

**DIRECTORATE FOR EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS
PUBLIC GOVERNANCE DIRECTORATE**

Decentralisation in the health sector and responsibilities across levels of government

Impact on spending decisions and the budget

**7th Meeting of the OECD Joint Network of Senior Budget and Health Officials
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This report provides background information for the meeting.

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Contents

1. Introduction and main findings	4
2. Questionnaire on responsibilities and performance in health systems.....	6
2.1. Background and definitions.....	6
2.2. Scope of questionnaire and responses.....	8
3. Spending and institutional characteristics in health care.....	9
3.1. Organisation of health financing and coverage arrangements.....	9
3.2. Decentralisation of health spending by expenditure shares.....	10
4. Decentralisation of decision-making autonomy in the health sector	13
4.1. Introduction.....	13
4.2. General results	13
4.2.1. Responsibilities across levels of government.....	13
4.2.2. Responsibilities across area of spending autonomy	15
4.2.3. Responsibilities across federal and unitary countries.....	16
4.3. Responsibility by area of spending autonomy	17
4.3.1. Policy decisions in health care	17
4.3.2. Budgeting decisions in health care.....	18
4.3.3. Labour and input decisions in health care.....	21
4.3.4. Output and monitoring decisions in health care.....	23
4.4. Shared responsibilities	24
4.5. Comparing responsibility against expenditure.....	26
5. Conclusions	29
6. References	30
7. Annex.....	31
7.1. OECD Questionnaire on Performance Measurement Systems in the Health Sector and Responsibilities across Levels of Government	34
Part 1.A) Degree of Decentralisation in Decision-Making in Health Care	34
Part 1.B) Spending Power Across Levels of Government	36

Tables

Table 2.1. Country respondents classified into federal and unitary countries.....	8
Table 3.1. Main source of basic health coverage across OECD and other surveyed countries.....	9
Table 4.1. Country responses (% of responses ticked for each level of government).....	15
Table 4.2. Average proportion of shared decisions (%).....	26
Table 7.1. Proportion of respondents that stated the key health care decision was the responsibility of central, regional, or local governments, or other entities	31
Table 7.2. Proportion of shared responsibility across federal and unitary countries.....	33

Figures

Figure 2.1. Classification of spending power	7
Figure 3.1. Health expenditure by type of financing, 2015 (or nearest year)	10
Figure 3.2. Sub-national expenditure by economic function (% , 2015).....	11
Figure 3.3. Sub-national health expenditure as a percentage of total sub-national expenditure (2015) 12	
Figure 4.1. Decision-making power in the health sector, across levels of government (proportion, in %)	14
Figure 4.2. Responsibilities across areas of spending autonomy	16
Figure 4.3. Responsibility across federal and unitary countries (%).....	17
Figure 4.4. Responsibilities for key policy decisions between central and regional governments (%) 18	
Figure 4.5. Responsibilities for key budgeting decisions in across levels of government (%)	20
Figure 4.6. Regional government responsibility for key budgeting decisions, by federal and unitary countries (%)	21
Figure 4.7. Responsibilities for labour and input decisions, across levels of government (%).....	23
Figure 4.8. Responsibilities for key output and monitoring decisions, across levels of government (%).....	24
Figure 4.9. Cumulative country responses	25
Figure 4.10. Responsibility of sub-national governments against expenditure for health (%)	27

1. Introduction and main findings

1. Decentralisation is a fundamental characteristic of many health systems, with sub-national governments often responsible for the delivery and financing of health services. But the degree of decentralisation varies markedly across OECD countries. Although it can be a result of historical context, for example the influence of federal or unitary systems, decentralisation is often caused by the need of central government to alleviate budget pressures (OECD, 2015^[1]). Decentralisation of the health system may also be viewed as a mechanism to improve health outcomes, through stimulating efficiency or providing a more focused set of health care services based on need.

2. More broadly, a trend towards the decentralisation of government and the ensuing dispersion of power is taking place across OECD countries. This has led to an increased recognition of the significant effect decentralisation can have in shaping the governance and spending frameworks ascribed to public services and how productivity and service quality are monitored. Most central governments see it as their role to ensure health services are delivered efficiently and equitably, due to a range of economic, social and financial reasons. Therefore sub-central health spending and standards of delivery are often influenced by central government regulation, legislation and convention, which reduces the discretion sub-national governments have over health policy and service delivery.

3. This paper builds on a literature review that was presented at the 2017 meeting of the Network on Fiscal Relations across Levels of Government (Phillips, 2018^[2]). The main aim of this paper is to summarise the results of a recent OECD survey. Part 1 of the questionnaire focused on responsibilities across decision makers, while part 2 focused on performance systems in the health care sector. This paper concentrates on the results of part 1, to build an understanding of the roles of the different decision-making powers in the health sector. An accompanying paper analyses part 2, looking at the use of health performance measurement systems. Participants of the OECD Joint Network of Senior Budget and Health Officials – government officials with responsibility for the health budget – answered the questionnaire. This Joint Network brings together government officials who work on the health budget and health financing, including representatives from ministries of finance, health and social security organisations. Over the years it has provided an effective space for government officials to openly discuss challenges and solutions to the fiscal sustainability of health systems.

4. This paper presents quantitative and qualitative information on the decentralised nature of health systems, mainly hospitals, and how the degree of decentralisation and spending power varies according to different institutional characteristics. The questionnaire on performance measurement systems in the health sector and responsibilities across levels of government is included at Annex A.

5. Main trends from the survey results are:

- Decision-making in health care tends to rest largely with the central government on average, which has considerable power across many aspects of the delivery of health services. More specifically, central governments are more likely to be responsible for decisions regarding the policy aspects of health care. But they have less control over decisions regarding the inputs and outputs or monitoring of health care services. In most countries, sub-national governments have vast responsibility for input-related matters, such as determining which services can be outsourced

and deciding on the contractual status of staff. On average, local governments have little decision-making power in the health sector, but have more responsibility with regard to health inputs.

- The role of the central governments in health care does not vary markedly between federal and unitary countries. However, sub-national governments, especially regional governments, can still have significant shared decision-making responsibilities. Such sub-national governments tend to have more decision-making power in federal than in unitary countries.

2. Questionnaire on responsibilities and performance in health systems

6. A recent survey was designed to collect information from OECD and partner countries on decentralisation and decision-making power, as well as the monitoring and measurement arrangements in health care across levels of government. The questionnaire comprised approximately 70 questions, including checkboxes with optional comments sections and multiline answer responses. The questionnaire was succinct to avoid a large administrative burden on participating countries. Respondents comprised of government officials from ministries of finance and health who are directly engaged in their country's budget for health.

2.1. Background and definitions

7. Governments play a critical role in providing health care and other public services, which are needed to support economic growth (Lau, Lonti and Schultz, 2017^[3]). Often, sub-national governments are responsible for delivering health services, or central governments delegate this responsibility to sub-national actors. In the survey, sub-national governments were defined as sub-central levels of government. Regional governments are upper-tier municipalities including states, territories or provinces. Local governments are the lowest tier of government including counties, cities, districts, municipalities, councils or shires. In the context of countries with only two levels of government, the lower level was defined as local government.

8. The main characteristic of a decentralised government is the existence of several governing bodies, which have the power for political, administrative or budgetary decision-making at a regional or local level. Three levels of government are defined: central/federal, state/province/region, and local/municipality. Generally, the decision maker is a level of government. However, it can also include decision-makers at the provider level. Indeed, survey respondents were also asked to specify other entities that were involved in decision-making, for example, hospitals or care providers.

9. Different types of decentralisation include fiscal decentralisation (the transfer of financial resources in the form of grants and tax raising powers to sub-national units of government); administrative decentralisation (the functions of central government are shifted to geographically distinct administrative units); and political decentralisation (where powers and responsibilities are devolved to elected sub-national governments). The spending autonomy concept encompasses some facet of all these types of decentralisation, but mainly focuses on administrative decentralisation.

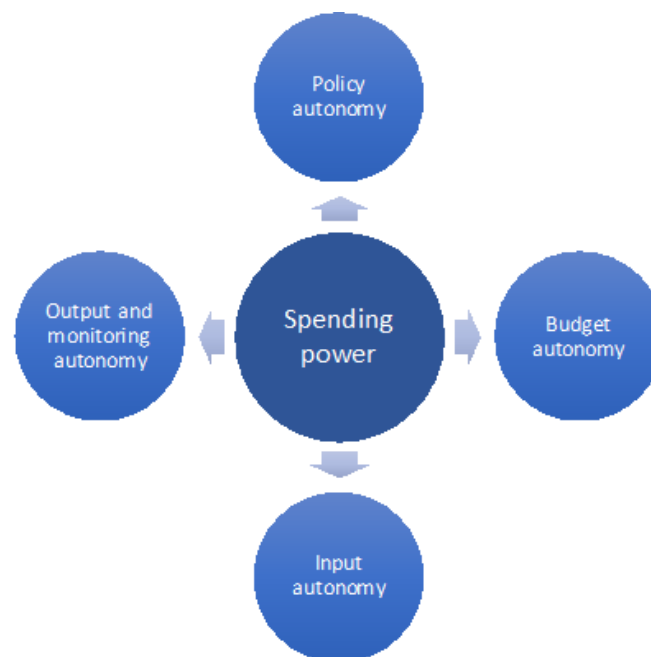
10. Accurately comparing and measuring decentralisation across countries is difficult. Part 1 of the questionnaire asked about the roles and responsibilities of health care service delivery between levels of government, in order to gauge the spending power of sub-national actors. Spending power describes the ability of sub-national decision-makers to shape, determine and change their policy setting. It describes the level of control or authority of sub-national decision-makers over policy and budgeting decisions, including deciding how services are organised, how funds are allocated, the ideal level and quality of inputs and outputs and how service delivery is measured and monitored. Spending power of sub-national actors is often restricted by a multitude of barriers on sub-national decision makers across various aspects of health care, that reduce the freedom governments have over their own spending. Barriers include mandatory spending, regulatory constraints, minimum national standards on inputs and outputs, or budget conventions. In addition,

some sub-national responsibilities can be mandatory through legislation or regulation while others may be optional, but expected.

11. Spending power can be classified into four major facets of autonomy. These four aspects of autonomy aim to provide an overall picture of the spending power of a sub-national decision maker. These dimensions are shown in Figure 2.1 (Bach, Blöchliger and Wallau, 2009^[4]).

