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Decentralisation and performance measurement systems in healthcare

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Abstract

Decentralisation and performance measurement systems in health care

Based on an OECD survey, this paper presents quantitative and qualitative data on the decentralisation of health systems, focusing on how they vary according to different institutional characteristics and what types of performance measurement systems are used in the health sector. Decision-making in health care tends to rest largely with the central government, which has considerable power across many aspects of the delivery of health services. However, sub-national governments have more control over decisions regarding the inputs, outputs and monitoring of health care services. The majority of OECD countries tends to rely on centralised performance measurement systems, especially to monitor the performance of hospital providers, focusing more on improving performance rather than reducing service costs. Less likely to be monitored under a specific performance framework are providers of ancillary services, retailers and other providers of medical goods, and providers of preventive care.

Keywords: Health systems, performance monitoring, intergovernmental relations

JEL classification: H75, I18, O43

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Résumé

Décentralisation des systèmes de santé et mesure des résultats

À partir d'une étude de l'OCDE, ce document présente des données quantitatives et qualitatives sur la décentralisation des systèmes de santé, en s'attachant à montrer combien ils diffèrent en fonction de leurs spécificités institutionnelles et de la typologie des systèmes de mesure de résultats utilisés dans le secteur. Il semble que la prise de décision en matière de santé soit largement du ressort de l'administration centrale, qui détient un pouvoir considérable sur de nombreux aspects de la prestation des services de santé. Pour autant, les administrations infranationales disposent d'un plus grand pouvoir de contrôle sur les décisions relatives aux moyens mis en œuvre, aux réalisations et au suivi des performances des services de santé. La majorité des pays de l'OCDE s'en remettent à des systèmes de mesure de résultats centralisés, en particulier pour suivre les performances des prestataires hospitaliers, en s'attachant moins à réduire le coût des services qu'à améliorer leurs résultats. Les prestataires de services auxiliaires, les détaillants et autres fournisseurs de biens médicaux, et les prestataires de soins préventifs sont, quant à eux, moins susceptibles de faire l'objet d'un suivi de leurs performances selon un cadre de mesure leur étant propre.

Mots-clés : Systèmes de santé, suivi de performances, relations inter-administrations.

Classement JEL : H75, I18, O43

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Decentralisation and performance measurement systems in health care

By Ivor Beazley, Sean Dougherty, Chris James, Caroline Penn, Leah Phillips[1]

1. Introduction and main findings

1. The trend towards the decentralisation of government and the ensuing dispersion of power has resulted in many sub-national governments across OECD and partner countries being responsible for the delivery and financing of health services. Improving the performance of such a core public good is a top priority for governments, in order to increase productivity, cost effectiveness, access and service quality in the health sector. Furthermore, OECD countries are increasingly recognising 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.

2. Most central governments still see it as their role to ensure health services are delivered efficiently and equitably, due to a range of economic, social and financial reasons. The central government is in a unique position, which generally allows it to monitor the health of all citizens no matter where they live, and benefit from the positive externalities that high quality health care and healthy communities bring to society and public budgets. In this context, 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. There are many different types of government systems to monitor performance across OECD countries, and these performance frameworks and mechanisms play an important role in bolstering productivity of the health sector across countries.

3. This paper builds on a preliminary literature review that was presented at the 2017 meeting of the Network on Fiscal Relations across Levels of Government (Phillips, 2018[1]). The main aim of this paper is to summarise the results of a recent OECD questionnaire on responsibilities and performance systems in the health care sector. For the most part, 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 from both ministries of finance and health.

4. This paper has two main sections. The first section presents quantitative and qualitative data on the decentralisation of health systems, focusing on how this varies according to different institutional characteristics. The second section summarises performance measurement systems in the health sector across OECD and partner countries that participated in the survey. Although there is no perfect performance measurement system, the paper provides some key insights on the commonly applied institutional structures when monitoring or measuring the performance of service delivery, as well as obstacles to implementing such systems. The questionnaire on performance measurement systems in the health sector and responsibilities across levels of government is included in Annex A.

1. This paper was prepared for the OECD Network on Fiscal Relations across Levels of Government, and presented at the 2018 Annual Meeting (19-20 November). The authors are grateful to Francesca Colombo, Peter Hoeller, Valerie Paris and Wojciech Zielinski from the OECD Secretariat and Fiscal Network delegates for their useful comments. The paper builds upon collaborative work conducted with the OECD Joint Network of Senior Budget and Health Officials.

5. Conditional on the incomplete sample of participating countries, the main trends from the survey results are:

- Decision-making in health care tends to rest largely with the central government, 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 have less control over decisions regarding the inputs, outputs and monitoring of health care services. In most countries, sub-national governments have large responsibility for input-related matters, such as determining the outsourcing of services and deciding on the contractual status of staff. On average, local governments have little decision-making power in the health sector, but have the most responsibility with regard to decisions about health care inputs.
- The role of the central governments in health care does not vary markedly between federal and unitary countries. However, sub-national government decision-making power tends to be higher in federal than in unitary countries.
- The majority of OECD countries tends to rely on centralised performance measurement systems, especially to monitor the performance of hospital providers. Systems vary markedly between countries, although some trends across countries exist, including the observation that health performance systems are generally more geared towards improving performance rather than reducing service costs.
- Less likely to be monitored under a specific performance framework are providers of ancillary services, retailers and other providers of medical goods, and providers of preventive care. Common reasons for the non-establishment of performance systems in these sectors, and in general, include a lack of capacity at the national level, a lack of available data and challenges to co-ordinate actors.

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 government officials from ministries of finance and health who are directly engaged in drawing up their country's budget for health care.

2.1. Background and definitions

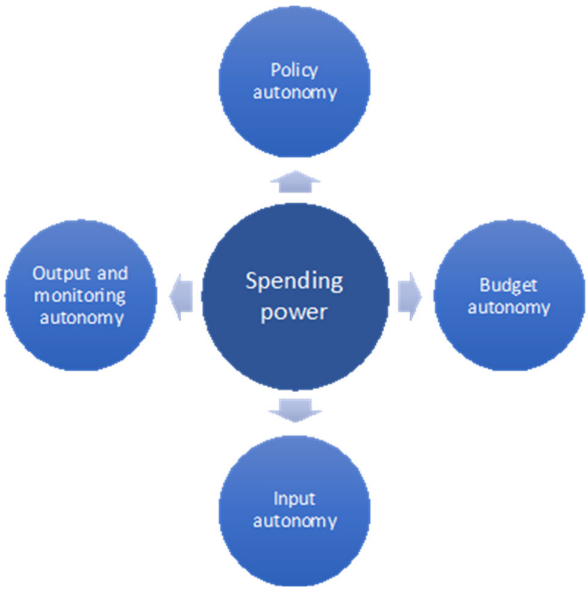
7. Governments play a critical role in providing health care and other public services (Lau, Lonti and Schultz, 2017[2]). Often, sub-national governments are responsible for delivering health services, or central governments delegate this responsibility to sub-national actors. In the survey, sub-national governments are defined as sub-central levels of government. Regional governments include 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. These can include deciding how services are organised, the allocation of funds, the level and quality of inputs and outputs, and the measurement and monitoring of service delivery. 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.

Figure 1. Classification of spending power



Source: Adapted from Bach et al. (2009).

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-makers. These dimensions are shown in Figure 1 (Bach, Blöchliger and Wallau, 2009[3]).

- *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 have devices to monitor and evaluate standards, such as benchmarking?

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[1]; OECD, 2018[4]). The classification of countries into federal and unitary is shown in Table 1.

Table 1. The classification of 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), Sub-national Governments around the World: Structure and Finance.

13. The health sector was disaggregated by the OECD's classification of six primary health care providers. The categorisation of health care providers is hospitals; residential long-term care facilities; providers of ambulatory health care; providers of ancillary services; retailers and other providers of medical goods; and providers of preventive care. More information on the categorisation of health care providers can be found in the System of Health Accounts 2011 (OECD/Eurostat/WHO, 2017[5]).

14. The second part of the questionnaire covered national performance measurement systems. The questionnaire was concerned with national government performance measurement systems, rather than systems used or established solely by sub-national governments to assess their own performance.

15. A performance measurement system is defined as the systematic collection of information or data that is then used to monitor, analyse and manage health care services. The motives for performance measurement systems and the information collected differs between countries and health care areas – some performance measurement systems focus on efficiency or productivity, whereas others provide a broader view of service delivery, measuring quality and equity of service delivery and boosting transparency and accountability. Still others focus on the use of performance information to improve management of health care services and to improve alignment between budget allocations and policy priorities. Some examples of performance measurement systems that the survey was aimed at, include systems that:

- Monitor access to different services across geographical areas of the population, or access by specific target groups;
- aim to measure and compare costs or outputs of goods/services/materials across providers of sub-national governments; or

- measure performance through qualitative mechanisms in the form of formal external inspections to ensure providers are meeting minimum national standards; surveys on user experience; and/or league tables that rank specific providers.

2.2. Scope of questionnaire and responses

16. 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.

17. The second part of the questionnaire covered national performance measurement systems, and was further split into two sections. Section 1 asked respondents to provide detailed information about performance measurement systems across the health care sector that have been implemented by the national government, based on the OECD/Eurostat/WHO categorisation of health care providers. Examples of survey questions include the objectives of the system, the usefulness of different performance measurement practices, how the measurement system affected policy decisions at the national level, and potential consequences of the system for sub-national authorities and service providers. Section 2 included questions on health care providers that were not covered under a national government performance measurement system, in order to understand the main obstacles of introducing such a system.

18. 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 December 2018. Twenty-four OECD countries and three partner countries responded to the survey in full and Austria, Ireland, Israel, Turkey, and Argentina completed the first Part of the survey.

19. Countries were encouraged to provide information on all performance measurement systems that are used to monitor health care providers. For most countries, a single performance measurement system covered multiple health providers. Thirty-three responses from 23 countries provided details on existing national performance measurement systems, as shown in Table 2 below.

20. Australia, Japan and Norway provided two separate performance measurement systems; Luxembourg provided details on three performance measurement systems; and Chile provided details on four performance measurement systems. The Netherlands provided three separate responses to Part 2 from each organisation that is involved in performance measurement, reflecting the healthcare structure in the Netherlands. Every question in Part 2 was first filled in by the central government and later checked by the respective organisation to ensure the validity of the answers.

21. The Czech Republic, Germany, Iceland and Malta stated that there were no national performance measurement systems currently in place.

Table 2. Questionnaire responses

	Part 1: Responsibilities across levels of government	Part 2: Details on performance measurement systems
Australia	X	XX
Austria	X	
Belgium	X	X
Canada	X	X
Chile	X	XXXX
Czech Republic	X	
Denmark	X	X
Estonia	X	X
Finland	X	X
Germany	X	
Greece	X	X
Iceland	X	
Ireland	X	
Israel	X	
Italy	X	X
Japan	X	XX
Latvia	X	X
Lithuania	X	X
Luxembourg	X	XXX
Mexico	X	X
Netherlands	X	XXX
New Zealand	X	X
Norway	X	XX
Poland	X	X
Slovenia	X	X
Spain	X	X
Switzerland	X	X
Turkey	X	
United Kingdom	X	X
Argentina	X	
Kazakhstan	X	X
Malta	X	

Note: Multiple crosses implies that a country provided multiple answers.

