

Health care organization and financing in eleven federal countries

A compilation of knowledge
to benefit the “Federal Democratic Republic State” of Nepal

Detlef Schwefel ¹

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Background ²

Nepal’s
drive
towards
federalism

The First Amendment of the Interim Constitution of Nepal (April, 2007) warrants the restructuring of the state into a democratic federal system³. Subsequent Fourth Amendment of the Interim Constitution has declared Nepal a ‘Federal Democratic Republic State⁴.’ Constituent Assembly formed after the elections of April 2008 will decide on the structure of the federal system based on the recommendations of a High Level Commission that is yet to be constituted. Federalism, needless to say, has thus become a topic of contention in Nepal with debates ensuing, from different quarters, especially on the structure of the forthcoming federal system. With no clear-cut consensus yet on the model, federalism has nevertheless become a major agenda for different political actors and interest groups. So far, the locus of debate centres on the structural aspects; discourses on what federalism means functionally to different sectors have yet to feature prominently.

This concept note outlines a proposition for Ministry of Health and Population (MoHP) to develop a preliminary understanding on different options in which to organize the health sector in the federal structure. For this a desk study is planned which will be supported by GTZ through the cooperation projects Federalism Support Programme (FSP) and Health Sector Support Programme (HSSP).

In 2008, Federal Foreign Office of Germany commissioned GTZ to support the federalism process in Nepal through the cooperation project Federalism Support Programme. FSP works with the Constituent Assembly, Ministry of Local Development and has a mandate to work with the aforementioned High Level State Restructuring Committee. To date, FSP has organized information workshops and provided federalism related support to young political leaders, civil society and NGOs in cooperation and collaboration with Government of Nepal (GoN) and other development partners.

The joint Health Sector Support Programme is executed under the overall coordination of the Ministry of Health and Population (MoHP) and in joint responsibility with GTZ. HSSP aims to improve the access to effective healthcare services in particular for disadvantaged population groups of Nepal.

² Introduction to the terms of reference for a “Comparative Analysis Study on Federalism for the Ministry of Health and Population” of Nepal, formulated by Sudip Pokhrel, Adviser, Information Management, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH, Health Sector Support Programme (HSSP), P.O. Box 1457, Kathmandu / Nepal.

³ Article 138 - Interim Constitution of Nepal 2063 (2007) as amended by the First, Second, and Third Amendments. United Nations Development Programme (UNDP) Nepal. January 2008.

⁴ *ibid*

Terms of reference for a desk study⁵

The objective of the assignment is to look (study) comparatively at different federations around the world vis-à-vis how they have organized their health sector. The inference from this comparative analysis could then be applied to the local context – by MoHP and other partner institutions – to gauge the implications to the Nepalese health sector of various models of federalism.

An international consultant shall comparatively analyze the experience of 4 to 6 federated states on how they have organized the health sector. Specifically, the consultant shall carry out the followings:

- As a feasibility study, identify ‘case study’ countries, sources, and collect preliminary information to produce the comparative analysis.
- Develop framework and format for the comparative analysis and presentation including, but not limiting to, how the constitutions of the respective ‘case study’ countries have provisioned for the health sector; the focus on health service delivery, institutional structure and reforms, financing and resource mobilization, sector control/stewardship, etc.
- Produce a comparative analysis study of the 4 to 6 federated states in accordance to the developed framework.
- Present the analysis of the study to MoHP, partner institutions, and stakeholders and facilitate for the next steps forward.

Methodology of the desk study

The work was intended to start as a desk study. A desktop was used – therefore – as the main tool to discover information and knowledge on the organization of health care in selected federal countries of the world. It started as a feasibility study to get information on eight key issues:

- The federal set-up of various countries
- The constitution of these countries
- The explicit mentioning of health and related subjects in the constitution
- The basic organization of health care
- The responsibilities of the federal level of government for health and health care
- The responsibilities of the state and lower levels of government for health and health care
- The financial contributions of these levels of government for health care
- Stewardship and governance

For some countries further elements will be mentioned, e.g. transition management and decentralization.

These seven issues formed the initial framework for the feasibility study. The internet was explored to check if updated information on these issues is available

- for a considerable number of federal countries – to avoid a premature and biased selection
- in various continents, i.e. Africa, America, Asia, Australia, Europe and Oceania
- at various levels of development, i.e. poor and rich countries, poor and good performers in terms of health system performance and human development
- from sources with a good reputation of producing valid and reliable information – like the World Health Organization and its regional offices, other international institutions and research organizations
- in the context of larger health system profiles which could be used later on as a reference or starting point for in-depth studies or specific queries.

The internet was googled extensively according to more than 50 keywords. Several thousands of entries were checked; more than 300 articles were downloaded and reviewed and more than 60 used for the following presentation.

⁵ Same as footnote 1

The outcome is a comparative presentation of the before-mentioned seven key issues for eleven countries. This is based on available knowledge as it is formulated in the original sources of the information – most of the text is a direct citation and marked as such. All sources are available without user fees on the internet. Detailed e-links are given in the list of references. This approach of compiling available knowledge instead of writing a new analysis might provoke unfounded irritations. It is fully justified by the facts

- that the basic task is a start-up desk study to initiate a longer process of understanding and sharing based on the available knowledge and
- that there is a sufficient number of rather good pieces of knowledge to explore or describe the relationships between federalism and health care which seem to be peer-reviewed from within international organizations or research groups with good reputation. It would be an exercise in futility to rewrite such basic documents.

The aim for compiling the available knowledge is the discovery and presentation of important knowledge pieces, i.e. analysis. A synthesis of available information and knowledge will have to be done later on after a collaborative exercise will have expanded and improved this knowledge base.

Limitations of this desk study might be overcome by a future collaborative exercise of various contributors:

- A specialist on constitutional law shall analyse in more detail the linkages between constitution and health care at various levels of government
- The country-wise information is still rather short and sometimes outdated or even biased
- A more systematic analysis of federal versus lower-level responsibilities is needed
- A deeper analysis and comparison of decentralization and devolution issues might be useful
- The information basis for some countries seems to be rather poor, for others good analyses are available, e.g. on details on levels and health responsibilities of government
- Country specialists have to review the validity of information and add missing knowledge
- An international collaborative team shall review this paper and add information and knowledge
- A synthesis of this knowledge might be a next step in a longer process of understanding and sharing.

This paper is considered to be a first step towards a better understanding of the relations between federalism and health. Good governance is aimed at. It is a long way.

Overview
on countries
chosen

The following table gives a short overview on the eleven countries included in this study.

- Population-wise the countries are quite different. Federal countries can range from less than 20.000 inhabitants like Palau to more than one billion people, like in India.
- According to the human development index federal countries range from one of the best – this is Switzerland – to one of the worst off, i.e. Nigeria.
- The same variation applies to the ability of managing health systems as measured by an international performance ranking of all member states of the World Health Organization. In this regard Austria is doing quite well whereas Brazil and especially Nigeria are poor performers.
- Private health expenditure is rather low in Germany and Austria and very high in India. This means that in India the public hand does not care that much about health and health care of the population and that health spending is mainly unorganised and uninformed.

- The countries are quite different, too, regarding the lengths of their constitutions. Some have opted for very general framework-constitutions. United States of America and Canada are examples for this. The constitutions of India, Brazil and Nigeria go into many details.
- Health issues are not mentioned in all constitutions. Switzerland and especially Brazil dedicate quite some paragraphs to health. There is no correlation of this with the health sector performance.

Federal countries – some data on population, performance and constitution							
Indicator Country	Population	HDI 2007 (177)	HSP 2000 (191)	PEH 2005	Number of words of constitution	Constitution words on health care	Main year of information
Australia	21,475,000	3	32	33	11.320	70	2006-2008
India	1,140,080,000	128	112	81	117.369	99	2006-2007
Austria	8,340,924	15	9	24	38.446	227	2004-2006
Germany	82,169,000	22	25	23	21.758	58	2004
Switzerland	7,647,600	7	20	23	23.243	0	2007-2008
Canada	33,418,500	4	30	30	4.462	501	2005-2007
United States	305,563,000	12	37	55	4.526	0	2002-2007
Mexico	106,682,500	52	61	55	29.299	168	2005-2007
Brazil	188,015,000	70	125	56	67.206	996	1999-2005
Argentina	40,301,927	38	75	56	12.844	0	1999-2007
Nigeria	148,093,000	158	187	69	65.724	76	2000-2008

Population [Wikipedia]
HDI = Human development index of United Nations Development Programme
The Human Development Index (HDI) is a comparative measure of life expectancy, literacy, education and standards of living for countries worldwide. [Wikipedia]
http://en.wikipedia.org/wiki/List_of_countries_by_Human_Development_Index
HSP = Health system performance ranking of World Health Organization – Data 1997
WHO's assessment system was based on five indicators: overall level of population health; health inequalities (or disparities) within the population; overall level of health system responsiveness (a combination of patient satisfaction and how well the system acts); distribution of responsiveness within the population (how well people of varying economic status find that they are served by the health system); and the distribution of the health system's financial burden within the population (who pays the costs [WHO])
() Total number of countries under study
http://www.who.int/whr/2000/media_centre/press_release/en/index.html
PEH = Private expenditure for health according to World Health Organization [WHO]
<http://www.who.int/nha/en/>

Tasks
ahead

The last column of the fore-going table pinpoints to the need of a future collaborative approach. Partners of this exercise will certainly know better and more updated sources of background information for starting to understand and master the relationship between federalism and health care. It would be good if some more countries could be included which are closer to the specific situation in Nepal.

Introduction

Federal countries

About 40% of the world's population live in 25 federal countries: Argentina, Australia, Austria, Belgium, Bosnia and Herzegovina, Brazil, Canada, Comoros, Ethiopia, Germany, India, Malaysia, Mexico, Micronesia, Nigeria, Pakistan, Russia, St. Kitts and Nevis, South Africa, Spain, Switzerland, United Arab Emirates, United States of America, and Venezuela. Some sources add Palau and Congo (Democratic Republic) to the list of federal countries. The following countries are considering or preparing their federal set-up: Iraq, Sudan, Sri Lanka, and Nepal. [Forum of Federations 2008]



[Wikipedia:
Federal
countries
marked]

Federalism

Federalism is a form of government: "... emphasizing both vertical power-sharing across different levels of governance and, at the same time, the integration of different territorial and socio-economic units, cultural and ethnic groups in one single polity." [McLean Oxford Dictionary 2008] A certain degree of autonomy of two or more levels of government is an essential aspect of federalism. A "binding partnership among co-equals", "an enduring, even perpetual, relationship" is considered to be a characteristic of federations. [Kincaid 2008] The democratic accountability of political decision-making and implementation is an important principle of federalism.

Differences

Some countries are federal but do not prefer this label, like Spain. Some are quite centralized, like Malaysia. In some countries the federal level can override the lower level of government. Some non-federal countries are more decentralised than federal countries; they can have rather strong regional governments like Colombia, Italy and Japan. In the United Kingdom a region - Scotland – achieved considerable power on education, health and local affairs, more than Wales and Northern Ireland. [Anderson 2008] In some countries – like USA – power shifted somehow from the states to the national government with the approval of the Supreme Court. In Belgium there are only two constituent parts of the federation, the Dutch and the French speaking populations. There is a de-facto-federation in China. The same applies to the European Union.

Federalism versus decentralisation

"Federalism entails a level of political autonomy, even sovereignty, for constituent communities that rests uneasily, even threateningly, with traditional or elite conceptions of national unity. Federalism involves a polycentric non-centralized arrangement in which neither the constituent governments nor the general government can unilaterally alter the constitutional distribution of power." [Kincaid 2008]

"Decentralization involves a central power possessing authority to decentralize or devolve functional and administrative responsibilities to lower levels of government. The authority to decentralize, however, also includes the authority to recentralize

power. Decentralization is concerned with administrative efficiency and functional efficacy in an otherwise unitary system.” [Kincaid 2008

Federal countries and good governance

There seems to be an intrinsic relationship between federalism and good governance. This assumption is based on the very principle of ‘subsidiarity’. It means that higher levels of government should be active only if lower levels can not do. It refers not only to two levels of government but to all instances between people and government, i.e. families, communities, and any kind of institutions. Federalism is trying to be closely linked up with or even subordinated to lower level governance. In the following table it can be seen that the eleven federal countries under study range especially high in terms of ‘voice and accountability’. This is one criterion of good governance among some others like government effectiveness and rule of law. The overall averages are influenced by the very low scores obtained by Nigeria and India, especially. The table hints at interesting differences between the federal countries included in this study. Status of corruption and control of corruption are other indicators of governance or stewardship. In terms of corruption in the medical services there are no extreme differences perceived to exist. The table demonstrates that federal countries do not automatically have very high scores. It would be revealing to compare all federal countries with all other countries regarding stewardship performance. This is a task for the future.

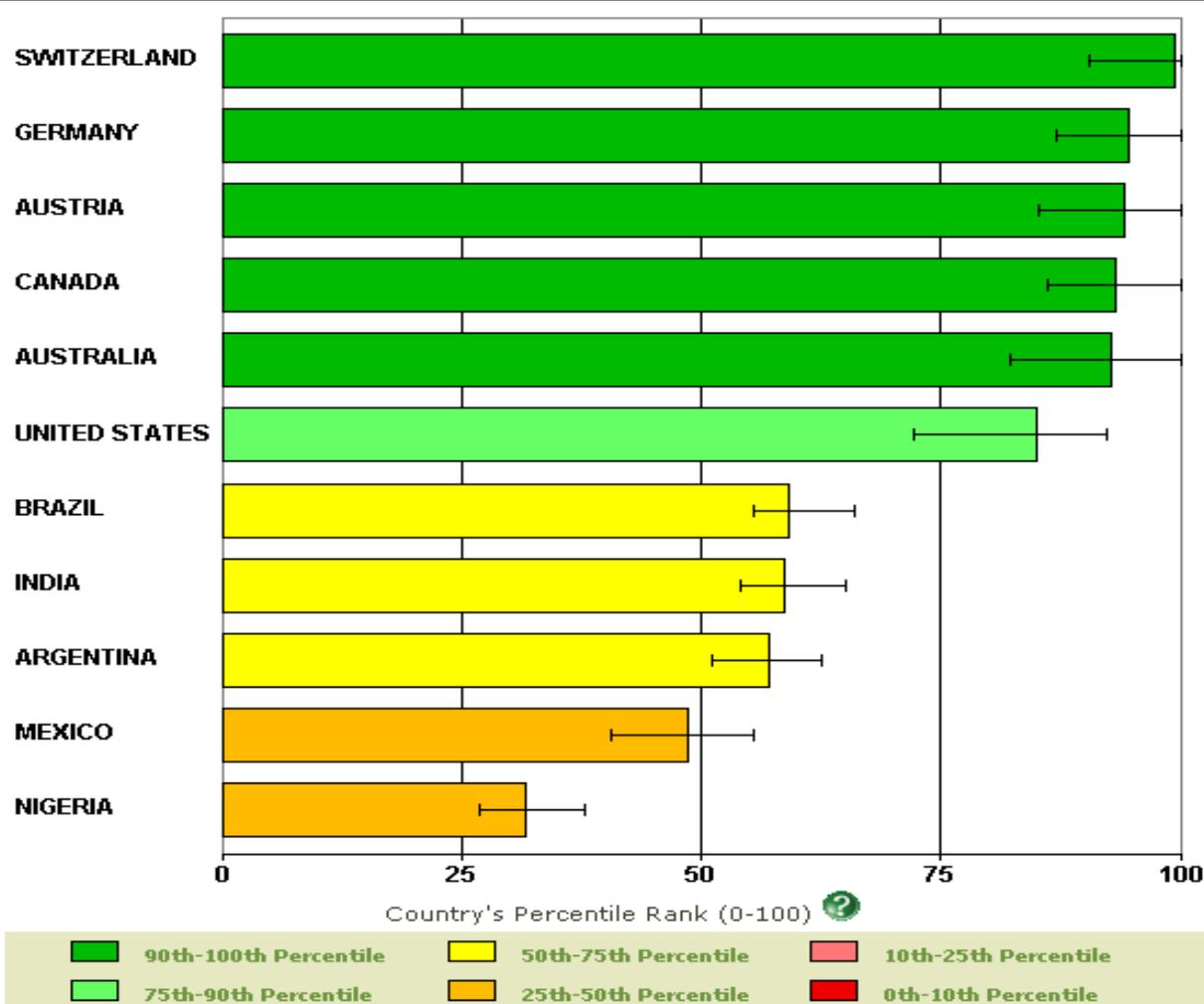
Governance indicators for eleven federal states											
Indicator	Corruption index	Corruption in medical services	Measles immunization coverage	Status index	Management Index	Voice and accountability	Political stability and absence of violence	Government effectiveness	Regulatory quality	Rule of law	Control of corruption
Country	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
Argentina	2,9	3,1	99	26	36	57	50	52	22	39	43
Australia	8,7	n/a	94	n/a	n/a	93	79	97	96	95	95
Austria	8,1	2,5	79	n/a	n/a	94	94	93	95	97	94
Brazil	3,5	n/a	99	20	15	59	37	53	53	43	52
Canada	8,7	2,6	94	n/a	n/a	93	85	96	94	96	96
Germany	7,9	2,8	94	n/a	n/a	95	81	92	93	94	93
India	3,4	3,3	67	25	19	59	18	27	46	56	47
Mexico	3,6	n/a	96	28	36	49	25	60	64	34	49
Nigeria	2,7	3,1	62	66	48	32	4	15	19	9	12
Switzerland	9,0	2,2	86	n/a	n/a	100	99	100	93	100	98
United States	7,3	3,2	93	n/a	n/a	85	56	91	91	92	91
Average	6,0	3,3	88	33	31	74	57	71	70	69	70

(1) Corruption index ranges from 0 to 10. 10 means absence of corruption. [Transparency Index 2008]
 (2) Corruption in medical services ranges from 0 to 5, i.e. extremely high. South East Europe has an average value of 4.0 [Transparency barometer 2007]
 (3) “Measles immunization coverage provides a robust measure of public service performance as it reflects government’s ability to perform a critical and basic health service. “[Lewis 2006] Measles immunization rates were obtained from World Health Organization [WHO MCV coverage 2007]

Governance indicators for eleven federal states

- (4) Status index is composed of 32 indicators for 12 criteria on 2 dimensions. The dimensions are democracy status and market economy status. The criteria for the democracy status are: stateness, political participation, rule of law, stability of democratic institutions, and political and social integration. The criteria for the market economy status are: level of socioeconomic development, organization of the market and competition, currency and price stability, private property, welfare regime, economic performance, and sustainability. Data were collected for 125 transition countries. The values range between 0 and 10, i.e. between extremely poor and excellent. [Bertelsmann Transformation Index 2008]
- (5) Management index has 5 criteria and 20 indicators. The criteria for management performance are: steering capability, resource efficiency, international cooperation. The respective indicator values are weighted according to a 6-indicator 'level of difficulty'-criterion. Values range between 0 and 10, i.e. between very poor and excellent. [Bertelsmann Transformation Index 2008]
- (6)-(11) Governance indicators measured in percentiles by the World Bank. Percentile 50, for example means, that 50% of the countries are better and 50% are worse. [World Bank Governance Indicators 2008]

'Voice and accountability' in eleven federal countries



Source [World Bank Governance Graphs 2008]

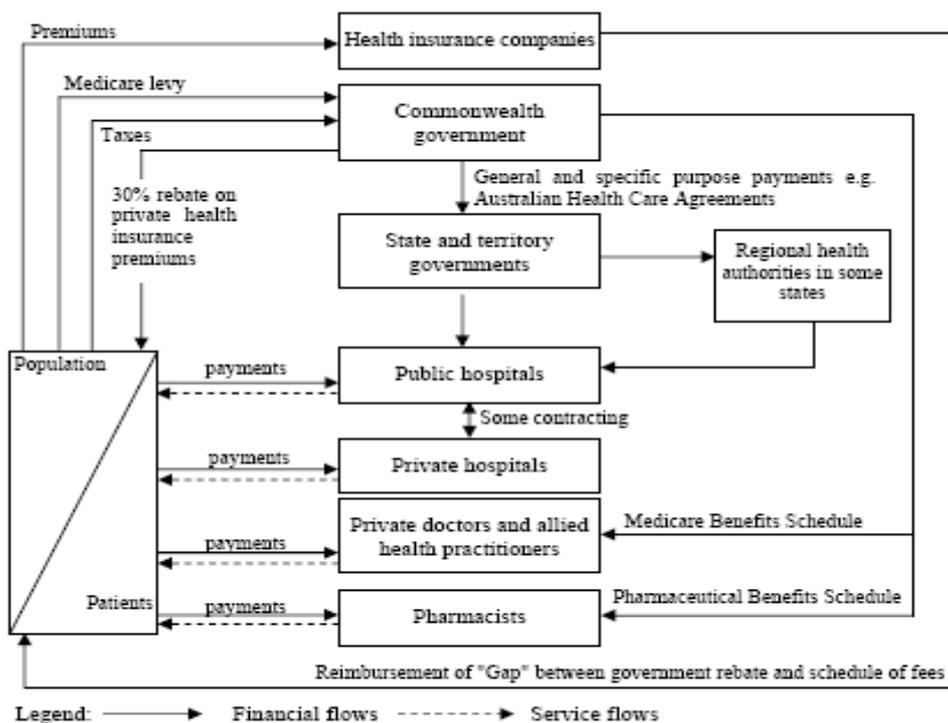
Australia

Federation's set-up The Commonwealth of Australia is made up of 8 states and territories controlled under a federal system of government. [Wikipedia 2008]

Constitution "Constitution of Australia is the law under which the Australian Commonwealth Government operates. It consists of several documents. The most important is the Constitution of the Commonwealth of Australia." [Wikipedia 2008] It consists of 128 articles with 11.320 on 40 pages. "Other pieces of legislation have constitutional significance for Australia. These are the Statute of Westminster, as adopted by the Commonwealth in the *Statute of Westminster Adoption Act 1942*, and the *Australia Act 1986*." [Wikipedia 2008]

Constitution and health "Article 51 Legislative powers of the Parliament
The Parliament shall, subject to this Constitution, have power to make laws for the peace, order, and good government of the Commonwealth with respect to: ... (xxiiiA) the provision of maternity allowances, widows' pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorize any form of civil conscription), benefits to students and family allowances;" [Australia Constitution]

Healthcare organisation in Australia Health care system of Australia



Sources: Organisation for Economic Co-operation and Development (2005a) and *Yearbook of Australia 2006*.

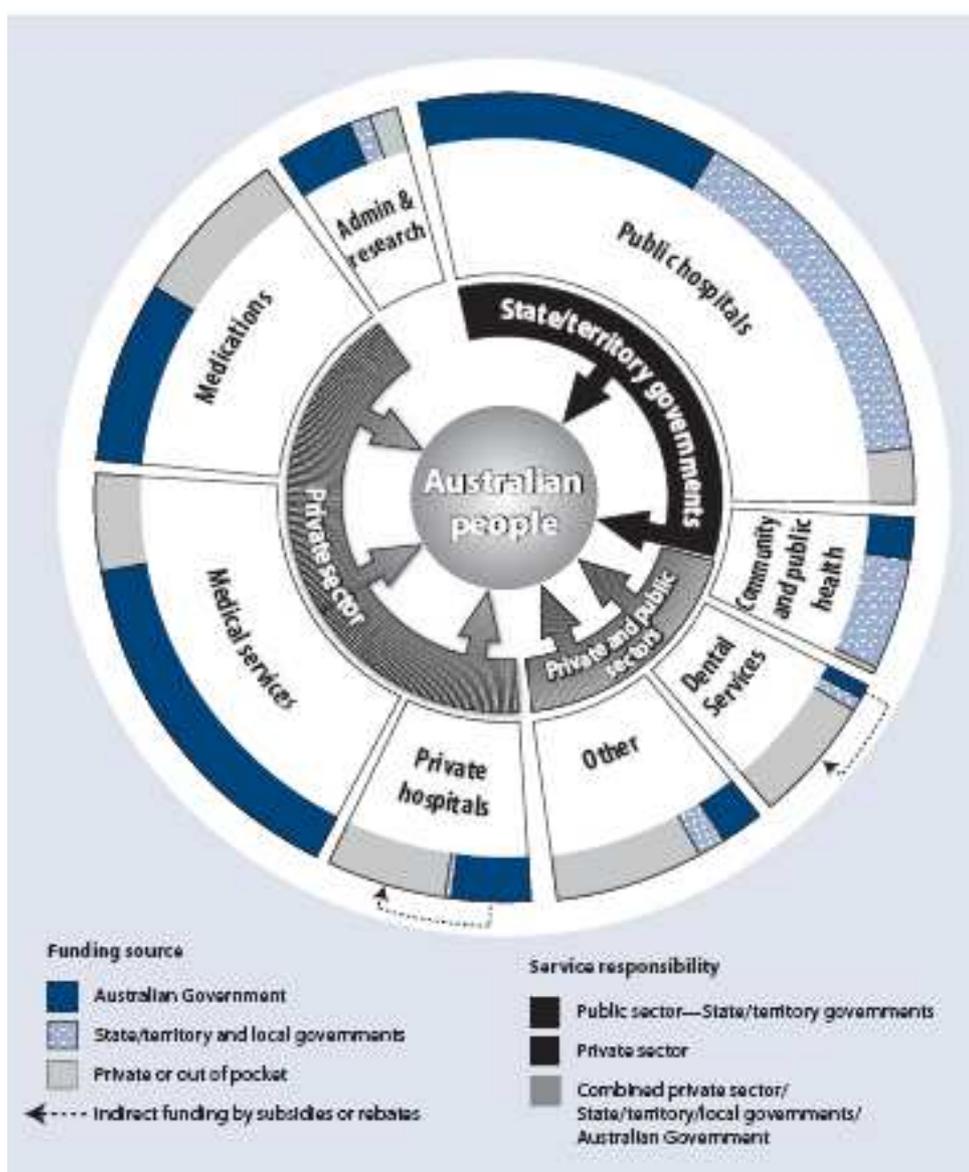
[Australia Li 2006]

"Australia has a mainly publicly funded health system financed through general taxation and a small compulsory tax-based health insurance levy. Medicare, the tax-funded national health insurance scheme, offers patients subsidized access to their doctor of choice for out-of-hospital care, free public hospital care and subsidized pharmaceuticals. About 68% of total health expenditure comes from public sources, with the Australian Government financing 46% and the States 22%; the remaining 32% comes from private sources. In the late 1990s, the Australian Government

introduced several measures to halt falling membership in voluntary private health insurance schemes, and as a consequence coverage has risen from one third to 43% of the population. Out-of-pocket payments by patients have risen, however, to 20% of total health expenditure. The main consumer payments are for pharmaceuticals not covered by government subsidies and for pharmaceutical co-payments, dental treatment, the gap between the Medicare benefit and fees charged by doctors, and payments to other health professionals. Health care remains largely free to the user, however, and its use is largely unlimited, with little public debate so far over health care funding priorities.” [Australia Observatory 2006]

The following figure “represents the main groups of health services, their funding sources and who has responsibility for their provision. It provides an at-a-glance picture to assist in answering the question, ‘who funds and who runs the health system in Australia?’” [Australia’s health 2008]

- “Starting with the outer ring, the proportion of different funding sources for each service group is colour coded. Funding is provided by the Australian Government, or state, territory and local governments, as well as private health insurance and out-of-pocket payments by individuals. Where Australian Government funding is provided indirectly in the form of subsidies or rebates, this is indicated by a broken arrow.” [Australia’s health 2008]



