



**European Committee
of the Regions**

**Commission for
Natural Resources**

NAT

The management of health systems in the EU Member States

**The role of
local and regional authorities**



© European Union, 2017

Partial reproduction is permitted, provided that the source is explicitly mentioned.

More information on the European Union and the Committee of the Regions is available online at <http://www.europa.eu> and <http://www.cor.europa.eu> respectively.

Catalogue number: QG-02-17-977-EN-N; ISBN: 978-92-895-0943-5; doi:10.2863/514678

**This report was written by Rossella Soldi (Progress Consulting S.r.l)
with the contribution of Cecilia Odone.**

**It does not represent the official views of the European Committee of the
Regions.**

Table of contents

- Executive Summary 1**
- 1. A governance-based classification of EU health systems 3**
 - 1.1 Some existing models and classifications of health systems 3
 - 1.2 Highlighting the role of LRAs in health management systems 6
 - 1.2.1 Criteria considered 6
 - 1.2.2 Outlining the types 9
- 2. Country profiles..... 15**
 - 2.1 Main data sources 15
 - 2.2 On the infographics..... 16
 - 2.3 Country profiles 17
 - AUSTRIA..... 18
 - BELGIUM..... 21
 - BULGARIA 24
 - CROATIA 27
 - CYPRUS 30
 - CZECH REPUBLIC 32
 - DENMARK..... 35
 - ESTONIA..... 38
 - FINLAND 41
 - FRANCE 44
 - GERMANY..... 47
 - GREECE 50
 - HUNGARY 52
 - IRELAND 55
 - ITALY..... 58
 - LATVIA 61
 - LITHUANIA..... 64
 - LUXEMBOURG..... 67
 - MALTA..... 69
 - NETHERLANDS..... 71
 - POLAND..... 74
 - PORTUGAL 77
 - ROMANIA..... 80
 - SLOVAKIA 83
 - SLOVENIA..... 86
 - SPAIN 89
 - SWEDEN 92
 - UNITED KINGDOM..... 95

3. Conclusions	99
Explanatory note	101
Annex I – References.....	103

List of acronyms

CONS	Council of the European Union
CoR/CdR	European Committee of the Regions/ <i>Comité européen des régions</i>
CSR	Country Specific Recommendation
DG SANCO	Directorate General for Health and Food Safety
EC	European Commission
EEA	European Economic Area
EU	European Union
GP	General Practitioner
HSPA	Health Systems Performance Assessment
LRAs	Local and Regional Authorities
MS	Member States
MoH	Ministry of Health
NHS	National Health Service
OECD	Organisation for Economic Co-operation and Development
OOP	Out-of-pocket
WHO	World Health Organization

Executive Summary

Health systems across the European Union (EU) are managed and organised in very diverse ways. This study is a re-make of the work carried out in 2011 for the Committee of the Regions (CoR). Like its precursor, it focuses on the role local and regional authorities (LRAs) have within the health management systems of EU Member States (MS). This role is investigated in terms of power, responsibility and functions with respect to health legislation and policy development as well as healthcare planning, organisation, delivery and funding.

Overall, the work aims at contributing the LRAs' perspective to the current review of the state of health in the EU jointly carried out by the European Commission (EC) and the Organisation for Economic Co-operation and Development (OECD). It provides updated evidence that in several EU countries LRAs have a significant role with regard to health issues. As a consequence, LRAs and national authorities often share the same concerns on most common challenges faced by health management systems across the Union. These include, for example, the medium-to-long term fiscal sustainability of the systems; increasing expenditure driven, among other factors, by ageing population; health inequalities in access and quality of care; and excessive reliance on costly organisational models such as the hospital-centric one.