2.3. Further uses of the survey data

22. The data provided through Part 1 of the questionnaire is being used for another quantitative study, which will link institutional indicators to health system and hospital-level performance data (which have been compiled in a parallel effort) to examine arrangements that are most likely to promote efficiency. The first effort in this direction was issued as Dougherty et al. (2019[6]), which finds a non-linear relationship between decentralisation and public spending as well as quality-of-life outcomes: a moderate degree of decentralisation reduces expenditure and raises life expectancy, "excess" decentralisation tends to reverse both outcomes, raising expenditure and lowering life expectancy.

23. These data are also presented in a parallel paper Dougherty and Phillips (2019[7]) that covers four other public service areas (education, aged care, transport and housing). It aims to provide a preliminary, quantitative indication of the spending power by sub-national governments across each sector, based on a detailed assessment of the institutional, regulatory and administrative control sub-central governments exert over various policy areas. The paper aims to up-date and broaden a previous pilot project for the Fiscal Network on spending power (Bach, Blöchliger and Wallau, 2009[3]).

3. Spending and institutional characteristics in health care

3.1. Organisation of health financing and coverage arrangements

24. 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.

25. Table 3 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. Main source of basic health coverage across OECD and other surveyed countries

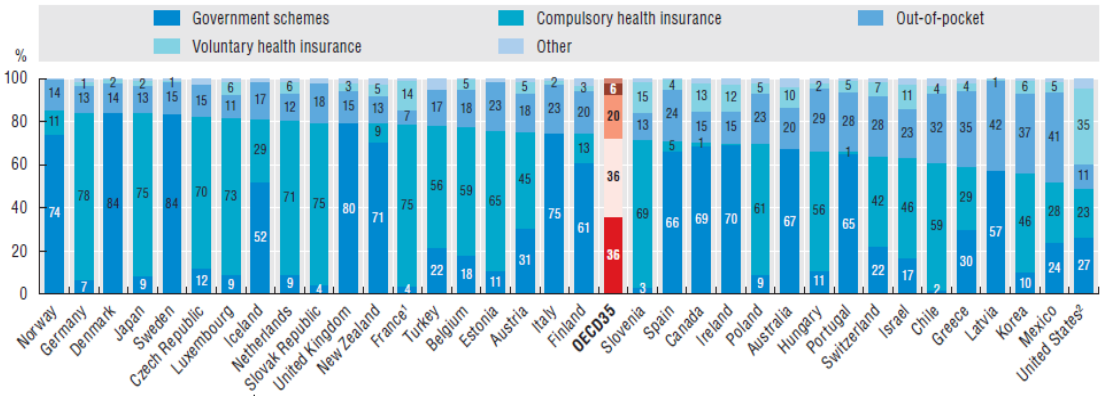
National health system (including those with distinct localised services)	Australia, Canada, Denmark, Finland, Iceland, Ireland, Italy, Latvia, New Zealand, Norway, Portugal, Spain, Sweden, United Kingdom
Single health insurance fund (single payer)	Estonia, France, Greece, Hungary, Korea, Lithuania, 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.

26. Government schemes and compulsory health insurance (whether organised as single or multiple funds) together accounted for almost three-quarters of all health care spending on average across the OECD (OECD, 2017[8]), shown in Figure 2 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 2. Health expenditure by type of financing

2015 (or nearest year)



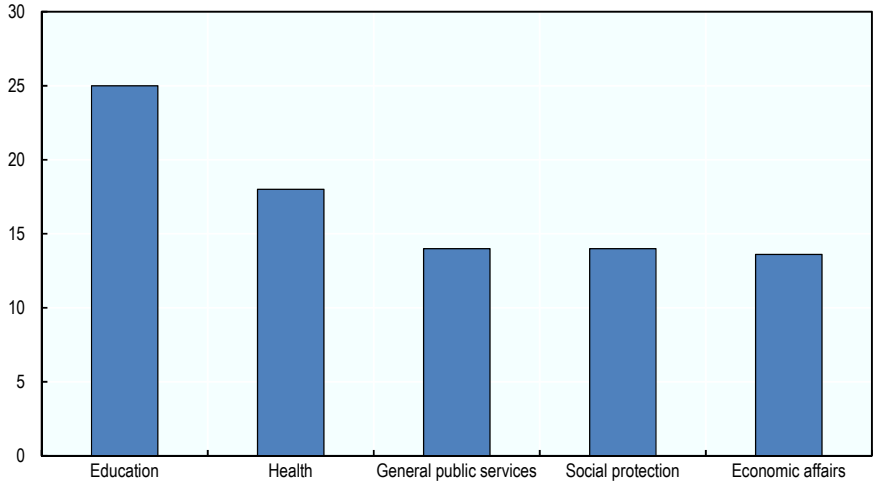
Note: 1. France does not include out-of-pocket payments for inpatient LTC thus resulting in an underestimation of the out-of-pocket share. 2. Spending by private health insurance companies in the United States is reported under voluntary health insurance.
Source: OECD Health at a Glance 2017.

3.2. Decentralisation of health spending by expenditure shares

27. Data on government spending by level of government can provide an indication of 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[9]).

28. 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).

Figure 3. Sub-national share of public expenditure by economic function

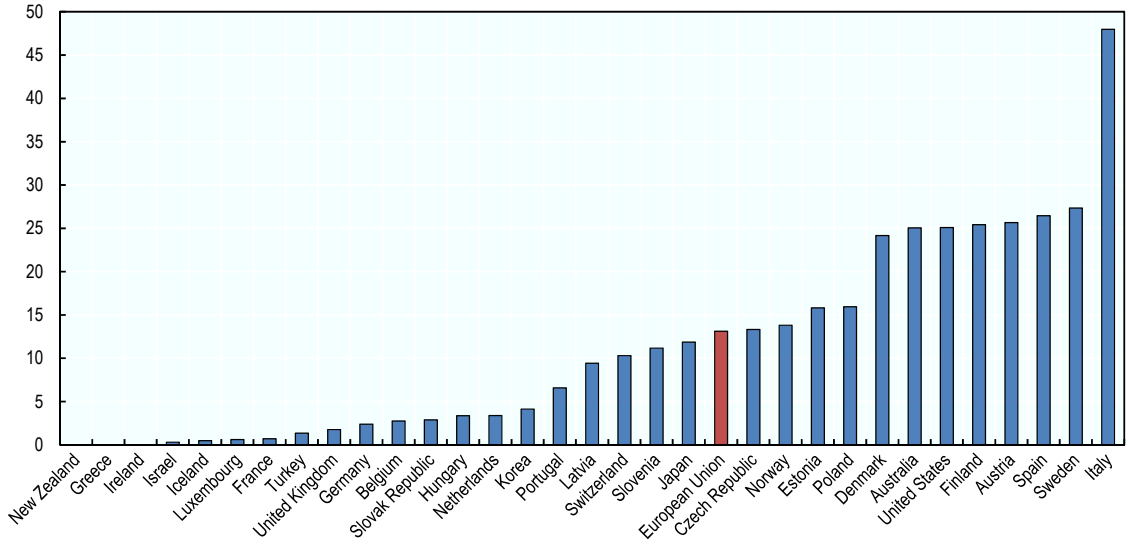


Note: Sub-national 2015 expenditure by function are shown as a percentage of total sub-national expenditure. OECD weighted average (weighted by population size of each country). Excludes Canada, Mexico and Chile. Other expenditure data include defence; public order and safety; housing and community amenities; recreation, culture and religion; environment; social protection expenditure includes both capital and current expenditure.
Source: OECD Regions and Cities database.

29. Figure 4 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.

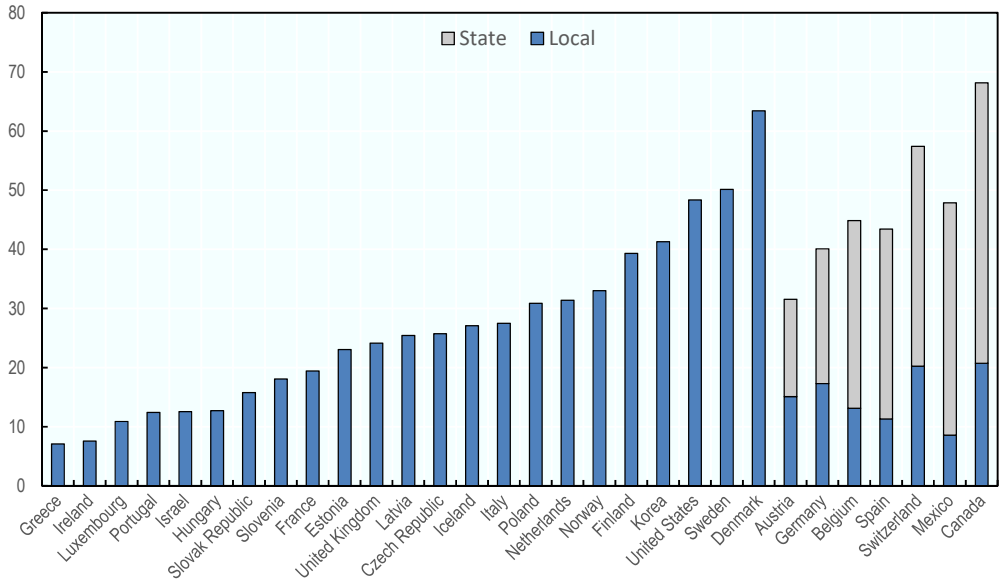
30. Out of the federal countries shown in Figure 5 below, sub-national government expenditure is 19% of GDP and 48% of public expenditure (unweighted average). Of the unitary countries, local government expenditure represented 12% of GDP and 26% of public expenditure (unweighted average) (OECD/KIPF, 2018[10]).

Figure 4. Sub-national health expenditure as a percentage of total sub-national expenditure



Note: OECD weighted average in 2015 (by population of each country). Excludes Canada, Mexico and Chile.
Source: OECD Regions and Cities database

Figure 5. Sub-national expenditure as a share of total public expenditure



Note: For most countries, data are for the year 2016; Korea data from 2012; Mexico data from 2015. No values are available for the breakdown of local and state expenditure for the United States.
Source: OECD Fiscal Decentralisation database.

31. Sub-national expenditure on health care accounted for 24% (unweighted average) of public health spending across OECD countries in 2015. However, the average hides wide variations across counties. 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[4]).

32. 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 funds health care via taxes. Additionally, a specific social security fee is collected from all employees to finance specific health care costs provided through the statutory sickness insurance scheme.