- “The next ring shows the major groups of services that comprise the health system. The size of each service group relates to its total expenditure. *Public hospitals, Private hospitals, Dental services, and Medications* are familiar elements of the system. The *Community and public health* group includes community nursing and public health education campaigns, among others. *Medical services* include general practice and specialist care as well as pathology and medical imaging. *Other* includes patient transport and aids, as well as health professionals such as physiotherapists and psychologists. *Administration and research* includes state departments of health and hospital or community health administration, as well as research and its funding. Examples are not exhaustive, and each group of services consists of many types of activities.” [Australia’s health 2008]
- “The darker arc inside the circle shows whether the service is provided by the private sector, public sector, or both. Examples of private sector providers include individual medical practices and pharmacies. Public sector service provision is the responsibility of state and territory governments, in the case of public hospitals, and a mixture of Australian Government and state, territory and local governments for community and public health services.” [Australia’s health 2008]

Health financing in Australia

Total health expenditure, by financing agents, current prices, 2005-06 and 2006-07

SHA code	Description	2005-06		2006-07	
		Amount (\$m)	Proportion (%)	Amount (\$m)	Proportion (%)
HF.1	General government	56,949	67.4	61,922	67.7
HF.1.1	General government excluding social security funds	56,949	67.4	61,922	67.7
HF.1.1.1	Central government	35,404	41.9	37,699	41.2
HF.1.1.2, 1.1.3	Provincial/local government	21,546	25.5	24,224	26.5
HF.1.2	Social security funds	—	—	—	—
HF.2	Private sector	27,528	32.6	29,502	32.3
HF.2.1	Private social insurance	—	—	—	—
HF.2.2	Private insurance enterprises (other than social insurance)	6,284	7.4	6,836	7.5
HF.2.3	Private household out-of-pocket expenditure	15,648	18.5	16,632	18.2
HF.2.4	Non-profit institutions serving households (other than social insurance)	—	—	—	—
HF.2.5	Corporations (other than health insurance)	5,596	6.6	6,034	6.6
HF.3	Rest of the world	—	—	—	—
Total health expenditure		84,477	100.0	91,424	100.0

[Australia AIHW 2008]

Federation’s responsibility for health in Australia

“The Australian Government has a national role in health policy-making and possesses the “power of the purse”, but funds, rather than provides, health services. It funds and administers the Medicare scheme that subsidizes ambulatory medical services, and the Pharmaceutical Benefits Scheme that subsidizes essential drugs, and through the Australian Health Care Agreements contributes funds to the States to run public hospitals. The Department of Health and Ageing engages in national health policy-making, funds health care and is concerned with population health, and with research and monitoring on population health and health system activities.” [Australia Observatory 2006]

Federal
Ministry of
Health
responsibilities
in Australia

“Australia’s health system is world class, supporting universal and affordable access to high quality medical, pharmaceutical and hospital services, while helping people to stay healthy through health promotion and disease prevention activities. The Department of Health and Ageing has a diverse set of responsibilities, but throughout there is a common purpose, which is reflected in our Vision statement: *Better health and active ageing for all Australians*. We aim to achieve our Vision through strengthening evidence-based policy advising, improving program management, research, regulation and partnerships with other government agencies, consumers and stakeholders.” [Australia MoH website 2008]

”Our current priorities include:

- focusing the health and aged care system more on healthy lifestyles, prevention and early intervention and a 'best practice' handling of chronic disease;
- improving the transparency, accessibility, accountability and quality of public and private health and aged care service provision through financing and agreements with stakeholders, industry and State and Territory governments;
- consolidating and progressing reforms to ensure choice and access to quality aged care services;
- working together with the States and Territories to reduce duplication and gaps, and to deliver efficient, value-for-money health and aged care services through an adaptable and sustainable health and aged care workforce;
- working towards improved health for Aboriginal and Torres Strait Islander peoples through whole-of-government arrangements for policy development and service delivery, and improved access to, and responsiveness of, the mainstream health system;
- improving choice for consumers through strong private sector involvement, effectively integrated with the public sector; and
- leading a whole-of-government approach to strengthening Australia’s readiness for disease threats, national emergencies and other large scale health incidents.” [Australia MoH website 2008]

“The services provided by the Health and Ageing portfolio are delivered through 23 portfolio outcomes. The Department of Health and Ageing pursues the achievement of portfolio outcomes in association with the following portfolio agencies:

- Aged Care Standards and Accreditation Agency Ltd;
- Australian Institute of Health and Welfare;
- Australian Radiation Protection and Nuclear Safety Agency;
- Cancer Australia;
- Food Standards Australia New Zealand;
- General Practice Education and Training Ltd;
- National Blood Authority;
- National Institute of Clinical Studies;
- Private Health Insurance Administration Council;
- Private Health Insurance Ombudsman; and
- Professional Services Review.”

[Australia MoH website 2008]

State
responsibilities
for health
in Australia

”The States are essentially autonomous in administering health services, subject to intergovernmental agreements, and thus vary somewhat in policies, administrative structures, per-capita expenditure, resource distribution and service utilization rates. State health departments administer public hospitals and other services, such as mental health services, school dental services, family health services, health promotion and rehabilitation services. Local governments (over 850 municipal or shire councils) are responsible for some environmental health services and public health programmes but play no role in clinical services.” [Australia Observatory 2008]

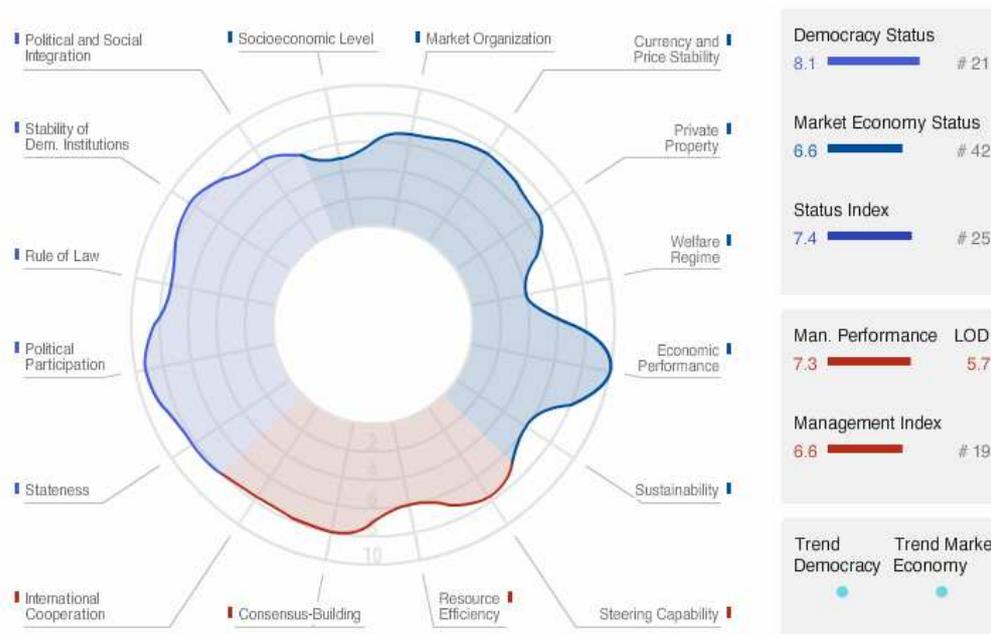
India

Federation's set-up

India is a parliamentary republic consisting of 28 states and 7 union territories. [Wikipedia 2008]

Transition stewardship

The transformation index of Bertelsmann assesses important dimensions and criteria for measuring the transformation stewardship of the country. The following scores were obtained in 2008.



[World Bertelsmann Atlas 2008 – see endnote on page 74]

Constitution

“The Constitution of India is the supreme law of India. It lays down the framework defining fundamental political principles, establishing the structure, procedures, powers and duties, of the government and spells out the fundamental rights, directive principles and duties of citizens. Passed by the Constituent Assembly on November 26, 1949, it came into effect on January 26, 1950. It declares *The Union of India* to be a sovereign, democratic republic, assuring its citizens of justice, equality, and liberty; the words “*socialist*” and “*secular*” were added to the definition in 1976 by constitutional amendment. India celebrates the adoption of the constitution on January 26 each year as Republic Day. It is the longest written constitution of any sovereign nation in the world, containing 395 articles, 12 schedules and 83 amendments, for a total of 117,369 words in the English language version. Besides the English version, there is an official Hindi translation. Being the supreme law of the country, every law enacted by the government must conform to the constitution.” [Wikipedia 2008]

Constitution and health

Article “47. Duty of the State to raise the level of nutrition and the standard of living and to improve public health.—The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health.” [India Constitution]

“State responsibilities Seventh Schedule, List II – State List
6. Public health and sanitation; hospitals and dispensaries.” [India Constitution]

Healthcare
organisation
in India

“Organization: India is a Democratic Republic consisting of 28 States and 7 Union Territories (directly administered by the Central Government). According to the Constitution of India, state governments have jurisdiction over public health, sanitation and hospitals while the Central Government is responsible for medical education. State and Central Governments have concurrent jurisdiction over food and drug administration, and family welfare. Even though health is the responsibility of the states, under the Constitution, the Central Government has been financing the national disease control, family welfare and reproductive and child health programmes. India is home to many indigenous systems of medicine, including Ayurveda and Siddha. Homeopathy, Unani, Naturopathy and various other systems are also widely practiced. The Government of India and many state governments have taken steps to formalize and initiate standardization of these systems. These include evolving pharmacopoeia standards for drugs, upgrading educational standards in indigenous medicine and in homeopathy colleges in the country and encouraging research on applicability of these systems to specific diseases. In terms of its organization, the health sector primarily comprises of the public and private sectors.” [India WHO Cooperation 2006]

“Public sector: Government health care services are organised at different levels, generally corresponding to the organisational structure of the administrative machinery. The Primary Health Centre (PHC) is the core of the rural health services infrastructure in India. It has both outpatient and outreach services. These outreach services are provided by sub-centres and staffed by multipurpose health workers. Inpatient and more specialised services are provided at the community health centres (CHC). Each sub-centre is expected to cater to a population of 5,000; each PHC to a population of 30,000; and a CHC serves a population of 100,000. District hospitals and medical college teaching hospitals along with specialized institutions provide referral care.” [India WHO Cooperation 2006]

“Private sector: India has a large and unregulated private sector, both in formal and informal sectors. In the formal sector, the private sector accounts for 68 percent of the hospitals and 64 percent of the beds.²⁰ There are large numbers of informal health care providers, most of them being less than fully qualified service providers. Adequate information is not available on the number of informal health care providers. Expenditure data reveals that more than three-fourths of outpatient curative care services are accessed through private health care providers.” [India WHO Cooperation 2006]

Federation’s,
state
and other
government
levels
responsibilities
for health
in India

“The healthcare services’ organization in the country extends from the national level to village level. From the total organization structure, we can slice the structure of healthcare system at national, state, district, community, PHC and sub-centre levels.” [India WHO Profile 2007]

“National level – The organization at the national level consists of the Union Ministry of Health and Family Welfare. The Ministry has three departments, viz. – Health, Family Welfare, and Indian System of Medicine and Homeopathy, headed by two Secretaries, one for Health and Family Welfare and the other for ISM and H. The department of Health is supported by a technical wing, the Directorate General of Health Services, headed by Director General of Health Services (DGHS).” [India WHO Profile 2007]

“State level – The organization at State level is under the State Department of Health and Family Welfare in each State headed by Minister and with a Secretariat under the charge of Secretary/Commissioner (Health and Family Welfare) belonging to the cadre of Indian Administrative Service (IAS). By and large, the organizational Structure adopted by the State is in conformity with the pattern of the Central Government. The State Directorate of Health Services, as the technical wing, is an

attached office of the State Department of Health and Family Welfare and is headed by a Director of Health Services. However, the organizational structure of the State Directorate of Health Services is not uniform throughout the country. For example, in some states, the Programme Officers below the rank of Director of Health Services are called Additional Director of Health Services, while in other states they are called Joint/Deputy Director, Health Services. But regardless of the job title, each programme officer below the Director of Health Services deals with one or more subject(s). Every State Directorate has supportive categories comprising of both technical and administrative staff. ” [India WHO Profile 2007]

“The area of medical education which was integrated with the Directorate of Health Services at the State, has once again shown a tendency of maintaining a separate identity as Directorate of Medical Education and Research. This Directorate is under the charge of Director of Medical Education, who is answerable directly to the Health Secretary/Commissioner of the State. Some states have created the posts of Director (Ayurveda) and Director (Homeopathy). These officers enjoy a larger autonomy in day-to-day work, although sometimes they still fall under the Directorate of Health Services of the State. ” [India WHO Profile 2007]

“Regional level – In the state of Bihar, Madhya Pradesh, Uttar Pradesh, Andhra Pradesh, Karnataka and others, zonal or regional or divisional set-ups have been created between the State Directorate of Health Services and District Health Administration. Each regional/zonal set-up covers three to five districts and acts under authority delegated by the State Directorate of Health Services. The status of officers/in-charge of such regional/zonal organizations differs, but they are known as Additional/Joint/Deputy Directors of Health Services in different States. ” [India WHO Profile 2007]

“District level – In the recent past, states have reorganized their health services structures in order to bring all healthcare programmes in a district under unified control. The district level structure of health services is a middle level management organisation and it is a link between the State as well as regional structure on one side and the peripheral level structures such as PHC as well as sub-centre on the other side. It receives information from the State level and transmits the same to the periphery by suitable modifications to meet the local needs. In doing so, it adopts the functions of a manager and brings out various issues of general, organizational and administrative types in relation to the management of health services. The district officer with the overall control is designated as the Chief Medical and Health Officer (CM & HO) or as the District Medical and Health Officer (DM & HO). These officers are popularly known as DMOs or CMOs, and are overall in-charge of the health and family welfare programmes in the district. They are responsible for implementing the programmes according to policies laid down and finalized at higher levels, i.e. State and Centre. These DMOs/CMOs are assisted by Dy. CMOs and programme officers. The number of such officers, their specialization, and status in the cadre of State Civil Medical Services differ from the State to State. Due to this, the span of control and hierarchy of reporting of these programme officers vary from state to state. ” [India WHO Profile 2007]

“Sub-divisional/Taluka level – At the Taluka level, healthcare services are rendered through the office of Assistant District Health and Family Welfare Officer (ADHO). Some specialties are made available at the taluka hospital. The ADHO is assisted by Medical Officers of Health, Lady Medical Officers and Medical Officers of general hospital. These hospitals are being gradually converted into Community Health Centres (CHCs). ” [India WHO 2007]

“Community level – For a successful primary healthcare programme, effective referral support is to be provided. For this purpose one Community Health Centre

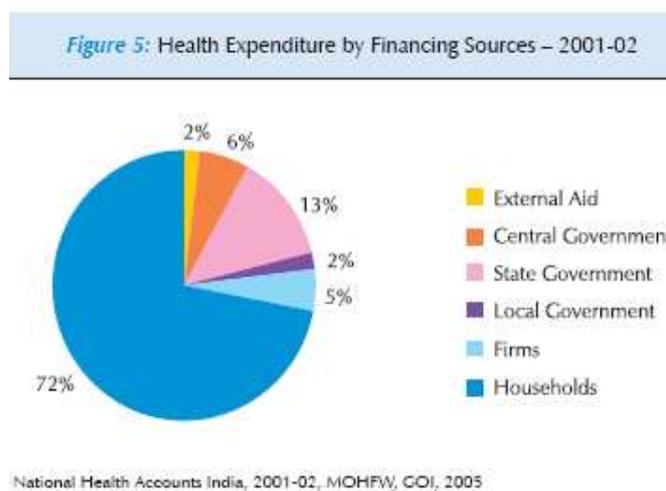
(CHC) has been established for every 80,000 to 1, 20,000 population, and this centre provides the basic specialty services in general medicine, pediatrics, surgery, obstetrics and gynecology. The CHCs are established by upgrading the sub-district/taluka hospitals or some of the block level Primary Health Centres (PHCs) or by creating a new centre wherever absolutely needed.” [India WHO Profile 2007]

“PHC level – At present there is one Primary Health Centre covering about 30,000 (20,000 in hilly, desert and difficult terrains) or more population. Many rural dispensaries have been upgraded to create these PHCs. Each PHC has one medical officer, two health assistants – one male and one female, and the health workers and supporting staff. For strengthening preventive and promotive aspects of healthcare, a post of Community Health Officer (CHO) was proposed to be provided at each new PHC, but most states did not take it up.” [India WHO Profile 2007]

“Sub-centre level – The most peripheral health institutional facility is the sub-centre manned by one male and one female multi-purpose health worker. At present, in most places there is one sub-centre for about 5,000 populations (3,000 in hilly and desert areas and in difficult terrain).” [India WHO Profile 2007]

“The 73rd and 74th constitutional amendments have given the powers to the local bodies in some states of India. In the process, different states have adopted different stakeholders for the benefit of health services, with the help of community participation, which gives stress on safe drinking water and sanitation at village level. The Panchayats are given the power to look after the welfare of the people.” [India WHO Profile 2007]

Health financing in India



[India WHO Cooperation 2006]

State government expenditure for health

	Per capita state govt health exp in 2001-02 (in Rs.)
Punjab	150.51
Karnataka	135.06
Kerala	128.4
Tamil Nadu	122.35
Maharashtra	115.38
Rajasthan	110.08
Andhra Pradesh	106.17
West Bengal	102.31
Gujarat	97.06
Haryana	86.88
Assam	73.64
Orissa	72.24
Uttar Pradesh	48.29
Madhya Pradesh	35.97

[India ERF 2006]

Sources of funding for health

Financing Agent	Expenditure in Rs millions	% Distribution
Ministry of Health and Family Welfare	24,629	2.3
Other Central Ministries/Departments	2,132	0.2
State Government Department of Health	141,699	13.4
Other State Ministries/Departments	2,311	0.2
Urban Local Bodies and Panchayat Raj Institutions	31,784	3.0
Social Security Funds	790	0.1
Central Government Employee Schemes	25,797	2.4
State Government Employee Schemes	5,119	0.5
Employee State Insurance Scheme	17,954	1.7
Public Health Insurance Providers (GIC Companies)	7,823	0.7
Private Health Insurance Providers	202	0.0
Households	744,225	70.4
NGOs	8,540	0.8
Private Firms and Public Firms	44,336	4.3
Total funds provided	1,957,341	100.0

Government expenditure

Out-of-pocket

[India USAID 2008]

Source: National Health Accounts 2001-2002; No updated information on NHA was available from the MoHFW

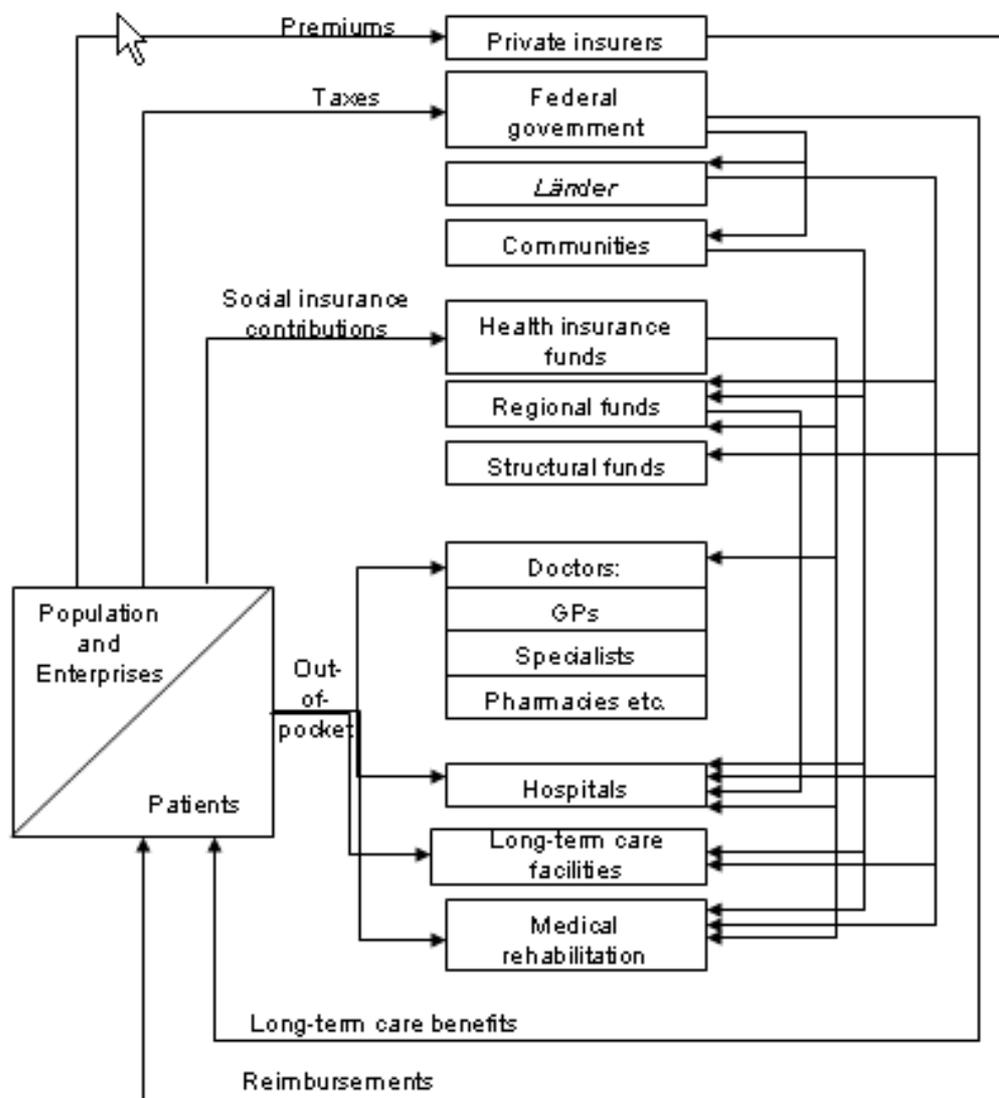
Austria

Federation's set-up	<p>“Austria is a parliamentary representative democracy comprising nine federal states. [Wikipedia 2008]</p>
Constitution	<p>“The Constitution of Austria (<i>Österreichische Bundesverfassung</i>) is the body of all constitutional law of the Republic of Austria on the federal level. It is split up over many different acts. Its ¶ ectoral¶ ¶ a is the <i>Bundes-Verfassungsgesetz (B-VG)</i>, which includes the most important federal constitutional provisions.” [Wikipedia 2008] It consists of 38.446 words.</p> <p>“Apart from the B-VG, there are a large number of other constitutional acts (called <i>Bundesverfassungsgesetze</i>, singular <i>Bundesverfassungsgesetz</i>, abbrev. <i>BVG</i>, ie without the dash) and individual provisions in statutes and treaties which are designated as constitutional (“<i>Verfassungsbestimmung</i>”). For example, the B-VG does not include a bill of rights, but provisions on civil liberties are split up over different constitutional legislative acts. Over time, both the B-VG and the numerous pieces of constitutional law supplementing it have undergone literally hundreds of minor and major amendments and revisions.” [Wikipedia 2008]</p>
Constitution and health care	<p>“Article 10 (1) The Federation has powers of legislation and execution in the following matters: 12. public health with the exception of burial and disposal of the dead and municipal sanitation and first aid services, but only sanitary supervision with respect to hospitals, nursing homes, health resorts and natural curative resources; measures to counter factors hazardous to the environment through the transcendence of input limits; clear air maintenance notwithstanding the competence of the Laender for heating installations; refuse disposal in respect of dangerous refuse, but in respect of other refuse only in so far as a need for the issue of uniform regulations exists; veterinary affairs; nutrition affairs, including foodstuffs inspection; regulation of commercial transactions in seed and plant commodities, in fodder and fertilizer as well as plant preservatives, and in plant safety appliances including their admission and, in the case of seed and plant commodities, likewise their acceptance;” [Austria Constitution]</p> <p>“Art. 12. (1) In the following matters legislation as regards principles is the business of the Federation, the issue of implementing laws and execution the business of the Laender: 1. social welfare; population policy in so far as it does not fall under Art. 10; public social and welfare establishments; maternity, infant and adolescent welfare; hospitals and nursing homes; requirements to be imposed for health reasons on health resorts, sanatoria, and health establishments; natural curative resources; ” [Austria Constitution]</p>
Healthcare organisation	<p>“The Austrian health system is shaped by statutory health insurance that covers about 95% of the population on a mandatory and 2% on a voluntary basis. Of the 3.1% of the population not covered in 2003, 0.7% had taken out voluntary substitutive insurance, while 2.4% had no cover at all (for example some groups of unemployed as well as asylum seekers). The 26 statutory health insurance funds are organized in the Federation of Austrian Social Security Institutions and do not compete with each other since membership is mainly mandatory and based on occupation or domicile. Since 2001 family coinsurance has required a (reduced) contribution but many household members remain exempt for example children, child-raising spouses or individuals in need of substantial nursing care.” [Europe Snapshots 2004]</p> <p>“The Federal Ministry of Health and Women is the main policymaker in health care, responsible for supervising the statutory health insurance actors and issuing</p>

nationwide regulations for example on drug licensing and pricing. The nine *Länder* governments deliver public health services and have strong competences to finance and regulate inpatient care. Capacity planning increasingly has been undertaken by a structural commission at federal level and nine commissions at *Länder* level and is gradually being extended to all sectors and types of care.” [Europe Snapshots 2004]

Health care financing in Austria

Austria’s system of health financing, 2003



[Europe OECD 2008]

“The social health insurance system, which is the most important source of financing, provided a total of 45.3% of total health care expenditure in 2004. 25% of total health care expenditure is financed by the federal government, the *Länder* and local authorities. In 2004, around 25% of health care expenditure was financed privately.” [Austria Observatory 2006]

Federation’s and state responsibilities for health in Austria

“The Austrian health care system is characterized by the federalist structure of the country, the delegation of competencies to self-governing stakeholders in the social insurance system as well as by cross-stakeholder structures at federal and *Länder* level which possess competencies in cooperative planning, coordination and financing. According to the Federal Constitution, almost all areas of the health care system are primarily the regulatory responsibility of the federal government. The most important exception is the hospital sector. In this area, the federal government is only responsible for enacting basic law; legislation on implementation and enforcement is the responsibility of the nine *Länder*. In the outpatient sector, but also

in the rehabilitation sector and in the field of medicines, health care is organized by negotiations between the 21 health insurance funds and the Federation of Austrian Social Insurance Institutions on the one hand and the chambers of physicians and pharmacists (which are organized as public-law bodies) and the statutory professional associations of midwives or other health professions on the other.” [Austria Observatory 2006]

State responsibilities for health in Austria

“The Länder and municipalities play an important role in establishing, implementing and monitoring the various aspects of the public health service. Legislation at Länder level is made by the Länder parliaments, whose members are elected by proportional representation. The state government is the supreme health authority of the Land. It is supported by the office of the state government and by the state health board. There is thus a separate department for health in each state government, which is led by a physician with civil servant status, the State Health Director. The office of each state government has a state health board at its disposal for advisory purposes. The state administrations have established departments to combat notifiable infectious diseases. There are also vaccination centres and various advice centres, including centres providing advice on health promotion, as well as institutions which keep health statistics for the respective Land. Furthermore, the job market in the public health service along with adherence to the training regulations for medical personnel other than physicians are monitored. “[Austria Observatory 2006]

“In addition, each district administration has a health department (health office), which is headed by a district medical officer. The tasks of the district medical officers are also carried out by advice centres and counselling centres (antenatal clinics, vaccination centres, AIDS help centres, etc.). Some matters, such as health inspections at local level, are the responsibility of the local governments. Some local communities have also set up joint health districts (*Sanitätsdistrikte*). In the local communities, the municipal medical officers (*Gemeindeärzte*) or the district medical officers (*Sprengel- oder Kreisärzte*) act as experts for consultation purposes. The supervisory authorities at this level are general state administrative authorities such as the district administrative authorities, the state governor in the case of delegated federal responsibilities, and the state government in the case of delegated Länder responsibilities.” [Austria Observatory 2006]

