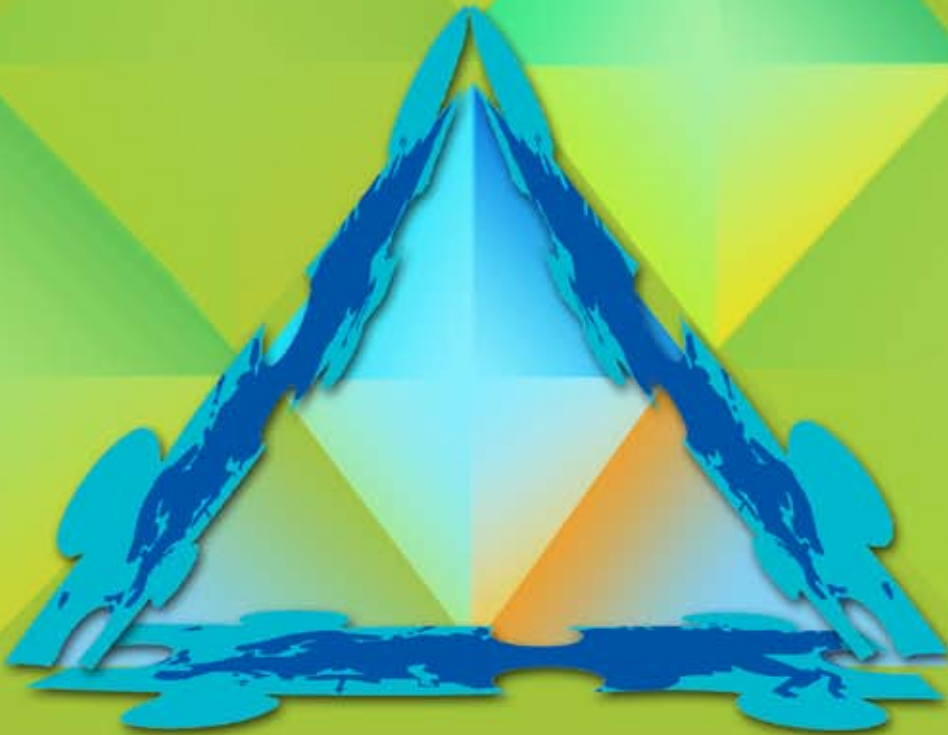




EUROPE



REGIONS FOR HEALTH NETWORK
IN EUROPE



DECENTRALIZED HEALTH SYSTEMS
IN TRANSITION

KEYWORDS

DELIVERY OF HEALTH CARE - organization and administration - trends
REGIONAL HEALTH PLANNING
HEALTH CARE REFORM
COMPARATIVE STUDY
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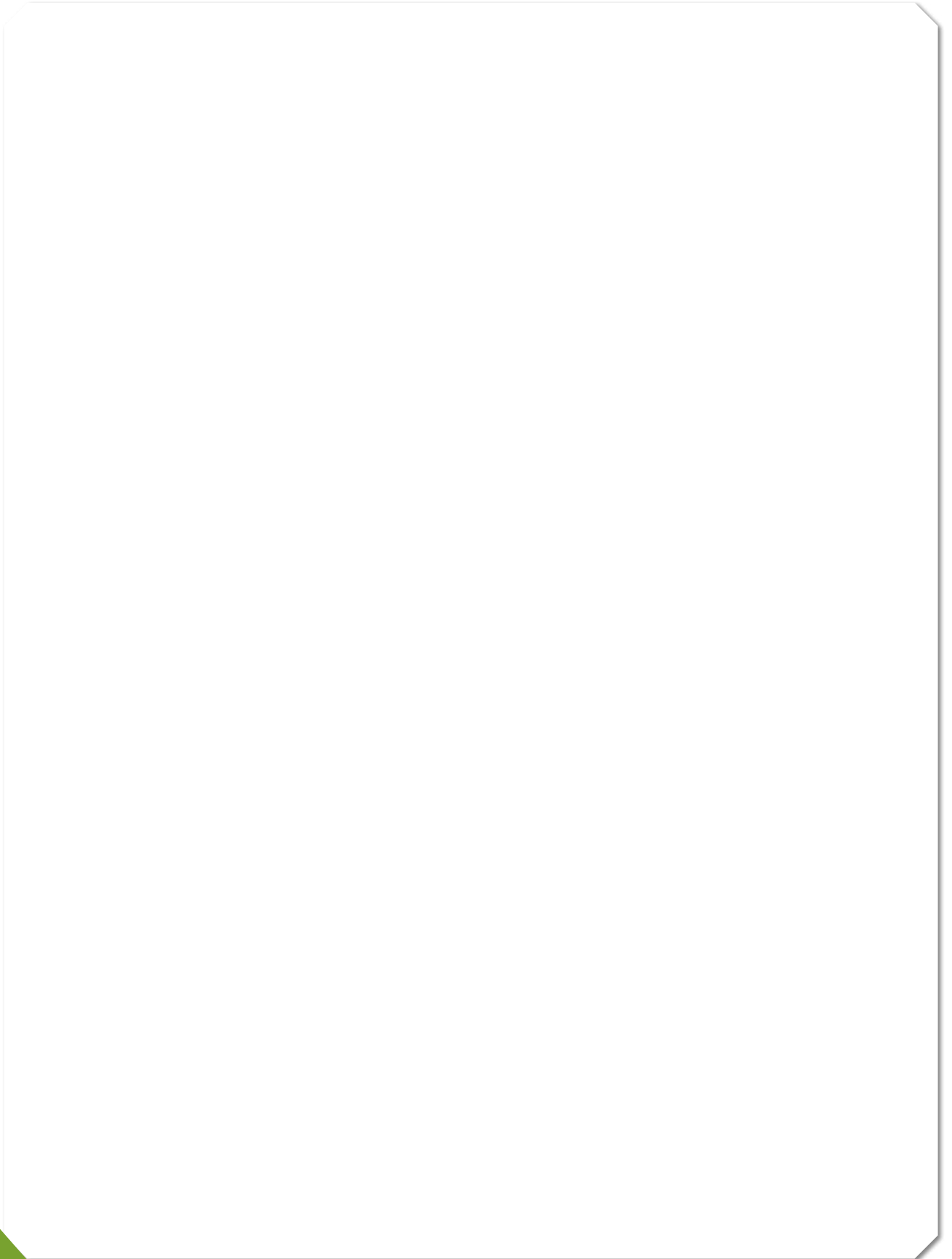
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REGIONS FOR HEALTH NETWORK IN EUROPE

