Fiscal Sustainability of Health Systems
Bridging Health and Finance Perspectives

Chapter 4

Decentralisation of health financing and expenditure

by
Claudia Hulbert and Camila Vammalle*

In a majority of OECD countries, sub-national governments (SNGs) play some role in health-care spending. The allocation of health care expenditure between central, state and local levels has significant repercussions over the design, financing and sustainability of health care systems. This chapter gives an overview of health care decentralisation in OECD countries, and analyses the main differences in spending allocations between levels of government, as well as revenue distribution (taxes, transfers, etc.). It also focuses on recent reforms in OECD countries devolving further responsibilities for health expenditure to sub-national governments.

* Claudia Hulbert is a consultant and Camila Vammalle is with the OECD.

The statistical data for Israel are supplied by and under the responsibility of the relevant Israeli authorities. The use of such data by the OECD is without prejudice to the status of the Golan Heights, East Jerusalem and Israeli settlements in the West Bank under the terms of international law.

4.1. Introduction

In a majority of OECD countries, sub-national governments (SNGs) play some role in health care spending. The allocation of health care expenditure between central, state and local levels has significant repercussions over the design and financing of health care systems.

While such allocations may result from historical developments (for instance, federal countries typically assign a higher share of health care spending to SNGs), a trend towards greater decentralisation of health expenditure is under way in a number of OECD countries, often to alleviate fiscal pressure on central governments. Reforms to increase the size of territories to obtain greater efficiency in health expenditure have also been introduced recently in a number of countries.

The issue of the allocation of health expenditure between levels of governments and the organisation of tax and transfer systems financing sub-national health care services is therefore crucial in the light of recent reforms. While there is no consensus on an "ideal" system, international differences in health expenditure decentralisation, revenue distribution and related problems faced by governments can yield insightful comparisons.

This chapter gives an overview of health care decentralisation in OECD countries, and analyses the main differences in spending allocations between levels of government, as well as revenue distribution (taxes, transfers, etc.). It also focuses on recent reforms in OECD countries devolving further responsibilities for health expenditure to sub-national governments.

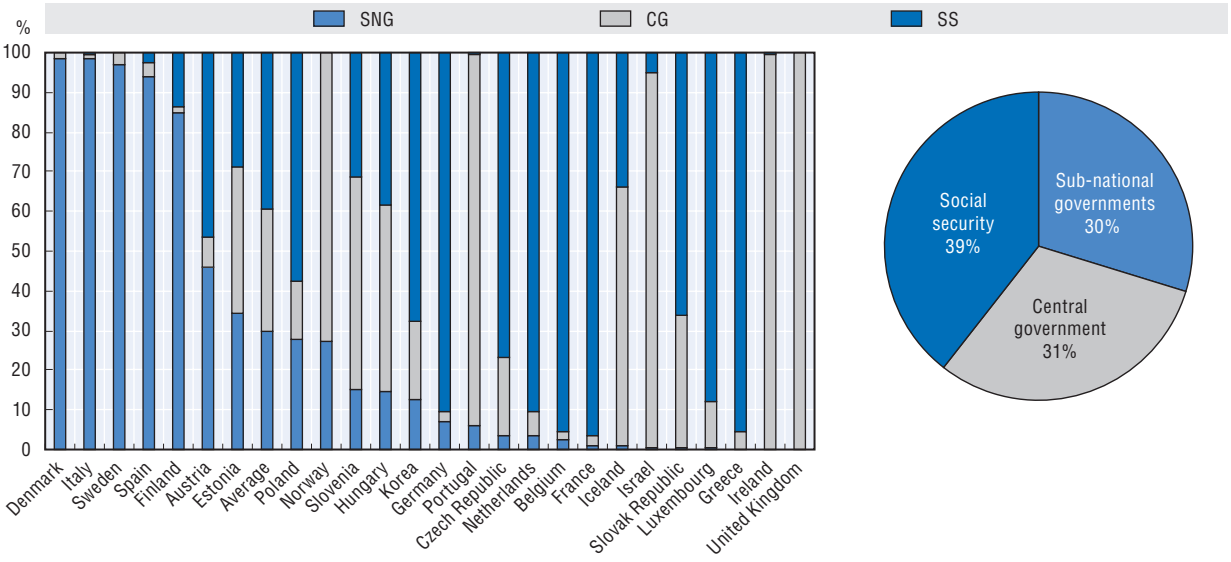
4.2. Role of sub-national governments in health care provision and financing

Sub-national governments are the main actors in health care spending in some decentralised countries (in particular in federal, quasi-federal and North European countries) (Figure 4.1).

A trend towards greater decentralisation of health care spending is under way in a significant number of OECD countries (Box 4.1), often to alleviate pressure faced by central governments' budgets. This additional devolution of responsibilities to sub-national governments is not always accompanied by an equivalent transfer of financial resources.

