# 6 The governance of public service delivery across territories

The provision of health and education services has become increasingly decentralised in OECD countries, affecting how public services are delivered across territories. This chapter analyses the relationship between decentralisation and the provision of public services, while discussing the challenges of decentralisation and multi-level governance, such as overlapping responsibilities and coordination. It also examines how subnational governments and schools organize the provision of education services and looks at strategies to make this provision more effective through governance solutions. Finally, the chapter assesses the benefits and challenges of decentralising the diverse health systems in OECD countries and the quality of health care according to the degree of decentralisation.

## Introduction

Public social, education and health services have expanded in the last century, including those with universal access. The increasing expenditures on social and health care provision place governments in a challenging position, particularly where there is a tandem decline in tax revenue due to a smaller working-age population. How should decisions about the location of these services be made and what types of evaluative frameworks can be used to help guide these decisions? Even in countries where the national government is not responsible for health, social services or education, the nature of fiscal relations, in turn, structures the ability of subnational governments to respond. Chapters 3 and 4 discussed territorial approaches to the provision of education and health care. The present chapter focuses on the question of how governments organise the provision of education and health care services across national territories.

The scope of services provision and the role of the government in providing them have not been constant. Over the past decades, there is a discernible trend towards decentralisation across many OECD countries. Subnational governments play an increasingly critical role in the delivery of many essential public services and this has affected how public services are delivered across different territories. Decentralisation, devolution, regionalisation and privatisation have taken place to varying degrees. While some view this as the "hollowing out" of the state, others describe it as public management efficiency and needed reform (Rhodes, 1994[1]). Debates about public services are thus fundamentally linked to debates about the role of the government.

The arguments for and against decentralisation play out in public policy across OECD member countries. Where public services have been decentralised, upper-level governments (national or regional depending on whether it is a unitary or federal state) generally continue to play a role in defining, monitoring and assessing the quality of public services. They are also centrally concerned with addressing equity – this may include equity of access to public services for different populations (e.g. those that are deemed marginalised and at risk) and equity of access and quality across different territories. There, redistributive fiscal policies are important. Conditional intergovernmental transfers can be used to ensure that subnational governments design their programmes to national standards. Equalisation mechanisms can also be used to reduce territorial inequalities. These can be structured in a number of ways and may or may not account for population characteristics and population density, fiscal and institutional capacities. This chapter elaborates on these aspects in greater detail.

The first part of this chapter discusses the relationship between decentralisation and public service provision and outlines the challenges of multi-level governance in the context of public service provision. The second part discusses the role of subnational governments and schools in education-related decision-making and outlines strategies to increase the efficiency of education delivery through governance solutions. The third part discusses the decentralisation of health systems in OECD countries and discusses the possible effects of higher decentralisation on the quality of healthcare.

## Decentralisation, multi-level governance and service provision

The OECD defines decentralisation as a set of measures that transfer a range of powers, responsibilities and resources from the central government to subnational governments. In a decentralised system, subnational governments are governed by political bodies with assemblies and executive bodies and have their own administrative staff. In a decentralised setting, subnational governments can raise own-source revenues, such as taxes, fees and user charges and they manage their own budget.

Decentralisation can take different forms: i) delegation wherein the central government transfers decision-making and administration to regional or local governments; and ii) devolution wherein the central government transfers authority for decision-making, finance/taxation and administration to regional or local governments. The degree of decentralisation also depends on the extent of political, administrative and

fiscal autonomy of subnational units. See Box 6.1 for an explanation on the difference between these concepts and deconcentration.

Decentralisation reforms can be motivated by various political, administrative and fiscal reasons (Rondinelli, Nellis and Shabbir Cheema, 1983[2]). From an economic and fiscal perspective, decentralisation has been a method to improve the efficiency of public services and curb the growth of government spending. From a political viewpoint, decentralisation of authority is often expected to result in more accountable and transparent public governance, lower corruption, higher political participation and policy innovation (OECD, 2019[3]). Any decentralisation discussion should have clarity on the difference between devolution, delegation and deconcentration.

### Box 6.1. Devolution, delegation and deconcentration

**Important differences between these concepts**

Devolution and delegation form the two main degrees of decentralisation (Rondinelli, Nellis and Shabbir Cheema, 1983[2]). In devolution, national governments transfer functions to a subnational government with decision-making powers. Compared with delegation, devolution is a stronger form of decentralisation because devolution assigns real powers from the central government to lower-level autonomous governments, which are legally constituted as separate levels of government. In contrast, delegation transfers limited decision-making and administrative authority for specific tasks from the central government to subnational governments. In delegation, subnational governments act merely as agents for the central government and remain under the direct or indirect control of the central government. In fact, the delegated tasks may be withdrawn or altered by the central government. Regulations and contracts allow delegating tasks from the central government to a subnational government.

Decentralisation should not be confused with deconcentration. Deconcentration is a governance model, which alters the responsibilities within levels of organisation. For example, tasks may be shifted within the central government organisation from the ministry to central government-led offices in regions. In most countries, the central government has established regional offices for planning, monitoring and co-ordination purposes and for granting permits and licences. Deconcentrated central government tiers may co-exist with fiscally and legally self-governing regional or local governments. From this perspective, then, it is a mistake to consider reorganisation of health care into smaller units as decentralisation. It is not uncommon that health sector reforms have been labelled “decentralisation”, even when it is not clear that the term applies (Saltman, Bankauskaite and Vrangbæk, 2007[4]).

Source: Rondinelli, D., J. Nellis and G. Shabbir Cheema (1983[2]), *Decentralization in Developing Countries A Review of Recent Experience*, World Bank.

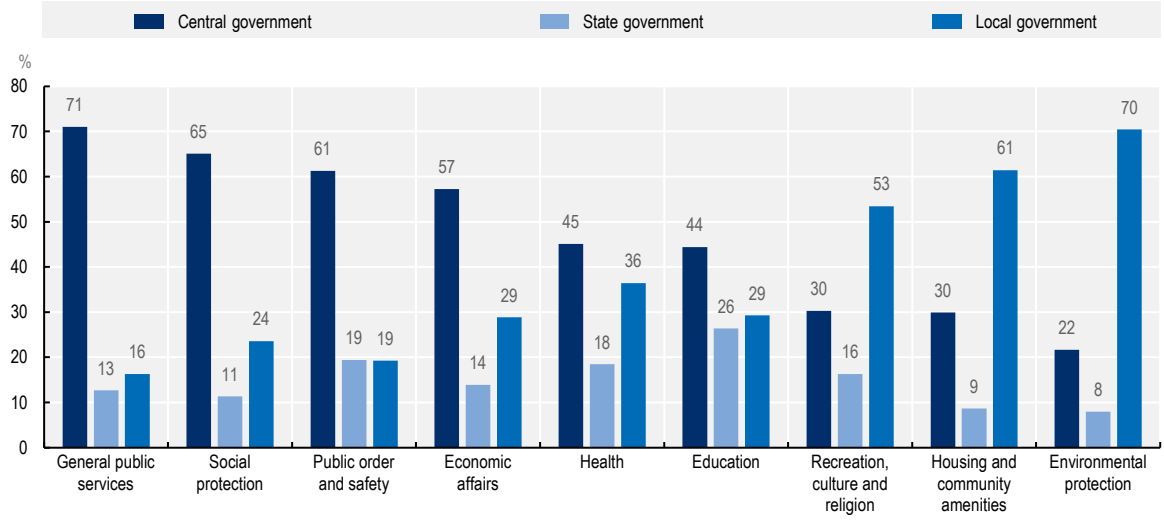
Overall, there are no clear-cut frontiers within decentralised governance systems. Rather, there are different degrees of decentralisation, depending on the extent of political, administrative and fiscal powers that have been assigned to lower levels of government. In this framework, full devolution of health services is a relatively rare phenomenon (this will be discussed in more detail in a later section). In social services or education, decentralisation is much more common and widespread.

Expenditures are another way of characterising who does what and the level of centralisation versus decentralisation of public services in a country. Across the EU28, central government expenditures consisted of around 60% of all expenditures in 2017 while the state (regional) and local governments were responsible for around 15% and 25% of total expenditures across all functions (including spending on

defence) (Figure 6.1). Across the various functions, EU28 central governments had the highest expenditures in general public services, social protection, and public order and safety (at 71%, 65% and 61% respectively within each function category).

## Figure 6.1. Government expenditure by function and level of government, EU28

Percentage out of total expenditure by function, 2017




Note: Chart excludes defence spending which is almost entirely the purview of central governments. Data excludes social security funds. Government function according to the Classification of the Functions of Government (COFOG).
Source: Eurostat (2020[5]), *General Government Expenditure by Function (COFOG)*, https://ec.europa.eu/eurostat/web/products-datasets/-/gov_10a_exp (accessed on 15 May 2020).

StatLink https://doi.org/10.1787/888934226785

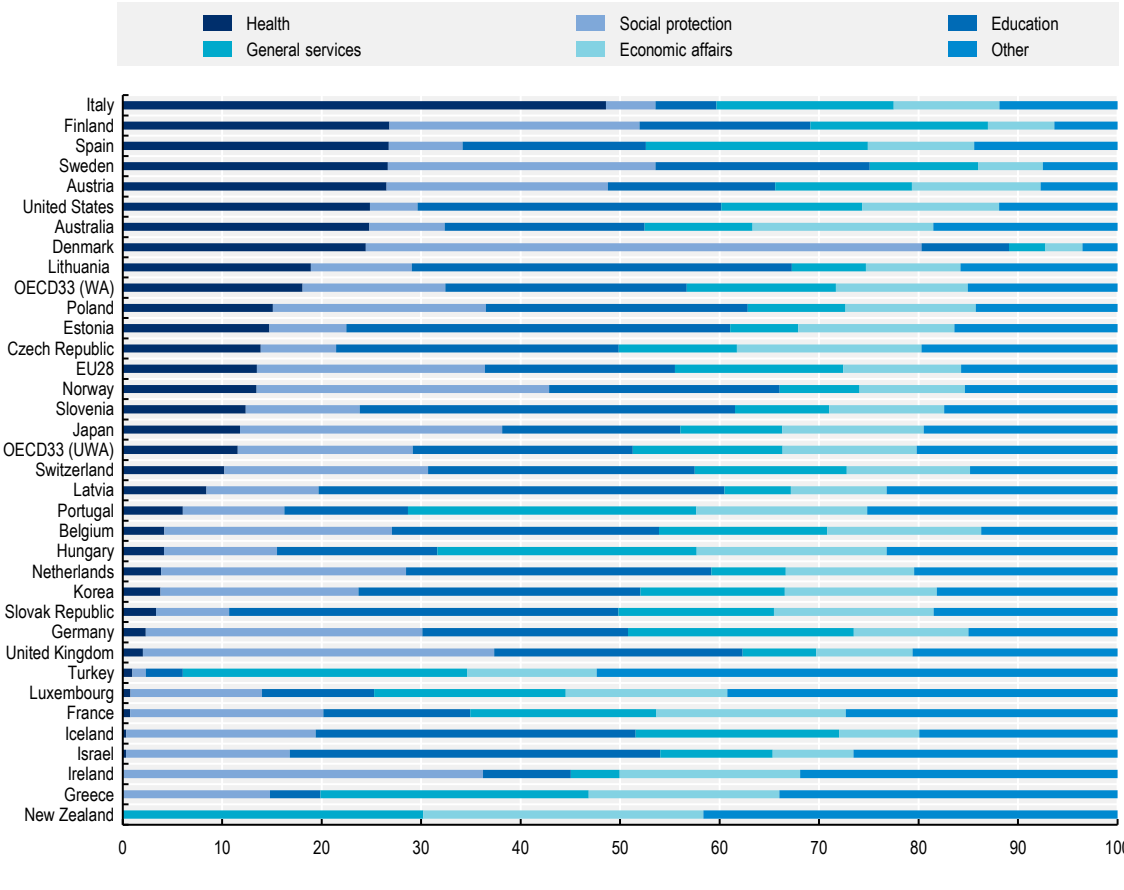
In contrast, local governments held the highest share out of total expenditures in environmental protection, housing and community amenities and health respectively (at 70%, 61% and 36% respectively out of each function category). State/regional governments do not dominate any category of expenditure by function. However, they are most active in the area of education, accounting for 26% of all expenditures in that category among levels of government. In the OECD, education, social protection, general services and economic affairs form the most important service categories for subnational governments (Figure 6.2).

### *Spending and revenue assignments to subnational government*

Decentralisation consists of decentralised spending and revenue assignments, transfer system and well-functioning local democracy. For example, an effective accountability mechanism of decentralisation requires that local residents have a strong incentive to evaluate the efficiency of their local administration. Such incentive exists if a considerable share of local public services is financed with local taxes. If local residents must finance additional spending by paying more local taxes, they will have a strong incentive to monitor their local administration and, if needed, punish them for poor performance (OECD, 2019[3]). Obtaining the full benefits from decentralisation requires careful implementation of the decentralised system, as explained in more detail in Box 6.2.

## Figure 6.2. Subnational government expenditure, sectoral spending shares

2017, Classification of the Functions of Government (COFOG) classification




Note: Category "Other" is the sum of categories Defence, Public order, Environment, Recreation, Culture and Religion, and Housing and community. No data for Canada, Chile and Mexico. For the United States (US), data showed in the function "Housing and community amenities" include the "Environment protection" function data. OECD7 and OECD26 refer respectively to the averages for OECD federal countries and OECD unitary countries. (WA) denotes weighted average and (UWA) means unweighted average of countries included.

Source: OECD (2020[6]), "The territorial impact of COVID-19: Managing the crisis across levels of government", https://doi.org/10.1787/d3e314e1-en; OECD (2020[7]), *OECD National Account Statistics*, https://doi.org/10.1787/na-data-en (accessed on 15 May 2020); estimates from IMF Government Statistics for Australia and Chile; OECD (2020[8]), *Regions and Cities at a Glance 2020*, https://doi.org/10.1787/959d5ba0-en; OECD (2020[9]), *Regional Statistics*, https://www.oecd.org/regional/regional-statistics/.

StatLink https://doi.org/10.1787/888934226804

### Box 6.2. Current debates on the benefits of decentralisation

**Is more decentralisation always desirable?**

Decentralisation has been associated with a number of economic, political and administrative benefits, such as better efficiency of public service delivery, improved accountability and transparency of public decision-making, and strengthened citizen participation in government. Decentralisation has also been found to constrain rent-seeking and corruption in the public sector (OECD, 2019[3]). Moreover, decentralisation can provide a platform for experimenting and bottom-up policy innovation.

Decentralisation has also been found to associate with enhanced overall and regional economic growth as well as lower regional disparities in economic growth (Bartolini, Stossberg and Blöchliger, 2016[10]). While a positive correlation with decentralisation and economic growth does not imply causality, there is evidence that decentralisation contributes to economic capacity in ways that can lead to faster growth. It has been argued that subnational fiscal power is associated with higher economic activity through productivity and human capital improvement, for example, because investment in physical and human capital increases with decentralisation (Blöchliger, 2013[11]). Furthermore, decentralisation can lead to better-performing education systems, which in turn may contribute to growth (Blöchliger, Égert and Fredriksen, 2013[12]). Regionalisation may as well correct inter-regional disparities and give local actors the means to implement better regional development policies such as EU funds management in the European Union (EU) (Morgan, 2006[13]).

The opponents of decentralisation doubt such positive effects of decentralisation and instead emphasise the risks and challenges of decentralisation. The potential problems of decentralisation mentioned include especially diseconomies of scale, inability to deal with externalities, weaker stabilisation policy, increased inequity and corruption. Many of the potential issues of decentralisation can, however, be solved with careful design and implementation.