DECENTRALIZED HEALTH SYSTEMS IN TRANSITION

Technical Report based on the Fourteenth Annual Conference of RHN



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1. INTRODUCTION

The WHO Regions for Health Network (RHN) was established in 1992 in order to complement the work carried out at the national level, by supporting the development of policies and strategies to improve health at the level immediately below the national level. Today, the network consists of twenty-nine members with population coverage of about 85 million European citizens living in the 53 member states of the WHO European Region. Each year, the WHO Regions for Health Network organizes a conference on a theme considered as a priority for the regions of Europe and in line with the strategic work of the WHO Regional Office for Europe. In light of the Ministerial Conference on Health Systems in 2008, the network also noted the importance of health systems work and their relevance in the European region. Thus, the network decided to focus the proceeding two Annual Conferences on the theme of Health Systems. This report is based on the results of the 14th Annual conference on the theme of Decentralized Health Systems in Transition. This choice seemed logical in light of ever increasing attention that the issue of decentralization attracts in policy discussions in the European health systems fora. Ways to ensure accountability for performance, improve equity, strengthen solidarity, maintain responsiveness, and increase efficiency - are some of the key questions that policy makers at the regional and national level are trying to address together. The 14th Annual Conference provided a forum for the regions to discuss some of the outstanding issues related to health systems at the decentralized level, and for participants to share among themselves their experience and views on possible ways of dealing with opportunities and challenges.

As defined by the World Health Report 2000 (1), Health systems comprise all organizations, institutions and resources that are devoted to producing health actions principally aimed at improving, maintaining or restoring health. Decentralization as it relates to health systems

has the main objective to “improve responsiveness and incentive structures by transferring ownership, responsibility and accountability to lower levels of the public sector.”¹ Keeping this objective in mind, and in view of the European ministerial conference on health systems for 2008, the Conference aimed to explore, share and analyse regional case studies.

Thus, the specific themes related to decentralization and health systems that were explored included European trends and prospects; Challenges as well as opportunities of decentralized health systems.

1. European Trends and Prospects in Health Care²

Common Challenges in Health Care: the case of Denmark

The main health care challenges in the European Union are related to an ageing population, an increase in chronic conditions related to diet and lifestyle, an increased demand by the public for new technologies and medicines, staffing shortages, and health care spending,

Ageing Population

Europe is experiencing an ageing population. The demographic development in Denmark indicates that by 2010, there will be 90,000 more Danes over 65 years old. In addition, more than 50,000 people will leave the labour force. Less people will be working to pay for more people in our society.

Chronic Conditions

More and more people are suffering from chronic conditions, partly as a result of the ageing population and also due to the increase in lifestyle related diseases (non-communicable diseases) caused by tobacco, alcohol and stress.

¹ World Health Report 2000. Health Systems: Improving Performance <http://www.who.int/whr/2000/en/index.html>

² This section is based on a presentation to the 14th Annual Conference of RHN in 2006 by Marie Louise B. Poulsen- Hansen on behalf of Ms Bente Nielsen, Member, Committee of Regions, and material from the Danish Regions, 3rd revised edition, 2007.

Demand for New Technologies and Medicines

Denmark is under increasing pressure to keep up with the development of new technologies and medicines. As the society becomes wealthier, demands and expectations for services and treatments increase. Patients are more educated and have higher demands. There is a need to document quality in the health care sector, to provide evidence-based treatment and exchanges of best practices in quality improvement.

However, new technologies and medicines are costly and put pressure on health care spending. The introduction of just one new type of cancer medicine can cost more than 100 million DKK, or €15 million. Yet the development of new technologies never stops.

Shortage of Health Care Professionals

Denmark is experiencing a shortage of health care professionals. Specifically, there is a shortage of doctors in the west and of nurses in the east, due to the demographic shift and to an expanding private health sector. These shortages challenge the traditional organization of the public health sector.

Structural Reform

A structural reform was decided in 2004 to meet these challenges in the health care sector. The implementation of the reform commenced in January 2007.

The Structural Reform: Before and After

Before the Reform

Prior to the reform, Denmark was very decentralized, with 14 counties and 271 municipalities. The counties were responsible for hospitals, health insurance and primary health care. The Danish municipalities were responsible for home nursing, elderly care, and child care. Danish health care was financed by county and municipality taxes. Health care amounts to 9% of the Danish Gross Domestic

Product (GDP). Public spending on health care in Denmark was 80 billion DKK a year, or €10.5 billion. Hospital spending accounted for more than 70% of this amount.

There are 57 hospitals in Denmark but the number is decreasing, both as organizational units and as physical locations. Advances in technology, such as new anesthetics, allow for an increase in outpatients. The average length of stay at a hospital is 4.7 days. General hospitals have become more productive, with a 1.5% increase in productivity. For the 14 psychiatric hospitals, the number of beds has decreased over the past years.

Despite the increase over the years in the number of physicians and nurses employed by hospitals (currently at 11,000 physicians, 3,400 general practitioners and 30,000 nurses), the hospital sector is still understaffed.

After the Reform

The reform called for the recentralization of health care. The state will play a greater role in health care and will be the main financial contributor. Instead of direct taxes, the health care sector will be financed by the state and municipalities. The state block grant will be allocated using a number of objective criteria, reflecting health expenditure, demography, social structure etc. The National Board of Health will set the guidelines for hospitals regarding specific conditions for treatment, as well as the type of specific technologies they may employ.

Denmark will have five new regions that will replace the 14 counties. The five new regions are: The Capital Region of Denmark, The Sealand Region, Region of Southern Denmark, Central Denmark Region, and North Denmark Region.