“The Federal Hospitals Act (KAKuG) stipulates that each Land is obliged to ensure the availability of inpatient care for people who require it. The Länder establish the structure of inpatient acute care in quantitative and qualitative terms according to the specifications set out in health planning. Until December 2005, the Länder hospital plans had to adhere to the specifications of the ÖKAP/GGP. Since 2006, the Austrian Structural Plan for Health is in effect (see Section 2.2 on planning, regulation and management). Negotiations have not yet been finalized. In case no agreements can be achieved, the ÖKAP/GGP will remain binding. It sets out the framework for detailed planning specific to the relevant Land (see Chapter 6 on health care reforms). ... According to valid agreements between the Federal Government and the Länder (agreement according to Federal Constitution Article 15a), the Länder will be supported in the provision of health care by State Health Funds at Länder level. In addition, hospital operation companies have been established in almost all the Länder; most of which have private law status.” [Austria Observatory 2006]

“The Länder and local communities are responsible for the provision of hospitals and for maintaining their infrastructure. They are obliged to adhere to the framework legislation of the Federal Government and thus to nationwide planning and specifications. In addition, they regulate matters concerning the public health care system, which they mostly delegate to the local communities. They are also responsible for social assistance and partly for the award of long-term care benefit and for the financing and monitoring of training institutions for health professionals

apart from physicians. They fulfil the role of supervisory authority for the physicians' chambers and for health insurance funds operating at federal level which do not exceed a certain number of insured people." [Austria Observatory 2006]

Levels and health responsibilities of government in Austria

Number and size of levels of national government, whether appointed or elected, and tax-raising powers (2004)

Country	Levels of government, including administrative health structures	Number ¹	Inhabitants per entity: average ² (and approximate range) (× 1000)	Appointed/ Elected	Raising taxes ³
Germany*	Central government	1	82 537	Elected	X
	Regions (<i>Länder</i>)	16	5159 (661–18 080)	Elected	X
	Districts (<i>Regierungsbezirke</i>)	29	2846 (517–5245)	Appointed	
	<i>Kreisfreie Städte and Landkreise</i>	439	188 (36–1248)	Appointed	
	<i>Ämter & Gemeindeverbände</i>	1603	51 (1–106)	Appointed	
	Local governments (<i>Gemeinden / Städte</i>)	14 703	6 (0.004–152)	Elected	X

Levels and respective responsibilities in health care (2004)

Country	Levels ¹	Health care responsibilities					
		Raises health care funds (public)	Contracts hospitals	Owens secondary hospitals	Owens long-term care institutions	Owens primary care centres	Pays GPs
Germany	Central government						
	Regions (<i>Länder</i>)			X			
	Districts (<i>Regierungsbezirke</i>)						
	<i>Kreisfreie Städte / Landkreise</i>			X			
	<i>Ämter / Gemeindeverbände</i>						
	Local governments (<i>Gemeinden / Städte</i>)			X	X		
	Sickness funds	X	X				
Private			X	X	X	X	

[Europe Bankauskaite 2007]

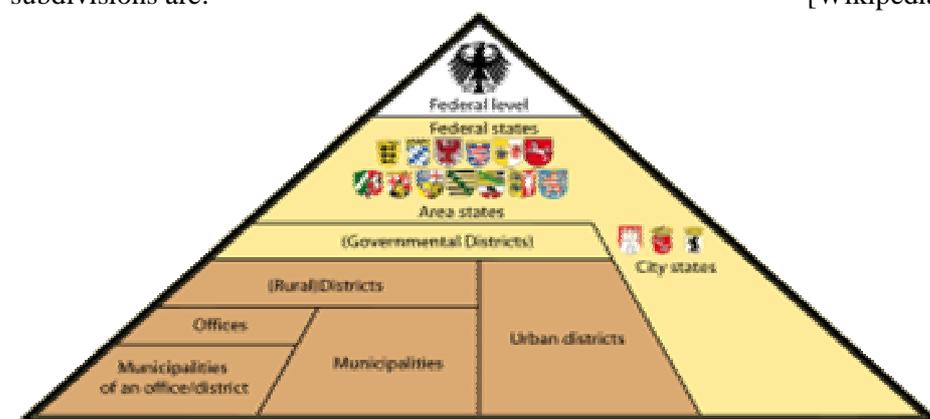
Important other actors for health

Statutory health insurance companies, professional associations, hospital associations, and voluntary and consumer organizations

Germany

Federation's set-up

Germany is a federal parliamentary republic of sixteen states (*Länder*). Further subdivisions are: [Wikipedia 2008]



Constitution

One basic document with 146 articles – 58 pages – 21.758 words

Constitution and health care in Germany

“Article 74 Concurrent legislative powers extend to the following matters:
19. measures against epidemic and infectious diseases of humans and animals, admission to medical and other professions and practices in the field of healing, traffic in drugs, medicines, narcotics, and poisons;
19a. the economic viability of hospitals and the regulation of hospitalization fees;
(inserted 12 May 1969” [Germany Constitution]

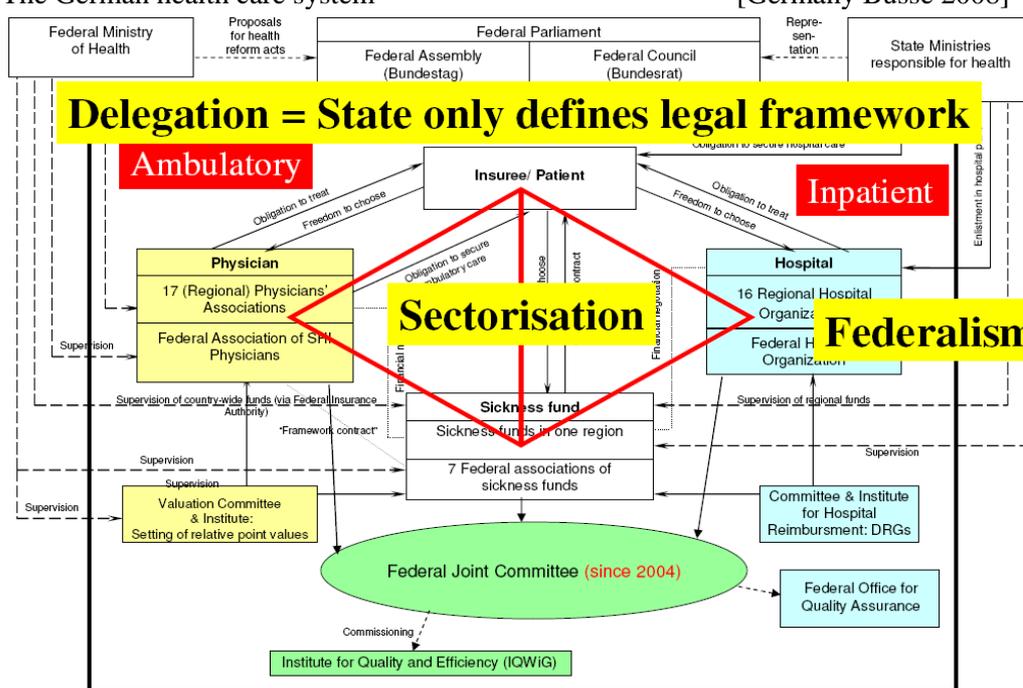
Healthcare organisation in Germany

“The roots of the German health system date back to 1883, when nationwide health insurance became compulsory. Today’s system is based on social health insurance and characterized by three co-existing schemes. In 2003, about 87% of the population were covered by statutory health insurance; based on income, membership was mandatory for about 77% and voluntary for 10%. An additional 10% of the population took out private health insurance; 2% were covered by governmental schemes and 0.2% were not covered by any third-party-payer scheme.” [European Snapshots 2004]

The health care system has a decentralized organization, characterized by federalism and delegation to nongovernmental corporatist bodies as the main actors in the social health insurance system: the physicians’ and dentists’ associations on the providers’ side and the sickness funds and their associations on the purchasers’ side. Hospitals are not represented by any legal corporatist institution, but by organizations based on private law. The actors are organized on the federal as well as the state (*Land*) level. The Ministry of Health and Social Security proposes the health acts that – when passed by parliament – define the legislative framework of the social health insurance system. It also supervises the corporatist bodies and – with the assistance of a number of subordinate authorities – fulfils various licensing and supervisory functions, performs scientific consultancy work and provides information services. The 292 sickness funds collect the contributions of the statutory insurance for health and long-term care. They also negotiate contracts with the health care providers. Since 1996 almost every insured person has had the right to choose a sickness fund freely, while funds are obliged to accept any applicant. Since 2004, decision-making in statutory health insurance has been integrated into a trans-sectoral joint federal committee that is supported by an independent institute for quality and efficiency.” [European Snapshots 2004]

The German health care system

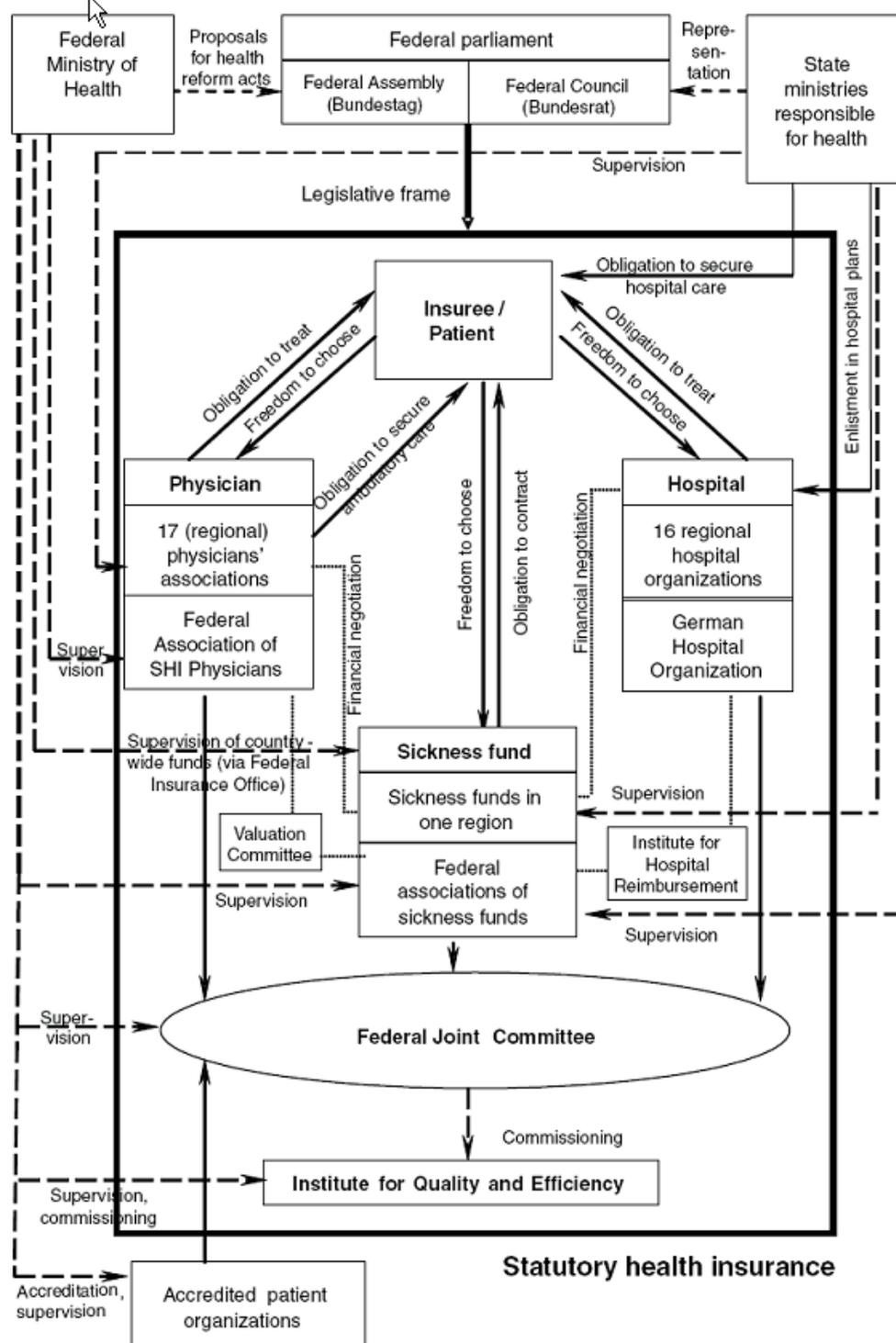
[Germany Busse 2008]



Statutory health insurance early 2008

Health financing in Germany

Germany's system of health financing, 2005



[Europe OECD 2008]

“Of total expenditure, 57% of the funds came from statutory health insurance, 7% from statutory long-term care insurance, 4% from other statutory insurance schemes and 8% from government sources. Private health insurers financed 8%, employers 4% and non-profit-making organizations and households 12%. ” [European Snapshots 2004]

Federation's responsibility for health

“The Federal Ministry of Health is responsible for:

- maintaining the effectiveness and efficiency of the statutory health insurance and long-term care insurance systems
- maintaining and enhancing the quality of the health care system

- strengthening the interests of patients
- maintaining economic viability and stabilization of contribution levels
- preventive and prophylactic healthcare
- the Protection against Infection Act
- establishing guidelines for the manufacture, clinical trial, approval, distribution channels and monitoring of medicines and medical devices. The objectives are:
 - quality, medical efficacy and safety
 - safety of biological medical products such as blood products
- narcotics and addiction risk prevention
- prevention, rehabilitation and disability policy
 - medical and occupational rehabilitation
 - disability law
 - providing assistance to the disabled and promoting their interests
- European and international health policy, including the work of the Federal Government Narcotics Officer and the patients' ombudsman." [Wikipedia 2008]

State
responsibility
for health
in Germany

"The federal structure is represented mainly by the 16 state governments and, to a very small extent, by the state legislatures. In 2003, 13 out of the 16 *Länder* governments had a ministry with "health" in its name. However, none has an exclusive health ministry. In most of these *Länder* it is most commonly combined with Labour and Social Policy (which is also the case in the remaining three *Länder*), less commonly with family or youth affairs, and only in one Land is it combined with environmental affairs, a combination more common in the 1970s and 1980s. Within a *Land's* Labour Ministry, "health" is typically one of four or five divisions. In Lower Saxony for example, the health division is further subdivided into units concerned with public health services and environmental hygiene health promotion, prevention and AIDS care state-owned hospitals hospital planning supervision of health professions and their professional institutions psychiatry and illegal drugs pharmaceuticals and supervision of pharmacists and their professional institutions. Most other areas affecting health such as traffic, city planning or education are controlled by other ministries." [Germany Observatory 2004]

"Hospitals are financed on a dual basis: investments are planned by the governments of the 16 *Länder*, and subsequently co-financed by the *Länder* as well as the federal government, while sickness funds finance recurrent expenditures and maintenance costs." [European Snapshots 2004]

Lower area
responsibilities
in Germany

"*Gemeinden* (municipalities) have two major policy responsibilities. First, they administer programs authorized by the federal or state government. Such programs typically might relate to youth, schools, public health, and social assistance. Second, Article 28(2) of the Basic Law guarantees *Gemeinden* "the right to regulate on their own responsibility all the affairs of the local community within the limits set by law." Under this broad statement of competence, local governments can justify a wide range of activities. For instance, many municipalities develop and expand the economic infrastructure of their communities through the development of industrial parks." [Wikipedia 2008]

Important
other actors
for health
in Germany

Statutory health insurance companies, 2007: 238 'sickness funds', professional associations, hospital associations, voluntary and consumer organizations.

"In health care, governments traditionally delegate competencies to membership-based, self-regulated organizations of payers and providers. In the – for health care – most prominent scheme, the statutory health insurance, sickness funds, their associations and associations of SHI-affiliated physicians have assumed the status of quasi-public corporations. These corporatist bodies constitute the selfregulated structures that operate the financing and delivery of benefits covered by statutory health insurance within the legal framework. They are based on mandatory

membership and internal democratic legitimization. They may define and raise membership fees and finance or deliver services to their members. In joint committees of payers (associations of sickness funds) and providers (physicians' or dentists' associations or single hospitals) legitimized actors have the duty and right to define benefits, prices and standards (federal level) and to negotiate horizontal contracts, to control and sanction their members (regional level). The vertical implementation of decisions taken by senior levels is combined with a strong horizontal decision-making and contracting among the legitimated actors involved in the various sectors of care." [Germany Levenets 2008]

"Deconcentration is only of minor importance in the German health care system, due to most levels of administration (with the exception of some *Länder* administrations) lacking any sub-level administrative offices since all political units from the local level upwards have their own autonomous, elected representatives and governments. The most striking component of the decentralized health care system is the delegation of state power to corporatist actors." [Germany Levenets 2008]

Switzerland

Federation's set-up "Since 1979, Switzerland has been made up of 23 cantons, three of which are divided into demi-cantons. Thus, Switzerland today is composed of 26 entities that are sovereign in all matters that are not specifically designated the responsibility of the Swiss Confederation by the federal constitution. Each canton and demi-canton has its own constitution and a comprehensive body of legislation stemming from its constitution." [Switzerland Observatory 2000]

"Switzerland has about 2900 municipalities that constitute the level of authority closest to the people within the federal structure. The rights and duties of municipalities are not always identical but are laid down in the different cantonal laws applying to municipalities. The most obvious sign of autonomy is the tax sovereignty of the municipalities. Like the Confederation and the cantons, the municipalities are entitled to levy income tax and property tax on individuals and corporations in the municipality. They are also free to set the rate of tax." [Switzerland Observatory 2000]

"Swiss municipalities vary greatly in size, and their organization also differs. In many small municipalities, especially in the part of Switzerland in which German speakers predominate, all citizens with the right to vote can take part in the municipal assembly, which is the highest legislative body, whereas the larger municipalities have municipal parliaments. In most places, the executive authority is the district or town council, which is directly elected and functions as a collegial authority. The municipalities can formulate policies in many areas. Depending on the rules laid down by the canton, these can include policies on nurseries, schools, energy supplies, refuse collection, building regulations, transport, social care, cultural activities, adult education and sport. Numerous tasks of political leadership in many smaller and medium-sized municipalities are carried out on a voluntary basis or in return for merely symbolic compensation." [Switzerland Observatory 2000]

Constitution Federal Constitution of 18 April 1999. 197 Articles on 34 pages, 23.243 words.

Constitution and health care "Art. 41
1 The Confederation and the Cantons shall, as a complement to personal responsibility and private initiative, endeavour to ensure that:
a. everyone has access to social security;

b. everyone has access to the health care that they require

Art. 117 Health and accident insurance

1 The Confederation shall legislate on health and accident insurance.

2 It may declare health and the accident insurance to be compulsory, either in general terms or for individual sections of the population.

Art. 118 Health protection

1 The Confederation shall, within the limits of its powers, take measures for the protection of health.

2 It shall legislate on:

a. the use of foodstuffs as well as therapeutic products, narcotics, organisms, chemicals and items that may be dangerous to health;

b. the combating of communicable, widespread or particularly dangerous human and animal diseases;

c. protection against ionising radiation.

Art. 119 Reproductive medicine and gene technology involving human beings

1 Human beings shall be protected against the misuse of reproductive medicine and gene technology.

2 The Confederation shall legislate on the use of human reproductive and genetic material. In doing so, it shall ensure the protection of human dignity, privacy and the family and shall adhere in particular to the following principles:

a. all forms of cloning and interference with the genetic material of human reproductive cells and embryos are unlawful.

b. non-human reproductive and genetic material may neither be introduced into nor combined with human reproductive material.

c. the procedure for medically-assisted reproduction may be used only if infertility or the risk of transmitting a serious illness cannot otherwise be overcome, but not in order to conceive a child with specific characteristics or to further research; the fertilisation of human egg cells outside a woman's body is permitted only under the conditions laid down by the law; no more human egg cells may be developed into embryos outside a woman's body than are capable of being immediately implanted into her.

d. the donation of embryos and all forms of surrogate motherhood are unlawful.

e. the trade in human reproductive material and in products obtained from embryos is prohibited.

f. the genetic material of a person may be analysed, registered or made public only with the consent of the person concerned or if the law so provides.

g. everyone shall have access to data relating to their ancestry.

Art. 119a 50 Transplant medicine

1 The Confederation shall legislate in the field of organ, tissue and cell transplants. In doing so, it shall ensure the protection of human dignity, privacy and health.

2 It shall in particular lay down criteria for the fair allocation of organs.

3 Any donation of human organs, tissue and cells must be free of charge. The trade in human organs is prohibited.

Art. 13059 Value added tax*.....

4 5 per cent of the non-earmarked revenues shall be used to reduce the health insurance premiums of persons on low incomes, unless an alternative method of assisting such persons is provided for by law. ” [Switzerland Constitution]

Healthcare
organisation
in Switzerland

“Healthcare in Switzerland is regulated by the Federal Health Insurance Act. Health insurance is compulsory for all persons resident in Switzerland (within three months of taking up residence or being born in the country). International civil servants, members of permanent missions and their family members are exempted from compulsory health insurance. They can, however, apply to join the Swiss health insurance system, within six months of taking up residence in the country.” [Wikipedia 2008]

The Swiss healthcare system is a combination of public, subsidised private and totally private systems:

- public: e. g. the University of Geneva Hospital (HUG) with 2,350 beds, 8,300 staff and 50,000 patients per year;
- subsidised private: the home care services to which one may have recourse in case of a difficult pregnancy, after childbirth, illness, accident, handicap or old age;
- totally private: doctors in private practice and in private clinics.

The insured person has full freedom of choice among the recognised healthcare providers competent to treat their condition (in his region) on the understanding that the costs are covered by the insurance up to the level of the official tariff. There is freedom of choice when selecting an insurance company (provided it is an officially registered *caisse-maladie* or a private insurance company authorised by the Federal Act) to which one pays a premium, usually on a monthly basis.” [Wikipedia 2008]

“The health care system in Switzerland is consistent with the long-standing national sentiment of allowing state activity ‘only when private initiative fails to produce satisfactory results.’ The system is largely consumer driven, with a combination of public and private efforts. Switzerland operates the second most expensive health care system behind the United States, with health care expenditure totaling 11.3% of the GDP. The federal government provides oversight to the system, and 23 cantons are responsible for regulation and financing of the public delivery system. Public expenditure is among the lowest in Europe, at about 60% of total contributions.” [Switzerland Dougherty 2008]

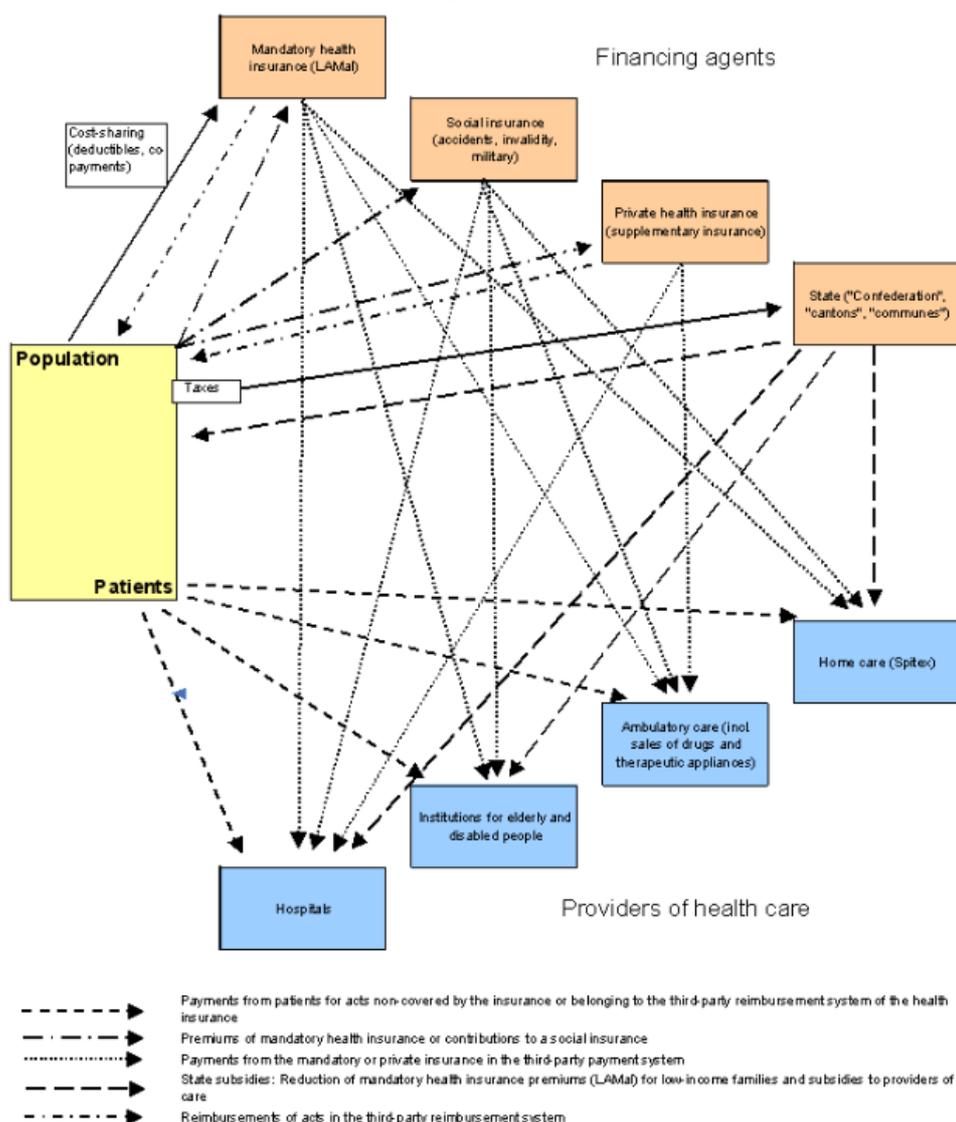
“A national mandate requires every person to individually purchase health insurance. Consumers can choose from about 100 public and private insurers, all of which are required by law to be not-for-profit. Insurers must offer a basic package of comprehensive benefits, and are obliged to accept all applicants. The nationally standardized set of services must meet criteria of both clinical and cost effectiveness. The insurers vary in size from 2,000 members to well over one million. Insurance is not employer based but many plans are grouped on varying levels; national, regional, religious, and occupational plans are common. A clause named Foundation 18 also establishes a risk-adjustment scheme between insurers to support plans attracting higher-risk individuals. Plans cannot compete through benefit packages, but rather via premiums and deductible pricing. These prices may vary considerably between cantons, as they are community-rated (prior to 1996 premiums were risk-related).” [Switzerland Dougherty 2008]

“The national average cost is about \$2,500-2,900 per individual annually, with much lower premiums for those under 25 years old. Federal subsidies are granted to persons whose premiums comprise more than 8-10% of annual income. About 30% of the population receives this benefit. Deductible options also lower premium rates, with discounts up to 40% for high deductibles. User fees are also present for most medical care and are capped at about \$600 per year. HMO-type policies have also emerged, offering lower premiums (10-20% reduction) for more restricted provider choice. Smaller regional plans have also developed general practitioner physician networks to act as gatekeepers, which allow 5-15% reduction in premium prices. 25-40% of the population also elects to purchase supplementary insurance to cover dental care and other amenities like private hospital rooms. Individuals generally have unlimited free choice of providers, though almost all have a regular physician. Doctors are mostly private and office-based, operating in a fee-for-service structure. All prices are negotiated at the cantonal level. Hospital and outpatient care can be either private (managed as for-profit or not-for-profit) or publicly based. Cantons subsidize 50% of operating costs for public and non-profit hospitals. Insurers and hospitals may also contract directly with physicians, and they are typically paid through a salary. Insurers are not allowed to negotiate preferred provider contracts

with hospitals in return for lower fees, thus restraining hospital price competition. With the most expensive system outside of the United States, criticism is aimed at high costs and the need for more cost-effective delivery. Switzerland has the second highest (to the US) utilization of cutting-edge technology. Little negative financial incentive for utilization combined with a high density of providers results in an average 11 doctor contacts per person per year; the highest in Western Europe and nearly three times the US rate. A majority of doctors are paid via fee-for-service, which drives up utilization and cost, in addition to a general lack of less expensive 'non-doctor' care. Respected local economists are suggesting greater price competition between providers and purchasers, which they believe will improve efficiency.¹ To decrease costs, insurers are also hoping to thin the standard package of benefits by more critically determining the real health benefits for certain services. Global budgeting for hospitals operating subsidies is now in place in several cantons and may spread to more; this may also help to stem rising expenditures. There is also a lack of comparative statistical data, which could promote benchmarks in quality and efficiency. The combination of universal care through an individual mandate with subsidies and insurers' price competition guarantees every Swiss citizen high quality, readily accessible care. Targeting system-wide inefficiencies (oversupplied and over-utilized) will aid in reducing total expenditure." [Switzerland Dougherty 2008]