Source: OECD (2019[3]), Making Decentralisation Work: A Handbook for Policy-Makers, https://dx.doi.org/10.1787/g2g9faa7-en; Bartolini, D., S. Stossberg and H. Blöchliger (2016[10]), "Fiscal Decentralisation and Regional Disparities", https://dx.doi.org/10.1787/5jlpq7v3j237-en; Blöchliger, H. (2013[11]), "Decentralisation and Economic Growth - Part 1: How Fiscal Federalism Affects Long-Term Development", https://dx.doi.org/10.1787/5k4559gx1q8r-en; Blöchliger, H., B. Égert and K. Fredriksen (2013[12]), "Fiscal Federalism and its Impact on Economic Activity, Public Investment and the Performance of Educational Systems", https://doi.org/10.1787/5k4695840w7b-en; Morgan, K. (2006[13]), "Devolution and development: Territorial justice and the North-South divide", http://dx.doi.org/10.1093/publius/pji003.

### *Spending assignments: Theory and practice*

The economic theory divides public functions into three branches: allocation, redistribution and stabilisation (Oates, 1972[14]; Musgrave and Musgrave, 1980[15]). In this framework, the stabilisation function is considered to be mostly the responsibility of the central government as it is best suited to deal with monetary and fiscal policies. Also, the redistribution function is regarded mostly as the central level's responsibility because the central government is much better positioned to carry out income redistribution from the rich to the poor and in establishing minimum standards of public services across regions.

The allocation function – i.e. public services provision – can be the responsibility of both the central government and subnational governments. In allocation, the central level of responsibility is best applied when the services have no specific local interest. Subnational government responsibility is justified when the benefits of the goods or services are spatially limited and if the preferences for the service-tax mix are heterogeneous. Moreover, according to "Decentralisation theorem" (Oates, 1972[14]), the subnational level is the most suitable level to provide public services, unless the central government has a clear advance in service provision. This could be, for example, if the central government is clearly better able to utilise economies of scale in public service provision.

The services with mostly local effects, such as local infrastructure, sewerage, local land use, housing or basic education, are usually considered best suited for subnational government provision. For such public services, both *direct* and *indirect* benefits can be obtained from decentralised service provision. Probably the most important direct benefit from decentralisation is the ability of regional and local governments to tailor the services to meet residents' needs, the so-called allocative efficiency effect. The basis of this argument is that subnational governments often hold valuable information on local demands and conditions. Obtaining such information would be costly for the central government and therefore the central level is likely to provide a uniform level of public output in all jurisdictions. Therefore, if the preferences and

needs between local jurisdictions differ in these services, the subnational governments have the potential to outperform central government in allocating public sector resources (OECD, 2019[3]).

The central government usually has a strong interest in ensuring equity for citizens in different parts of the country, especially in the event of decentralised redistribution. Therefore, central governments tend to retain responsibility for *designing and planning the policy, setting the standards and carrying out the oversight* (the first column of Table 6.1). Even in the case of strong central government steering and monitoring, it is justified that regions and local authorities are involved (or at least heard) in planning policies and service standards because subnational governments hold important information on local conditions. For public services with mostly local effects, the regions and local government can more freely design their own policies and service delivery methods.

As for *service provision and administration* (second column of Table 6.1), the responsibility of regions and local governments is justified in particular in case of services with mostly local of regional benefits, such as local and regional land use planning, water and sewerage, solid waste disposal, fire protection and police. Regional governments should be responsible for services with regionwide benefits such as regional economic development or transportation. It should also be noted that in the case of some services, central government responsibility for service delivery can also be justified if considerable externalities are involved. Examples of such services include roads of national importance, services dealing with natural resources, specialised health, higher education and social welfare. In these cases, shared responsibility across levels of government is often justified, as the externalities may vary in scope.

### Table 6.1. Assigning spending responsibilities in a multi-level government framework

| | Policy, standards, oversight | Service provision, administration | Production, distribution | Comments |
|---|---|---|---|---|
| Local land use planning, building permits | N, R, L | L | L | Mainly local benefits |
| Regional land use planning | N, R, L | R | R | Externalities, mainly regional benefits |
| Water and sewers | N, R, L | L | L, P | Mainly local benefits |
| Solid waste | N, R, L | L | L, P | Mainly local benefits |
| Fire protection | N, R, L | R, L | R, L | Mainly regional or local benefits |
| Police | N, R, L | R, L | R, L | Mainly regional or local benefits |
| Parks, recreation | N, R, L | R, L | R, L, P | Benefits vary in scope |
| Public transport | N, R, L | R, L | R, L, P | Externalities vary in scope |
| Economic development | N, R, L | R, L | R, L | Externalities vary in scope |
| Roads | N, R, L | N, R, L | R, L, P | Benefits vary in scope |
| Natural resources | N, R, L | N, R, L | N, R, L, P | Benefits vary in scope |
| Environment | N, R, L | N, R, L | N, R, L, P | Externalities vary in scope |
| Education | N, R, L | N, R, L | R, L, P | Externalities, transfers in kind |
| Health | N, R, L | N, R, L | R, L, P | Externalities, transfers in kind |
| Social welfare | N, R, L | N, R, L | R, L, P | Redistribution |

Note: N = National; R = Regional; L = Local; P = Private or non-governmental.
Source: Author's modification and extension of the material presented in Bahl, R. and R. Bird (2018[16]), *Fiscal Decentralization and Local Finance in Developing Countries*, https://www.e-elgar.com/shop/gbp/fiscal-decentralization-and-local-finance-in-developing-countries-9781786435293.html.

While in general, these theoretical principles seem to correlate with the policy practices observed in different countries, there are also important differences between countries in the implementation of spending assignments. In some unitary countries, such as the Nordic countries, subnational governments have exceptionally wide-ranging responsibilities, as the regions and municipalities in the Nordic countries provide most redistributive services (education, health and social services). In other countries, like in Chile, France, Italy, New Zealand and Portugal, education and health services are largely provided by the central government, or, even if services are partially decentralised, the delivery is strictly regulated (OECD, 2019[3]; OECD/UCLG, 2019[17]).

In practice, spending assignments across levels of government depend not only on economic efficiency arguments but also on historical, cultural and political factors. The question is how to manage the shared assignments and responsibilities so that each level of government can focus on its own tasks and that there are no incentives to shift costs to other levels of government. In recent years, many countries have attempted to reform spending assignments. For example, in Denmark, an important goal of the subnational government reform in 2007 was to reduce the shared responsibilities and to diminish incentives for cost-shifting between government levels. At the same time, the number of municipalities and counties was reduced and the spending assignments were reorganised between levels of government. Counties were assigned the responsibility for most demanding healthcare services including hospital services. Municipalities gained responsibilities for health promotion, social welfare and education. In the Netherlands, the decentralisation reform of 2012-15 focused on reallocating competencies between the different levels of government and establishing a simpler and clearer division of responsibilities between the different public actors (OECD, 2019[3]).

### *Assigning subnational government revenues: The "finance should follow function" principle*

The usual recommendation for decentralising revenues is that finance should follow function. In other words, the spending assignments should be defined before making decisions on subnational government revenue sources. More importantly, the spending assignments should largely define the subnational government own revenue assignment (and not vice versa) and the design of the transfer system (Boadway and Tremblay, 2012[18]).

There are two key decisions to be made with respect to revenue assignment to subnational governments: first, given the spending assignments, which revenue bases should be allocated to subnational government levels and second, how much responsibility the subnational governments should have in financing their own expenditures. Table 6.2 summarises the appropriate subnational government revenues for different expenditure categories. *User charges* are considered the most efficient local financing instruments, provided that two conditions are fulfilled: i) the benefits of local public services and goods in question are spatially limited within the borders of the jurisdiction; and ii) the exclusion principle[1] can be applied in pricing. As is summarised in Table 6.2, user charges can form the primary source of funding in public utilities, such as water, sewerage, public housing and public transport (Bahl and Bird, 2018[16]).

Local taxes should be the primary revenue source for most other local public spending categories, provided that the benefits of these services accrue mostly to the local population. This would secure the principle that those who bear the local tax burden will also receive the benefits from the expenditures that are financed by the local taxes. Such services include general administration, primary education, local streets, lightning, drainage, garbage collection, public parks, fire protection, police and recreation services (Bahl and Bird, 2018[16]).

For the services with major externalities and benefit spill-overs to other jurisdictions or the whole country, like major roads and highways, health services or higher education, intergovernmental transfers should be the primary source of local revenue. This is because local authorities are likely to neglect the potential benefits received by users in other jurisdictions, which would lead to under-provision of these services from wider (national and regional) perspective (Bahl and Bird, 2018[16]; King, 1984[19]).

## Table 6.2. Appropriate subnational government revenue by category of expenditure

| Service | Local taxes | User charges | Transfers | Borrowing |
|---|---|---|---|---|
| General administration | P | .. | .. | .. |
| Education | P | S | P | (A) |
| Health | S | S | P | (A) |
| Welfare | S | .. | P | .. |
| Water supply | S | P* | .. | A |
| Sewerage | S | P* | .. | A |
| Drainage | P | P* | .. | A |
| Markets and abattoirs | S | P* | .. | (A) |
| Housing | S | P | S | A |
| Land development | .. | P* | .. | A |
| Streets | P | S* | .. | A |
| Motorways | S | P* | P | A |
| Public transportation | S | P | .. | A |
| Garbage collection | P | P | .. | (A) |
| Garbage disposal | S | P | S | A |
| Parks and recreation | P | .. | .. | (A) |
| Fire protection | P | .. | .. | (A) |
| Police | P | .. | .. | .. |

Note: P= Primary source funding; S = Secondary source; A = Borrowing appropriate for major capital expenditures; (A) = Borrowing appropriate for capital expenditures but likely to account for a small share of spending.
* = Development charges (special assessments, valorisation charges, etc.) are appropriate where benefits are spatially well defined within a jurisdiction. ** Transfers may be from regional or central government.
Source: Author's modification and extension of the material presented in Bahl, R. and R. Bird (2018[16]), *Fiscal Decentralization and Local Finance in Developing Countries*, https://www.e-elgar.com/shop/gbp/fiscal-decentralization-and-local-finance-in-developing-countries-9781786435293.html.

It is generally agreed that the efficiency and accountability of local service provision are best secured if subnational governments finance a considerable share of their spending with own revenues (OECD, 2019[3]). While the literature does not provide a blueprint on the target share of own revenues, it is widely accepted that subnational governments should finance their spending with own revenues at the margin. Such a principle would help ensure that decisions to expand public programmes are made keeping in mind the additional costs (Oates, 2008[20]). Moreover, when local residents self-finance the local services through local taxes and charges, they have an incentive to evaluate the costs and benefits of local service provision and benchmark local government performance against neighbouring jurisdictions. Such "yardstick competition" can encourage local politicians to maximise the welfare of local residents instead of promoting their own self-interested goals.

As for the question of tax assignment, the usual recommendation is that subnational government tax revenues should be mainly based on land or property taxes and user fees (Boadway and Tremblay, 2012[18]; Bahl and Bird, 2018[16]). But if the service menu consists of services with high spending needs and if subnational governments are expected to finance a considerable share of their spending from their own revenue sources, it is likely that property tax bases and other user charge type of revenues are not enough to cover adequate levels of own revenue. In that case, subnational governments should be given some broad residence-based tax bases such as income tax, payroll tax or sales tax. Each of these taxes, if given to subnational governments with some power to decide tax rates, can have side effects on the mobility of households, business location and shopping.

To avoid unwanted effects, it is usually recommended that subnational governments are given powers to choose rates but not tax bases. If subnational governments are able to choose both tax bases and tax rates, the national redistributive objectives and equity of taxpayers in different subnational governments could be compromised. There would also be potential problems with vertical tax externalities (Boadway and Tremblay, 2012[18]). Other taxes suitable for subnational governments include resource royalties, conservation charges, sin taxes, motor vehicle registration taxes, frontage charges and poll taxes (see also Table 6.3). In addition, subnational governments may be allowed to piggyback on national taxes on personal income (residence-based), wealth and carbon taxes (OECD, 2019[3]).

### Table 6.3. Tax assignment across levels of government

| National | National/Provincial | State/Provincial | Local | All levels |
|---|---|---|---|---|
| Customs<br>Value added tax (VAT)<br>Corporate income tax (CIT)<br>Resource rents/profits<br>Wealth/Inheritance<br>Carbon | Personal income taxes (PIT) (residence-based)<br>Payroll taxes<br>Excises on alcohol and tobacco | Single-stage sales taxes<br>Motor vehicle registrations<br>Business<br>Royalties<br>Conservation charges | Property taxes<br>Land taxes<br>Betterment/Frontage charges<br>Surcharge on PIT<br>Parking fees | Sin taxes<br>Taxation of bads (environmental pollution)<br>Poll taxes<br>User charges |

Source: OECD (2019[3]), *Making Decentralisation Work: A Handbook for Policy-Makers*, https://dx.doi.org/10.1787/g2g9faa7-en.

#### *Transfer systems to reduce fiscal disparities*

Transfer systems form an important element of subnational government financing. Transfer systems ensure that different subnational governments are able to provide at least the minimum level of services. In general, transfers are used to reduce fiscal disparities at two levels: i) between the central government and subnational governments (vertical fiscal gap); and ii) between subnational governments (horizontal fiscal gap). The vertical fiscal gap can be diminished by paying lump-sum transfers to subnational governments. The horizontal fiscal gap is usually tackled with equalisation system, which is based on indicators and formulae that take into account differences between subnational governments in tax bases (tax base equalisation) and in service needs and special circumstances (expenditure equalisation).

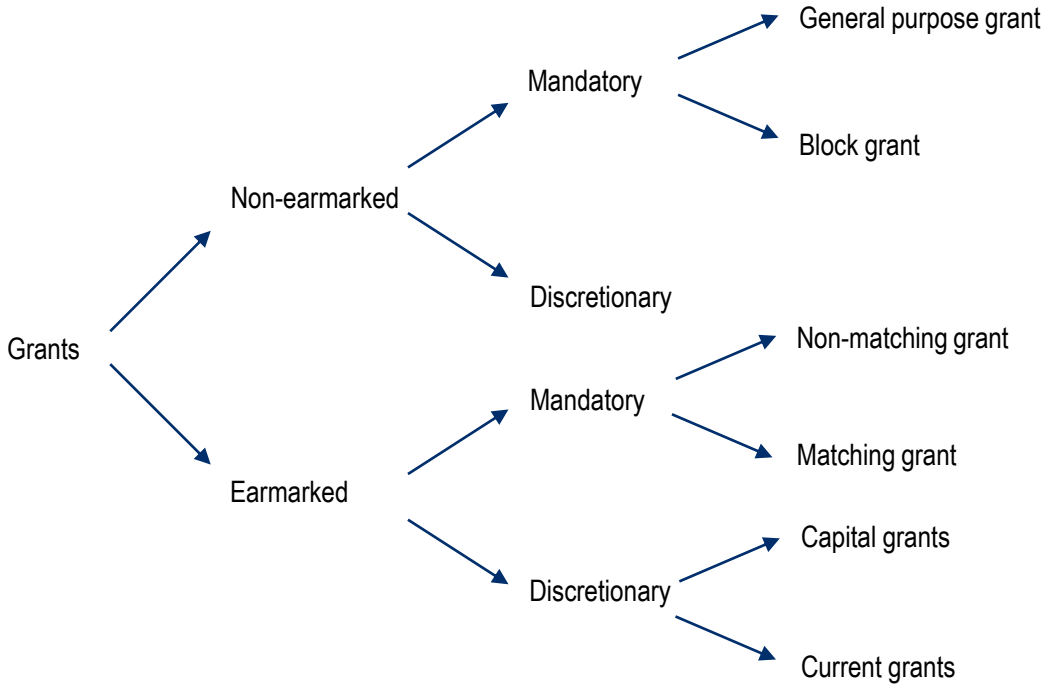
A well-working transfer system ensures that subnational governments can provide a comparable level of public services at comparable tax rates. Comparability is important mainly for two reasons: first, the central government can better monitor the subnational governments using indicators on service availability and quality and, second, local residents can compare local public services and tax rates of their own jurisdiction to situations in their neighbouring jurisdictions.

