacy chains. Pharmaceutical policy is the responsibility of the Ministry of Social Affairs, which is also involved in planning, pricing and reimbursement decisions, while the State Agency of Medicines is responsible for permits, medicines classification and supervision.

Finance and health care expenditure

Health care is mainly funded through EHIF contributions in the form of earmarked social payroll tax paid by salaried and self-employed workers, making the revenue dependent on the contribution of the employed only. Since the other categories are ‘subsidised’ by the active workforce, the system is considered to be based on a strong component of solidarity.

Other public sources of health care financing from general taxes include state (from the Ministry of Social Affairs for the emergency care of uninsured people, ambulance services and public health programmes) and municipal contributions, covering, in 2006, 9.4% and 1.8% of total health care expenditure, respectively.

One quarter of all expenditure is private, mostly represented by upfront payments for pharmaceutical co-payments and dental care and, to a lesser extent, the undertaking of voluntary health insurance.

References:

- European Federation of Public Service Unions [website](#)
- Koppel A. *et al.* (2008), Health Systems in Transition, Vol. 10 No.1, [Estonia: Health system review](#), European Observatory on Health Systems and Policies
- Vörk A. *et al.* (2010), Annual National Report 2010 – Pensions, Health and Long-term Care: Estonia. [ASISP](#): Analytical support on the Socio-Economic Impact of Social Protection Reforms

FINLAND

Main characteristics of the Finnish health care system

- ▶ Highly decentralised, with an important role played by local authorities (municipalities)
 - ▶ Providing coverage through a compulsory health insurance system for all citizens
 - ▶ Prevailing public financing of health care – out of general taxation, including municipal taxes, and National Health Insurance
 - ▶ Mixed service provision because of different arrangements pursued by municipalities in purchasing/providing the services
-

Structure of the system

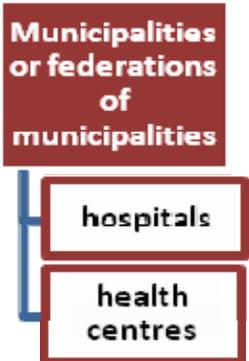


At the central level, the Ministry of Social Affairs and Health is responsible for health policy and the setting of broad development goals. The legislative framework is also set at the national level and there are several programmes undertaken by the central authorities to support local and regional development as well as the restructuring of the health system by encouraging merging and partnering among municipalities for a more effective delivery of services.

The social and health departments of the five provincial administrations (Provincial State Offices) provide guidance to municipal and private health care providers, and also play a supervisory role. However, according to the Primary Health Care Act of 1972, **responsibilities for the provision of health care lie with the municipalities** (348 at the beginning of 2009) and for such scope each municipality must have a health centre providing primary health services. Also social care is delegated to the municipal level.

The municipal health care system provides primary and specialised health care, the latter being regulated by the Act on Specialised Medical Care. Primary care is provided through health centres that control municipal hospitals and health stations. Modalities for delivery are determined by each municipality and may range from the direct employment of health specialists in the health centres to contracting out the provision of services to private providers/non-profit

organisations or reliance on private companies for the hiring of the professionals working in the health centres. For primary and, in particular, for secondary care, aggregation processes have also occurred. While primary care is usually provided by individual municipalities or federations of municipalities through joint health centres, specialised services are organised by 20 federations of municipalities corresponding to 20 hospital districts, with a catchment population varying from 65,000 to 1.4 million inhabitants. Hospital districts are financed and managed by the member municipalities (the number of members per district varies between 6 and 58) and are grouped into five tertiary care regions around university-level teaching hospitals.

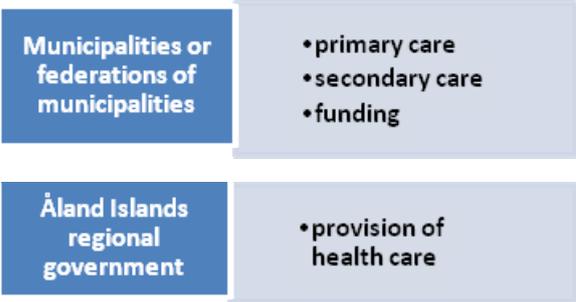


In addition to the municipal health care system, two others exist: (i) a private health care system, common in urban areas and paid for by users, with upfront payments, and by public funds, through the National Health Insurance (NHI) system; and (ii) an occupational health care system, derived from the obligation of employers to provide employees with first-aid and preventive health services, and later developed, especially within big and medium-sized firms, into a more comprehensive service inclusive of curative outpatient care, financially supported through the compulsory payments of both employers (contributing two thirds) and employees (contributing one third) to the NHI Income Insurance pool. In the autonomous region of Åland Islands the regional government bears responsibility for the provision of health care.

As a statutory scheme, NHI covers all citizens: it is run by the Social Insurance Institution under the authority of the Parliament and is funded by employers, the insured (through income-based insurance fees) and the state.

Delivery of the services

Theoretically, it is possible to choose between three health systems but in practice, the private system requires a payment and the occupational system is for employed people only. Thus, the majority of the population is covered by



the municipal system where patients have to refer to the health centre of the municipality they belong to; within the centre they may be able to choose a physician. Among the services provided by the centres are: outpatient medical care, in-patient care, preventive services, dental care, maternity care, juvenile health care, school health care, emergency care, care for elderly, family planning, rehabilitation and occupational health care. No package of benefits exists. Some of these services are free of charge, others require the payment of user charges. Access to care at the hospital districts requires a referral from a licensed physician, either working in the health centre, being private or providing occupational health services.

The municipal health system and the high level of autonomy of municipalities in arranging the services imply geographical inequalities in the way services are delivered across the country.

The pharmaceutical sector is regulated by the National Agency for Medicines, under the Ministry of Social Affairs and Health. Outpatient medicines may only be sold by pharmacies; they are partially reimbursed by the NHI, with reimbursement paid directly to pharmacies. Pharmacies are privately owned by pharmacists.

OECD survey

Setting the level of taxes to be earmarked for health care	L	Financing new hospital building	L
Setting the basis and level of social contributions for health		Financing new high-cost equipment	L
Setting the total budget for public funds allocated to health	L	Financing the maintenance of existing hospitals	L
Deciding resource allocation between sectors of care	L	Financing primary care services Setting public health objectives	L
Determining resource allocation between regions		Financing specialists in outpatient care	L

Setting remuneration methods for physicians	L	Financing hospital current spending	L
Defining payment methods for hospitals	L	Setting public health objectives	C,L

Source: Paris, Devaux, Wei (2010)

Note: C (central/federal government); R (regional/state government); L (local/municipal government)

Finance and health care expenditure

In 2005, municipalities financed 40% of total health care costs; 21% was funded by the state, 17% by NHI and 22% by private sources (Magnussen J. *et al.*, 2009).

Municipal funding is generated through taxes, and in particular through a municipal income tax ranging from 16% to 21% of taxable income, depending on the municipality, and a real estate tax. In addition, municipalities receive subsidies from the central government covering about 25-30% of their expenditure on health services, and charge users of services with user fees. At the central level, funds are raised mainly through taxation (income tax, VAT, corporate tax, etc). Private expenditure is mainly composed of upfront payments.

Both private and occupational health care are partially funded by NHI. NHI funding covers also outpatient drugs, allowances (sickness and maternity leave) and transport costs of the insured. Voluntary health insurances are taken to cover upfront payments.

References:

- Vuorenkoski L. (2008), [Finland: Health System Review](#). Health Systems in Transition, 2008; 10(4): 1–168, European Observatory on Health Systems and Policies;
- Kivelä S. and Vidlund M. (2010), Annual National Report 2010 – Pensions, Health and Long-term Care: Finland. [ASISP](#): Analytical support on the Socio-Economic Impact of Social Protection Reforms.
- Magnussen J. *et al.* (2009), [Nordic health care systems: recent reforms and current policy challenges](#), Open University Press, European Observatory on Health Systems and Policies

FRANCE

Main characteristics of the French health care system

- ▶ Centralised, although structured at the territorial (regional and departmental) level, with a few functions held by local authorities especially in the support of the elderly and the disabled
 - ▶ Providing universal coverage on the basis of resident status through statutory health insurance and, for the poorest, universal medical coverage
 - ▶ Mainly (for three quarters) public financing of health care – out of income-based contribution and taxation
 - ▶ Mixed service provision – public and private
-

Structure of the system



The health care system is organised on a local as well as a national level, with financial responsibilities delegated to the health insurance/social security system. Health policy and regulation is mainly under the responsibility of the state and of the Statutory Health Insurance (SHI). The Administration of Health and Social Affairs and its four directorates fall under the responsibility of various ministries, namely, the Ministry of Health Youth, Sports and Associations is responsible for health policy and management of resources for health care supply, while responsibility for financial matters and supervision of SHI is shared with the Ministry of Finance, Public Accounts, Civil Service and State Reforms and the Ministry of Labour, Solidarity and Public Services. Other responsibilities at the central level include: quality of care regulation; allocation of budgeted expenditure; medical education; endorsement of agreements concluded between SHI and unions; price setting for medical procedures and drugs. Since 2009 and the introduction of the Hospital, Patients, Health and Territories Act, the Administration of Health and Social Affairs is represented at the regional level by regional health agencies (*agences régionales de santé* - ARS). ARS are responsible for health care planning, delivery and finance at the regional and departmental level. They are subsidiaries of the state, while retaining their autonomy. The intermediate body between the state and the ARS is the National Council for the Governance of Regional Health Agencies. At the department level, the ARS work through local delegations.



Regional authorities, through the Surveillance Council, headed by the regional prefect, approve the budget and the expenses of the ARS and may also intervene in the main

regional capacity planning tool, i.e. the regional strategic health plan or PRS. Commissions including representatives of the local governments play an advisory role to the ARS; general councils at the department level are involved in the planning of health and social care services for the elderly and disabled. In particular, the following health and social services are under the responsibility of the general council, at departmental level: (i) health and social care institutions and services for elderly and disabled people; (ii) financial support of those with low income or fragile categories, including with regard to the funding of home assistance and long-term care; (iii) child protection through the management of mother and child health centres; (iv) disease prevention; and (v) public health and hygiene.

The SHI is composed of several health schemes, the main ones being: (i) the general scheme covering employees in industry and commerce and their families (some 87% of the population) and universal health coverage beneficiaries (some 2% of the population), i.e. the poorest, regardless of their employment status; (ii) the agricultural scheme for farmers, agricultural employees and their families (some 6% of the population); and (iii) the scheme for self-employed individuals and professionals (some 5% of the population). Each scheme has a national insurance fund, structured at the territorial level; for example, the general scheme is composed of regional and local funds with different reimbursement responsibilities. One common federation at the negotiation level represents the three main schemes with service providers. Each individual belongs to only one of the existing schemes.

Delivery of services

The delivery of health care is through public and private providers. Primary care is mainly delivered in ambulatory settings where self-employed professionals practice. These professionals do not necessarily play a gate-keeping role, although incentives have been created to try to encourage this habit. Secondary care can be delivered both at the ambulatory level or in hospitals; hospitals may

be publicly owned or may belong to non-profit or profit-making organisations, although the state maintains a monitoring role, including within private hospitals as they have to comply with quality standards and be certified on a regular basis. Public hospitals are autonomous entities, independently managing their budget; the hospital director bears executive responsibilities while the hospital administrative board, that may be composed of representatives of the state, local authorities, hospital staff etc., maintains only a strategy setting and monitoring role.

Providers are paid out of the SHI or directly by patients who are later reimbursed on the basis of statutory tariffs agreed through negotiation and approved by the state. The SHI covers, on average, 75% of a basic benefit package, the rest being either covered by private health insurance or upfront payments.

Drugs are dispensed by self-employed pharmacists; prices are set centrally and administratively for all drugs covered by the SHI.

OECD survey

Setting the level of taxes to be earmarked for health care	C	Financing new hospital building	
Setting the basis and level of social contributions for health		Financing new high-cost equipment	
Setting the total budget for public funds allocated to health		Financing the maintenance of existing hospitals	
Deciding resource allocation between sectors of care		Financing primary care services Setting public health objectives	
Determining resource allocation between regions	C	Financing specialists in outpatient care	
Setting remuneration methods for physicians	C	Financing hospital current spending	
Defining payment methods for hospitals	C	Setting public health objectives	

Source: Paris, Devaux, Wei (2010)

Note: C (central/federal government); R (regional/state government); L (local/municipal government)

Finance and health care expenditure

Responsibility for health financing is with the SHI that funded some three quarters of total health expenditure in 2007. The rest was covered through complementary sources such as state funds (5%), voluntary health insurance (13%, corresponding to a coverage of some 88% of the population), and upfront payments (7%). SHI resources come mainly from income-based contributions by employers and employees and, to a lesser extent, from contributions of the pharmaceutical industry, profit of companies having a turnover over a certain level, state budget, and the National Solidarity Fund for Autonomy dedicated to health and social services for the elderly and the disabled. This last category of services is also funded through the financial contributions of local authorities and general councils.

Reference:

Chevreur K. *et al.* (2010), [France: Health system review](#). Health Systems in Transition, 2010; 12(6): 1– 291, European Observatory on Health Systems and Policies.

GERMANY

Main characteristics of the German health care system

- ▶ Decentralised, with several competences delegated to state level (*Länder*) and an important role played by civil society organisations (sickness funds and doctors' associations)
- ▶ Providing universal coverage through statutory and private health insurance
- ▶ Health expenditure is mostly funded through public funds – out of social insurance contributions and taxation, and complemented by private payments.
- ▶ Mixed service provision – public and private

Structure of the system



At the central level, the Federal Assembly, the Federal Council and the Federal Ministry of Health are responsible for legislative and supervisory functions. The federal legal framework regulates governance, services to be provided and the funding mechanisms of the health system. Policy-making for health care is **shared between the federal government, the *Länder***, and a large number of civil society organisations.

These organisations are self-governing bodies representing the various existing sickness funds and the doctors' associations, i.e. the payers and the providers. Delivery of health care is determined to an important extent through joint committees of these organisations at the federal and regional level. These joint committees are governed at the federal level by the Joint Federal Committee (*Gemeinsamer Bundesausschuss* or G-BA) whose decisions establish: which services are paid for by the statutory health insurance; standard requirements for implementation of the federal laws, in terms of service provision; and the adoption of quality management measures.

The 16 *Länder* are responsible for ensuring hospital care. In particular, the states' health care responsibilities include hospital planning, hospital financing investments, disease and drug abuse prevention, and vaccination. They are also responsible for medical education and for ensuring public health services such as the prevention of transmissible diseases or environmental hygiene, although these tasks have mostly been delegated to the local level (municipalities). Public health activities are coordinated across *Länder* through the Working Group of Senior Health Officials and the Conference of Health Ministers; additionally, *Länder* share joint institutions, for example for the training of health physicians.



Since 2009, health insurance has been mandatory. Individuals are covered by Statutory Health Insurance (SHI) on the basis of their income (some 88% of the population being covered by SHI). High earners may choose to be covered by Private Health Insurance (PHI), which also applies to civil servants and the self-employed (some 10% of the population being covered by PHI). Special regimes apply to other categories, such as soldiers and policemen. As at March 2010, insurance was provided by some 169 quasi-public sickness funds for SHI and 46 private insurance companies for PHI, though these numbers continuously change, the market being competitive.

Delivery of services

The SHI provides for a comprehensive benefits package including, among other things, preventive services, in-patient and outpatient hospital care, dental care, rehabilitation and prescribed drugs. Long-term care is covered by a separate mandatory insurance scheme.



Ambulatory care (primary and secondary) is provided through individual private practice or polyclinic-type ambulatory care centres and includes both generalist and specialist care. There is no referral system and patients can choose the doctor they prefer. In-patient care is provided in public and private hospitals. The number of for-profit hospitals is increasing, mainly through the takeover of public hospitals, as policies aim at securing or attracting new capital investments in the sector and reducing health expenditure. There are also numerous non-profit organisations involved in the provision of health care. Public hospitals may belong to the *Länder*, local authorities or their associations.¹³

Medicines are dispensed by hospital, institutional and, in particular, by public pharmacies, the latter often being privately owned and operated by self-employed pharmacists.

OECD survey

Setting the level of taxes to be earmarked for health care		Financing new hospital building	R
Setting the basis and level of social contributions for health		Financing new high-cost equipment	
Setting the total budget for public funds allocated to health	C	Financing the maintenance of existing hospitals	
Deciding resource allocation between sectors of care	C	Financing primary care services Setting public health objectives	
Determining resource allocation between regions	C	Financing specialists in outpatient care	

¹³ HOPE online country profile –Germany: latest information refer to 2007

Setting remuneration methods for physicians		Financing hospital current spending	
Defining payment methods for hospitals	C	Setting public health objectives	L

Source: Paris, Devaux, Wei (2010)

Note: C (central/federal government); R (regional/state government); L (local/municipal government)

Finance and health care expenditure

In 2006, public contributions accounted for 77% of total health expenditure, the rest coming from private sources.