The first part of the work presents a governance-based classification of the health systems of the 28 Member States, highlighting the level of involvement of LRAs in the management of the systems. The role of LRAs often reflects the constitutional structure of the country in question. However, there are several factors which add complexity to this simple relationship, such as the prevailing type of governance of healthcare facilities, or the LRAs' capacity for locally raising the financial resources used for health-related capital investments and services. The classification shows that 20 countries in the EU have management systems which are decentralised to a certain degree. In five (5) countries, health systems are 'decentralised'. Italy and Spain stand out among these countries for the importance subnational authorities have in determining and operating their regional systems. In six (6) other countries, health systems are 'partially decentralised'. They differ from the decentralised ones because LRAs do not have legislative power and do not take formal responsibility for health policymaking (with the exception of Belgium). In decentralised and partially decentralised systems, the subnational health funding level is higher than the national one (with the exception of the UK). In nine (9) other countries, health systems are classified as 'operatively decentralised' meaning that in these systems LRAs hold a variable degree of delivery and implementation functions,

often derived from the ownership and/or management of healthcare facilities. Within these systems LRAs also finance healthcare and are able to independently raise part of their resources. However, overall, their contribution to health spending is lower than the national one. The remaining eight (8) European countries have ‘mostly centralised’ or ‘centralised’ health systems.

The bulk of the work is represented by the compilation of short profiles of the health management systems of the 28 Member States. This part is the result of a systematic desk review of the most recent and publicly available data and documents. With respect to the 2011 report, profiles are more comprehensive and comparable with each other. They are meant to provide timely evidence of what LRAs are called to do (power and responsibility) or actually do (capacity and functions, regardless of the statutory role assigned to them) within their respective health systems. Profiles provide evidence that LRAs are responsible for the management of the health systems in 5 MS. In 6 other MS, LRAs are importantly involved in the territorial management of healthcare. LRAs own healthcare facilities in 20 MS, and directly or indirectly manage these facilities in most of the cases. Furthermore, LRAs are importantly responsible for public health in 6 MS. In 13 other countries they are involved to different degrees in health prevention and promotion activities. Finally, LRAs participate in the funding of healthcare in 23 MS and in all but one of these cases they are also able to raise their own revenues through subnational levies. In 9 MS, the subnational health funding level is higher than the national one.

Profiles also report on the tendency of the systems towards lesser or greater decentralisation, according to recent structural reforms, if any. In general, it is noted that decentralised health systems are the most stable in this sense. In these systems, the emphasis is on the strengthening of coordination and cooperation mechanisms among the participating actors. Alternatively, the systems tend towards the strengthening of competition, hence the privatization of health services is also emphasised. The other types of health systems appear to be less stable, with evolution towards centralisation slightly prevailing on decentralisation trends, especially in the systems classified as ‘operatively decentralised’.

Drawing from the evidence collected in this study, it is concluded that there are health-related policy areas where local and regional inputs may add value to EU policy development processes. In particular, evidence suggests that there is scope for structured input by LRAs in those policy domains which are related to the effectiveness, accessibility and resilience of health systems. This may be achieved through the participation by the Committee of the Regions, or by representative associations of regions, in relevant existing EU expert groups.

1. A governance-based classification of EU health systems

Health management systems are classified according to different criteria. In this chapter, first, some existing models and classifications are presented (paragraph 1.1). Next (paragraph 1.2), a classification based on the degree of decentralisation of the health systems to subnational authorities – with respect to power, responsibility and functions – is outlined.

1.1 Some existing models and classifications of health systems

There are several ways of classifying health systems. Since funding and payer/provider relationship are both strictly linked to the financial sustainability of the systems, these criteria are usually given high relevance.

According to *the way healthcare systems are financed* (i.e. through taxation, health insurance, or private sources), three main models are distinguished:

- The ‘Beveridge model’ relates to a *public tax-financed* system. Also referred to as National Health Service, this model usually provides universal coverage and depends on residency or citizenship.
- In the Social Health Insurance System, or ‘Bismarck model’, the funding of healthcare is through *compulsory social security contributions*, usually by employers and employees.
- In the ‘mixed model’ or Private Health Insurance System, *private funding* from voluntary insurance schemes, or out-of-pocket (OOP) payments, is significant.

Another classification¹ considers *the type of payers and of providers* and still distinguishes three models:

- The ‘public-integrated model’ is characterised by *public payers and public healthcare providers*, i.e. healthcare professionals are for the most part public sector employees.
- The ‘public-contract model’ combines *public payers and private healthcare providers*.

¹ Reported in EC-DG ECFIN (2010), the classification is by Docteur and Oxley (2003) and the OECD (2004).