To classify the different types of transfers, the OECD Fiscal Federalism Network has developed a taxonomy of grants (Figure 6.3) (Blöchliger and King, 2006[21]). The main separation is between *earmarked* and *non-earmarked grants*. Subnational governments must use earmarked grants for a specific purpose whereas they can spend non-earmarked grants freely. Both main types of transfers are further divided into *mandatory* and *discretionary transfers*. Mandatory transfers are defined in the law, whereas discretionary transfers do not have such clear base. Discretionary grants are generally not recommended in wider use, as they diminish the transparency of the transfer system and are prone for lobbying and even corruption.

Earmarked grants may be further subdivided into *matching* and *non-matching grants*. Matching grants (a certain percentage of subnational government expenditure in specific service, say in education) can be useful especially when a new public service is launched. Wider use of matching grants and use for a long time is not advisable, because matching grants tend to boost spending growth. Moreover, matching grants favour richer municipalities, although tax base equalisation or using differentiated matching rates for rich and poor municipalities, can diminish risks of inequity created by such effects. The non-earmarked grants

can be divided into block and general-purpose grants. Block grants and general grants are typically defined using formulae, and they are usually recommended for financing subnational governments because they come with no strings attached. It is recommended that the formulae used for determining central government transfers should be transparent and non-discretionary. Block grants are usually meant for specific services but there is no strict regulation for the eventual use. General grants are the least restrictive of all transfers, as they are basically pure income support for subnational governments and there is no regulation on how the moneys should be used. Finally, the transfers can be divided into grants for *capital expenditure* and grants for *current expenditure* (Blöchliger and King, 2006[21]; Bahl and Bird, 2018[16]).

### Figure 6.3. The OECD taxonomy of grants




Source: OECD (2019[22]), *OECD Fiscal Decentralisation Database*, https://www.oecd.org/tax/federalism/fiscal-decentralisation-database.htm#A_1 (accessed on 30 August 2019).

### Box 6.3. Administrative federalism versus decentralisation and centralisation

The theoretical research literature on administrative federalism argues that there is a third alternative between a fully centralised and a fully decentralised system (Schwager, 1999[23]). Administrative federalism means a situation where subnational governments act mostly as agencies that respond to central government directives (Oates, 2005[24]). The proponents of administrative federalism argue that decentralised decisions are inefficient because of the spill-overs between jurisdictional borders. On the other hand, a centralised system is also inefficient because the centre often acts as a non-benevolent planner, favouring one or few regions over all regions (Schwager, 1999[23]). In such a setup, administrative federalism can be a safeguard against the central government with regionally biased preferences. It is also argued that administrative federalism can solve the benefit spill-over problem occurring in decentralisation because local jurisdictions are fully controlled by the central government.

The critics of administrative federalism argue that administrative federalism does not acknowledge the benefits from the electoral and fiscal autonomy associated with truly decentralised spending and revenue decision/making. Perhaps the biggest loss resulting from the "principal-agent model" type of administrative federalism, compared with decentralisation, is the reduced accountability of local governance operating under central control. Also, it has been shown both in theory and in practice that benefit spill-over problems can be solved in a decentralised system with central government matching grants or with co-operation between local jurisdictions. Furthermore, in the case of major externalities, centralisation can be an effective way to organise the services.

In practice, administrative systems are usually mixed and the degree of decentralisation or centralisation depends on political, historical, cultural factors along with the economic motives. The Nordic countries provide one example of such a mixed approach, sometimes called the Nordic application of administrative federalism (Borge and Rattsø, 2012[25]). Denmark, Finland, Norway and Sweden have each developed their own model of fiscal federalism characterised by local responsibility for welfare services, local tax financing through an income tax and extensive equalisation systems. At the same time, central governments are actively involved in policy, standards and oversight because subnational governments have been assigned many services with redistributive effects (health, social services, education).

Source: Schwager, R. (1999[23]), *Administrative Federalism and a Central Government with Regionally Based Preferences*; Oates, W. (2005[24]), "Toward a second-generation theory of fiscal federalism", *International Tax and Public Finance*, http://dx.doi.org/10.1007/s10797-005-1619-9; Borge, L. and J. Rattsø (2012[25]), "Fiscal federalism: International experiences and the Nordic response", https://www.doria.fi/handle/10024/148896.

### *Addressing the challenges of decentralisation to improve service provision*

Decentralisation reforms should be carefully planned and implemented because decentralisation is not without its challenges and shortcomings (OECD, 2019[3]). Some of these challenges relate to decentralisation in general but often problems arise because of unsuccessful implementation of decentralisation reforms. Examples of general problems of decentralisation include risks of diseconomies of scale and benefit spill-overs of subnational government service provision. Problems of implementation include overlapping responsibilities between the central government and subnational government tiers, unfunded mandates, partial decentralisation and lack of capacities of subnational governments to deliver the tasks assigned to them. These problems and the solutions to tackle the issues are discussed briefly below.

#### *Benefit spill-overs and externalities*

Benefit spill-overs across jurisdiction borders form a typical challenge of decentralisation. Benefit spill-overs exist in decentralised systems because it is often difficult to ensure that jurisdiction's administrative boundaries coincide with the service benefit areas. These spill-overs mean that residents in neighbouring jurisdictions benefit from services paid by other jurisdiction's taxpayers (like roads/streets, parks, sports facilities, theatres). This can be a problem if it leads to under-provision of public services, notably if subnational governments do not take into account the benefits received from the service by residents in other jurisdictions. While "internalising" such externalities is not easy, mainly because information on the size of externalities is usually scant, the potential solutions are relatively straightforward. Central governments may intervene using earmarked transfers to subnational governments to encourage extended service delivery that also takes into account non-resident users. Another potential solution is co-operation between subnational governments. Joint service delivery enlarges the service area and helps divide the cost among the services users (see Box 6.4). A third potential solution could be to move service responsibility from lower to upper level of government.

### Box 6.4. Is bigger always better? Results on economies of scale and optimal subnational government size

While the research evidence on the economies of scale in the provision of public services seems to be mixed, policymaking often departs from the assumption that "bigger is better". Thus, the policy trend in recent decades has been towards increased size in public services by amalgamations of local governments, mergers of service units and closures of facilities (Kortelainen et al., 2019[26]).

Economies of size arise for two main reasons: first, spreading large fixed costs (for example big investments on utilities) over a larger user base ensures lower unit cost and prices of service. Second, a larger local government unit may be better able to hire skilled workers, which can help to maintain a higher quality of services (Bahl and Bird, 2018[16]).

But there is no strong empirical evidence of economies of scale once localities exceed relatively small population levels. Moreover, the biggest local government units are often among the most inefficient. In fact, a U-shaped cost curve is often found for local public services (except the most capital-intensive ones), that is, costs decrease up to some point and then increase as population size increases (Bahl and Bird, 2018[16]).

The results on the optimal size can be summarised as follows (Holzer et al., 2009[27]):

- There is little overall correlation between size and efficiency for municipalities with populations between 25 000 and 250 000.
- The literature does suggest that smaller municipalities (population under 25 000) are less efficient, but details are important.
- Much of the literature argues that small municipalities are not less efficient, except in specialised services.
- Increasing size is related to increased efficiency in capital-intensive services such as utility systems or public works.
- For labour-intensive services, such as police work, an increase in size is related to a decrease in efficiency − smaller units are more efficient than larger units.
- Larger municipalities with populations over 250 000 are clearly less efficient.
- The literature suggests that cost per capita may not be a good measure of efficiency or performance because of the distorting effect of other factors. Yet, studies use this measure commonly.

Source: Holzer, M. et al. (2009[27]), *Literature review and analysis related to optimal municipal size and efficiency*, School of Public Affairs and Administration (SPAA) at Rutgers University; Bahl, R. and R. Bird (2018[16]), *Fiscal Decentralization and Local Finance in Developing Countries*, https://www.e-elgar.com/shop/gbp/fiscal-decentralization-and-local-finance-in-developing-countries-9781786435293.html; Kortelainen, M. et al. (2019[26]), *Effects of Healthcare District Secessions on Costs, Productivity and Quality of Services*.

#### *Lack of scale economies*

Decentralisation may result in a loss of economies of scale and fragmentation of public policies (OECD, 2019[3]). Determining the efficiency maximising subnational unit size and designing policies that help approach the optimum are highly important. It is not straightforward to determine the optimal subnational unit size, however, notably because the best subnational unit size depends largely on the policy area. For example, basic health services, child day-care, waste disposal and sewerage, regional planning and primary education all have different optimal population sizes (see Box 6.5). While there is only little empirical evidence on the optimal municipal size, some studies have concluded that the optimal municipal

size could be somewhere between 20 000 and 50 000 inhabitants (Bahl and Bird, 2018[16]). Despite problems in defining the optimal subnational unit size, it can nevertheless be argued that larger subnational governments are often stronger financially, have a better investment capacity and are in a superior position for recruiting skilled personnel. But as the distance between local or regional decision-makers grows, so increases the risks of allocative inefficiency.

Economies of scale can be generated with municipal mergers and with inter-jurisdictional co-operation. In some cases, services may also be outsourced to private entities. Municipal mergers can, however, be problematic if they create economies of scale for some services but diseconomies of scale in others. Moreover, there is no evidence that municipal mergers automatically lead to costs savings. In fact, the mergers often result in faster growth of expenditure especially during the first years after the merger but also on the longer run (Moisio and Uusitalo, 2013[28]; Blom-Hansen et al., 2016[29]). Compared with mergers, inter-jurisdictional co-operation can be a more flexible alternative because it enables utilising economies of scale where it is most beneficial. The problem with inter-municipal co-operation is the risk for "democracy deficit", because the decision-makers of the co-operative units are usually nominated and not elected (OECD, 2019[3]).

National governments play an important role in establishing legal, regulatory arrangements and incentives to foster voluntary mergers and co-operation across jurisdictions. In countries with small subnational government units, such as the Nordic countries, but also in France, the Slovak Republic and Spain, central governments have been active in promoting merger reforms and inter-jurisdictional co-operation.

### Box 6.5. The rationale, benefits and challenges of inter-jurisdictional co-operation

Inter-municipal co-operation means that two or more municipalities work together to provide some specific task or several tasks. There are both voluntary and compulsory types of co-operation. In the former, the municipalities are free to establish long- or short-term co-operation and also to withdraw from co-operation. Mandatory co-operation is defined by law and compliance is monitored and sanctioned by the central government.

Inter-municipal co-operation is usually understood as expenditure sharing. In this case, municipalities provide joint services and share the costs associated with the delivery of the service. Inter-municipal co-operation can also include joint efforts on the revenue side, although this is less common than expenditure co-operation (Slack, 1997[30]).

There can be various motivations for voluntary inter-municipal co-operation but often the rationale is simply to enable more efficient service delivery and better services for the local inhabitants. In order to reach these ultimate goals, utilising economies of scale and creating better capacity for know-how or human resources is essential.

Inter-municipal co-operation is not the only way to utilise economies of scale in municipal service delivery, however. Municipal mergers, or outsourcing service production to private companies, can also lead to a bigger scale of production and cost savings. Municipal mergers can be politically difficult to accomplish though. Besides, based on research evidence, it is not clear that municipal mergers will automatically lead to costs savings (Blom-Hansen et al., 2016[29]; Moisio and Uusitalo, 2013[28]). It should also be noted that municipalities usually provide a wide variety of services and the optimal production size varies by service. Municipal mergers may then lead to economies of scale in some services but diseconomies of scale in others.

Furthermore, outsourcing is not always a feasible alternative because of legal reasons or lack of private markets. Regions and municipalities are also in a very different position in ability to utilise private

markets. Often the need to enhance economies of scale is greatest in small and remote regions and municipalities, where little suitable private provision may be available.

Compared with municipal mergers, inter-municipal co-operation seems an attractive option especially because it is relatively straightforward to establish. Voluntary inter-municipal co-operation involves a sort of a "minimal" government restructuring and this probably explains why it has been so popular in many countries (Slack and Bird, 2010[31]; OECD, 2019[3]). Due to the simplicity of the arrangement, a municipality can easily engage in many different co-operative deals at the same time without high administrative costs.

Inter-municipal co-operation is also a flexible solution. As times change, co-operation can be strengthened, scaled back or ended according to the needs of co-operating partners. Joint service provision can lead to a deeper engagement: a successful inter-municipal co-operation in one service area may lead to widened co-operation in other services and in some cases even to a later voluntary merger.

Economies of scale undoubtedly form the major benefit of inter-municipal co-operation. Especially capital-intensive public services (e.g. utility systems such as water, waste, energy) often require a certain minimum size for efficient service delivery. In such a framework, inter-municipal co-operation can be a feasible solution because it enables both improved economies of scale and tailoring of services to local needs.

Inter-municipal co-operation may also help secure local democracy because the number of elected local politicians does not diminish as a result of co-operation. Inter-municipal co-operation is not without its challenges, however. Perhaps the main disadvantage is that an extra tier in the hierarchy is introduced. Adding hierarchical layers may increase administration and monitoring costs. Inter-municipal co-operation may also result in "democracy deficit", as inter-municipal organisations are usually governed by representatives that are nominated by the member municipalities. This may reduce the accountability and transparency of local decision-making, compared with municipalities' own production (and with directly elected councils).

An important challenge of inter-municipal co-operation is also that the member municipalities engaging the co-operation inevitably have less power to affect the services than if the service was provided by their own organisation.

It has also been argued that inter-municipal co-operation may create a harmful common pool, which can lead to increased costs and inefficiency. Depending on the size of the pool, monitoring of inter-municipal co-operation by member municipalities may be lower if a common pool creates a disincentive to do so (Allers and van Ommeren, 2016[32]).

Source: Slack, N. (1997[30]), "Intermunicipal cooperation: Sharing of expenditures and revenues"; Blom-Hansen, J. et al. (2016[29]), "Jurisdiction size and local government policy expenditure: Assessing the effect of municipal amalgamation", http://dx.doi.org/10.1017/S0003055416000320; Moisio, A. and R. Uusitalo (2013[28]), "The impact of municipal mergers on local public expenditures in Finland", https://www.researchgate.net/publication/272795680; Slack, N. and R. Bird (2010[31]), "Merging municipalities: Is bigger better?", http://www.doria.fi/handle/10024/148891; OECD (2019[3]), *Making Decentralisation Work: A Handbook for Policy-Makers*, https://dx.doi.org/10.1787/g2g9faa7-en; Allers, M. and B. van Ommeren (2016[32]), "Intermunicipal cooperation, municipal amalgamation and the price of credit", http://dx.doi.org/10.1080/03003930.2016.1171754; OECD (2017[33]), *Multi-level Governance Reforms: Overview of OECD Country Experiences*, https://dx.doi.org/10.1787/9789264272866-en.