33. By contrast, health care financing 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. The privately administered health insurers set health insurance premiums. 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. Measuring decentralisation

34. 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, 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.

35. The following section focuses on the survey data 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 with regard 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.

36. 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 for and rights and obligations of hospitals).

4.2. Responsibilities across levels of government

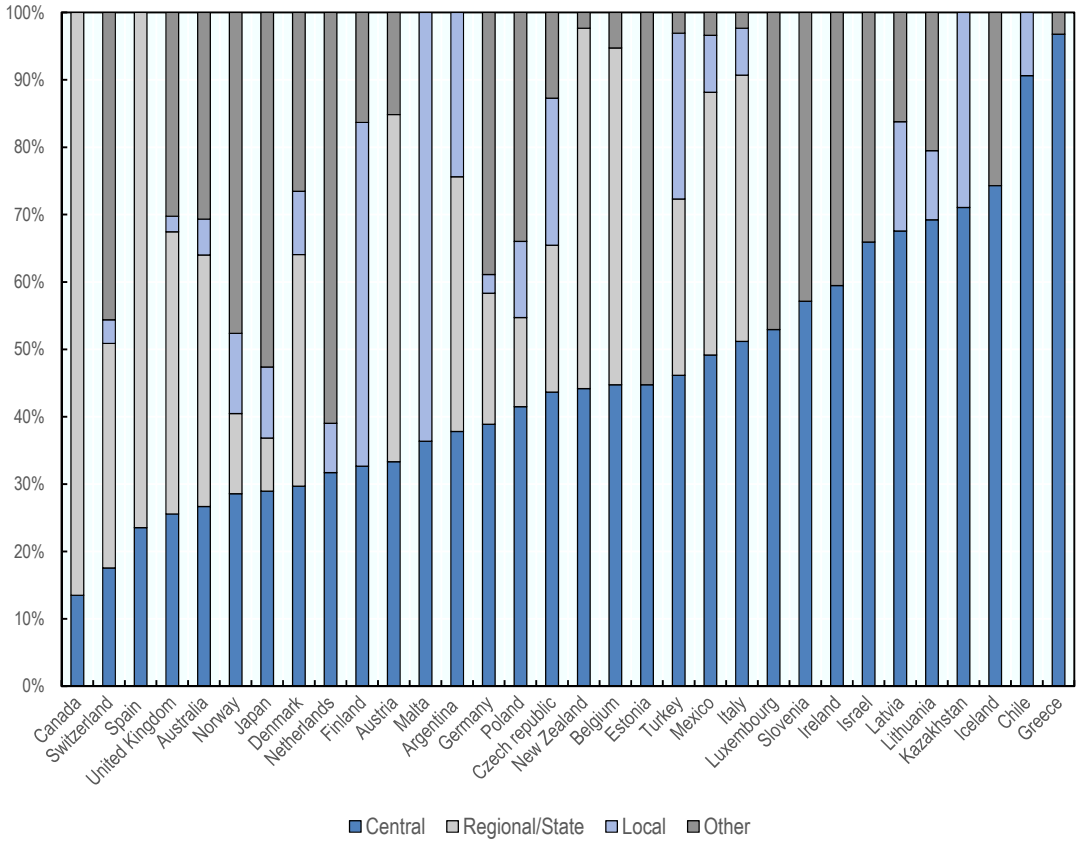
37. Figure 6 shows the allocation of responsibility for decisions in health care, across respondents. It is calculated as the number of times a country responded that a level of

government was responsible for a health decision, and then shows these sub-totals as a proportion of the total 'yes' responses, for each country.

38. 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[4]). 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 usually responsible for health decisions in Canada, Switzerland and Spain.

Figure 6. Decision-making power in the health sector, across levels of government

% of decisions at each level



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

39. Reponses 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.

40. Table 4 shows the proportion of decisions that were the responsibility of each level of government. For example, in Greece, the central government was responsible for 94% of health care decisions, showing a high degree of centralisation. In many countries, decisions were shared across levels of government.

Table 4. 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 of decisions a level of government was responsible for. Responses are not mutually exclusive and several levels of governments can share a responsibility.
Source: OECD survey on performance measurement systems in the health sector and responsibilities across levels of government (2018).

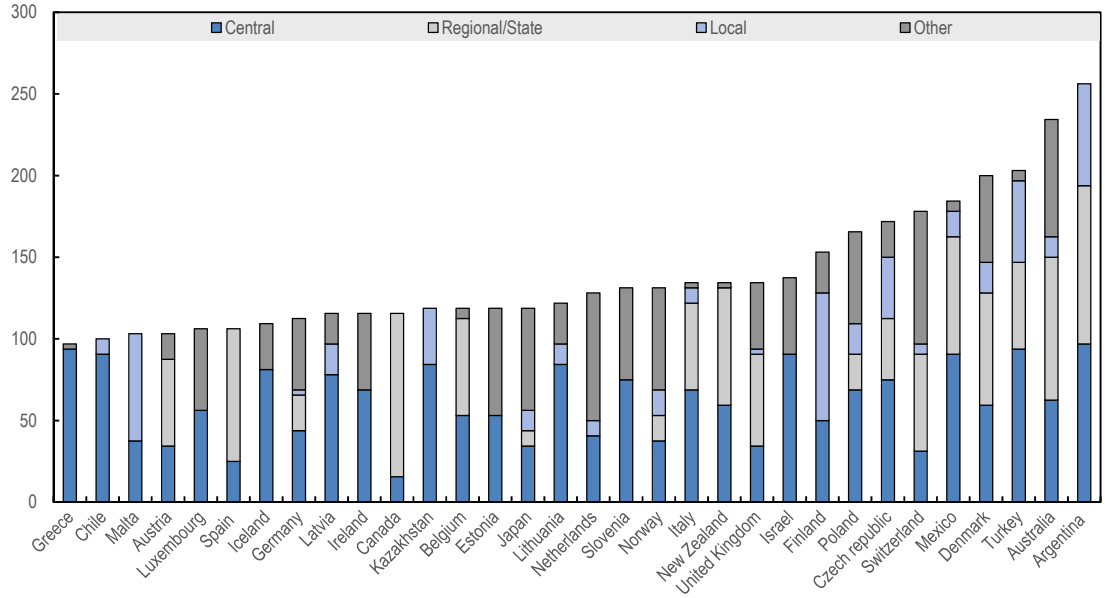
41. A shared responsibility is when two or more decision-makers are responsible for the same decisions and is the result of multiple levels of government or authorities being

responsible for the financing or policy making of service delivery. A high number of shared decisions suggests the presence of 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.

42. Figure 7 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.

Figure 7. 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).

4.3. Policy decisions in health care

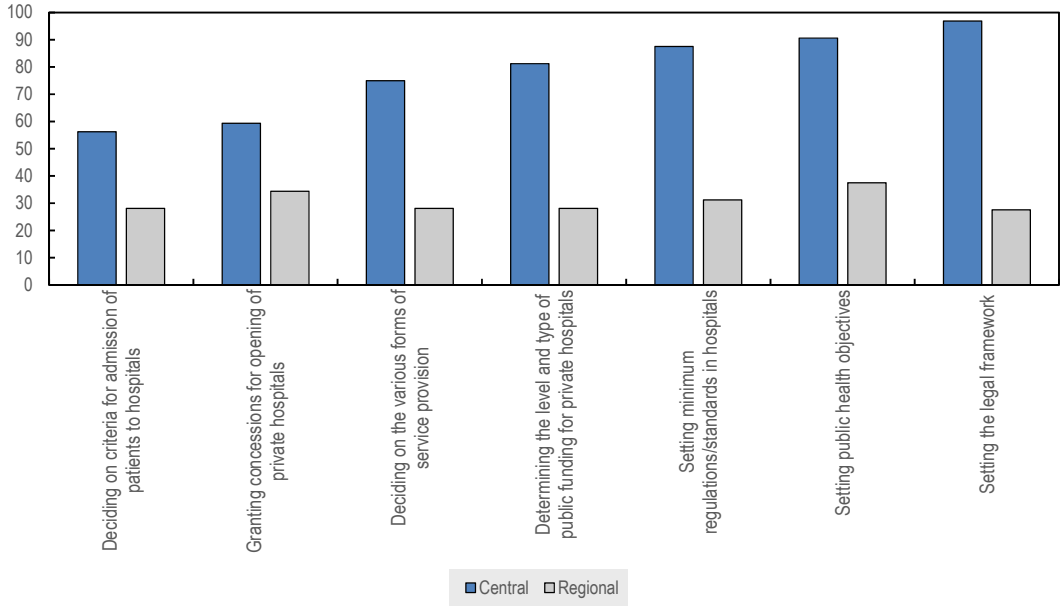
43. The majority of survey respondents stated that the central government is responsible for key decisions about policy (Figure 8). Specifically, setting public health objectives was a central government responsibility and a regional government responsibility, for 91% and 38% of respondents, respectively. Setting the legal framework (*e.g.*, a law establishing objectives for and rights and obligations of 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.

44. Setting minimum regulations/standards in hospitals was the responsibility of the central government in many countries (88% of respondents), but not in Belgium, Canada, Norway or the United Kingdom. Explicit minimum standards for service coverage, whether

social and/or geographical, promote equal access for 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 health care competences (mainly for elderly residential care, mental health, recognition of medical professions and hospital standardisation) 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 national co-ordination or framework of rules. For example, *regional* rules for hospital standards cannot change the rules for social security, or the exercising of medical professions, or the financing rules of hospitals.

Figure 8. Responsibilities for key policy decisions between central and regional governments

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



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

4.4. Budgeting decisions in health care

45. Compared to policy decisions, key budgeting decisions were more evenly split across decision-makers, but central governments have considerable power (Figure 9). 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.

46. The same percentage of respondents answered that the central government was responsible for designing and implementing a scale for user contributions or co-payments, 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[11]). 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[12]).

47. 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.

48. 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.

49. Budgeting decisions concerning hospitals were more evenly shared across decision-makers compared to other budgeting responsibilities (Figure 9). Financing new hospital buildings was a central government responsibility and a regional government responsibility, for 59% and 47% of respondents, respectively. In Italy, a specific national fund for investment in health care is 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.

50. 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 governments are able to influence decisions through their service plans.