The range of population in these new regions varies from 600,000 inhabitants in the smallest region to 1.6 million inhabitants in the largest region. The regions will be mainly responsible for health care, namely the hospitals and the national health insurance system. They will also be responsible for regional development and selected social services,

including the management of specialized social institutions, which the municipalities cannot or did not want to take over. The regions will no longer levy taxes.

Regional Tasks:

Health

- Somatic hospital service
- Health Insurance
- Mental Health treatment

Social Services and special education:

- Operation of institutions for exposed groups

Regional Development:

- Business promotion
- Tourism
- Nature and environment
- Employment
- Education and culture
- Development in remote areas and in rural districts
- Soil pollution, raw material mapping and planning
- Public transport

Regional Financing:

Health

- Block grants
- State activity-related subsidy
- Local basic contribution
- Local activity-related contribution

Social Services and Special Education

- Rate financing and objective financing

Regional Development

- Block grants
- Local development contribution

The regions will be responsible for the entire hospital service, including mental health treatment and health insurance. Total operational expenditure

will amount to approx. DKK 76 billion in 2007. The regions' tasks within the health care sector will be financed through four types of subsidies where the allocation is based on objective distribution criteria:

- A block grant from the state- will constitute 75 percent of the financing
- A state activity-related subsidy- will constitute up to 5 percent
- A local basic contribution- approx. 10 percent that will amount to DKK 1,100 per inhabitant in 2007
- A local activity-related contribution- approx. 10 percent that will depend on how much the citizen uses the health care services

With respect to health insurance, the regions will enter into agreements with general practitioners, dentists and others depending on the type of services that they will subsidize. Therefore, the regions will pay for medical care and subsidies for dental care, medicines, etc.

Municipalities will play a larger role in the Danish health care system. Due to the decrease in the number of municipalities from 271 to 98, municipalities will be larger and therefore more capable to manage different health tasks. They will be responsible for all health care outside the hospitals, including health promotion, rehabilitation, specialized dental care and abuse treatment. In order to support co-operation with the municipalities, health co-ordination committees will be established in order to ensure correlation of the regional and local activities regarding rehabilitation, prevention and care. In addition, health care agreements including agreements on the discharge process for the vulnerable and elderly patients and agreements on prevention and rehabilitation will be made. Municipalities will also be given a new co-financing role, in order that they will be able to focus more on health promotion with a goal of reducing the need for hospitalization and treatment. (2)

The financing paradox will be that the state and regions will want to increase the level of activities, while the municipalities will want to decrease the activities since they are co-paying. It will be important that the new collaboration between regions and municipalities does not end up in an economic discussion.

Expected Challenges of the Danish Reform

New challenges will be related to staffing, cooperation and financing.

The 110,000 employees of the new regions will have to adjust to the new structure, coming from many different systems with differences in management, values and routines.

In co-operation with the state and the municipalities, the regions will need to have new methods for co-operation to ensure “seamless care”. An agreement will have to take place on the division of tasks between specialized and local care.

Finally, the change in financing will involve new principles and incentives. The effect of the new financing structure is not yet clear. The government’s decision to give a one-month waiting guarantee by October 2007 will make the health sector even more demand-oriented.

Health Reform in the European Union

There seems to be a European trend in health reform in order to better meet the common health care challenges. Some countries which have had reforms are England, Germany and Portugal.

The EU is taking more of an interest in the health arena. While Article 152 (3) of the Amsterdam Treaty underlines that EU should not interfere with the organization and financing of national health care systems, the EU is considering legislations on health services. It has launched a consultation process to be concluded in January 2007. Since many local and regional authorities are responsible for health care, these authorities across Europe should work more on influencing the EU legislation on health.

Health care is costly. It is necessary that available resources are used optimally to meet health challenges. A health reform, either involving decentralization or recentralization, does not necessarily solve the health problems of a country. While the reform gives Denmark a new framework, it is considered a challenge in itself.

Working Group Results¹

DECENTRALIZATION AND RECENTRALIZATION:

Trends towards recentralization of previously decentralized health care services

A balance is needed between the two:

CENTRALIZE

DECENTRALIZE

- Specialized surgery
- Treatment of rare diseases, epidemiology
- Accreditation and planning of training
- Procurement/supplies – (economics and economy of scale)
- Service delivery (shorten the chain of delivery)
- Process innovation of work routines
- Educational offers

Political issues must be taken into consideration, such as minimum quality standards, funding, etc.

¹ This section is based on discussions during the parallel working session on decentralization and recentralization during the 14th Annual Conference of the RHN in 2006 by regions of Emilia Romagna, Kaunas, and Upper Silesia

2. Decentralization in health care: efficiency and equity issues³

The term decentralization is generally used to describe a transfer of financial and /or political powers from higher to lower levels of government, or from national to subnational levels. It has been argued that decentralization can achieve multiple objectives, such as efficiency, equity, accountability, local democracy and innovation (4). As a consequence, decentralization has been a common health policy tool in many countries in Europe, yet it is not always a solution to problems.

Rationale for Decentralization

Decentralization is supposed to improve governance and public service delivery by:

- Increasing equity of service delivery by enabling marginalized and poor groups to access health care providers and to influence decisions on service mix and expenditures;
- Increasing allocative efficiency (through better matching of public services to local preferences);
- Increasing technical efficiency (through fewer levels of bureaucracy and better knowledge of local costs).

Challenges in achieving equity and efficiency

Achieving equity and efficiency encounter the following challenges:

- Complexity and controversy in concepts, such as decentralization, equity and efficiency brings about difficulties in measuring and assessing the impact of decentralization in health care.
- The impact of decentralization on interregional and interpersonal equity can vary greatly depending on institutional arrangements and policy design details.

- Despite fairly substantial experience of the implementation of decentralization policies, it is still not precisely clear what actions and conditions are necessary for decentralization to be a success. Governments are often reluctant to transfer sufficient responsibility, particularly financial authority.
- There is limited evidence on the effects of decentralization in health care. In 1993, Finland changed its state subsidies from earmarked to block grants, aiming to give municipalities more responsibilities and independence in using resources in order to improve efficiency with both primary and secondary health care.