- *Policy autonomy*: Do sub-central decision makers exert control over main policy objectives and main aspects of service delivery?
- *Budget autonomy*: Do sub-central decision makers exert control over the budget (e.g. is budget autonomy limited by upper level regulation)?
- *Input autonomy*: Do sub-central decision makers exert control over the civil service (personnel management, salaries) and other input-side aspects (e.g. right to tender or contract out services)?
- *Output and monitoring autonomy*: Do sub-central decision makers exert control over standards such as quality and quantity of services delivered and devices to monitor and evaluate standards, such as benchmarking?

Figure 2.1. Classification of spending power



Source: Adapted from Bach et al.

12. Federal countries have constitutionally protected sub-national governments, which have their own parliament, government, and large competences. Quasi-subordinate levels in unitary countries have no constitutional powers or responsibilities, and can only exercise the powers that the central state level delegates, leaving greater scope for intervention by central governments (Phillips, 2018^[2]) (OECD, 2018^[5]). The classification of the participating countries into federal and unitary categories is shown below in Table 2.1.

2.2. Scope of questionnaire and responses

13. The questionnaire included two main parts. Part 1 of the questionnaire asked about the roles and responsibilities of health care service delivery between levels of government, generally focusing on hospitals. Table 2.1 shows the countries that responded to part 1 of the questionnaire. The second part of the questionnaire covers national performance measurement systems, and the results of which are discussed in a subsequent paper.

14. The survey was sent to countries in early November 2017 with an initial due date by January 2018. Most countries responded to the survey at the beginning of 2018 with all responses received from participants by May 2018. Twenty-nine OECD countries and three partner countries responded to the survey part 1 of the survey.

Table 2.1. Country respondents classified into federal and unitary countries

Federal countries	Quasi-federal	Unitary countries
Australia	Spain	Chile
Austria		Czech republic
Belgium		Denmark
Canada		Estonia
Germany		Finland
Italy		Greece
Mexico		Iceland
Switzerland		Ireland
Argentina		Japan
		Latvia
		Lithuania
		Luxembourg
		Netherlands
		New Zealand
		Norway
		Poland
		Slovenia
		Turkey
		United Kingdom
		Kazakhstan
		Malta

Source: OECD/UCLG (2016), Subnational Governments around the world: Structure and finance.

3. Spending and institutional characteristics in health care

3.1. Organisation of health financing and coverage arrangements

15. Health care coverage arrangements vary across OECD countries, with coverage organised within three main types: national health systems (including those with distinct localised services), single health insurance funds or multiple health insurance funds/companies. In OECD countries with insurance-based systems, health insurance is compulsory in all countries except the United States.

16. Table 3.1 summarises the main source of basic health care coverage across OECD countries, based on results from the latest OECD Health Systems Characteristics Survey:

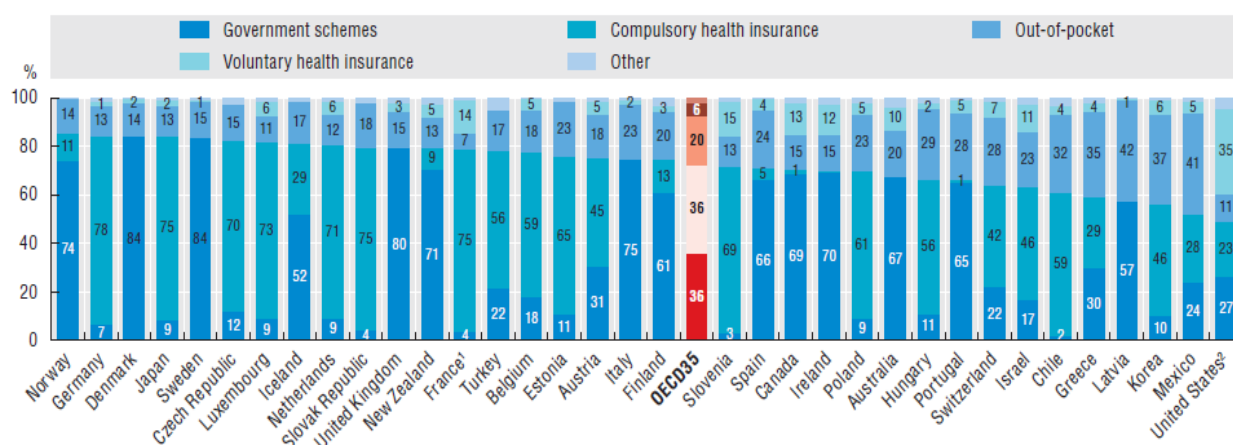
Table 3.1. Main source of basic health coverage across OECD and other surveyed countries

National health system (including those with distinct localised services)	Australia, Canada, Denmark, Finland, Iceland, Ireland, Italy, Latvia, New Zealand, Norway, Portugal, Spain, Sweden, United Kingdom
Single health insurance fund (single payer)	Estonia, France, Greece, Hungary, Korea, Lithuania, Luxembourg, Poland, Slovenia, Turkey
Multiple health insurance funds or companies	Austria, Belgium, Chile, Czech Republic, Germany, Israel, Japan, Mexico, Netherlands, Slovak Republic, Switzerland, United States

Source: OECD 2016 Health Systems Characteristics Survey, authors' analysis of survey results. Full results of this survey available here: <https://qdd.oecd.org/subject.aspx?Subject=hsc>.

17. Government schemes and compulsory health insurance (whether organised as single or multiple funds) together accounted for almost three-quarters of all health care spending in 2015, on average across the OECD (OECD, 2017^[6]), shown on Figure 3.1 below. In Denmark, Sweden and the United Kingdom, central or sub-national governments financed 80% or more of all health spending. In Germany, Japan, France and the Slovak Republic more than 75% of health expenditures were paid through compulsory health insurance. Only in the United States, government or compulsory health insurance financed less than half of all health spending.

Figure 3.1. Health expenditure by type of financing, 2015 (or nearest year)

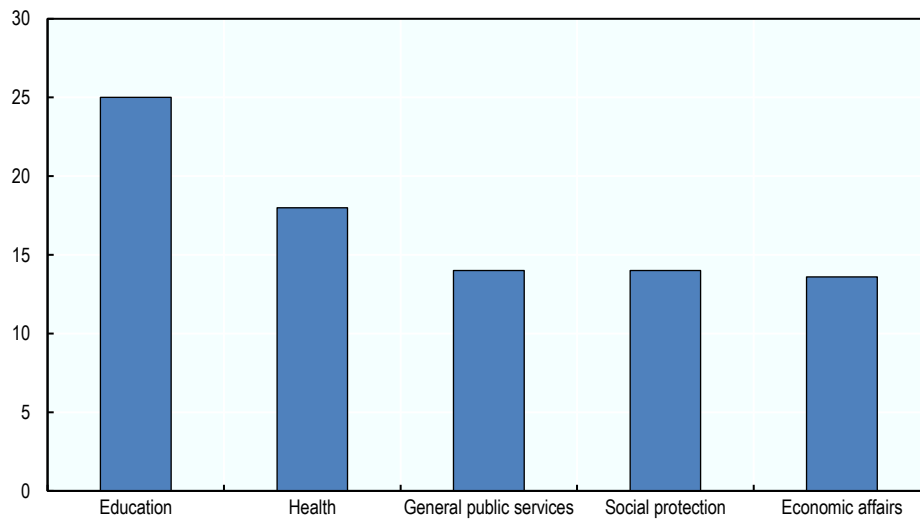


Source: OECD Health at a Glance 2017.

3.2. Decentralisation of health spending by expenditure shares

18. Data on government spending by level of government can indicate the level of sub-national spending power. The degree and type of sub-national government spending is generally calculated as the sub-national expenditure share as a proportion of total expenditure and the breakdown of sub-national expenditure according to national accounts using the Classification of Functions of Government (COFOG). While these indicators do not capture the complexity of fiscal arrangements, they can give a first impression of how much fiscal power regional and local jurisdictions enjoy (Blöchliger and King, 2006^[7]).

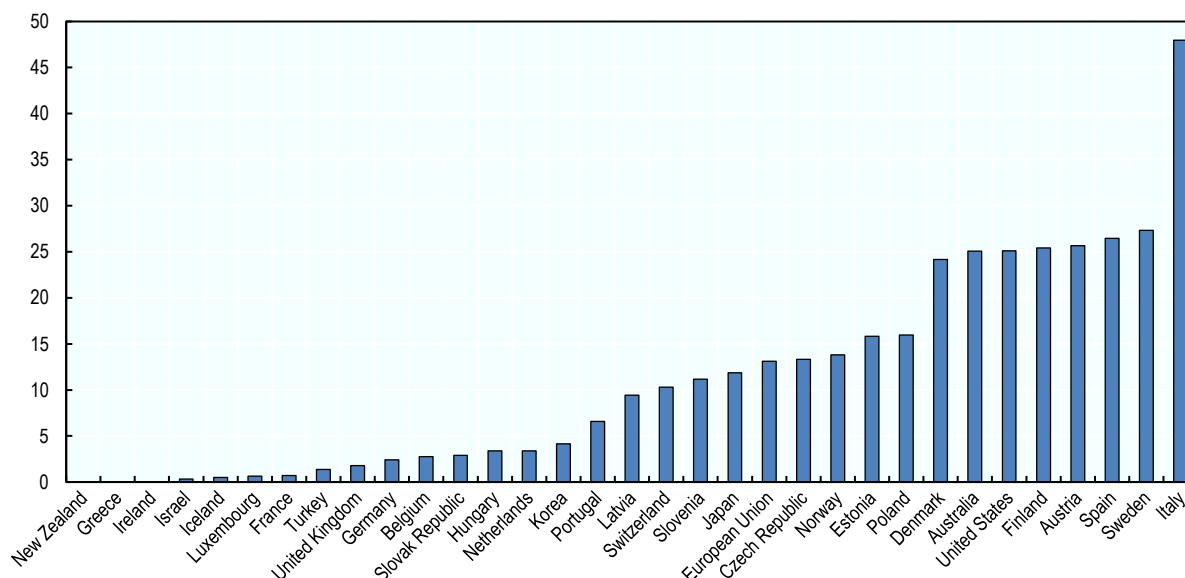
19. The categorisation of sub-national government expenditure by sub-sector provides a measure of the role of sub-national government. Health represents the second largest sector for sub-national government expenditure after education, accounting for 18% of sub-national expenditure in 2015 (Figure 3.2)

Figure 3.2. Sub-national expenditure by economic function (% , 2015)

Note: Sub-national expenditure by function are shown as a percentage of total sub-national expenditure. OECD weighted average (weighted by population size of each country). Excludes Canada, Mexico and Chile. Other expenditure data include defence; public order and safety; housing and community amenities; recreation, culture and religion; environment; social protection expenditure includes both capital and current expenditure. Source: OECD Regions and Cities database.