Increased decentralisation of health care expenditure and increasing health care costs have generated pressure on sub-national government budgets over the last decade. In many OECD countries, the share of sub-national government budget allocated to health care has increased significantly over 2000-11 (Figure 4.2). Such a trend may threaten sub-national governments' finances in the medium-to-long term, and generate difficulties in public service provision.

Figure 4.1. **Division of public health care spending between levels of government, 2012**



Note: Data for Austria and Korea are for 2011 instead of 2012. CG: Central government; SNG: Sub-national government.

Source: OECD National Accounts Statistics, http://dx.doi.org/10.1787/na-data-en.

StatLink http://dx.doi.org/10.1787/888933218812

Box 4.1. **Recent reforms towards greater decentralisation in health care spending in OECD countries**

Belgium passed a reform in 2012 granting to regions and communities more spending responsibilities for health care (hospital infrastructures, mental health services and preventive medicine). In parallel, the fiscal autonomy of sub-national governments is expected to be reinforced as transfers by the federal government are expected to be replaced by new autonomous revenues (the equalisation system will be maintained).

In the **Czech Republic**, central authorities, insurance companies and local health authorities are currently planning a reform in order to optimise the distribution of central, local and private funding, with the aim of generating savings in the health care sector.

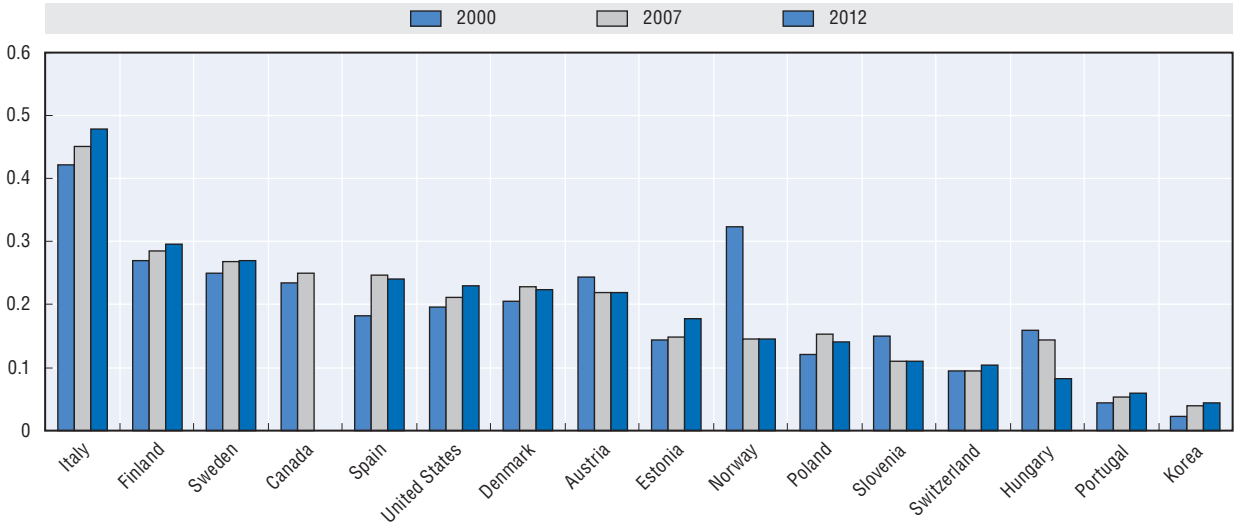
In **Greece**, in parallel to the Kallikratis reform (2011), a health care reform transferred some responsibilities to local governments relative to elderly care, health care and health prevention. Health and social care committees were introduced at the municipal and regional level. They are responsible for monitoring health care needs, making proposals for increasing efficiency and improving planning capacity. These committees were also given authority over spending control (over accountability and performance evaluations) (ASISP, 2011).

In **Finland**, significant reform of health care spending is under consideration (see Box 4.4).

In **the Netherlands**, central authorities decided to transfer some responsibilities to municipalities regarding health care and social expenditures. These transfers of responsibilities are not compensated by an equivalent transfer of revenues to local authorities. Sub-national governments will therefore have to reach efficiency gains from 5 to 30% (Dexia, 2012).

In **Norway**, municipalities were granted additional responsibilities for health care from January 2012. This reform was to rearrange the allocation of responsibilities between the central government and municipalities, and between primary and specialised health care services (ASISP, 2012).

Figure 4.2. **SNG health care expenditure as a share of total SNG expenditure, 2000-12**



SNG: Sub-national government.

Note: Data for Poland: 2002 instead of 2000. Switzerland: 2005 instead of 2000. Austria, Korea and the United States: 2011 instead of 2012. Canada: 2009 instead of 2012.

Source: OECD National Accounts Statistics, http://dx.doi.org/10.1787/na-data-en.