- The ‘private insurance/provider model’ applies when *private insurance entities contract private healthcare providers*.

In 2008, the OECD carried out a survey on the institutional characteristics of the health systems of the OECD member countries (Box 1). The survey was a one-off exercise but it was important in highlighting the relevance of the organisational features of the systems when investigating their performance as well as the level of health spending. The classification which was derived from the OECD work (Joumard, André and Nicq, 2010) was based on the *level of reliance of the health systems on market mechanisms* for the regulation of the demand and supply of health services. In particular, they distinguished:

- *Heavy reliance on market mechanisms* and hence importance of the private sector for the provision of services and/or the insurance coverage.
- *Limited reliance on private supply* but wide choice of providers.
- *Heavily regulated public systems* with limited choice of providers.

Box 1 – The 2008 OECD Survey on Health System Institutional Characteristics

Although never replicated, the survey provided a comprehensive source of information on governance and decentralisation in decision-making with regard to resource allocation and financing responsibilities¹. A summary of the 2008 results related to subnational authorities is reported below for the 19 EU Member States covered by the exercise. In the table, red indicates the involvement of the local level and yellow that of the regional level.

	AT	BE	CZ	DK	FI	FR	DE	EL	HU	IE	IT	LU	NL	PL	PT	SK	ES	SE	UK
Setting the level of taxes which will be earmarked to health care																			
Setting the basis and level of social contributions for health																			
Setting the total budget for public funds allocated to health																			
Deciding resource allocation between sectors of care																			
Determining resource allocation between regions																			
Setting remuneration methods for physicians																			
Defining payment methods for hospitals																			
Financing new hospital building																			
Financing new high-cost equipment																			
Financing the maintenance of existing hospitals																			
Financing primary care services																			
Setting public health objectives																			
Financing specialists in out-patient care																			
Financing hospital current spending																			
Setting public health objectives																			

Source: elaborated by the Contractor on the basis of data included in Paris, Devaux and Wei (2010).

Note ¹: the OECD carries out the Health Systems Characteristics Survey (two rounds have been implemented so far, in 2012 and 2016) which, nevertheless, does not investigate the same aspects.

In the same period, Hope and Dexia (2009) developed another classification of the EU health systems still focussed on the supply side but based on the *prevailing type of hospital governance*. Three main types were distinguished:

- *Decentralised*, with the power of the hospital management system transferred from the state to regional or local authorities.
- *Deconcentrated*, with the management of the hospital system being controlled at the central level but operated at the territorial level through local or regional agencies/branches of the central administration.
- *Centralised*, with the management and operation of the hospital system held by the state.

This hospital governance work investigated an important area in terms of institutional settings because the ownership of healthcare facilities across the EU is often with subnational authorities. Furthermore, it highlighted the fact that the decentralisation of a health system is frequently associated to the decentralisation of the hospital system.

The groupings of countries according to the above two works are reported in Table 1.

Table 1 – Country groupings derived from relevant classifications

Level of reliance on market mechanisms for provision of health services (1)	Heavy. Importance of private providers.	Limited private supply but wide choice	Limited choice of providers, heavily regulated public systems with gate-keeping
	Austria, Belgium, Czech Republic, France, Germany, Greece, Luxembourg, Netherlands, Slovakia	Sweden	Denmark, Finland, Hungary, Ireland, Italy, Poland, Portugal, Spain, United Kingdom
Hospital management system (2)	Decentralised	Centralised	Deconcentrated
	Austria, Belgium, Czech Republic, Denmark, Finland, Germany, Hungary, Italy, Latvia, Lithuania, Poland, Slovakia, Spain, Sweden, United Kingdom	Cyprus, Estonia, Ireland, Luxembourg, Malta, Netherlands, Romania, Slovenia	Bulgaria, France, Greece, Portugal

Notes:

(1) From Joumard, André and Nicq, 2010. The six groups originally distinguished by the authors have been merged into three groups for simplification purposes.

(2) From Hope and Dexia, 2009.