20. Figure 3.3 shows sub-national expenditure shares as percentage of total sub-national expenditure for OECD countries. In Austria, Finland, Italy, Spain, Sweden and the United States, sub-national health spending exceeded 25% of total sub-national expenditure, suggesting that health costs can have a significant impact on sub-national government budgets.

Figure 3.3. Sub-national health expenditure as a percentage of total sub-national expenditure (2015)



Note: OECD weighted average (weighted by population of each country). Excludes Canada, Mexico and Chile.
Source: OECD Regions and Cities database

21. In the health sector, sub-national expenditure on health accounted for 24% (unweighted average) of public health spending across OECD countries in 2015, the average, however, hides wide variations across countries. Based on expenditure shares, health remains highly centralised in many countries, including Greece, Ireland, New Zealand, Israel, Luxembourg, Turkey, and France. In contrast, sub-national government health spending exceeds 85% of total public health spending in Sweden, Spain, and Switzerland, where wide responsibilities for healthcare services and financing are decentralised to the municipal, regional or health district levels (OECD, 2018^[5]).

22. Mechanisms for health financing across levels of government vary. In Australia for example, the central government funds health care in accordance with national agreements, which have been established between the central and regional governments. Regional governments also fund health care through taxes and own-source revenue, in accordance with their own legislation. In Finland, the central government is responsible for collecting general taxes, with some funding being used for health care. Additionally, a specific social security fee is collected from all employees to finance specific health care costs provided through the statutory sickness insurance scheme.

23. By contrast, health is more decentralised in Switzerland. Regional and local governments are sovereign as to the allocation of the taxes they collect. Generally, taxes are not earmarked for health care provision, except with regard to certain areas like a share of central government excise duties on tobacco products for public health purposes and a centrally set contribution from health insurances for prevention activities. Health insurance premiums are set by the privately administered health insurers. However, the Federal Office of Public Health regulates premiums and approves all premium levels on a yearly basis.

4. Decentralisation of decision-making autonomy in the health sector

4.1. Introduction

24. The degree of sub-national government spending power is generally depicted as the sub-national expenditure share as a proportion of total government expenditure. This holds when looking at general government expenditure, as well as for health expenditure. However, because of barriers and restrictions on sub-national decision-making, including earmarked grants and mandatory spending and national standards, simple expenditure shares can misrepresent the true level of sub-national decision-making autonomy. This makes accurately comparing and measuring decentralisation across countries difficult, far beyond the purely statistical challenges that cross-country comparisons face.

25. The following section focuses on the survey data gathered on the degree of decentralisation of decision-making in the health care sector. This part of the questionnaire asked respondents to detail which level of government is responsible for particular decisions in health care, generally in regards to hospitals. Around 50 questions were asked in this part of the survey, relating to the allocation of responsibilities for around 50 key decisions in the delivery of health care. 10 questions were related to policy autonomy, 17 decisions related to budget autonomy, 9 related to input autonomy, and 9 related to input and output autonomy.

26. Key decision-making responsibilities in health care include the right to amend regulations, grant subsidies and concessions, finance capital and medical staff, and allocate funding across hospitals. More specifically, questions asked in the survey included which level of government is responsible for: financing new hospital buildings; setting the level of taxes that will be earmarked for health care; and setting the legal framework (e.g. laws establishing objectives, rights and obligations in hospitals).

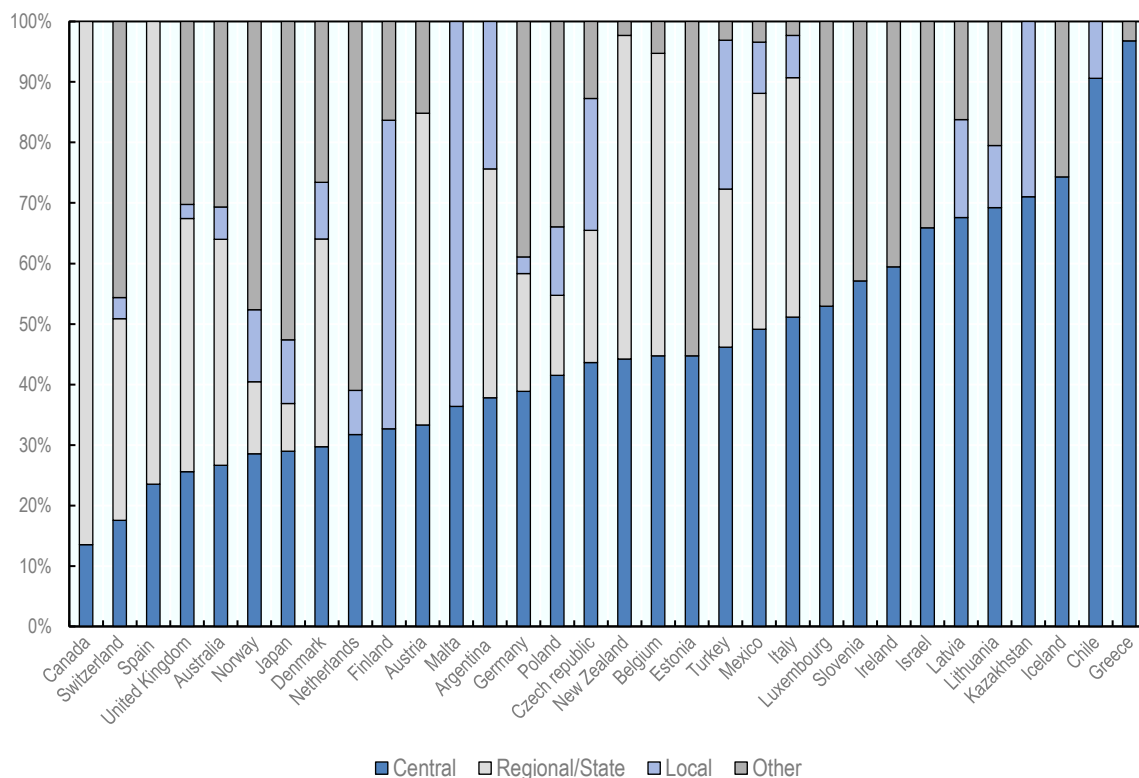
4.2. General results

4.2.1. Responsibilities across levels of government

27. Figure 4.1 shows the allocation of responsibility for decisions in health care, across respondents. It is calculated as the number of times a country responded that a level of government was responsible for a health decision, and then shows these sub-totals as a proportion of the total 'yes' responses, for each country.

28. Decision-making power across many facets of the health sector in surveyed countries is strongly skewed towards the central government. This strong centralisation of health responsibilities is despite a general trend towards decentralisation of health care over the last 20 years, which has transferred competences to the sub-national level. However, some OECD countries such as Australia, Germany or Sweden, have recentralised over the last 20 years (OECD, 2018^[5]). On average, central governments are nearly twice as likely to be responsible for the health decisions surveyed, compared with regional governments, and four times more likely compared with local governments. As shown in the figure below, health remains a centralised responsibility in several countries, but most strongly in Greece, Chile and Iceland. At the other end of the spectrum, the sub-national government is habitually responsibility for health decisions in Canada, Switzerland and Spain.

Figure 4.1. Decision-making power in the health sector, across levels of government (proportion, in %)



Source: OECD survey on performance measurement systems in the health sector and responsibilities across levels of government (2018).

29. Responses to ‘other’ gave the opportunity for countries to express the presence of any other significant decision-making power across areas of spending power. Responses to other included public and private health insurance funds, and public and private service providers, particularly hospitals.

30. Table 4.1 shows the proportion of decisions that were the responsibility of each level of government. For example, in Greece, central government was responsible for 94% of health care decisions, showing the high degree of centralisation. In many countries, decisions were shared across levels of government. In Mexico, central and regional governments were responsible for 91% and 72% of decisions respectively – indicating that many decisions are a shared responsibility between these two levels of government. Shared responsibilities are discussed more in section 4.4.

Table 4.1. Country responses (% of responses ticked for each level of government)

	Central	Regional	Local	Other
Argentina	97	97	63	0
Greece	94	0	0	3
Turkey	94	53	50	6
Chile	91	0	9	0
Israel	91	0	0	47
Mexico	91	72	16	6
Kazakhstan	84	0	34	0
Lithuania	84	0	13	25
Iceland	81	0	0	28
Latvia	78	0	19	19
Slovenia	75	0	0	56
Czech republic	75	38	38	22
Ireland	69	0	0	47
Italy	69	53	9	3
Poland	69	22	19	56
Australia	63	88	13	72
New Zealand	59	72	0	3
Denmark	59	69	19	53
Luxembourg	56	0	0	50
Belgium	53	59	0	6
Estonia	53	0	0	66
Finland	50	0	78	25
Germany	44	22	3	44
Netherlands	41	0	9	78
Malta	38	0	66	0
Norway	38	16	16	63
Austria	34	53	0	16
Japan	34	9	13	63
United Kingdom	34	56	3	41
Switzerland	31	59	6	81
Spain	25	81	0	0
Canada	16	100	0	0

Note: Figures represent the proportion that a country indicated that a level of government was responsible for each different decision in health care. Responses are not mutually exclusive and several levels of governments can share one responsibility.

Source: OECD survey on performance measurement systems in the health sector and responsibilities across levels of government (2018).