Health financing in Switzerland

Switzerland's system of health financing, 2005



[Europe OECD 2008]

Sources of health financing in Switzerland	Percent
Taxes	24,9
Compulsory health insurances	27,5
Other statutory insurance	6,7
Out-of-Pocket payments	27,6
Supplementary health insurance	11,2
Other payments	2,1
Sum	100
Source: [Switzerland Observatory 2000]	

Federation's
responsibility
for health
in Switzerland

“The federal constitution lists in full the legally defined responsibilities of the federal government. Those areas that relate principally to health are:

- Eradication of communicable or very widespread or virulent diseases of humans and animals
- Promotion of exercise and sport
- Social insurance provision
- Medical examinations and qualifications
- Promotion of science, research and tertiary education
- Genetic engineering, reproductive medicine, transplant medicine and medical research
- Statistics
- Environmental protection
- International relations.” [Switzerland Observatory 2000]

“There is intense debate over whether state intervention in Swiss health care can be heralded as “the very visible hand of a smart, largely efficient, government that accounts for Switzerland’s relative success”, or whether the “micromanagement of both prices and products is precisely what keeps Switzerland from becoming an unfettered consumer market [and even more productive].” [Switzerland Daley 2007]

“The OECD certainly seems to agree with the latter; its recent report concluding that the Swiss health sector “is suffering from regulatory problems”. In particular it is argued that the Federal structure somewhat undermines attempts to create national standards in health care and, as a corollary, that real competition is hindered by fragmented markets and inconsistent regulation across the Confederation. The OECD recommended an “overarching framework law for health which would include existing legislation on health insurance, future policies on prevention, gathering national health data, and oversight of health-system performance.” However, simply nationalising regulation may not be a catch-all solution.” [Switzerland Daley 2007]

State
responsibilities
for health
in Switzerland

“Switzerland’s 7.2 million inhabitants reside in 26 cantons that enjoy authority over all matters not explicitly transferred to the Confederation, Switzerland’s federal government. Following that constitutional structure, health policy for most of Switzerland’s history has been left to the authority of the cantons. Until the mid 1990s, therefore, the Swiss health system was merely a mosaic of 26 distinct cantonal health systems.” [Switzerland Reinhardt 2004]

“Switzerland’s health system is individually-focused and insurance-based, reflecting the decentralisation of the political system into ‘cantons’. It is the 26 cantons that are largely responsible for the provision of health care; the role of national government is restricted by the constitution to one largely of public health and regulation. Iv But, while the specifics of health care provision vary across the country, “demand for medical services is channelled through an insurance system that guarantees individual access to care”. Within each canton, individuals are free to choose between health plans and providers offered by competing insurers and subsidies are given to the poor and needy to ensure coverage is universal.“ [Switzerland Daley 2007]

- “Regulation of health matters
 - Licensing of the health professions
 - Authorization to open a medical practice or pharmacy
 - Market authorization and control of medicines
- Provision of health care
 - Inpatient care (hospitals and residential nursing homes)
 - Nursing and home care
 - Fees
 - Emergency, rescue and disaster-aid services
 - Basic and specialty medical training
 - Training in paramedical occupations
- Disease prevention and health education
- Implementation of federal laws.” [Switzerland Observatory 2000]

Municipalities responsibilities for health in Switzerland

“The cantonal health laws confer responsibility for health policy on the municipalities. The responsibility for providing nursing care for certain vulnerable groups is usually delegated to the municipalities, with the emphasis on home care, residential and nursing homes for elderly people and community-based mental health services. The municipalities have delegated responsibility to independent organizations for most home care services. Larger municipalities and associations of municipalities often run their own residential and nursing homes for elderly people. Municipalities run nursing homes and hospitals either alone or in conjunction with other municipalities (through hospital associations) or are represented on the boards of such facilities. The municipalities are also responsible for supporting and counselling pregnant women and mothers, providing obstetric services and health and dental care in schools.” [Switzerland Observatory 2000]

Levels and health responsibilities of government in Switzerland

Number and size of levels of national government, whether appointed or elected, and tax-raising powers (2004)

Country	Levels of government, including administrative health structures	Number ¹	Inhabitants per entity: average ² (and approximate range) (× 1000)	Appointed/ Elected	Raising taxes ³
Switzerland*	Central government	1	7318	Elected	X
	Regions (<i>Kantone</i>)	26	281 (15–1182)	Elected ¹³	X
	Districts (<i>Bezirke</i>)	181	40 (2–403)	Appointed	
	Local governments (<i>Gemeinden</i>)	2929	2	Elected	X

Levels and respective responsibilities in health care (2004)

Country	Levels ¹	Health care responsibilities					
		Raises health care funds (public)	Contracts hospitals	Owens secondary hospitals	Owens long-term care institutions	Owens primary care centres	Pays GPs
Switzerland	Central government						
	Regions (<i>Kantone</i>)			X			
	Districts (<i>Bezirke</i>)						
	Local governments (<i>Gemeinden</i>)				X	X	
	Sickness funds Private	X	X	X	X	X	X

[Europe Bankauskaite 2007]

Decentrali-
zation of
health services
in Switzerland

“Switzerland has a federal structure with three different levels: the confederation (or, federal government), the cantons and the communes (or, municipalities). There are 26 cantons¹⁶ with a population of between 15 000 (Appenzell Innerrhoden) and 947 100 (Berne).¹⁷ Each canton has its own constitution, parliament, government and courts. These cantons are divided in 2 873 communes in total. Around one-fifth of these communes have their own parliament; in the other four-fifths, a process of direct democracy takes decisions in the local assembly. Citizens have the right to initiate laws and referendums at municipal, cantonal and federal level.” [Europe Saltman 2007]

“At the federal level there is no Ministry of Health. Several government offices share the responsibility for health and matters related to health services. They are all accountable to the federal parliament. Three of the executive offices are part of the Federal Department of Home Affairs: the Federal Office of Public Health, the Federal Social Insurance Office and the Federal Statistical Office. Another, the State Secretariat for Economic Affairs depends on the Federal Department of Economic Affairs. The role of the Federal Office of Public Health is limited to regulation and supervision of functions in the field of narcotics, serums and vaccines, poisons, food quality and radiation protection. Its activities in combating disease are directed towards epidemics, tuberculosis, rheumatism and HIV/AIDS. The Federal Social Insurance Office has the function of officially recognizing health insurance companies, of monitoring and controlling their activities, and of approving health insurance premiums every year. The Federal Office of Trade and Industry financially protects people who receive welfare payments from the federal disability or accident insurance. Income taxes are mainly levied by municipalities and cantons, and rates vary from place to place.” [Europe Saltman 2007]

“Health care providers are mostly financed by payments from health insurance companies or by direct payments by patients. In 2002, there were 93 private, non-profit sickness funds that have to offer the same, basic, compulsory health insurance. The services covered by the compulsory health insurance are defined in federal law. Insurance companies are free to set the premiums, which are allowed to vary among cantons, but not within one canton. Of public expenditures for health, the major part is borne by cantons and, less, by municipalities. Cantons are constitutionally independent of the federal government. They have the responsibility for planning, monitoring and partly providing health care within a defined geographical area. The cantonal responsibilities encompass the elaboration of health and hygiene policy, the planning, operation and construction of hospitals, the regulation of hospital external care, the management of medical and paramedical schools, activities in the field of health prevention and promotion, and the regulation of patient rights. Cantons enjoy sovereignty to define principles and standards on which premium subsidies for low-income households are based and can choose, within some limits given by the federal level, to fix the cantonal budget available for premium subsidy. The federal level then matches the cantonal expenditures. With regard to the provision of health services, private and public providers co-exist, but private providers have a large area of responsibility, mainly for outpatient care and to a minor degree for hospital care. Ambulatory (outpatient) services and short inpatient stays are usually paid through fee-for-service payment. Point values are agreed upon annually and appear in a national fee schedule which has to be approved by the Federal Council. The price attached to the point value is negotiated at a cantonal level for compulsory health insurance, but at the federal level for other types of insurance. If health care providers and insurance companies cannot agree on the fee schedule, the government of the canton in which the provider is located fixes the level of fees. Federal and cantonal authorities have no direct planning controls over ambulatory services but have significant control over hospitals and residential nursing homes. Hospitals and nursing homes can only be reimbursed for services under compulsory health insurance if they are included in the canton’s official list of hospitals and nursing

homes. Cantons are responsible for the planning of these health care facilities. The cantons' decisions on hospital planning and lists can be challenged by submission to the Federal Council. At the cantonal level, the public and publicly subsidised hospitals have formed hospital associations that negotiate fees with the health insurance companies. To complement inpatient hospital care at the cantonal level, it is the task of the municipalities to arrange professional support for home care, which is often covered by voluntary organizations. Municipalities have the task of organizing health promotion programmes and medical care in schools, as well as assistance for home deliveries. In the field of home and hospital external care, municipalities either employ municipal nurses or contract with private organizations depending on the needs and the political, demographic and economic situation of the locality." [Europe Saltman 2007]

“Historical process: At the inception of the Swiss Federal state in 1848, there were practically no legislative powers in health care. Cantons, municipalities, private health care providers and private insurers were highly autonomous, but this situation gradually changed. Referendums proposing reforms and transfer of powers to the state often failed, but were usually adapted, repeated and finally approved. The administrative structure has remained rather constant. Since the creation of the canton Jura in 1978, Switzerland has consisted of 26 cantons. The number of communes declined slightly over the last few years due to amalgamations. Nevertheless, concentration did take place in the sickness fund sector: the number of sickness funds decreased from 207 in 1993 to 93 in 2002. In 1877, qualifying examinations for doctors, pharmacists and veterinarians were standardized. Soon after, in 1886, a federal law to combat epidemic diseases came into force. At the end of the nineteenth century, the federal government was given a constitutional mandate to implement legislation on food and consumer safety; legislation based on this mandate came into force in 1909. A federal law on narcotic substances was implemented in 1925 and a law on tuberculosis in 1928. The federal government has been responsible for monitoring serums and vaccines since 1931. The new federal constitution, adopted on 18 April 1999, laid down the responsibility of the federal government for the training of health-related professionals other than doctors.” [Europe Saltman 2007]

“The area of sickness insurance clearly shows the gradual transfer of powers to the federal government. In 1890, the federal government was given a constitutional mandate to legislate on sickness and accidental insurance. The 1911 Federal Law on Sickness and Accident Insurance required health insurance funds that wished to take advantage of federal subsidies to register with the Federal Office for Social Insurance and abide by its rules. The law left it to the cantons to declare whether the insurance was compulsory. A 1964 law revised the system of subsidies to the funds, based on age and gender, and introduced user charges in the statutory health insurance system. In 1993, a within-canton risk-compensation scheme was started based on age and sex to compensate insurers for people with higher than average risks among their members; the sickness fund association became responsible for making the transfer between the companies. The Federal Law on Sickness Insurance (*Krankenversicherungsgesetz*, or KVG), implemented on 1 January 1996, contributed largely to the increase of power of the federal government and was in itself a manifestation of it. It replaced the 1911 Federal Law on Sickness and Accident Insurance, and introduced compulsory health insurance. The KVG compelled the cantons to plan hospital provision and to limit the range of providers who will be reimbursed. It also defined the general conditions by which all services will be assessed for reimbursement. The KVG allows cantons to impose fixed budgets for subsidies paid to public and publicly subsidised hospitals and nursing homes. Global budgets were introduced in five cantons in 1994 and have since, in varying configurations, been implemented in other cantons. The KVG also legalized a broad spectrum of HMO-like provider networks.” [Europe Saltman 2007]

Important other actors for health in Switzerland	Statutory Health insurance companies (1999: 109) Professional associations Hospital associations Voluntary and consumer organizations
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Canada

Federation's set-up	“A federation comprising ten provinces and three territories, Canada is a parliamentary democracy and a constitutional monarchy, with Queen Elizabeth II as its head of state. It is a bilingual and multicultural country, with both English and French as official languages at the federal level.” [Wikipedia 2008]
Constitution	The constitution act of 1982 has 16 pages with less than 5.000 words
Constitution and health	The words health, disease, hospitals or synonyms are not mentioned in the constitution act of 1982.
Healthcare organisation	<p>“Canada has a predominantly publicly financed health system with services provided through private (for-profit and not-for-profit) and public (arm's-length or state-run) bodies. There are 13 single-payer, universal systems for “medically necessary” or “medically required” services – largely hospital and physician services defined as “insured services” under the federal Canada Health Act. The 13 provinces and territories vary considerably in terms of the financing, administration, delivery modes and range of public health care services. The federal government is responsible for collecting and providing health data, research and regulatory infrastructure, in addition to directly financing and administering a number of health services for selected population groups. While the health care system has been successful in maintaining a high level of population health and has undergone a series of reforms, many challenges are emerging. These include the ageing population, increasing health care expenditure, particularly for pharmaceuticals, lengthy waiting times, and shortages of health human resources.” [Canada Observatory 2005]</p> <p>“Planning, regulation and management: Health facilities and organizations, including hospitals and regional health authorities, are accredited on a voluntary basis through a nongovernmental organization (the Canadian Council on Health Services Accreditation). Health institutions and their providers, in particular physicians, are liable to patients for negligence. The provincial minister of health and cabinet are ultimately accountable to all provincial residents for administering and delivering public health care and thus for the performance of regional health authorities. Professional standards and codes of conduct are set through the relevant profession's regulatory body and the provincial laws that give the profession the right to self-regulate, subject to certain terms and conditions. There are three different approaches to provider regulation in Canada: “exclusive scope of practice”, also known as licensure; “right to title”, also known as certification or registration; and “controlled acts system”, which regulates specific tasks or activities. Although specific regulatory approaches for provider groups can vary considerably across provinces, the approach is remarkably consistent among certain professional groups such as physicians and dentists.” [Canada Observatory 2005]</p> <p>“Decentralization of the health care system: The administration of public health services in Canada is highly decentralized, owing to at least three factors: provincial responsibility for the administration and delivery of most public health care services; the historic arm's-length relationship between government on the one hand and the</p>

hospital sector and physicians on the other; and recent regionalization reforms in which subprovincial organizations are now responsible for the allocation of most publicly-funded health resources.” [Canada Observatory 2005]

“There are three main levels to the organizational structure of the health system: the federal government, the provinces and territories, and the intergovernmental level.” [Canada Observatory 2005]

Federal responsibilities for health in Canada

“The federal government is responsible for protecting the health and security of Canadians by setting the standards for the national Medicare system, as well as public health, drug and food safety regulation, data collection and health research – as outlined in the Canadian constitution. The federal government also has responsibility for directly providing health care for selected population groups, including First Nations people living on reserves and the Inuit, members of the armed forces, veterans, the Royal Canadian Mounted Police and inmates of federal penitentiaries.” [Canada Observatory 2005]

State responsibilities for health in Canada

“Each province and territory have legislation governing the administration of a single-payer system for universal hospital and medical services. They are responsible for funding hospitals, either directly or through global funding for regional health authorities, setting rates of remuneration for physicians (after negotiation with the professional associations), providing public health services and, in some cases, assessing health technologies and funding health research. Provinces also provide, directly or indirectly, a variety of home care and long-term care subsidies and services. All provinces administer their own prescription drug plans, providing varying degrees of coverage to residents. Regional health authorities within the provinces are responsible for allocating health resources and planning public health programmes.” [Canada Observatory 2005]

Intergovernmental coordination in Canada

“Intergovernmental councils, committees and organizations facilitate and coordinate numerous policy and programme areas. Included in this level are advisory committees to the Conference of Federal/Provincial/Territorial Ministers of Health in four areas: health delivery and human resources; population health and health security; information and emerging technologies; governance and accountability. Over time, federal, provincial and territorial governments established and funded a number of arm’s-length intergovernmental health organizations including: Canada Health Infoway Inc.; the Canadian Coordinating Office for Health Technology Assessment; the Canadian Council for Donation and Transplantation; the Canadian Health Services Research Foundation; the Canadian Institutes for Health Information; the Canadian Patient Safety Institute; and the Health Council of Canada.” [Canada Observatory 2005]

Health financing in Canada

Distribution of Public Sector Health Expenditure by Source of Finance. Canada. 1975 and 2005

	1975		2005	
	(\$' 000,000)	(%)	(\$' 000,000)	(%)
Provincial/Territorial Governments	8,709.3	93.6	90,745.7	91.6
Federal Direct	398.3	4.3	5,288.6	5.3
Social Security Funds	121.1	1.3	1,965.1	2.0
Municipal Governments	71.6	0.8	1,074.0	1.1
Total Expense	9,300.3	100.0	99,073.3	100.0

Source: National Health Expenditure Database, CIHI.

[Canada CIHI 2007]

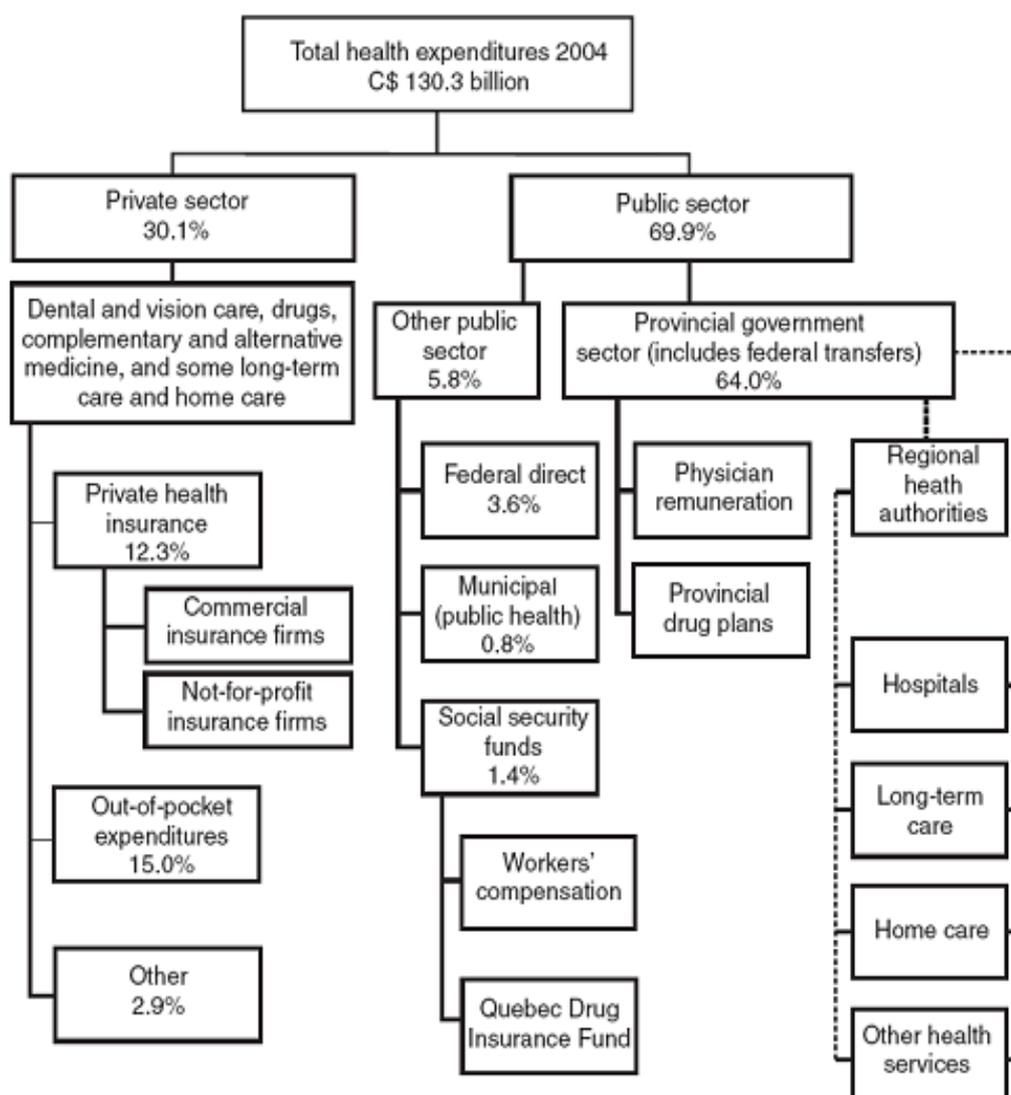
Distribution of Private Sector Health Expenditure by Source of Finance. Canada. 1988 and 2005

Source of Finance	1988		2005	
	(\$' 000,000)	(%)	(\$' 000,000)	(%)
Household (out-of-pocket)	7,434.8	58.1	20,305.9	48.2
Private Health Insurance	3,735.7	29.2	17,245.1	40.9
Non-Consumption	1,625.9	12.7	4,618.9	10.9
Total Expense	12,796.4	100.0	42,167.9	100.0

Source: National Health Expenditure Database, CIHI.

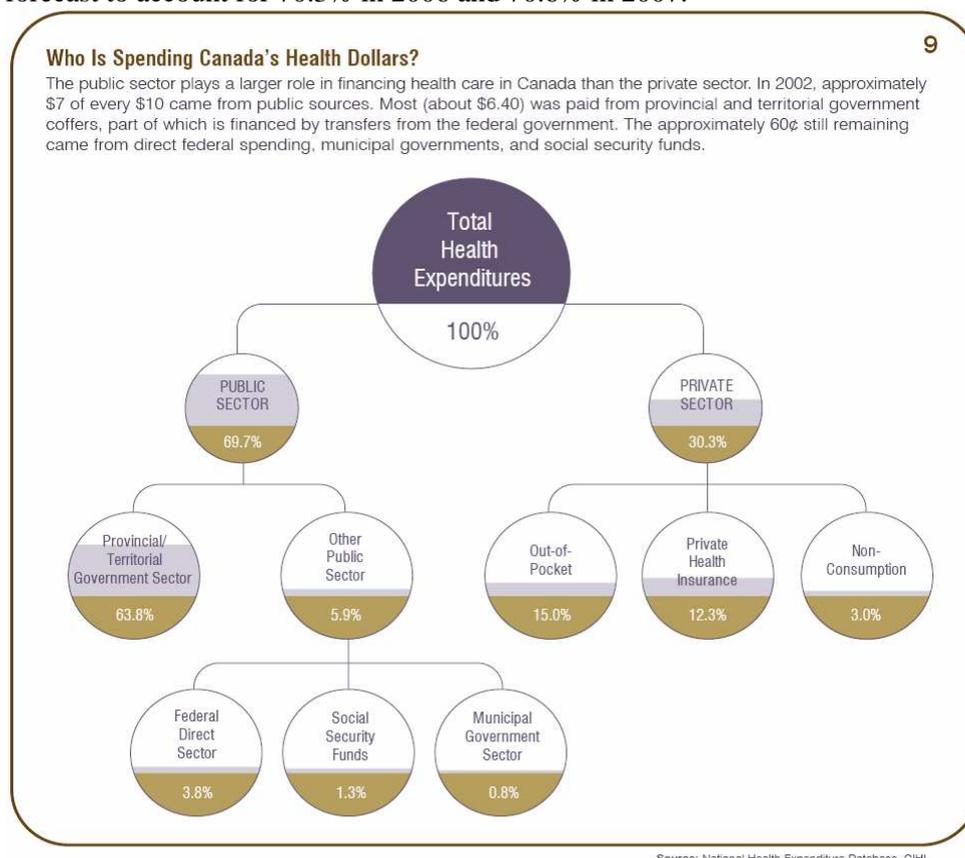
[Canada CIHI 2007]

Canada's system of health financing, 2004



[Europe OECD 2008]

Public health expenditure “accounted for 70.1% of total expenditure in 2005 and is forecast to account for 70.3% in 2006 and 70.6% in 2007.”