1.2 Highlighting the role of LRAs in health management systems

The classifications presented in the previous paragraph do not inform on the level of decentralisation or on the institutional settings of the health management systems. In fact:

- In terms of funding mechanisms, systems relying on public taxation may be either decentralised (e.g. Denmark) or centralised (e.g. Cyprus).
- In terms of type of payers and of providers, public payers/providers may be within centralised (e.g. Malta) or decentralised types of health governance (e.g. Italy). Additionally, a few systems are solely based on one of these types of relationships, a mixed public/private provision of services being the most frequent situation regardless of the source of funding.
- Decentralisation and delegation were only two of the several indicators used in the classification based on the OECD Survey on Health System Institutional Characteristics data, and were not even steering ones. As a consequence, both centralised and decentralised health management systems may be found in the same group (e.g. Ireland and Spain).
- Hospital governance frequently but not systematically reflects the type of governance of the corresponding health management system (e.g. Estonia).

1.2.1 Criteria considered

In order to develop a classification of European health management systems which highlights the role of subnational authorities in the governance of the systems, three categories of criteria are considered:

- (1) Health funding.
- (2) Health-related power and responsibility.
- (3) Ownership, financing and management of healthcare facilities.

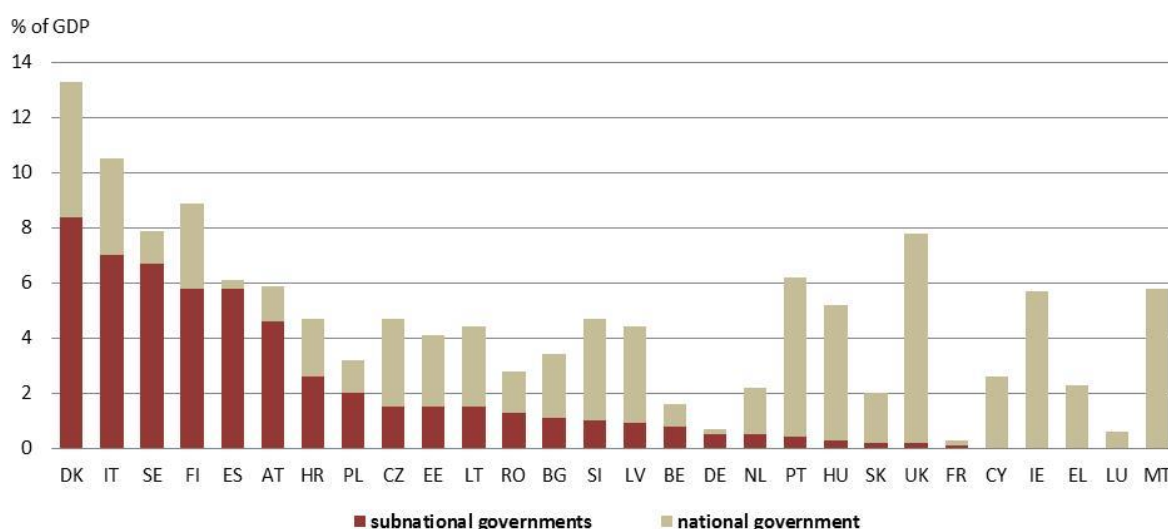
1. Health funding.

It is considered in terms of (i) presence/absence of health funding responsibility by LRAs and of (ii) level of health funding by LRAs.

Rationale: public spending by LRAs for health is an indicator of their active involvement in the functioning of the health management system. Where resources are generated locally through taxes or other levies the funding role also presumably points to some autonomy with regard to spending decisions.

Evidence: Eurostat data (Chart 1) show that subnational funding for health occurs in 23 MS. In Cyprus, Greece, Ireland, Luxembourg and Malta there is no subnational funding for health. In 9 MS, subnational funding for health is higher than national funding. In 22 countries out of 23, subnational authorities not only have funding responsibility for health but have also the capacity to raise revenues through local levies. Eurostat data (Chart 2) further show that expenditure for hospital services is the most commonly undertaken at the subnational level, followed by expenditure for outpatient services.