The United Kingdom introduced the New Public Management in the 1990s to increase efficiency through administrative decentralization, which involved the devolution of control to NHS trusts and GPs and the use of competition to improve performance. Five national agencies now exist to regulate the NHS, allowing centralized micromanagement. This was a new paradigm where operational decentralization was combined with further centralization of strategic command.

- Efficiency and equity could be achieved through recentralization measures as well. In 2002, Norway abolished counties. Secondary care was moved to the national level and state appointed regional boards. The aim was to increase efficiency by reducing incentives for soft budgeting, reducing local autonomy, reinforcing central planning, and merging administrative units (e.g. county counties) and sickness funds.
- The conflicts between the equity and efficiency objectives in health policy in general and in decentralization in particular may occur.
- Regional differences in health care might be historical and caused by other than health sector factors, and therefore difficult to be tackled by decentralization in health care reform.

³ This section is based on a presentation to the 14th Annual Conference of the RHN in 2006 by Vaida Vaida Bankauskaite, Scientific Project Officer, Public Health Executive Agency, European Commission

Policy implications

Policy implications of the decentralization of the health sector largely depend on the country's political, economic, social, and historical context. A country needs to opt for the most suitable model for decentralization depending on contextual factors. The success of decentralization depends on design of decentralization and institutional arrangements, and the appropriate degree of decentralization depends upon which level of government will have the most incentives to bring about the desired outcomes. A balance must be maintained between short term and long term objectives of the health system.

It is important to take some issues and conditions into account:

- What exactly was decentralized and whether the responsibility (including financial responsibility) was transferred under the health sector reform.
- Whether the drivers for decentralization were political or efficiency based/ technical.
- Whether decentralization ensures the central cohesion of resource planning and distribution in health care.

Preconditions for decentralizing the health sector:

- Each country needs to opt for the most suitable model for decentralization depending on contextual factors. There is no one perfect solution for all problems which decentralization is supposed to tackle. Limited evidence suggests that the effectiveness of decentralized service delivery depends on design of decentralization and on the institutional arrangements governing implementation.
- The role of central government is crucial in redistributing resources: if the central government is concerned about preserving equity, it can implement various mechanisms, e.g. through the design of intergovernmental transfers.

- In terms of efficiency, it is important that the level and size of the geographic units chosen should be appropriate for the health services to be managed. The arrangements for paying providers should give the necessary incentives for efficient performance.
- In terms of equity, questions to be asked are whether or not the proposed arrangements ensure equal access for equal need across all decentralized entities and whether funding mechanisms and amounts compensate for existing inequalities in the distribution of health resources.
- Efficiency improvements should be attempted without compromising equity of access. One option for this is to expand the provision of preventive medical services, which appeared to be important contributors to overall efficiency.
- Decentralization is a political process, since it involves allocation of resources and the distribution of political power among policy and decision makers. The value placed on decentralization depends on the way we define it and its political use.
- Decentralization requires investment in the strengthening of local management levels and improvement of information systems. It is important to assess whether the investment in these domains and the costs of maintaining the new management structures is outweighed by efficiency gains.

Working Group Results¹

DECENTRALIZATION IN HEALTH CARE: Efficiency and equity issues

Case Study: South Tyrol, Italy

South Tyrol's health system

Over 5.7 million specialized hospital services

About 80,000 hospitalizations

Over 8,000 health personnel, among which are 900 hospital physicians

Over 250 General Practitioners

About 50 family pediatricians

About 200 primary health care nurses

Regional Budget 2006

Health Service: € 1,087,961,000

Health Expenditures Per Capita 2004: € 2,019

Health Services - 90,3% in South Tyrol are public

Challenges

Ageing Population has led to an increased number of chronic diseases and increased demand for care.

Quality is expensive. For e.g., the cost of a Positron Emission Tomography (PET)/ and Computerized Tomography (CT) Instrument for better early diagnosis of cancer is € 3 Million.

Services in South Tyrol, additional to NHS Expenditures 2005

At home care €18,835,000.00

Several medicines and medical supplies € 9,250,000.00

Dental prosthesis € 8,250,000.00

Hospitalization in foreign high specialized structures € 7,490,000.00

Specialized medical care € 2,178,898.00

Possible UNPOPULAR Solutions

- Privatization of the Health System and "two classes" medicine

- Limitation of medical options for ageing people
- Closing of hospitals

The Health Policy Decision

- No further reduction of expenditures to maintain quality and equity of service delivery
- Increase administrative efficiency
- Reform of Regional Health Service (RHS) through reorganization of decisional and management levels

Objectives of the Reform

- To assure maintenance and development of quality with special attention to special emergency sectors
- To optimize efficiency through elimination of surplus structures or inadequate services
- To guarantee well-distributed and equal basic services with implementation and rationalization of primary care
- To work towards reallocation of resources and development of networks
- To assure financial sustainability

RHS Reform – Time schedule

- Establishment of the new RHS (1.1.2007)
- Reorganization of technical and administrative area (within 3 years)
- Reorganization of medical health services (within 5 years)

Organisational changes

- Institutional Level, Strategic Level, Operational Level
- The most difficult step of our Health Reform? Convincing all the reform partners!!

¹ This section is based on discussions during the parallel working session on Equity and Efficiency during the 14th Annual Conference of the RHN in 2006 by regions of South Tyrol, Emilia Romagna, Tuscany, Szabolcs-Szatmar-Bereg, and Varna

3. The Role of Regional Healthcare Systems in Federal Systems- The Russian Federation and Canada: a comparison⁴

Levels and responsibilities and financing in the Russian Federation:

Levels and Responsibilities

Each level of the government has different responsibilities for health care in the Russian Federation.