[Canada CIHI 2005]

Levels and health responsibilities of government in Canada

Number and size of levels of national government, whether appointed or elected, and tax-raising powers (2004)

Country	Levels of government, including administrative health structures	Number ¹	Inhabitants per entity: average ² (and approximate range) (× 1000)	Appointed/ Elected	Raising taxes ³
Canada	Central government	1	31 946	Elected	X
	Regions (<i>Provinces and Territories</i>)	13	2457 (28–11 874)	Elected	X
	Regional Health Authorities	91	351 (1–1783)	Appointed	
	Local governments	3715	9 (0.005–2481)	Elected	

[Europe Bankauskaite 2007]

Levels and respective responsibilities in health care (2004)

Country	Levels ¹	Health care responsibilities					
		Raises health funds (public)	Contracts hospitals	Owens secondary hospitals	Owens long-term care institutions	Owens primary care centres	Pays GPs
Canada ²	Central government						
	Regions (<i>Provinces and Territories</i>)	X	X				
	Regional Health Authorities			X	X	X ³	
	Local governments				X		X

[Europe Bankauskaite 2007]

Decentralization of health services in Canada

“Levels of government: current status: Although Canada’s constitution vests jurisdiction over most health care activities at the sub-national (provincial) level, the Canadian Federal Government nonetheless exercises some broad direction over the provincial health insurance programmes by attaching conditions to its intergovernmental transfers. In addition to its regulatory responsibilities in terms of drug patents and food and drug safety, the federal government is also responsible for providing health care services and benefits to designated groups,¹⁹ although it increasingly purchases such services rather than providing them directly. It also funds most health research, and may choose to take on a coordinating role for health-related functions such as health protection, disease prevention, and health promotion. The Canadian Institute of Health Information (CIHI) gathers Canadian health information which can be used to stimulate health policy, management of the health care system and public awareness of health affecting factors. Canada’s ten provinces and three territories are primarily responsible for financing certain “insured” health services – about 70% of Canadian health expenditures comes from public sector sources. This is accomplished through universal insurance programmes in each province/territory. To receive full federal funds, these plans must provide full coverage, without co-payments, to all insured persons for all “medically required” inpatient and outpatient services. Health care services are mostly delivered by private providers, with varying degrees of provincial control. Provinces also may be involved in planning, financing, regulating, and (on occasion) delivering additional services, including public health (surveillance, illness prevention and health promotion), mental health, rehabilitation, long-term care and home care services, and prescription drugs coverage. The precise arrangements can vary considerable from province to province and from community to community.” [Europe Saltman 2007]

“During the 1990s, nine of the ten provinces and one of the three territories restructured health care delivery by setting up Regional Health Authorities (RHAs). The province of Ontario, with a population of 12 million people (about 38% of Canada’s total population), was the one exception; it instead regionalized on a sector-specific basis (e.g., such services as public health and home care were managed by decentralized regional bodies). RHAs were envisioned as intermediate bodies between the provincial government, on the one hand, and individual health institutions and providers, on the other. The health mandate of the RHAs varies in scope among the provinces and territories, as does the autonomy given to their managers. All of them included hospitals and none included physicians or drugs. Provinces varied in the extent to which other sub-sectors such as public health, home care, addiction services or mental health were assigned to RHAs, retained as provincial programmes, or left to private providers. RHA funding comes entirely from the provincial budgets. Unlike municipal governments or administrative units such as school boards, RHAs do not directly raise any revenues through taxation. The budget allocation varies according to provinces/territory: some adopted population-based funding formulas that take into consideration various factors including the age/gender and socio-economic composition of the population and its health needs, while others combine historical funding levels with business plans submitted by the RHAs. RHAs also vary in their freedom to allocate resources within their assigned budgets; some provincial governments have set up accountability arrangements, designated certain programmes as “protected” and otherwise restricted the extent of variability which they will permit across regions, while others have not.” [Europe Saltman 2007]

“Hospitals in Canada are officially not-for-profit organizations, owned by nongovernmental organizations or sometimes by municipal governments. RHAs thus constituted a major centralization (rather than decentralization) of hospital services, moving operational control from formerly self-sufficient organizations to nominally private, quasi-public RHA boards. Physicians were not incorporated into regional reforms and remain largely self-employed. Many health care professionals, including

physicians, are self-regulated. The majority of physicians are in private practice and paid on a fee-for-service basis by provincial government health insurance plans. However, most provinces are attempting to encourage “primary care reform” and move general practitioners away from solo practice arrangements. Long-term care, home care, rehabilitation, mental health, and the other services falling outside the federal terms and conditions, in contrast, are largely privately delivered. Public health tends to be publicly delivered, often through RHAs or (in Ontario) local public health units.” [Europe Saltman 2007]

“Historical process: In general, after the Second World War, when the Canadian health care system gradually took shape, it became largely the responsibility of the provinces and mostly publicly financed. As the costs of provincial and territorial health plans escalated through the 1980s, the sponsoring governments initiated a variety of studies, advisory committees and independent commissions of inquiries. Their task was to provide advice on how to constrain costs and improve the continuum of health services provided, paid for, or subsidised by the provinces and territories. The majority of the reports recommended the creation of geographically based RHAs, as it was argued that the province was too big a unit to be able to do this. In 1989, the first province (Quebec) transferred powers to RHAs. Later eight of the nine other provinces and one of the territories followed this example.” [Europe Saltman 2007]

“While the creation of RHAs is sometimes portrayed as decentralization, governance and decision-making were taken out of the hands of individual hospitals, nursing homes and similar institutions, thus representing a centralizing element as well. Numerous hospital (and elderly home, home care, etc.) boards were replaced by a more limited number of RHA boards. On several occasions, the number of RHAs decreased: e.g. Alberta collapsed its 17 RHAs into nine in April 2003, Saskatchewan collapsed 32 district boards into 12 RHAs in August 2002, Prince Edward Island amalgamated two RHAs and British Columbia reduced the number of RHAs to five in 2001 and Prince Edward Island abolished RHAs altogether in the 2005 budget.²⁰ Furthermore, some provinces changed their governance model. For example, in 2001, Alberta became the second province (after Saskatchewan) to have two-thirds of its board members elected by popular vote. In 2005, Ontario abolished its District Health Councils (which had been given responsibility for planning on a regional basis) and is setting up Local Health Integration Networks (LHINs), which could have the potential to develop into regional funding and management models.” [Europe Saltman 2007]

United States of America

Federation's set-up	The United States of America is a federal constitutional republic comprising fifty states and a federal district.
Constitution	Seven articles – 4.526 words on 6 pages – plus 27 short amendments on less than 6 pages.
Constitution and health	The words health, disease and/or hospital are not mentioned in the constitution. General welfare is mentioned in the preamble “We the People of the United States, in Order to form a more perfect Union, establish Justice, insure domestic Tranquility, provide for the common defence, promote the general Welfare, and secure the Blessings of Liberty to ourselves and our Posterity, do ordain and establish this Constitution for the United States of America.” [USA Constitution]

Welfare is also mentioned in section 8 of article 1: The Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States; but all Duties, Imposts and Excises shall be uniform throughout the United States. ” [USA Constitution]

Healthcare organisation including federal and state responsibilities for health in USA

“Health services are largely delivered by the private sector and commercial insurers play a major role in the financing of health care. Most coverage for health services is obtained through a third-party payer, such as an employer or the government, which makes payments, directly or indirectly, to the service providers. This may include covering physician, hospital, laboratory, pharmaceutical costs, etc., depending on the type of insurance.” [USA PAHO 2002]

“The federal government is a direct provider of health services for military personnel, veterans with service-connected disabilities, Native Americans (American Indians and Alaskan Natives) and inmates of federal prisons. HHS is the United States government’s principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. The Department has a budget, determined by the Congress, amounting to \$429 billion for fiscal year 2001. Many HHS-funded services are provided at the local level by state, county or tribal agencies, or through private sector grantees. Eleven HHS operating divisions administer the Department’s programs. In addition to the services they deliver, the HHS programs provide for equitable treatment of beneficiaries nationwide, and they enable the collection of national health and other data. HHS is not a direct provider of health services to the population of the United States, with one exception: The Indian Health Service (I). The I is the principal federal health care provider and health advocate for Indian people, and its goal is to assure that comprehensive, culturally acceptable, personal and public health services are available and accessible to American Indian and Alaska Native people. The provision of health services to members of federally recognized tribes grew out of the special government-to-government relationship between the United States federal government and Indian tribes established in 1787. Outside HHS, the Department of Veterans Affairs (VA) and the Department of Defense (DOD) are the only federal government agencies that directly provide health services. The Department of Transportation (DOT) also provides direct health care services to Coast Guard enlisted officers and personnel. According to the Employee Benefit Research Institute, in 1999, 6.5 million Americans were enrolled in Tricare or Civilian Health and Medical Program for the Department of Veterans’ Affairs (CHAMPVA). With a budget of more than \$20 billion, the Veterans Health Administration within the VA provides health care to veterans. In addition to its medical care mission, the veterans health care system is the nation’s largest provider of graduate medical education and one of the nation’s largest medical research organizations. It also provides backup to the DOD and the National Disaster Medical System.” [USA PAHO 2002]

“The federal government provides insurance to all Americans over 65 years of age, those who have permanent kidney failure and certain people with disabilities through a program known as Medicare. The Centers for Medicare and Medicaid Services (CMS), part of HHS, administers Medicare, the nation’s largest health insurance program, which covers approximately 39 million Americans. Medicare is generally financed through a combination of payroll taxes, general revenues, and beneficiary premiums. Medicare has three Parts, Part A, which provides hospital insurance, Part B, which provides supplementary medical insurance, and Part C, which allows for Parts A and B to be delivered through private health plans. The federal Government, through CMS, also works with state governments to provide health insurance to the nation’s poor. Medicaid is a jointly funded, federal-state health insurance program for certain low-income and needy people. It covers approximately 36 million

individuals including children, the aged, blind, and/or disabled, and people who are eligible to receive income maintenance payments from the federal government. Title XIX of the Social Security Act created Medicaid in 1965 as a cooperative venture between the federal and state governments to assist states in the provision of adequate medical care to eligible needy persons. Medicaid is the largest program providing medical and health-related services to America's poorest people. The Medicaid program varies considerably from state to state, as well as within each state over time, but the federal government requires certain basic services to all enrolled. Modifications to Medicaid include expansions in the late 1980s to cover additional low-income women and children who are living slightly above the official federal poverty line. The Balanced Budget Act (BBA) of 1997 amended the Social Security Act to add a new title—Title XXI—State Children's Health Insurance Program. The purpose was to enable States to initiate and expand child health assistance to uninsured, low-income children. Assistance would come through expanding Medicaid or offering private insurance, or a combination of both.²⁰ The traditional public health functions of monitoring food and water quality, sanitation, vital statistics, licensure of hospitals and various health professionals (e.g., doctors, nurses, dentists), are also handled at the state and local levels.” [USA PAHO 2002]

“The United States' health system is actually a cluster of health systems of diverse complexity. Federal, state, and local governments have defined, often in concert with one another, their roles in protecting the public's health. State public health departments are not under the jurisdiction of federal health agencies and administrations, and, in many states, city and county local public health departments are not under the jurisdiction of state public health departments. As a rule, direct health care services are provided by the private sector. Many of these governmental and nongovernmental services share public funds, technical advice, regulatory standards, and health research provided by federal, state, and local governments.

- The federal government manages various programs; oversees research; and provides technical advice and direction, training, funding, and other public health resources, mainly through the Department of Health and Human Services. The Department often works through state and local government programs and with other partners. Many other federal government organizations outside the Department's jurisdiction, such as the Environmental Protection Agency, the Social Security Administration, the Department of Agriculture, the Department of Transportation, and the Department of Homeland Security, also are active in securing the population's safety and health.
- Responsibility for individual health care issues is much more decentralized. The government provides health insurance to highly vulnerable groups, such as some families in poverty, the disabled, and the elderly. Most persons, however, acquire private health insurance coverage through their employers or on their own. Direct health care services, including primary, secondary, and tertiary care, are provided primarily by thousands of private sector hospitals and clinics throughout the country. The federal government directly funds additional hospitals and clinics that care for military personnel and veterans and for American Indians and Alaskan Natives.“ [USA Americas PAHO 2007]

The case of public health in USA

“The mission of public health is to promote physical and mental health and prevent disease, injury, and disability. The U.S. public health system comprises a wide array of governmental and nongovernmental entities, including:

- over 3,000 county and city health departments and local boards of health;
- 59 state and territorial health departments;
- tribal health departments;
- more than 160,000 public and private laboratories;
- parts of multiple federal departments and agencies;

- hospitals and other healthcare providers; and
- volunteer organizations such as the Red Cross.

Definitions vary but, in practical terms, public health infrastructure is the federal, state, and local public health organizations and the resources they need to operate effectively. These governmental organizations form “the nerve center of the public health system” and interact with a wide array of other partners to ensure public health.” [USA Lister 2005]

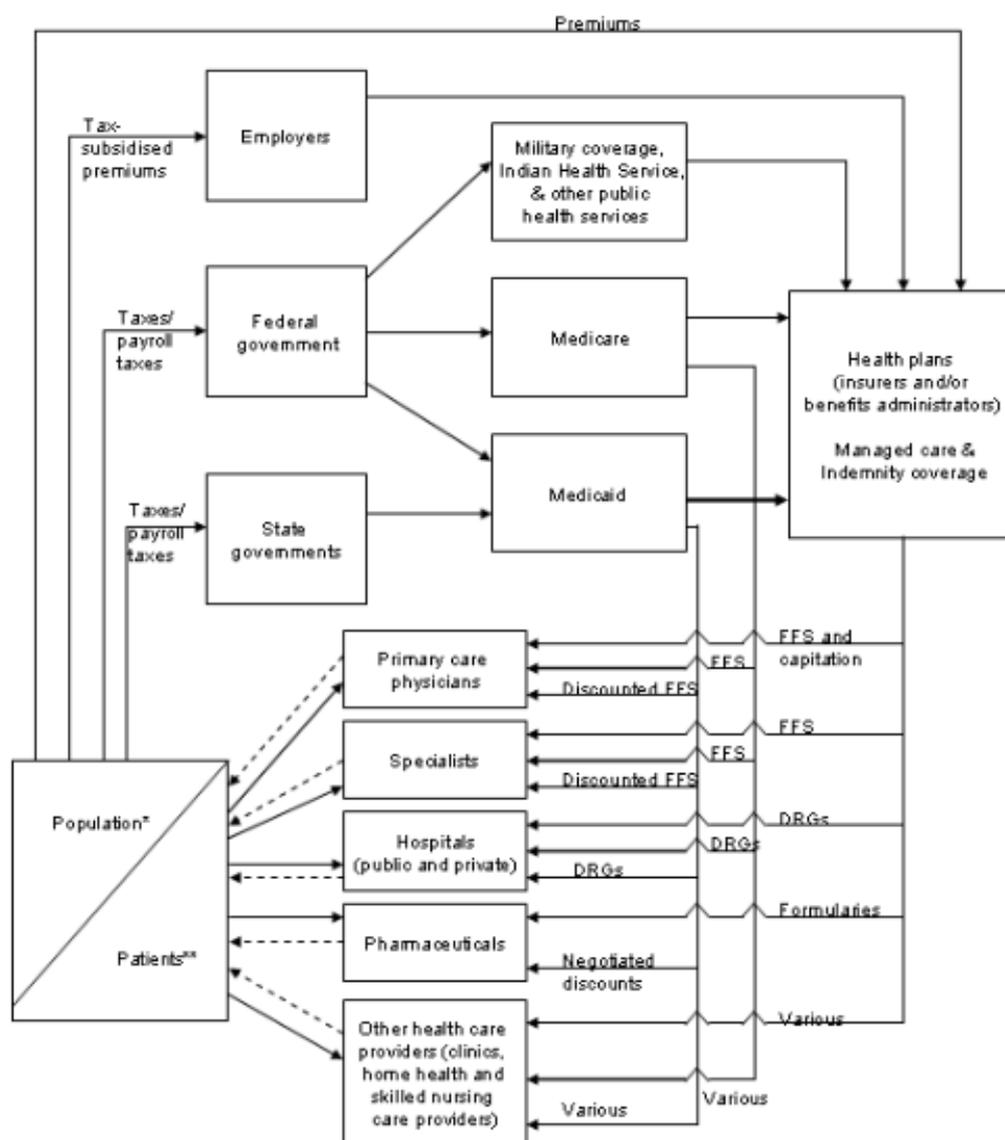
“Public health practice is governed by federal, state, and local law. The federal government can influence public health practice through its funding decisions and by exercising its jurisdiction over interstate commerce. However, most public health authority rests with the states. ” [USA Lister 2005]

“Most public health authority is based in the states, as an exercise of their *police powers*. States use this authority in a number of ways to protect public health, from enforcing safety and sanitary codes, to conducting inspections, to mandating the reporting of certain diseases to state authorities, to compelling isolation or quarantine, to licensing healthcare workers and facilities. Local governments are often responsible for some of these activities, using powers largely derived from delegation of state authority. Since states are the basis for most authority in public health, the traditional relationship of state and federal agencies has placed states in a leading role, with CDC providing support through funding, training, and technical assistance, advanced laboratory support and data analysis, and other activities. The Public Health Service Act grants the Secretary of HHS the authority to declare a situation a public health emergency, which triggers an expansion of federal authority (such as federal quarantine authority) as needed. The only such declaration made in recent memory was on September 11, 2001. On the other hand, even though states already have considerable power in responding to public health events, most can also declare public health emergencies and expand their powers further. ” [USA Lister 2005]

“Though most public health authority is based in state law, the federal government nonetheless exerts a strong influence on public health practice through its ability to tax and spend and its responsibility for regulating interstate commerce. Using its commerce authority, the federal government can act to protect the environment, ensure food and drug safety, and promote occupational health and safety. The power to tax allows the federal government to encourage certain behaviors (e.g., deductibility of employee health insurance costs encourages employers to provide insurance) and to discourage others (e.g., raising taxes on cigarettes discourages smoking). The federal government can also set conditions on the expenditure of federal funds. For example, states must set 21 as the minimum age for the legal consumption of alcohol in order to qualify for federal highway funds. Federal public health recommendations, while lacking the force of law, nonetheless often exert considerable influence on medical and public health practice, and may be incorporated into state laws. The federal government also has authority for disease control functions concerning entries of persons, goods and conveyances from other countries, where its activities to compel disease reporting and impose quarantine mirror the activities carried out by states within their borders. Federal leadership for public health is based in the Department of Health and Human Services (HHS) and in particular at the Centers for Disease Control and Prevention (CDC).“ [USA Lister 2005]

Health financing in USA

USA's system of health financing, 2003



NOTE: FFS is fee-for-service payment. DRGs are case-based payments to hospitals based on a diagnosis-related group system.

*Health care for the 14% of the population lacking health insurance coverage is financed by publicly subsidised charity care and patients' out-of-pocket payments to health care providers.

**Patient cost-sharing arrangements vary widely by type of coverage. Indemnity coverage generally includes deductibles and co-insurance. Managed care plans often require co-payments for certain services.

Source: OECD Secretariat, 2003.

Legend:

→ Financial flows - - - -> Service flows \ / \ / -> Transfer flows

Europe OECD 2008]

National Health Expenditures Aggregate, Per Capita Amounts, Percent Distribution, and Average Annual Percent Growth, by Source of Funds

National Health Expenditures Aggregate, Per Capita Amounts, Percent Distribution, and Average Annual Percent Growth, by Source of Funds: Selected Calendar Years 1960-2006															
Item	1960	1970	1980	1990	1993	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Billions of Dollars															
National Health Expenditures	\$27.5	\$74.9	\$253.4	\$714.0	\$912.6	\$1,125.3	\$1,190.5	\$1,265.6	\$1,353.6	\$1,469.6	\$1,603.4	\$1,732.4	\$1,852.3	\$1,973.3	\$2,105.5
Private	20.7	46.8	147.0	427.3	512.5	614.1	662.6	709.8	757.0	807.6	882.3	955.1	1,014.8	1,076.6	1,135.2
Public	6.8	28.1	106.3	286.7	400.1	511.3	527.9	555.8	596.6	662.0	721.1	777.3	837.5	886.8	970.3
Federal	2.9	17.7	71.6	193.9	279.2	364.9	372.1	389.6	417.6	464.1	508.6	550.7	597.1	639.1	704.9
State and Local	3.9	10.4	34.8	92.8	120.9	146.3	155.8	166.2	179.0	197.9	212.5	226.6	240.4	257.7	265.4
Millions															
U.S. Population ¹	186	210	230	254	263	274	277	280	283	285	288	291	294	297	300
Billions of Dollars															
Gross Domestic Product ²	\$526	\$1,039	\$2,790	\$5,803	\$6,657	\$8,304	\$8,747	\$9,268	\$9,817	\$10,128	\$10,470	\$10,961	\$11,686	\$12,434	\$13,195
Per Capita Amount in Dollars															
National Health Expenditures	\$148	\$356	\$1,100	\$2,813	\$3,469	\$4,104	\$4,297	\$4,523	\$4,790	\$5,148	\$5,560	\$5,952	\$6,301	\$6,649	\$7,026
Private	111	222	638	1,684	1,948	2,239	2,392	2,537	2,679	2,829	3,059	3,281	3,452	3,627	3,788
Public	36	134	462	1,130	1,521	1,864	1,905	1,986	2,111	2,319	2,500	2,670	2,849	3,022	3,238
Federal	15	84	311	764	1,061	1,331	1,343	1,393	1,478	1,626	1,763	1,892	2,031	2,153	2,352
State and Local	21	49	151	366	459	534	562	594	634	693	737	779	818	868	886
Percent Distribution															
National Health Expenditures	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Private	75.3	62.4	58.0	59.8	56.2	54.6	55.7	56.1	55.9	55.0	55.0	55.1	54.8	54.6	53.9
Public	24.7	37.6	42.0	40.2	43.8	45.4	44.3	43.9	44.1	45.0	45.0	44.9	45.2	45.4	46.1
Federal	10.4	23.7	28.2	27.1	30.6	32.4	31.3	30.8	30.8	31.6	31.7	31.8	32.2	32.4	33.5
State and Local	14.3	13.9	13.7	13.0	13.2	13.0	13.1	13.1	13.2	13.5	13.3	13.1	13.0	13.1	12.6
Percent of Gross Domestic Product															
National Health Expenditures	5.2	7.2	9.1	12.3	13.7	13.6	13.6	13.7	13.8	14.5	15.3	15.8	15.9	15.9	16.0
Average Annual Percent Growth from Previous Year Shown															
National Health Expenditures		10.5	13.0	10.9	8.5	5.4	5.8	6.3	7.0	8.6	9.1	8.0	6.9	6.5	6.7
Private		8.5	12.1	11.3	6.2	4.6	7.9	7.1	6.7	6.7	9.3	8.3	6.2	6.1	5.4
Public		15.3	14.2	10.4	11.8	6.3	3.2	5.3	7.3	11.0	8.9	7.8	7.7	7.1	8.2
Federal		20.0	15.0	10.5	12.9	6.9	2.0	4.7	7.2	11.2	9.6	8.3	8.4	7.0	10.3
State and Local		10.2	12.8	10.3	9.2	4.9	6.4	6.7	7.7	10.5	7.4	6.6	6.1	7.2	3.0
U.S. Population ¹		1.2	0.9	1.0	1.2	1.0	1.0	1.0	1.0	1.0	1.0	0.9	1.0	1.0	1.0
Gross Domestic Product ²		7.0	10.4	7.6	4.7	5.7	5.3	6.0	5.9	3.2	3.4	4.7	6.6	6.4	6.1

¹Census resident-based population less armed forces overseas and population of outlying areas. Source: U.S. Bureau of the Census.

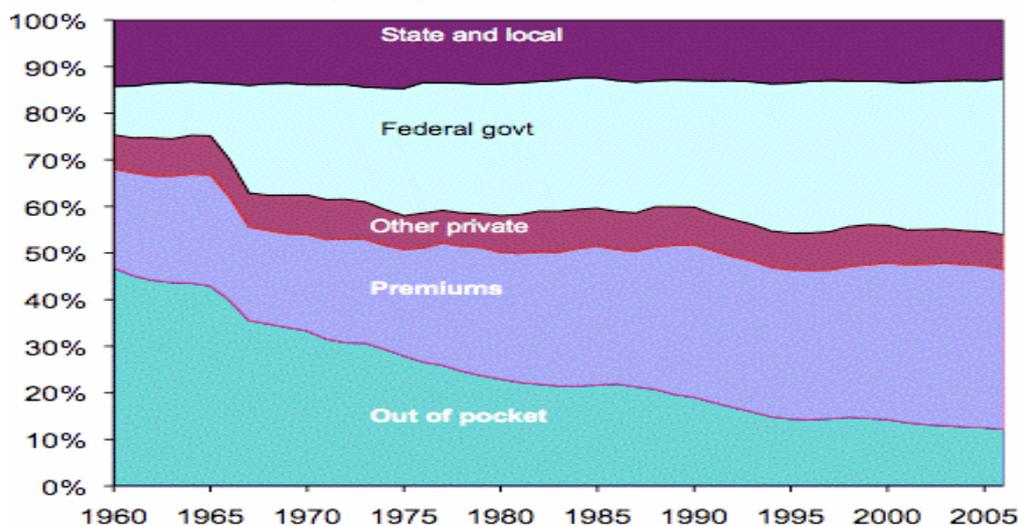
²U.S. Department of Commerce, Bureau of Economic Analysis.

NOTE: Numbers and percents may not add to totals because of rounding. Dollar amounts shown are in current dollars.

SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group; U.S. Department of Commerce, Bureau of Economic Analysis; and U.S. Bureau of the Census.

[USA CMM 2008]

Percent of national health spending in USA 1960-2006



[USA Baker 2008]

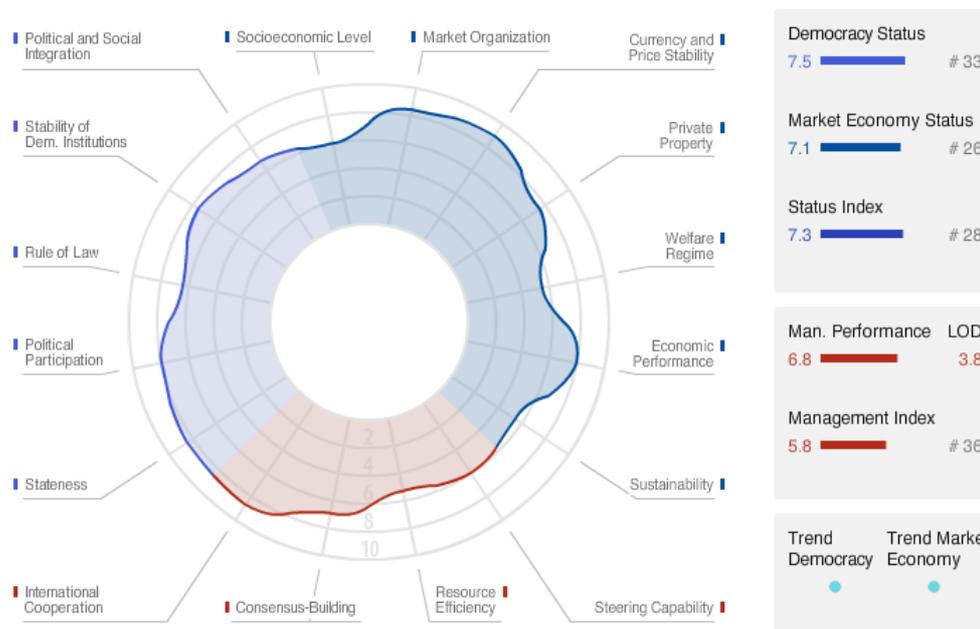
Mexico

Federation's set-up

“The United Mexican States is a federal constitutional republic in North America. The United Mexican States are a federation comprising thirty-one states and a federal district, the capital Mexico City, whose metropolitan area is one of the world's most populous.” [Wikipedia 2008]

Transition stewardship

The transformation index of Bertelsmann assesses important dimensions and criteria for measuring the transformation stewardship of the country. The following scores were obtained in 2008.



[World Bertelsmann Atlas 2008 – see endnote on page 74]

Constitution

The Political Constitution of the United Mexican States of 1917 is the present constitution of Mexico. It contains 29.299 words for 135 articles.

Constitution and health

“Article 73. The Congress has the power:

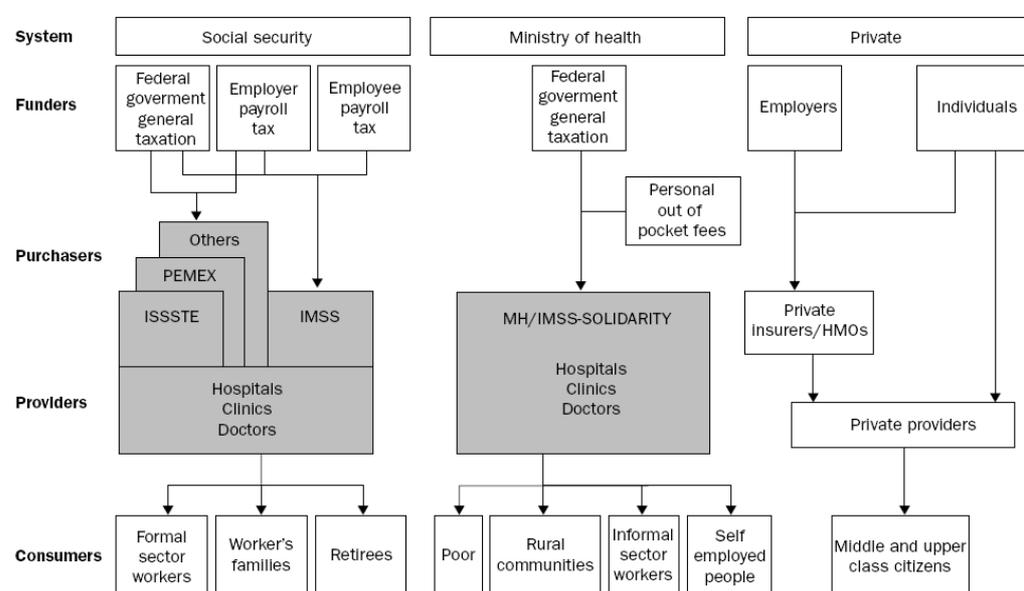
XVI. To enact laws in regard to nationality, the legal status of foreigners, citizenship, naturalization, colonization, emigration and immigration, and the general health of the country.