51. Figure 10 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.

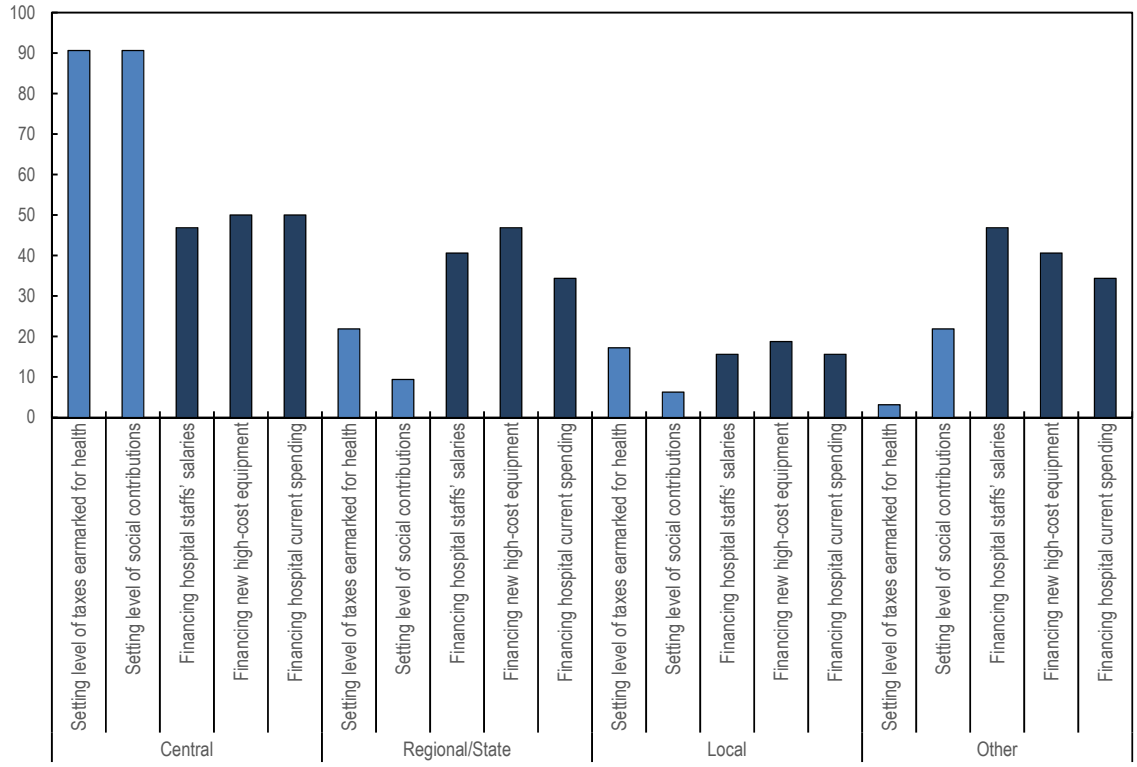
52. Despite greater decision-making power by sub-national governments, central government has much of the responsibility over key budgeting decisions. Some of these key budget decisions, like setting the level of taxes, and setting the total budget for public health care, can restrict the revenue-raising 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.

53. 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 exacerbated, 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[13])

Figure 9. Responsibilities for key budgeting decisions across levels of government

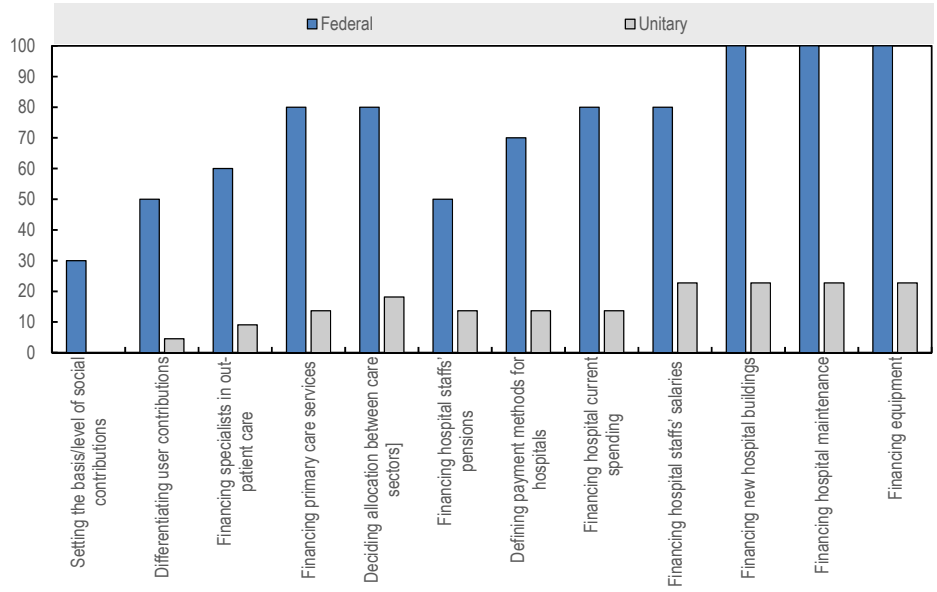
% of respondents that stated it was the responsibility of central, regional, or local governments or other



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 10. Regional government responsibility for key budgeting decisions, by federal and unitary countries

% of respondents that stated it was the responsibility of regional governments



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

4.5. Labour and input decisions in health care

54. 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.

55. 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.

56. 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 by sub-central decision-makers like insurers, health care 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.

57. 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.

58. 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[4]). 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.

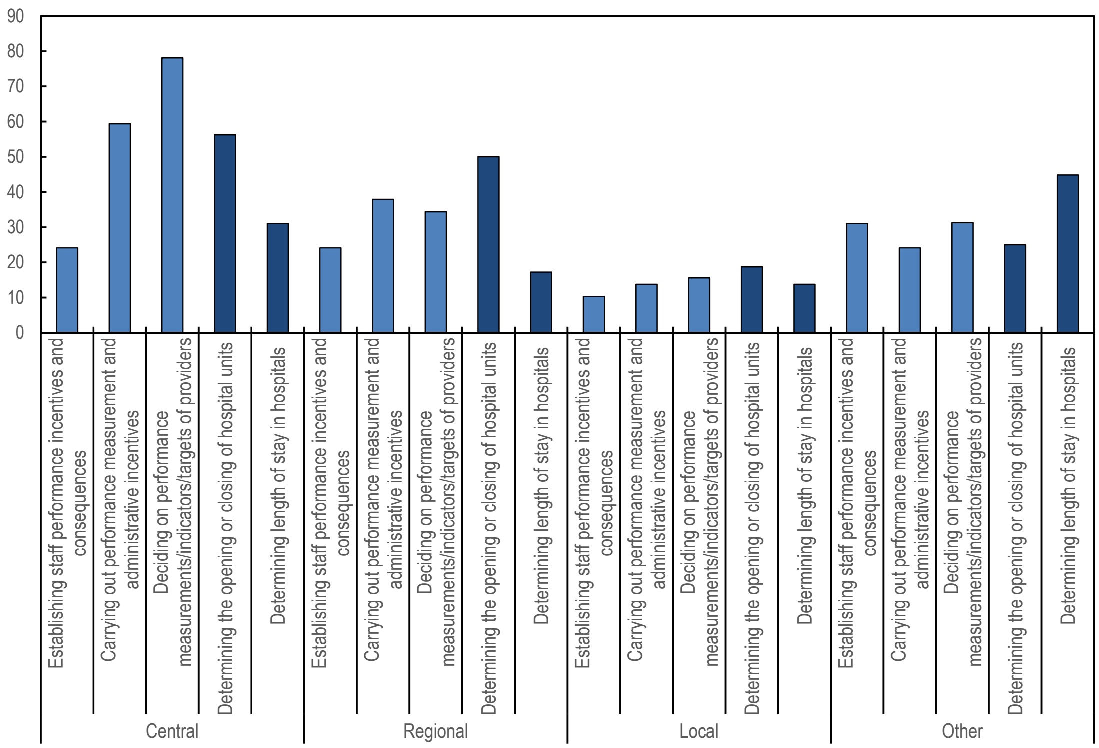
4.6. Output and monitoring decisions in health care

59. Key output and monitoring decisions in health care are shown in Figure 11, 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.

60. 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 11. Responsibilities for key output and monitoring decisions, across levels of government

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



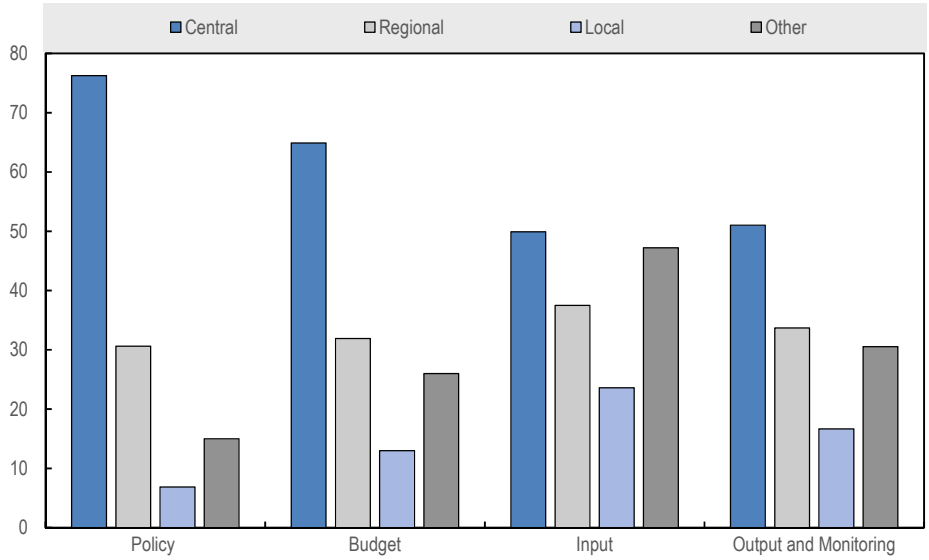
Note: The graph shows the responsibility of key output and monitoring decisions. The darker bars indicate output decisions concerning hospitals.
Source: OECD survey on performance measurement systems in the health sector and responsibilities across levels of government (2018).

4.7. Comparing responsibilities between different aspects of spending autonomy

61. Areas of spending power consist of policy, budget, input, output and monitoring. As shown in Figure 12, 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 out-sourced and deciding on the contractual status of staff, fall more on sub-national governments, especially for regional governments in federal countries.

62. 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 12. 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.
Source: OECD survey on performance measurement systems in the health sector and responsibilities across levels of government (2018).

5. Performance measurement systems in health care

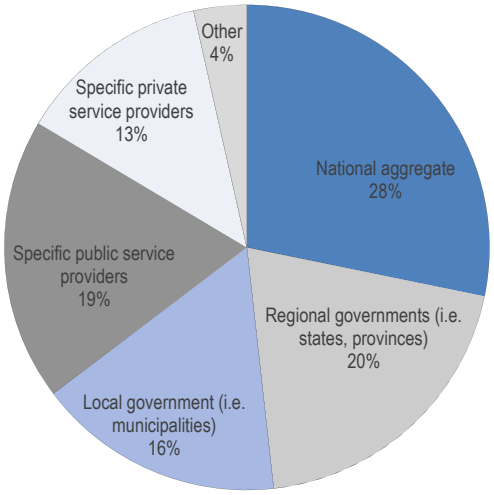
5.1. General results: What performance measurement systems are in place

63. For the majority of countries that participated in the survey, central governments had established a performance measurement system to monitor services in the health sector. These services can be classified into six health care providers. The categorisation of health care providers is hospitals; residential long-term care facilities; providers of ambulatory health care; providers of ancillary services; retailers and other providers of medical goods; and providers of preventive care.