The federal level has legislative, financial, licensing, educational and data collection responsibilities:

- Legislative – policy setting through establishing standards, norms, etc. There is a State Guaranteed package of what is to be covered
- Financial – providing funds for “federal” health facilities and programs
- Licensing facilities and health providers
- Education – establishing curriculum
- Data – collecting and setting requirements

The regional or republic level of government has the following responsibilities:

- Planning of regional health care systems
- Specialized health care facilities and services
- Regional health prevention centres
- Financing: budget financing of infrastructure costs of “regional” facilities and financing of regional and municipal medical facilities through compulsory health insurance system (including contribution for non-working population)

The local/municipal level is responsible for

- Provision of primary care (interpreted to include hospital care, ambulance care, care for pregnant women)
- Local health promotion
- Budget funding of infrastructure costs of “municipal” facilities

⁴ This section is based on a presentation to the 14th Annual Conference of the RHN in 2006 by Mary Collins, Former Acting Head of the WHO Country Office in the Russian Federation

Financing

Public financing for health care in the Russian Federation has two channels – budget and health insurance. Health insurance is paid by employers for the working population. Health insurance for the unemployed population is financed by regional governments. Health insurance covers all medical services except for services for patients with socially important diseases. Budgets of different levels cover infrastructure costs for the medical facilities.

Levels and responsibilities in Canada

Levels and Responsibilities

Responsibilities in health in Canada are guided by the Canada Health Act, which outlines the implementation and enforcement for a universal health care system.

At the federal level, responsibilities include the following:

- Funding – through transfers and targeted programs
- Health protection
- Health promotion (shared responsibilities)
- Research
- Aboriginal population health care services

At the provincial level they include:

- Provincial planning, organization and delivery of health services within each province, interpretation of “scope of coverage”
- Licensing of facilities and of health providers
- Public funding of health services (budget, transfer payments and in some provinces – insurance)
- Legislative –standards, access
- Health promotion (shared responsibilities)
- Education of health professionals and healthcare workers

Responsibilities at the local level vary by province. Many have created regional authorities (covering

a number of municipalities) which are responsible for delivery of all health services and report to the provincial Ministry of Health, with municipalities no longer having responsibility for delivering health services. The local level receives funding and where applicable, health insurance funds from the province. There have been many changes and restructuring over the past 15 years. For example, Prince Edward Island (PEI) created regional authorities for health and social services, but has now disbanded them and taken responsibilities back to provincial level.

The size and number of health authorities has varied. British Columbia started with 55 health authorities, then reduced them to 18. It now has only five plus a Provincial Health Services Authority which oversees all provincial level services. There are considerable variations between provinces, for example, in ambulance services, which in some cases are funded and provided by the province, and in others through local municipalities.

Issues

The issues related to regions with health care responsibilities in a federal state include the following:

- Significant differences in funding capacities for health services between regions in a federal state
- Lack of coordination between regions within a federal state.
- Differing priorities result in different standards and approaches to health care between regions.

Challenges in the Russian Federation

- There is difficulty in restructuring to improve efficiency when regions do not have control over local health care services, e.g. hospitals, ambulance.
- Federal expectations may not be possible to achieve and depends upon financial capacity of each region.

- Relationships between regional and local governments vary as does their ability to implement changes, which are often dependent upon political alignments

Challenges in Canada

- It is difficult for the federal government to enforce policy in areas where they have no legislative responsibility.
- There is lack of consistency in approaches and delivery of care, as these vary across the country despite supposed harmonization.
- There is little involvement of local governments in health services delivery in many provinces as a result of Regional Authorities assuming responsibilities.

In planning health care systems, there are criteria to consider regarding regional and local authorities:

- There should be alignment of funding with delivery responsibilities.
- There should be alignment of legislative authority with delivery responsibilities.
- Governing and implementing bodies should be of appropriate size (geographical and population) to create the most effective and efficient delivery system.
- Public and health provider preferences should be considered.
- Clear lines of accountability and authority must be established.

Finally, questions to consider at the national level in planning health care systems include the following:

- Is there a national coordinating mechanism that involves all levels of government to oversee implementation and monitoring of health system?
- Are there minimum standards for health that can be both measured and enforced throughout the country?
- Is there a National Plan of Action to which regions have contributed and commented?

Working Group Results¹

THE ROLE OF REGIONAL HEALTHCARE SYSTEMS IN FEDERAL SYSTEMS

CASE STUDY: RUSSIAN FEDERATION

Federal vs Municipal Levels

Federal Law 131 provides for local self governance² (5)

Federal level: volumes of health services norms and highly specialized, costly health services

Municipalities: primary health care (polyclinics and hospitals), ambulance care

Problems

Management of hospital sector is complex

Bed capacity issue becomes a tool of election campaigns

Ambulance care has no corporate use of resources

Duplication of health services instead of nationalization

Possible Solutions

Approach to decentralization should be customized to the needs of each country.

There is a need for a rational combination of centralization and decentralization.

Hospital and ambulance care at the administrative levels should cover a population of not less than 500,000 people.

The municipal level should focus on prevention, healthy lifestyle and (perhaps) on general practice/primary care.

¹ This section is based on discussions during the parallel working session on Role of healthcare systems in federal systems during the 14th Annual Conference of the RHN in 2006 by regions of Kaunas, Chuvashia, Vologda, and Sunik

² Federal Law No. 131 of October 6, 2003 on the General Organizational Principles of Local Self-Government in the Russian Federation, Adopted by the State Duma September 16, 2003, Approved by the Federation Council September 24, 2003

4. Decentralization and health insurance provision⁵

The fundamental objective of every welfare state is to ensure access to a comprehensive set of health services, which is of high-quality and efficiently managed. Traditionally, national authorities in Europe have claimed overall responsibility over health systems and derived legitimacy from it.

The constant increase of healthcare expenditure over the last 25 years, as well as the prospect of an even steeper climb of health spending due to an ageing population has urged countries to start reforming their health systems. Healthcare reforms undertaken since the 1980's have mainly focused on improving efficiency through increasing accountability of the actors involved. Depending on the specific organisational format, this process has either devolved responsibilities to lower administrative levels (regional and/or local authorities) or delegated tasks to financing and providing agents (sickness funds, autonomous hospitals).