Public sources of the health system include: statutory health insurance contributions (occupation-based contributions for employers and employees, unemployment entitlements for the unemployed and government flat rate per capita for long-term unemployed people) and federal grants derived from taxation. Private sources include private health insurance contributions and upfront payments, as some of the services provided for by the benefits package imply cost-sharing by patients.

More than a quarter of total health care expenditure is allocated to the hospital sector; within hospitals, operating costs are financed by payments from sickness funds and private insurers (calculated on a daily basis), while capital expenditure is financed by state budget funds.

References:

- Schmähl W. *et al.* (2010), Annual National Report 2010 – Pensions, Health and Long-term Care: Germany. [ASISP](#): Analytical support on the Socio-Economic Impact of Social Protection Reforms
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GREECE

Main characteristics of the Greek health care system

- ▶ Highly regulated at the central level, although structured at the territorial (regional) level
- ▶ Theoretically universal but in practice the system is not yet fully-fledged as such
- ▶ Health care financing is public – through social insurance and taxation - and private
- ▶ Mixed service provision – public and private

Structure of the system



Both funding and delivery of services are provided through a mixed system including a national health service (NHS), occupation-based health insurance and private providers. The existence of many different players and the lack of an effective coordination mechanism imply inequalities in both service provision and funding.

At the central level, the Ministry of Health and Social Solidarity is responsible for the regulation, planning and management of the NHS, including allocation of resources and funds to the priorities set at the national level, and regulation of the private sector, while the Ministry of Employment and Social Protection is responsible for the social insurance system. The latter encompasses several funds and a variety of schemes, with some 30 social insurance organisations, many of which are administered as public entities but operate within different regulatory frameworks and based on different levels of contribution, coverage, benefits and criteria for accessing these benefits. The social insurance system comprises a large number of funds. Membership of one of the social insurance funds is compulsory for the employed population (employers and employees), the fund being determined by the type of occupation.

Under the Ministry of Health and Social Solidarity are several organisations and institutions, the health administrations at the regional level (Health Region Administrations) and the National Centre for Emergency Care that has also regional branches. Centrally, there are other bodies that participate in the

governance and regulation of the sector, among which is the Central Council of Health Regions that plays a coordination role with regard to the policies of the regional health administrations and ensures their cooperation with the Ministry of Health. The Ministry of Health and Social Solidarity is structured around five directorates, two of which are responsible for public health and for social solidarity and oversee regional directorates and prefectural directorates. The directorate on health services oversees the Health Region Administrations that, in turn, are responsible for health centres and public hospitals. Regional directorates for public health are responsible for the delivery of health services at the regional and local level, in the latter case through public health departments. Administratively, the regional directorates belong to the Health Region Administration.

There are seven Administrations in the country, each responsible, in its catchment area, for: coordinating and implementing health policies; preparing business plans; organising health facilities and deciding on assets; managing health personnel; and preparing, approving and monitoring budgets and their implementation. Several of these functions, though, are made on a proposition basis only and are for the approval of the central level. Devolution is thus within a controlled and centralised framework, although Law 3852/2010, enacted in June 2010, provides for the competence of the Health Region Administrations to be transferred to municipalities within the so called ‘Kallikratis Plan’.

Responsibilities of regional and local (prefectural) authorities in the field of health are currently limited to: distribution of financial resources to hospitals, as determined centrally; endorsement of health personnel; licensing and monitoring of the operation of the private sector; and tasks related to environmental and public health. Municipalities run public centres for children and the elderly. In the region of Attica, exceptionally, large municipalities run a few health care centres.

Delivery of services

Delivery of primary health care is through public and private health service providers. The NHS provides both primary and secondary care; in rural areas it is still the main provider, but the role played by the private sector is growing in importance.

Delivery of public health services is through 114 outpatient departments of public hospitals and some 201 rural health centres that, administratively, are attached to the hospitals and funded through hospital budgets. However, primary care is also provided by: health centres and special units owned and operated by social insurance funds; clinics and welfare services run by municipalities; and physicians working in private practice.



Health centres are staffed with general practitioners and specialists that deliver primary care free of charge; 1,458 health surgeries with public medical staff are administratively dependent on the health centres. However, there is no gate-keeping mechanism and patients may refer themselves directly to secondary care.

Secondary and tertiary care is provided through public and private hospitals. There are about 155 public hospitals, 23 of which operate outside the national health system; there are 218 private profit-making hospitals, equivalent to 26% of total bed capacity; and social insurance fund hospitals mainly funded by social security revenues.

Emergency care is provided by the National Centre for Emergency Care in Athens, with branches across the whole country. Pharmaceutical care is universal and prescribed medicines are reimbursed by social insurance, although 25% of the cost is co-paid by patients. Exemptions from, or reduction of, co-payments are granted depending on the health status (chronic diseases) and income level. Planning and implementation of pharmaceutical policy is at the central level.

OECD survey

Setting the level of taxes to be earmarked for health care	C	Financing new hospital building	C
Setting the basis and level of social contributions for health	C	Financing new high-cost equipment	C
Setting the total budget for public funds allocated to health	C	Financing the maintenance of existing hospitals	C
Deciding resource allocation between sectors of care		Financing primary care services Setting public health objectives	C
Determining resource allocation between regions		Financing specialists in outpatient care	C
Setting remuneration methods for physicians	C	Financing hospital current spending	C
Defining payment methods for hospitals	C	Setting public health objectives	

Source: Paris, Devaux, Wei (2010)

Note: C (central/federal government); R (regional/state government); L (local/municipal government)

Finance and health care expenditure

Health care is funded through public and private resources. Public resources come from social insurance (contribution of employers and employees) and taxation (direct and indirect tax revenues). Private funding is mainly in the form of: upfront payments for services not covered by social insurance or covered but not reimbursed because they were purchased outside the formal system; co-payments; and private expenses. Upfront payments account for a high share of total health expenditure (almost 38%), one third being then contributed to the total health expenditure through taxation and social insurance. The role of private health insurance is still minor with only some 12% of the population having taken out private coverage with just a 2.1% contribution to total health expenditure.

References:

- Economou C. (2010), [Greece Health System Review](#). Health Systems in Transition, 2010, 12(7):1–180, European Observatory on Health Systems and Policies

- Petmesidou M. (2010), Annual National Report 2010 – Pensions, Health and Long-term Care: Greece. [ASISP](#): Analytical support on the Socio-Economic Impact of Social Protection Reforms.

HUNGARY

Main characteristics of the Hungarian health care system

- ▶ Centrally regulated but with an executive role played by county and municipalities as owners of health care facilities
- ▶ Providing nearly universal coverage through statutory social health insurance system based on citizenship
- ▶ Mainly public financing of health care – out of contribution and state and local budgets
- ▶ Mixed service provision – public and private, the latter especially at primary care level

Structure of the system and responsibilities



At the central level, the Ministry of Health is responsible for health policy development and health sector regulation, as well as for the planning and operation of the health care system. Under the Ministry of Health are the National Public Health and Medical Officer Service, responsible, among other things, for the supervision of health care delivery; and the National Health Insurance Fund Administration (NHIFA), responsible for administering insurance contributions to the mandatory national health insurance as well as for sourcing and paying for health care services and medicines. Since 2009, the NHIFA has been structured into seven regional institutions.

County (or regional) and local authorities own and manage health care facilities; thus, they are directly involved in the **delivery of health care services and in the funding of investment costs** for care facilities **through local budgets**. Responsibility for the delivery of health care services on a territorial basis is defined within the 1997 Act CLIV on Health.

The social health insurance scheme is compulsory for all citizens and provides nearly universal coverage. Employers and employees pay contributions to the Health Insurance Fund through a payroll tax; some categories, such as

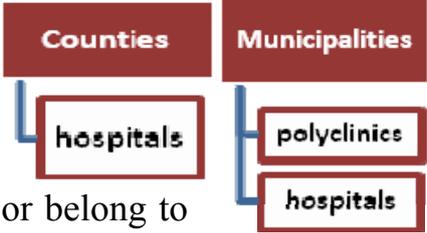
dependants, pensioners and people with very low income, are exempted from payment. The level of contribution and the modalities for taxation, however, change according to the administration in charge, as new fiscal policies were put in place in July 2009 and then again in April 2010. In practice, health policy is currently under review as the new administration has prepared and is discussing a reform plan, the ‘Semmelweis Plan’, that is expected to restructure, among other things, also the health care delivery system.

Delivery of services

The insurance provides access to a package of benefits. Primary care is delivered through general practitioners working in private practice; outpatient care is mostly delivered in polyclinics that are owned by municipalities. There is a free choice of the general practitioner by patients. A referral is needed for accessing specialist care and secondary care in hospitals.



Secondary care is delivered through so called ‘territorial hospitals’, the majority of which are also owned by the municipalities, while tertiary care is delivered through ‘high priority hospitals’. Almost all hospitals are publicly owned or belong to foundations or universities. Specifically: 66% of the hospitals are owned by local governments; 16% by the church or foundations; 9% are owned by the state or by universities; and 7% by the private sector. With regard to management, publicly owned hospitals may be run directly by public owners as budgetary institutions or for-profit or non-profit companies (about 30% of the facilities are run as companies), or are handed over to private management (ESKI, 2009; ESKI, 2011).



New rules for the establishment and ownership of pharmacies are being developed in 2011 by the new administration.

OECD survey

Setting the level of taxes to be earmarked for health care		Financing new hospital building	C
Setting the basis and level of social contributions for health		Financing new high-cost equipment	C
Setting the total budget for public funds allocated to health		Financing the maintenance of existing hospitals	R,L
Deciding resource allocation between sectors of care		Financing primary care services Setting public health objectives	C,L
Determining resource allocation between regions		Financing specialists in outpatient care	C,L
Setting remuneration methods for physicians		Financing hospital current spending	
Defining payment methods for hospitals		Setting public health objectives	

Source: Paris, Devaux, Wei (2010)

Note: C (central/federal government); R (regional/state government); L (local/municipal government)

Finance and health care expenditure

Total health expenditure is mainly funded through public sources (70.6% in 2007), the rest being private expenditure, most of which is represented by upfront payments (accounting for approximately 25% of total private expenditure) and cost-sharing for services delivered through the insurance system. Public expenditure is mainly financed by contributions through the NHIF, and by funding from the central budget. While recurrent and operational costs of hospitals are financed through the NHIF, capital costs are funded through capital grants from the central governments or the local budgets of the owning municipalities.

References:

- National Institute for Strategic Health Research (ESKI) [website](#), Health System Scan newsletters January 2011 and December 2009 & Hungarian Health Care System 2009

- Gál R. (2010), Annual National Report 2010 – Pensions, Health and Long-term Care: Hungary. [ASISP](#): Analytical support on the Socio-Economic Impact of Social Protection Reforms.

IRELAND

Main characteristics of the Irish health care system

- ▶ Centralised, with main responsibilities held by the Health Service Executive
- ▶ Providing universal coverage for the ‘ordinarily resident’
- ▶ Mainly public financing of health care – out of general taxation
- ▶ Mixed service provision – public and private

Structure of the system and responsibilities



Overall responsibility for the health care system lies with the Government, exercised through the Department of Health and Children (DoHC) under the direction of the Minister of Health and Children (MoHC). The MoHC is responsible for the strategic development and overall organisation of the health service, including legislation and regulation; it also approves annual National Health Service plans where priorities and activities as well as the governance structures needed for delivery are specified. These plans are prepared by the Health Service Executive (HSE), accountable directly to the Minister of Health, established in 2005 to take responsibility for budgetary and management functions related to health services, along with a centralisation process that saw the abolition of Regional Health Boards and of a series of statutory agencies.

The HSE deals with health and personal social services through three divisions responsible for (i) population health, (ii) hospitals, and (iii) primary, community and continuing care. The Population Health Directorate is mainly responsible for the strategic planning; a National Hospitals Office is responsible for the organisation, planning and coordination of acute services in 51 hospitals; and the Primary, Community and Continuing Care (PCCC) Directorate is responsible for general practice services, community-based health and personal social services, services for older people and children, disability services, mental health services and social inclusion. The PCCC consists of 32 Local Health Offices (LHOs), representing the first point of access to services and the place

where dialogue and involvement with local stakeholders is expected to take place.

The HSE is divided into four administrative areas: West, South, Dublin North-East, and Dublin Mid-Leinster. Four administrative offices, one for each area, directly accountable to the HSE chief executive officer (CEO), assist in the coordination of services delivered through the LHOs. Each of the administrative areas has a Regional Health Forum made up of representatives of the city and county councils within that area: *‘The Fora make representations to the HSE on the range and operation of health and personal social services in their area, and the HSE in turn provides administrative services to the Forum’* (HSE, 2011).

A range of other statutory and non-statutory agencies have a role in the regulation and provision of health and social services, in particular voluntary NGOs in conjunction with, or on behalf of, the HSE; further, some social actors such as trade unions, employers, farming organisations and representatives of the community and voluntary sectors may formally have a role in the broad direction of health policy.

Delivery of services

Local governments (county, city and town councils) have a limited role in health care; the HSE provides many health care services directly while the voluntary sector, including religious organisations, plays an important role.

Primary care is usually provided through general practitioners. GPs are the gatekeepers to secondary care as they provide referral to specialist physicians or publicly-funded acute hospitals. However, secondary care may be accessed directly upon the payment of a standard fee. GPs are self-employed and most of them treat both private and public patients, but recently, integrated multi-disciplinary teams have been developed to facilitate the provision of services at the community level and reduce the dependency of the system on secondary care services. Out of the 519 planned Primary Care Teams, including a range of health professionals from GPs to nurses, 348 teams were, in March 2011, at an advanced functioning stage (HSE, 2011).

The public hospital sector incorporates voluntary and HSE hospitals, further distinguished into regional, county and district hospitals. Beds within hospitals may be designated for either public or private use, with the latter usually accounting for 20% of all beds. HSE hospitals are funded directly by the government, via the HSE, according to the NSP. Public voluntary hospitals, of which there are about 29, mostly established by religious orders and philanthropic groups, are primarily financed by the government but may be owned and operated on a non-profit basis by other organisations. There are also some 20 private hospitals.

Those ‘ordinarily resident’ citizens with Medical Card/Category I status, granted according to income levels and representing about one third of the population, are entitled to most services free of charge. Those without such status make upfront payments for both hospital and primary care services, unless they have the right to benefit from other exemption schemes. Some of these upfront costs may be covered by private health insurance, currently taken out by about 50% of the population, mostly with the Voluntary Health Insurance Board that has a 75% share of the voluntary insurance market. All health insurance schemes provide open enrolment with lifetime cover, with a premium depending on the insurance package but not on age or health status.

Health inequalities are an issue. Among the instruments developed to tackle inequities is the National Treatment Purchase Fund which allows public patients who have waited for over two months for treatment to obtain, at public expense, treatment in the private sector either in Ireland or abroad.

OECD survey

Setting the level of taxes to be earmarked for health care	C	Financing new hospital building	C
Setting the basis and level of social contributions for health	C	Financing new high-cost equipment	C
Setting the total budget for public funds allocated to health	C	Financing the maintenance of existing hospitals	C
Deciding resource allocation between sectors of care	C	Financing primary care services Setting public health objectives	C

Determining resource allocation between regions		Financing specialists in outpatient care	
Setting remuneration methods for physicians	C	Financing hospital current spending	
Defining payment methods for hospitals	C	Setting public health objectives	C

Source: Paris, Devaux, Wei (2010)

Note: C (central/federal government); R (regional/state government); L (local/municipal government)

Finance and health care expenditure

The health care system is predominantly tax-funded (78.3% in 2006), the remaining components of total health expenditure being from private sources such as upfront payments for services (approximately 13% of all health care costs) and payments to private health insurance providers (8%). Taxation is non-earmarked, collected at the national level and includes VAT, income tax, corporation tax, and excise duty, overall accounting for 86% of total net tax receipts; ‘*the remainder is made up of customs, agricultural levies, capital gains and acquisitions, and stamp duty on property sales*’ (WHO, 2009).

The hospital sector accounts for approximately 50% of health expenditure.

References:

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- McDaid D. *et al.* (2009), [Ireland: Health system review](#). Health Systems in Transition, 2009; 11(4): 1 – 268. European Observatory on Health Systems and Policies.

ITALY

Main characteristics of the Italian health care system

- ▶ Highly decentralised to regional authorities
- ▶ Providing nearly universal coverage mostly free of charge at the point of service
- ▶ Mainly public financing of health care – out of national and regional taxation
- ▶ Mixed service provision – public and private

Structure of the system and responsibilities



The National Health Service is organised into three levels: national, regional and local. At the national level, the Ministry of Health is responsible for ensuring the right to health by citizens as defined in article 32 of the Constitution. The Ministry of Health guarantees equity, quality and efficiency of the NHS and, along with a monitoring role, promotes improvement actions, innovation and change. The central Government is responsible for setting the ‘minimum level of health assistance’ (*livelli essenziali di assistenza sanitaria – LEA*), i.e. the services the NHS is obliged to deliver to all citizens for free or upon the payment of a contribution (‘ticket’).¹⁴ Additionally, it allocates health care resources to regional governments according to ‘Health Pacts’ agreed upon by the Government, the regions and the two autonomous Provinces of Trento and Bolzano. The Health Pact 2010-2012 provides for the contribution by the government of 104,614 million EUR for 2010, 106,934 million EUR for 2011 and an equivalent amount increased by 2.8% for 2012.