StatLink http://dx.doi.org/10.1787/888933218821

In addition to the widespread challenge of ageing populations, sub-national governments face an additional challenge compared to central governments. Indeed, they may be subject to faster changes in population, especially in countries with a high mobility of population. Some countries may also experience internal migrations of population, whereby people may not wish to retire in the same region as they have been working. These changes of population imply changes both in needs and in the financial capacity to pay for the services. For instance, in Japan the rapidly-ageing population is seen as a major challenge to the sustainability of municipal health care spending. Municipalities in Japan are responsible for the National Health Insurance, one of the major health insurance schemes in the nation. As aged citizens may be concentrated in specific areas (in particular rural), and as the shrinking population creates a significant pressure on tax bases, financing health expenditure is a major challenge for some municipalities. Japan decided to increase its VAT rate in 2013. All revenues generated by this rate increase will fund expenditures on health care, long-term care, child care and pensions, of which around half will be used for enhancing the current social security system and the remainder for reducing the deficit financing of current social security expenditures. As Japanese provinces and municipalities are major actors in these areas and will benefit from these additional revenues, sub-national spending should increase significantly.

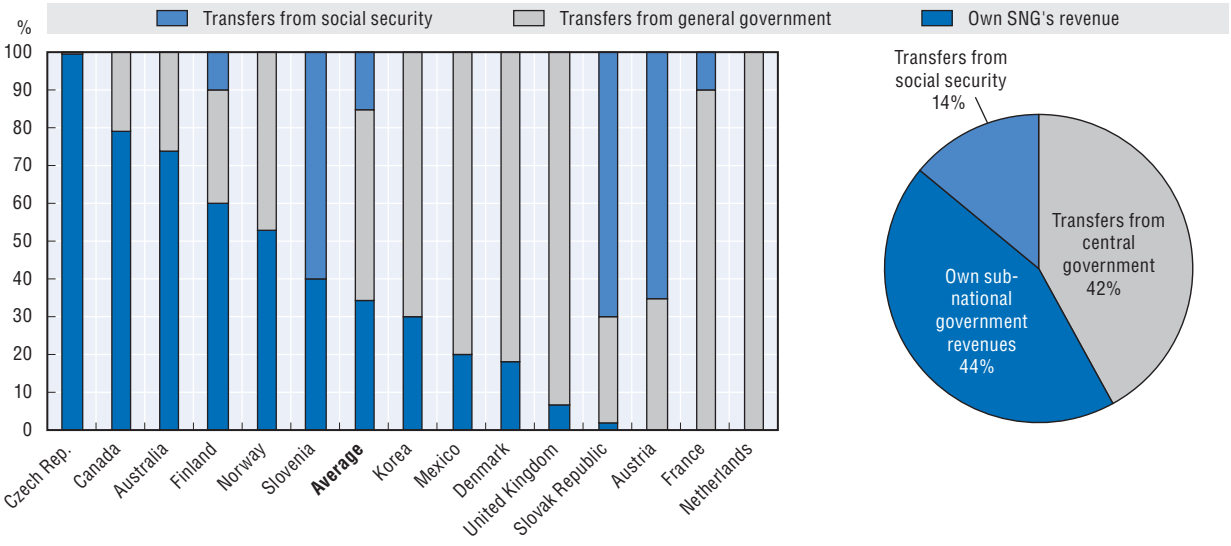
4.3. Overview of sub-national revenues for funding health care expenditures

Composition of sub-national government revenues for health

In most OECD countries, sub-national governments rely both on transfers from central authorities and on own revenues to finance health care expenditure (Figure 4.3). However, the share of these two main sources of revenue varies widely between countries. At both ends of the spectrum, sub-national governments in the Netherlands rely exclusively on

transfers, while in Switzerland, more than 90% of spending is funded by own revenues. In a few OECD countries, sub-national governments also receive transfers from social security bodies to finance health care spending (Austria, Finland, Slovak Republic and Slovenia).

Figure 4.3. **Sources of revenues financing SNG health expenditure**



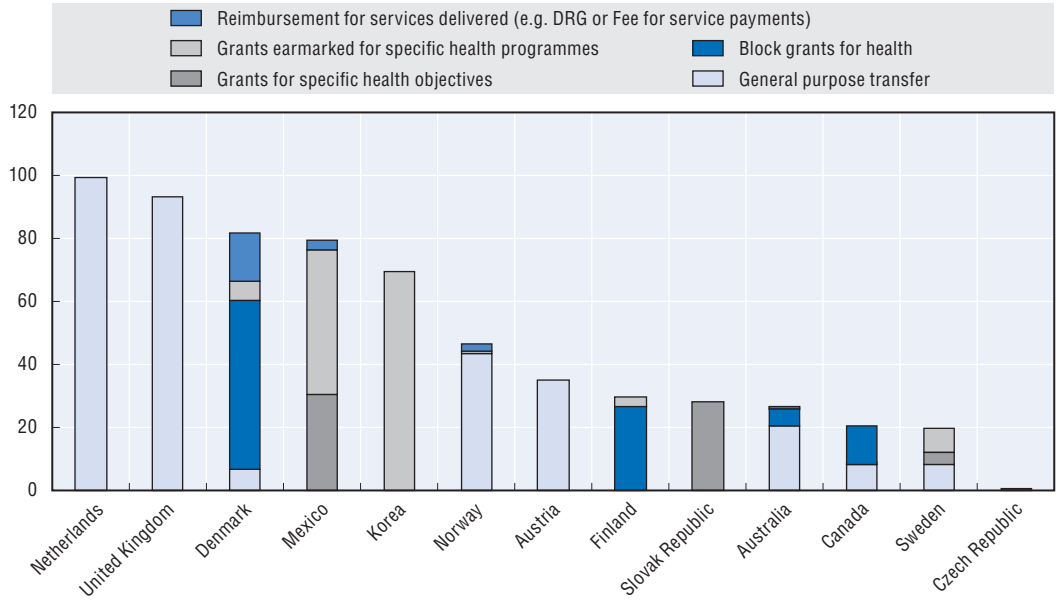
SNG: Sub-national government.
Note: In Switzerland (not shown), more than 90% of sub-national spending is funded by own revenues.
Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 14.