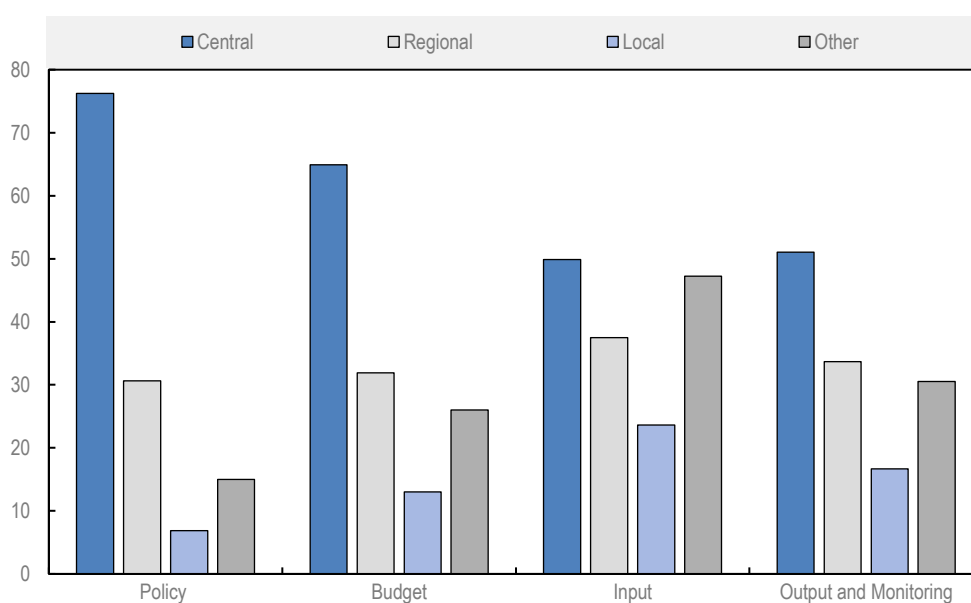
4.2.2. Responsibilities across area of spending autonomy

31. Areas of spending power consist of policy, budget, input, and output and monitoring. As shown in Figure 4.2, central governments still have considerable spending autonomy. However, they are most likely to be responsible for decisions regarding the policy and budgetary aspects of health care, and have less control over decisions regarding the inputs and outputs as well as monitoring of health care. Decisions for input-related matters, such as determining which services can be outsourced and deciding on the

contractual status of staff, fall more so on sub-national governments, especially for regional governments in federal countries.

32. Local governments have little decision-making power in the health care sector, but have more responsibility with regard to health inputs, namely, deciding on hospital infrastructure maintenance and planning hospital infrastructure. Financing the current spending of hospitals and financing new high-cost equipment are more likely to be the responsibility of local governments in federal countries.

Figure 4.2. Responsibilities across areas of spending autonomy

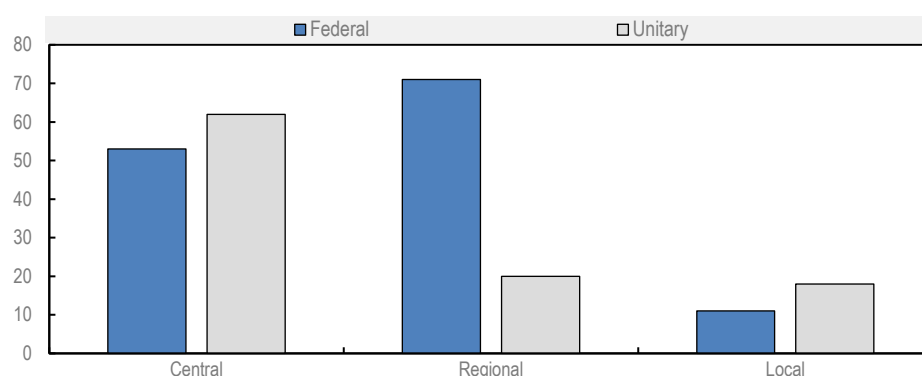


Note: Graph shows the average level of responsibility across policy, budget, input, and output and monitoring autonomy across all decisions, for central, regional, local, and other decision makers. The breakdown of individual decisions is given in table 7.1 in the annex.

Source: OECD survey on performance measurement systems in the health sector and responsibilities across levels of government (2018).

4.2.3. Responsibilities across federal and unitary countries

33. The role of the central governments in health care does not vary markedly between federal and unitary countries (Figure 4.3). However, sub-national government decision-making power tends to be higher in federal than in unitary countries. On average, regional governments in federal countries are responsible for 71% of decisions, compared to 20% in unitary countries.

Figure 4.3. Responsibility across federal and unitary countries (%)

Note: The graph shows levels average level of responsibility in central, regional, and local governments across all health care decisions.

Source: OECD survey on performance measurement systems in the health sector and responsibilities across levels of government (2018)

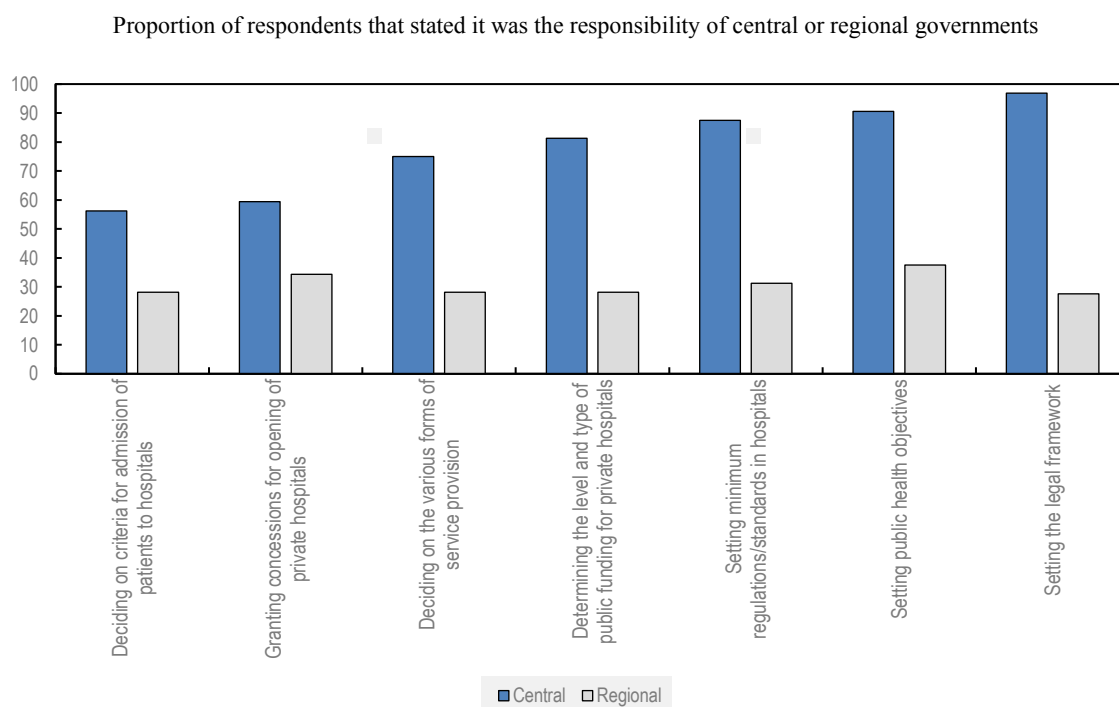
4.3. Responsibility by area of spending autonomy

4.3.1. Policy decisions in health care

34. The majority of survey respondents stated that the central government is responsible for key decisions about policy (Figure 4.4). Specifically, setting public health objectives was a central government responsibility and a regional government responsibility, for 91% and 38% of respondents respectively. Setting the legal framework (e.g., a law establishing objectives, rights and obligations in hospitals) was the responsibility of the central government for 97% of respondents, and deciding on the various forms of service provision (public vs. private provision) was the responsibility of the central government and the regional government for 75% and 28% of respondents respectively.

35. Setting minimum regulations/standards in hospitals was the responsibility of the central government in many countries (88% of respondents), excluding Belgium, Canada, Norway and the United Kingdom. Explicit minimum standards for service coverage, whether social and/or geographical, promote equal access across all citizens. Belgium's current framework of minimum standards has been in place since the '6th state reform', of which the last stage was finalised in July 2014. This reform involved transferring some competences (mainly for elderly residential care, mental health, recognition of medical professions and hospital standardisation) in health care from the central government to communities. However, even if competences in some fields were transferred, the 'playing field' for the communities is still subject to a national coordination or framework of rules. For example, regional rules for hospital standards cannot alter rules for social security, or the exercising of medical professions, or the financing rules of hospitals.

Figure 4.4. Responsibilities for key policy decisions between central and regional governments (%)



Source: OECD survey on performance measurement systems in the health sector and responsibilities across levels of government (2018).

4.3.2. Budgeting decisions in health care

36. Compared to policy decisions, key budgeting decisions were more evenly split across decision-makers, but central governments have considerable power (Figure 4.5). Setting the level of taxes earmarked for health care and setting the base and level of social contributions/premiums for health care was the responsibility of the central government for 91% of respondents.

37. The same percentage of respondents answered that the central government was responsible for designing and implementing a scale for user contributions, as well as differentiating user contributions according to the social situation of users. User contributions cover all individual payments to service providers, including private co-payments through insurance schemes, in return for a service. User contributions for health services can potentially contain excess demand, reducing pressure on government budgets and improving the quality of public services. However, user fees may be less suited for demand management when services are not particularly price sensitive, which may be the case for acute hospital care (Blöchliger, 2008^[8]). Indeed, there is an abundance of evidence demonstrating that excessive user fees and other out-of-pocket payments can impede access to care and cause financial hardship (WHO, 2010^[9]).

38. Deciding on the resource allocation between sectors of care, in terms of hospital care, outpatient care, long-term care etc. was more evenly split with 66% and 39% of respondents suggesting that it was a central and regional government responsibility respectively.

39. The central government is often responsible for regulating private hospital activity and determining the level and type of public funding for private hospitals. In Belgium, the definition of ‘hospitals’ is officially regulated and private health sector providers must be not-for-profit. For-profit institutions can enter the market but do not receive direct public financing. In Denmark, if public hospitals are unable to offer a service within a given timeframe determined by the central government, public hospitals may refer the patient to a private hospital, and the public sector pays the costs. In addition, private hospitals offer treatments funded by user fees or private insurance.

40. Budgeting decisions concerning hospitals were more evenly shared across decisions-makers compared to other budgeting responsibilities (Figure 4.5). Financing new hospital buildings was a central government responsibility and a regional government responsibility, for 59% and 47% of respondents respectively. In Italy, there is a specific national fund for investment in health care that can be used for the financing of new hospital buildings. Previously, regions used to finance new hospital buildings through public-private partnerships. Financing new high-cost equipment was the responsibility of the central government for 50% of respondents, the responsibility of regional governments for 47% of respondents, and the responsibility of the other entities, like hospitals, for 41% of respondents. Similarly, financing the maintenance of existing hospitals was a central government responsibility and a regional government responsibility, for 50% and 47% of respondents respectively. Financing hospital current spending was a central government responsibility (50%) and a regional government responsibility (34%). As would be expected, these key financing decisions are more likely to be the joint responsibility of central and regional governments in federal countries

41. Many countries responded that entities other than central, regional or local governments were responsible for budgeting decisions in hospitals. These key decisions, for example financing hospital staff’s salaries, are often made internally by the individual hospital. For example in Switzerland, most hospitals have sufficient autonomy to decide on their own investments, but regional government are able to influence decisions through their service plans.