The 20 Regional Authorities and the two autonomous Provinces of Trento and Bolzano bear responsibility for the governance and organisation of all activities related to health care and health service delivery. The regional level has legislative, administrative, planning, financing and monitoring functions. Executive functions are based on 3-year regional health plans. Regional Authorities are responsible, among other things, for: allocating resources to Local Health Enterprises (*Aziende Sanitarie Locali - ASLs*) and public hospital

¹⁴ More than 5,700 assistance types and services are defined with regard to prevention, care and rehabilitation.

enterprises (AOs - *Aziende Ospedaliere*); defining criteria for accreditation of private and public health care entities; appointing general

Regions

- policy development
- legislation
- planning
- funding

managers of ASLs and public hospitals; defining the regulatory framework of operation of ASLs and public hospitals; and defining the technical and management guidelines for the provision of services. Since regions set their health policy independently, their level of involvement in the direct management of health services varies greatly; for example, the hospital beds directly managed by the regional level may range from over 60% to less than 1%.

Delivery of services

As of October 2009, delivery of services at the territorial level is through a network of some 184 Local Health Enterprises. ASLs are public entities with an autonomous entrepreneurship role for their organisation, administration, accountancy and management. Services are delivered through accredited public or private structures. Public structures include hospitals directly administered by the ASL (*Presidi ospedalieri*) and public hospital enterprises (AOs), i.e. independent entities, usually with a regional or interregional catchment population, with autonomous management and purchasing power, including ‘research hospitals’.

Regions

hospitals

General practitioners have a gate-keeping function within the NHS. Primary care is provided by GPs, paediatricians, and self-employed and independent physicians, who are paid a fee based on the number of people (adults or children) registered with them. Specialist care is provided either by ASLs or by accredited public and private facilities with which ASLs have agreements and contracts. Specialist care may be accessed through a referral by GPs or, for some services such as dental care, directly through a centralised booking system. Hospital care is delivered through some 669 public facilities providing both outpatient and in-patient services, or through some 559 private hospitals contracted by ASLs.

Pharmaceutical care is regulated by the Italian Agency of Pharmacy (AIFA), which deals with licensing, monitoring, pricing, and drug reimbursement. Drugs can be delivered directly by ASLs or pharmacies spread all over the territory.

Pharmacies may be public or private, with revenues going to the pharmacy's owner.

OECD survey

Setting the level of taxes to be earmarked for health care	R	Financing new hospital building	C,R
Setting the basis and level of social contributions for health		Financing new high-cost equipment	C,R
Setting the total budget for public funds allocated to health	C,R	Financing the maintenance of existing hospitals	C,R
Deciding resource allocation between sectors of care	C,R	Financing primary care services Setting public health objectives	C
Determining resource allocation between regions	C	Financing specialists in outpatient care	C,R
Setting remuneration methods for physicians		Financing hospital current spending	C,R
Defining payment methods for hospitals	C,R	Setting public health objectives	

Source: Paris, Devaux, Wei (2010)

Note: C (central/federal government); R (regional/state government); L (local/municipal government)

Finance and health care expenditure

Health care is mainly financed by earmarked taxes applied at the regional and national level. Direct taxes include (i) IRAP, a regional corporation tax levied nationally but mostly (90%) allocated back to the regions where it is levied, imposed on the value added of companies and on the salaries of public sector employees, and (ii) 'additional IRPEF', a regional tax imposed on top of the national personal income tax. Indirect taxes include a share on VAT and petrol excise. Additionally, ASLs rely on revenues from the purchase of services and over-the-counter drugs and from co-payments by patients for pharmaceuticals, diagnostic procedures and specialist visits.

Public funding accounts for about 70% of total health care expenditure and private insurance companies (non-public funding) account for about 11%.

Upfront payments and co-payments account for the remaining part of expenditure (approximately 19%). Voluntary health insurance does not play a significant role in funding.

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- Italian Ministry of Health [website](#)
- Lo Scalzo A. *et al.* (2009), [Italy: Health system review](#). Health Systems in Transition, 2009; 11(6)1-216. European Observatory on Health Systems and Policies
- Corte dei Conti, Sezione Regionale di Controllo per la Lombardia (2010), [Relazione sulla Spesa Sanitaria Regionale](#).

LATVIA

Main characteristics of the Latvian health care system

- ▶ Centralised, with an important role played by the newly established Health Payment Centre
- ▶ Coverage is based on residence and is often dependent on the payment of fees or contributions
- ▶ Mainly public and private financing of health care – out of general taxation and upfront payments
- ▶ Mixed service provision – public and private

Structure of the system and responsibilities



At the central level, the Ministry of Health (MoH) bears the main responsibility for the development of national health policies and regulations. Local governments, that were initially given broad responsibilities in both the financing and provision of health services, are now mainly responsible for ensuring access to health care services. Local governments own hospitals and clinics but in several cases these are rented out or have become self-managing health centres and institutions.

Subordinated to the Ministry of Health is the Health Payment Centre that, since late 2009, has replaced the functions of the Compulsory Health Insurance State Agency. The Centre is responsible for *‘realizing and implementing state policy for the availability of health care services, as well as for administering the state budgetary funds prescribed for health care’* (MoH website); , its functions

include administration of the state budget, the purchase of services (selection, conclusion of agreements, maintenance of a registry of providers), making payments to service providers, and supervising expenditure. The centre has five territorial units : Riga, Kurzeme, Latgale, Zemgale, and Vidzeme.

Delivery of services

Health care is provided on the basis of residence, regardless of citizenship, according to a list of benefits and through state, municipality and private in-patient and outpatient health care institutions.

A distinction is made between primary, secondary, and tertiary health care, and emergency medical care. General practitioners, usually working together with a nurse and an assistant, provide primary health care; GPs function as gate-keepers to secondary health care. A referral from a primary care physician or a specialist is also needed to access diagnostic examinations and ambulatory surgery services, but it is not required to access some specialists such as, for example, paediatric services. Secondary health care is provided at ambulatory (outpatient) level, emergency medical care level, through day-patient facilities or at regional and local hospitals. Tertiary care is provided in specialised medical institutions.

Health care services are delivered in a variety of institutional settings and legal forms. Providers may be independent or employed by, among others, local governments. The condition for patients being able to receive services is that providers have an agreement in place with the Health Payment Centre.

In recent years, several structural changes have taken place in the health sector, implying a restructuring of state agencies and reduction of personnel (the staff of the Ministry of Health was reduced by 43% in 2009).

Hospitals were also drastically re-organised: those providing emergency care were reduced from 59 to 20 in 2010; some 41 hospitals were progressively closed and transformed into health care day centres. In

2009, all planned surgery and other treatment was halted, with the exception of emergency cases, and performed only if patients could afford to pay. Hospitals



may be state or district/municipality owned, or private. District/municipal hospitals have the status of a limited company or municipal agency. Current legislation does not attribute a specific role in health care to local government; they no longer bear financial responsibility, their main responsibility being to ensure access to health care services.

The State Agency of Medicines of Latvia is a Regulatory Authority under the MoH, responsible for authorisation, monitoring, inspection and market regulation of medicines. Distribution is through pharmacies or wholesalers. Medicines are subject to full or partial (75% or 50%) reimbursement depending whether they are vital for the patient's life, or refer to chronic or acute diseases.

Finance and health care expenditure

The level of subsidy for health care by public financing through general taxation is determined by the state budget law. The funds for health derived from national revenue represent one of the two main sources of funding, the other being upfront payments by patients that include user charges for all statutorily financed services and direct payments for those services that are not financed by the state and are specified in the so-called 'negative list of benefits'. Public expenditure on health was slightly over 50% of total health expenditure in 2005 (52.6%), 46.6% being the share contributed by upfront payments.

In 2010, reductions in or abolition of patient fees and co-payment levels were introduced for those on low incomes. Payments for voluntary insurance schemes sank when, in 2009, the Prime Minister prohibited the buying of insurance policies for civil servants. All funds devoted to health expenditure are pooled through the Health Payment Centre.

References:

- Curkina I. (2009), [Healthcare sector hit by recessionary cutbacks](#), EIROnline
 - Ministry of Health of the Republic of Latvia [website](#)
 - Bite I. (2010), Annual National Report 2010 – Pensions, Health and Long-term Care: Latvia. [ASISP](#): Analytical support on the Socio-Economic Impact of Social Protection Reforms
 - Tragakes E. *et al.* (2008), Health Systems in Transition, Vol. 10 No.8, [Latvia: Health system review](#), European Observatory on Health Systems and Policies.
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LITHUANIA

Main characteristics of the Lithuanian health care system

- ▶ Centrally regulated but with several executive responsibilities delegated to local authorities (municipalities)
- ▶ Nearly universal coverage based on compulsory health insurance
- ▶ Mainly public financing of health care – out of earmarked taxation and state budget
- ▶ Mixed service provision – public and private

Structure of the system and responsibilities



The health care system of Lithuania is undergoing a restructuring process as outlined in the Plan of Measures for Implementation of the Third Stage of the Restructuring of Health Care Institutions and Services, approved by the Minister of Health at the end of 2009. In addition, in 2010, county administrations were abolished. These two circumstances have impacted, and continue to do so, on applying responsibilities, ownership and implementation mechanisms.

At the central level, the Ministry of Health is responsible for the overall performance of the national health system. It develops policies, issues regulations, oversees the licensing of the medical and pharmaceutical sectors, and determines the development of public health care infrastructure. Under the Ministry of Health, but also accountable to the Ministry of Finance, is the National Health Insurance Fund (NHIF). The NHIF is a state authority providing the compulsory health insurance and coordinating the activities of five territorial health insurance funds: Vilnius, Kaunas, Panevėžys, Šiauliai, and Klaipėda. Since 1997, Lithuania has had a Compulsory Health Insurance Fund that represents the basis for the financing of the public health system; through the territorial health insurance funds contracts are concluded with health care service providers (institutions and pharmacies); on the basis of these contracts, providers are paid the cost of rendered services through the funds. Representatives of local authorities sit on both the Mandatory Health Insurance Board, through an association of municipalities, and on each of the supervisory boards of the territorial funds, through members of municipality councils. The Ministry of Health has other several institutions under its control, including eight hospitals and clinics.

The governance structure of health care has changed since July 2010, when the county administrations were abolished and their responsibilities taken back by the Ministry or delegated to municipalities. **Municipalities are responsible for**

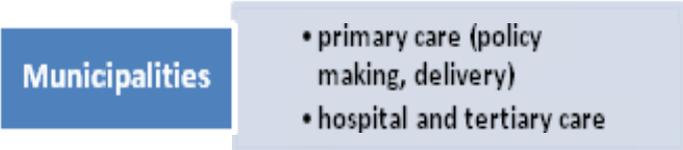


primary care, including decisionmaking, delivery of services and supervision. They also run some small and medium-sized hospitals, or have subordinated secondary and tertiary institutions; , they are also responsible for the implementation of local health

programmes and for activities related to the improvement of public health.

Delivery of services

Insured individuals have access to a range of services including, primary outpatient, specialised outpatient and in-patient health care, first aid, nursing care, screenings, rehabilitation, and medicines. Primary health care is provided through 452 state facilities such as general practitioners’ offices, ambulatory clinics, or polyclinics (if in bigger urban areas), or medical posts in schools (in rural areas). GPs are publicly employed or work under contractual arrangements, but private practice is also common with some 1,284 private institutions delivering primary health care. Secondary care is provided through general and specialised hospitals.



Patients are free to choose the doctor, the specialist and the institution; the GPs have a gate-keeping function to secondary care but access to specialists and private health professionals is possible also without referral.

Finance and health care expenditure

In 2008, the publicly financed health system covered all residents for emergency care and about 96-97% of the population; in the same year, about 75% of total health expenditure was public, the rest being private. Public expenditure was for mandatory health insurance reimbursements (87%), health programmes (7%) and state investment programmes (6%). Sources of public funding include: earmarked taxation (since 2009), health insurance contributions, state and, to a

lesser extent, local budgets. Private expenditure is mostly represented by upfront payments.

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LUXEMBOURG

Main characteristics of the Luxembourg health care system

- ▶ Centralised and regulated
- ▶ Providing nearly universal coverage, through statutory public health insurance and care insurance
- ▶ Mainly public financing of health care – out of state budget and taxation of gross earnings
- ▶ Mostly public service provision

Structure of the system and responsibilities

The Ministry of Health is responsible for the regulation, planning and organisation of the national health care system. Additionally, it takes responsibility for funding, authorising service providers, implementing or delegating implementation, and for monitoring and evaluation. Health services are provided on the basis of two types of insurance, both under the responsibility of the Ministry of Social Security: (i) universal health insurance (*Caisse Nationale de Santé* - CNS), funded by the state, the active population and their employers (5.4% of gross earnings); and (ii) compulsory (long-term) care insurance, financed by the state and individuals. Public health insurance is mandatory for all economically active persons, including their family members; it gives access to a comprehensive package of services.



Provision of primary care is not regulated. The hospital and pharmaceutical sectors are regulated, including the number of pharmacies. All health providers have to be authorised by the Ministry of Health in order to practice. Fees for the

provision of services are negotiated between trade unions or professional associations and employers (in case of secondary care settings such as hospitals) or the national health insurance, in the case of primary care. Patients pay the cost of the services (upfront payments) and are later reimbursed in the region of 80% to 100% of the cost.

A reform of the health insurance and of the organisation of the health care system is currently under consideration.

Delivery of services

Services are delivered through primary care providers, hospitals (private and non-profit), long-term care settings, and specialists. The non-profit hospitals are owned and managed either by local authorities or foundations and religious orders.¹⁵



Patients are free to choose the doctor, the specialists, and the hospital. There is no referral system in place. The hospital sector is divided into three geographical areas and includes five general hospitals and six specialised institutions.

OECD survey

Setting the level of taxes to be earmarked for health care		Financing new hospital building	C
Setting the basis and level of social contributions for health		Financing new high-cost equipment	
Setting the total budget for public funds allocated to health		Financing the maintenance of existing hospitals	
Deciding resource allocation between sectors of care		Financing primary care services Setting public health objectives	
Determining resource allocation between regions		Financing specialists in outpatient care	
Setting remuneration methods for physicians		Financing hospital current spending	
Defining payment methods for		Setting public health	C

¹⁵ HOPE online country profile – Luxembourg: latest information from 2007

hospitals		objectives	
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Source: Paris, Devaux, Wei (2010)

Note: C (central/federal government); R (regional/state government); L (local/municipal government)

Finance and health care expenditure

Public expenditure covers most health expenditure (90.1% in 2006) the rest being covered by private expenditure which is mainly provided by upfront payments and, to a lesser extent, payments for/to? private insurance schemes. The health insurance works on a reimbursement basis; only services rendered in hospitals are in kind, with the exception of doctors' bills which still have to be paid by patients.

Funding of hospitals is via national health insurance; investment costs are contributed by the state to the tune of 80%, the rest being covered by national health insurance. Long-term and palliative care is financed by the compulsory care insurance ('assurance dépendance').

References:

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MALTA

Main characteristics of the Maltese health care system

- ▶ Centralised and tightly regulated
 - ▶ Providing coverage free of charge for residents at the point of service
 - ▶ Mainly public financing of health care – out of taxation and national insurance
 - ▶ Mixed service provision – public and private
-

Structure of the system and responsibilities

Health care in the public sector is centralised and tightly regulated, with the Public Health Act the most relevant piece of legislation. The Ministry of Health, the Elderly and Community Care is responsible for health policies and planning as well as for the financing and provision of publicly-funded health care services. The Ministry's Health Care Services Division encompasses three departments: Elderly, Primary Health Care, and Government Health Procurement Services. The Primary Health Care department takes responsibility for the provision of services at primary health care level and for the coordination and organisation of a Government Health Centre system.



Delivery of services

Statutory primary care is provided through eight Health Centres (*Centri tas-Sacca*), some of which have one or two satellites. This statutory system delivers general practitioner and nursing services, as well as some specialist services such as immunisation, antenatal and postnatal clinics, diabetes clinics, ophthalmic clinics, paediatric clinics, dental services, etc. Patients are requested to attend the Centre serving their locality of residence. Health Centres do not have a strong gate-keeping function, leading to an excessive use of secondary care services. Secondary care and tertiary care are provided through public hospitals. There are currently eight public hospitals in Malta, the most important, opened in 2007, being the Mater Dei hospital in Msida.

Provision of medical services at the Health Centres and public hospitals is free of charge but patients are expected to make upfront payments for outpatient pharmaceuticals. Some vulnerable groups (low income and those with chronic diseases) are exempted from these payments.

The private sector is gaining in importance in the delivery of health-related services. There are private general practitioners and specialists as well as a number of private hospitals, clinics and other facilities providing private health care. There is both a lack of regulation of private health care practice and of coordination between public and private providers.