64. Hospital services and providers of ambulatory care were the main types of provider that were monitored through a performance measurement system. This was anticipated as expenditure on these types of services makes up the highest proportion of health expenditure for the majority of OECD countries (OECD, 2017[8]). Providers of ancillary services (which include providers of medical laboratories and emergency transport), and retailers and other providers of medical goods (which, for example, could include producers of lenses, orthopaedic products or prosthetic appliances) were the areas of health care that were least covered by a performance measurement system. The majority of performance measurement systems also covered multiple aspects of health service.

65. Figure 13 shows that performance systems were more likely to measure or monitor the services provided at the national and the regional government level. Monitoring local governments' services was less common, as the responsibility for monitoring this lower level would likely be delegated to regional or local governments. Responses to the 'other' category shown in Figure 13 includes more specialised types of health care facilities in Canada and Finland.

Figure 13. Main level that the performance measurement system aims to measure



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

5.2. Focus of performance measurement systems

5.2.1. Objectives of the performance measurement system

66. Health performance measurement systems vary in their objectives, with some focused on transparency and accountability, others on budget allocation and cost containment, or improving policy and service delivery. Figure 14 summarises the objectives of the performance measurement systems, showing the proportion of responses that noted different goals as being a primary objective of the system.

67. Objectives surrounding budget control and cost containment were the focus of only a limited number of performance measurement systems, with budget allocation noted as the primary objective for 27% and 11% of systems in unitary and federal countries, respectively. These countries included Chile, Greece, Italy, Luxembourg, the Netherlands and Poland. The majority of these performance measurement systems focused the measurement on indicators to guide and inform the allocation of funds between geographic areas or service providers. Performance measurement systems aimed at budget allocations were also commonly associated with objectives such as cost containment or asserting budgeting and financial control. However, these objectives were less likely to be a primary objectives and were often reported to be a secondary objective or as an objective that could not be ranked.

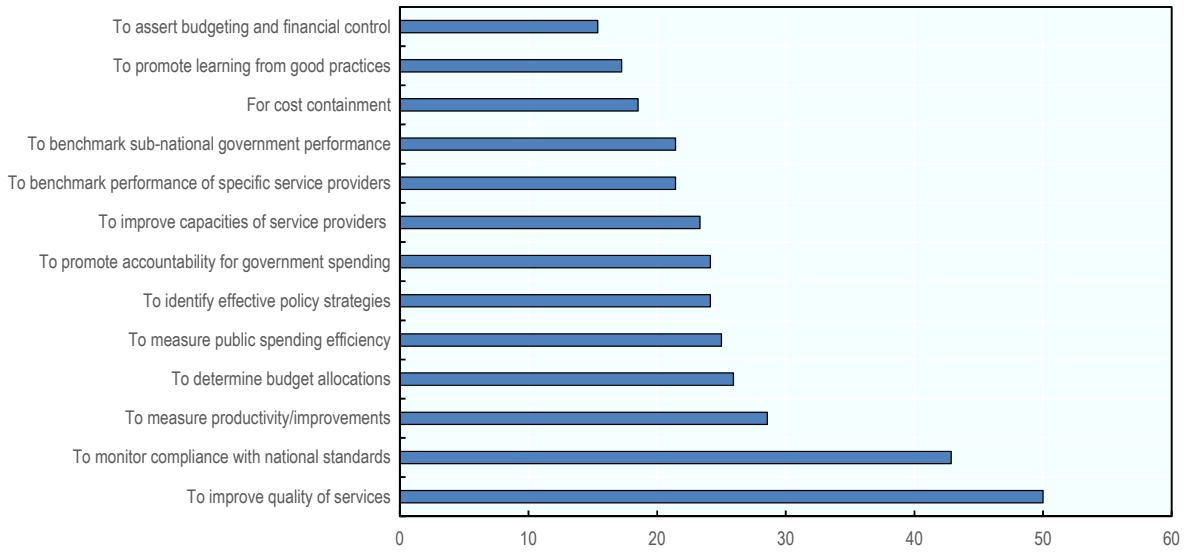
68. Instead, performance measurement systems were more likely to focus on transparency and accountability, or improving policy or health care service delivery. In particular, improving the quality of service and measuring productivity were objectives in over 65% of the performance measurement systems. Performance systems in unitary countries were also often aimed at monitoring compliance with national standards, which should be well aligned with benchmarking frameworks in which the central government plays the dominant role (Phillips, 2018[1]).

69. Benchmarking the performance of specific service providers or sub-national governments, and learning from best practice were also the objective of many performance measurement systems. For example, Australia, Canada, Italy and New Zealand have

developed a performance measurement system with indicators that are designed to track the performance of sub-national governments, who have responsibility for delivery of health care services. This allows them to benchmark their performance to hold them accountable for providing high quality services but also to achieve wider objectives such as improving the quality of care. These objectives were especially important in federal countries. This is not surprising as benchmarking and peer learning will be more amenable to sub-national governments with greater autonomy in terms of revenue power, administrative responsibilities and political influence.

70. Other objectives listed included to improve transparency, promote freedom of choice, and to allow consumers to make more informed decisions about their use of health services. Chile, Estonia, Lithuania, Luxembourg and Kazakhstan, reported on performance measurement systems that facilitate the use of pay-for-performance schemes for various forms of service providers.

Figure 14. Responses regarding the national government's objectives of the performance measurement system



Note: Other possible survey response options to this question were 'secondary objective', 'an objective but I don't know how to rank it' and 'not an objective'.
Source: OECD survey on performance measurement systems in the health sector and responsibilities across levels of government (2018).

5.2.2. Health initiatives as a useful component of performance measurement systems

71. Some patterns emerge concerning the effectiveness of different mechanisms whereby performance systems lead to improved performance of the health sector (Figure 15). Central governments generally found public league tables/ratings, and the monitoring of health access across the population or specific target groups, to be a useful mechanism in over 75% of the performance measurement systems, to monitor and improve performance in the health sector. The publication of performance information of hospitals or providers, including through league tables, is important in ensuring the transparency and accountability of government

spending and decision-making. In addition, improving provider performance and encouraging consumer choice are important. Benchmarking through league tables can offer interesting comparisons. This can encourage better performance through peer pressure. In theory it could also help people choose among different health service providers – although there is little evidence that such public information has this effect (Rechel et al., 2016[14]).

72. Monitoring minimum national standards was also found to be a very useful component of performance measurement systems. Minimum national standards can be applied to service providers to establish the minimum national expectations. This should encourage providers to work towards achieving the standards if not already met, and therefore increase the quality of service delivery over time.

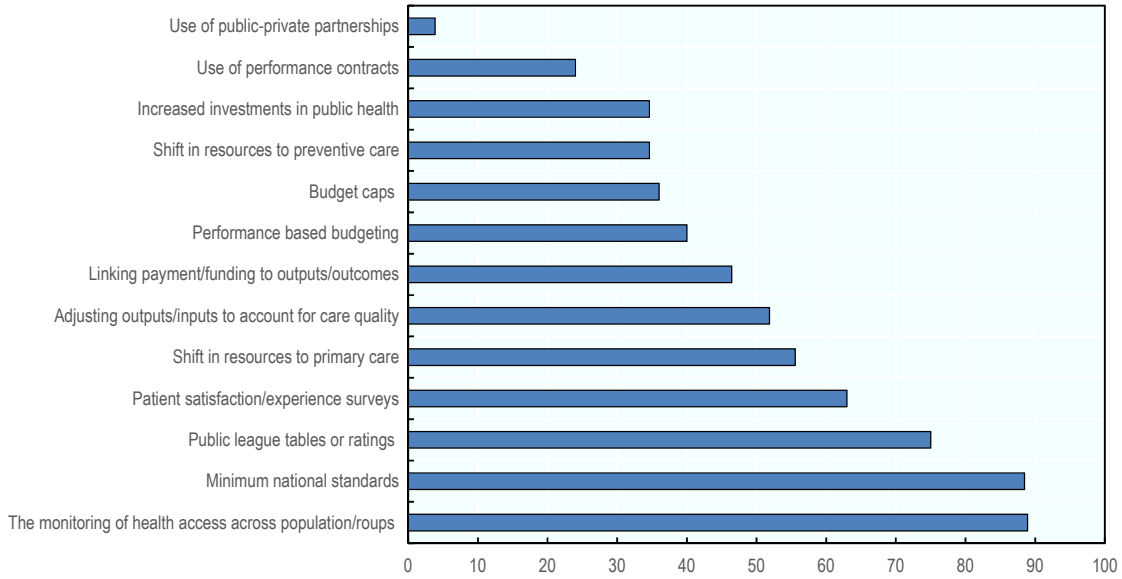
73. Just over half of the respondents saw patient satisfaction and experience surveys as useful components of a performance system. This performance mechanism could be more widely adopted, as standardised surveys of patients and relatives can help measure hospital performance against explicit standards. Patient-reported experience and outcome measures, such as whether patients feels they were adequately involved in important decisions about their care, and whether the patient is free of pain after an operation, are important for monitoring and understanding the more qualitative aspects of service delivery, especially with the increasing focus on patient empowerment and satisfaction.

74. By comparison, the use of public-private partnerships and performance contracts were generally not a component of performance systems. Performance budgeting was more frequently a component but only Chile, Greece, and Spain stated that performance budgeting was a 'very useful' component of their performance measurement systems. Performance budgeting involves incorporating performance information into the budget setting process in order to inform and guide budget allocations. This type of budgeting replaces traditional budgeting methods, by shifting the focus away from inputs, to the achievement of policy objectives or outcomes.

75. There were very few mechanisms that were used by governments that were deemed 'not useful'. Furthermore, the mechanisms used did not vary markedly between federal and unitary countries. However, unitary countries were more likely to use mechanisms such as minimum national standards; budget caps; policies that shift resources to primary or preventive care; and policies that increase investment in public health. This is likely due to budget control being more centralised in unitary countries, which allows unitary central authorities to make decisions regarding the allocation of funding to priority areas.

Figure 15. Responses regarding the usefulness of health initiatives for a national government's performance measurement

Proportion of responses where the following health initiatives are noted as a 'very useful' or 'somewhat useful'



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

Box 1. Australia's National Healthcare Agreement guidelines

In Australia, under the National Healthcare Agreement (NHA) guidelines, league tables and comparative charts are available for regional governments (but are not required by service providers), but data are also disaggregated by other variables (e.g. indigenous status, gender) which offers a further point of comparison. The NHA is an agreement between the central government and regional governments that outlines the role and goals of Australia's health system; the roles and responsibilities of the parties; policy and reform directions proposed to achieve desired outcomes; and accountability requirements. The accountability requirements include reporting against specific performance indicators and performance benchmarks that are outlined within the specified outcome areas (better health; better health services; social inclusion and indigenous health; and sustainability of the health system). The NHA indicator set outlines 33 performance indicator topics and 7 performance benchmarks, which are reported annually. The indicators draw on population-level data (usually survey data) and data derived from information captured by health services or within payment systems (administrative by-product data). The health services data are used both for performance reporting related to a particular sector/service (e.g. waiting times for elective surgery), and for broader-based reporting on the effectiveness of the health system as a whole or other parts of the health system (e.g. potentially preventable hospitalisations).