1. The General Health Council shall depend directly upon the President of the Republic, without the intervention of any Secretariat of State, and its general provisions shall be compulsory throughout the country.
2. In case of serious epidemics or danger of invasion of the country by exotic diseases, the Department of Health shall be required to dictate immediately the necessary preventive measures, subject to subsequent approval by the President of the Republic.
3. The health authority shall be executive and its provisions shall be obeyed by the administrative authorities of the country.
4. The measures which the Council shall have put into effect in the campaign against alcoholism and the sale of substances which poison the individual and degenerate the race shall afterwards be examined by the Congress of the Union, in cases within its competency.” [Mexico Constitution]

Healthcare organisation in Mexico

“The public health-care sector is characterised by the presence of several vertically integrated insurer/providers, serving different parts of the population and with little connection between them. In addition, there is a very large, and mostly unregulated, private sector. Social security institutions cover salaried workers in the formal sector. Although estimates vary, individuals contributing to social security institutions and their dependents are estimated at around half of the population. The Ministry of Health, which provides health-care services to the population uninsured by social security, has decentralised most of the supply of care for those groups. The states now operate their own State Health Service systems of public hospitals and clinics. There are wide differences between states in the per-capita resources available for providing public health-care services and rural areas face particular problems of access. Each institution – whether state or social security – provides health services at all levels of care in their own facilities. The State Health Services (SHS) are perceived by the general public as providing lower-quality care than the social security system, although this partly reflects the fact that the resources per household allocated to the social insurers are roughly two thirds greater than those allocated to the State Health Services.” [Mexico OECD 2005]

An overview for the Mexican health system



[Mexico Frenk 2003]

“Doctors and nurses are salaried workers in all institutions which does not favour efficiency and a large proportion of doctors also have private practices, on a fee-for-service basis. The private-hospital sector provides around one third of all hospital beds in the country. These are concentrated in larger cities in richer states with nearly half of private hospital facilities found in Mexico City.” [Mexico OECD 2005]

“The Mexican Health System is characterized by its fragmentation in financing as well as in access to health care services. This lack of institutional integration is the source of inequalities in the benefits the population receives, since the various providers receive different levels of payment and provide different levels of care at various levels of quality.” [Mexico PAHO Americas 2007]

“The public sector is characterized by the presence of various insurers and service providers integrated in a vertical fashion that care for different population types, maintain very little contact among them, and differ in the type of financing and organization of the provision of care; the latter is the cause of inefficiencies in the spending of public funds. Furthermore, the system includes a broad, lucrative private health care services sector; persons with the ability to pay can make use of services

by paying for the services they receive.” [Mexico PAHO Americas 2007]

“In 2005, the social security institutions covered 55 million salaried workers in the formal sector, representing a decrease of 2.56% from 2000, due to a variation in the unemployment rate from 2.2% in 2000 to 3.75% in 2005. The IMSS is the largest insurer, with 44.5 million insured, followed by the Insurance and Social Service Institute for State Workers (ISSSTE), with 10.6 million. This is followed by Petróleos Mexicanos (PEMEX) with 700,000 insured persons and the Armed Forces, the Secretariat of the Navy, and various other insurers for state workers with 600,000. Additionally, the IMSS offers family health insurance for persons with the ability to pay who wish to purchase it through an annual quota payment.” [Mexico PAHO Americas 2007]

“Informal workers, the rural uninsured population, and the unemployed accounted for 45 million people in 2005. They received care from the SSA and the SESA, which oversee public hospitals and clinics. There are huge differences between the states in terms of their availability of per capita resources to provide health services, and there are access problems for those in rural areas. Furthermore, private nonprofit institutions exist, such as the Mexican Red Cross and numerous nongovernmental organizations (NGOs), which provide medical care with little emphasis on primary health care but play an important role in issues such as HIV/AIDS and the sexual and reproductive health rights of women.” [Mexico PAHO Americas 2007]

Federal
responsibilities
for health
in Mexico

“National health authorities have not developed a specific policy for cost containment and have focused sector resources on strengthening prevention programs, whose objective is to improve the quality of life of the population, such as the Even Start in Life (Arranque Parejo en la Vida) Program. The objective of this program is to provide care to boys and girls less than 2 years of age as well as women during pregnancy, childbirth, and postpartum periods, with the goal of combating maternal, neonatal, and infant mortality. The “Care for Pregnant Women” Program (AME) strengthens care to women during pregnancy, birth, and postpartum.” [Mexico PAHO Americas 2007]

“The health system in Mexico is basically focused on two general laws carried out continuously by the state: the General Law of Health and the Social Security Law. The General Law of Health was reformed on January 1, 2004, to create the System for Social Protection in Health (SPSS) which offers access to health services to all uninsured Mexicans.” [Mexico PAHO Americas 2007]

“The System of Popular Social Security (SISSP), implemented by the National Council for Social Protection, began in February 2006 and guarantees medical care services, pensions and retirement, and housing to the poorest and is considered a mechanism of equity to fight marginalization. The SISSP functions as an interagency body headed by the President of the Republic. This new system of social security offers beneficiaries a Retirement Savings System, through the Opportunities Program; subsidies for housing, authorized by the National Development Commission; and medical care provided by Popular Insurance.” [Mexico PAHO Americas 2007]

State
responsibilities
for health
in Mexico

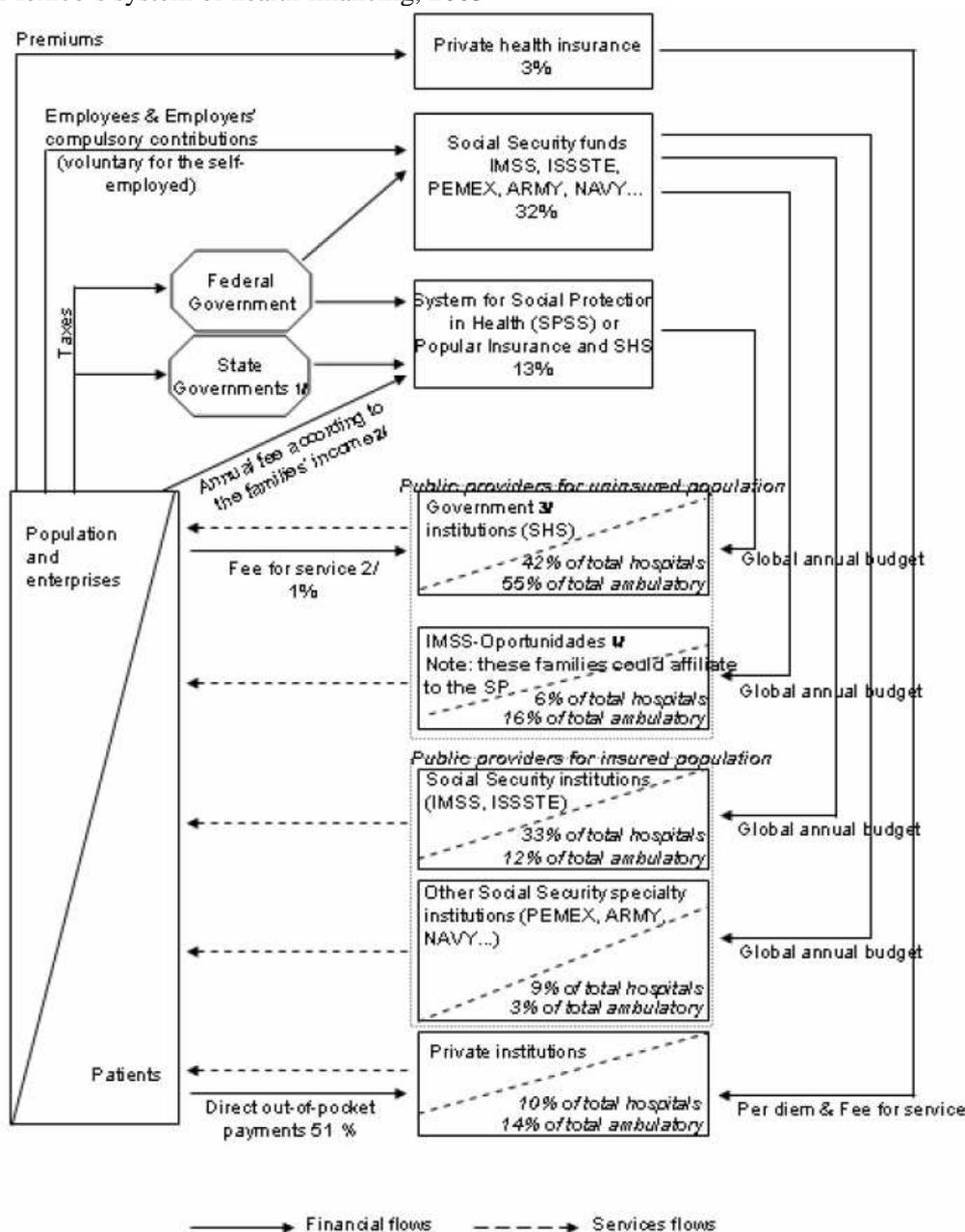
“The provision of health services by the SSA was decentralized in two stages: the first during the 1980s and the second during the 1990s. Both processes came about as a response to the perception that the system was bureaucratic and centralized by design. Furthermore, they were developed because health policies resulted in an inefficient assignment of resources to the states and difficult coordination between providers of health services and the uninsured population. The decentralization resulted in a clearer division of responsibilities between federal and state authorities. The federal authorities are responsible for establishing the objectives for health care,

defining a legal framework for general system functioning, and ensuring coordination, planning, and follow-up on results. The State Secretariats of Health (SESA) have ample operational flexibility and are responsible for determining the organization and operation of health services for the uninsured population. Coordination between the federal and state authorities is carried out through the National Health Council (CNS), which is made up of the secretaries of health of each state and is presided over by the federal secretary. The CNS has an important role in strengthening and achieving better coordination among the SESA.” [Mexico PAHO Americas 2007]

The IMSS also decentralized its operations, and the reforms tended to transfer the daily administrative decisions to the health service providers, although administration and control of the system remain with the central authorities. The IMSS is divided into 35 delegations clustered into four regions, which are responsible for the strategic planning and control of activities.” [Mexico PAHO Americas 2007]

Health financing in Mexico

Mexico’s system of health financing, 2003



1/ State health expenditure has been voluntary. However, from 2004 under the SP a contribution for each affiliated family is compulsory.

2/ The uninsured population accesses health services through “user fees”. Under the SP access will be ensured through an “annual fee” per family.

3/ Federal and State health services for the uninsured population (State Health Services, National Institutes of Health, etc.).

4/ Federal resources for IMSS-Oportunidades programme (for the uninsured) are allocated through IMSS budget (given that the programme is run by a Coordination Unit set within IMSS for that purpose). These resources should not be considered within Social Security expenditure.

SHS = State Health Services.

Source : System of National and State Health Accounts, MOH, 2003. Ministry of Health.“

[Europe OECD 2008]

“Health services are financed by different sources. Social security is financed through worker-employer quotas and the services to the population at large through two large funds: those generated by the federal government and those that are provided by federal entities. Private financing largely comes from out-of pocket expenditures or through private insurance. In Mexico it is estimated that only 4% of the population has private insurance and that half of that insurance is covered by employers who have the ability to deduct the cost of the premiums through their taxable income. The buyers of private insurance largely come from the high-income segments of the population. The health sector is characterized by its relatively low public expenditure, below the Latin American average of 7% of the GDP, equivalent to 76,455.9 million pesos in 2005 (US\$ 6.863 million). Nonetheless, health expenditures in recent years increased from 5.6% of the GDP in 2000 to 6.3% in 2004, for a 13% increase.” [Mexico PAHO Americas 2007]

“Of the total public expenditure, 37.2% was spent in institutions that cover the uninsured population, through the SSA, the Institutes of Health, and the federal entities, which receive resources from the Contribution Fund to Health Services (FASSA); the remaining 62.8% was distributed to institutions that provide care to the insured population, such as the Secretariat of National Defense (SEDENA), PEMEX, IMSS, and ISSSTE, as well as the Secretariat of the Navy.” [Mexico PAHO Americas 2007]

Decentrali-
zation of
health services
in Mexico

“The public health sector in Mexico consists of several entities. Historically, the Ministry of Health (SSA) has been responsible for the definition of health sector policies and the regulation and supervision of, and strategic planning for, the health system, and for the provision of health care for the uninsured population (currently about 42 million people) through its own extensive network of health facilities. In addition, the Social Security Institute (IMSS) provides comprehensive health insurance to some 41.5 million people through its own provider network. Sixty-seven percent of IMSS health insurance revenues come from payroll taxes and 33 percent from general taxation.” [America’s Decentralization WB 1999]

“Another insurance scheme, jointly funded by the SSA and the IMSS, brings coverage to an additional 11 million people, mostly in rural and indigenous communities. Parallel social security schemes exist, such as those for public employees and for the national oil company. The private sector, on both the provision and financing sides, is small but growing. Currently some two million Mexicans have private health coverage.” [America’s Decentralization WB 1999]

“Decentralization efforts, initiated in 1983, constituted an effort to share political power with the state governments, reduce the fiscal burden at the central level, rationalize the supply structure, and improve management. The process was a gradual one involving only 14 of the 32 states and limited in scope. It did not involve either health jurisdictions or health facilities. Resource allocation autonomy at the state level was limited to revenues obtained locally. Budget execution remained

highly centralized: The share of their budget executed at the state level was the same for decentralized states (24 percent in 1995) and for those states that had not been involved in the process (21 percent in 1995) (Centro Estudios para America Latina [CEPAL 1998]). The period was characterized by rival efforts on the part of the IMSS to deconcentrate (more for self-preservation than to promote devolution).” [America’s Decentralization WB 1999]

“With the arrival of the Zedillo administration in 1994, decentralization was back on the agenda. Although the government was primarily motivated by pressure to share political power with the state governments, the Zedillo reforms also aimed to increase coverage and improve the quality of care for the uninsured population as well as increase the efficiency of public administration. The second phase of decentralization was initiated in 1996. It differed from the first phase in that it involved all of the states and made the sharing of roles and responsibilities between levels more explicit, but it resembled the first phase in that decentralization did not reach the level of health jurisdictions or facilities. The second phase of decentralization brought about the creation of “decentralized public organisms” (OPDs), semiautonomous state agencies whose governing board includes the state governor, a representative of the federal Ministry of Health, a trade union representative, and the state health minister. Clarity has been achieved in a number of areas. Resources from the federal level to the states are allocated according to well-established criteria; the transfer of human resources from the federal level to the states has been negotiated with the national union; infrastructure, goods, and equipment have been transferred to the states; and municipalities have been given limited responsibilities in the areas of planning and infrastructure. Monitoring and conflict resolution are done by the National Health Council.” [America’s Decentralization WB 1999]

“With the reform, the states became accountable for all health care services for the uninsured population, and obtained control over the execution of its health budget. The decentralized budget increased from 4.8 million pesos in 1995 to 16.4 million pesos in 1999. The functions of the federal Ministry of Health were concomitantly redesigned and its normative and planning role strengthened. Spending at the federal ministry level decreased from 12.2 million pesos in 1995 to 9.5 million in 1999.” “The IMSS has been involved in parallel deconcentration efforts, with the creation of seven regional directorates in 1995, and 139 medical zones in 1997 (each providing health care to a population of between 100,000 and 200,000 people). These medical zones are expected to evolve into budget-holding “medical areas of autonomous management.” So far deconcentration has fallen short of the planned full management autonomy in such areas as personnel, procurement, equipment, infrastructure, and maintenance. Plans for the next few years, however, hold promises of a purchaser-provider split involving development of the purchasing function within the IMSS and introduction of reimbursement to providers through riskadjusted capitation and Diagnostic Related Group (DRG) systems.” [America’s Decentralization WB 1999]

“The political decentralization process within the SSA is making slow progress, and autonomy and capacity at subnational levels are gradually being strengthened. In contrast, there seems to be little or no progress in separating financing of purchasing from the provision function. The decentralization process in the IMSS has been equally slow, but there are more explicit plans to operate a purchaser-provider split. The initial steps toward this split are evident in the recent agreements signed with the Ministry of Finance and the Ministry of Auditing and Administrative Development, which are aimed at financial autonomy and commitments by the IMSS to sign agreements with specialty hospitals and medical zones.” [America’s Dec. WB 1999]

Brazil

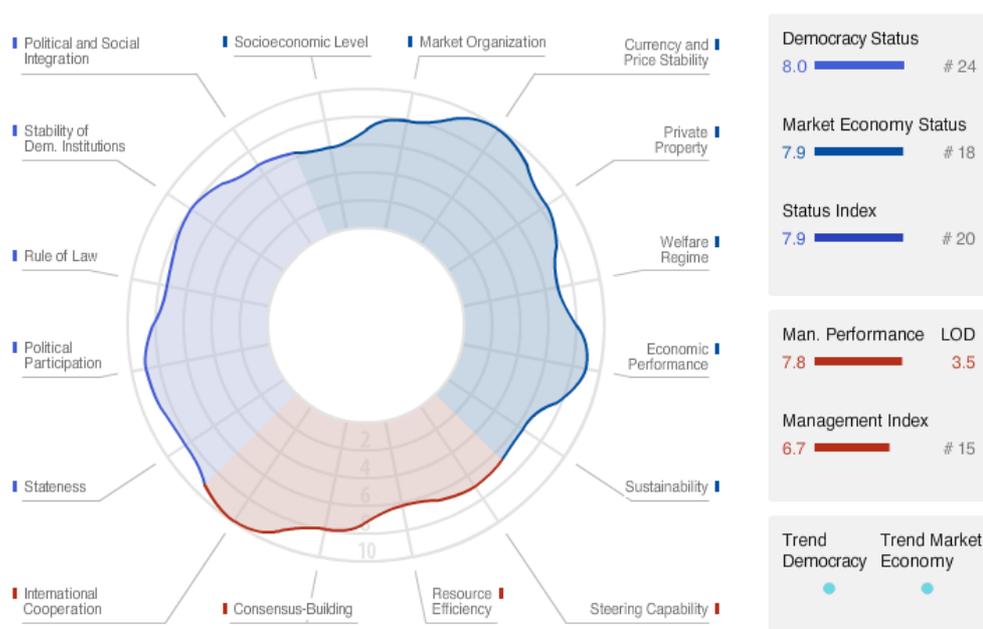
Federation's set-up

“The Brazilian Federation is based on the union of three autonomous political entities: the States, the Municipalities and the Federal District. A fourth entity originated in the aforementioned association: the Union. There is no hierarchy among the political entities..“ [Wikipedia] “The Federal Republic of Brazil, a democratic state of law, is made up of the indissoluble union of its 26 States, 5,560 Municipalities, and the Federal District, all with political, fiscal, and administrative autonomy.“ [Brazil PAHO 2005]

The Constitution defines Brazil as a Federal Republic formed by the union of 26 States, the Federal District and the Municipalities (nowadays more than 5,564). [Brazil Constitution]

Transition stewardship

The transformation index of Bertelsmann assesses important dimensions and criteria for measuring the transformation stewardship of the country. The following scores were obtained in 2008.



[World Bertelsmann Atlas 2008 – see endnote on page 74]

Constitution

“Because of its troubled political history, Brazil has had a number of constitutions. The most recent was ratified on October 5, 1988.” [Wikipedia 2008] More than 71.000 words in 346 articles on 147 pages.

Constitution and health

Health is mentioned about 100 times in this constitution. Only one article and one section is cited in the following: [Brazil Constitution]]

“Article 6. Education, health, work, habitation, leisure, security, social security, protection of motherhood and childhood, and assistance to the destitute, are social rights, as set forth by this Constitution. (The word “habitation” was included by CA nr. 26, Feb. 146h. 2000.)

Article 23. The Union, the States, the Federal District and the municipalities, in common, have the power: ... II – to provide for health and public assistance, for the protection and safeguard of handicapped persons;

“Title VIII – The Social Order – Chapter II – Social Welfare – Section II – Health

Article 196. Health is a right of all and a duty of the State and shall be guaranteed by means of social and economic policies aimed at reducing the risk of illness and other hazards and at the universal and equal access to actions and services for its promotion, protection and recovery.

Article 197. Health actions and services are of public importance, and it is incumbent upon the Government to provide, in accordance with the law, for their regulation, supervision and control, and they shall be carried out directly or by third parties and also by individuals or private legal entities.

Article 198. Health actions and public services integrate a regionalized and hierarchical network and constitute a single system, organized according to the following directives:

I – decentralization, with a single management in each sphere of government;

II – full service, priority being given to preventive activities, without prejudice to assistance services;

III – participation of the community.

Paragraph 1. – The unified health system shall be financed, as set forth in article 195, with funds from the social welfare budget of the Union, the states, the Federal District and the municipalities, as well as from other sources.

Paragraph 2. The Union, the States, the Federal District and the municipalities shall invest, annually, a minimum amount in public health activities and services, calculated as percentages of proceeds and revenues, as follows:

I – in the case of the Union, as per the provisions of the supplementary law subject of paragraph 3;

II – in the case of States and Federal District, the proceeds of taxes subject of the article 155 and the revenues subject of articles 157 and 159, I, a, and clause II, discounted the amounts which shall be remitted to the municipalities;

III – in the case of municipalities and Federal District, the proceeds of the taxes subject of article 156 and the revenues subject of articles 158 and 159, I, b and paragraph 3.

Paragraph 3. A supplementary law, which shall be reassessed at least every five years, shall establish:

I – the percentages mentioned by paragraph 2;

II – the criteria by which the following shall be shared: the fundings of the Union bound to health spendings to be remitted to the States, Federal District and municipalities, and the respective State funds to be remitted to the municipalities, with the aim of a progressive reduction of regional inequalities;

III – the norms for accounting, assessment and control of expenditures with health at federal, state, districtal and municipal levels;

IV – the norms for calculation of the amount to be invested by the Union.

Paragraphs 2 and 3 and respective clauses added by CA 29, September 13th 2000.

Paragraph 4 – The local managers of the Unified Health System may admit community health agents and endemy combat agents, by means of a public admission process, in accordance with the nature and complexity of the assignments and with specific requirements of performance.

Paragraph 5 – Federal law shall provide for the juridical regime and the regulatory norms of the activities of the community health agents and the endemy combat agents.

Paragraph 6 – Besides the cases mentioned by paragraph 1 of article 41 and paragraph 4 of article 169 of the Federal Constitution, the civil servant who exercises functions equivalents to those of the community health agents and endemy combat agents may lose office in case of non meeting of specific requirements, established by law, to its exercise.

Paragraphs 4, 5 and 6 added by CA 51, February 14th 2006.

Article 199. Health assistance is open to private enterprise.

Paragraph 1 – Private institutions may participate in a supplementary manner in the unified health system, in accordance with the directives established by the latter, by

means of public law contracts or agreements, preference being given to philanthropic and non-profit entities.

Paragraph 2 – The allocation of public funds to aid or subsidize profit-oriented private institutions is forbidden.

Paragraph 3 – Direct or indirect participation of foreign companies or capital in health assistance in the country is forbidden, except in cases provided by law.

Paragraph 4 – The law shall provide for the conditions and requirements which facilitate the removal of organs, tissues and human substances for the purpose of transplants, research and treatment, as well as the collection, processing and transfusion of blood and its by-products, all kinds of sale being forbidden.

Article 200. It is incumbent upon the unified health system, in addition to other duties, as set forth by the law: I – to supervise and control proceedings, products and substances of interest to health and to participate in the production of drugs, equipments, immunobiological products, blood products and other inputs;

II – to carry out actions of sanitary and epidemiologic vigilance as well as those relating to the health of workers;

III – to organize the training of personnel in the area of health;

IV – to participate in the definition of the policy and in the implementation of basic sanitation actions;

V – to foster, within its scope of action, scientific and technological development;

VI – to supervise and control foodstuffs, including their nutritional contents, as well as drinks and water for human consumption;

VII – to participate in the supervision and control of the production, transportation, storage and use of psychoactive, toxic and radioactive substances and products;

VIII – to cooperate in the preservation of the environment, including that of the workplace.” [Brazil Constitution]

Health financing in Brazil

“In 1998, national health expenditure, including both public and private spending, was estimated at R\$ 72 billion, or 7.88% of GDP. Public spending was 41.2% of the total, or 3.25% of GDP. In 2002, public health expenditure, including the three levels of government, was US\$ 15,893 million, corresponding to 3.32% of GDP.³⁰ The federal level was responsible for 53% of the resources provided, the states for 22%, and the municipalities for 25%.” [Brazil PAHO 2005]

Healthcare organisation in Brazil

“Health system background: The reform process under way in Brazil since the late 1980s has led to significant changes in access, the institutional structure, and mechanisms for financing the health system in the country. In 1988, the establishment of the constitutional and universal right to health marked the beginning of profound transformations in health care for the population. Legislation supplementary to the 1988 Federal Constitution promoted the implementation of the Unified Health System (SUS), which involved both institutional unification at the federal level and decentralization of the system. Implementation of the Unified Health System sought to establish a regionalized, hierarchical public network in the nation’s territory, based on the constitutional principles of universality, comprehensive care, decentralization, social participation, and the equal right of access by all citizens to health programs and services at all levels of complexity. The private network can participate in a complementary way in the Unified Health System, with preference given to charitable and nonprofit entities. The private sector operates freely but is subject to regulation, monitoring, and control by the State, since health programs and services are considered “of public relevance” in the Constitution.” [Brazil PAHO 2005]

“Organization of the Health Care Network (public-private mix): Health care in Brazil is delivered through a combination of two systems: the public system with universal access, and the so-called supplementary health care system, which is private. The public system involves public and private providers. A significant number of private providers serve both the public system and the supplementary system. Private

facilities, nonprofit or for-profit, still can be paid directly by patients. For 76% of the population, care is provided exclusively by the public system, although a significant portion of the population covered by the supplementary system also uses the public network, particularly for more complex and expensive procedures. The contracting of services to the private sector and direct payment of providers is the responsibility of state and/or municipal managers, depending on their degree of autonomy in terms of empowerment under the system's different conditions of decentralized management. In the contracting of private providers by the public system, priority should be given to nonprofit and charitable institutions. The state reform instituted by the Brazilian Government in the 1990s legally established the entity called "public interest civil society organization" (Law No. 9790, of 23 March 1999) laying out the terms for the establishment of partnerships with public authorities in the promotion and implementation of public interest activities whenever their social objectives and statutory rules meet the requirements set forth by the aforementioned law. In 1998, the country's supplementary medical care system covered about 38.7 million policyholders and their dependents, representing nearly 24% of the population. Most of those insured by this system were affiliated to plans through the companies they worked for. This group is highly concentrated in the Southeast, which accounts for 60% of the population in the country covered by the system, mainly in the states of São Paulo, Minas Gerais, and Rio de Janeiro—that is, the more industrialized and economically developed areas of the country, where formal labor contracts are more prevalent. Data from the Supplementary Health Care National Agency (ANS) showed that in December 2004, the number of beneficiaries of the private supplementary system was 33.7 million, nearly 19% of the population. Of these, 47% had contracts that predated Law 9656/98, which regulated the activities of health plans and health insurance. The IBGE Health Care Survey (AMS) reported the existence of 53,825 health care establishments in the country in 2002 (excluding those providing mainly diagnostic and therapeutic care). Of these, 13.7% had facilities for in-patient care, where the presence of the private sector is relevant (65% of facilities are private). On the other hand, 76% of the establishments without in-patient care are public. This also reveals a significant change in the network profile: in 1980, 67% of establishments lacked in-patient facilities; in 2002 this percentage rose to 86%." [Brazil PAHO 2005]

"Unified Health System (SUS): Under the law, the three levels of government should participate in the Unified Health System, organized in a network that is linked, regionalized, hierarchical, and decentralized, with unified leadership at each level of government, exercised, respectively, by the Ministry of Health (MS), the State Health Secretariats (SES), and Municipal Health Secretariats (SMS). Activities and services should be provided according to the policies and guidelines approved by the Health Councils – composed of representatives of the government, health professionals, service providers, and users – linked institutionally to the executive agencies, respectively the National Health Council, State Health Councils, and Municipal Health Councils. The Councils' actions are guided by the recommendations from the health conferences, which take place at the three levels of government, with the broad participation of several social sectors. These conferences are convened every four years by the executive branch to evaluate the health situation and propose guidelines for the formulation of health policy." [Brazil PAHO 2005]

Federation's
and state
responsibilities
for health
in Brazil

"The legislation regulating the public health system does not provide for rigorous separation of the functions of financing, procurement, and service delivery. The three levels of government participate in financing. Management of the public system is decentralized. The national level performs functions of predominantly regulatory nature and is responsible for technical and financial cooperation with the subnational levels, being charged with formulating, standardizing, and evaluating national health policy, guaranteeing the consistency of the system with its principal guidelines, regulating action by the private sector and public-private relations, establishing

norms and standards for quality control of products and services, evaluating technologies and promoting their use. Leadership at the state level is responsible for the coordination of the system and of regionalization processes, and technical and financial cooperation with the municipalities, especially in the regulation and organization of referral systems to specialized programs and services and those of greater complexity that extend beyond municipal borders. Municipal leadership is responsible for the planning and delivery of services, the operation of the existing network in its territory, according to the responsibilities it assumes in the management of the local system (management of basic care or management of all the activities of the local system), within the context of the strategy of decentralized program and service implementation, in addition to participation in financing. A significant portion of the services of the public system comes from private providers, especially services of greater technological complexity. In recent years, SES, SMS, and the MS itself have been continually enhancing their administrative structures to exercise the new functions, especially those of regulation and control.” [Brazil PAHO 2005] – (Acronyms: MS = Ministry of Health, SES = State Health Secretariat; SMS = Municipal Health Secretariat)