42. Figure 4.6 shows the responsibility of regional governments in key budgeting decisions in federal and unitary countries. In federal countries, regional governments have a high level of responsibility for key financing decisions especially concerning hospital decisions, such as financing new hospitals, and hospital maintenance.

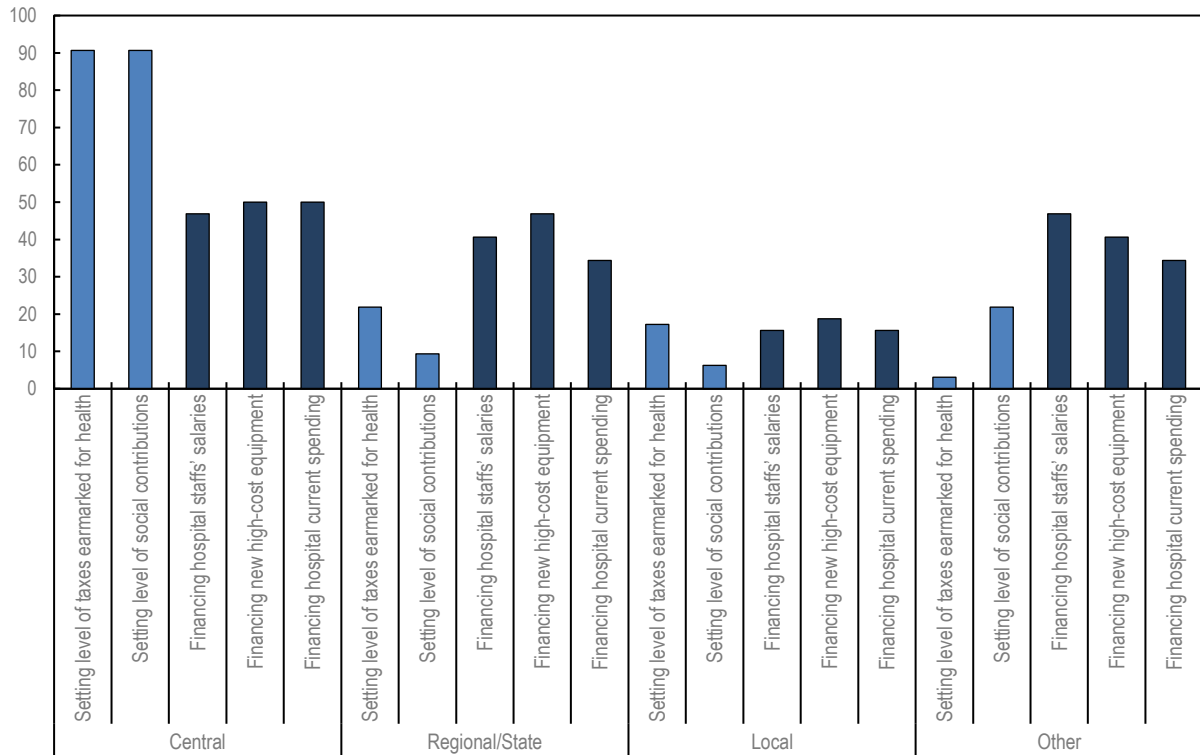
43. Despite greater decision-making power in sub-national governments, central government has much of the responsibility over key budgeting decisions. Some of these key budget decisions, like setting the level of taxes, and setting the total budget for public health care, can restrict the revenue-raising potential of regional governments. This creates a mismatch, where the central government has greater influence with regard to revenue-raising decisions, while regional governments are more often responsible for financing, especially concerning hospitals. This mismatch suggests that the traditional indicator of decentralisation, measured as the sub-national expenditure share as a proportion of total expenditure, overestimates the true level of budget autonomy in some, mainly federal, countries.

44. When roles and responsibilities across politically elected governments are blurred or there are soft budget constraints, such a misalignment of decision-making powers can lead to inefficiencies and excessive borrowing. This issue may be enhanced if there is a high level of political decentralisation, but sub-national actors lack spending autonomy. Research suggests that this can be overcome when the financial implications of spending

decisions are internalised within a jurisdiction, which can be achieved by assigning revenue autonomy to sub- national governments (Asatryan, Feld.L.P. and Geys, 2012_[10])

Figure 4.5. Responsibilities for key budgeting decisions in across levels of government (%)

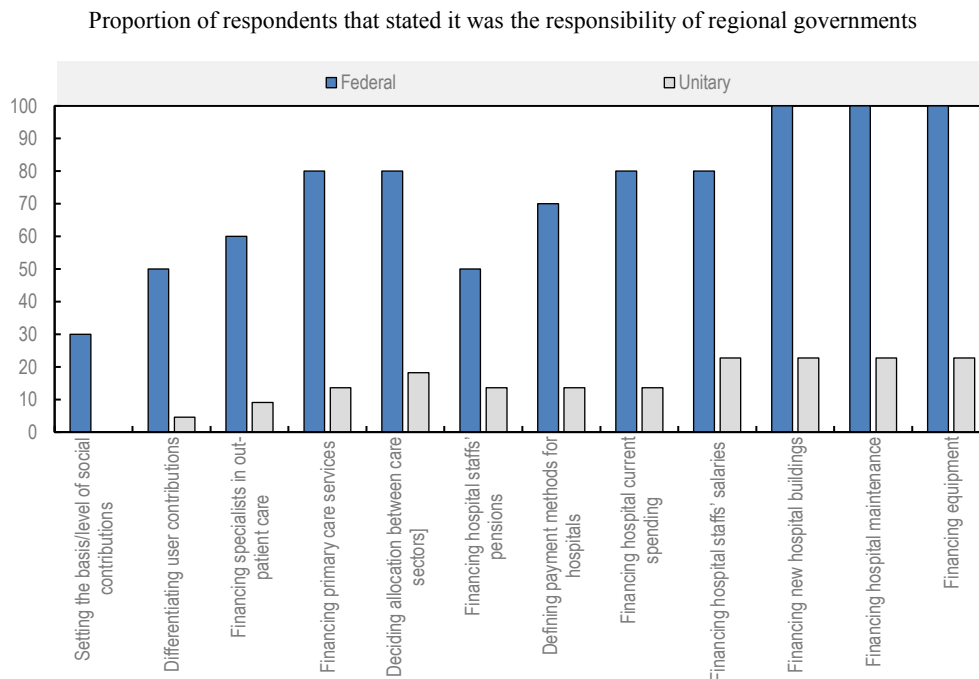
Proportion of respondents that stated it was the responsibility of central, regional, or local governments or other



Note: The graph shows the responsibility of key budgeting decisions. The darker bars show decisions concerning hospitals.

Source: OECD survey on performance measurement systems in the health sector and responsibilities across levels of government (2018).

Figure 4.6. Regional government responsibility for key budgeting decisions, by federal and unitary countries (%)



Source: OECD survey on performance measurement systems in the health sector and responsibilities across levels of government (2018).

4.3.3. Labour and input decisions in health care

45. Labour and input decisions include the hiring and firing of staff, determining working conditions, establishing training rules and planning of necessary hospital infrastructure. The responsibility for these decisions was more evenly shared across levels of decision-makers (Figure 4.7).

46. The hiring and firing of staff was the responsibility of the central government for 31% of respondents, the responsibility of regional governments for 31% of respondents, and the responsibility of the other entities, like hospitals, for 59% of respondents. Determining working conditions (salary scales, pension rules, and working hours) was often a shared responsibility across decision-makers, and was a central government responsibility, a regional government responsibility, and the responsibility of other entities, for 88%, 34% and 47% of respondents respectively. In Australia, the relevant employer determines working conditions but must do so in accordance with legislated conditions of the central and regional governments. In the Netherlands, health care providers are responsible for determining working conditions but must comply with collective labour agreements.

47. Setting remuneration methods for physicians was a central government responsibility, a regional government responsibility, and the responsibility of other entities for 78%, 28% and 31% of respondents respectively. This shared responsibility generally involves the central government establishing an overall framework for remuneration, with joint responsibility from sub-central decision-makers like insurers, healthcare institutions or doctors' associations. In the Netherlands for instance, the national market authority provides the regulatory framework for remuneration, which is implemented with

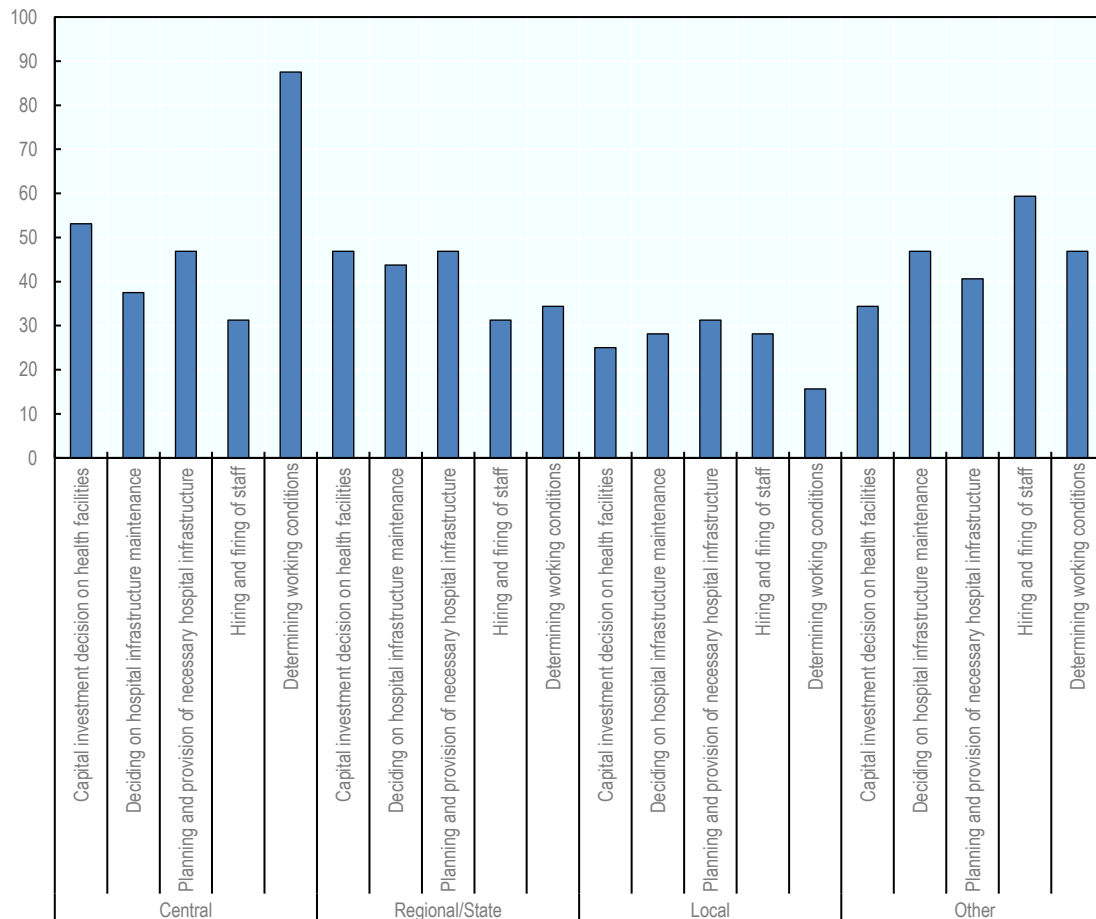
considerable discretionary power by private insurers. Independent physicians benefit directly from this and remuneration of employed physicians also depends on their employer's policy. Physician remuneration is also often the responsibility of regional governments in federal countries.