StatLink http://dx.doi.org/10.1787/888933218832

Most transfers from central authorities are general-purpose, i.e. non earmarked (Figure 4.4). In such systems, sub-national governments have a high degree of autonomy over the use of funds to finance their health care expenditure. In parallel, Korea, Mexico and Sweden rely to a large extent on transfers earmarked for specific health programmes, hence limiting sub-national government spending autonomy and/or focusing resources on governments' priorities.

General purpose transfers give sub-national governments the most room for manoeuvre on how to spend the money (they represent the largest share of transfers in Australia, Austria, Notway and the United Kingdom) (Figure 4.4). These are contained quite frequently in the composition of sub-national government resources allocated to health. Block grants for health also provide spending autonomy, as their only conditionality is to be spent within the health sector respecting the general policy framework, leaving sub-national governments free to determine specifically how. These are mainly used in Canada, Denmark and Finland. In Canada, for example, provinces and territories are free to decide how to spend the amounts received from the Canadian Health Transfer, as long as they respect the conditions specified in the Canada Health Act (universality, portability, accessibility, public administration and comprehensiveness, and the prohibition of extra-billing and user charges). Grants may also be attached to specific health objectives (Mexico, Netherlands and the Slovak Republic). The highest degree of control from central governments over spending decisions is financing through grants earmarked for specific health programmes (Korea and Mexico).

Figure 4.4. **Composition of transfers from central authorities as a share of total SNG health care spending**



SNG: Sub-national government.

Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 15.

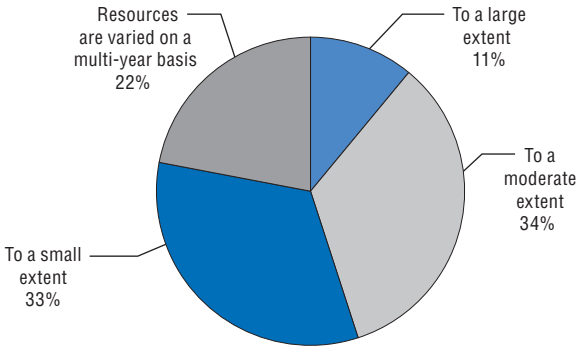
StatLink http://dx.doi.org/10.1787/888933218848

Stability and predictability of sub-national government revenues for health

The ability of central authorities to modify sub-national health care resources from one year to another is critical for the stability of health care policies and of sub-national government finances. In countries where sub-national governments play a major role in health care expenditure, the degree of central government discretion over such funding is typically limited – central authorities may only modify resources on a multi-year basis, or have a limited capacity to vary resources from year to year (Denmark, Finland, Italy, Switzerland, etc.) (Figure 4.5). In Austria, funds collected by the central government are automatically transferred to the state governments according to multi-annual regulations governing the financing of state and local governments (including financing for hospitals). The funds collected by the autonomous social security system are distributed by the system and cannot be checked or influenced by the government. In contrast, central governments in some countries may significantly modify resources allocated to sub-national government spending from one year to another. In the Czech Republic, this concerns only 0.2% of SNG health expenditure and corresponds to subsidies from the central government, excluding EU financial support. In addition, sub-national governments only play a minor role in health care spending.

In most cases, variations in resources transferred to sub-national governments are decided unilaterally by central authorities or social security bodies (Figure 4.6). In Australia, Chile, Denmark and Slovenia, negotiations to change the formula are necessary to modify sub-national government revenues for health care. In most federal countries, such a modification is not possible without reaching an agreement between levels of governments and/or waiting for the next statutory date to modify the existing formula.