### *Unbalance between spending and revenue assignments*

From the implementation aspect, the challenges of decentralisation are often associated with the ratio of expenditure to revenue decentralisation, i.e. the so-called vertical fiscal gap. While in all countries spending is more decentralised than revenues (OECD, 2019[3]), problems are often linked with situations where

spending is highly decentralised but subnational governments' own revenue is very limited (Oates, 2008[20]). In such situations, a large share of subnational government expenditures is financed with central government transfers.[2] A considerable unbalance with spending and revenue assignments is likely to reduce incentives for efficient service delivery, for instance, because the local decision-makers are less compelled to justify additional spending to their own voters who bear the tax burden. At worst, a high degree of transfer dependency of subnational governments may lead to a soft budget constraint problem, which can destabilise total public sector finances (Rodden, Eskeland Gunnar S. and Litvack, 2003[34]). The risk of inefficient outcomes is smaller if subnational governments rely on their own revenues for financing their services at the margin (OECD, 2019[3]).

### *Unfunded or underfunded mandates*

One of the most frequent challenges of decentralisation is the misalignment between responsibilities allocated to subnational governments and the actual resources available to them. If the central government delegates or devolves tasks to subnational governments, the central government should also ensure that such mandates can be financed also in practice. Transfer systems should support especially local governments with low own-source potentials and/or higher costs due to greater service needs or unfavourable conditions. Access to finance should be consistent with functional responsibilities. Unfunded mandates are meaningless and underfunding is a source for disparities between subnational governments.

### *Insufficient capacity of subnational governments*

Successful implementation of decentralisation requires certain economic, administrative, institutional and strategic capacities from the subnational governments (OECD, 2019[3]). The capacities required from the subnational governments depend largely on tasks assigned to them and the regulation concerning the provision of tasks. There can be significant differences between subnational governments in their capacities and skills. Unless the capacity challenge is addressed, there is a risk that decentralisation intensifies differences between jurisdictions (OECD, 2019[3]). On the other hand, decentralisation can create responsibility and ownership of public programmes, which may help in building public sector capacity.

Capacity building at the subnational level requires a long-term commitment from both central and subnational governments. Addressing capacity gaps consist of several measures, which go well beyond simple training and technical assistance schemes. At best, capacity development programmes are based upon a careful assessment of local strengths and weaknesses and then tailored to the needs of individual local government units.

### *Overlapping responsibilities*

One potential challenge of decentralisation is formed by overlapping assignments among levels of government. In this respect, much depends on how the service assignments have been planned. A explained above, in theory, the designing of spending assignments depends on three aspects: the beneficiaries of the services; the externalities involved; and whether or not the service includes redistribution. According to that view, in a decentralised system, the central government's role is mostly in policy design, standards-setting and oversight. While regional and local governments could also have a role in these, their main focus should be in providing, administrating and producing the decentralised public services. Furthermore, the division of tasks between regional and local levels depends on the economies of scale, distribution of benefits and size of externalities.

In reality, such optimal assignment of tasks may not materialise and several tiers of government may engage in the provision of the same services. Such situations risk that incentives for cost transfers between levels of government ("passing the buck") arise, leading to inefficiency, lack of transparency and higher costs of service provision. In addition, without a clear assignment of responsibilities, it may become

impossible for citizens to hold the decision-makers accountable for shortcomings or policy failures. Such a situation may hinder efforts at transparency and citizen engagement, leading to democratic deficit.

*Intermediary institutions and cross-border services*

A previously noted, there has been a growth of intermediary institutions across OECD member countries – that is, forms of service provision that exist below the regional scale but above the local one. Special purpose bodies for transportation and transit services are one such example. Here the logic for the right scale of the service is determined by how the area is functionally connected – e.g. the areas across which people live, work and commute. There are economies of scale to be gained where one service provider can deliver across the functionally connected territory. These types of institutions are most common in metropolitan areas, connecting the city to the suburbs, but less so in rural ones. They can take a variety of forms: public bodies, public entities, regional co-ordinating bodies, transport associations, public benefit corporations, intercommunal authorities or regional transportation partnerships.

The intermediary scale makes sense for transportation and transit planning because the service being delivered is a network. But what of point services such as education and health care? The types of services and the characteristics of the population are an important consideration. For example, it may not be appropriate for young children to have to travel long distances in order to access education but it may be possible for older students. As such, education provision in many countries is scaled such that younger cohorts attend smaller neighbourhood schools but high school is provided at a larger scale.

One unique and emerging scale for public services is cross-border services. It can be extremely challenging to provide certain services across borders even where they are functionally closely connected or where economies of scale would make that the logical and most cost-effective choice. With free movement between borders, EU countries have spearheaded such co-ordination. The EU Directive No. 2011/24 – which stipulates that EU citizens have the right to access healthcare in any EU country and to be reimbursed for care abroad by their home country – has raised this issue on the policy agenda. This directive, combined with a number of EU financial instruments has been used to promote border-region projects alongside facilitating legal frameworks to enhance collaboration. However, despite these incentives, a study on the desirability and feasibility of cross-border hospital collaboration in Europe has found that such collaboration encounters a number of impediments such as the challenge of navigating distinct regulatory regimes (Glinos and Baeten, 2014[35]).

## Decentralisation and education services

From the political perspective, equity aspects often form an important motivation for the central government to steer subnational governments. Education is not an exception in this. Regulation of education services can be divided into three main categories: normative steering, resource control and information steering. In education, the typical forms of normative guidance include staff (teacher) qualifications, the curricula and the number of personnel (class size). Resource control involves the transfer system, in particular the use of earmarked and/or conditional grants to finance education. Information steering is a milder form of steering. It involves, for example, providing the municipalities, school boards and teachers the relevant information on good practices and the tools for preparing the curricula and teaching practices that can still be tailored to local conditions. In Finland, the central government steering in education was shifted at the end of 1990s from strict normative guidance to “information steering”, reflecting the general view that excessive guidance was detrimental to good education outcomes.

Since the early 1980s, a key aim of education reform has been to place more decision-making authority at lower levels of education systems. At the same time, many countries have strengthened the influence of central authorities in setting standards, curricula and assessments (OECD, 2018[36]). Less decentralised education systems may rely more on performance measurement and on rewarding good performance and

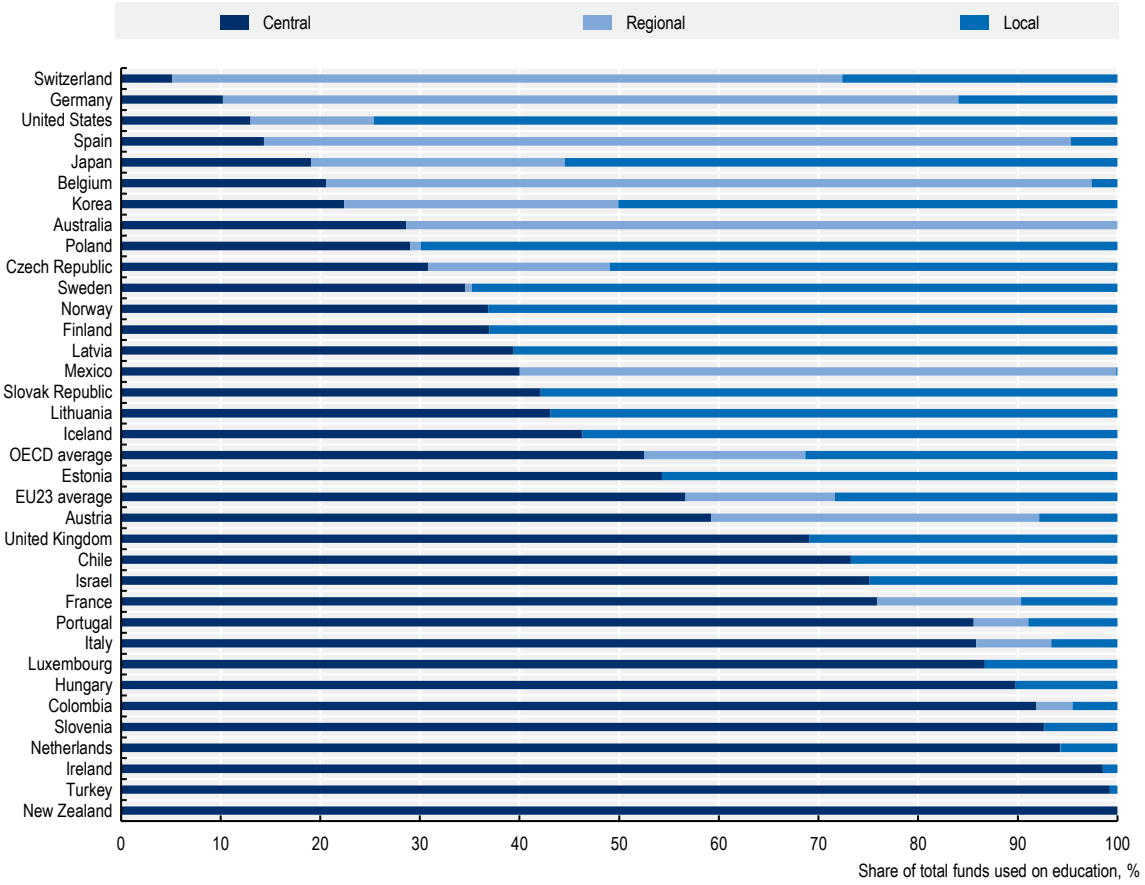
sanctioning “underperformance”. Such systems are typically built on financial incentives for schools and teachers to provide good student achievement. While such models may suit certain conditions, it is likely that in situations where differences between schools are small, the application of performance funding is less useful or even counterproductive.

### *Education is the main spending item of subnational governments*

While central governments have the main responsibility of financing education in the OECD, in many countries also subnational governments play an important role in education[3] spending (Figure 6.4). In the OECD, the central government is on average responsible for 52% of funds used on education, after transfers between levels of government have been taken into account, whereas regions are responsible for 16% and local governments for 32%. From this “use of funds” perspective, the most decentralised countries in education are the federal countries (Germany, Spain, Switzerland, the United States, and also Australia and Belgium are high in the country list) followed by unitary countries like the Czech Republic, Japan, Korea, Poland and Sweden. The least decentralised countries include Colombia, Ireland, the Netherlands, New Zealand, Slovenia and Turkey.

## Figure 6.4. The role of different levels of government in the use of public funds devoted to education

Shares %, 2016



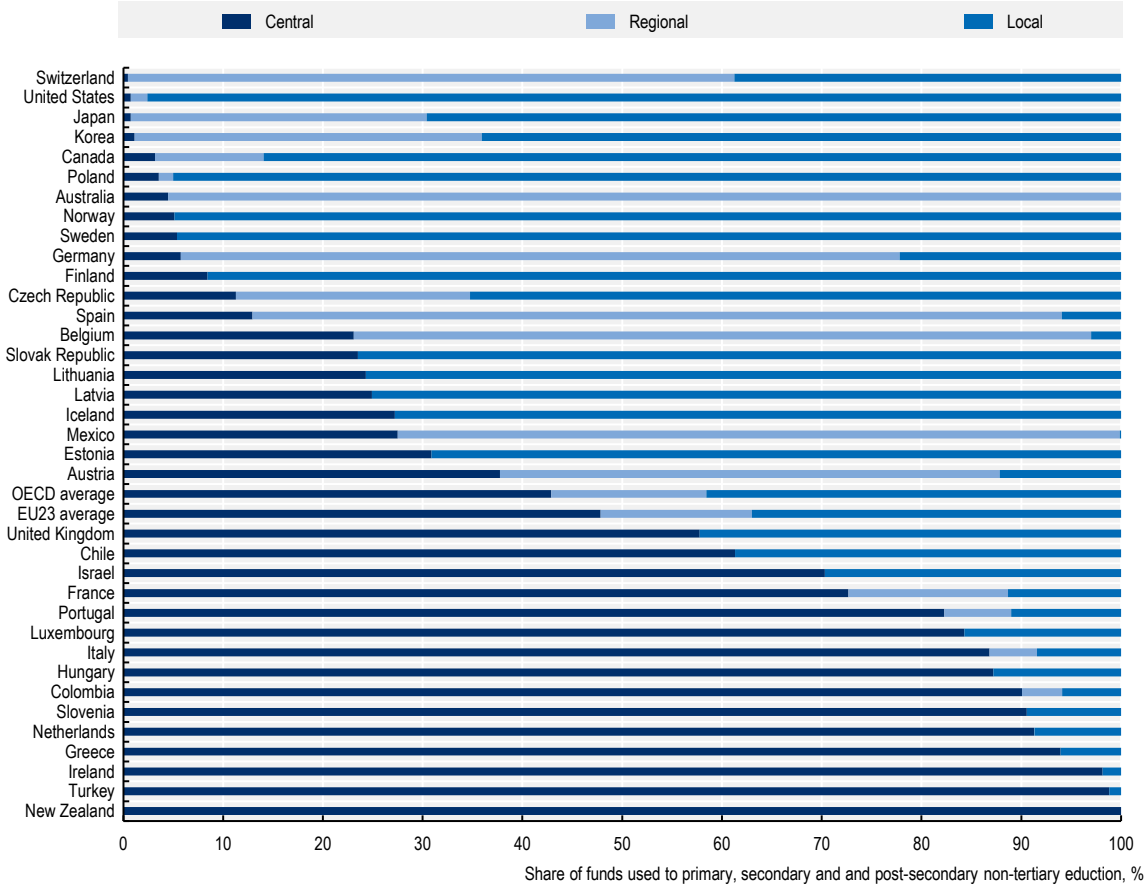

Note: The data covers education funds from primary to tertiary levels. No data was available for Denmark and Greece.
Source: OECD (2019[37]), *Education at a Glance 2019: OECD Indicators*, https://doi.org/10.1787/f8d7880d-en.

StatLink https://doi.org/10.1787/888934226823

In non-tertiary[4] education, the role of subnational governments, in particular the local governments, is emphasised. In the OECD, the central government share of non-tertiary education is 42.9%, whereas regional level is responsible for 15.6% and local governments for 41.6% of expenditure (Figure 6.5). The most decentralised non-tertiary education systems are in Australia, Canada, Japan, Korea, Poland, Switzerland and the US. The least decentralised systems are Colombia, Greece, Ireland, the Netherlands, New Zealand, Slovenia and Turkey.

## Figure 6.5. The role of government levels in the use of public funds devoted to primary secondary and post-secondary non-tertiary education

Shares %, 2016




Note: The data covers education from primary to secondary and other non-tertiary levels. No data was available for Denmark.
Source: OECD (2019[37]), *Education at a Glance 2019: OECD Indicators*, https://doi.org/10.1787/f8d7880d-en.

StatLink https://doi.org/10.1787/888934226842

Education forms the most important expenditure category for subnational governments in OECD countries (Figure 6.2). In 2017, education accounted for 24.3% of subnational government expenditure in the OECD. Education's share of subnational government expenditure was particularly high in Latvia, 40.8% of total local government spending in 2017. The share was high also in the Slovak Republic (39.1%), Estonia (38.6%), Lithuania (38.2%), Slovenia (37.7%) and Israel (37.2%). The data shows also that education forms a bigger share of subnational government expenditure in federal countries compared with unitary

countries in the OECD. Among unitary OECD countries, education forms a bigger share of expenditure in the small country group (by population).