Voluntary actors also deliver health-related services; public-private partnerships are encouraged primarily in the establishment, operations and management of

community homes for the elderly. It is in the care of the elderly that local authorities (local councils) may play a role.

Finance and health care expenditure

The public health care system in Malta is funded through general taxation and national insurance paid by workers and employees, although the latter is not earmarked for health but goes to welfare services in general. The central government is both purchaser and provider of services. Public funding represented 78.1% of total health expenditure in 2005.

Care in private facilities is funded by private insurance, purchased on a voluntary basis, or upfront (direct) payments. Those joining a private scheme are, nevertheless, not allowed to exit the public system. Private health spending in Malta accounted for 21.3% of total health expenditure in 2005 (2.1% from private insurance and 19.2% from upfront payments).

References:

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THE NETHERLANDS

Main characteristics of the Dutch health care system

- ▶ Market-based, with an important role played locally by the municipal health services (GGDs)
- ▶ Nearly universal (99%) coverage through compulsory health insurance
- ▶ Mainly funded through compulsory income-related contributions and premiums paid to insurers
- ▶ Service provision is private, on the basis of a regulated competitive market

Since 2006, with the entering into force of the Health Insurance Act, the introduction of a compulsory health insurance scheme has changed the role of

the government in terms of health care. Its main task is now to ensure the functioning of a regulated competitive insurance market. Thus, responsibilities have been passed to insurers, providers and patients, while the government controls quality, accessibility and affordability of health care. Supervision and management of the system has been delegated to independent bodies. Insurance is compulsory (even though not all citizens are insured and some default, i.e. citizens do not pay their premium). Private health insurers compete for clients; they can negotiate with health care providers on cost, volume and quality of care; and they can make a profit. They are obliged to accept new applicants and cannot charge applicants differently based on different risk factors. The reform process, however, is still ongoing as stakeholders get used to the new roles. Within the reform, some responsibilities for home care have been delegated to municipalities.

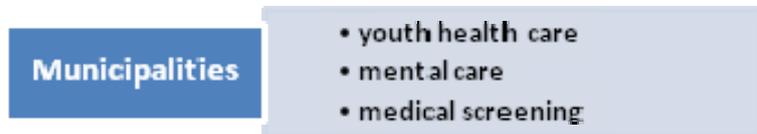


The Ministry of Health, Welfare and Sport defines health policies; jointly with local authorities, it bears responsibility for public health services. **To meet this responsibility, municipalities have established 29 municipal health services (GGDs - Gemeentelijk Gezondheidsdiensten)**, regionally organised, that are involved in the prevention, promotion, and implementation of youth health care; additionally, since 2007, according to the Social Support Act, they are also partly responsible for the provision of long-term care, through home care services and the management of nursing homes. **Municipalities set their own policies for the provision of care**; accountability for implementation is only at the local level, a circumstance that may lead to inequalities in access to care depending on the municipality.

Delivery of services

Patients are free to select their health insurer and providers, unless some restrictions are applied by the insurance package. There are two main types of arrangement between the insurer and the applicant: the ‘in-kind arrangement’, where services are paid in full but the choice of providers is restricted; and the ‘restitution arrangement’, where there is a free choice of providers but if the cost of services is above a certain maximum level of reimbursement, the difference is paid by the patient. Insurers are obliged to provide a basic health insurance package defined by the government; citizens may decide to complement this package with voluntary health insurance schemes.

Preventive care and in particular disease prevention, health promotion and health protection are delivered through municipal public health services (GGDs). GGDs' tasks, as specified in the Public Health Act include: youth health care; environmental health; socio-medical advice; periodic sanitary inspections; public health for asylum seekers; medical screening; epidemiology; health education and community mental health.



With regard to primary care, all citizens are registered with a general practitioner practice. A very high percentage (96%) of contacts is handled within the general practice that is part of the basic health package provided by insurers. Other primary care providers include physiotherapists, dentists, midwives, pharmacists, and psychologists. A gate-keeping system through the GPs is in place for accessing specialist and hospital care (with the exception of emergencies). Secondary care is provided in hospitals and in different types of 'centres' (independent treatment centres, top clinical centres and trauma centres). Hospitals are differentiated into general, academic and categorical hospitals, the latter focussing on specific forms of care or illness. In most cases, hospitals are non-profit corporations: *'The public hospitals belong to the State'*.¹⁶ Emergency care is provided through GPs, emergency wards and trauma centres. Finally, long-term care, also under the responsibility of municipalities, is provided by nursing homes, residential homes and home care organisations.

Pharmacies are public, hospital or general practice dispensers. Public pharmacies cover 92% of the population; general practice dispensers cover the remaining 8% and are important in rural areas. Pharmacies are going through an aggregation process; several are currently retail and chemist chains and pharmaceutical wholesalers.

¹⁶ HOPE online country profile – The Netherlands: latest information from 2007

OECD survey

Setting the level of taxes to be earmarked for health care	C	Financing new hospital building	
Setting the basis and level of social contributions for health	C	Financing new high-cost equipment	
Setting the total budget for public funds allocated to health	C	Financing the maintenance of existing hospitals	
Deciding resource allocation between sectors of care	C	Financing primary care services Setting public health objectives	
Determining resource allocation between regions		Financing specialists in outpatient care	
Setting remuneration methods for physicians	C	Financing hospital current spending	
Defining payment methods for hospitals	C	Setting public health objectives	C

Source: Paris, Devaux, Wei (2010)

Note: C (central/federal government); R (regional/state government); L (local/municipal government)

Finance and health care expenditure

The Health Insurance Act refers to a basic health insurance scheme covering primary and secondary outpatient care, in-patient care and, up to the age of 18, dental care. The Exceptional Medical Expenses Act provides for long-term and mental care insurance. These two statutory insurances are funded through a combination of income-related contributions (levied from salary and/or social security payments and/or profit for entrepreneurs, and transferred to the Health Insurance Fund for further re-distribution to health insurers according to a risk-adjustment system) and premiums (paid directly to the insurers). Complementary private health insurance is purchased on a voluntary basis. The basic health insurance makes some 59% of the contribution-financed health care, the remaining 49% being attributed to long-term care insurance (2008 data).

Funding of the health system is mainly through compulsory contributions and premiums (66%), followed by private expenditure (14%, of which 10%

comprised upfront payments and 4% voluntary insurance schemes) and state contribution (14%).

The Municipality Fund is contributed to by the central government. The fund is to allow municipalities to provide social care. Municipalities purchase care from organisations by means of public procurement, or provide those in need with a personal budget for their individual organisation of care. Municipal health care expenditure in 2007 was only 1.9% of total health care expenditure.

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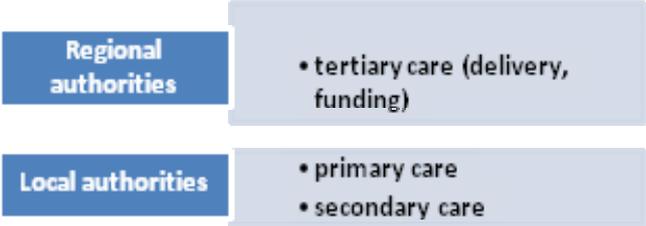
POLAND

Main characteristics of the Polish health care system

- ▶ Partially decentralised, with some competencies delegated to regional and local authorities
- ▶ Providing universal coverage through mandatory health insurance
- ▶ Mostly public funding - out of health insurance contributions and taxation
- ▶ Mixed service provision – public and private

Structure of the system

With the Health Care Institutions Act of 1991, the Ministry of Health became responsible for health policy, education and research; **regional authorities became responsible for organising and financing tertiary care; and local authorities became responsible for primary and secondary care, the latter through county-level hospitals.** The Ministry of Health also supervises the National Health Fund, directly accountable to the government, and shares responsibility for approving the Fund’s financial plan with the Ministry of Finance. The National Health Fund (NHF) is the



institution responsible for the pooling of resources raised through the insurance scheme, for the provision of health care services to citizens, and for the funding of services and the reimbursement of medicines. The Fund has branches in all 16 regions, and offices at the local level.

The health insurance scheme is mandatory by law and universal. Farmers have also been included under the scheme’s coverage. Contributions are pooled into the NHF and represent the major part of revenue for health care expenditure.

Delivery of services

The health insurance provides access to a range of services including prevention, diagnosis, medical treatment and outpatient care. Benefits not covered by the insurance are included in the so-called ‘negative basket’. There is free choice of doctors and of health care facility, as far as providers have contractual arrangements with the regional branches of the Fund; however, a referral from a physician is needed to access both specialist care and in-patient care.

Health care providers are contracted by the NHF and may be public or private. Providers include physicians, public and non-public health care facilities (hospitals and surgeries). Primary care is through a general practitioner. Secondary care is delivered in facilities that may be owned by the State, regional or local authorities or private actors; *‘Healthcare institutions are autonomous in terms of the planning, regulation and management of their own services.’*¹⁷



OECD survey

Setting the level of taxes to be earmarked for health care		Financing new hospital building	C,R,L
Setting the basis and level of social contributions for health		Financing new high-cost equipment	C,R,L
Setting the total budget for public funds allocated to health	C,R,L	Financing the maintenance of existing hospitals	C,R,L

¹⁷ HOPE online country profile – Poland: latest information from 2007

Deciding resource allocation between sectors of care	C,L	Financing primary care services Setting public health objectives	
Determining resource allocation between regions	C	Financing specialists in outpatient care	
Setting remuneration methods for physicians	C	Financing hospital current spending	
Defining payment methods for hospitals		Setting public health objectives	C,R,L

Source: Paris, Devaux, Wei (2010)

Note: C (central/federal government); R (regional/state government); L (local/municipal government)

Finance and health care expenditure

The health care system is funded mainly from health insurance contributions and, to a lesser extent, from state and self-government budgets, used for paying the contributions of specific categories of people and for investments in public health care facilities. In 2005, social insurance contributions accounted for almost 57% of total health care expenditure, some 13% being still public contribution in the form of taxation. Private revenue was about 30% of the total health expenditure in 2005, mainly from upfront payments. Upfront payments still amounted to 24.3% in 2007.

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PORTUGAL

Main characteristics of the Portuguese health care system

- ▶ Regulated, planned and managed at the central level although the delivery of health care services has been structured at the regional level
 - ▶ Guaranteeing universal coverage mostly free of charge at the point of service
 - ▶ Mainly public financing of health care – out of general taxation
 - ▶ Mixed service provision – public and private; various public and private ‘sub-systems’ complement the national system
-

Structure of the system

At the central level, the Ministry of Health is responsible for defining health policy and for the regulation, planning and management of the NHS. It also regulates and controls private health service providers.



Under the Ministry’s direct or indirect administration are several institutions and Regional Health Administrations (RHA): for the North, the Centre, Alentejo, Algarve, and Lisbon/Vale do Tejo. Each RHA is governed by a board that is accountable to the Minister of Health. These five administrations are responsible for managing the health system at the regional level, within their catchment area they: coordinate, guide and evaluate the implementation of the national health policy, taking into account the principles and directives contained in regional plans; coordinate health care provision; supervise the management of primary health care and of hospitals; interact with the private sector and other non-profit organisations and municipal councils. Municipal councils are involved in specific actions or project-based initiatives. Under the RHAs are health centres and hospitals. Further to Decree-law n° 28/2008, health care centres have been grouped into local organisations called ACES (*Agrupamentos de Centros de Saúde*) with functional units for the provision of family health care (USF - *Unidades de Saúde Familiares*), community health care (UCC- *Unidades de Cuidados na Comunidade*), personalised health care (UCSP - *Unidades de Cuidados de Saúde Personalizados*), and public health coverage (USP - *Unidades de Saúde pública*). Through these ACES, the management of health care provision is decentralised, although the role played by local authorities is minimal.

The National Health System is complemented by other public or private schemes or health ‘sub-systems’ through which health care is also provided. These include ‘*civil servants and other state employees’ health subsystems, health insurance and other private occupational subsystems, financed by employers and users contributions*’ (ASISP, 2010).

Delivery of the services

Health care services are provided through primary health care centres, specialised health units and hospitals. Primary care is provided through the USFs. As of April 2010 there were 420 USFs: these are self-organised multi-disciplinary teams, including general practitioners, selected through public tender procedure and operating on a contract basis, the contract being with the respective RHA.

Secondary in-patient and outpatient care is mainly provided in hospitals. Hospital emergency units are also approached directly by patients and not necessarily for emergency care, thus general practitioners do not play a systematic gate-keeping role. As of 2005, there were 111 public hospitals and 93 private units. Hospitals may be public or private, and the latter may be for-profit or not-for-profit. Public hospitals belong to the State; their management may be given to private actors on a contractual basis.¹⁸ Hospitals based on public-private partnerships are becoming common.

The private sector (profit and non-profit) operates admission units, medical consultation rooms, diagnosis and therapeutic centres, a network of ambulances and of pharmacies. Private providers may have contracts with the national health system or with other sub-systems to provide care services.

INFARMED, accountable to the Ministry of Health, is the health authority dealing with the evaluation, authorisation, inspection and production control, distribution, commercialisation and use of medicines.

¹⁸ HOPE online country profile – Portugal: latest information from 2007

OECD survey

Setting the level of taxes to be earmarked for health care	C	Financing new hospital building	C
Setting the basis and level of social contributions for health		Financing new high-cost equipment	C,R
Setting the total budget for public funds allocated to health		Financing the maintenance of existing hospitals	C,R
Deciding resource allocation between sectors of care	C	Financing primary care services Setting public health objectives	C,R
Determining resource allocation between regions	C	Financing specialists in outpatient care	C,R
Setting remuneration methods for physicians	C	Financing hospital current spending	C,R
Defining payment methods for hospitals	C	Setting public health objectives	C

Source: Paris, Devaux, Wei (2010)

Note: C (central/federal government); R (regional/state government); L (local/municipal government)

Finance and health care expenditure

The public health system is mainly financed through general taxation, mostly (60%) from indirect taxes. In 2005, public health expenditure from general taxation represented 71.9% of total health expenditure. Private expenditure accounted for 26.1% of total expenditure in 2005 (22.3% from upfront payments and 3.8% from private insurance).

The Ministry of Finance allocates funds to the Ministry of Health that, in turn, allocates budgets to the RHAs which use these funds for primary health care centres. Hospitals are remunerated directly by the Ministry of Health on the basis of contracts. Public and private health sub-systems are funded through employer and employee contributions; they account for some 9% of total health expenditure. Both public and private financing arrangements imply cost-sharing which represents a significant share of total health expenditure (29% in 2004).

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ROMANIA

Main characteristics of the Romanian health care system

- ▶ Mostly centralised but under a decentralisation process, especially with regard to hospital facilities, with some responsibilities held by local authorities (district councils)
- ▶ Providing universal coverage free of charge at the point of service
- ▶ Mainly public financing of health care – contributions from national insurance system and general taxation at national and, to a lesser extent, district level
- ▶ Mainly public service provision

Structure of the system

At the central level, the Ministry of Public Health is responsible for developing policies, defining the legal framework and issuing regulations (including for the pharmaceutical sector), setting the operational standards, monitoring and evaluating health care provision and the organisation of health care providers. It is represented at the district level by 42 district public health authorities (DPHAs), one for each of the 41 districts and one for Bucharest.



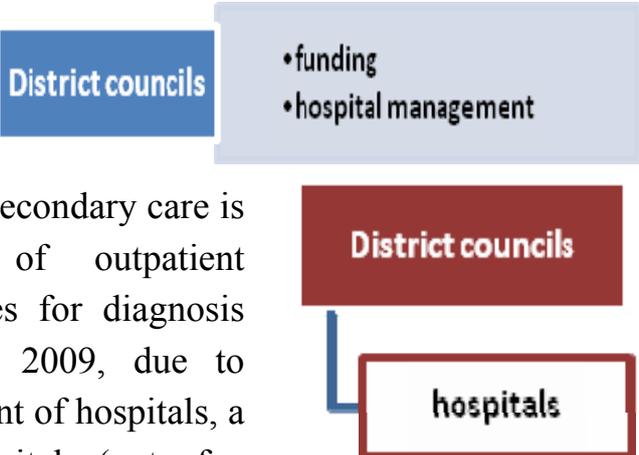
The National Health Insurance House is the autonomous public institution administering and regulating the National Health Insurance Fund (NHIF), and responsible, in particular, for deciding on the benefits package and on the resources allocated across districts (through 42 District Health Insurance Funds - DHIFs) and types of care, and for drawing up the yearly framework contract on the basis of which services from public and private providers are contracted.

Local authorities (district councils) are responsible for providing the framework conditions for the delivery of services of public interest, among which is health care, and for **deciding on local budget and taxes. Since 2002, they have also been the owners of almost all public health care facilities. Even if theoretically they could play a significant role, their input is minor due to constraints in financial and human resources.** At district level, provision of health care is in fact controlled and organised by DPHAs, with DHIFs playing a major role in the contracting of service providers (in fact, DPHAs manage less than one third of the available public budget, the rest being managed by DHIFs). The district council nominates one of the members of the Council of Administration leading each DHIF.