5.3. Impact of the performance measurement system

5.3.1. What is the effect of the performance measurement system at the national level

76. Performance measurement systems affected policy at the national level – in terms of determining or adjusting policies, budgets and performance targets. However, this impact was, in most countries, only 'occasionally' rather than 'frequently or always' the case (Table 5). Exceptions to this were Chile, Finland, Italy, Japan, Norway, New Zealand, and Spain, where performance measurement systems were typically seen as having more effect on decisions at the national level, although some of these countries had multiple performance systems, and only selected one that had this effect.

77. The effects of the performance measurement systems at the national level were also greater in unitary countries than in federal countries. This is especially true in terms of the performance measurement system affecting budget allocations at the national level. Federal countries have constitutionally protected sub-national governments with greater decision power. The performance measurement systems may instead have an effect at the sub-national level.

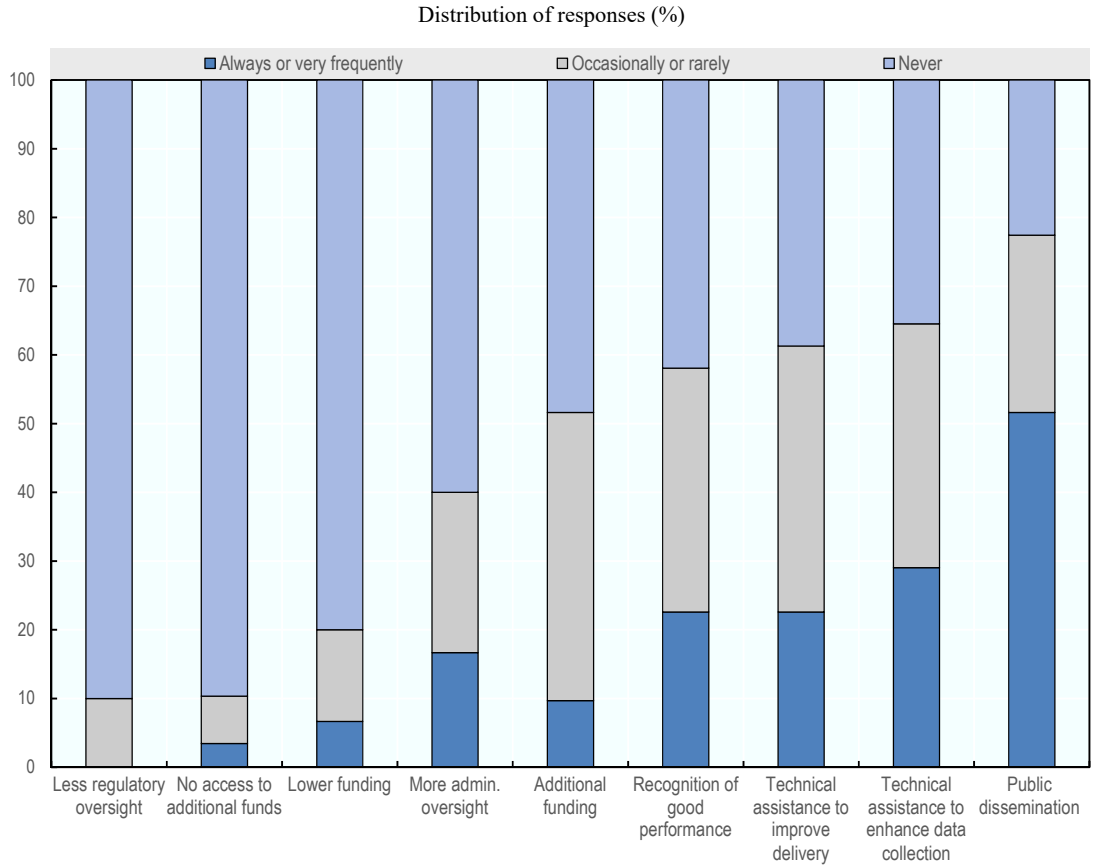
Table 5. The effect of the performance measurement system at the national level

	Policy priorities are determined or adjusted	Policy strategies are determined or adjusted	Budgets are determined or adjusted	Performance targets are determined or adjusted
Australia*	-	-	-	-
Belgium	o	o	o	O
Canada	o	o	o	o
Chile*	X	X	X o	X
Denmark	o	o	o	o
Estonia	o	o	o	o
Finland	X	X	X	o
Greece	o	o	o	o
Italy	X o	o	X	X
Japan*	X o	X o	o	o -
Kazakhstan	-	-	-	o
Lithuania		o	X	o
Luxembourg*	-	-	X -	o
Mexico	o	o	-	o
The Netherlands*	o	o	o	o
New Zealand	X	o		X
Norway*	X	X	o	X
Poland	X	o	o	o
Spain	X	X	o	o
Switzerland	-	-	-	-
United Kingdom	o	o	o	o

Note: X=always or very frequently, o=occasionally or rarely, - =never. * Reflects multiple performance measurement systems used in this country. Multiple symbols reflect the different performance measurement systems.
Source: OECD survey on performance measurement systems in the health sector and responsibilities across levels of government (2018).

78. Performance measurement systems were seen by survey respondents to have an impact on budget allocations at the national level in five countries: Chile, Italy, Finland, Lithuania, and Luxembourg. In Chile, one performance measurement system has an impact on the allocation of resources between the institutions under the Ministry of Health. The other system (PRAPS), describes a mechanism for the prospective payment of primary care, in the case that resource adjustments need to be made due to an overrun in planned expenditure. Similarly, in Lithuania, resources adjustments are made to primary health care providers in the form of a pay-for-performance scheme. In Luxembourg, the budget allocations are made by the statuary health insurance between hospitals based on the results of the performance measurement system. In Italy, additional resources are offered to regional governments depending on the fulfilment of predefined goals captured by a set of indicators. In Finland, no detail was given as to the effect on budgets at the national level.

Figure 16. Responses regarding the consequences of the performance system for sub-national authorities



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

5.3.2. Impact of the performance measurement system for sub-national government

79. Central governments can utilise rewards and sanctions on sub-national governments, to incentivise service providers to improve performance and meet certain standards. There are two main types of explicit reward/sanction systems for sub-national governments:

financial and administrative. Figure 16 illustrates the distribution of country responses regarding the effects performance systems in health care can have on regional or local governments. The possible response options for the survey questions were ‘always’; ‘very frequently’; ‘occasionally’; ‘rarely’; and ‘never’ with regard to their occurrence.

80. The public dissemination of performance information is a common aspect of the health performance systems. The public dissemination of information exerts reputational effects that generate pressure for accountability and reform (OECD, 2009[15]). Competition aims to improve government behaviour, as providers aim to improve their performance to avoid being labelled as poor or failing organisations. Other common consequences of health performance systems are the formal recognition of good performance and technical assistance for enhancing data collection and to improve service delivery.

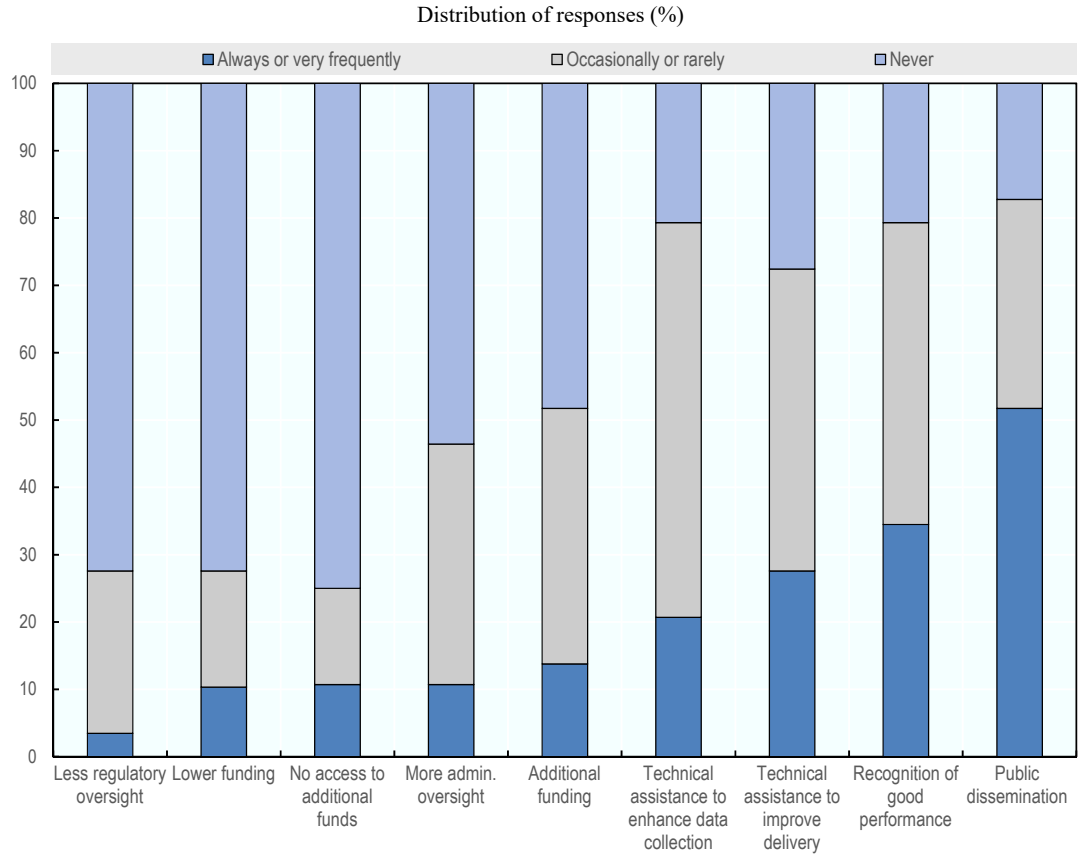
81. Uncommon consequences include rewards to sub-national governments through the relaxation of budget rules, financial sanctions through withdrawal of funding or lower funding, and financial sanctions through no access to additional funds. Some consequences are more common in unitary countries, namely, technical assistance to governments to improve service delivery and increased administrative oversight of sub-national governments.

82. Countries with performance measurement systems that frequently had impacts on sub-national government include Chile, Italy, and New Zealand. These performance measurement systems are designed specifically to track the performance of regional or local governments.