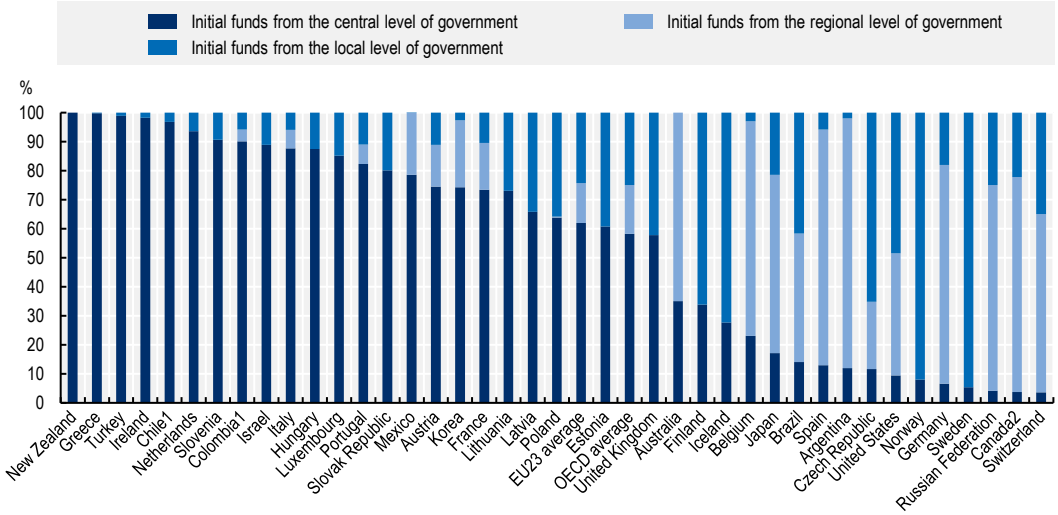
### *In many countries, transfers form a major source of education funding for subnational governments*

Transfers are an important source of education funding for subnational governments. From local autonomy perspective, however, a major role of central government grants in subnational government education financing may mean weaker decision-making autonomy of subnational governments. Consequently, education funding should be analysed both at the level of government where the funds originate (the initial level) and at the level of government at which they are ultimately spent (the final level). At the initial level,[5] decisions are made about the size of the funding, the allocation mechanism (transfer system) and the regulation, i.e. the restrictions on how the transfers can be spent. Some education financing systems are mixed so that the higher level of government pays directly for educational resources (e.g. teachers' salaries) and subnational governments are responsible for other spending.

The division of responsibility for public funding in non-tertiary levels of education varies greatly among countries (Figure 6.6). In countries such as Chile, Colombia, France, Greece, Hungary, Ireland, Israel, Italy, Luxembourg, the Netherlands, Portugal, Slovenia, Turkey and the United Kingdom (UK), the central government is the source of the majority of initial funds and the main final purchaser of educational goods and services. In New Zealand, the central government is solely responsible for the source of funds and for purchasing educational services. In Australia, Belgium, Canada, the Czech Republic, Finland, Germany, Iceland, Japan, Norway, Spain, Sweden, Switzerland and the US, the subnational government level has the main role in financing education.

## Figure 6.6. Distribution of initial sources of public funds for education, by level of government

2016 values



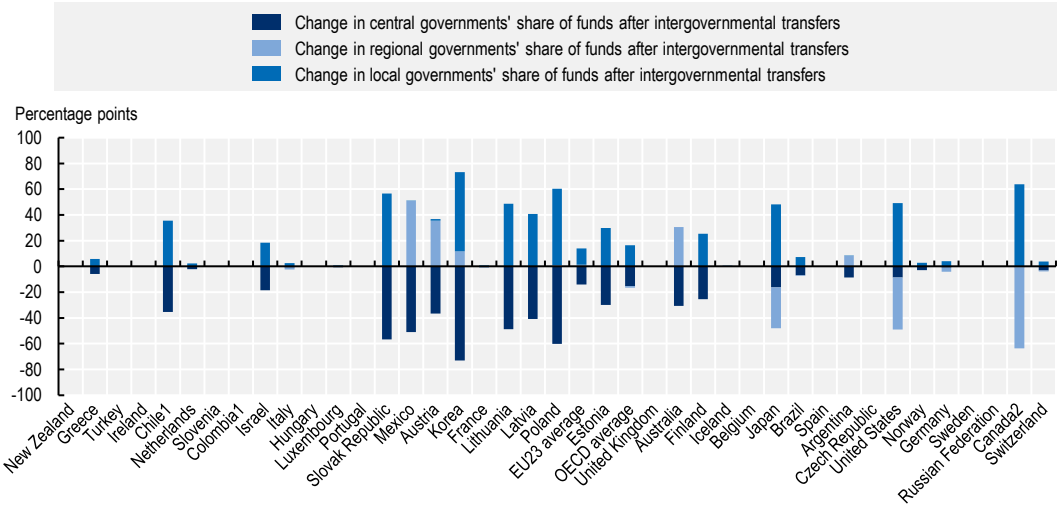

1. Year of reference 2017.
2. Primary education includes pre-primary programmes.
Source: OECD (2019[37]), *Education at a Glance 2019: OECD Indicators*, https://doi.org/10.1787/f8d7880d-en.

StatLink https://doi.org/10.1787/9d5314e3-en

Another way to approach the effect of transfer financing is to look at how to transfer financing changes the resources available for education services (Figure 6.7). In the OECD, transfer systems increase the subnational share of public funds available to education by 15 percentage points. Transfer systems are particularly important in Korea (change in subnational share of funds is 73.2%), Canada (63.2%), Poland (60.3%), the Slovak Republic (56.6%), Mexico (51%), Lithuania (48.8%) and Latvia (40.8%). Regional transfers vary considerably across countries: in Japan and the US, the regions – in addition to central government – pay transfers to local governments, while in Australia, Austria, Korea and Mexico, regions are considerable recipients of central government transfers. In between, there are countries like Canada, where only regions pay transfers to local governments.

## Figure 6.7. Change in government levels' share of funds after intergovernmental transfers

2016 values




Notes: 1. Year of reference 2018. 2. Primary, secondary and post-secondary non-tertiary education includes pre-primary programmes. Countries are ranked in descending order of the share of initial sources of funds from the central level of government.
Source: OECD (2019[37]), *Education at a Glance 2019: OECD Indicators*, https://doi.org/10.1787/f8d7880d-en.

StatLink https://doi.org/10.1787/9d5314e3-en

Looking at the share of subnational government of public funds together with the role of transfer system shows that in countries like Canada, the Czech Republic, Germany, Norway, Spain Sweden and Switzerland, the subnational government share of public funds devoted to non-tertiary education is high and the role of the transfer system is low (Figure 6.8). In these cases, the degree of decentralisation appears to be higher than average. On the other hand, in countries like Australia, Finland, Korea and Poland, although subnational governments use a major share of public funds available to non-tertiary education, they are reliant on central government transfers, possibly reducing their degree of decision-making autonomy.[6]

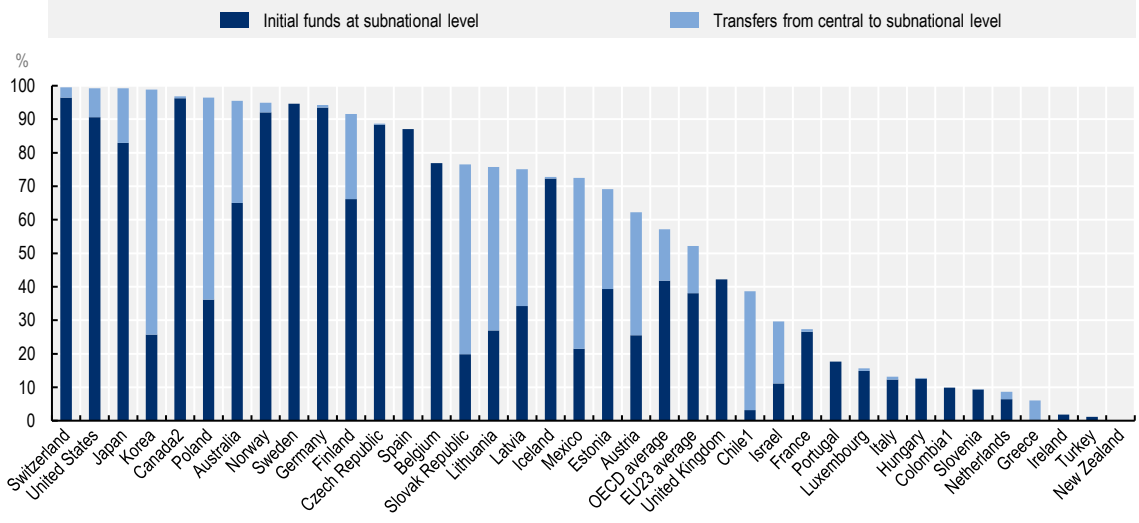
### *About half of the education decision-making is done at school or subnational government level*

The data collected for *OECD Education at a Glance* shows where key decisions are made in public institutions at the lower secondary level of education (OECD, 2018[36]).[7] In 16 of 38 countries covered by the study, education-related decisions are most often taken at the school level. In ten of these countries,

half or more of the decisions are taken at the school level. In the Czech Republic and the Netherlands, two-thirds or more of decisions are taken at the school level (Figure 6.9). In 11 of 38 countries, decisions made at the state or central level were the most prevalent. Luxembourg, Mexico and Portugal are the OECD countries and economies with the most centralised decision-making (more than three-quarters of decisions are taken at the central or state level).

## Figure 6.8. The composition of the share of public funds available for primary, secondary and post-secondary non-tertiary education at subnational government level

2016 values




Note: Data on Denmark was not available.
1. Primary education includes pre-primary programmes.
2. Year of reference 2017.
Source: Table C4.2. Total public expenditure on education as a percentage of total government expenditure, by source of funds (2016), OECD (2019[37]), *Education at a Glance 2019: OECD Indicators*, https://doi.org/10.1787/f8d7880d-en.

StatLink https://doi.org/10.1787/888934226861

There are large differences between countries on how decisions on teaching in lower secondary education are made. While in most countries such decisions are made by schools or the local government level, for example in Germany, two out of three decisions are taken at the central or state level. Most decisions on personnel management and the use of resources are taken at the local or school level in around one-half of countries. Decisions on planning and structures are mostly taken at one of the more centralised tiers of government (OECD, 2018[36]).

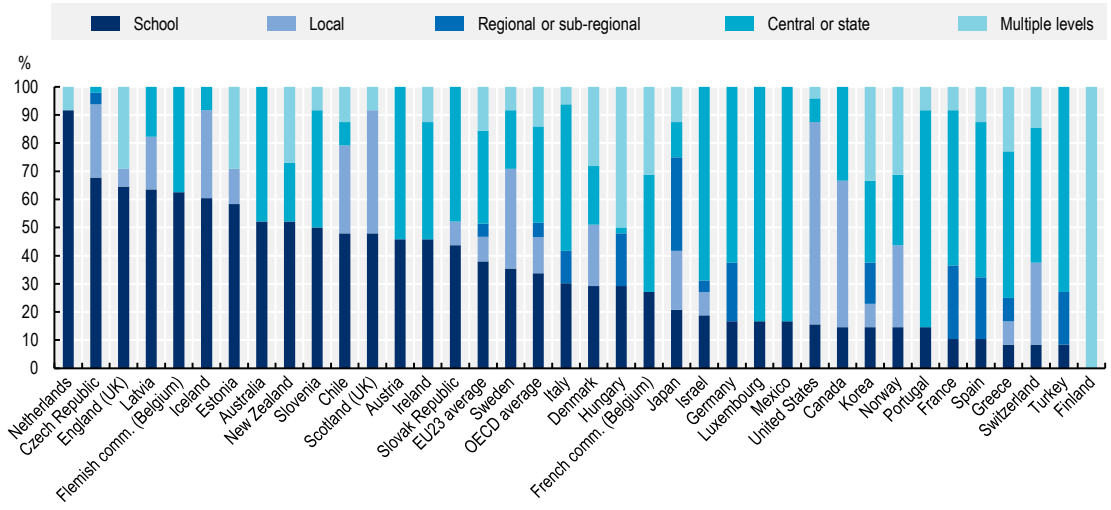
In some countries all or almost all levels of government are involved in a wide range of decisions concerning education. In Denmark, Hungary and Korea, multiple levels are involved in decisions on some or all subjects covered in the four domains (organisation of instruction, management of teachers, management of principals, planning and structures) (OECD, 2018[36]). In Finland, all decisions are taken by multiple levels, as local and school levels are involved in all decisions, even when a more general framework is set at a higher level of government for some subjects (OECD, 2018[36]).

There are considerable differences between countries in the ways in which decisions are taken. On average across OECD countries, nearly one-third of the decisions taken at the school or local levels are taken in full autonomy and two-thirds are within a framework set by a higher authority (Figure 6.10). A

single level of authority rarely decides with full autonomy, however. Decisions are often made after consulting with other bodies or within a framework set by a higher level of authority. On average across OECD countries, nearly half of all decisions are made at the school or local level. About one-third of these decisions are made in full autonomy, whereas most are made within a framework set by a higher authority (OECD, 2018[36]).

## Figure 6.9. Percentage of decisions taken at each level of government in public lower secondary education

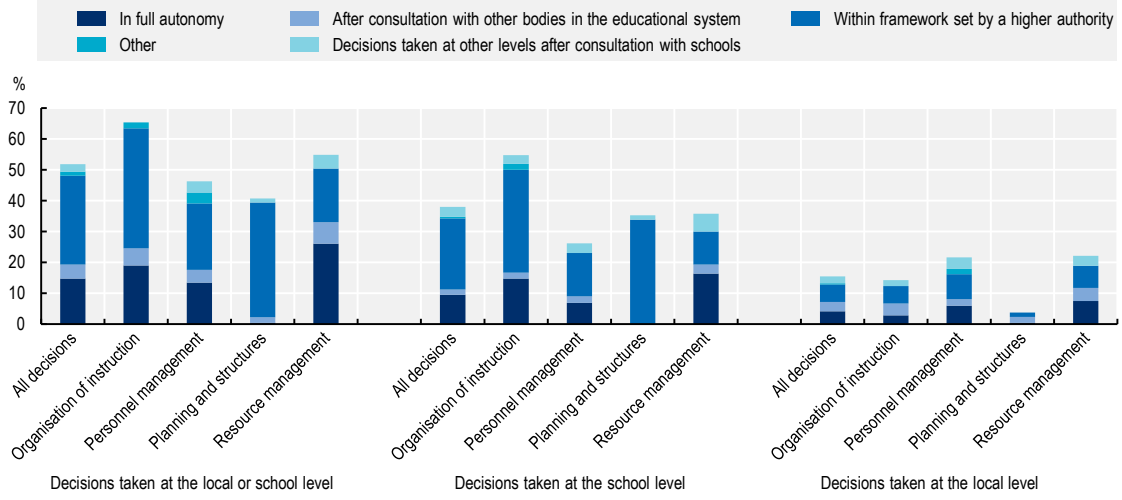
2017 values




Source: OECD (2018[36]), "Sources, Methods and Technical Notes", https://dx.doi.org/10.1787/eag-2018-36-en.

## Figure 6.10. Percentage of decisions taken at the local or school level in public lower secondary education in OECD countries, by mode of decision-making and domain

2017 values




Source: OECD (2018[36]), "Sources, Methods and Technical Notes", https://dx.doi.org/10.1787/eag-2018-36-en.