The introduction of market mechanisms and competitive incentives, the growing use of user charges, the gradual extension of choice options and private funding have fundamentally changed the outlook of health systems and have even stimulated convergence towards mixed systems,

To what extent these evolutions have an impact upon the fundamental values underpinning Europe's health systems, especially solidarity and universality is heavily debated. Regional variations, as well as inequalities in access to health, are often considered unacceptable. At the same time, the effect of decentralization in terms of improved efficiency is not always supported by evidence. It is even sometimes argued that it adds to the fragmentation of health systems, since it increases transaction costs and reduces steering capacity. (6)

⁵ This section is based on a presentation to the 14th Annual Conference of the RHN in 2006 by Willy Palm, Dissemination Development Officer, European Observatory on Health Systems and Policies

Especially on the financing side, it is widely accepted that market-based reforms require a fair level of regulation in order to ensure efficiency and equity in the health system. Compulsory affiliation, open enrolment, the definition of a uniform basket of services as well as progressive (or at least risk-adverse) financing are considered as pre-conditions. An efficient system of risk adjustment is necessary for discouraging indirect risk selection and creating a level-playing field for competing insurers.

In view of the challenges that all health systems face, there is growing need for accountability on the part of all actors, forcing them to make informed and rational decisions. The success of health insurance competition largely depends upon the capability to translate competition and accountability to the provider sector, rather than only to the patient/insured side. In some areas a collaborative rather than a competitive approach, also across regional and national borders, might even have more effect.

In the context of the European Union, the introduction of market competition in health systems has led to the application of EU competition rules on market regulation and behavior. This has created some tensions as well as scope for legal uncertainty.

Decentralization and Insurance

Decentralization covers a wide variety of transfer of power or responsibility to lower levels and can fall under the categories of “Regional decentralization” or “Functional decentralization” which ranges from private ownership of health care assets to the use of private sector methods.

There is a conceptual confusion and a lack of clear definitions. Privatization and private sector involvement is often linked with other concepts that do not necessarily have any direct relation but have more broadly to do with attempts to make health systems more efficient through introducing more incentives for cost-effective behaviour. Stimulating entrepreneurialism in the health sector embraces

strategies which enhance the accountability of actors and increase choice options and comprises instruments such as performance-based payments, contracting, corporatisation of providers. But it may apply as well to actors of a public nature. Privatization is not the only way to increasing competition and market forces in health care, in some cases, it could even contradict it.

How these concepts are implemented in the various health systems varies heavily:

	Funding side	Provision side
Social health insurance (Bismarck)	Semi-public actors Integrating private insurers User charges complementary HI	Mainly private actors Selective contracting, performance-based payments, integrated care models
Tax funded (Beveridge)	Public actors Supplementary HI	Mainly public actors Autonomisation, contracting in, outsourcing, PPP
CEE and NIS (Shemasko)	Public actors Informal payments Social health insurance	Public actors Private practice

Although the particular public-private mix is specific to each country and reflects the historical background and balance in power between different interest groups and actors involved in the health sector, the traditional splitting up of European health system models in Bismarckian, Beveridge and former Shemashko models may type, to some extent, the specific public-private mix found in different health systems (although none of these models still exists in its full and original form).

Bismarckian Model

Bismarckian health systems traditionally left provision mainly private, especially in the outpatient sector. These private services are purchased

into the public system through contracts, mainly collective agreements, by health insurance funds, which often have a semi-public/semi-private status. Compared to other models, SHI systems have relatively higher private funding, especially user charges, which in its turn also explains the existence of complementary forms of private health insurance, either non-for-profit or for-profit. Reforms aimed at introducing more cost-effectiveness through market mechanisms mainly look at increasing choice options on the insurance side, including the possibility of including private-for-profit insurers in the compulsory field, but also open choices to more integrated care models. In the provider market, more efficiency is pursued through selective contracting and more performance-based financing of providers.

Beveridge Model

In Beveridge models, public financing and provision traditionally dominated. However, there is always some room for private sector involvement, which typically grew as health care consumption and expenditure increased and public budget froze. Problems in the public health service have spurred the development of supplementary insurance. On the delivery side, public hospitals have moved towards more autonomy as trust or public firms. The private sector has become more involved through outsourcing certain services and private financing initiatives.

Shemasko Model

The Shemasko model in the former Eastern bloc traditionally did not allow private funding or practice. However, because of low remuneration of health professionals informal payments and private practice developed and was even implicitly tolerated. After the political transition, these systems turned towards social health insurance and privatization of healthcare delivery.

Differences within these groups are still quite important. For instance, to understand the difference in sickness funds between the Netherlands and

other social insurance countries, such as Belgium or France, it is important to know that sickness funds in the latter mainly grew out of the social movement of workers unions, whereas in the Netherlands they were mainly established by the doctors themselves in an attempt to raise purchasing power in health care for lower income groups. This explains why Dutch higher incomes were kept out of compulsory social health insurance.

Regional decentralization appears in all types of systems, and is not linked with health care itself as much as with the political configuration and background of the country itself.

Another aspect adding to the complexity is that the debate on public – private mix is often ideologically biased. Basically, believers expect that private market forces will make health care more efficient and cheaper, enhance quality of services and responsiveness towards consumers, as well as encourage innovation and kill bureaucracy and corruption. Non-believers generally think exactly the opposite. But most importantly, they also believe it will kill solidarity and increase inequalities. In the 2005 Hungarian referendum, even if results were not valid (because of too low participation rate), 66% of voters were against privatization plans.

Ideological biases on debate on public – private mix:

Believers	Non-Believers
Better quality of service	Jeopardizes quality
More efficient	Less efficient
Cheaper	More expensive
More responsive/choice	More inequalities
Enhances user information	Increases non-transparency
Encourages innovation	Induces demand
Bureaucracy-corruption killer	Solidarity killer

The debate should be on the extent to which it achieves outcomes such as increased efficiency, equity and choice.

By making priorities and objectives explicit, some kind of decision making framework can be established against which measures of decentralization can be evaluated, as well as against the trade offs they would produce.