48. Local governments have little overall power regarding health care decisions, but were most likely to be responsible for input related decisions. In particular, these decisions include the planning and provision of necessary hospital infrastructure and infrastructure maintenance, and the hiring and firing of staff.

49. National accounts expenditure shares also suggest that sub-national governments play a critical role as employers, and financing staff costs. Staff spending is the largest expense in sub-national government budgets, representing on average 36% of expenditure in the OECD area, and ranging from less than 20% in New Zealand to more than 50% in Norway. On average in the OECD area, sub-national governments undertook 63% of public staff expenditure in 2014 (OECD, 2018^[5]). High budget shares for staff spending seem to reflect the fact that sub-national actors in several countries have the responsibility, delegated from the central government, for the payment of public workers' salaries, including medical staff.

Figure 4.7. Responsibilities for labour and input decisions, across levels of government (%)

Proportion of respondents that stated it was the responsibility of central, regional, or local governments or other



Source: OECD survey on performance measurement systems in the health sector and responsibilities across levels of government (2018).

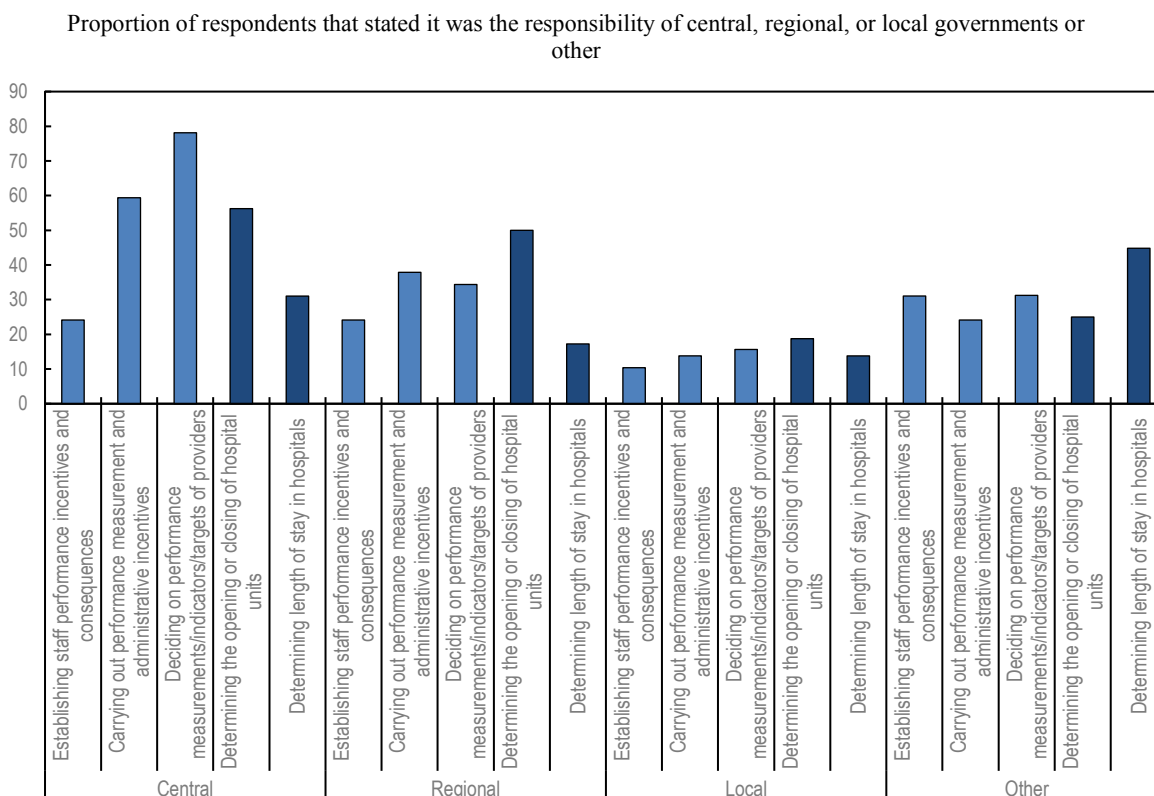
4.3.4. Output and monitoring decisions in health care

50. Key output and monitoring decisions in health care are shown in Figure 4.8, which includes the breakdown of responsibilities across levels of government. Output decisions, especially regarding hospitals, were split across decision makers. For example, determining the opening or closing of hospital units was a central government responsibility and a regional government responsibility for 56% and 50% of respondents, respectively. Determining the allotment of hospital beds across hospitals was the responsibility of the central, regional, and local governments for 50%, 38%, and 22% of respondents respectively, and the responsibility of other entities for 31% of respondents. Determining the size of health care districts was the responsibility of the central government for 47% of respondents, and the responsibility of regional governments for 38% of respondents

51. Monitoring decisions were more likely to be the responsibility of central government. Deciding on performance measurements, indicators and targets of service

providers was a central, regional and local responsibility for 78%, 34% and 31% of respondents, respectively. Monitoring of service provision (does supply meet users’ needs, and is access for users from different regions or different social groups ensured) was the responsibly of central government for 78% of respondents and 34% and 16% for regional and local governments respectively.

Figure 4.8. Responsibilities for key output and monitoring decisions, across levels of government (%)



Note: The graph shows the responsibility of key output and monitoring decisions. The darker bars indicate output decisions concerning hospitals.

Source: OECD survey on performance measurement systems in the health sector and responsibilities across levels of government (2018).

4.4. Shared responsibilities

52. A shared responsibility is when two or more decision makers are responsible for the same decisions and is the result of multiple levels of government or authorities being responsible for the financing or policy making of service delivery. A high number of shared decisions, suggests the presence more complex frameworks and more overlapping responsibilities. This has the potential to generate inefficiencies in intergovernmental relations, and reduce transparency and accountability of public policies and government spending, if the division of competences is not clearly set.

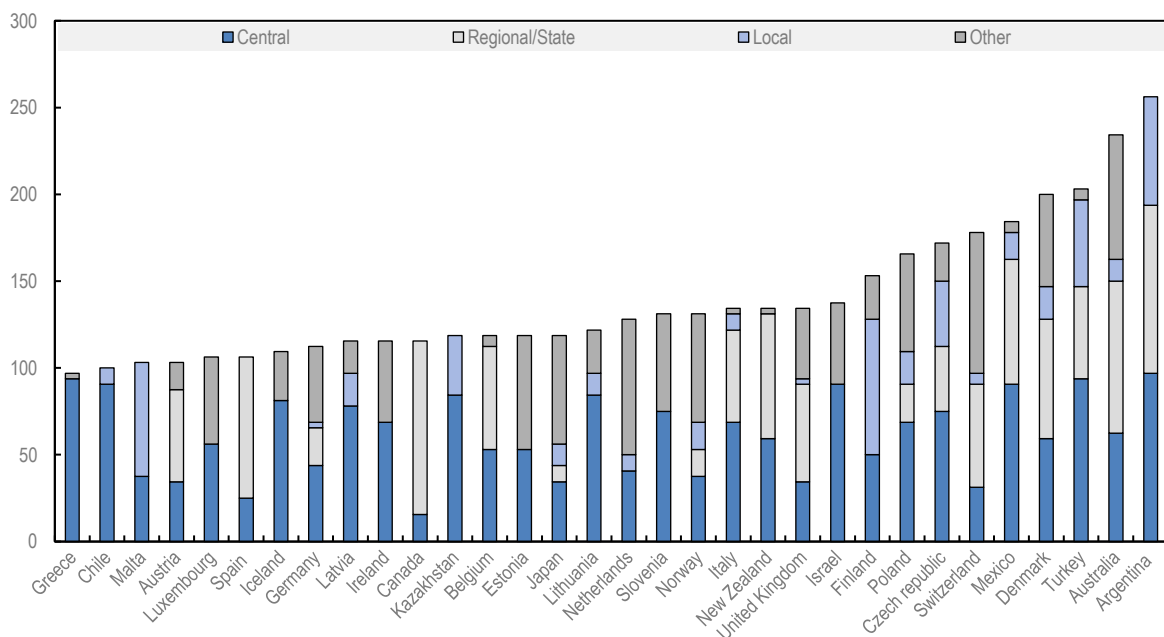
53. Figure 4.9 shows the level of shared responsibilities in health care. Taller columns represent countries with a greater number of shared responsibilities in health care, including Argentina, Australia, and Denmark. Interestingly, Canada, Germany and Spain have low

levels of shared responsibilities despite these countries being federal, where power is shared with sub-national governments.

54. In Canada, health care is a shared responsibility between the central (federal) and sub-national (provincial and territorial) governments. However, the provincial and territorial governments have most of the responsibility for delivering health care services. The federal government is responsible for some delivery of services for only certain population groups. The federal government's other roles include setting and administering national principles for the health care system under the Canada Health Act (CHA); providing financial support to the provinces and territories; health protection, regulation and consumer safety; disease surveillance and prevention; and, support for health promotion and health research. Publicly funded health care is financed by general revenue raised through federal, provincial and territorial taxation. Provinces may also charge a health premium on their residents to help pay for publicly funded health care services, but non-payment of a premium must not limit access to medically necessary health services.

Figure 4.9. Cumulative country responses

Cumulative number of responses ticked for each level of government



Source: OECD survey on performance measurement systems in the health sector and responsibilities across levels of government (2018).