Decentrali-
zation of
health services
in Brazil

“Brazil’s decentralization process in the health sector was initiated in conjunction with efforts to integrate the social security institute, which provided health care to urban formal sector employees and their dependents, with the Ministry of Health, which provided health care to rural uninsured workers and indigents. The integration was achieved in 1988 with the establishment of the Unified Health System (Sistema Unice de Saude [SUS]), which provides nearuniversal coverage. SUS operates as a subsidized insurance scheme, in which the federal SUS administration reimburses providers for services rendered. The vast majority of such reimbursements go to private hospitals and clinics. State and municipal facilities of course are also eligible. While SUS is generally considered a success, it has suffered from financial problems. The reimbursements to public and private providers have been substantially lower than the costs of services (especially for preventive care). Private participation in the SUS is therefore decreasing, and private health care insurance is becoming more widespread.” [America’s Decentralization World Bank 1999]

“Publicly owned health care facilities are generally operated by municipalities. The process of enabling municipalities to manage their own health systems has been very gradual and has involved a formal qualification process. By December 1996, 137 municipalities, accounting for 16 percent of the Brazilian population, administered their own health systems. These mostly urban municipalities administered some 20 percent of hospital expenditures of the SUS. Approximately 2,300 more (or 42 percent of the total) municipalities had gained incipient autonomy, which allowed them to participate in planning activities and licensing private providers in their territories. Their ambulatory and hospital care budgets were, however, still prepared and approved by the federal government. For their part, states were responsible for reviewing policy implementation, monitoring and evaluating systems, and providing technical and financial assistance to municipalities in their jurisdictions.” [America’s Decentralization World Bank 1999]

“Because SUS reimbursements fall short of the cost of health services, municipalities are often forced to subsidize their hospitals from general municipal revenues. Notwithstanding the numerous shortcomings of the system, Brazil’s health system has definite virtues: The purchasing side is integrated; the purchasing and provision functions are separated; the provision of private health goods is largely done by the private sector (private providers account for over 70 percent of publicly funded hospital admissions); and the financing of public goods, goods with externalities, and “equity goods” (basic health measures, nutrition, epidemiological and sanitary surveillance, and so forth) is central, although their delivery tends to be through federal agencies rather than municipalities.” [America’s Decentralization WB 1999]

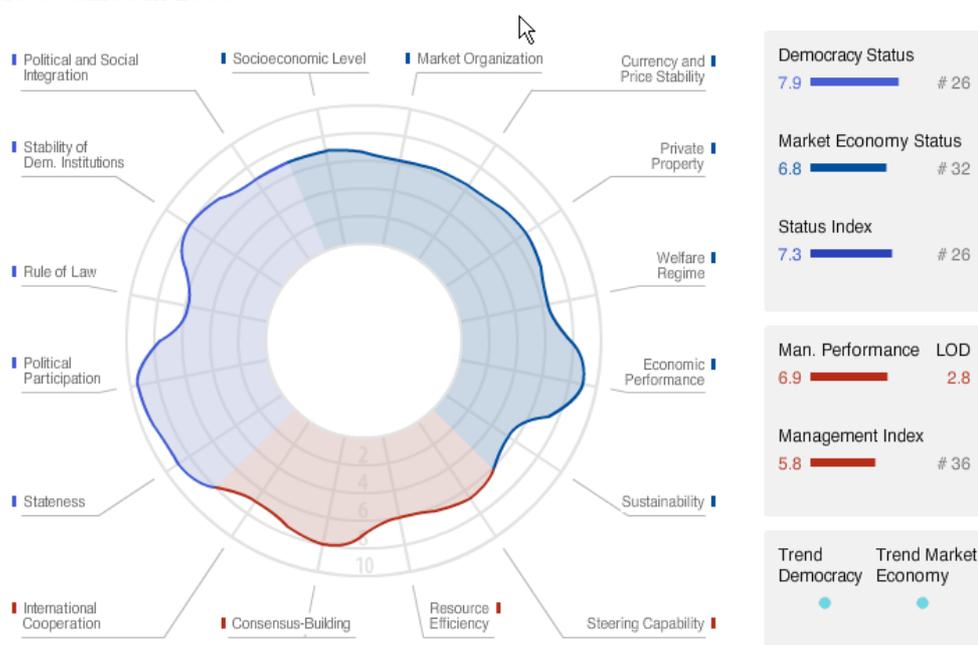
Argentina

Federation's set-up

Argentina, officially the Argentine Republic is a country in South America, constituted as a federation of 23 provinces and an autonomous city.” [Wikipedia 2008] Argentina has some 1.600 municipalities.

Transition stewardship

The transformation index of Bertelsmann assesses important dimensions and criteria for measuring the transformation stewardship of the country. The following scores were obtained in 2008.



[World Bertelsmann Atlas 2008 – see endnote on page 74]

Constitution

Constitution of 2004 with 25 pages, 12.844 words.

Constitution and health

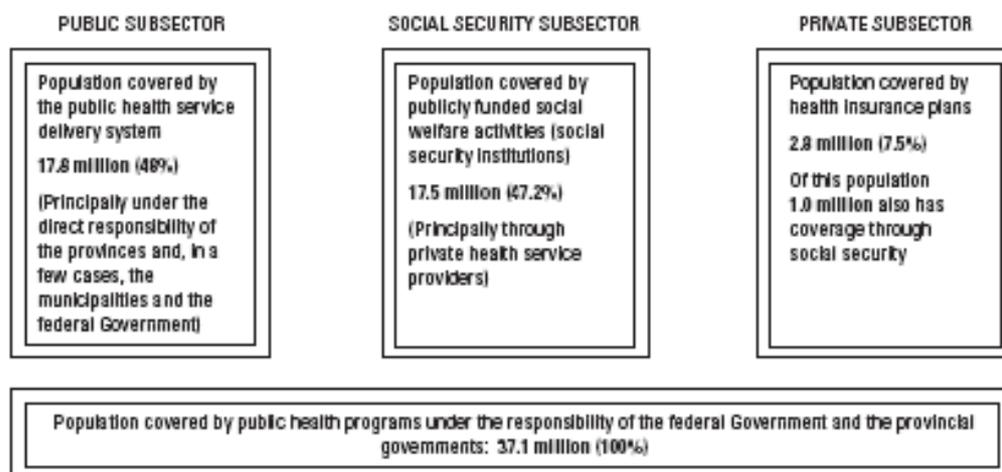
No mention of health, disease or hospital in the constitution.

Healthcare organisation

“Argentina’s health system reflects the federal nature of the country’s government, whereby provinces retain the authority to manage and deliver health care within their jurisdiction. The system encompasses three subsectors: public, private, and social security. The latter two are closely connected, given that the institutions responsible for social security contract out many health services to private health service providers of different types and sizes” (Figure below). [Argentina Americas PAHO 2007]

“In 2006, the health system was characterized by a high level of segmentation and fragmentation, which resulted in poor coordination among subsectors, inequality in financing, inequities in health care quality, and many access barriers for some population groups. In 2003, social security institutions covered approximately 17.5 million people (47.2% of the total population), distributed throughout almost 300 entities of varying sizes and importance. It is estimated that the public subsector covered 17.8 million persons (48%) and private health insurance plans covered 2.8 million persons, of which 1 million also had social security coverage.” [Argentina Americas PAHO 2007]

General scheme and estimated coverage of the health system. Argentina. 2001.



[Argentina Americas PAHO 2007]

“Throughout its history, the health system has operated with a degree of inefficiency and inequity. The diverse coverage that is available affects the 24 provincial public systems, approximately 300 national social security institutions, 24 provincial social security institutions, a few dozen health insurance plans, private health insurance plans, and many mutual insurance systems; the National Institute for Social Services for Retired People and Pensioners, known for its Spanish acronym, PAMI, also is affected. In 1993 a “free choice” option became available to workers affiliated with the social security system, as part of a deregulation effort and to improve efficiencies. The fragmentation and lack of coordination of this group of institutions have curtailed the establishment of a unified, efficient, universal health system. Thus, social security is managed by institutions that vary greatly in terms of the type of population they serve, the coverage they offer, the financial resources per member, operating modalities, and health service networks they contract out to.” [Argentina Americas PAHO 2007]

“The Ministry of Health is responsible for determining the health sector’s objectives and policies and for executing the plans, programs, and projects for the area under its jurisdiction, which are developed in accordance with directives from the Executive Branch. The Ministry also oversees the operation of the health services, facilities, and institutions, and conducts the overall planning for the sector in coordination with provincial health authorities. It is also responsible for issuing regulations and procedures to guarantee the quality of health care, as agreed to by consensus with the provinces, and participates in approving the health facility projects that are built by private companies. Through the National Food, Drug, and Health Technology Administration, the Ministry participates in matters related to the development, distribution, and marketing of products directly related to health. The Administration is responsible for implementing and enforcing compliance with legal, scientific, technical, and administrative provisions under its jurisdiction.” [Argentina Americas PAHO 2007]

“The Superintendency of Health Services is the regulatory and controlling agency overseeing those who handle the National Health Insurance (social security) System. Within the Congress, the Senate’s Health and Sport Committees and the Chamber of Deputies’ Social Action and Public Health Committees are responsible for passing judgment on health and medical-social activities; hygiene; sanitation; preventive medicine and nutrition; hospital subsidies; and societies, corporations, or institutions that carry out health-related activities.” [Argentina Americas PAHO 2007]

Health financing in Argentina

National health expenditure in Argentina 2001	Mio Pesos	Percent
National health services	755	3,42
National employees health insurance	3.282	14,88
National retirees and pensioners social services	2.110	9,56
Provinces health services	3.589	16,27
Provinces employees health insurance	2.007	9,10
Municipalities health services	758	3,44
Private	9.559	43,33
Total	22.060	100,00

[Argentina PAHO 2002]

Federation's and state responsibilities for health in Argentina

“By constitutional mandate, the provinces are the technical administrative units responsible for the health care and protection of the population. The municipalities, particularly those with the greatest economic power and demographic weight, usually administer their own resources and have the authority to program and carry out health actions independently. The Federal Health Council (COFESA) is the institutional forum for consensus-building, setting goals, and adopting common policies and decisions among sectors and jurisdictions. The National Government maintains a presence in the provinces through delegations of the Ministry of Health, the Health Services Authority, the Occupational Hazards Authority, and the Authority of Associations of Retirement and Pension Funds. Law 25,233 modified Ministries Law No. 24,190 and established the organizational structure and objectives of the Secretariats and Departments operating under the Nation's Presidency, the Leadership of the Cabinet of Ministers, and the Ministries. The Ministry of Health was organized into two Secretariats and five Departments in order to manage the institutional workload, but the health emergency (Decree No. 486, 2002) has altered this structure.” [Argentina PAHO 2002]

Decentralization of health services in Argentina

“Judging by the proportion of the health budget that is executed at the subnational level and by the decision powers that have been transferred to the provinces, decentralization of health services in Argentina both in the territorial political and the economic sense is quite advanced. Only about 14 percent of health spending in the public sector is done at the national level; 70 percent is done at the provincial level, and another 16 percent is done at the municipal level. Less than 1 percent of inpatient facilities are administered by the national health authorities, some 70 percent are administered at the provincial level, and 20 percent are administered at the municipal level.” [America's Decentralization World Bank 1999]

“The public sector provides health coverage to about 46 percent of the population and accounts for about 23 percent of total health spending in the country. The social security system (based on the so-called “Obras Sociales”) provides coverage to 47 percent of the population and accounts for 35 percent of health spending. The private sector covers 7 percent of the population and accounts for 42 percent of health spending (insurance and out-of-pocket). The public sector owns about 37 percent of health facilities and 54 percent of hospital beds, while the private sector owns 61 percent of health facilities and 43 percent of hospital beds.” [America's Decentralization World Bank 1999]

“The first wave of health sector decentralization in Argentina (1978) was aimed at the provincial—rather than the municipal—level. The primary motive for decentralization was the alleviation of the fiscal burden at the central level, rather than a quest for efficiency or equity. Responsibility for running health facilities and budgets was transferred to the provinces. The resources transferred from federal to the provincial level were not earmarked for the health sector; provinces could therefore choose how much they wanted to allocate to the health sector from their own budgets and from the federal transfers. The early 1990s brought a second wave of decentralization with the transfer of the last federal hospitals to the Municipality

of Buenos Aires, and the transfer of some provincial health responsibilities (especially primary health care) to the municipalities.” [America’s Decentralization World Bank 1999]

“The second wave also introduced the concept of the autonomous public hospital. The scope of autonomy of these hospitals was to include the ability to bill the social security system and private health insurers for services provided to their beneficiaries and to retain a part of their earnings. Adoption of the autonomous hospital model has been uneven, however. Two provinces (Córdoba and Neuquén) have rejected the concept entirely, fearing that it would lead to duplication of facilities and equipment, and to discrimination against the uninsured population (as hospitals become more and more dependent on reimbursements from insurers). Other provinces have adopted the concept but have implemented it slowly, fearing that it would increase the public deficit. They also feared strong opposition from labor unions and reduced political power at the provincial level. With one exception—the province of Salta—no province has given its autonomous hospitals control over personnel management.” [America’s Decentralization World Bank 1999]

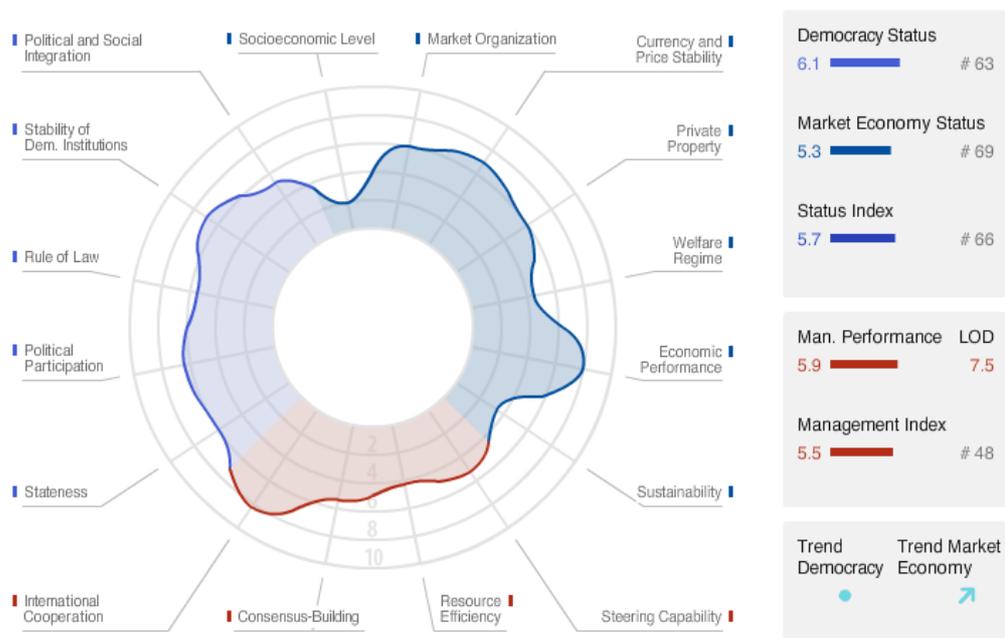
Nigeria

Federation’s set-up

Nigeria, officially named the Federal Republic of Nigeria, is a federal constitutional republic comprising thirty-six states and one Federal Capital Territory.” [Wikipedia 2008]

Transition stewardship

The transformation index of Bertelsmann assesses important dimensions and criteria for measuring the transformation stewardship of the country. The following scores were obtained in 2008.



[World Bertelsmann Atlas 2008 – see endnote on page 74]

Constitution

Constitution of 1999 with 65.724 words on 120 pages

Constitution
and health
in Nigeria

“Article 17.3.: The State shall direct its policy towards ensuring that I the health, safety and welfare of all persons in employment are safeguarded and not endangered or abused;
(d) there are adequate medical and health facilities for all persons:
Fourth schedule Point 2. The functions of a local government council shall include participation of such council in the Government of a State as respects the following matters I the provision and maintenance of health services;” [Nigeria Constitution]

Healthcare
organisation
in Nigeria

“All three levels of government, the Federal, State and Local Government Areas (LGAs), have responsibilities for the provision of health care. The 36 States and 774 LGA’s are responsible for all financial aspects of Secondary Health Care (SHC) and Primary Health Care (PHC) departments, including personnel costs, consumables, running costs and capital investment. The Federal government sets overall policy goals, co-ordinates activities, ensures quality, training and implements sector programmes such as immunisation. The co-ordination of activities is generally poor.” [Nigeria DFID 2000]

“The National Primary Health Care Development Agency (NPHCDA) provides a source of technical knowledge and expertise on the provision of PHC and monitors PHC delivery on behalf of the Federal Ministry of Health. Capacity to undertake this is limited. Public PHC services are funded and administered by the state MoHs, which provide technical assistance to the LGAs under the PHC Director in the State MoH. PHC services are the direct responsibility of LGAs whilst SHC services come under the State Hospital Management Board (HMB). However, there are very few links between the two. As a result, the referral system is weak and undeveloped.” [Nigeria DFID 2000]

“Hospitals are providing virtually no support or technical supervision of services provided by PHC facilities, and there are no outreach clinics or visits by hospital staff. In addition the relative independence of States means that pursuing consistent national policies across the country is problematic.” [Nigeria DFID 2000]

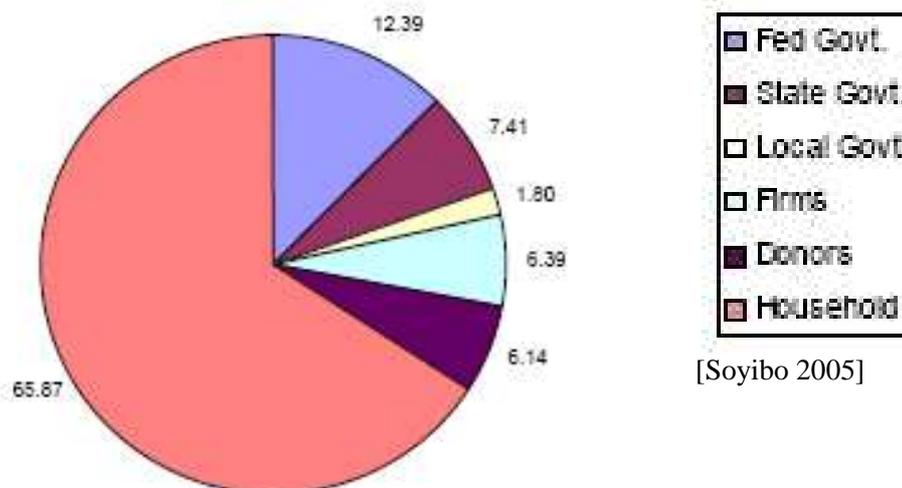
“Many of the health problems that the country faces could be reduced through improvements at the primary care level, but there are many constraints. Inadequate financial resources (\$2-3 per capita) for the health sector is a major problem. Since the beginning of the economic crisis in the 1980s the health sector has suffered dramatically in as has all other public service activity. Development and recurrent expenditure has declined resulting in a scarcity of drugs and medical supplies, and the deterioration of facilities.” [Nigeria DFID 2000]

Each LGA employs a primary care coordinator but communication and co-ordination between different service levels are poorly developed and data for planning purposes and management are sparse. Available resources are often not employed in a cost-effective manner where they would bring the highest benefit. In addition, health care is available from private and voluntary/mission sectors. “[Nigeria DFID 2000]

“The private sector and the traditional medicine settings are very important and jointly account for 60-80% service provision. There is little regulation and standardisation of services. One of the main reasons for the very low utilisation rates for public sector clinics has been the poor standard of facilities and care. User charges are also perceived as too high. In theory there should be some accountability of public facilities to the community through village development committees, and a range of systems at hospital level. In practice however these rarely function effectively.” [Nigeria DFID 2000]

Health financing in Nigeria

Sources of health financing in Nigeria, 2002, in percent



Federation's responsibility for health in Nigeria

“Vision: To reduce the morbidity and mortality due to communicable diseases to the barest minimum, reverse the increasing prevalence of non-communicable diseases, meet global targets on the elimination and eradication of diseases, and significantly increase the life expectancy and quality of life of Nigerians.” [Nigeria MoH website 2008]

“Mission: To develop and implement policies and programmes as well as undertake other necessary actions that will strengthen the national health system to be able to deliver effective, efficient, quality and affordable health services that foster improved health status of Nigerians to serve as the engine for the pursuit of accelerated economic growth and sustained development. .” [Nigeria MoH website 2008]

Mandate of the Federal Ministry of Health

1. Ensuring the development of National Health Policy and its implementation through supervision monitoring and inspection;
2. Ensuring the implementation of National Health Policy in so far as it relates to the Federal Ministry;
3. Issuance of guidelines for the implementation of National Health Policy;
4. Liaising with national health departments in other countries and with international agencies;
5. Issuing, and promoting adherence to, norms and standards, and providing guidelines on health matters, and any other matter that affects the health status of people, promoting adherence to norms and standards for the training of human resources for health;
6. Promoting adherence to norms and standards for the training of human resources for health;
7. Ensuring the continuous monitoring, evaluation and analysis of health;
8. Status and performance of all aspects of the National Health System, through systematic collection and use of health information and evidence;
9. Identifying health goals and priorities for the national as a whole and monitor the progress of their implementation;
10. Coordinating health and medical services delivery during national disasters;
11. Participating in inter-sectoral and inter-ministerial collaboration;
12. Promoting health and healthy lifestyles;
13. Conducting and facilitating health systems research in the planning, evaluation and management of health services;
14. Facilitating and promoting the provision of health services for the

- management, prevention and control of communicable and non-communicable diseases;
15. Ensuring the provision of tertiary and specialized hospital services;
 16. Facilitating and promoting the provision of health services at the ports of entry and exit;
 17. Coordinating health services rendered by the Federal Ministry of Health states, local government, wards private health care providers and Development partners and provide such additional health services as may be necessary to establish a comprehensive national health system;
 18. Determining the minimum indicators required to monitor the status and use of resources and services;
 19. Preparing strategic, medium-term health and human resources plans for the implementation its duties;
 20. Organizing the National Council on Health to create a forum for integrating all health plans of the Federal and state Ministries of Health and building consensus on national health issues; and
 21. Providing assistance to state Ministries of Health in the development of state health plans, technical materials, including methodologies, policies and standards and other technical assistance as may be necessary in order for the State Ministries to properly perform their functions. .” [Nigeria MoH website 2008]

“Programs of the Federal Ministry of Health

- Department of Health Planning, Research and Statistics (DHPRS)
 - National Health Management Information and Technology
 - Health Sector Reform
 - Health Situation and Trends Assessment
 - National Health Accounts
 - National Collaborating Centres for Education and Training
 - International Cooperation
 - Policy and Planning
- Department of Public Health (DPH)
 - Family Health
 - Non-communicable Disease
 - Epidemiology and Health Emergency Response
 - Health Promotion and occupational Health
 - National AIDS and STI Control Programme (NASCP)
 - TB/Leprosy and Neglected Diseases
 - Malaria and Vector Control
 - Nutrition
- Department of Food and Drugs Services (DFDS)
 - National Drug Information Services.
 - Food Safety
 - Traditional Medicine Development
 - National Pharmacopoeia
 - Monitoring and Evaluation of FDS Programmes
 - National Drug Formulary/Essential Drugs list.
 - Chemical Safety Management.
 - Water Safety Management.
 - National Drug Policy.
- Department of Hospital Services (DHS)
 - Hospital Services
 - Blood services
 - Regulations and Professional Schools
 - Nursing Services
 - Inspectorate

Parastatals of the Federal Ministry of Health

- National Primary Health Care Development Agency (NPHCDA)
- National Health Insurance Scheme (NHIS)
- National Agency For Food And Drug Administration And Control (NAFDAC)
- Nigerian Institute For Medical Research (NIMR)
- Nigerian Institute Of Pharmaceutical Research And Development (NIPRD)
- Regional Center for Oral Health Research and Training Initiatives (RCORTI)
- Teaching Hospitals, Specialized Hospitals and Federal Medical Centres

Regulatory Bodies of the Federal Ministry of Health

- Nigeria Medical & Dental Council
- Nurses & Midwifery Council of Nigeria
- Pharmacy Board of Nigeria
- Dental Technologist Board of Nigeria
- Health Records Officers Registration Board of Nigeria

Federal Health Service Institutions

- 15 teaching hospitals at universities
- 24 federal medical centres
- 13 special hospitals

[Nigeria MoH website 2008]

State responsibilities for health in Nigeria

Responsibilities of the State Ministry for Health (Example given for Akwa Ibom State): “The State Ministry of Health is a government establishment charged with responsibilities of planning, organizing and financing, health care programmes and services. The Ministry also formulates health policies and offers advice and guidance on matters affecting health-care delivery.” [Nigeria Akwa Ibom State website 2008]

Functions of the State Ministry of Health: The main functions of the Ministry of Health are as follows:

- To deliver and recognize the practice of medical services in the State (Health legislature).
 - To recognize/supervise the practice of homeopathic medicine (alterative medicine) given by registrable practitioners,
 - Registration of Private Clinics, Maternity Homes, Hospitals, Pharmacy and Patent Medicine Shops,
 - Provision of genuine drugs in Public Health Institutions and combating the production, distribution and sale of counterfeit, fake and expired drugs,
 - Maintaining and controlling of Training Schools in the Health sector.
 - Provision of training for all cadres of staff including Doctors, Pharmacists, Nurses and paramedical staff of the State’s public service,
 - To approve the refund of medical expenses to staff of all Ministries and parastatals.
 - To constitute Medical Board to ascertain the health Status of Public Servants,
 - Co-ordination, supervision of the management and implementation of integrated primary health care services in the State,
 - Control of Food and Drugs in liaison with the Federal Ministry of Health;
 - Conduct of Entrance Examinations for Student Nurses, Midwives and students in the School of Health technology;
- Representation at the Federal level on Health matters and on bodies including the medical and Dental Council of Nigeria, the Nursing and Midwifery Council of Nigeria, pharmaceutical Board of Nigeria, the Royal Society of Health, the National Council on Health, the Nigerian Association of Resident Doctors, Association of General and Private Medical Practitioners of Nigeria

(AGMPN);

- Liaise with the Federal Ministry of Health and International bodies on Health matters;
- Management and supervision of National and International Aids/Loans in the Health Sector.
- Monitoring and Evaluation of Health programmes/activities in the State.
- Collection and collation of varieties of Health Data and statistics for internal, National and International consumptions. [Nigeria Akwa Ibom State website 2008]