StatLink https://doi.org/10.1787/eag-2018-graph213-en

### *Effects of decentralisation on student achievement*

The empirical evidence on the effects of decentralisation reforms in education seems largely positive (Lastra-Anadón and Mukherjee, 2019[38]). An important caveat is that decentralisation and school autonomy may have different effects depending on countries' level of development (Hanushek, Link and Woessmann, 2013[39]). Decentralisation at subnational government and school levels can also have positive effects on student achievement. A recent OECD Fiscal Federalism Network paper found a consistent positive relationship between fiscal and administrative decentralisation and Programme for International Student Assessment (PISA) scores on the average study (Lastra-Anadón and Mukherjee, 2019[38]). For the main measure of fiscal decentralisation – the share of revenues collected sub-centrally – 10 percentage points more revenue collected sub-centrally was associated with about a 6-point increase in PISA scores. The study also found a positive relationship between school autonomy and average PISA outcomes.

## Decentralisation of the health systems

Most OECD countries aim to ensure universal access to health care for their citizens and to control the growth of public health expenditures. Various models are used to accomplish these two main goals. Some health systems are mostly publicly funded and provided, others combine market mechanisms and extensive public funding and regulation, and some health care models are mostly based on private health insurance.

While many OECD countries have shifted responsibilities for their health systems to subnational government levels during the past decades, decentralisation is by no means the only or even the most common way to organise healthcare. In 2017, subnational governments were responsible on average for about 23% of total general government health expenditure in 32 OECD countries.[8] Moreover, this share has slightly decreased since 2008/09, suggesting that some governments have in fact opted to centralise health care in response to the economic and financial crisis.

Decentralisation of health care has benefits and challenges. From the benefit aspect, decentralisation can improve the "allocative efficiency" of health services because local decision-makers are well informed about local needs and circumstances, and this enables effective and timely responses to local demand. Therefore, locally managed health services have the potential to improve access to health services and contribute to better overall health (Jiménez-Rubio and García-Gómez, 2017[40]). Decentralisation may also help reduce health inequalities both within and between regions. Health inequalities within regions may be diminished because local authorities are better placed to respond to the needs of vulnerable groups. Inequalities between regions may diminish if decentralisation promotes policy innovation and more diffusion of new ideas (Costa-Font and Turati, 2018[41]).

As for the challenges aspect, it has been argued that, compared with centralised service provision, decentralisation may generate the inefficient location of healthcare facilities (e.g. hospitals) and possibly also service duplication (Jiménez-Rubio and García-Gómez, 2017[40]). The risk for such an outcome would be particularly high in the case of a large number of very small subnational governments responsible for health services. This is rarely the case, however, and even in such a situation, subnational governments may utilise economies of scale by engaging in co-operative arrangements. For example, in Finland, where municipalities are responsible for both basic and specialised health care, municipalities are mandated to arrange hospital services through inter-municipal co-operative units, and in basic health services, voluntary co-operation is common. It has also been argued that decentralisation may lead to more inefficient pricing of inputs and higher and more complex levels of administration than a centralised health system. Also, in this case, co-operation or outsourcing can help tackle the problems of inadequate scale.

How, then, to reap the benefits and avoid the pitfalls of health care decentralisation? Much depends on the governance quality at both central and subnational government levels. Decentralisation reforms in public services provision should be looked at as an entity and successful implementation of decentralisation requires as a set of well-co-ordinated political, administrative and fiscal measures.

### *Financing of health systems across OECD countries*

Universal health coverage is a common policy goal across the OECD countries but international practices show that, from a financing perspective, there is no single way to approach this objective. While each country is a special case, the health systems in OECD countries can be roughly classified as tax-funded (sometimes also called the Beveridge model) and health insurance systems (sometimes called the Bismarck model) (OECD, 2015[42]) (Table 6.4).

**Table 6.4. Several ways to organise health care among OECD countries**

| | Main source of health care coverage | Country examples |
|---|---|---|
| Tax-funded health system | National health system | Australia, New Zealand, Portugal, UK |
| | Subnational level health system | Finland, Sweden |
| Health insurance system | Single-payer | Estonia, Korea |
| | Multiple insurers, no choice of insurer | Austria, Belgium, France |
| | Multiple insurers, with choice of insurer | Chile, Germany |

Source: Author's elaboration based on Auraaen, A. et al. (2016[43]), "How OECD health systems define the range of good and services to be financed collectively", https://dx.doi.org/10.1787/5jlnb59ll80x-en.

Tax-funded health systems can be further divided into national health systems and decentralised systems. Tax funding can be based on central government tax revenues, subnational government taxes or both. Examples of national health systems include the National Health Service (NHS) in the UK. Examples of decentralised health systems include the Nordic countries, especially Finland and Sweden, where all healthcare is organised and mostly financed by subnational governments. Further examples include Italy and Spain, where the regions have the responsibility of health services, and health care is financed both by national and regional taxes. Responsibility can also be shared with national and regional governments, each responsible for different parts of the system (e.g. regional control of hospital organisation and national control of hospital reimbursements). In the context of regional health, understanding this balance of power is an important step in implementing effective policy.

Health insurance systems are usually financed by employers and employees with fees collected from payroll. Health insurance systems can be based on single or multiple-payer models. The "single-payer" health insurance models are usually based on the government-run insurance programme which every citizen pays into. The "multiple-payer" models are usually private insurance companies from which citizens can choose. Multiple-payer models are usually tightly regulated by the state. Both single-payer and multiple-payer models usually contract with private health care producers (Stabile and Thomson, 2014[44]; Kutzin, 2011[45]).

The proponents of the tax-financed model argue that tax-based systems can benefit from scale economies in administration, risk management and purchasing power (Savedoff, 2004[46]). Moreover, since payment is mandatory, the system avoids many problems that are common especially to voluntary insurance markets. Tax-financed models are also claimed to enable more efficient income redistribution through health service provision and financing.

Supporters of health insurance emphasise the benefits of separating the purchasing and provision of healthcare and the possibility of selective contracting between providers. It has been argued that such

features can lead to better quality healthcare at a lower cost compared with tax-financed health systems (Wagstaff, 2009[47]). While no two systems are alike, there are key differences between the tax-financed and insurance-based model (Table 6.5).

## Table 6.5. Health insurance vs. tax-financed health care financing models

| | Health insurance model | Tax-financed model |
|---|---|---|
| Entitlement basis | Contribution | Citizenship/residence |
| Funding base | Wages | All public revenues |
| Insurer/payer | Occupational | State |
| Benefit package | Explicit | Implicit |
| Management | Independent | Government |
| Providers | Privately contracted | Publicly contracted |

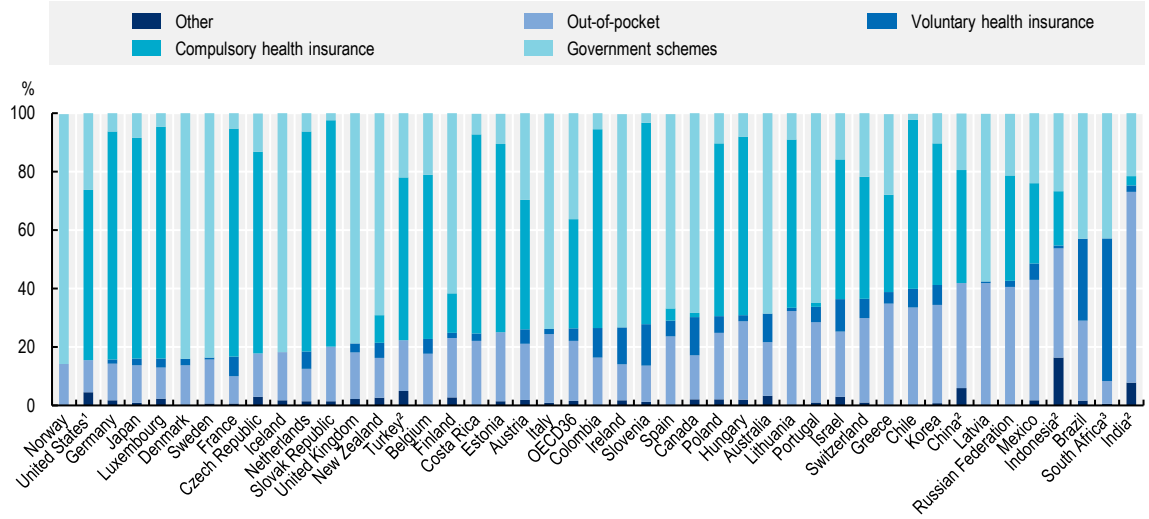
Source: Author's elaboration based on Kutzin, J. (2011[45]), "Bismarck vs. Beveridge: Is there increasing convergence between health financing systems?", https://www.oecd.org/gov/budgeting/49095378.pdf (accessed on 26 June 2020).

Health care financing systems in OECD countries and beyond are usually a mix of various financing models. For instance, in countries with mostly tax-financed health systems, there are often some elements of insurance models and out-of-pocket payments. In the same vein, countries relying mostly on an insurance model usually have at least some government schemes in place. Furthermore, the systems are far from "set in stone". Over the past decades, some countries have shifted emphasis from tax-financed to insurance-based models, or vice versa (Wagstaff, 2009[47]; Auraaen et al., 2016[43]).

The average shares of government schemes and health insurance-based systems across OECD countries are almost the same, 36% and 37% respectively (Figure 6.11). Government schemes (tax-financed models) have an important role in health care provision in Australia, Canada, Denmark, Finland, Iceland, Ireland, Italy, Latvia, New Zealand, Norway, Portugal, Spain, Sweden and the UK.

## Figure 6.11. Health expenditure by type of financing

2017 (or nearest year)




Note: 1. All spending by private health insurance companies in the US is reported under compulsory health insurance; 2. Health payment schemes unable to be disaggregated into voluntary health insurance, NPISH and enterprise financing are reported under other; 3. Voluntary payment schemes unable to be disaggregated are reported under voluntary health insurance.
Source: OECD (2019[48]), "Health expenditure by type of financing, 2017 (or nearest year)", https://doi.org/10.1787/1e3c9dd7-en.

### *Why do countries decentralise their health care?*

The most common reasons for health care decentralisation are related to the objectives of increasing the technical and allocative efficiency of health service provision. Table 6.6 summarises the main motivations and the issues associated with the decision to decentralise. Decentralisation has often been implemented in hope of improved political and fiscal accountability, leading to improved efficiency, enhanced cost-consciousness and constrained growth of health expenditure (Saltman, Bankauskaite and Vrangbæk, 2007[4]; Costa-Font and Turati, 2018[41]).

From the service quality and availability aspect, decentralisation is expected to help establish more patient-oriented systems through greater local participation and better information on local needs. The motivation to decentralise also often arises from the need to ensure government accountability to citizens and to comply with heterogeneous needs and preferences (Jiménez-Rubio and García-Gómez, 2017[40]).

The risks of healthcare decentralisation are mostly the same as the risks of decentralisation in general. In particular, without special measures, the increasing efficiency in delivering health care may come at the expense of higher disparities in health outcomes. At worst, decentralisation may benefit only the subnational governments with a strong fiscal base (Costa-Font and Turati, 2018[41]). Therefore, equalisation systems that take both expenditure needs and differences in subnational government revenue bases into account are usually needed in decentralised models (OECD, 2019[3]).[9] For example, in Sweden, where health care provision and financing are decentralised to counties and where most of the health expenditure is financed by counties' own tax revenues, subnational governments' own financing is complemented with strong equalisation system (Box 6.6). Other potential risks of decentralisation, although manageable with the right implementation, include benefit spill-over effects and diseconomies of scale. The former can be dealt with earmarked grants and the latter with inter-municipal or inter-regional co-operation, as discussed previously.

#### Box 6.6. Sweden's health expenditure equalisation model

**Healthcare equalisation is part of the overall expenditure equalisation model**

Cost equalising grant system is based on "standard costs" which are calculated using formulae for each mandatory subnational service. There are ten formulae, one for each service taken into account in the equalisation. The formulae are based on research results highlighting factors that affect subnational costs. The models include indicators describing different aspects of subnational costs, such as demographic structure, ethnicity, socio-economic situation and geography. The indicators used in the formulae are selected so that subnational governments themselves cannot affect the equalisation. Only differences between estimated costs and the average standard cost are taken into account. Contrary to income equalisation, which is mostly centrally funded, Swedish cost equalisation is strictly between municipalities/counties, though there is a different system of each of these subnational government levels.

**Healthcare expenditure equalisation is based on a formula**

Healthcare is solely a county responsibility in Sweden and health care of forms the main task of counties. The health care cost equalisation system aims to compensate the counties which have higher health costs, because of demand or special circumstances for example. As stated above, to avoid a situation where the recipient county could affect the equalisation it receives, the indicators used are relatively general. The health care formula describes the population for each county using the following variables: gender (2 groups), age (13 groups), civil status (3 groups), employment status (3 groups), earned income (3 groups), type of housing (2 groups). In addition to these variables, additions or deductions to the standard costs are calculated using the differences in the incidence of human

immunodeficiency virus (HIV), population sparsity and wage levels. All in all, in 2018, the model redistributed SEK 3.7 billion between counties, which is approximately 1.5% of the total health expenditure in the country.

Source: Finansdepartementet (2018[49]), "Lite mer lika. Översyn av kostnadsutjämningen för kommuner och landsting", https://www.regeringen.se/4a78db/contentassets/484eed9ac52944b18eea995eb2f6c178/lite-mer-lika.-oversyn-av-kostnadsutjamningen-for-kommuner-och-landsting-sou-201874.pdf; OECD (2017[50]), *OECD Territorial Reviews: Sweden 2017: Monitoring Progress in Multi-level Governance and Rural Policy*, https://dx.doi.org/10.1787/9789264268883-en.

### Table 6.6. Examples of objectives, rationale and issues related to health care decentralisation

| Objectives | Rationale | Issues and controversies |
|---|---|---|
| To improve technical efficiency | • Through fewer levels of bureaucracy and greater cost-consciousness at the local level | • Implementation is the key.<br>• Right incentives are needed for providers. |
| To increase allocative efficiency | • Through better matching of public services to local preferences<br>• Through improved patient responsiveness | • Risk of increased inequalities among subnational governments.<br>• Need to decentralise both the spending and revenue side. |
| To empower local governments | • Through more active local participation<br>• Through improved capacities of local administration | • Need to ensure that subnational governments have adequate capacities. |
| To utilise the local innovation potential in service delivery | • Through experimentation and learning by doing<br>• Through increased fiscal autonomy of local governments and institutions | • Increased inequalities may result if capacity issues are not solved. |
| To increase accountability | • Through elected decision-makers | • Nominated decision-makers, which are often used in co-operative bodies, may not fulfil an accountability requirement. |
| To increase the quality of health services | • Through improved information on local conditions and needs<br>• Through improved access to health services for vulnerable groups | • Equalisation system is needed to ensure a level playing field.<br>• Economies of scale should be utilised to ensure quality potential, for example with co-operation, mergers and outsourcing. |
| To increase equity | • Through equalisation systems that take into account local needs and circumstances<br>• Through normative regulation and steering by central government (vertical co-ordination)<br>• Through capacity building schemes and co-operative mechanisms (horizontal co-ordination) | • Need to ensure that local autonomy is not limited because of upper-level government steering.<br>• Decentralisation may improve some equity measures but may worsen others. |

Source: Author's elaboration and modification of the material presented in Saltman, R., V. Bankauskaite and K. Vrangbæk (eds.) (2007[4]), *Decentralization in Health Care: Strategies and Outcomes*, https://www.euro.who.int/__data/assets/pdf_file/0004/98275/E89891.pdf.