Delivery of services

The mandatory health insurance scheme introduced in 1998 covers the whole population. Health insurance gives access to a basic benefits package that includes, among other things, health care services (ambulatory care, hospital care, and emergency services), pharmaceuticals, dentistry services, and rehabilitation.

Almost all health providers are independent practitioners contracted by DHIFs. Primary health care services are provided through family doctors. Ambulatory secondary care is delivered through a network of outpatient departments within hospitals, centres for diagnosis and treatment, and specialists. In 2009, due to evidence of unsatisfactory management of hospitals, a decentralisation process of 373 hospitals (out of a total of 435) was begun; decentralised hospitals will be funded through state and local budgets as well as from the NHIF. Local authorities will nominate the hospital management and finance administrative expenses.



People may choose their provider freely; access to secondary care in hospitals needs a referral from the family doctor, with the exception of emergencies.

Finance and health care expenditure

The major funding source of health care is from contributions paid by the insured totalling almost 83% in 2004 (estimated at 75% in 2007); there are several categories exempted from this payment, including, for example, the dependants of the insured, the unemployed, those on military service or those aged under 18. In 2010, employed people contributed 10.7% of their payroll (5.5% paid by the employees and 5.2% by the employers). Taxes represent the second most important source of revenue for health expenditure: in 2004, these contributions amounted to 15.8% of the total, of which 14.4% came from general taxes and 1.4% from local taxes.

Upfront payments refer to co-payments for services included in the benefits package or to direct payments for services purchased directly from private providers. There is no recent estimate of such payments; in 1996 they were considered to account for 29% of total health expenditure, while in 2002 WHO data stated the figure was 34%. In April 2010 a new co-payment mechanism called the 'health ticket' was introduced, defining a contribution rate per type of service (for example, contributions for medicines may vary from 0% to 50% of the reference price); exemptions from the payment of contributions apply.

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SLOVAK REPUBLIC

Main characteristics of the Slovak health care system

- ▶ Partially decentralised, with some responsibilities held by regional authorities (self-governing regions) and municipalities with respect to secondary and primary care facilities, respectively
- ▶ Providing universal coverage mostly free of charge at the point of service through a mandatory health insurance system
- ▶ Mainly public financing of health care – contributions from the insurance system
- ▶ Mixed service provision – public and private

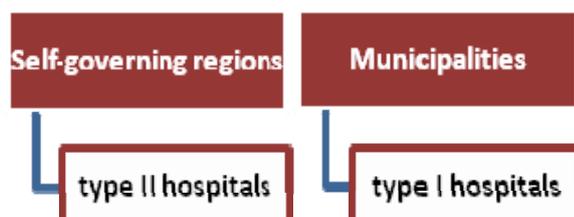
Structure of the system

At central government level, the Ministry of Health is responsible for policy and regulation of the health care, including pricing; it also manages national health programmes, determines quality criteria and the scope of the benefits package to be provided to insured people. Finally, it is the owner of care facilities and of one of the three existing insurance companies. The Ministry of Labour, Social Affairs and Family is responsible for social care, a circumstance that has led to the two systems developing separately. Other Ministries such as, for example, the Ministry of Finance which is responsible for budgeting, are involved in other health-related aspects.



The Health Care Surveillance Authority (HCSA) was established in 2004 to overcome obvious conflicts of interest. HCSA supervises health insurance, the purchasing and provision of service market, and the risk adjustment mechanism for redistributing contributions collected with the insurance schemes. Various central authorities and bodies oversee other health-related tasks.

Some tasks have been decentralised to the eight self-governing regions in particular with regard to monitoring, issuing of permits to providers, and



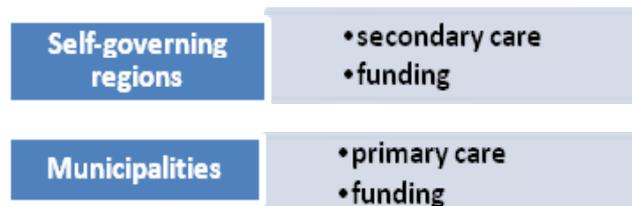
securing health care provision in specific circumstances, such as the temporary withdrawal of a provider or upon detection of poor accessibility of services by patients – then, in the latter case, they can directly appoint physicians to overcome the shortage. Based on evidence provided, they can ban a provider from the market, but only upon recommendation of the HCSA. Additionally, the central government has to approve the ‘Chief Physician’ of each self-governing region. Regions also own and independently manage, and often invest in, some health care facilities. **Ownership of facilities was transferred in 2003: self-governing regions received the so called ‘type II’ hospitals providing secondary care, while ‘type I’ hospitals with facilities for primary care were devolved to municipalities.** Coordination between the central government and the self-governing regions is not always smooth. Additionally, self-governing regions and municipalities are also involved in the financing of social care through their respective budgets.

The central government has retained the ownership of the largest and highly specialised structures, often in the form of ‘contributory organisations’, i.e. entities where government authorities are not the only funding sources and revenues from other sources are possible. Health departments within other ministries than the Ministry of Health manage health facilities of their own. Pharmacies and diagnostic laboratories and the majority (90%) of outpatient facilities are private.

A key role in the system is played by the three health insurance companies, as they purchase the services they are obliged to deliver to the insured according to a benefits package determined by law. One of these companies provides mandatory insurance is provided to the population, these earlier health insurance funds were public institutions and have been profit-making joint stock companies since 2005. The Ministry of Health owns the largest of the three, which had a market share of 68% in 2010, while the other two are private. These companies are subject to managed competition. Providers may be public, private, non-profit or contributory organisations; all but 39 state hospitals, considered fundamental to the maintenance of a fair geographical distribution of services, compete to win contracts on the basis of quality criteria and prices.

Delivery of services

Patients may freely choose their general practitioner or specialist professional, but apart from general practitioners, all other providers have to be contracted by the insurance companies. Service



provision does not require co-payments, with a few exceptions, such as dental care. Ambulatory care is provided through general practice, one-day surgery or outpatient departments in polyclinics. Secondary care is provided in general hospitals (including university hospitals) and specialised hospitals, owned publicly or privately. Secondary care requires a referral from a GP or a specialist (gate-keeping system). Emergency care services are provided by private or public provider, while pharmacies and drug distributors are almost all private.

OECD survey

Setting the level of taxes to be earmarked for health care		Financing new hospital building	
Setting the basis and level of social contributions for health		Financing new high-cost equipment	
Setting the total budget for public funds allocated to health	C	Financing the maintenance of existing hospitals	
Deciding resource allocation between sectors of care		Financing primary care services Setting public health objectives	
Determining resource allocation between regions		Financing specialists in outpatient care	
Setting remuneration methods for physicians		Financing hospital current spending	
Defining payment methods for hospitals		Setting public health objectives	C,R,L

Source: Paris, Devaux, Wei (2010)

Note: C (central/federal government); R (regional/state government); L (local/municipal government)

Finance and health care expenditure

Contributions collected through health insurance payments represent the main source of funding of the public system. Contributors include the employed population, the voluntarily unemployed and non-employed people, for whom the state pays contributions. A governmental financing system also exists, based on general taxation at the national, regional and municipal levels. Private contributions are from user charges and co-payments from patients. Voluntary insurance schemes are not usually undertaken. In 2007, public sector expenditure was 76.5% of total health expenditure, the rest being privately sourced through private revenues. Private expenditure is rising mostly because of higher expenditure on medicines.

Reference:

Szalay T. *et al.* (2011), [Slovakia: Health system review](#). Health Systems in Transition, 2011; 13(2):1–200, European Observatory on Health Systems and Policies.

SLOVENIA

Main characteristics of the Slovene health care system

- ▶ Mostly centralised although executed through local branches, with some responsibilities held by local authorities (municipalities) at primary care level
- ▶ Providing nearly (99%) universal coverage through a mandatory health insurance system
- ▶ Mainly public financing of health care – contributions from the national insurance system and, to a much lesser extent, general taxation at a national and municipal level
- ▶ Mixed service provision – public and private

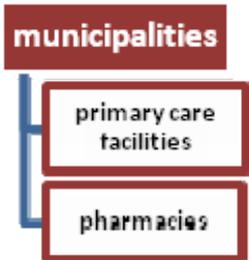
Structure of the system

The central level, through several bodies, is responsible for administrative and regulatory functions, policy, planning (including those of health personnel), establishing priorities and budgetary issues. The Ministry of Health prepares legislation and monitors its implementation, deals with health financing, public health and medicine supply and market; it also manages public health care institutions at the secondary and tertiary level. The Health Insurance Institute – HIIS, is a public independent



body supervised by the government in charge of administering the social health insurance regulated by national legislation and on which the national health system has been based since 1992 with the adoption of the Health Care and Health Insurance Act. This statutory and universal health insurance covers those with an employment status or a ‘legally defined dependency’ status, as is the case, for example, for minors or registered unemployed persons. The HIIS purchases services for those that are insured. It is structured at regional and local level with 10 and 45 branches, respectively.

Public health facilities at the secondary and tertiary care levels are owned by the government. **Local governments are responsible for planning and maintaining the primary care network, including pharmacies.** Municipalities own public primary health care centres and grant concessions for private health care providers at primary care level, where concessions allow providers to access the market of services to be reimbursed by compulsory and complementary insurance schemes. Overall, the role of the local government is still limited and in practice their planning functions are mostly theoretical. Besides receiving funding from the central level, municipalities also raise their own financial resources through local taxation. Since long-term care is also provided within the scope of primary care, in the forms of community nursing care and home health care, local authorities also contribute financially to these services.



Delivery of services

Service providers are mainly public but the number of private providers is increasing, especially at primary care level. Primary care, including diagnostic services, is delivered through public primary health care centres, for emergency care and general practice, health stations, and private general practitioners. At secondary care level, services are provided by hospitals (or polyclinics) and private facilities. Almost all hospitals are public. Secondary care is accessible through referral of the personal physician (gate-keeping system). Patients can freely choose their physician. Emergency care services are integrated within the primary and secondary care structures.



Services are purchased by the HIIS and health insurance companies. Usually negotiations occur, ending up in general and special agreements between the HIIS and the providers (individual professionals or institutions such as hospitals and primary care centres). Compulsory health insurance provides access to a package of benefits; services not included in the package require co-payments (from 5% to 75% depending on the service) that are covered by complementary or voluntary insurance.

Pharmacies were all owned by municipalities in 1992, while in 2005 out of the 273 existing pharmacies, 84 were private.

Finance and health care expenditure

The system is mainly funded through public sources but there is a significant share of private funding (27.8% in 2006) through co-payments and complementary insurance. Complementary insurance is taken up by the majority of those contributing to compulsory insurance (98%, equivalent to the coverage of 85% of the whole population) and is solely for covering co-payments; since 2005, the same premium has applied to all individuals, regardless of age and company, according to a 'risk equalisation scheme' put in place by the Ministry of Health (all funds collected by the voluntary insurance companies are firstly pooled together and then re-distributed according to the scheme). Most of the public expenditure (67.1% in 2006) is out of the public insurance system; contributions to the public insurance systems are from earnings. Another public source contributing to some 5.2% of total health expenditure in 2006 is general taxation, at the national (from income tax, corporate tax, VAT and excise tax) and municipal level; this is mostly to cover capital investments in publicly owned structures, in particular, for local authorities, for the provision and maintenance of health care centres, health stations and public pharmacies.

Reference:

Albrecht T. *et al.* (2009), Health Systems in Transition. [Slovenia: Health system review](#), European Observatory on Health Systems and Policies.

SPAIN

Main characteristics of the Spanish health care system

- ▶ Highly decentralised, with an important role played by regional authorities (Autonomous Communities)
 - ▶ Providing universal coverage mostly free of charge at the point of service
 - ▶ Mainly public financing of health care – out of general taxation, including regional taxes
 - ▶ Mixed service provision – mainly public and only to a lesser extent private
-

Structure of the system

Since 2002, responsibilities for health care have been devolved to the 17 Autonomous Communities. The national Ministry of Health and Social Policy is responsible for the financing of the system. Additionally, it oversees the pharmaceutical sector, guarantees proper functioning of the system, issues basic health and social care legislation, defines minimum benefits packages and quality standards, monitors, and provides general coordination; the coordination body is the Inter-territorial Council of the national health system, chaired by the national Minister and including the 17 regional ministers of health; the Council may only produce recommendations.



Policy, regulatory, planning, and organisational responsibilities for the regional health systems are with regional health ministries (*Consejería de Salud*). Within the

basic benefits package agreed at

the national level, regional health ministries may define packages tailored to regional preferences; they also define the system of health care areas and basic health zones. A regional health service (*Servicio Regional de Salud*) performs as service provider, usually through two organisations, one for primary and one for secondary care (ambulatory and hospitals), although integrated structures delivering both types of care are being piloted across regions. The regional health service may also purchase services from third parties, contracting non-public providers by means of several ‘legal formulae’ or arrangements. The

Autonomous
Communities

- policy development,
- regulation
- planning
- provision of services
- funding

regional health service assumes responsibility for operational planning, service network management and coordination of health care provision.

Historically, local authorities have been involved in the management of health care; their participation in health governance is through local councils where monitoring and consultation tasks are undertaken. Additionally, hospital participation committees, with representatives of municipalities and local consumer associations, allow for contributions to hospital management. However, overall, the role of local authorities is limited, although some large municipalities may still have the resources to carry out important health initiatives. In general, regional authorities administer almost 90% of the resources allocated to health; a small amount (more than 1%) is also directly administered by municipalities, the rest being spent at the central level.

Some 95% of the population is covered by a general social insurance regime that entitles access to the public health system; in addition, there are three special regimes for civil servants; finally, there are private voluntary schemes, increasingly carried out and covering, on average across regions, some 13% of the population. Voluntary insurance schemes enable access to services for which there are long waiting times in the public system, or that are not included in the benefits package, such as adult dental care.

Delivery of services

Delivery of services occurs within a structured territorial framework based on a system of health areas and zones (health care ‘map’) that often do not correspond to administrative boundaries. Each health care area (161 in 2010) has a catchment population between 200,000 and 250,000 people and comprises several basic health zones, which are the smallest units of the organisational structure for primary health care delivery. Primary care is delivered through a public network of Health Care Centres. In rural areas with a low population density there are local medical offices. In each health zone, with a catchment population varying between 5,000 and 25,000 inhabitants, a primary care team (PCT) has a gate-keeper function.

Access to specialised care requires a referral from a general practitioner, with the exception of emergencies



that are handled through 24-hour primary health care emergency centres or hospital emergency wards. Specialised care is provided in Specialist Care Centres (*centros de especialidades*) and hospitals in the form of outpatient and in-patient care. Each health area has at least one general hospital. In 2008, there were some 804 hospitals, with around 40% of them belonging to the public health system, the others being private. Hospital management is by the Autonomous Communities or through other arrangements such as public-private partnerships.¹⁹

⇒ In Catalonia, the Regional Health Service (*CatSalud*) is the purchaser of services through the Catalan Hospital Network of Public Utilisation (XHUP). This Network includes both public and private providers such as ‘*consortiums and municipal associations, public corporations, private foundations, workers’ mutualities, religious charities, private firms and professional associations/cooperatives*’ (García-Armesto S. *et al.*, 2010). These providers constitute associative-based entities (*Entitats de Base Associativa - EBAs*), i.e. groups of primary care professionals constituted as enterprises with their own legal status, that, on the basis of contracts finalised with the regional health services, manage basic health zones, becoming, in practice the Primary Care Team of reference.

The pharmaceutical sector is regulated by the central government but regions are represented in the National Commission for the Rational Use of Pharmaceuticals, under the Inter-territorial Council of the national health system, deciding on reimbursement. Prescription and dispensing is the responsibility of regional health departments within the respective ministries. Medicines can only be dispensed in pharmacies; these are private profit-making businesses that may be owned only by pharmacists and whose licence, once won through public tender, becomes a commodity. There is a 40% co-payment contribution by citizens on the retail price, with exemptions applied to some categories (pensioners and chronically ill patients).

¹⁹ HOPE online country profile – Spain: latest information refer to 2007

OECD survey

Setting the level of taxes to be earmarked for health care		Financing new hospital building	R
Setting the basis and level of social contributions for health		Financing new high-cost equipment	R
Setting the total budget for public funds allocated to health	R	Financing the maintenance of existing hospitals	R
Deciding resource allocation between sectors of care	R	Financing primary care services Setting public health objectives	R
Determining resource allocation between regions	C	Financing specialists in outpatient care	R
Setting remuneration methods for physicians	R	Financing hospital current spending	R
Defining payment methods for hospitals	R	Setting public health objectives	R

Source: Paris, Devaux, Wei (2010)

Note: C (central/federal government); R (regional/state government); L (local/municipal government)

Finance and health care expenditure

There is no earmarked budget for health; regions cover health expenditure out of their general budgets that, in turn, are determined by existing financing mechanisms from the central to the regional governments. On average, public health accounts for 30% of the regions' total budget.