However, evaluating the privatization of healthcare delivery in terms of impact on equity, on efficiency and other criteria, is not an easy task. The evidence remains weak on the effects of decentralization/private sector involvement. In addition, what works in one country may not necessarily work in another.

Generally, all health systems tend to improve health of the population they serve by being cost-effective (provide value for money) as well as by providing quality of care. These basic objectives are traded off with values and principles which make health systems acceptable in the eyes of citizens: solidarity, financial sustainability and responsiveness.

The priority given to each one of these objectives and values is variable among countries according to culture, values and ideology.

Eventually all funding comes from the population, which is covered by the system and which, in some cases, can choose among multiple (competing) actors. On the other hand, there is an important function of regulating the functions, the entitlements and the cost sharing, next to providing information.

One of the most essential objectives of health system policy is to ensure access to effective care when needed, by providing universal financial protection against the risk of illness and distributing the burden in an equitable manner. This is of course much linked with the core value of solidarity, which has a horizontal dimension (risk solidarity) and a vertical one (income solidarity)

Pooling

From both an efficiency and equity perspective, collected funds should be pooled at the highest

possible level. Fragmenting pooling will limit the potential of cross-subsidy.

A clear example was the German health insurance system before 1996, where sickness funds individually determined contribution rates on the basis of the cost of their insured people and on their income levels. This created high variations in the contribution rates among sickness funds. If these different pools were to be combined in one single pool, the variations in income level and risk profile could be alleviated.

The problem of fragmented pooling is not exclusive to insurance systems. It can also be observed in the former Shemasko systems, where vertically integrated delivery systems were run by regional, district and municipality levels, each one funded on the basis of separate pools. This was quite inefficient since it duplicated coverage for the same population and created excess capacity.

Competition and Purchasing

Where competition and purchasing are concerned, a risk adjustment formula is to compensate for the difference in risk profile and to maintain incentives for efficiency.

An instrument to influence cost-effectiveness and quality is selective (strategic) purchasing where it concerns a) choice of providers vs. choice of insurer; b) sufficient supply; and c) the transaction cost of care management programmes.

The other is the use of no-claim bonuses and deductibles.

Regulation

The EU Competition Law provides European insurance directives which allow imposing rules of general interest to health insurers. It also justifies public financing of private health insurers as state aid when compensating for public service obligations. The Law also outlines issues related to price agreements and the abuse of dominant positions.

Conclusion

In conclusion, inequalities are likely to increase as expenditure increases and medical technology advances. The traditional thinking that anything public is “good” and all things private is “bad” or vice versa is being replaced by the logic that performance and transparency is what counts.

In order for private or public models to succeed, there is a need for a strong regulatory, managerial and information capacity. If the stewardship role of government is weak, regardless of the merits of particular models privatization is bound to fail.

Working Group Results¹

DECENTRALIZATION AND HEALTH INSURANCE PROVISION

CHALLENGES AND KEY MESSAGES

Different systems, common challenges

- Regional implication in financing is different and usually based on historical basis:
 - Some regions are responsible for planning
 - Some are purchasers
 - Some raise proper finances
 - Size of population, e.g. San Marino - 30000; Sicily - 6 million
- They face common challenges:
 - Financial sustainability
 - Looking for more efficiency in the allocation of resources
 - User charges, private health insurance
 - Fragmentation of resources and services

Key Messages

- Decentralization in service and insurance provision can be different debates
- Pooling of funds should take into better account of regional needs:
 - e.g. illegal immigration in Sicily (Italy)
 - Health inequalities
- Increasing efficiency and quality of services by better coordination and integration of care (purchasing) vs. choice as a way to more responsiveness?

¹ This section is based on discussions during the parallel working session on Decentralization and health insurance provision during the 14th Annual Conference of the RHN in 2006 by regions of Upper Silesia, Sicily, and Varna

5. Public Private Cooperation in Health Care⁶

Health care systems across the world are facing unparalleled challenges. Managing the three interlinked dimensions of rising cost, increasing demand and scarcity of resource is however beginning to stimulate and accelerate the introduction of new concepts and ideas for bringing the healthcare equation into balance. Whilst the core issues are well defined, including the implications of epidemiological and demographic transitions; developing effective solutions can prove elusive and difficult. New forms of partnerships for service and capital investment are proving an important element within this changing environment.

In the context of front line service delivery, three principles now tend to influence the nature of new partnership concepts:

- Recognition that care is best organised and delivered on the basis of whole systems (disease pathway) integration, spanning all relevant health and social agencies. One of the principal aims; designing and delivering healthcare support that is closer to the citizen's home.
- Rebalancing service and capital investment away from its hospital centric focus of previous years, towards a more inclusive investment policy that facilitates the whole systems integration of care; more accessible to local community need.
- Evidence that these new strategic decisions for reshaping healthcare are best devolved to local population groups (e.g. regions) to improve service responsiveness and generate a stronger sense of community ownership to tackle the difficulties of the changing healthcare landscape. A strong prerequisite here is a clear framework of equity, quality and probity standards to create an appropriate environment within

which new 'partnerships in health' can be developed.

An overview of current service and capital strategy across Europe suggests two further changing ideologies:

- The trend towards open market competition in healthcare as an effective way of stimulating innovation and cost efficiency, for example, the competitive tariff system introduced in the Netherlands and the Public Private Treatment Centres advocated by the UK National Health Service (NHS).
- This change in outlook is accompanied by an acknowledgment that in future a significant part of healthcare delivery (and capital investment) will involve some form of partnership between the public and private sectors. Overall governments are increasingly separating strategic direction (retained as a central government 'public' role) from policy and operational implementation (devolved to more local level). In doing so they are often creating opportunities for innovation through endorsement of a more business related orientation for healthcare delivery.

Public private partnerships (PPP) are a manifestation of this business focus and offer significant opportunities to improve service delivery. However debate and discussion of advantages and disadvantages is often clouded by suspicion and doubt on the part of professionals and public as to motives and integrity – will private profit be put before public healthcare priorities?