### *Healthcare decentralisation in OECD countries*

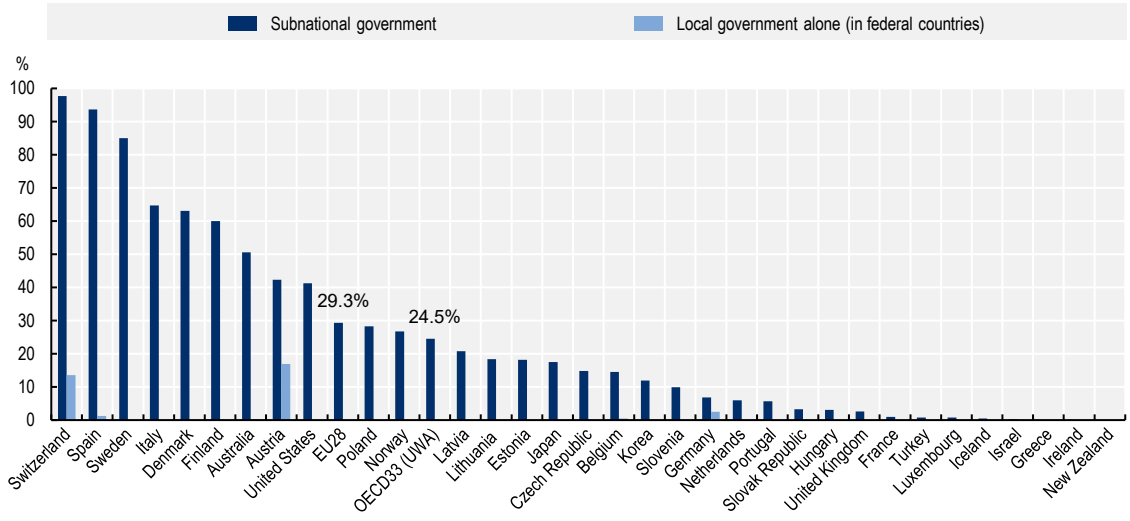
While the scope of decentralisation differs a great deal between OECD countries, subnational governments usually play at least some role in health care provision. There are two main ways to measure the degree of decentralisation: quantitatively and qualitatively. Quantitative indicators typically use fiscal data to

describe decentralisation. Qualitative approaches rely on questionnaires and expert interviews to collect information. While this section uses fiscal indicators constructed from OECD National Accounts data (OECD, 2020[7]) to describe decentralisation in health care, at the end of the section, there is a short discussion on current qualitative indicators, notably the OECD Fiscal Federalism Network's work on health decentralisation.

Although it is often argued that decentralisation is a general trend in both developed and developing countries, this does not seem to be the case for health care, at least from a fiscal data point of view. The subnational government share of general government expenditure suggests that in Denmark, Finland, Italy, Spain, Sweden and Switzerland, the subnational government share of general government health expenditure is the highest of all OECD countries, ranging between 60% and 98% (Figure 6.12). However, health expenditure decentralisation has been on the decline over the past two decades or so, especially after the economic and financial crisis in 2008/09 (Figure 6.13).

## Figure 6.12. Subnational government share of general government health expenditure

2017 or the latest year




Source: OECD (2020[7]), *OECD National Account Statistics*, https://doi.org/10.1787/na-data-en (accessed on 15 May 2020).

StatLink https://doi.org/10.1787/888934226880

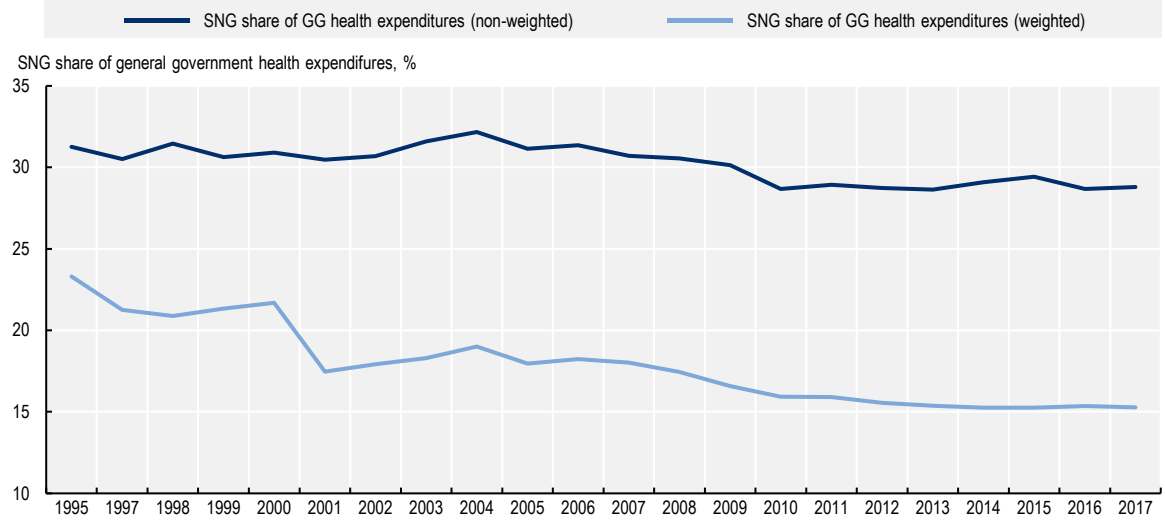
The trends of health expenditure decentralisation also vary considerably between countries (Figure 6.14). For instance, whereas in Denmark, Greece, Ireland, Korea and Norway there have been recentralisation reforms during this period, in Belgium, the Netherlands and Spain, the share of subnational governments of general government (GG) health spending has increased considerably. In many countries, the changes are less dramatic but, instead, there is a steady growth of subnational share (Australia, Austria, Latvia and Sweden) or a gradual decline of subnational government spending share (Czech Republic, Hungary, US). In the rest of the countries, the situation has been either relatively stable or the degree of decentralisation has changed from year to year, making it difficult to verify a trend.

In the case of health care, however, a simple share of subnational government expenditure of GG expenditure may not be sufficient to describe the true degree of health expenditure decentralisation. The reason is that in many countries, government schemes do not form a large share of total health expenditure (Figure 6.11) which can comprise several types of spending items, such as government schemes, compulsory health insurance and out-of-pocket payments, among others (see Chapter 5). For instance, in

Switzerland, in 2017, government schemes formed 22% of total health spending, compulsory health insurance scheme formed 42% and out-of-pocket payments 27% of total health expenditure. In contrast, the situation is very different in Spain, where government schemes formed 66% of total health expenditure and subnational government responsibility was nearly 94% of GG health expenditure. It is therefore clear that in Spain health care decentralisation is a much more important phenomenon than in Switzerland.

## Figure 6.13. Trend in average subnational government share of general government health expenditure

1995-2017, 30 OECD countries




Note: SNG=Subnational government, GG=General government. The graph has been constructed using data on 30 OECD countries. No data for this period was available for Canada, Iceland, Mexico, New Zealand and Turkey. For Korea, the year 2017 data was not yet available, instead 2016 share was used twice because without Korea's data, the SNG weighted share would have been excessively high (31%).
Source: OECD (2020[7]), *OECD National Account Statistics*, https://doi.org/10.1787/na-data-en (accessed on 15 May 2020).

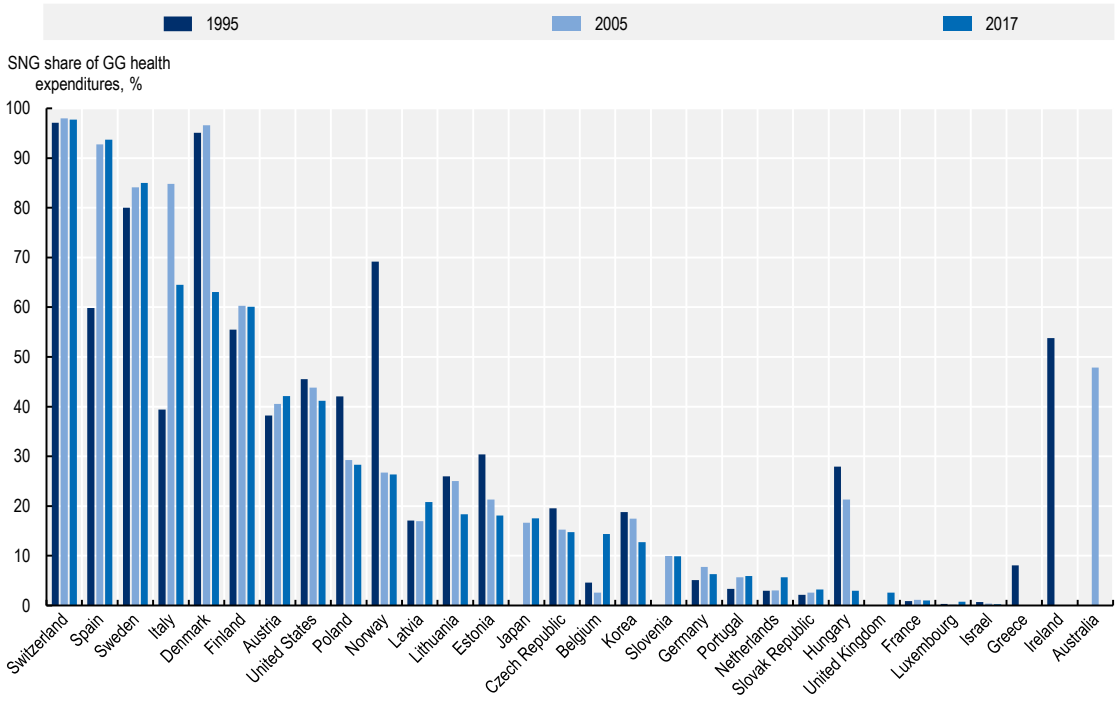
StatLink https://doi.org/10.1787/888934226899

In order to better identify countries that have higher than average degree of health decentralisation, a simple indicator on health expenditure decentralisation is composed using the share of government health schemes of total health expenditure and subnational government share of government schemes.[10] The countries listed according to this indicator (Figure 6.15) show that health expenditure decentralisation is most relevant in 6 out of the 32 OECD analysed: Australia, Denmark, Finland, Italy, Spain and Sweden. In these countries, between 30% and 70% of health expenditure is the responsibility of subnational governments. In Norway and Switzerland, the subnational government sector covers above 20% and in Austria, Latvia and the US, the share is above 10%. For the rest of the countries, subnational governments have only a small or negligible role in health care expenditure.

Countries differ also markedly in the importance of health expenditure of total subnational government expenditure. In Italy and Spain, health care is the main policy responsibility of regional governments and accounts for almost half of the total regional budgets. In Sweden, health care forms almost 90% of expenditure at the regional level. In Finland, health care is "only" about 25% of total municipal expenditure.[11]

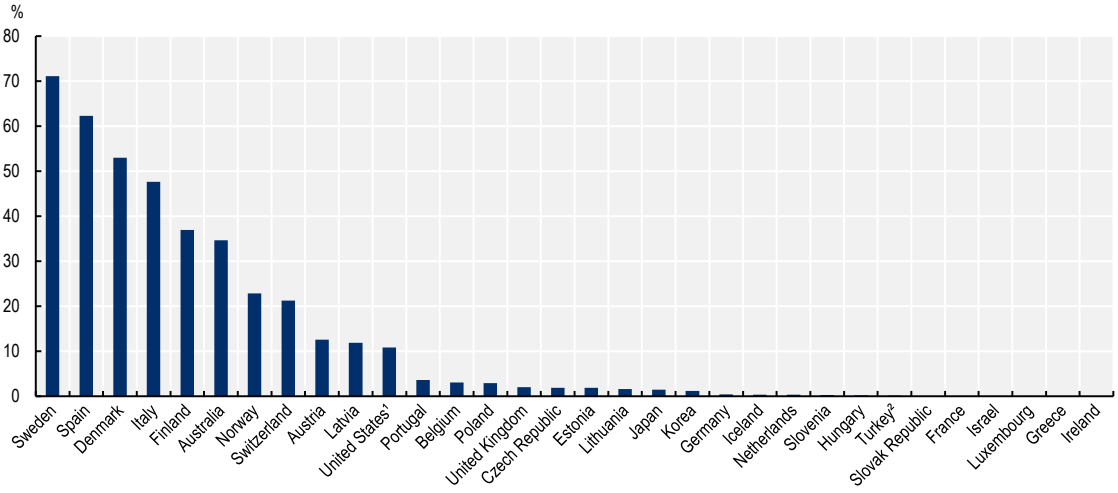
## Figure 6.14. Subnational government share of general government health expenditure, OECD

1995, 2005 and 2017 in 30 OECD countries




Source: OECD (2020[7]), *OECD National Account Statistics*, https://doi.org/10.1787/na-data-en (accessed on 15 May 2020).

## Figure 6.15. An indicator on subnational government share of health spending




Note: The indicator is formed as: Subnational government share of general government health expenditure × Share of government schemes of total health expenditure.

1. All spending by private health insurance companies in the United States is reported under compulsory health insurance.

2. Health payment schemes unable to be disaggregated into voluntary health insurance, NPISH and enterprise financing are reported under other.

Source: OECD (2020[7]), *OECD National Account Statistics*, https://doi.org/10.1787/na-data-en (accessed on 15 May 2020); OECD (2019[48]), "Health expenditure by type of financing, 2017 (or nearest year)", https://doi.org/10.1787/1e3c9dd7-en.

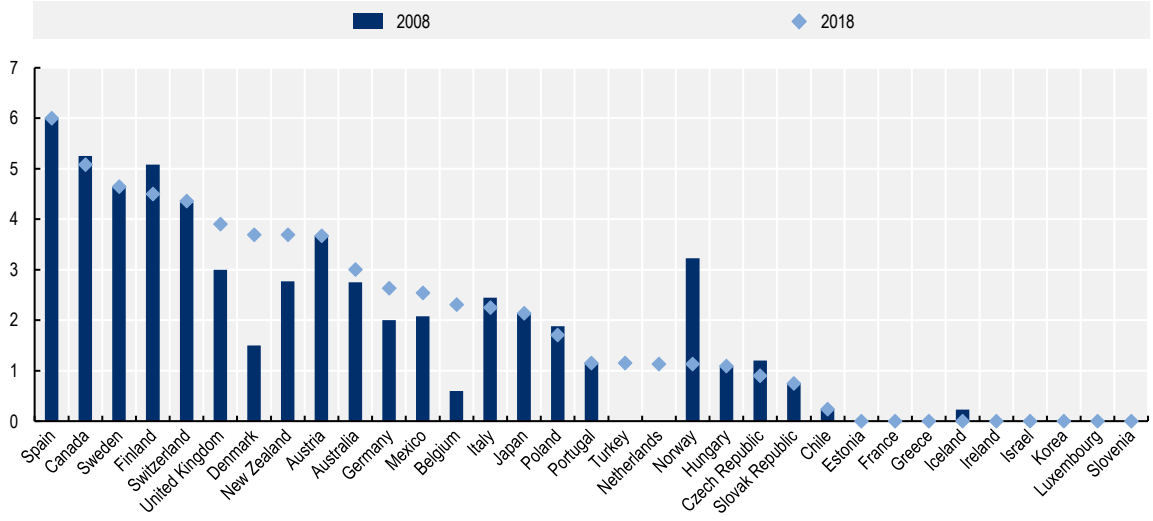
StatLink https://doi.org/10.1787/888934226918

Decentralisation can be analysed also from a normative regulation point of view. Normative and fiscal regulation can constrain the decision-making autonomy of subnational governments and hence reduce the degree of decentralisation. Normative regulation cannot be observed directly from National Accounts or other statistical databases, however. Instead, such information must be collected via questionnaires directly from local experts. Examples of such approaches include the OECD work on fiscal autonomy of subnational governments (OECD, 2019[22]), the Regional Authority Index (RAI) (Marks, Hooghe and Schakel, 2008[51]) and the Local Autonomy Index (LAI) (Ladner, Keuffer and Baldersheim, 2016[52]). Like the OECD Fiscal Federalism Network's work on subnational government autonomy, the RAI and LAI are also based mostly on expert judgements and the data is either collected by questionnaires or by setting up special expert panels. The RAI and LAI are built for describing the general regional and local authority. They combine several decision-making aspects and sectors, including health, but neither of them reports decision-making autonomy in health care specifically.