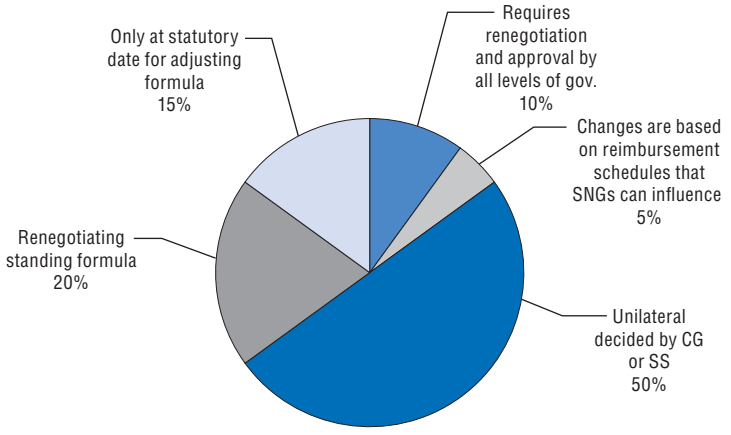
Figure 4.5. **To what extent can the central government or social security authority vary total resources transferred to SNGs for health from one year to the next?**



Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 16.

StatLink http://dx.doi.org/10.1787/888933218852

Figure 4.6. **What is the procedure for the central government or social security authority to vary total resources transferred?**



Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 17.

StatLink http://dx.doi.org/10.1787/888933218863

Responsibility of last resort for financing health expenditure

In 40% of surveyed countries, central governments are ultimately responsible for funding health care expenditures (Chile, Denmark, France, Hungary, Italy, Japan, Korea and Netherlands). Usually, in countries where sub-national governments play the largest role in financing health care, central governments are not explicitly ultimately responsible for financing health (Australia, Austria, Canada, Finland, Mexico, Sweden and Switzerland). As health is such a visible, high-priority expenditure for citizens, it is questionable whether the central government would not step in when a sub-national government cannot finance the health services for which it is responsible. But the fact that there is no legal obligation to do so probably reduces moral hazard. The "blame game" between levels of government for problems in the provision of health care services is a frequent occurrence in countries where sub-national governments play an important role in health provision.

4.4. Policy setting and control over sub-national health care expenditures

In a large majority of surveyed countries, the Ministry of Health is primarily responsible for establishing the policy framework for sub-national governments (Question 18). Other policy-setting bodies include the central budget authority (Italy), the executive (Australia) and the Parliament (Czech Republic, Germany, Hungary and Switzerland). Only in Canada (provinces) and the United Kingdom (devolved administrations) are sub-national governments responsible for setting their own health policy framework.

This control of central authorities over policy setting in the health sector is hence widespread throughout OECD countries. A number of countries consider that the responsibility of the Ministry of Finance is to manage overall public expenditure. Ultimately, most central governments will be held responsible for health-related services, as well as for the financial sustainability of sub-national authorities if they are threatened by increasing health expenditures.

Central governments often set spending targets for health to be met by sub-national governments to ensure compliance with national objectives and monitor aggregate public spending (Table 4.1). These targets may be part of a more general framework of expenditure ceilings for sub-national governments (for example, in the case of Denmark). Other countries have introduced temporary ceilings to limit health care spending within the framework of recent consolidation plans. In Austria, the 2012 health care reform was undertaken to enhance co-ordination among the federal government, provinces and social security bodies in order to achieve greater efficiency in spending. The federal and sub-national governments agreed to limit health care expenditure: until 2016, spending should not exceed the nominal GDP growth and from 2016 onwards it should not exceed 3.6% (OECD, 2013).

In some cases, sub-national governments themselves introduce targets to limit health expenditures. This is the case, for instance, in Canada where the province of Ontario announced that it would cap growth in health care spending at 2.1% a year over 2013-15, and the province's 2013-14 budget forecast an increase of 2.0% for 2012-13 to 2015-16.

The use of performance targets for sub-national governments seems to be widespread among OECD countries, with over half of the surveyed countries using such targets (Table 4.1). In comparison, requiring sub-national governments to carry out output or outcome measures or value-for-money analyses is not as common (even in countries where sub-national governments are major players in health care provision and financing) (Figure 4.7). In some countries, central governments may take drastic actions regarding non-efficient health care services. For instance, in Poland in 2013 municipalities were forced to privatise hospitals that were losing money. This decision came as part of a large-scale trend towards privatisation of the Polish health care system.