The share of public health expenditure is about 71%; private financing within total health expenditure is 28.8% (2007), sourced almost entirely from upfront payments by citizens for medicines (40% co-payment).

Public health care expenditure is almost exclusively funded (some 94%) through general taxation. Revenues from taxes are totally or partially assigned to regions; regions have direct control over taxes on gifts and inheritances, properties and property transfers, and gambling taxes; while they receive around

35% of personal income taxes and VAT, and 40% of taxes on consumption of hydrocarbon-based products, tobacco, alcoholic beverages and electricity.

The regional ministries allocate the funding, in most of the cases to the regional health service, as the main provider, with whom global annual budgets are negotiated. In turn, the regional service negotiates global annual contracts with providers of primary care, specialised and hospital care. Private providers may also be contracted, and the regional health service may act as a purchaser rather than a provider.

References:

- [National Health System of Spain](#), 2010. Ministry of Health and Social Policy
- García-Armesto S. *et al.* (2010), Health Systems in Transition, Vol. 12 No.4, [Spain Health System Review](#), European Observatory on Health Systems and Policies
- Guillén Rodríguez A.M. *et al.* (2010), Annual National Report 2010 – Pensions, Health and Long-term Care: Spain. [ASISP](#): Analytical support on the Socio-Economic Impact of Social Protection Reforms.

SWEDEN

Main characteristics of the Swedish health care system

- ▶ Highly decentralised, with an important role played by regional (county councils) and, to a lesser extent, local authorities (municipalities), also in financial terms
- ▶ Providing universal coverage upon the payment of a nominal fee at the point of use
- ▶ Mainly public financing of health care – mostly out of regional and municipal taxation
- ▶ Mixed service provision – public and private

Structure of the system

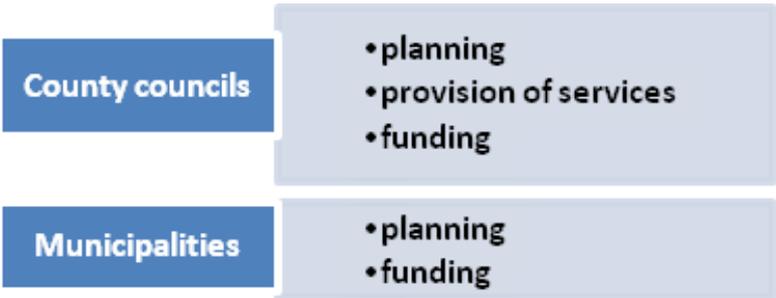
The state is responsible for overall health and medical care policy and legislation but responsibilities for organising health care services lie mostly with regional and local authorities. At the central level, health and medical care is under the Ministry of Health and Social Affairs, supported in its activities by five agencies. The Ministry drafts legislation,



shapes policy, distributes resources, monitors implementation and negotiates with county councils and municipalities on issues concerning the delivery of services. Negotiation is through the Swedish Association of Local Authorities and Regions, a body representing the interests of regional and local authorities.

The national health system is based on the decentralisation of responsibilities to the regional and local level; the responsibilities of county

councils and municipalities in health and medical care are regulated by the Health and Medical Services Act. There are 18 county



councils and two regions, with different organisational structures but usually organised around district health authorities. County councils are responsible for organising services related to health and medical care. The responsibilities of municipalities usually focus on the care of the elderly, of those discharged from hospitals, and on people with disabilities.

Delivery of services

Primary care includes medical treatment, care, preventive measures and rehabilitation and is delivered through doctors, nurses, and other health professionals either working on a private practice basis or as public employees. Primary care is often delivered through primary care centres whose management has been contracted by the county councils to other providers. Overall, in 2005, some 10% of the total health care expenditure of the county councils was for the contracting of private providers. General practitioners have a gate-keeping function in some counties, while in others patients have direct access to specialist care. Patients can choose their doctor and hospital in any county and region.

Provision of services by the private sector is increasing in outpatient and medical care, but specialist and in-patient care remain dominated by public providers. County medical care provides a second, more specialised level of care through county hospitals including both outpatient and in-patient facilities. Hospitals mostly



belong to county councils but may be managed by private companies to which county councils have transferred all or part of operational responsibilities. A third level of care is ‘regional care’, provided in regional hospitals and usually dealing with more complex diseases and injuries.

OECD survey

Setting the level of taxes to be earmarked for health care	C,R,L	Financing new hospital building	C,R
Setting the basis and level of social contributions for health	C,R,L	Financing new high-cost equipment	C,R
Setting the total budget for public funds allocated to health	C,R,L	Financing the maintenance of existing hospitals	R
Deciding resource allocation between sectors of care	R	Financing primary care services Setting public health objectives	R
Determining resource allocation between regions	C	Financing specialists in outpatient care	R
Setting remuneration methods for physicians		Financing hospital current spending	R
Defining payment methods for hospitals	R,L	Setting public health objectives	

Source: Paris, Devaux, Wei (2010)

Note: C (central/federal government); R (regional/state government); L (local/municipal government)

Finance and health care expenditure

Health care expenditure mainly comes out of general taxation at the national and local level, accounting for 84.9% of total health expenditure in 2005. In 2005, private funding of health care in the form of co-payments accounted for 13.9% of total health care expenditure. The number of those purchasing private health insurance is relatively small but increasing (4.6% in 2008).

Expenditure for health and medical care (and dental care) represents 89% of county council budgets. A very high (71% in 2007) percentage of county council services are financed by county council taxes. Other revenues are from user charges, the sale of services and earmarked state grants (2%).

Expenditure on care for the elderly and disabled represents about one third of municipalities' total expenditure. Municipalities also generate a high share of their revenues through local taxes, contributing to some 8% of total health expenditure.

References:

- Ministry of Health and Social Affairs [website](#)
- Magnussen J. *et al.* (2009), [Nordic Health Care Systems – Recent Reforms and Current Policy Challenges](#). Open University Press, European Observatory on Health Systems and Policies
- Wadensjö E. and Axelsson R. (2010), Annual National Report 2010 – Pensions, Health and Long-term Care: Sweden. [ASISP](#): Analytical support on the Socio-Economic Impact of Social Protection Reforms

UNITED KINGDOM

Main characteristics of the English health care system

- ▶ Decentralised to each of the constituent countries; centralised within each constituent country, although organised and administered on a local basis; in England, local authorities (councils) play a role in the delivery and funding of social care
- ▶ Providing coverage to 'ordinarily residents' in England, largely free at the point of service
- ▶ Mainly public financing of health care – out of general taxation and national insurance contributions
- ▶ Mostly public service provision

Each of the four constituent countries of the United Kingdom (England, Scotland, Wales, and Northern Ireland) has its own, publicly-funded, 'National Health Service' (NHS). Since the English NHS covers 84% of the total population of the United Kingdom, more emphasis has been given to its description.



England

The Secretary of State for Health bears overall responsibility for public health. It is accountable to the UK Parliament. The Department



of Health, run by the Secretary of State and a Permanent Secretary, is responsible for health policy and regulation and for central budget disbursement; it operates at the regional level through ten Strategic Health Authorities. Locally, there is a division between commissioning and delivery of services; health services are purchased by 151 primary care organisations, mainly Primary Care Trusts (PCTs), each with a catchment population of about 340,000 inhabitants. PCTs may also provide some health services directly. General practitioners also play a role in purchasing through practice-based commissioning.

Primary care is delivered through self-employed general practitioners and their practices, and other structures such as community health services, NHS walk-in centres etc. The primary care system has a gate-keeping function to secondary care. Secondary care is provided through salaried health professionals, publicly-owned hospitals (NHS trusts) and 'foundation trusts'. Foundation trusts are an example of devolution of responsibilities from the central level for hospital management and governance; they are run by local managers, staff and members of the local community. Private sector provision of services is limited. More specialised tertiary care is provided by NHS trusts. Almost all emergency care is provided by public services within the NHS and funded through public funds; there are, for example 11 NHS ambulance trusts for the delivery of ambulance services.

Local authorities (councils) are responsible for social care. Social care is the statutory responsibility of 152 Councils with Adult Social Services Responsibilities (CASSRs). Such care is financed through public (local authority budgets, sourced through council taxes and business rates) and private funds (mainly upfront or private insurance contributions). 'Direct payments' is another form of support provided by local authorities to individuals for care needs; on the basis of assessment needs, local authorities allocate individual budgets that are used by recipients to purchase the requisite services. Local authorities are also consulted by PCTs in the setting of local priorities and, in particular they participate in the production of a 'local area agreement' setting priorities for action and health outcome targets. Additionally, further to the Local Government and Public Involvement in Health Act of 2007, Local Involvement Networks were established in 2008. These networks allow the participation of

people in the commissioning, provision and scrutiny of local health and social care services: they are financially and organisationally supported by the local authority, although funding is from the central level.

Services are mainly financed from public sources – primarily general taxation (income tax, VAT, corporation tax and excise duties) and national insurance contributions (as compulsory contributions paid by employers and employees on gross earnings, and by self-employed people on profit). Private expenditure is made up of private medical insurance, user charges or cost sharing for those services not provided or not fully paid for by the NHS, and direct payments for services delivered by private providers. Funds are allocated by the central government to the Department of Health, which passes some 80% of this NHS budget to PCTs. PCTs are responsible for purchasing primary, community, intermediate, and hospital services. Providers are mainly public but may also include some private and voluntary-sector providers. In 2008, more than 82% of total health expenditure was from public sources.

Scotland

The Scottish Government Health Directorate is responsible both for the National Health Service (NHS) of Scotland and for the development and implementation of health and community care policy. Primary and secondary health care services are planned through 14 regional NHS Boards. ‘Local Delivery Plans’ are agreed between the government and the boards; these plans are 3-year performance contracts expected to deliver on a series of targets, referred to as HEAT targets (Health Improvement; Efficiency and Governance Improvements; Access to Services; Treatment Appropriate to Individuals). Boards have statutory obligations with regard to co-operation and public involvement.

Wales

The Welsh Assembly Government is responsible for the NHS. The Department for Health and Social Services advises the Assembly Government on health and social care strategies, policies, regulatory and funding issues. Since late 2009, the NHS has been re-structured to include 7 Local Health Boards (LHBs) and three NHS Trusts (the Welsh Ambulance Services Trust for emergency services; Velindre NHS Trust focussing on cancer-related specialist services; and the Public Health Wales). The LHBs plan, secure and deliver health care services in

their areas. Primary care is delivered through general practitioners and other health professionals in health centres and surgeries; secondary and tertiary care is delivered through hospitals. Community care services are usually provided in partnership with local social services.

Northern Ireland

The Health and Social Care Board, under the Northern Ireland Government Department of Health, Social Services and Public Safety, has been responsible since April 2009, when it was established, for commissioning health and social services; cooperating with the health and social care trusts that provide the services; and deploying and managing the annual funding received from the Northern Ireland Executive. It operates through Local Commissioning Groups covering the areas of competence of existing HSC Trusts. The Board is expected to achieve engagement with providers, local government, users, local communities, the voluntary-sector and other relevant stakeholders. The peculiarity of the NHS of Northern Ireland is that it combines health and social care administration. Integrated health and social care services are delivered through five Health and Social Care (HSC) Trusts; a sixth Trust is the Ambulance Service, operating throughout Northern Ireland. HSC Trusts manage and administer hospitals, health centres, residential homes, day centres and other health and social care facilities.

OECD survey

Setting the level of taxes to be earmarked for health care	C,R	Financing new hospital building	C,R
Setting the basis and level of social contributions for health	C,R	Financing new high-cost equipment	C,R
Setting the total budget for public funds allocated to health	C,R	Financing the maintenance of existing hospitals	C,R
Deciding resource allocation between sectors of care	C,R	Financing primary care services Setting public health objectives	C,R
Determining resource allocation between regions	C,R	Financing specialists in outpatient care	C,R
Setting remuneration methods for physicians	C,R	Financing hospital current spending	C,R
Defining payment methods for hospitals	C,R	Setting public health objectives	C,R

Source: Paris, Devaux, Wei (2010)

Note: C (central/federal government); R (regional/state government); L (local/municipal government)

References:

- Boyle S. (2011), [United Kingdom \(England\): Health system review](#). Health Systems in Transition, 2011; 13(1):1–486, European Observatory on Health Systems and Policies
- Scottish Government Health and Community Care [website](#)
- NHS Wales's [website](#)
- HSSPS of Northern Ireland [website](#)

3. Typology of health care systems

Classifications of health care systems have traditionally been articulated around the types of funding mechanism for health care or on the basis of the prevailing contractual relationships between health care service providers and payers.

The dimensions to be considered for a classification are obviously determined by the scope of the classification itself; since funding and provider/payer modalities are both strictly linked to the financial sustainability of health systems, they have been given high relevance, especially in light of the current financial and economic downturn, the related need to improve the efficiency and effectiveness of expenditure, and the projected further increase of public spending on health.²⁰ However, the last Joint EPC/EC Report on health systems highlighted how the understanding of drivers of health expenditure and of the overall performance also requires an understanding of the organisational features of the health systems. In particular, *'Levels of health spending are the result of the interaction between demand side factors and supply side factors and the way health services are funded and delivered i.e. the organisational features of health systems.'* (Council of the European Union, 2010a)

Recognising that little information was, in fact, available on organisational and institutional features of health systems, in 2008, the OECD undertook a survey to collect information across its member countries (Paris, Devaux and Wei, 2010). On the basis of that information, the OECD subsequently identified clusters of countries sharing similar institutions (Joumard *et al.*, 2010) even though from an efficiency perspective, such clustering did not highlight *'larger differences within each institutional group than between institutional groups, which suggests that there is no type of health system that performs better than another.'* (Council of the European Union, 2010a)

²⁰ According to EC forecasts, on the basis of a reference scenario, in 2060 there will be an *'average growth in public health care spending of 1.7% of GDP in the EU27 Member States, which equals approximately 25% of the initial (2007) level. The relative percentage increase varies considerably across countries, from 11% in Sweden and 15% in France to as much as 45% in Slovakia and 71% in Malta. The relative increase is on average slightly higher in the EU12 (30%) than in the EU15 countries (23%)'* (European Commission, DG Economic and Financial Affairs, 2010, where the assumptions made for the 'reference scenario' are also explained).

On the supply side, other relevant information related to the ownership, management and financing of health care facilities, or ‘hospital governance’, was compiled on a comparative basis across Europe by Hope and Dexia.²¹ This analysis, with only an informative scope and refraining from drawing conclusions on the performance of hospital systems, investigated an area that is very important in terms of institutional settings and modalities for the delivery of health care services, since hospitals purchase goods (medicines, medical devices) or services (health professionals), make investments, and, not least, are significantly involved in the testing, development or deployment of ICT applications for health.

Section 3.1 briefly reports on the classifications mentioned above. In section 3.2, the focus is on those elements of the above classifications that are of some interest for the scope of this study, i.e. outlining a classification of health management systems that highlights the role of local and regional authorities within the systems.

3.1 Some main existing models or classifications

3.1.1 Health care funding

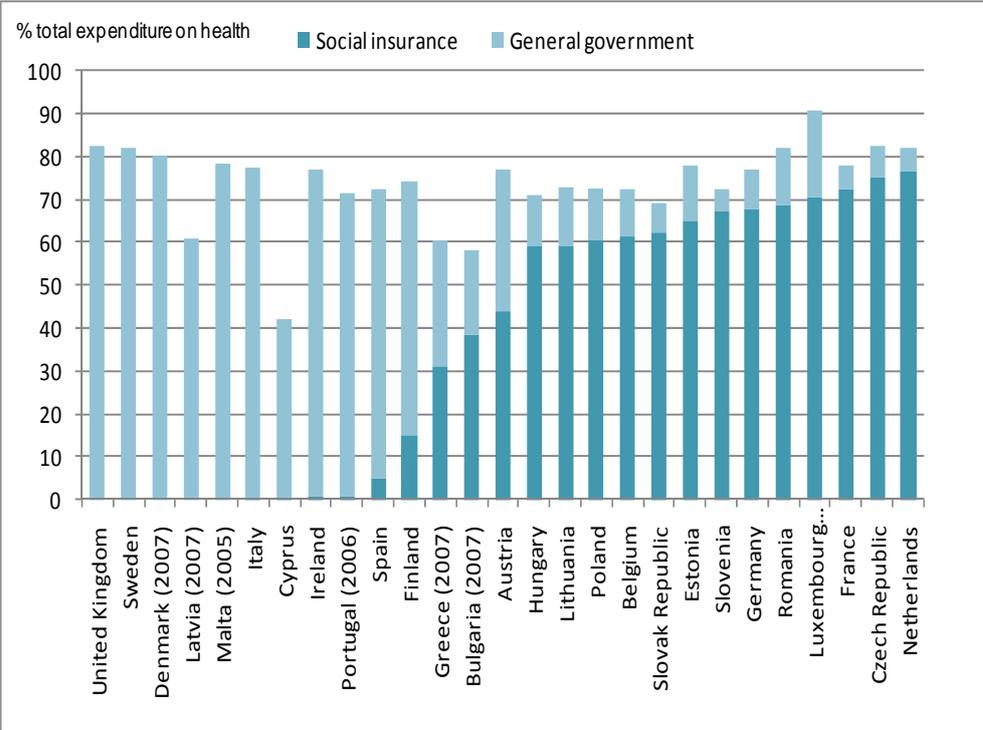
With regard to the way health care systems are financed, there are three main models (Busse *et al.*, 2007):

- (i) the Beveridge model
- (ii) the Bismarck model
- (iii) a mixed model

The Beveridge model relates to public tax-financed systems, i.e. funding is by means of fiscal tools. This model is also referred to as National Health System and usually provides universal coverage.