The OECD Fiscal Federalism Network has published a special study on the effects of decentralisation in healthcare. For this analysis, an indicator describing decentralisation in health care was established using data collected for the OECD Health Systems Characteristics Survey (Dougherty et al., 2019[53]). In the survey, countries were asked to indicate the level of government that is responsible for 13 policy or service areas.[12] The indicator was based on grading on each 13 service areas/functions so that 3 points were given if the subnational government level and central government were jointly responsible for the function, 6 points if subnational government was responsible alone, and zero points if only central government was responsible. The indicator shows a high degree of health care decentralisation in Australia, Canada, Denmark, Finland, New Zealand, Spain, Sweden, Switzerland and the UK (Figure 6.16). This indicator, however, does not take into account the size of decentralisation.

## Figure 6.16. Indicator on subnational government fiscal autonomy in health by country

2008 and 2018




Source: Dougherty, S. et al. (2019[54]), "The impact of decentralisation on the performance of health care systems", https://doi.org/10.1787/22265848 (accessed on 15 May 2020).

### *The effects of decentralisation on health outcomes*

The scant evidence on the effects of health care decentralisation suggests that the effects of fiscal and political decentralisation are mainly positive in terms of efficiency and quality, but that the implementation matters. For Spain, for example, the evidence shows that decentralisation is associated with better health outcomes, without sizeable effects in regional disparities (Jiménez-Rubio and García-Gómez, 2017[40]). However, a study using a difference-in-differences estimation strategy on micro-data from the Spanish Health Barometer 1996-2009 finds a negative association between decentralisation reforms and citizens' satisfaction on primary and hospital care (Antón et al., 2014[55]).

A recent study utilising a natural experiment on the effects of decentralisation on infant and neonatal mortality rates in Spain finds a sizeable positive effect of decentralisation reform. The result applies to regions that are subject to both fiscal and political decentralisation. According to the results, decentralisation resulted in roughly a 1.1 reduction in the number of deaths per thousand live births of children under 1 year of age, and around a 0.8 reduction in the number of deaths of children under a month of age per thousand live births (Jiménez-Rubio and García-Gómez, 2017[40]). An older study that analyses data from the Canadian provinces during 1979-95 finds the positive and substantial influence of decentralisation on the effectiveness of public policy in improving population's health in terms of infant mortality (Jiménez-Rubio and Smith, 2005[56]).

As for the equity aspect, Zhong (2010[57]) found that increasing the degree of decentralisation was related to lower overall and within-province inequity in the use of general practitioner (GP) and hospital services, and lower between-province inequity. Similarly, Costa-Font and Turati (2018[41]) used data from decentralisation reforms in Italy and Spain, finding no evidence on increasing regional inequalities on health outcomes or outputs after decentralisation reforms. The authors argue that healthcare decentralisation is unlikely to be a concern for equity in unitary countries, provided that the reform design promotes competition and policy innovation and as long as equalisation mechanisms and framework regulation do not exert unintended effects.

A recent study found a non-linear relationship between the association between "administrative decentralisation" and health spending and life expectancy (Dougherty et al., 2019[54]). According to the study of 22 OECD countries, a moderate degree of decentralisation reduces public health spending and increases life expectancy but a high degree of decentralisation has an opposite effect. According to the authors, this suggests that there is an optimum level of decentralisation in terms of per capita expenditure and life expectancy. The study also estimated the association between decentralisation and hospital costs, finding significantly lower hospital costs for countries with high decentralisation compared to countries with no decentralisation.

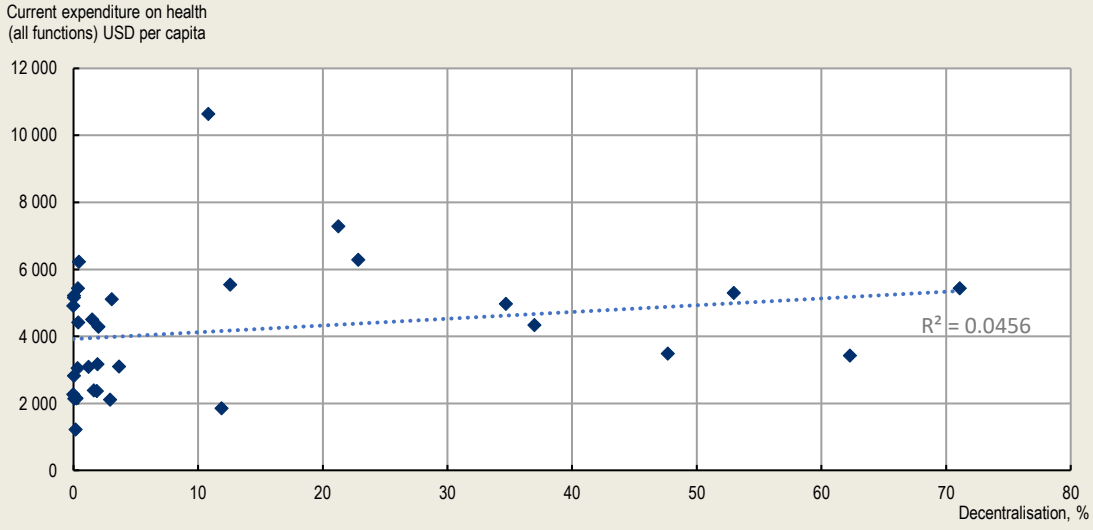
Another recent study studied the effect of the overall quality of government, focusing on the differences between countries with high-quality governance and countries with low-quality governance (Rodríguez-Pose and Tselios, 2019[58]). In the former country group, political decentralisation may result in greater satisfaction with health provision, whereas in the latter country group, decentralisation may result in overall satisfaction but not necessarily with more satisfaction in health-related services. Box 6.7 discusses some potential associations with decentralisation, expenditures and health outcomes.

## Box 6.7. Potential associations with decentralisation, expenditures and health outcomes

In order to make some country comparisons using OECD data, the simple indicator for health care decentralisation developed in this paper is used to demonstrate the potential associations with decentralisation, expenditures and health outcomes. First, plotting the decentralisation indicator with per capita health expenditure (Figure 6.17), only a very weak positive association is found between decentralisation and expenditure. Plotting degree of decentralisation (2017 situation) and percentage change in per capita expenditures during 2010-18 shows no association at all. This could be because there is no correlation or because the association is non-linear (as was suggested by Dougherty et al. (2019[54])). A more careful statistical analysis would be needed to understand the relationship better although, in any case, a causal relationship could not be revealed with traditional regression analysis.

### Figure 6.17. Degree of fiscal decentralisation and per capita health expenditure

2017 and 2018 values respectively

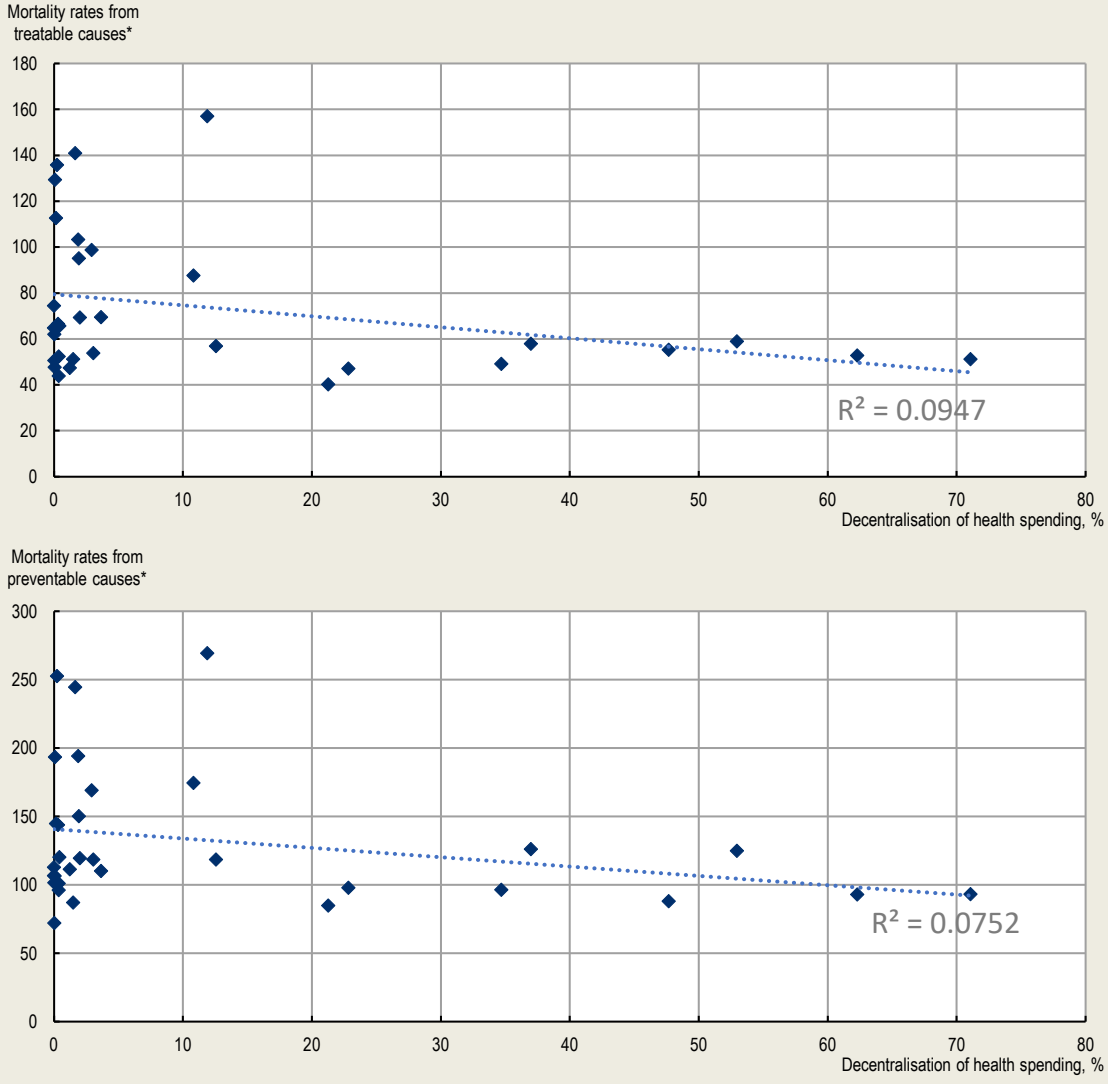



Note: Decentralisation is defined here as: Subnational government share of general government health expenditure × Share of government schemes of total health expenditure. The two rightmost data points are Spain and Sweden.
Source: OECD (2020[7]), *OECD National Account Statistics*, https://doi.org/10.1787/na-data-en (accessed on 15 May 2020), Main aggregates, PPP for Actual Individual Consumption.

StatLink https://doi.org/10.1787/888934226937

Next, the association between decentralisation and two traditional OECD health indicators, namely the mortality from preventive causes and mortality from treatable causes (Figure 6.18) is examined. In both cases, decentralisation is negatively associated with the indicators, suggesting that mortality is lower in more decentralised countries. The association is very weak, however, and more careful analysis would be needed to have a better understanding of the association. As in case of per capita expenditures, in any case, a causal inference is not possible using this approach.

## Figure 6.18. Decentralisation and mortality from preventable and treatable causes




Note: Decentralisation is defined as: Subnational government share of general government health expenditure × Share of government schemes of total health expenditure. The health outcome used here is the average aged-standardised mortality rate from treatable causes per 100 000 people. The health outcome used here is the average aged-standardised mortality rate from preventable causes per 100 000 people.

* Age-standardised rate per 100 000 population.

Source: OECD (2020[7]), *OECD National Account Statistics*, https://doi.org/10.1787/na-data-en (accessed on 15 May 2020), Main aggregates, PPP for Actual Individual Consumption and OECD (2019[48]), "Health expenditure by type of financing, 2017 (or nearest year)", https://doi.org/10.1787/1e3c9dd7-en.

StatLink https://doi.org/10.1787/888934226956

## Conclusion

This chapter discussed governance aspects of territorial service provision, with a focus on education and health care services. Regarding education, the economic justification for central government involvement in decentralised education systems depends on the degree of externalities involved. Local authorities may not take into account the externalities in their own decision-making, which may justify central government intervention. Education is also a redistributive service, which often explains the central governments' interest. Regarding health care, the chapter has shown that systems can be very complex and quite different across OECD countries. Commonly used elements to classify a health system include how the system is financed, the freedom to access various parts of the system, and the role of private vs. public health care providers.

The potential gains to be realised on the provision of public services from decentralisation are usually conditional on many factors, such as effective channels and incentives for voters in subnational governments to express their preferences. In addition, the local policymakers must have incentives in place to respond to local demands and needs. The basic accountability mechanisms of decentralisation can function only if local residents have relatively strong incentive to evaluate the efficiency of their local administration – and if needed, to punish their local politicians for bad performance. Such motivation depends primarily on the financing system of locally provided public services and on the information available on the service outcomes. In particular, if local residents finance a considerable share of local services by paying local taxes, they will have a strong incentive to monitor their local administration (OECD, 2019[3]).

Furthermore, the quality and strength of normative regulations matter, because true decision-making autonomy requires that decisions be made at the local level in practice and not just in principle. If service provision is only nominally decentralised, for example in the case of very strict normative regulation, and if financing comes fully from the central government, it is unlikely that decentralisation will provide the full benefits that could otherwise be obtained.

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## Notes

[1] Exclusion principle means that a consumer can be excluded from using the service if he/she is not willing to pay for its use.

[2] In other words, the vertical fiscal gap is large.

[3] Taking into account education from primary to tertiary levels.

[4] Primary, secondary and post-secondary non-tertiary education.

[5] Usually, the initial level means the central government level but sometimes also the regional level.

[6] Much depends on the form of transfers. General grants or block grants are much less intrusive from a decision-making autonomy point of view than earmarked grants.

[7] The data comprises a set of 23 key decisions, organised across 4 domains. The data does not therefore capture the totality of decisions made within a school system.

[8] No comparable data was available for Canada, Iceland, Mexico, New Zealand, Turkey. For Korea, the year 2017 data was not yet available.

[9] This argument applies especially to situations where redistributive services like health of education have been decentralised.

[10] Indicator on health expenditure decentralisation = (SNG share of GG health expenditure) × (Share of government schemes of total health expenditure).

[11] In Finland, in addition to health care, all education, social services and local infrastructure have been assigned to municipalities. In Sweden, the counties (regions) focus on solely on health services and regional development, and other services are municipal responsibilities.

[12] The policy areas covered by the study included: i) setting the level of taxes which will be earmarked for health care spending; ii) setting the basis and the level of social contributions/premiums for health care; iii) setting the total budget for public funds allocated to health care; iv) deciding resource allocation between sectors of care; v) setting remuneration methods for physicians; vi) defining payment methods for hospitals; vii) financing new hospital buildings; viii) financing new high-cost equipment; ix) financing the maintenance of existing hospitals; x) financing primary care services; xi) financing specialist out-patient care; xii) financing current hospital spending; and xiii) setting public health objectives.