Table 4.1. **Central governments set targets for health spending by SNGs**

Yes	No
Australia	Canada
Austria	Chile
Denmark	Czech Republic

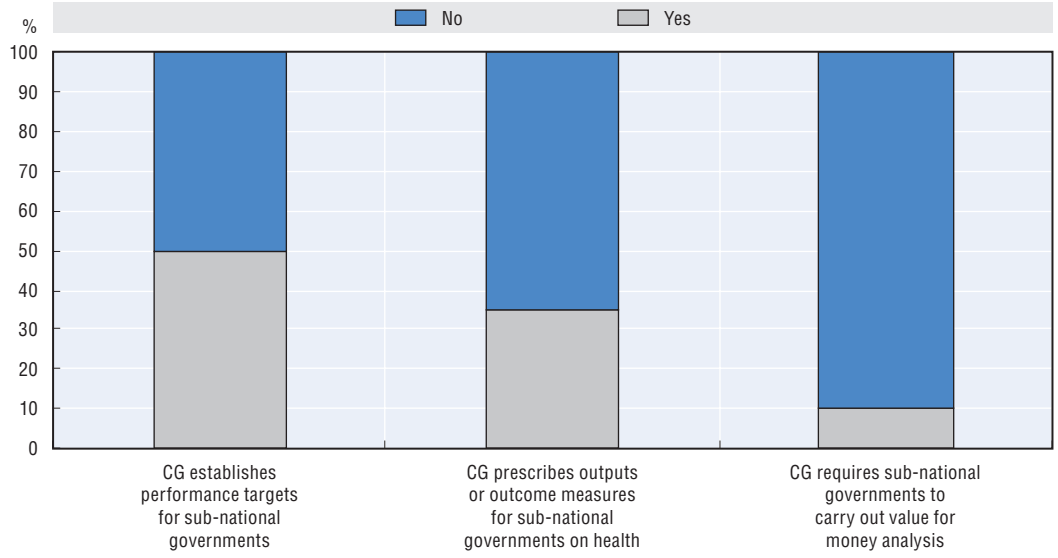
Table 4.1. **Central governments set targets for health spending by SNGs** *(cont.)*

Yes	No
Finland	Hungary
France	Norway
Italy	Switzerland
Japan	Sweden
Korea	United Kingdom
Mexico	
Netherlands	
Slovak Republic	
Slovenia	

SNGs: Sub-national governments.

Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 19.

Figure 4.7. **Central government monitoring of sub-national government performance for health expenditure**

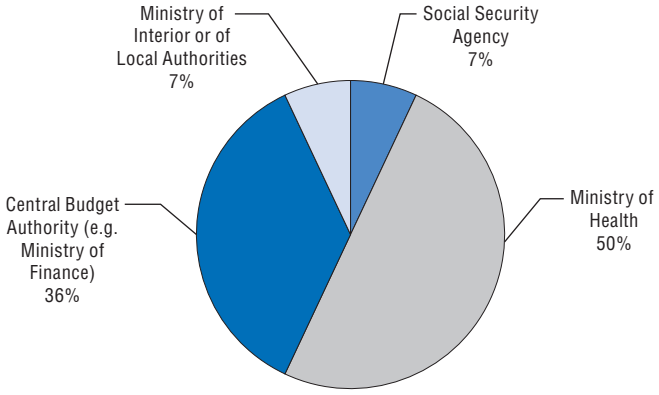


Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 19.

StatLink http://dx.doi.org/10.1787/888933218877

It is often the Ministry of Health which is responsible for controlling sub-national health care expenditure (Figure 4.8) (Finland, France, Hungary, Japan, Korea, Netherlands and Slovak Republic). The central budget authority is responsible for supervising sub-national government health expenditure in 36% of the cases (Czech Republic, Denmark, France, Italy and Sweden). The social security agency is responsible for such control only in Slovenia.

Figure 4.8. **Institutions in charge of controlling SNG health care spending**



SNG: Sub-national government.

Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 20.

StatLink http://dx.doi.org/10.1787/888933218885

4.5. Specific challenges in controlling health expenditure in decentralised settings

Challenges in controlling public health expenditure are different in centralised and in decentralised countries. Some countries find it easier to control costs when health is financed and provided by sub-national governments (Box 4.2). Citizens in most countries tend to ignore the allocation of responsibilities between levels of government and usually complain direct to the central government Ministry of Health when there is a problem – therefore, local governments do not bear the full political cost of unpopular decisions. Other countries, on the other hand, may find control more difficult as it increases the number of stakeholders and softens budget constraints. For instance, facing low efficiency of health care expenditure, geographical variations in the quality of health services, duplication of services and high deficits, Norway decided to re-centralise its specialised health care system in 2002 (Box 4.3). A challenge may also arise if the reporting of health care expenditure from sub-national governments to central authorities is not prompt.

The size of sub-national governments is not always optimal for the provision of health services. In Sweden, for example, there are 21 county councils; but studies show that six would be more efficient (Blomqvist and Bergman, 2007). Reducing the number of sub-national governments is politically difficult – and sometimes constitutionally or historically impossible, in particular in federal countries where states/Lander pre-existed the federation (Austria, for instance). Denmark successfully merged municipalities in 2007, reducing the total number to 100 from 300 and the number of councils to 5 from 14. One of the main drivers of this reform was to reach a more adequate size for health care service provision. The reform was implemented in parallel to the Health Act of 2007. New medical technologies in Denmark increased specialisation and called for larger regions (OECD, 2012). These problems had already led to hospital reform in the region of Copenhagen, when several small municipalities merged their hospitals to provide better service. Finland

has also been implementing a gradual reform of its health care system since 2007 (Box 4.4). In March 2014, it reached an initial political agreement to take health and welfare services away from municipalities and give the responsibility for them to five regions. The reform is still under negotiation at the time of writing and details are not available.