55. Table 4.2 shows shared responsibility across areas of spending autonomy. In federal countries, policy decisions are most likely to be shared between decisions makers, with the average policy decisions being a shared responsibility in 37% of federal countries. In particular, setting public health objectives was a shared responsibility in 60% of federal countries. In Australia for example, broad public health objectives are set through the Council of Australian Governments Health Council, which includes representatives from each jurisdiction. Budgeting decisions were less likely to be a shared responsibility between decision makers in federal countries. Decisions such as financing hospital staff's pensions,

financing hospital current spending, and financing specialist out-patient care, were not often shared across decisions makers, as central government had less overall power.

56. Some key budgeting decisions such as setting the level of taxes that will be earmarked for health and setting the basis level of social contributions for health care were a shared responsibility for 40% of federal countries. In countries, where sub-national governments have more responsibility for delivering health care services, revenue-raising and financing power may also be devolved to the sub-national level. This is the case in Australia, Belgium, Canada, Italy, and Spain, where both central and sub-national governments are responsible for setting levels of tax allocated to health care.

57. In unitary countries, policy decisions were least likely to be a shared responsibility between decision-makers, as many of these decisions are made at the central level. Input decisions were often a shared responsibility between decision makers. Particularly determining working conditions (salary scales, pension rules, working hours) was a shared responsibility in 72% of unitary countries. This decision was often a shared responsibility between central or sub-national governments and health care providers or trade unions.

58. Interestingly, looking across all areas of spending autonomy, decisions were on average a shared responsibility 31% of the time in federal countries and 32% in unitary countries. In some federal countries (Austria, Canada, and Germany), many decisions were not shared, however, this is due to central government responsibilities being lower overall. In contrast, in Australia, 87.5% of the decisions were shared across decision makers, with both national and sub-national government having considerable decision-making power.

59. In unitary countries such as Mexico, Denmark and Switzerland, over 65% of the decisions were shared. In Denmark, financing decisions are made by both regional governments and the municipalities, who pay co-payments based on a fixed share of their citizen's use in the health care sector. In Mexico, many decisions are a shared responsibility between national and regional governments as each are responsible for delivery of hospital services.

Table 4.2. Average proportion of shared decisions (%)

	Average proportion of shared if federal	Average proportion of shared if unitary
Policy	37	23
Budget	27	34
Input	34	43
Output	30	26

Note: The figures show the proportion of shared responsibility across an average of key decisions in each area of spending autonomy. The breakdown of individual decisions is shown in table 7.2 in the annex.

Source: OECD survey on performance measurement systems in the health sector and responsibilities across levels of government (2018).

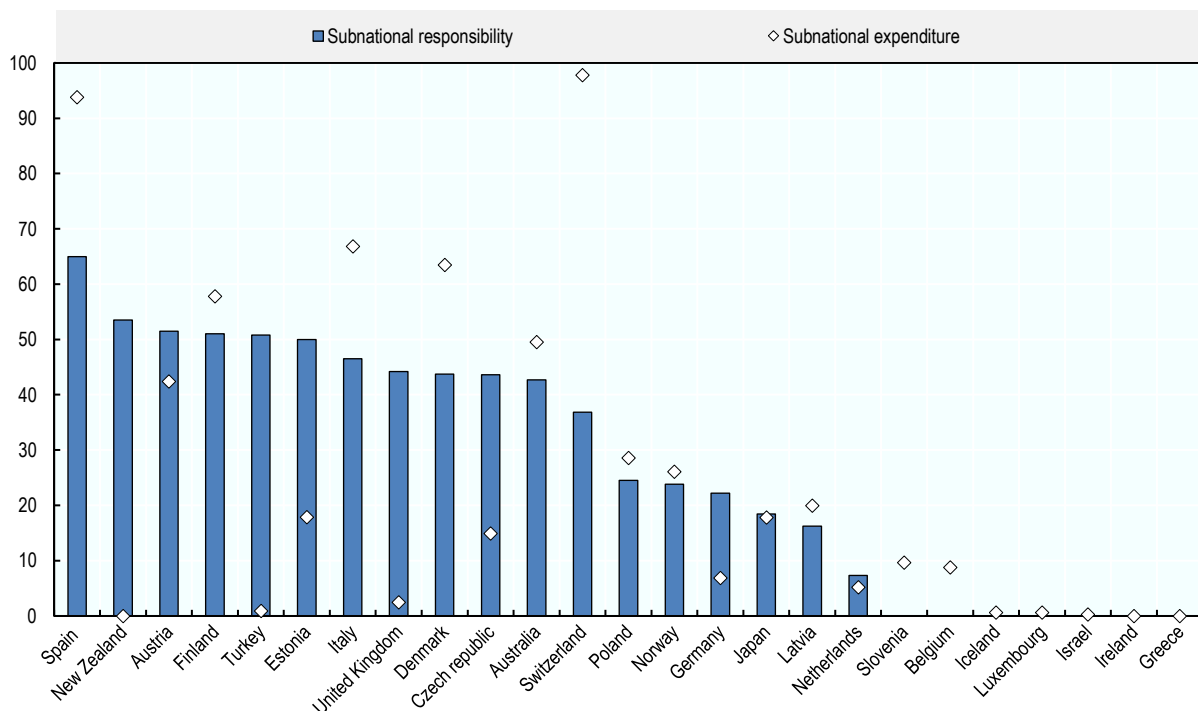
4.5. Comparing responsibility against expenditure

60. Figure 4.10 shows the level of responsibility of sub-national governments in health care, against sub-national health expenditure as a proportion of total health expenditure. The level responsibility is calculated as the number of times a country responded that regional or local level of government was responsible for a health decision, as a proportion of the total 'yes' responses, for each country. For the majority of countries, the proportion of sub-national expenditure on health is greater than the decision-making power of sub-

national governments. This indicates that expenditure shares misrepresent the actual spending power of sub-national governments and the presence of barriers on decision-making ability.

61. In Italy, regional governments are responsible for delivery health care services. Regional governments receive earmarked grants from central government to cover health service provision. Earmarked grants limit the spending autonomy of sub-national governments, compared to general purpose transfers, which give sub-national governments greater flexibility. The Ministry of Health is also responsible for key decisions such as defining the minimum statutory benefits package and designing and implementing a scale for user contributions. The central government is responsible for many decisions regarding hospitals, such as deciding on admission criteria and determining the length of stay in hospitals. Therefore, even though sub-national expenditure on health in Italy accounts for 67% of total expenditure on health, this figure is misrepresentative of the true level of sub-national decision-making autonomy. Survey results indicate that sub-national governments in Italy are responsible for 46% of key health decisions.

Figure 4.10. Responsibility of sub-national governments against expenditure for health (%)



Source: OECD survey on performance measurement systems in the health sector and responsibilities across levels of government (2018). Expenditure data comes National Account Statistics (database), OECD (2018), <http://dx.doi.org/10.1718/na-data-en>.

62. A parallel paper explored the relationship between decentralisation (as defined in the survey used for this paper) and health care system performance, modelled as the interaction of health expenditure and life expectancy [COM/CTPA/ECO/GOV(2018)7]. A measure of the degree of decentralisation across levels of government was constructed from the survey data described in this section. For each decision where the government is

involved, a score was attributed (0 for fully central decision, 6 for fully local). An overall score was computed as the simple average of sub-scores related to each decision.

63. This decentralisation index was then used as an input for a simultaneous equation non-linear regression model, together with several other policy variables. The two equations model health expenditure and life expectancy separately, and look at the impact of each policy driver (including the impact of more decentralised decision-making) on both equations. Higher decentralisation was associated with a positive impact on performance (higher life expectancy and lower expenditure), but the trend started marginally decreasing around 2.5 on the index, reaching the inversion point towards very high decentralisation levels (over 5). A limitation of this model, though, is that it cannot determine whether some decisions have a higher impact than others, since it uses a simple average of all parameters that form the decentralisation index.

5. Conclusions

64. The degree of sub-national government spending power is generally calculated as the level of sub-national expenditure share as a proportion of total government expenditure. However, due to barriers and restrictions in sub-national spending, calculating expenditure shares can be misleading in the degree of sub-national government autonomy. Examining responsibility in four areas of spending autonomy, policy, budget, input, and output and monitoring, can help to provide a clearer view of decentralisation in health systems.

65. Despite the trend towards decentralisation of health systems, central government still has considerable power across many decisions regarding the delivery of health services. This decision-making power is particularly strong in regard to key policy and budgeting decisions, but is weaker over decisions concerning the inputs and outputs of health care services. Regional governments have less responsibility, but are most likely to be responsible for input related decisions, such as determining which services can be outsourced and deciding on the contractual status of staff. Overall, the decision-making power of local government in health care is limited. Decisions concerning hospitals were split more evenly across central and regional governments. However, in many countries, individual hospitals had autonomy over these decisions

66. While there is no conclusion on how responsibilities should be distributed across decision-makers, issues can potentially arise if there is a misalignment between levels of government. One possible source of misalignment is if the devolution of financing responsibilities to sub-national governments is not accompanied with equal devolving of revenue-raising powers or alternatively additional resource transfers from central government. Moreover, when the responsibility for decisions is shared across multiple decision-makers, this entails risk of overlapping and inefficiencies if the responsibilities are not clearly defined. Interestingly however, despite greater spending power of sub-national governments in federal countries, the overall proportion of shared responsibilities for key health care decisions did not vary between federal and unitary countries.