²¹ Hope & Dexia (2009)

On the same principle as the Beveridge model is the Semashko model, where funding is through taxation and health care coverage is universal but the state has more control than in the Beveridge model with regard to funding, management and ownership of health care facilities. The Semashko model, which leads to hospital-centred services, was common in central and eastern European countries before reforms were implemented in the early nineties (Hope and Dexia, 2009).



Data sources: OECD (2010); Thomson S. *et al.* (2009) for Malta

The Bismarck model implies that the funding of the health care system is through compulsory social security contributions, usually by employers and employees. It is also referred to as Social Health Insurance System.

In the mixed model, private funding from voluntary insurance schemes or upfront payments is significant. This model is also referred to as the Private Health Insurance System.

Data on the predominant system of health care financing by country is provided in Chart 1.

3.1.2 Public/private financing and type of health care providers

Another classification by Docteur and Oxley (2003) and the OECD (2004) is based on the criteria of public or private financing, and the prevailing

contractual relationships between health care service providers and payers. According to this classification, health care systems are classified as either a (European Commission, DG Economic and Financial Affairs, 2010):

- (i) public-integrated model,
- (ii) public-contract model, or,
- (iii) private insurance/provider model.

The public-integrated model implies public financing and public health care providers, i.e. health care professionals, are for the most part public sector employees. The public-contract model combines public financing, either through taxation or social security funds, with private health care providers. The private insurance/provider model refers to private insurance entities contracting private health care providers.

3.1.3 Institutional features of health systems

On the basis of the information gathered through a survey across its member countries (Paris, Devaux and Wei, 2010), the OECD first defined a set of indicators to assess health care system performance and then outlined six groups of countries sharing similar institutional features (Joumard *et al.*, 2010). This classification is largely based on the level of reliance of the systems on market mechanisms for the regulation of the demand and supply of health services, namely:

- (i) Group 1 includes countries relying heavily on market mechanisms for both the regulation of insurance coverage and the provision of services: private providers therefore play an important role in health care.
- (ii) Groups 2 and 3 include countries with basic insurance coverage and heavy reliance on market mechanisms for the provision of services. Private providers thus still play an important role. In group 2, services beyond the basic package are mostly covered by private health insurance, while in group 3 over-the-basic coverage is limited.
- (iii) Group 4 includes countries with limited private supply but wide choice of providers.

- (iv) Groups 5 and 6 include countries with heavily regulated public systems, where the choice of providers is limited and steered by the existence of a gate-keeping system (group 5) or budget constraints (group 6).

As a general conclusion of this cluster analysis, it is noted by the authors that *‘Most decentralised countries tend to regulate health care resources and/or prices more than the OECD average. A high degree of decentralisation is often associated with a relatively weak consistency of responsibility assignments across levels of governments, suggesting that overlap in responsibilities for health care management tends to be present in decentralised systems.’* (Joumard *et al.*, 2010)

3.1.4 Hospital governance

An analysis of the hospital sector across Europe by Hope and Dexia²² provides comparable information on hospital governance, on the basis of which a classification of hospital management systems has been derived in terms of:

- (i) decentralisation
- (ii) centralisation
- (iii) ‘deconcentration’

Decentralisation of hospital management systems implies the transfer of power, at different levels, from the State to regional or local authorities; where this transfer has not occurred, a centralised management of the hospital sector prevails; ‘deconcentration’, on the other hand, implies that the management is still controlled at the central level but is operated at the territorial level through local or regional ‘agencies’ or branches of the central administration.

A general conclusion by the authors is that *‘the more a health system is decentralised, the more the hospital system is as well’* (Hope and Dexia, 2009). According to their report, decentralised hospital management is found in the federal MS (Austria, Belgium and Germany), in the Scandinavian countries (Denmark, Finland and Sweden), and in Italy and Spain, as well as in several central and eastern countries; the United Kingdom also has different hospital

²² Hope and Dexia (2009)

systems managed at the level of its four constituency nations. 'Deconcentrated' systems are found in Bulgaria, France, Greece and Portugal, the rest of the countries being characterised by centralised systems.

Table 3 – Clustering of countries according to some main typologies of health care systems

Funding mechanism (*)	Beveridge model		Bismarck model			Mixed public and private
	Cyprus, Denmark, Finland, Ireland, Italy, Latvia, Malta, Portugal, Spain, Sweden, United Kingdom		Belgium, Czech Republic, Estonia, France, Germany, Hungary, Lithuania, Luxembourg, the Netherlands, Poland, Romania, Slovak Republic, Slovenia			Austria, Bulgaria, Greece
Institutional features of health systems (**)	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6
	Germany, the Netherlands, Slovak Republic	Belgium, France	Austria, Czech Republic, Greece, Luxembourg	Sweden	Denmark, Finland, Portugal, Spain	Hungary, Ireland, Italy, Poland, United Kingdom
Hospital management system (***)	Decentralised		Centralised		‘Deconcentrated’	
	Austria, Belgium, Czech Republic, Denmark, Germany, Finland, Sweden, Italy Spain, Hungary, Latvia, Lithuania, Poland, Slovak Republic, United Kingdom		Cyprus, Estonia, Luxembourg, Malta, Slovenia, Romania, Ireland, the Netherlands		Bulgaria, France, Greece, Portugal	

(*) Based on data from OECD (2010), and Thomson S. *et al.* (2009) for Malta

(**) Source: Joumard *et al.*, 2010. Only showing those OECD member countries belonging to the EU

(***) Source: Hope and Dexia, 2009

3.2 Methodological approach

Existing typologies do not highlight the role of local and regional authorities within health management systems or consider such a role only with respect to one criterion, as in the case of the hospital management classification.

In particular, by looking at the funding mechanisms no information is given on the territorial organisation of healthcare systems, since health systems relying on public taxation, for example, may be highly decentralised (Finland) or centralised (Malta). The type of funding and of service provider also do not disclose information on the institutional settings of health management systems as public providers may be within centralised (Cyprus) or decentralised systems (Italy). Additionally, few systems are solely based on one of these types of relationship, a mixed public/private provision of services being present in several countries, regardless of the source of funding.

‘Decentralisation’ and ‘delegation’ are only two of the indicators used by the OECD in its clustering exercise highlighting the institutional features of health management systems with respect to performance, and are not steering ones, since in the same group both centralised and decentralised health management systems may be found (for example, in group 6, are included both Ireland and Italy, characterised, respectively, by a centralised and decentralised management). Additionally, they only refer to the decision-making autonomy by sub-national governments in key health care spending issues.

On the other hand, there seems, in fact, to be a correlation between the types of hospital governance and the level of decentralisation of health management systems.

In line with the scope of this report, the proposed typology builds on a number of dimensions directly or indirectly correlated to the above classifications but all characterised by a clearly distinguishable regional and/or local contribution.

3.2.1 Criteria considered

The following criteria have been considered for outlining a typology of European health management systems with respect to their territorial organisation:

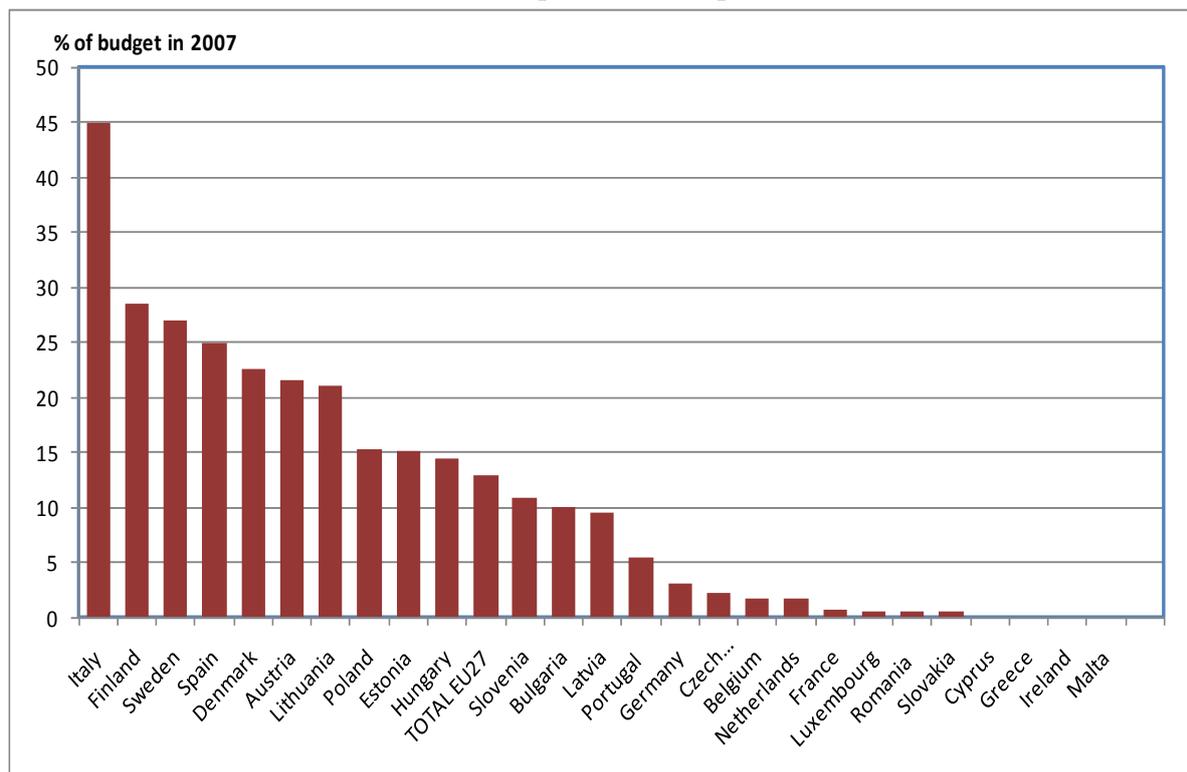
1. Presence/absence of health funding responsibility by LRAs (sources: various, as outlined in the inventory of this report) and level of health funding at the sub-national level, as a percentage of total sub-national public sector expenditure (source: Council of European Municipalities and Regions & Dexia, 2009).
2. Presence/absence of power/responsibility by LRAs with regard to the following functions: health-related legislation, planning of health care services, and delivery (implementation) of health care services (sources: various, as outlined in the inventory of this report)
3. Ownership and/or management of health care facilities, in particular hospitals, by LRAs (sources: various, as outlined in the inventory of this report, with particular reference to Hope & Dexia, 2009, and to the hospital country profiles published online by Hope).

Since the information gathered through the OECD survey and the indicators built on this information refer to OECD member countries, OECD data has only been used for double-checking purposes with respect to available countries.

Criterion 1: health funding by LRAs

Public spending by LRAs for health care delivery is an indicator of active involvement in the functioning of health management systems; in those cases where funding is generated locally through taxes or other levies, the funding role also presumably points to a level of autonomy with regard to spending. Beside responsibility for funding, the level of funding is also considered.

Chart 2 – Sub-national public sector expenditure on health



Data source: Council of European Municipalities and Regions & Dexia (2009)

Through the inventory, evidence for funding responsibility was found for 19 countries. All countries but one generate revenue directly, mostly through taxation.²³ The level of funding is shown in Chart 2, where the OECD classification of the functions of government is used and ‘health’ includes ‘*medical products, appliances and equipment, outpatient, hospital and public health service, R&D related to health*’ (Oireachtas Library & Research Service, 2010).

Criterion 2: power and responsibility by LRAs with regard to health-related legislative, planning, and implementation functions

The presence/absence of power and responsibility with regard to the mentioned functions is evidently and directly linked to the level of decentralisation of health management systems.

²³ In the case of France, funding responsibility seems to be limited to the health care of the elderly and the disabled; while in Germany and Hungary the funding seems limited to capital investments for hospitals.

The inventory provides the following evidence:

- LRAs legislate on health-related matters in only three countries: Austria, Italy and Spain.
- Policy development or planning is undertaken by LRAs in 16 countries.
- LRAs have direct implementation tasks of one type or another, and at different levels, in 22 countries.

Criterion 3: ownership and management of health care facilities by LRAs

The transfer of power in the hospital system from the central to the local level is a move towards decentralisation. Several central and eastern European countries underwent this process in the early 2000s, such as the Slovak Republic and Romania. Ownership usually implies funding responsibilities and, in most cases, management functions that may be implemented directly by LRAs or contracted out to service providers.

The inventory provides the following evidence:

- Ownership of health care facilities by LRAs is common in 19 countries.
- Ownership always implies the management of health care facilities that may be direct or indirect through contractors.
- In three countries LRAs are responsible for the management of health care facilities without owning them.
- In four countries LRAs do not own health care facilities, nor do they manage them.

3.2.2 Outlining the types

The types were outlined following a simple labelling exercise of countries with respect to the criteria presented under 3.2.1.

When LRAs contribute to the funding of health care and raise financial resources locally through, for example, taxation, the corresponding countries have been labelled ‘*max*’; if funding is only channelled through LRAs but provided by the state or if LRAs do not handle health-related financial resources at all, the corresponding countries were labelled ‘*0*’. With respect to the level of funding, three categories were distinguished: (i) countries where LRA funding is above the EU27 average of 12.9% of sub-national budget contributed to health (labelled ‘*max*’); (ii) countries where LRA funding is below the EU27 average

(labelled '*min*'); (iii) countries where LRAs do not fund health through a sub-national budget (labelled '*0*').

Legislative power on health matters was given high relevance as it affects the way health management systems are structured and operated. Where LRAs have legislative power, the reference may, in fact, straightforwardly be to 'regional health systems': corresponding countries were labelled '*max*'. Countries where there is no evidence of legislative power by LRAs for health-related matters were labelled '*0*'.

With respect to planning and implementation functions, countries were distinguished into three groups: (i) countries where LRAs have both planning and implementation functions (labelled '*max*'); (ii) countries where LRAs exercise only one of the two functions (labelled '*min*'); and (iii) countries where LRAs have no planning and implementation functions with respect to health (labelled '*0*').

Finally, with regard to the ownership and management of health care facilities, countries were also distinguished into three groups: (i) countries where LRAs own and manage (directly or indirectly) health care facilities (labelled '*max*'); (ii) countries where LRAs only manage health care facilities but do not own them (labelled '*min*'); and (iii) countries where LRAs do not own or manage health care facilities (labelled '*0*').

3.3 A new typology of health management systems

Table 4 summarises the proposed new typology according to the criteria and approach presented in sections 3.2.1 and 3.2.2.

Five types of health management systems at the local and regional level are distinguished within the proposed typology.

Type 1 includes 'regional health management systems', i.e. whose regulation, management, operation and partially also funding is delegated to regional authorities or States. Funding through sub-national budgets is above the EU average and sub-national authorities also own and manage health care facilities.

Type 2 includes those health management systems where local and regional governments are responsible for several planning and implementation functions, besides funding; further, they own and manage health care facilities. Within this type, sub-types are distinguished on the basis of the level of funding from sub-national budgets (above or below the EU average).

Type 3 refers to health management systems where local and regional authorities have operational (implementation) functions, including as a consequence of owning health care facilities; funding from sub-national budgets is limited. The Netherlands are in a peculiar position; they are centralised with respect to hospital governance, but LRAs have a role in planning and implementation, including limited funding contribution from the sub-national budget. As the ‘operative’ function of Dutch local authorities is evident, their health management system has been attributed to this type. Another particular case is that of the United Kingdom, as each of its four constituent countries (England, Scotland, Wales, and Northern Ireland) has its own ‘National Health Service’ but within each constituency the prevailing type refers to a system that is ‘centralised but structured at the territorial level’. The UK has been attributed to type 3 according to the ‘operative’ function of the four constituencies.

Types 4 and 5 are characterised by health management systems that are centralised in full (type 5) or to a great extent (type 4); in type 4, most of the responsibilities lie with the central government even if implementation is at the territorial level through bodies representing the central administration; additionally, with the exception of Portugal, LRAs of a type 4 system may also manage health care facilities.