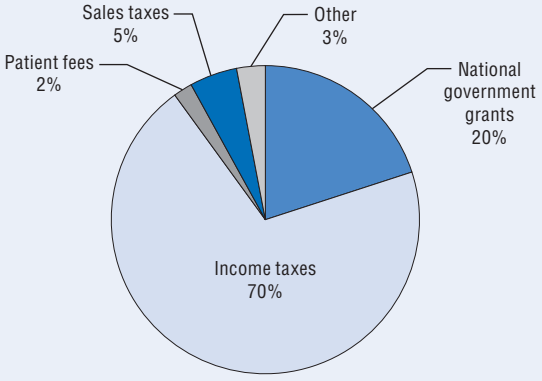
Box 4.2. **Controlling health care expenditure in decentralised frameworks: The case of Sweden**

The Swedish health care system ranks amongst the most decentralised health care systems of OECD countries, with sub-national governments responsible for 80% of public health expenditure. Sweden is also one of the OECD countries with below-average growth in health expenditure during the period 2000-09. The decentralised framework is perceived as helping to control health care expenditure growth.

The Swedish health care system is organised into three levels: national, regional (county councils) and local. The central government is responsible for the overall health care policy. County councils are responsible for funding and providing health care services to their population, while municipalities are in charge of long-term care for elderly and disabled people. The Health and Medical Services Act gives county councils and municipalities considerable freedom with regard to the organisation of their health services.

Eighty per cent of health care expenditure by sub-national governments is covered by their own revenues (income taxes, patient fees and sales taxes) Both the county councils and the municipalities levy proportional income taxes to cover services that they provide. They also generate income through user charges. The central government provides funding for prescription drug subsidies and financial support to county councils and municipalities through grants allocated using a risk-adjusted capitation formula. It may also provide one-off grants to focus on specific problem areas such as geographical inequalities in access to health care.

Figure 4.9. **Health care resources for county councils, Sweden, 2011**



Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013.

StatLink http://dx.doi.org/10.1787/888933218890

Since 2000, the county councils and municipalities have been required to balance their budgets (a deficit should be compensated for within three years). This implies that an increase in health care expenditure in a given year requires a similar decrease in other spending or an increase in the tax burden that year. This gives great incentives to sub-national governments and citizens to control health care expenditure growth.

Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013.

Box 4.3. **Re-centralisation of specialised health care services in Norway in 2002**

Norway was characterised by highly decentralised health care spending over 1980-2002. During that period, counties were responsible for funding specialised health care services and municipalities were responsible for primary health services. The central government retained authority regarding supervision, control and planning.

However, a number of concerns arose and led ultimately to services being returned to the central government. First, the decentralised system had led to large geographic variations across counties/municipalities for health care services. Secondly, competition for capacity between counties produced excess capacity and duplication of services. Finally, this system introduced a soft budget constraint, large deficits and a "blame game" between counties and the central government.

To alleviate these issues, Norway decided in 2002 to re-centralise specialised health care services. The provision of services was organised into five "regional health enterprises" (RHE) and funding was set as a combination of block and earmarked grants to the RHE.

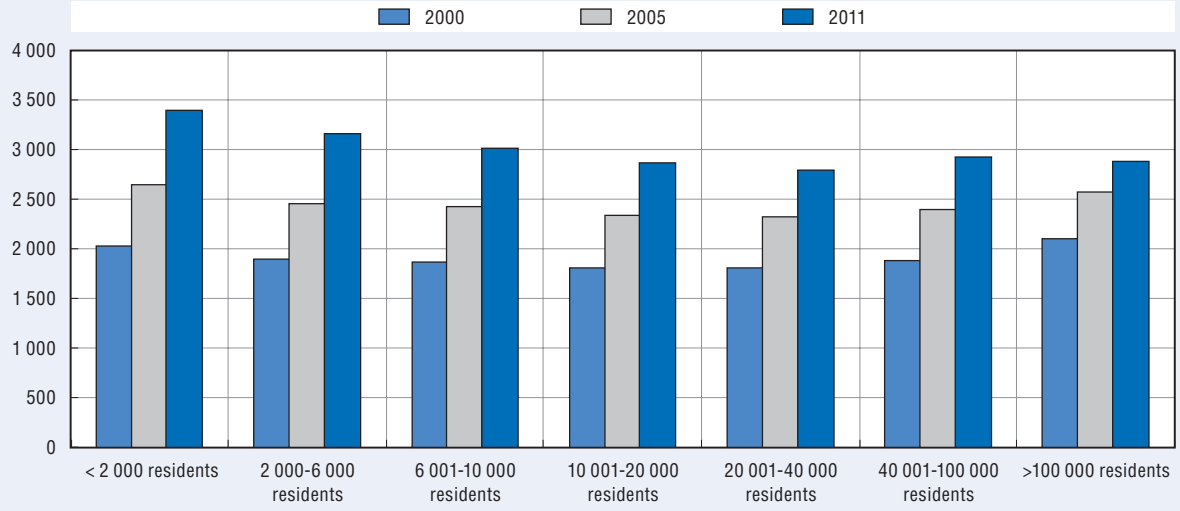
Source: Magnussen, J. (2009), "Healthcare in Norway: Re-centralisation with a Twist", AcademyHealth, Washington, DC, *www.academyhealth.org/files/2009/monday/magnussen.pdf*.