A major study of capital strategies in Europe (a project partnership between the European Health Property Network (EUHPN) (7) and the European Observatory on Health Systems and Policies) that is due to be published in 2008, is producing evidence not only to help allay these fears but to support the proposition that well structured entrepreneurial partnerships can make a significant contribution to achieving greater effectiveness and value for money in healthcare. However the benefits realized have as

⁶ This section is based on a presentation to the 14th Annual Conference of the RHN in 2006 by Barrie Dowdeswell, Director, European Health Property Network

much to do with cultural and professional attitude change, as the type of partnership adopted.

Partnership models can range from simple outsourcing of service elements (e.g. laboratory services) to full-scale contracting out of whole health systems service delivery (sometimes incorporating primary and acute care).

Critical success factors are being defined such as:

- The need for a population based overarching structural planning framework within which issues of equity, quality and stewardship can be aligned with clinical and service aims.
- The importance of shared values between the key players in the partnership - and transparency in their relationships.
- The need for measurable benefits and risks analysis - and effective performance monitoring.
- The imperative of closer synergy between service models, infrastructure design (which in future must be more adaptable) and capital procurement and financing models.
- The necessity to improve the business competencies of those in the public sector having accountability for partnership strategies.
- Understanding the need for cultural and workforce change to support the rapid and continuous evolution now evident within modern healthcare.
- Leadership qualities necessary to drive forward complex reform.

Partnership opportunities are diverse in nature, have grown rapidly in recent years and precedent models are available to span a wide range of circumstances. For example, there are PPPs to match the different time horizons of health need: for short-term requirements (for example reducing unacceptable waiting times for routine surgery) met by equally short life specialist treatment centres; for the medium term, under-performing public hospitals being taken over by PPPs that specialize

in performance recovery; and for the longer-term new types of partnerships that extend the scope of treatment well outside the boundaries of the hospital to create new health networks that encompass community services – a significant shift in the direction of integrated care. Furthermore there is evidence that more local community involvement in partnership project planning can offer the citizen a greater say in how services should be designed and delivered and which can often stimulate more radical and effective solutions.

However it is not always so simple in practice, there are problems to be recognized and resolved; typical are issues of reconciling the cross cutting nature of integrated care models with the institutional focus of hospitals; matching the capital financing and procurement models to service aims; the need to encourage partnerships that can manage the continuous and unpredictable nature of change in healthcare.

Overall, there seems little doubt that a new direction of travel is starting to reshape healthcare. Taking full advantage of new partnership opportunities will require new insight, new tools, techniques and competencies and professional and public culture change. Evidence so far suggests that the benefits of new entrepreneurial concepts can outweigh the complexities and uncertainties of breaking with the past, with one overriding qualification; the overall goal remains achieving more efficient, transparent and accountable health systems.

CASE STUDY: COXA HOSPITAL, FINLAND

- Quality driven initiative
- PPP vehicle to create freedoms: workforce, capital, revenue regime
 - Limited company
 - Mixed shareholding; local hospitals, private equity, local government
- Concept – integrated, whole systems care – focus on elective production (classic treatment centre principle)
- Business model - Systemized care (reinforced by clinical governance) a foundation for service and capital investment, and tendering
- Viability, dependant upon:
 - Role delineation within other ‘competing’ local hospitals
 - Competitive tendering (cost and quality)
 - Adequate debt servicing (capital and equity)
- Strong integrating of ICT platform
- Clear evidence of improved (comparative) performance

Case Study Lessons

- Population focused structure plan - clarity of health aims
- Shared values
- Concept assessment is a critical success factor
- Measurable:
 - Risks
 - Benefits
 - Performance
- Synergies - service, capital, financing
- Competency
- Cultural and professional attitude change
- Leadership
- Political commitment and realism

In conclusion, the era of ‘command’ government is closing, government by partnership is dawning. There is increasing mutual dependency between the public and private sector, and Public Private Partnerships can be beneficial and will grow in scale and diversity. Public engagement, democracy, transparency, and probity are critical success factors. While regulation will be necessary, it will be difficult. There is a worrying asymmetry between private and public sector skills. The evidence remains weak as to health benefits of PPP. The focus should be on partnership and not adversity.

Working Group Results¹

PUBLIC PRIVATE COOPERATION IN HEALTH CARE

HOSPITALS – Public Private Partnerships (PPP) vs Private Finance Initiatives (PFI)

Hospitals will last 25 years. We need to understand:

- demographic shift,
- epidemiological trends
- Adaptability/flexibility
- Patient flow across whole system
- One model of flexibility is the Health campus.

PPP vs PFI:

- PPP model needs a good definition of the problem to be solved – not just to focus on pure capital infrastructure.
- Social enterprise is a Hybrid Model and is best thought of as a transition strategy.
- The acceptance of risk is what changes culture, not competition. The concept of “if the enterprise fails, I fail” is a key motivator. Need for a business culture – i.e. a willingness to make tough decisions.
- PPP need to move from being a stakeholder to shareholder.
- PPP based on episodes of care will always be corrupted by clinicians who can always find a further need for a complicated more expensive intervention.
- Need to purchase (whole system) processes rather than episodes. This might also focus on outcomes but would need to specify processes and intermediary measures e.g. patient satisfaction, infection rates, etc.
- Where systems are commissioned, it can be difficult for other players to enter system due to cost of market entry. So commissioning needs to safeguard against monopoly supplier power.
- PPP better than PFI – there is little evidence of PFI delivering benefit apart from easier access to capital.
- To be most effective PPP needs inspired clinical leadership with political support to make it happen.
- Best way to start in other hospitals – pick chronic disease or factory process e.g. hip replacement.

¹ This section is based on discussions during the parallel working session on Public Private cooperation during the 14th Annual Conference of the RHN in 2006 by regions of North Rhine-Westphalia, North West England, Catalonia, Madeira, and Västra Götaland

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World Health Organization
Regional Office for Europe
Scherfigsvej 8
DK-2100 Copenhagen Ø
Denmark

Tel.: +45 39 17 17 17. Fax: +45 39 17 18 18. E-mail: postmaster@euro.who.int
Web site: www.euro.who.int

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