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7. Annex

Table 7.1. Proportion of respondents that stated the key health care decision was the responsibility of central, regional, or local governments, or other entities

	Central	Regional/ State	Local	Other
Policy				
Determining the size of hospital/health care districts	47	38	13	16
Deciding on criteria for admission of patients to hospitals	56	28	6	28
Granting concessions for opening of private hospitals	59	34	3	6
Deciding on the various forms of service provision (public vs. private provision)	75	28	9	22
Setting remuneration methods for physicians	78	28	6	31
Determining the level and type of public funding for private hospitals (subsidies, other means of financial aid, e.g., tax exemption for providers)	81	28	3	16
Setting minimum regulations/standards in hospitals (public and private)	88	31	3	9
Setting public health objectives	91	38	22	6
Regulating private hospital activity (e.g., setting the rules for concessions and funding for private hospitals)	91	31	0	16
Setting the legal framework (e.g., a law establishing objectives, rights and obligations in hospitals)	97	22	3	0
Budget				
Deciding on budget allocation among hospitals within the same region or municipality	31	44	6	31
Financing hospital staffs' salaries and benefits	47	41	16	47
Financing new high-cost equipment	50	47	19	41
Financing hospital current spending	50	34	16	34
Financing the maintenance of existing hospitals	50	47	25	31
Financing specialists in out-patient care	53	25	13	41
Financing hospital staffs' pensions	56	25	3	34
Financing primary care services	56	34	22	31
Financing new hospital buildings	59	47	22	22
Deciding on budget allocation among regions, districts or municipalities	59	31	3	19
Deciding resource allocation between sectors of care	66	38	16	28
Defining payment methods for hospitals	75	31	9	25
Setting the total budget for public funds allocated to health care	88	31	16	3
Setting the level of taxes which will be earmarked for health care	91	22	16	3
Differentiation of user contributions according to social situation of users	91	19	6	13
Designing and implementing a scale for user contributions	91	19	9	9
Setting the basis and level of social contributions/premiums for health care	91	9	6	22
Input				
Determining which services can be outsourced (services obtained from outside providers, such as cleaning or meals) and choosing external providers	25	38	22	53
Hiring and firing of staff	31	31	28	59
Deciding on hospital infrastructure maintenance	38	44	28	47
Deciding on contractual status of staff (e.g., non-redeemable contracts)	41	25	22	53
Capital investment decisions for medical equipment	41	41	25	53
Planning and provision of necessary hospital infrastructure (e.g., vehicles, buildings)	47	47	31	41
Capital investment decision on health facilities (hospitals, etc.)	53	47	25	34
Establishing rules for the training and education of staff	78	31	16	38
Determining working conditions (salary scales, pension rules, working hours)	88	34	16	47
Output and monitoring				

Determining length of stay in hospitals	28	13	16	47
Establishing performance incentives for staff and consequences for high/poor performance (if any)	28	25	13	34
Managing hospital/health care districts	34		19	13
Deciding whether performance assessment of staff must be used (if any)	47	41	16	34
Determining the allotment of hospital beds across hospitals	50	38	22	31
Determining the opening or closing of hospital units	56	50	19	25
Carrying out performance measurement and implementing administrative incentives (sanctions/rewards) associated with performance results as evaluated against targets (if any)	59	38	16	28
Monitoring of hospital service provision (does supply meet users' needs, is access for users from different regions or different social groups ensured?)	78	34	16	31
Deciding on the performance measurements/indicators/targets of service institutions/providers (if any)	78	34	16	31

Table 7.2. Proportion of shared responsibility across federal and unitary countries

	Proportion of shared if Federal	Proportion of shared if unitary
Policy		
Setting public health objectives	60	33
Setting the legal framework (e.g., a law establishing objectives, rights and obligations in hospitals)	20	17
Setting minimum regulations/standards in hospitals (public and private)	30	28
Deciding on criteria for admission of patients to hospitals	20	22
Regulating private hospital activity (e.g., setting the rules for concessions and funding for private hospitals)	40	28
Determining the size of hospital/health care districts	50	11
Budget		
Designing and implementing a scale for user contributions	20	28
Differentiation of user contributions according to social situation of users (e.g., income, region, social status, etc.)	30	28
Financing hospital staffs' salaries and benefits	50	39
Financing hospital staffs' pensions	10	33
Setting the level of taxes which will be earmarked for health care	40	22
Setting the basis and level of social contributions/premiums for health care	40	22
Financing new hospital buildings	20	39
Financing new high-cost equipment	40	39
Financing the maintenance of existing hospitals	30	39
Financing primary care services	20	44
Financing specialists in out-patient care	10	33
Financing hospital current spending	10	39
Input		
Hiring and firing of staff	30	28
Determining working conditions (salary scales, pension rules, working hours)	40	72
Establishing rules for the training and education of staff	50	50
Deciding on contractual status of staff (e.g., non-redeemable contracts)	30	28
Planning and provision of necessary hospital infrastructure (e.g., vehicles, buildings)	30	44
Deciding on hospital infrastructure maintenance	30	44
Determining which services can be outsourced (services obtained from outside providers, such as cleaning or meals) and choosing external providers	30	33
Output and Monitoring		
Monitoring of hospital service provision (does supply meet users' needs, is access for users from different regions or different social groups ensured?)	40	44
Deciding on the performance measurements/indicators/targets of service institutions/providers (if any)	60	44
Carrying out performance measurement and implementing administrative incentives (sanctions/rewards) associated with performance results as evaluated against targets (if any)	40	28
Deciding whether performance assessment of staff must be used (if any)	20	28
Establishing performance incentives for staff and consequences for high/poor performance (if any)	20	6
Determining length of stay in hospitals	0	6

7.1. OECD Questionnaire on Performance Measurement Systems in the Health Sector and Responsibilities across Levels of Government

Part 1

Part 1.A) Degree of Decentralisation in Decision-Making in Health Care

- 1. Please tick the boxes to indicate the level of government that is responsible for each policy or service area.** For areas of shared responsibilities across levels of government, please tick multiple boxes. If you tick 'other' please specify in question 2 below.

	Central gov't	Regional/ state gov't	Local gov't	Other (specify)	Notes*
Setting the level of taxes which will be earmarked for health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Setting the basis and level of social contributions/premiums for health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Setting the total budget for public funds allocated to health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Deciding resource allocation between sectors of care (e.g. hospital care, outpatient care, long-term care)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Setting remuneration methods for physicians	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Defining payment methods for hospitals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Financing new hospital buildings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Financing new high-cost equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Financing the maintenance of existing hospitals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Financing primary care services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Financing specialists in out-patient care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Financing hospital current spending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Setting public health objectives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

*If more than one box is ticked per row, please briefly describe – with an addendum or footnote – how the co-decision process (across levels of government) works in practice. Also, if policy settings vary across distinct sub-national jurisdictions or health care facilities, please add an explanation.

2. If you have ticked *other*, please specify the composition of this alternative institution, including any overlap between its public and private components.

3. Have major changes in the de(centralisation) of decision-making occurred in the past 5 years? If so, please describe:

Part 1.B) Spending Power Across Levels of Government

Policy autonomy

1. **Please tick the boxes to indicate the level of government that is responsible for each policy or service area.** For areas of shared responsibilities across levels of government, please tick multiple boxes. If you tick 'other' please specify in question 2 below.

	Central gov't	Regional/ state gov't	Local gov't	Other (specify)	Notes*
<i>General policy decisions</i>					
Setting the legal framework (e.g. a law establishing objectives, rights and obligations in hospitals)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Setting minimum regulations/standards in hospitals (public and private)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Deciding on the various forms of service provision (public vs. private provision)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Deciding on criteria for admission of patients to hospitals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Deciding on budget allocation among regions, districts or municipalities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Deciding on budget allocation among hospitals within the same region or municipality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Determining the opening or closing of hospital units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Determining length of stay in hospitals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Determining the allotment of hospital beds across hospitals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Staff management</i>					
Hiring and firing of staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Determining working conditions (salary scales, pension rules, working hours)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Establishing rules for the training and education of staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Deciding on contractual status of staff (e.g., non-redeemable contracts)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Provision of input/infrastructure</i>					
Planning and provision of necessary hospital infrastructure (e.g., vehicles, buildings)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

	Central gov't	Regional/ state gov't	Local gov't	Other (specify)	Notes*
Deciding on hospital infrastructure maintenance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Right to use outsourcing					
Determining which services can be outsourced (services obtained from outside providers, such as cleaning or meals) and choosing external providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Private hospitals (if any)					
Regulating private hospital activity (e.g. setting the rules for concessions and funding for private hospitals)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Granting concessions for opening of private hospitals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Determining the level and type of public funding for private hospitals (subsidies, other means of financial aid, e.g., tax exemption for providers)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hospital/health care district (if any)					
Managing hospital/health care districts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Determining the size of hospital/health care districts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

*If more than one box is ticked per row, please briefly describe – with an addendum or footnote – how the co-decision process (across levels of government) works in practice. Also, if policy settings vary across distinct sub-national jurisdictions or health care facilities, please add an explanation.

2. If you have ticked other, please specify the composition of this alternative institution, including any overlap between its public and private components.

Financing autonomy

1. **Please tick the boxes to indicate the level of government that is responsible for each policy or service area.** For areas of shared responsibilities across levels of government, please tick multiple boxes. If you tick 'other' please specify in question 4 below.

Which level of government is responsible for:	Central gov't	Regional/ state gov't	Local gov't	Other (specify)	Notes*
Contributions of users (fares, user fees, tariffs, co-payments, etc.) to hospital financing					
Designing and implementing a scale for user contributions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Differentiation of user contributions according to social situation of users (e.g. income, region, social status, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Compensation of staff					
Financing hospital staffs' salaries and benefits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Financing hospital staffs' pensions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Capital investment decisions					
Health facilities (hospitals, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Medical equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

*If more than one box is ticked per row, please briefly describe – with an addendum or footnote – how the co-decision process (across levels of government) works in practice. Also, if policy settings vary across distinct sub-national jurisdictions or health care facilities, please add an explanation.

2. If you have ticked other, please specify the composition of this alternative institution, including any overlap between its public and private components.
3. What share of total public health expenditure is channeled through all sub-national governments from national governments?
- a) 0% - 10%
- b) 11% - 30%
- c) 31% - 50%
- d) 51% - 100%
4. Does the sub-national government receive earmarked grants for the provision of hospital activity? If yes, how much are these grants (in per cent terms) of total sub-national expenditure for the hospital activity?
5. Is the sub-national government obliged to spend a certain fixed amount of the budget on investments (fixed ratio of capital to current expenditure)? If so, please

indicate the required ratio and briefly state which level of government determines it.

Monitoring and evaluation

1. **Please tick the boxes to indicate the level of government that is responsible for each policy or service area.** For areas of shared responsibilities across levels of government, please tick multiple boxes. If you tick 'other' please specify in question 9 below.

Which level of government is responsible for:	Central gov't	Regional/ state gov't	Local gov't	Other (specify)	Notes*
Evaluating conformity with general policy goals					
Monitoring of hospital service provision (does supply meet users' needs, is access for users from different regions or different social groups ensured?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Performance of hospital institution/providers					
Deciding on the performance measurements/indicators/targets of service institutions/providers (if any)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Carrying out performance measurement and implementing administrative incentives (sanctions/rewards) associated with performance results as evaluated against targets (if any)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Performance of staff					
Deciding whether performance assessment of staff must be used (if any)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Establishing performance incentives for staff and consequences for high/poor performance (if any)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

*If more than one box is ticked per row, please briefly describe – with an addendum or footnote – how the co-decision process (across levels of government) works in practice. Also, if policy settings vary across distinct sub-national jurisdictions or health care facilities, please add an explanation.

2. If you have ticked other, please specify the composition of this institution. The other category can include public ownership but not by a government body.
3. Does the central or sub-national government(s) examine whether decentralisation affects hospital or health care efficiency? Have any previous studies been completed?