Box 4.4. **Reform of health care in Finland**

Municipalities are key actors of health care expenditure in Finland and spending in this area has increased steadily over the last decade. Growth in spending per inhabitant has been particularly strong in smaller municipalities (see Figure 4.10).

Figure 4.10. **Evolution of social and health care services in Finnish municipalities**

Net expenditures, EUR/resident, base year 2005



Source: OECD questionnaire (Directorate for Public Governance and Territorial Development) and OECD calculations.

StatLink http://dx.doi.org/10.1787/888933218909

In 2007, a first reform to achieve greater efficiency was carried out through municipal mergers (PARAS reform). With a similar objective, the Finnish government is currently discussing a new reform in which municipalities were being strongly encouraged to merge and to provide merger plans before July 2014, for mergers to be implemented between 2015 and 2017.

Box 4.4. **Reform of health care in Finland** *(cont.)*

In parallel, an agreement between the government and opposition parties was reached in late March 2014 on a major reform of the health care system. New regions are to be introduced on 1 January 2017 and will be run by a joint municipal authority.

The reform aims at delivering health care services on a larger scale through the creation of five "social welfare and health care regions". Services will be provided by these large regions instead of by municipalities. The concentration of health care services in larger organisations is to close efficiency gaps between specialised care units, make a more efficient use of information technologies and labour division, and introduce more efficient control at the national level, in particular regarding the strategic development of future health care policies. Some service provision will remain at the municipal level, in particular for every-day services. However these services will be organised by the five large regions.

The funding on the "social welfare and health care regions" will be provided by the municipalities, weighted according to each municipality's population. Moreover, in order to achieve fair funding, the population will be weighted by demographic structure and morbidity.

Source: Finnish Ministry of Social Affairs and Health, Helsinki.

4.6. Conclusion

Sub-national governments are responsible on average for 30% of health care expenditure in OECD countries, and this share reaches over 90% in some federal, quasi-federal and northern European countries (Denmark, Italy, Switzerland, Spain and Finland).

While some of the most efficient health care systems rely heavily on SNGs, decentralisation may introduce geographical differences in service provision, soften SNG budget constraints (as the central government may, at least implicitly, be responsible for bailouts) and induce excess capacity. Efficient, decentralised systems typically allocate precise responsibilities to each level of government in order to avoid duplication of services, and they may rely on sub-national fiscal rules to alleviate moral hazard behaviours.

The issue of the optimal size for health service provision in a decentralised context has been much discussed over recent years and was at the heart of Denmark's territorial reform in 2007. In a similar way, Finland plans to decrease the number of regions responsible for health expenditure in the years to come, and studies show that a similar reform in Sweden may significantly increase performance. However, large territorial reforms may be politically costly and more time may be needed to assess their impact on health spending efficiency.

There seems to exist no clear link between decentralisation of health expenditure and the composition of SNG revenues (i.e. distribution of sub-national revenues between taxes, transfers, etc.). However, countries in which SNGs are major actors in health expenditure typically protect sub-national governments from large variations in revenues from one year to another by making changes possible only on a multi-year basis or through the indexation of revenues to specific formulae.

References

ASISP – Analytical Support on the Socio-economic Impact of Social Protection Reforms (Europe) (2012), *Annual Report 2012, Pensions, Health Care and Long-Time Care, Norway*, European Commission.

ASISP (2011), *Annual Report 2011, Pensions, Health Care and Long-Time Care, Greece*, European Commission.

Blomqvist, P. and P. Bergman (2007), "Does Regionalisation of Nordic Health Care Systems Make Them Less Democratic? An Empirical Test of the Swedish Case", Uppsala University Working Paper No. 4, Sweden.

Dexia and CCRE – Conseil des Communes et Régions d'Europe (2012), *Les Finances publiques territoriales dans l'Union européenne*, 11th edition, July, *www.eetaa.gr/enimeroseis/17-01-13/Note_CCRE_Dexia_FR.pdf*.

Magnussen, J. (2009), *Health Care in Norway: Re-centralisation with a Twist*, *www.academyhealth.org/files/2009/monday/magnussen.pdf*.

OECD (2013), *Budgeting Practices and Procedures in OECD Countries*, OECD Publishing, Paris, *http://dx.doi.org/10.1787/9789264059696-en*.

OECD (2012), *Reforming Fiscal Federalism and Local Government: Beyond the Zero-Sum Game*, OECD Fiscal Federalism Studies, OECD Publishing, Paris, *http://dx.doi.org/10.1787/9789264119970-en*.