Activities of the State Ministry of Health

- The National Programme on Immunization (NPI): The State has been non-polio transmitting for more than two years now. To ensure that no effort is spared in the drive to eradicate polio in the country by the end of 2004, the State is actively participating in the National Campaign on Immunization. The First round of the campaign ended on 26th February, 2004.
- Onchocerciasis: Akwa Ibom State joins in Company Directed Distribution of Ivermectin (CDDI) following the Rapid Epidemiological mapping of onchocerciasis (Remo) of year 2000 and the Rapid Assessment of loasis (RAPLOA) of year 2002, 14 communities in Ibiono Ibom and Ini Local Government Areas in Akwa Ibom were confirmed as endemic for onchocerciasis. The good news for people of the affected communities is that with the recent completion of update in community registration and training for Severe Adverse Effect (SAE), the much awaited intervention – Community Directed Distribution of Ivermectin commenced in the month of March, 2004.
- HIV/AIDS: HIV/AIDS continues to challenge individual communities and government. During the year 2003 National Sero-prevalence Survey, the state raised a multi-disciplinary team of observers to monitor the activity in the state and to serve as core advocates for acceptance of the State result when released. Furthermore, in an effort to boost the State HIV/AIDS response, a three-week training programme was organized for a total of 160 HIV/AIDS workers.
- Modern General Hospitals: The State Government has in the past four years initiated 14 Hospitals Projects in the state for Local Government Areas that had none and three out of these are at Ukpom in Abak, Ikpe Ikot Nkon in Ini and Ammamong in Okobo. These three hospitals are at various stages of completion. When completed and equipped, the hospitals will have various specialty units and also serve as referral centres.
- Free Health Care Programme: This programme kicked off on 7th march, 2004 at Methodist General Hospital, Ituk Mbang in Uruan Local Government Area. The event covered free medical treatment in all areas of medical practice. This programme was sponsored by Pro-Health International in collaboration with NDDC and Akwa Ibom State Government.
- Health Education Programme: Health Education is an entry to all Public Health Programmes. Activities carried out in the unit include:
 - Regular advocacy to stakeholders in health matters;
 - Community/Public Health Education – Organizing Community Programmes;
 - Commemoration of special events – celebration of World Health Days, etc;
 - School Health Education – education of pupils on current health issues, prevention and control and hazards;
 - Production/distribution of Health Education materials, jingles are produced on health issues that affect the populace;
 - Development of Audio Visual Aids – select, develop and produce posters, handbills, banners, etc;
 - Radio Programmes – organize radio talk on health issues in English, pidgin and the local dialects;

- Collaborate with other organizations that may contribute to health promotion e.g. Ministries, Parastatals, NGOs, etc;
- Health Promotion – organizing campaigns on health issues;
- Staff Training – on –the-job training of staff. “ [Nigeria Akwa Ibom State website 2008]

Lower level responsibilities for health The Fifth Schedule to the 1999 Constitution includes the provision and maintenance of health services in the list of responsibilities for each of the 775 local government councils in Nigeria. [Nigeria Constitution]

Decentralization of primary health care in Nigeria “Nigeria has been organized as a federal country since 1954 with the responsibility for providing most public goods being concurrently shared between the federal and state governments. In 1976, local government authorities (LGAs) were established and recognized as the third tier of government, responsible for participating in the delivery of most local public services along with state governments, and entitled to statutory revenue allocations from both the federal and state governments for the discharge of their responsibilities. In the late 1980s there was a national initiative to overhaul the primary health care system through the adoption of a new national health policy, in the context of which the federal and state governments issued directives in giving LGAs full jurisdiction over the delivery of PHC services.” [Nigeria Das Gupta 2003]

“The current national health policy document, revised in 1996, indicates that local governments are expected to be the main implementers of PHC policies and programs, with the federal government responsible for formulating overall policy and for monitoring and evaluation, and state governments for providing logistical support to the LGAs such as personnel training, financial assistance, planning and operations. To quote: “*With the general guidance, support and technical supervision of State Health Ministries, under the aegis of Ministries of Local Government, Local Government Councils shall design and implement strategies to discharge the responsibilities assigned to them under the Constitution, and to meet the health needs of the local community.*” [Nigeria Das Gupta 2003]

“Yet, the current Constitution (1999) of Nigeria is ambiguous with regard to the authority and autonomy of local governments in providing basic services, such as primary health, for which they have been assigned responsibility through federal directives. The Fourth Schedule of the Constitution lists the functions of LGAs as follows: “*The functions of a local government council shall include participation of such council in the Government of a State as respects the following matters: (a) the provision and maintenance of primary, adult and vocational education; (b) the development of agriculture and natural resources, other than the exploitation of minerals; (c) the provision and maintenance of health services; and (d) such other functions as may be conferred on a local government council by the House of Assembly of the State.*” This implies that according to the Constitution, it is the state governments that have principal responsibility for basic services such as primary health and primary education, with the extent of participation of LGAs in the execution of these responsibilities determined at the discretion of individual state governments. The constitutional existence of state-level discretion may lead to disparities across local governments or across states in the extent to which responsibility for PHC services is effectively decentralized. In the face of such constitutional ambiguity, the survey of LGAs and health facilities attempted to assess the extent of decentralization of PHC services to local governments.” [Nigeria Das Gupta 2003]

“The survey asked respondents at both the LGA and facility level which agency, choosing one amongst the federal government, the state government, the LGA, community-based organizations, and facility head or staff, was the principal

decision-maker for each of the following areas of PHC service provision in health facilities:

- Undertaking new construction, such as facility expansion
- Acquiring new equipment
- Making drugs and medical supplies available
- Setting charges for drugs and treatment
- Use of facility revenues from treatment and consultation
- Disciplining staff
- Transferring staff between facilities” [Nigeria Das Gupta 2003]

“The overwhelming majority of LGA respondents indicated the LGA as the principal decision-maker for most of the areas of facility level provision of PHC services. Of the 29 LGAs that responded to these questions, 21 listed the LGA as the principal decision-maker for all of the areas listed above. Of the remaining LGAs, 7 listed the LGA as the principal decision-maker for most service delivery activities, except one or two areas that were non-systematically assigned to other agencies—for example, the state government was cited by 2 LGAs as the principal decision-maker for undertaking new construction, by 1 LGA for setting charges of drugs and treatment, and by 1 for decisions of transferring staff between facilities, with all other decisions being principally determined by the LGA. Only one LGA, Ibaji LGA in Kogi state, listed an agency other than the LGA, namely, community based organizations, as the principal authority for majority of the decisions of day-to-day running of facilities. This LGA had been pointed out during field-work for the survey as particularly remarkable for the extent of community participation in PHC service delivery.” [Nigeria Das Gupta 2003]

“The facility-level respondents similarly indicated the LGA as the principal decision-maker for most service provision decisions at the facility level, as compared to the other two tiers of government—the state and the federal government. Out of 249 facility-level respondents that answered most of the questions related to facility decision-making, 61% indicated the LGA as the principal decision-maker for all or most activities listed earlier. The state and federal governments were indicated very infrequently as principal decision-makers for any area, and even then for only one or two areas of decision-making in any individual facility. Table II.2.1 lists the frequency of responses for each agency by each type of service delivery decision area. There is, therefore, no evidence from the survey of state governments being actively engaged in the provision of PHC services, as appears to be indicated in the Constitution. Amongst government agencies, the LGA is overwhelmingly indicated as primarily responsible for PHC, with no significant variation in responses across the LGAs or between the two states surveyed.” [Nigeria Das Gupta 2003]

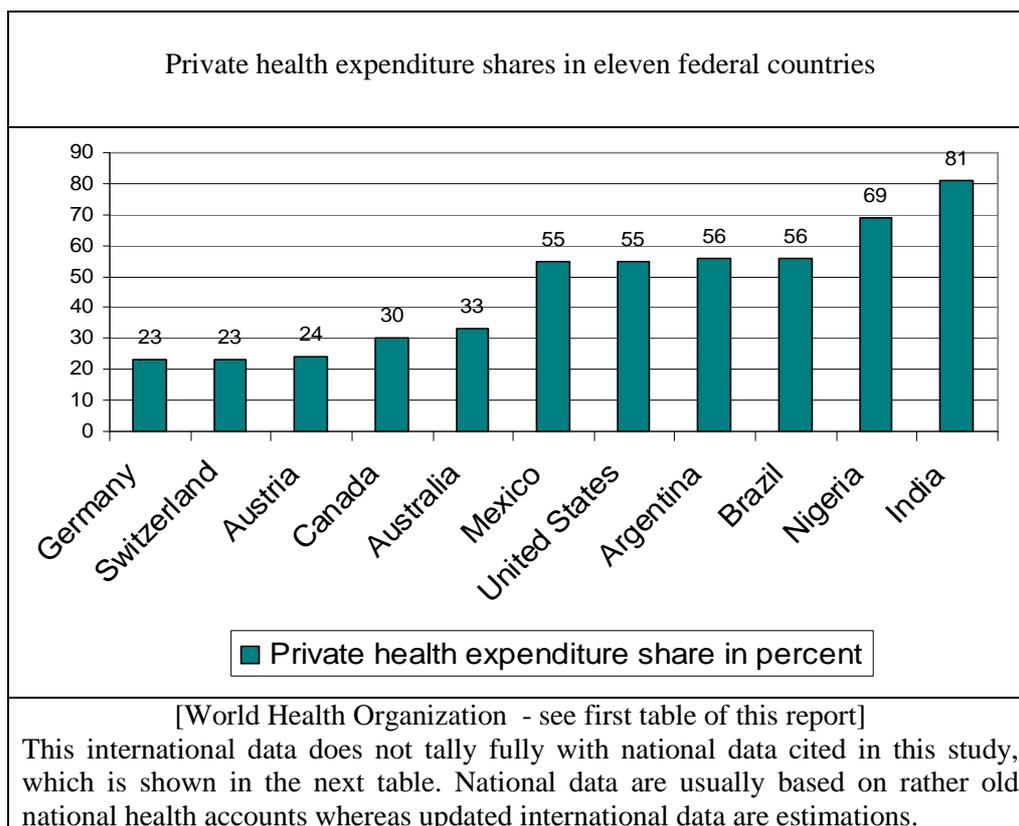
“In addition to the LGA, it was the community development committees and the facility head and staff that were indicated as principal decision-makers in some specific facility decisions. For making drugs, supplies, and equipment available, and/or setting charges of drugs, and/or determining use of facility revenues, the community development committees and/or facility head or staff was indicated for about 35% of the facilities surveyed.³ For decisions to undertake new construction or expansion, community development committees were indicated as principal decision-makers for 26% of all facilities surveyed. However, decisions related to staff discipline were overwhelmingly cited as the responsibility of the LGA. There are striking differences in the sharing of responsibilities between the LGA and community development committees in the two states of Lagos and Kogi studied here. Of the 97 facilities in Lagos that responded to most of these responsibility questions, 74% indicated the LGA as principal decision-maker, while of the 152 respondents in Kogi, only 52% indicated the LGA as principal decision-maker. The remaining facilities in Kogi listed either the community development committees or the facility head or both as the principal decision-makers. Of the 53 facilities in the

sample that listed community development committees as principal decision makers for one or more of the following areas— making drugs, supplies and/or medical equipment available, setting charges of drugs, determining use of facility revenues— 48 belonged to Kogi, and only 5 to Lagos. Of the 65 facilities where communities were reported as principal decision-makers for undertaking new construction, 61 belonged to Kogi and only 4 to Lagos. Hence, while the LGA has predominant responsibility for PHC service delivery in both states, as compared to the state and federal governments, in Kogi PHC service delivery appears to be characterized by active participation of communities and facility staff.” [Nigeria Das Gupta 2003]

“In its implementation guidelines for primary health care services the National Health Policy requires all local governments to establish committees that will manage, monitor, and evaluate health care programs and provide technical advice to the local government council. These are the Primary Health Care Management Committee (PHCMC) and its technical arm, the Primary Health Care Technical Committee (PHCTC). In order to get a picture of the extent of monitoring of health facilities by the PHCMC, the survey asked several questions related to the activities of this committee which is shown in Table II.2.2. PHCMCs appear to be quite active in Kogi, with over 80 percent of the sample reporting that the committee visits the facility regularly, monitors patient registers, drug stocks, and equipment, and discusses medical protocol and administrative issues. In Lagos, PHCMCs appear less active, with more than 40 percent of the sample either not responding to the questions or reporting that the committee visits rarely or never. In both states it is surprising to note the low frequency of responses for checking of user receipts in the facility by the PHCMC—as we will discuss in the section on financing, most facilities responded that revenues from user charges are supposed to be handed-over to the local government and not retained for general facility purposes.” [Nigeria Das Gupta 2003]

Outlook

No strict link between federalism and health care	Health care is organized and financed quite differently in different federal countries. There seems to be no blueprint or any ‘automatic’ relationship between federalism and health care. This assumption – nevertheless – needs careful analysis and synthesis. This is a task to be done by a multidisciplinary and international team of specialists. This task can not be done by one.
Federalism and private health expenditure	The following first attempt to synthesize some of the data given in this report produces quite some uncertainties. The next table shows the remarkable differences in private spending for health in the eleven countries included in this study. The share stretches from low 20% in old European countries to a very high private expenditure for health of more than 80% in India, where a government does not take over the responsibility for health of its people – they are left alone. Reliable data in Nigeria would probably show a similar result. Opposite to this reality European countries introduced a mandatory social health insurance system for its population resulting in rather low levels of private ‘voluntary’ out-of-pocket payments for health and health care. There is no automatism between a federal organization of the country and the public responsibility for health care of a country’s population.



Federalism
and
government
health
expenditure

A similar uncertainty relates to the shares of the federal and state governments for financing health and health care. In middle European countries they do not play the most important roles. Social health insurance systems dominate health financing and health insurance systems are built up very often according to segmentations that do not follow the delineation between a Federation and its constituents in terms of provinces, states or other geographical units. Health insurances in these countries are sometimes organized according to other geographical units or according to professions, companies, organizations or they are organized nationally.

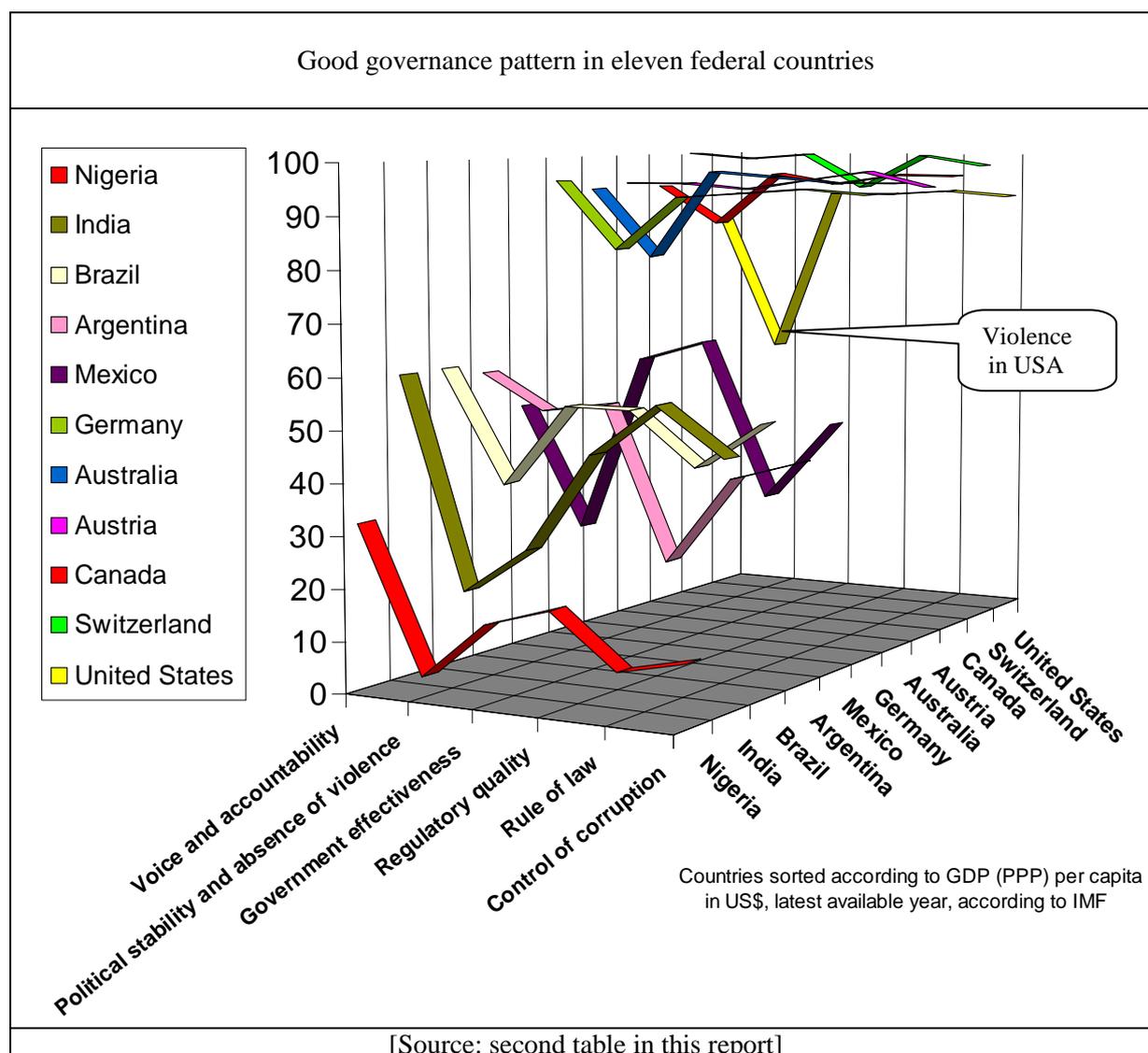
Federal shares in health expenditures in eleven federal countries				
	Federation	States	Private	Other
Australia	41	27	18	14
United States	34	13	53	0
Mexico	32	13	51	4
Argentina	28	26	43	3
Brazil	22	19	56	3
Austria	3	22	25	50
Switzerland	25		23	52
Nigeria	12	7	66	15
Canada	5	65	30	0
India	6	17	70	7
Germany	8		23	69

Very preliminary table: This data does not tally with other data, since sometimes social health insurance contributions are attributed to private expenditures, sometimes not. The separation of European data according to federation and states is a difficult job to be done still.

This table shows that the financial weight of the division of labour between the federal level of governments and its state levels varies considerably among the eleven countries under study. In Australia, USA and Mexico for example the Federations seem to be key actors whereas the States play a much more important role especially in Canada and Austria. In Argentina and Brazil there seems to be a balance between federal and state contributions for health and health care.

Federalism
and good
governance

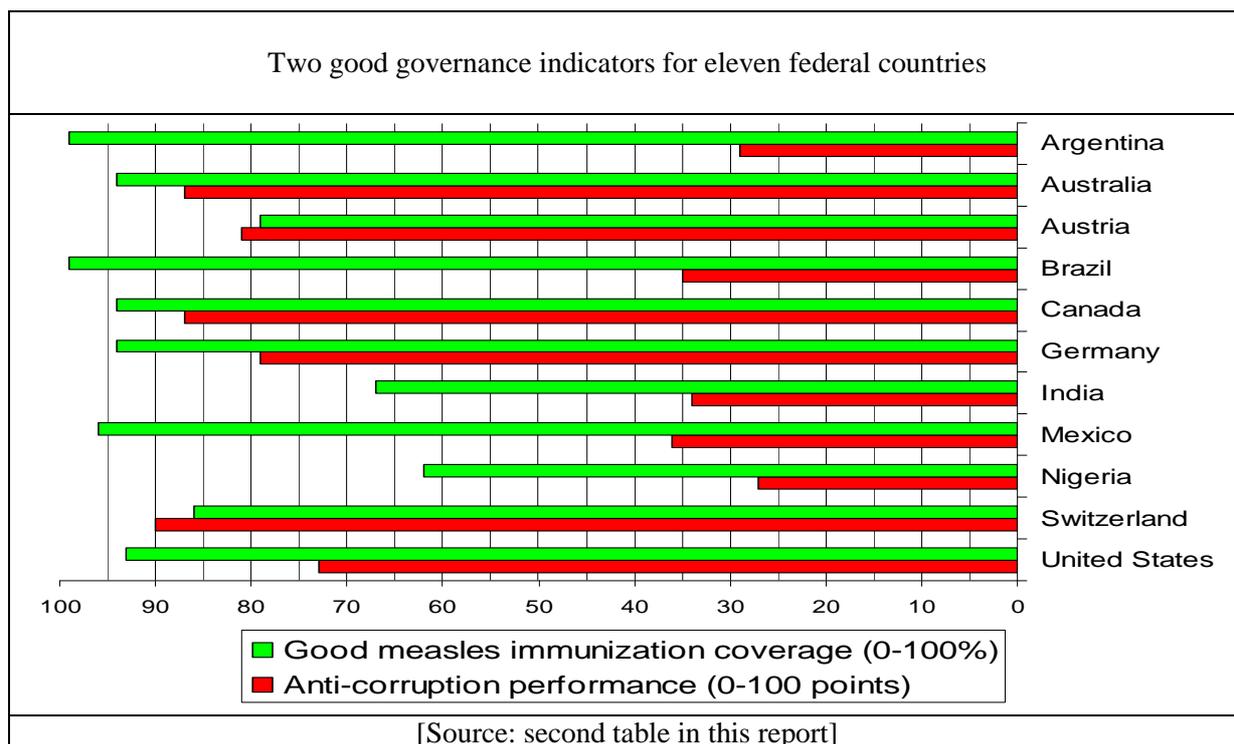
A similar picture can be painted regarding good governance. There is by no means an automatic relationship between federalism and good governance. The next graph shows quite clearly that it is rather the result of long-term historical processes and the status of economic development that may predict good governance, at least according to the indicators proposed by the World Bank.



Comparing the results of this good governance assessment with data on private out-of-pocket payments for health – as given in the tables before – a hypothesis emerges: the better the good governance scores, the smaller are the out-of-pocket payments for health care through the introduction of social health insurances. Good governance and social health insurance go together.

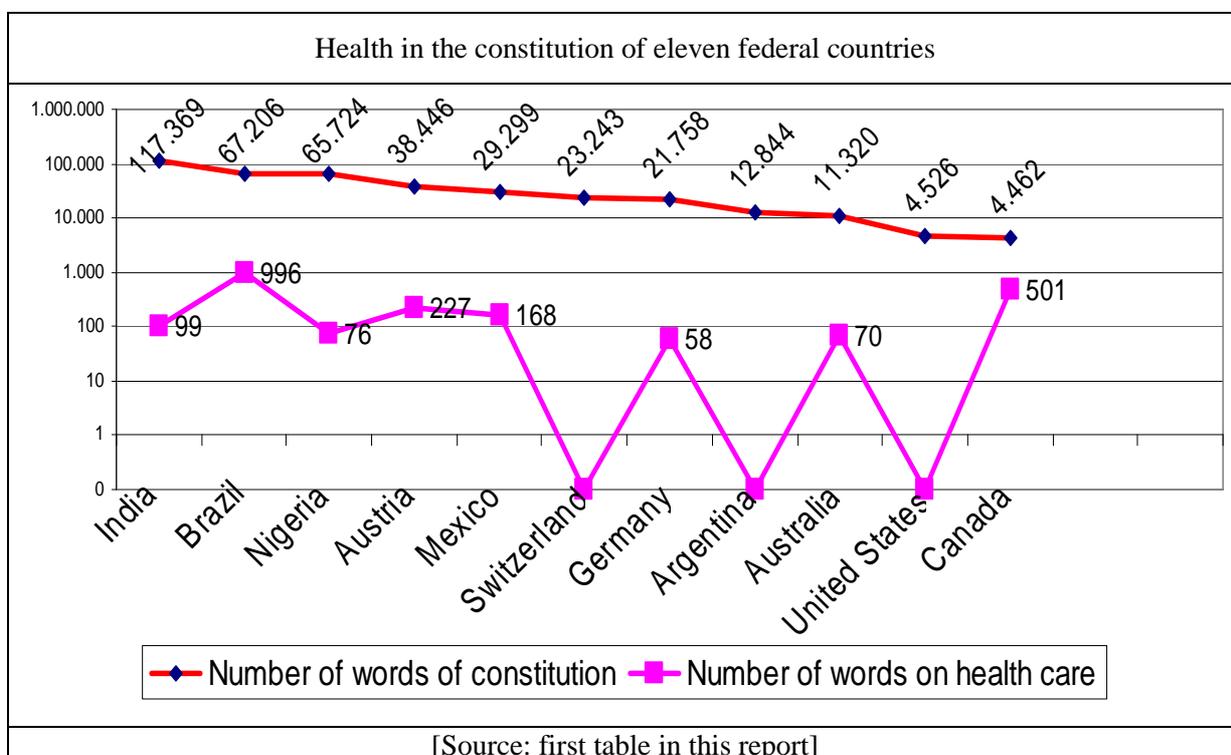
If an indicator of good public health care governance is introduced into this picture – for example good measles immunization coverage close to 100% – then some of the less advanced countries like Brazil, Argentina and Mexico perform better than highly

developed countries with high marks in anti-corruption performance – especially Latin American countries.



Federal constitutions

Another uncertainty is shown if we look into the national constitutions of federal countries and try to find what they say about health and health care. Very long, detailed and elaborated constitutions do not predict a good public performance as in the case of India and Nigeria.



Result

A very first and certainly superficial look at the relationship between federalism and public health produces quite some uncertainty.

Lesson learnt There is a first lesson to be learnt, nevertheless: It is not sufficient to discuss the division of labour between federal and state and lower levels of governance. It is essential to include in analysis and synthesis especially the aspects of intermingling, overlapping and additional health care financing strategies and practices. Health protection schemes and social health insurance systems are just one example.

A cognitive mapping of (public) health (care) tasks and key actors						
Tasks \ Agents	Regulation	Tertiary care	Secondary care	Primary care	Basics	
Federation						
Regions						
Provinces						
Municipalities						
Insurances, private sector, other agents						

A task ahead This sketch tries to present a cognitive mapping on most important (public) health tasks according to the key agents involved, including federal and state levels of government. To find a good governance oriented division of labour between them is a task for Sisyphus.

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Endnote

1. The Bertelsmann Transformation Index (BTI): Country reports detailing the state of development, management and the landscape of problems specific to a given country form the backbone of the BTI. Using a standardized codebook, experts for each of the 125 countries examine the extent to which a total of 17 criteria are fulfilled, providing scores as well as written assessments for each. Each country report substantiates the scores given and is available online. A second expert, generally from the country in question, reviews the scores and assessments given for each report. To ensure the consistency of 52 individual scores, each country's scores then undergo a regional and inter-regional comparison and calibration process, after which they are subjected to final review and approval by the BTI Board – a team of esteemed scholars and development professionals. The BTI's standardized analysis allows for a targeted comparison of reform policies. Indeed, its unique body of data aids in assessing and comparing the successes and failures of developing and transformation states. To keep

track of current developments and ensure data quality, the BTI is published every two years. The continuous evaluation of transformation and development makes it possible to assess observed trends and establish the results of transformation strategies. Now in its third edition, the BTI can expand the body of knowledge on political management for decision makers and the external organizations supporting them:

- Status index is composed of 32 indicators for 12 criteria on 2 dimensions. The dimensions are democracy status and market economy status. The criteria for the democracy status are: stateness, political participation, rule of law, stability of democratic institutions, and political and social integration. The criteria for the market economy status are: level of socioeconomic development, organization of the market and competition, currency and price stability, private property, welfare regime, economic performance, and sustainability. Data were collected for 125 transition countries. The values range between 0 and 10, i.e. between extremely poor and excellent
- Management index has 5 criteria and 20 indicators. The criteria for management performance are: steering capability, resource efficiency, international cooperation. The respective indicator values are weighted according to a 6-indicator 'level of difficulty'-criterion. Values range between 0 and 10, i.e. between very poor and excellent.

[Bertelsmann Transformation Index]

Acronyms⁷

FSP	Federalism Support Programme
GDP	Gross domestic product
GoN	Government of Nepal
GTZ	Deutsche Gesellschaft für technische Zusammenarbeit GmbH
HDI	Human development index (UNDP)
HSP	Health system performance index (WHO)
HSSP	Health Sector Support Programme
IMF	International Monetary Fund
MCV	Measles vaccination
MoH	Ministry of Health
MoHP	Ministry of Health and Population
n/a	Not available data
NGO	Non-governmental organization
PAHO	Pan American Health Organization
pc	per capita = per person
PEH	Private expenditure for health
PPP	Purchasing power parity
UNDP	United Nations Development Programme
UNICEF	United Nations International Children's Emergency Fund
USA	United States of America
WB	The World Bank
WHO	World Health Organization

⁷ Country-specific acronyms are explained in the text.