5.3.3. Impact of the performance measurement system for service providers

83. With regard to the potential impact for specific service providers, the public dissemination of performance information, formal recognition of good performance and technical assistance are again common consequences of health performance systems (Figure 17). Some consequences are more common in unitary countries, namely, technical assistance to governments to improve service delivery and rewards for service providers through the relaxation of regulatory oversight. The public dissemination of performance information is also used more in unitary countries. Furthermore, federal countries are more likely to provide public information on performance of regional governments rather than on service providers.

Figure 17. Responses regarding the consequences of the performance system for service providers



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

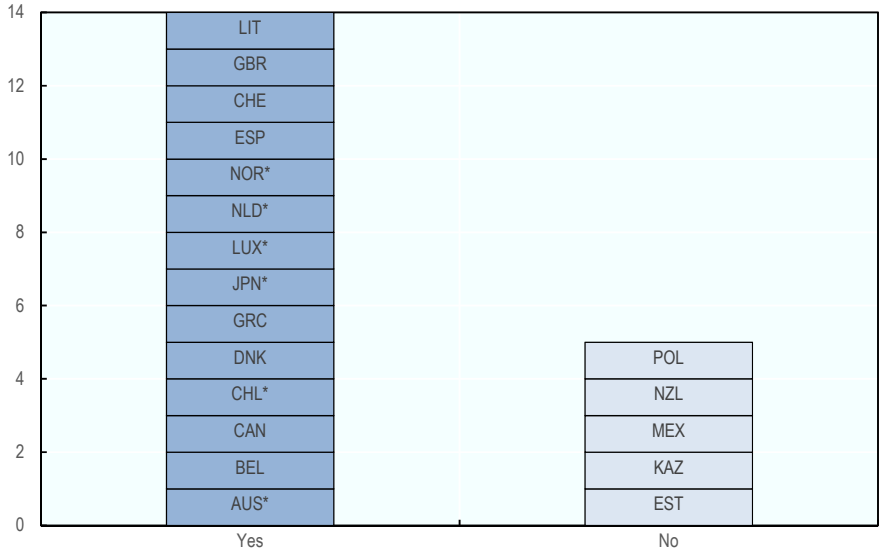
84. Overall, there was more impact of performance measurement systems for service providers than for sub-national governments, showing that performance measurement systems were more focused on providers rather than specific regions. In particular, Lithuania, the Netherlands, Greece, Luxembourg, Italy, and Estonia had performance measurement systems in place that provided more incentives for service providers.

5.4. Performance measurement system evaluations and challenges

5.4.1. Does the performance measurement system undergo routine evaluations?

85. Seventy-five percent of performance measurement systems reported to undergo routine evaluations or will do in the future (Figure 18). In Australia, Chile and the Netherlands, the evaluation is carried out on a yearly basis, whereas in Canada, the system is evaluated every five years. In Belgium, the system goes through an international evaluation through a peer review event.

Figure 18. Responses regarding whether performance measurement systems undergo routine evaluations (or will in the future)



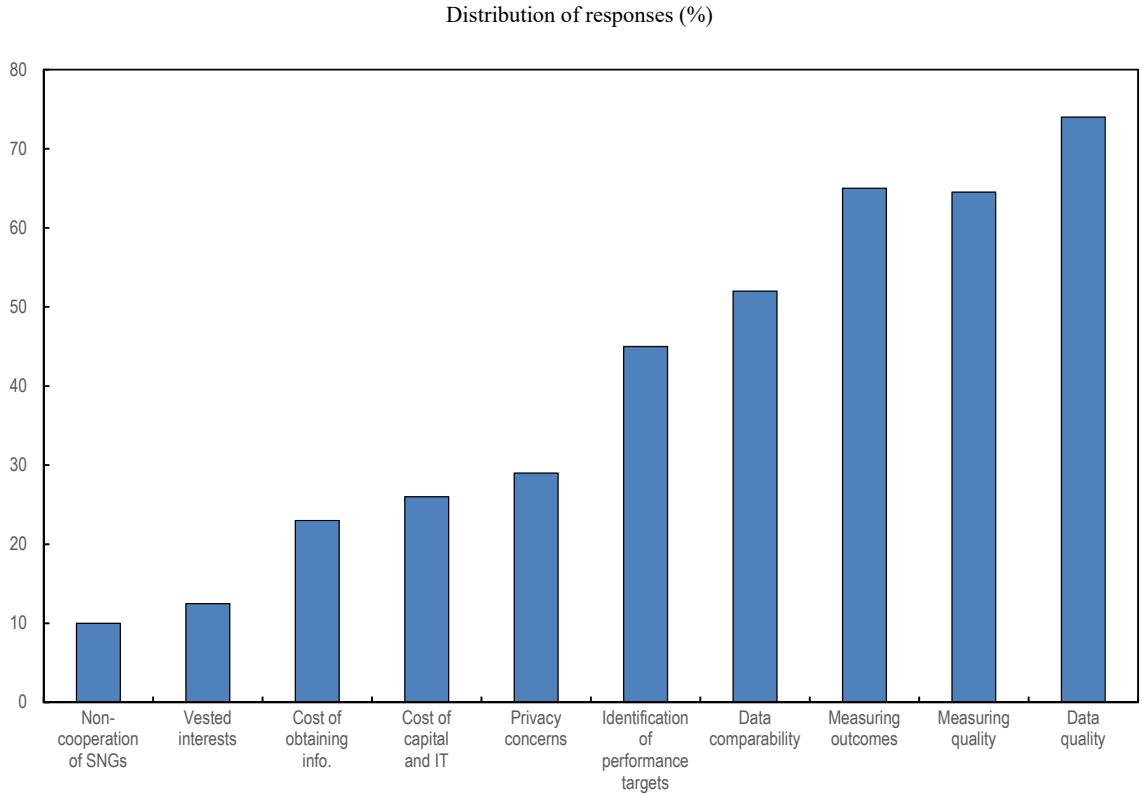
Note: * implies that the country replied yes for all performance measurement systems.
Source: OECD survey on performance measurement systems in the health sector and responsibilities across levels of government (2018).

5.4.2. Challenges for performance measurement systems

86. Countries identified some difficulties that have been encountered in assessing health service delivery (Figure 19). The most common challenges are of a technical nature such as the quality of data, the comparability of data (including the standardisation of coding) and measuring service outcomes and service quality. Other issues such as vested interests, the non-cooperation by sub-national governments and cost concerns were identified as much less problematic in developing a performance measurement system. This is encouraging, as it should provide an incentive to progress with the development of a performance measurement system, as improving systems is just a matter of improving the design of performance indicators and better data, rather than a question of a lack of interest or co-operation, which may require a more profound change.

87. Despite the decentralised nature of many health systems, no country identified the presence of a regional indicator system as the reason for a lack of national system in place.

Figure 19. Responses regarding the difficulties in assessing health service delivery



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

88. Hospitals were the most common health care providers to be monitored under a national performance system. Providers of ancillary services, retailers and other providers of medical goods and providers of preventive care were the least likely to be monitored. Common reasons for the non-establishment of performance systems in these sectors include a lack of capacity at the national level, a lack of available data and coordinating the actors is too difficult. For a few countries, the establishment of a performance system is currently under discussion.

6. Conclusions

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

90. Despite the trend towards decentralisation of health systems, central government has considerable power across many decisions regarding the delivery of health services. This decision-making power is particularly strong with 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 out-sourced 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.

91. Moreover, the majority of central governments have taken on the role of ensuring the equitable and efficient delivery of health care systems through establishing a performance measurement system. Such systems are different across OECD countries, varying mainly in their objectives and the potential consequences for levels of government or service providers. Most were focused on monitoring the performance of hospitals and providers of ambulatory care. Providers of ancillary services, retailers and other providers of medical goods, and providers of preventive care were much less likely to be monitored under a specific performance framework.

92. The design of performance measurement systems should depend on its functions and objectives. Many performance measurement systems were focused on the objectives of improving the quality of service delivery, monitoring compliance with national standards, or monitoring productivity and efficiency. Other objectives of the system, like learning from good practices, cost-containment, promoting accountability, were less common. The survey also gave valuable insights into the usefulness of different initiatives that were used in performance measurement systems, with the most important being the monitoring of health access across populations/groups and setting of minimum national standards.

93. The impact of performance measurement systems at the national level were limited. Some focused on the allocation of resources between service providers or sub-national authorities based on performance measures. However, this allocation did not represent a significant share of the overall budget. Instead, the impacts for service providers and sub-national authorities were mainly through the public dissemination of performance results and recognition of good performance.

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Annex A. Questionnaire

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

Part 1

Part 1A) 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	☐	☐	☐	☐	
Setting the basis and level of social contributions/premiums for health care	☐	☐	☐	☐	
Setting the total budget for public funds allocated to health care	☐	☐	☐	☐	
Deciding resource allocation between sectors of care (e.g. hospital care, outpatient care, long-term care)	☐	☐	☐	☐	
Setting remuneration methods for physicians	☐	☐	☐	☐	
Defining payment methods for hospitals	☐	☐	☐	☐	
Financing new hospital buildings	☐	☐	☐	☐	
Financing new high-cost equipment	☐	☐	☐	☐	
Financing the maintenance of existing hospitals	☐	☐	☐	☐	
Financing primary care services	☐	☐	☐	☐	
Financing specialists in out-patient care	☐	☐	☐	☐	
Financing hospital current spending	☐	☐	☐	☐	
Setting public health objectives	☐	☐	☐	☐	

***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 1B) 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.

Which level of government is responsible for:	Central gov't	Regional/ state gov't	Local gov't	Other *(specify)*	Notes*
General policy decisions					
Setting the legal framework (e.g. a law establishing objectives, rights and obligations in hospitals)	☐	☐	☐	☐	
Setting minimum regulations/standards in hospitals (public and private)	☐	☐	☐	☐	
Deciding on the various forms of service provision (public vs. private provision)	☐	☐	☐	☐	
Deciding on criteria for admission of patients to hospitals	☐	☐	☐	☐	
Deciding on budget allocation among regions, districts or municipalities	☐	☐	☐	☐	
Deciding on budget allocation among hospitals within the same region or municipality	☐	☐	☐	☐	
Determining the opening or closing of hospital units	☐	☐	☐	☐	
Determining length of stay in hospitals	☐	☐	☐	☐	
Determining the allotment of hospital beds across hospitals	☐	☐	☐	☐	
Staff management					
Hiring and firing of staff	☐	☐	☐	☐	
Determining working conditions (salary scales, pension rules, working hours)	☐	☐	☐	☐	

Which level of government is responsible for:	Central gov't	Regional/ state gov't	Local gov't	Other *(specify)*	Notes*
Establishing rules for the training and education of staff	☐	☐	☐	☐	
Deciding on contractual status of staff (e.g.., non-redeemable contracts)	☐	☐	☐	☐	
Provision of input/infrastructure					
Planning and provision of necessary hospital infrastructure (e.g.., vehicles, buildings)	☐	☐	☐	☐	
Deciding on hospital infrastructure maintenance	☐	☐	☐	☐	
Right to use outsourcing					
Determining which services can be outsourced (services obtained from outside providers, such as cleaning or meals) and choosing external providers	☐	☐	☐	☐	
Private hospitals (if any)					
Regulating private hospital activity (e.g. setting the rules for concessions and funding for private hospitals)	☐	☐	☐	☐	
Granting concessions for opening of private hospitals	☐	☐	☐	☐	
Determining the level and type of public funding for private hospitals (subsidies, other means of financial aid, e.g.., tax exemption for providers)	☐	☐	☐	☐	
Hospital/health care district (if any)					
Managing hospital/health care districts	☐	☐	☐	☐	
Determining the size of hospital/health care districts	☐	☐	☐	☐	

***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

3. 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	☐	☐	☐	☐	
Differentiation of user contributions according to social situation of users (e.g. income, region, social status, etc.)	☐	☐	☐	☐	
Compensation of staff					
Financing hospital staffs' salaries and benefits	☐	☐	☐	☐	
Financing hospital staffs' pensions	☐	☐	☐	☐	
Capital investment decisions					
Health facilities (hospitals, etc.)	☐	☐	☐	☐	
Medical equipment	☐	☐	☐	☐	

***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.**

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

5. 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%

6. 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?