Table 4 – Proposed new typology of health management systems

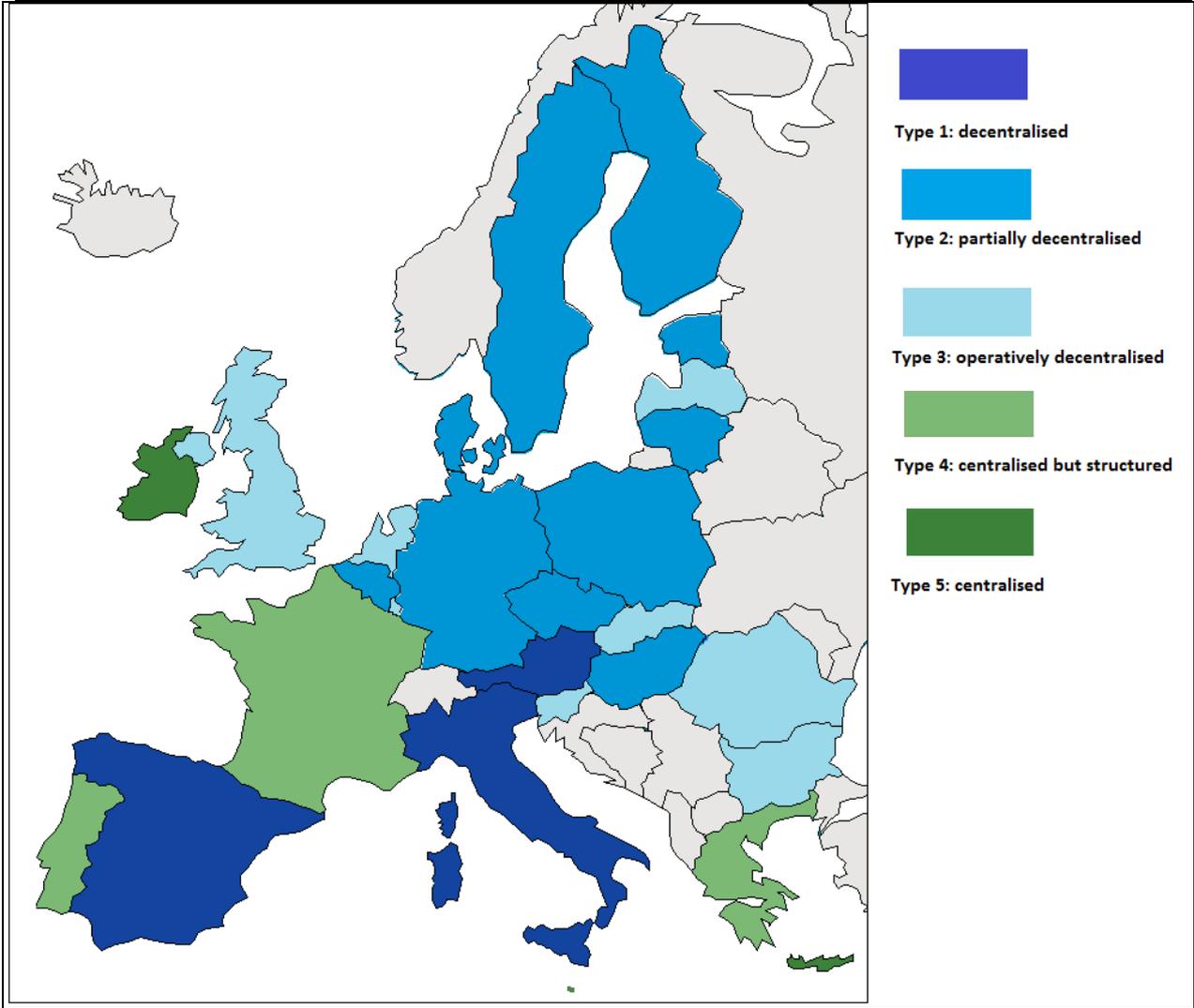
Type	Functions	Funding level	Health care facilities		Countries
			ownership	management	
1	Decentralised	Above EU average	YES	YES	Austria, Italy, Spain
2	Partially decentralised - several functions (but not legislation) decentralised	Above EU average	YES	YES	Denmark, Estonia, Finland, Lithuania, Poland, Sweden, Hungary (*)
		Below EU average			Belgium, Czech Republic, Germany
3	Operatively decentralised	Below EU average Low or nil	YES	YES	Bulgaria, Latvia, Luxembourg, Romania, Slovak Republic, Slovenia
			NO	NO/YES	Netherlands, United Kingdom
4	Centralised but structured at the territorial level	Low or nil	NO	YES (**)	France, Greece, Portugal
5	Centralised	NO	NO	NO	Cyprus, Ireland, Malta

(*) operatively decentralised but no planning functions

(**) with the exception of Portugal

The different types of health management systems are represented in Map 1.

Map 1 – Proposed typology of health management systems



Source: Progress Consulting S.r.l.

4. Conclusions and recommendations

4.1 Conclusions

LRAs **commonly implement tasks related to public health**. Notably, these tasks are a prerogative of LRAs also when the actual delivery of services is partially or fully centralised. Consequently, LRAs are affected by decisions related to **health promotion and disease prevention**, several of which fall under Objective 1 ‘Fostering good health in an ageing Europe’ of the EU Health Strategy.²⁴ Additionally, **LRAs are often specifically responsible for the provision of services to the youth and the elderly**. For the latter, these services also include long-term care.

In particular, ageing is a process that is affecting Europe in different ways. There are **‘old’ and ‘relatively young’ regions that will face diverse challenges** according to the dynamics of their population. **Population ageing is expected to impact public expenditure for health and long-term care, the demand for health services, and the need for health professionals and workforce** (Committee of the Regions, 2011b). Thus, the existence of very diverse situations across the EU and the important role played by LRAs in fostering the healthy ageing of the population make it imperative to take into account experiences and trends occurring at the territorial level while shaping health policies.

LRAs from 21 MS are involved in the territorial management of health systems, from a highly decentralised level where policy and regulatory issues are handled locally, to an operatively decentralised management level. **LRAs significantly²⁵ involved in the funding of health care are found in ten MS**, in most cases generating resources through local taxation. Further, **LRAs from 19 MS own and manage health care facilities** for the delivery of primary or secondary care, or of long-term care services. As a logical consequence of this

²⁴ Among the issues related to the fostering of good health are, for example: nutrition, physical activity, consumption of alcohol, drugs and tobacco, environmental risks, and accidents

²⁵ i.e. above the EU27 average of 12.9% of sub-national budget contributed to health, according to data from the Council of European Municipalities and Regions & Dexia (2009)

evidence, it seems important for the views and interests of LRAs to be systematically taken into account while shaping and implementing policies affecting **health management systems**, as **these systems, in several MS, are under the direct responsibility and power of territorial administrations**.

Health management systems-related topics that are relevant to LRAs fall both under Objective 1 of the EU Health Strategy, for example with regard to health inequalities, and under Objective 3 ‘Supporting dynamic health systems’ with regard to health workforce, cross-border health care, patient safety and quality of care. On the other hand, patient safety and quality of care are both relevant to the development of ICT applications for health. Since **there is the evidence of an important level of involvement by LRAs in the development of regional and/or hospital information systems** (Committee of the Regions, 2011a), data protection is also an issue to be considered when fostering local and regional input into health decision-making processes at the EU level.

Considering the important role played by LRAs in health care development and delivery of services across the EU, additional input from the local and regional level within relevant committees, working parties or expert groups would be beneficial to discussions contributing to health policy development. Such input would, among other things, bring policy-making closer to real needs and make it more demand driven. Therefore, rather than the sporadic participation of individual administrations, a more structured participation by LRAs, either through their associations or consultative body, is needed.

It is acknowledged that detailed procedures already exist for assisting the Commission in drafting legislation and identifying measures for its implementation. Thus, suggestions for involvement do not enter into the merit of feasibility of, or modalities for, a higher degree of participation by LRAs. Instead, they point to the level of representation that should be fostered within existing committees or working/expert groups, on the basis of the relevance to LRAs in general or to the type of health management system, as identified under chapter 3, in particular, of the topics handled by these committees and working/expert groups.

Types of formal cooperation mechanisms

Comitology committees assist the Commission by providing formal opinions on measures intended to implement EU legislation. Members of these committees are EU MS representatives. These committees are set up by the Council or by the Council and the European Parliament.

Commission expert groups are forums for discussion and provide high-level input to the Commission for the preparation of legislation or implementation of legislation, programmes and policies. Input is provided in the form of opinions, recommendations and reports. Members of these expert groups are: individuals in a personal capacity, individuals representing common interests, organisations, and authorities (including at the local and regional level).

4.2 Recommendations

There are several committees and working/expert groups at the EU level that are dealing with health-related topics partially or totally falling under the power and/or responsibility of LRAs. Some of these committees and groups where a structured participation of LRAs, through the appropriate bodies, is considered to be beneficial, are highlighted below.

The committees/groups highlighted are not to be regarded as exhaustive. Recommendations point to an opportunity for participation based on evidence, i.e. on the basis of information gathered through the inventories compiled in this report, and in other recent investigations carried out by the Committee of the Regions, all of which testify to an increasingly important role played by LRAs in health-related matters.²⁶

The reference to the types of health management systems has been made with respect to the new typology outlined in Chapter 3.

²⁶ Committee of the Regions (2011a), Dynamic health systems and new technologies: eHealth solutions at local and regional levels; Committee of the Regions (2011b), Active ageing: local and regional solutions.

Recommendation 1

Committee/ Experts group	Key information	Membership
High Level Group on Nutrition and Physical Activity	<p>Tasks: (i) informing about national policies related to nutrition and physical activity; (ii) facilitating the sharing of ‘policy ideas and practice’; (iii) liaising with the EU platform for diet, physical activity and health, in particular to encourage the establishment of public-private partnerships (PPP).</p> <p>Topics: poor nutrition, being overweight, obesity, physical inactivity, alcohol abuse, diet, product reformulation.</p>	<p>MS representatives and representatives from Norway and Switzerland</p>
Reasons for recommending local/regional input		
Added value by local/regional input	<ul style="list-style-type: none"> ▪ Enriching the sharing of ‘policy ideas and practice’ with experiences from the local and regional level. ▪ Accelerating the creation of PPP, as a consequence of directly involving local and regional administrations in the dialogue with the private sector. 	
Level of representation of LRAs	<p>All types of health management systems are potentially able to contribute to the enrichment of ideas and practice, while an engagement with the private sector is more likely in those types where LRAs have health-related power and/or responsibility (i.e. types 1, 2 and 3).</p> <p>Associations of LRAs would be the most suitable for presenting good practices from the local and regional level in the High Level Group and facilitating business-related developments where LRAs are directly responsible for implementation.</p>	

Recommendation 2

Committee/ Experts group	Key information	Membership
EU expert group on Social Determinants of Health and Health Inequalities	<p>It is a subgroup of the High Level Committee on Public Health (HLCPH).</p> <p>Mandate: (i) providing a forum for the exchange of information and good practices; (ii) functioning as an interface between policies and activities; (iii) evaluating and providing guidance and advice on the need for further action; (iv) reviewing the health strategy annual work plans with regard to those elements related to social determinants and health inequalities.</p> <p>Topics: level of physical access to health services, living conditions, status of the environment, distribution of resources, social status, employment status, income level, education level.</p>	<p>One policy expert nominated by each country belonging to the HLCPH.</p> <p>Experts nominated by the EC.</p> <p>WHO and other international organisations.</p> <p>EC services.</p>
Reasons for recommending local/regional input		
Added value by local/regional input	<ul style="list-style-type: none"> ▪ Monitoring the impact of the financial and economic crisis at the local and regional level, with regard to social and health aspects, including indicator development and modalities for streamlining data and indicator-based evidence into the policy-making process. ▪ Developing integrated regional strategies to reduce health inequalities. ▪ Promoting telemedicine, in particular for improving access to specialist care in border regions and for reducing geographical inequalities driven by remoteness or difficult topographic conditions. 	

	<ul style="list-style-type: none"> ▪ Partnering across border regions to reduce access inequalities by making facilities and personnel available across borders. ▪ Determining the requirements for the enhancement of public health capacity at the local and regional level through training on equity in health approaches across policy sectors.
Level of representation of LRAs	<p>Monitoring of the impact and the development of integrated regional strategies are particularly relevant to type 1 health management systems. Types 1, 2 and 3 are concerned with telemedicine development and partnering across border regions, while public health capacity building is particularly relevant in types 1 and 2, where LRAs have policy development and/or planning responsibility.</p> <p>According to the diverse types of health management systems concerned with the topics addressed within the EU expert group on Social Determinants of Health and Health Inequalities, the Committee of the Regions would be in the best position to represent interests equitably and channel the voices of the local and regional level.</p>

Recommendation 3

Committee/ Experts group	Key information	Membership
Committee on cross-border health care	<p>Legal act: Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border health care.</p> <p>Topics: patients' rights, quality and safety of cross-border health care, cooperation among health systems.</p>	-

Justification of the recommended local/regional input

Added value by local/regional input	<ul style="list-style-type: none"> ▪ Monitoring respect of the subsidiarity principle through sharing relevant feedback from LRAs. ▪ Monitoring the social, economic and financial impact of the Directive on (partially/operatively) decentralised health systems (types 1, 2 and 3) managed by sub-national authorities, including the effect on patient inflows and outflows.
Level of representation of LRAs	<p>At least three types of health management systems are directly concerned with the implementation of Directive 2011/24/EU. In particular, type 1 health management systems may be requested to deal with necessary amendments to enforcement legislation. Types 1 and 2 may be dealing with decisions on the health services which are subject to reimbursement in cross-border health care and on cost-sharing for services rendered between the various authorities concerned at the national and sub-national level. Type 3 will be affected in their daily operation of activities.</p> <p>According to the diverse impact of the Directive from the legislative to the operative level, the interest and voice of the different types of health management systems would be best represented by the consultative body of LRAs, the Committee of the Regions.</p>

Recommendation 4

Committee/ Experts group	Key information	Membership
Council Working Party on Public	The Working Party is supported by the activities of three working groups on : patient safety and quality of care, European reference networks, and health workforce.	MS representatives. EC services.

<p>Health at Senior Level & Working groups on: patient safety and quality of care, European reference networks, and health workforce</p>	<p>Mandate: (i) providing a forum for discussion of major health issues; (ii) contributing to a strategic vision for health; (iii) considering issues arising on health systems and health determinants; (iv) identifying priorities, objectives and actions; (v) contributing to the work of the Council; (vi) inviting technical input from the EC; (vii) monitoring and assessment of the implementation of health strategies and policies and of the ‘health in all policies’ approach; (viii) selecting topics needing in-depth review.</p> <p>Topics: implementation of the European Health Strategy.</p>	<p>Invited experts from other EU institutions and international organisations</p>
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Reasons for recommending local/regional input

<p>Added value by local/regional input</p>	<ul style="list-style-type: none"> ▪ Increasing the relevance of the actions outlined in the work plans, and subsequently the chances for success of the Health Strategy. ▪ Increasing the uptake of available funding opportunities by LRAs. ▪ Contributing to the shaping of Europe 2020 Health objectives.
<p>Level of representation of LRAs</p>	<p>The European Health Strategy 2008-2013 is implemented by means of Work Plans adopted annually by the Commission along with the setting of priority areas and of criteria for the selection and funding of actions. Work Plans touch upon health management issues that are of high relevance to LRAs, including matters related to investments in health such as making better use of EU cohesion policy and structural funds, the post-2013 structural funds preparation, and making health a thematic priority for investment.</p>

Priority concerns and needs existing at the local and regional level, especially in types 1, 2 and 3, need to be systematically taken into account in future work plans related to the implementation of the European Health Strategy. A fair and balanced representation of the diverse priorities, needs and emerging issues existing at the local and regional level would be accomplished by involving the consultative body of LRAs, the Committee of the Regions, in the programming phase of the plans and in the related discussions. Consequently, there may also be a need for the Committee of the Regions to be regularly represented in the three working groups supporting the Working Party.

Recommendation 5

Committee/ Experts group	Key information	Membership
Data Protection Working Party²⁷ (Article 29 Working Party)	<p>It has been established and maintained by Article 29 of Directive 95/46/EC. Its tasks are set in Article 30 of the same Directive and, in brief, include: (i) advise the Commission and make recommendations on data protection matters; (ii) promote cooperation among national data protection authorities; (iii) point to EU measures affecting personal data and privacy rights of individuals.</p> <p>Topics: data protection, privacy rights.</p>	<p>MS representatives. EC services.</p>
Reasons for recommending local/regional input		
Added value by local/regional	<p>Providing input to the revision process of the Directive, through specificities related to health data on the basis of experiences made at the regional level, especially in</p>	

²⁷ http://ec.europa.eu/justice/policies/privacy/workinggroup/index_en.htm

input	decentralised or partially decentralised health management systems (types 1 and 2).
Level of representation of LRAs	<p>Building on evidence gathered through the study on ‘Dynamic health systems and new technologies: eHealth solutions at local and regional levels’²⁸, LRAs belonging to all types of health management systems are involved in the development of ICT applications for health that in most cases touch upon data confidentiality and security issues. Privacy and accessibility are also strictly connected to ‘standardisation’ and ‘interoperability’, two areas where LRAs, in some cases, have gained important experience.</p> <p>According to the diverse and wide experience gained across Europe at the local and regional level, territorial input would be best and equitably channelled through the consultative body of LRAs, the Committee of the Regions.</p>

²⁸ Committee of the Regions (2011a)

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