7. 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

8. 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?)	☐	☐	☐	☐	
Performance of hospital institution/providers					
Deciding on the performance measurements/indicators/targets of service institutions/providers (if any)	☐	☐	☐	☐	
Carrying out performance measurement and implementing administrative incentives (sanctions/rewards) associated with performance results as evaluated against targets (if any)	☐	☐	☐	☐	
Performance of staff					

Which level of government is responsible for:	Central gov't	Regional/ state gov't	Local gov't	Other *(specify)*	Notes*
Deciding whether performance assessment of staff must be used (if any)	☐	☐	☐	☐	
Establishing performance incentives for staff and consequences for high/poor performance (if any)	☐	☐	☐	☐	

***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.**

9. 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.

10. Does the central or sub-national government(s) examine whether decentralisation affects hospital or health care efficiency? Have any previous studies been completed?

Part 2

Part 2A) Details on health performance measurement systems

Countries are encouraged to complete separate copies of Part 2.A for each health performance measurement system. Each copy of Section A should relate to a different health performance measurement system.

1. Which health providers are covered under this performance system? *(If a country has a single performance measurement system that covers multiple health providers, please tick all appropriate boxes).*

	Hospitals	Residential long-term facilities	Providers of ambulatory health care	Providers of ancillary services	Retailers and other providers of medical goods	Providers of preventive care
For what aspects of health care does this performance measurement system cover?	☐	☐	☐	☐	☐	☐

2. Briefly describe the specific performance measurement system that you will report on below. We are particularly interested in the specific public and private aspects covered by the system, the extent of diffusion across the country and the maturity of the system.

3. What level of government is in charge of <u>administering</u> the performance measurement system? *(please only tick for the health providers that are covered under this performance system)*

	Hospitals	Residential long term care facilities	Providers of ambulatory health care	Providers of ancillary services	Retailers and other providers of medical goods	Providers of preventive care
National	☐	☐	☐	☐	☐	☐
Regional	☐	☐	☐	☐	☐	☐
Local	☐	☐	☐	☐	☐	☐
Insurance companies	☐	☐	☐	☐	☐	☐
Other (please specify)	☐	☐	☐	☐	☐	☐

4. What is the main level that the system aims to monitor/measure *(tick all that apply)?*

☐ National aggregate
☐ Regional governments (i.e. states, provinces)
☐ Local government (i.e. municipalities)
☐ Specific public service providers
☐ Specific private service providers
☐ Other (please specify):

5. Please indicate the importance of the national government's objective(s) for this performance measurement system.

	Primary objective	Secondary objective	An objective, but I don't know how to rank it	Not an objective
To measure productivity and/or productivity improvements	☐	☐	☐	☐
For cost containment	☐	☐	☐	☐
To measure the efficiency of public spending	☐	☐	☐	☐
To assert budgeting and financial control	☐	☐	☐	☐
To benchmark performance of specific service providers	☐	☐	☐	☐
To benchmark performance of sub-national governments	☐	☐	☐	☐
To determine budget allocations	☐	☐	☐	☐
To identify effective policy strategies	☐	☐	☐	☐
To improve quality of services	☐	☐	☐	☐
To improve capacities of service providers	☐	☐	☐	☐
To monitor compliance with national standards/regulations	☐	☐	☐	☐
To promote accountability for government spending	☐	☐	☐	☐
To promote learning from good practices	☐	☐	☐	☐
Other (please, describe):	☐	☐	☐	☐

Please feel free to provide comments related to question 5 (optional):

6. Please indicate if the following health initiatives are a useful component of the national governments performance measurement system.

Measurement practice	How useful is the performance measurement practice, from the perspective of the national government?				Please provide comments or examples on how the performance measurement practice is used (if applicable)
	Very useful	Somewhat useful	Not useful	Not used at all	
Strategic re-allocation of resources within the health care system					
Performance based budgeting	☐	☐	☐	☐	
Shift in resources to primary care	☐	☐	☐	☐	
Shift in resources to preventive care	☐	☐	☐	☐	
Increased investments in public health	☐	☐	☐	☐	
Changes in financing methods					
Linking payment/funding to outputs/outcomes	☐	☐	☐	☐	
Budget caps	☐	☐	☐	☐	
Use of performance contracts	☐	☐	☐	☐	
Use of public-private partnerships	☐	☐	☐	☐	
Benchmarking and transparency					
Minimum national standards	☐	☐	☐	☐	
Public league tables or ratings	☐	☐	☐	☐	
Collection of performance information					
The monitoring of health access across the population or specific target groups	☐	☐	☐	☐	
Patient satisfaction/ experience surveys	☐	☐	☐	☐	
Adjusting outputs or inputs to account for quality of care	☐	☐	☐	☐	

Please feel free to provide comments related to question 6 (optional):

7. How are the performance results disseminated? *(tick all that apply)*

☐ Internal reporting only
☐ Internal meetings
☐ Events open to the public
☐ Publicly available report
☐ Press-release
☐ On-line open access
☐ Other (please specify):

Please feel free to provide comments related to question 7 (optional):

8. How does the performance measurement system affect policy decisions at the national level? *(Please tick)*

	Always	Very frequently	Occasionally	Rarely	Never
Policy priorities are determined or adjusted	☐	☐	☐	☐	☐
Policy strategies are determined or adjusted	☐	☐	☐	☐	☐
Budgets are determined or adjusted	☐	☐	☐	☐	☐
Performance targets are determined or adjusted	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

9. What are the potential consequences of the performance measurement system for <u>sub-national authorities</u>?

	Always	Very frequently	Occasionally	Rarely	Never
Public dissemination of performance information	☐	☐	☐	☐	☐
Technical assistance for enhancing data collection/utilisation	☐	☐	☐	☐	☐
Technical assistance for improving service delivery	☐	☐	☐	☐	☐
Additional funding	☐	☐	☐	☐	☐
Formal recognition of good performance	☐	☐	☐	☐	☐
Reward through relaxation of budget rules	☐	☐	☐	☐	☐

Financial sanctions through withdrawal of funding or lower funding	☐	☐	☐	☐	☐
Financial sanctions through no access to additional funds/funding pool	☐	☐	☐	☐	☐
Penalties through increased administrative oversight	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

10. What are the consequences of the performance measurement system for <u>service providers</u>?

	Always	Very frequently	Occasionally	Rarely	Never
Public dissemination of performance information	☐	☐	☐	☐	☐
Technical assistance for enhancing data collection/utilisation	☐	☐	☐	☐	☐
Technical assistance for improving public service delivery	☐	☐	☐	☐	☐
Additional funding	☐	☐	☐	☐	☐
Formal recognition of good performance	☐	☐	☐	☐	☐
Reward through relaxation of regulatory oversight	☐	☐	☐	☐	☐
Financial sanctions through withdrawal of funding or lower funding	☐	☐	☐	☐	☐
Financial sanctions through no access to additional funds/funding pool	☐	☐	☐	☐	☐
Penalties through increased administrative oversight	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

11. Is the performance measurement system used by any of the following, to improve performance or reduce costs?

☐ Regional governments

☐ Local governments
☐ Service providers
☐ Insurance companies

12. If yes, please provide examples. Do they compare performance with other providers? Is it used to monitor their own performance over time? To determine budget allocations? To adjust public service delivery processes?

13. Does the performance measurement system undergo routine evaluations (or will undergo in the future)?

☐ Yes
☐ No
☐ Don't know

14. If yes, please provide further comments in regards to the frameworks is place to organise and carry out evaluations?

15. Has the cost of the performance measurement system been assessed?

☐ Yes
☐ No
☐ Don't know

16. What difficulties have been encountered in assessing health service delivery? *(tick all that apply)*

☐ Data quality
☐ Privacy concerns
☐ Cost of obtaining information
☐ Cost of capital and IT requirements
☐ Comparability of data
☐ Organisations with vested interests
☐ Non-cooperation of sub-national governments
☐ Identification of performance targets
☐ Measuring service outcomes
☐ Measuring service quality
☐ Other (please specify):

Please feel free to provide comments related to question 16 (optional):

Additional comments: If you would like to add additional comments about performance measurement systems for monitoring/ measuring health care in your country, please do so here (optional).

Part 2B) Health care providers that are not covered under a national performance measurement system

Countries are encouraged to complete separate copies of Part 2.B for each health provider where the national government does not have a formal system to measure and monitor their performance.

Please tick which health care provider this copy relates to. Generally only one health care provider will be selected.

	Hospitals	Residential long-term facilities	Providers of ambulatory health care	Providers of ancillary services	Retailers and other providers of medical goods	Providers of preventive care
For what aspects of health care do performance measurement systems *not* exist?	☐	☐	☐	☐	☐	☐

1. Are there specific institutional reasons why a national performance measurement system for assessing public service delivery has not been adopted?

- ☐ Yes
- ☐ No
- ☐ Don't know

2. If yes:

- ☐ The national government has no formal power to introduce an indicator system
- ☐ The regional government has introduced an indicator system
- ☐ Other (please describe):

3. What are the main obstacles preventing implementation of a performance measurement system? *(tick all that apply)*

- ☐ It is too expensive
- ☐ It is technically too difficult to implement
- ☐ There is a lack of capacity at the national level
- ☐ There is a lack of capacity at the sub-national level
- ☐ There is a lack of motivation / commitment of the actors involved
- ☐ There is a lack of data available
- ☐ Coordinating the actors is too difficult
- ☐ It is not perceived to be useful
- ☐ We are currently experimenting with the use of indicators, but have not yet formalized a system
- ☐ The topic is currently under discussion
- ☐ It is not within the jurisdiction or the authority of the national government
- ☐ Other (please describe):