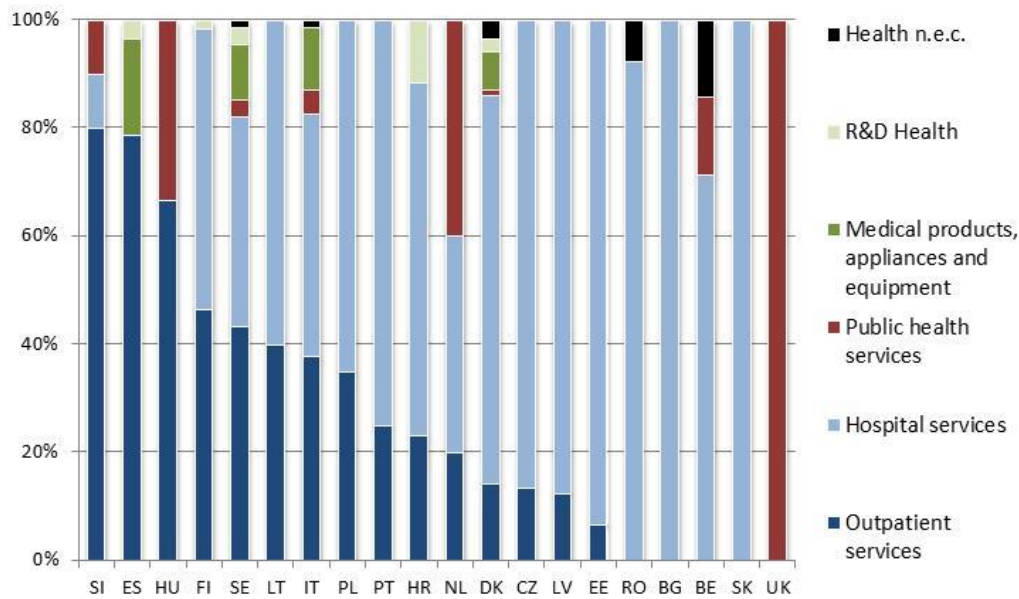
Chart 1 – National and subnational public expenditure on health, by country, 2015



Source: Eurostat table [gov_10a_exp], accessed on May 2017.

Notes: Countries are ordered from the highest to the lowest level of funding from the subnational level.

Chart 2 – Breakdown of subnational public sector expenditure on health, 2015



Source: Eurostat table [gov_10a_exp], accessed on May 2017.

Notes: data not available for Austria, France and Germany. Countries are ordered by the relative importance of expenditure for outpatient services. ‘Health n.e.c.’ stands for ‘not elsewhere classified’ expenditure for health and is defined in detail in Eurostat (2011).

2. Health-related power and responsibility.

It is considered in terms of presence/absence of power/responsibility by LRAs with regard to health legislation, health policymaking, planning of healthcare services and delivery (organisation and/or implementation) of healthcare services.

Rationale: the presence/absence of power for preparing health legislation and policy and the responsibility in operational areas such as planning, organisation and implementation of healthcare, are evidently and directly linked to the level of devolution of the health management systems.

Evidence: in five (5) MS, LRAs legislate on health-related matters. In six (6) MS, LRAs are responsible for health policymaking. In 15 MS, LRAs have health planning responsibility. In 23 MS, LRAs are responsible for and/or involved in the organisation and/or delivery of healthcare. In 20 MS, LRAs are involved in the planning and/or organisation and/or delivery of health promotion and prevention activities.

3. Healthcare facilities.

It is considered in terms of presence/absence of ownership by LRAs of hospitals, clinics or other infrastructure where healthcare is delivered. The focus is on the financing (including capital investments) and management of the facilities.

Rationale: ownership usually implies funding responsibilities and, in most cases, management functions that may be implemented directly by LRAs (which then become service providers) or be contracted out to third party providers.

Evidence: ownership of healthcare facilities by LRAs is found in 20 MS. Ownership always implies financing responsibilities, either in terms of capital investments and/or funding of recurrent and operational costs. Ownership implies direct or indirect (i.e. through third parties) management of the facilities by LRAs in 18 countries. In two countries LRAs are responsible for the management/financing of healthcare facilities without owning them. In only six countries LRAs do not own healthcare facilities, nor do they manage/finance them.

1.2.2 Outlining the types

Types are outlined classifying the countries against each of the three main categories of criteria presented above. As a result of the classification, five types of health management systems are distinguished:

- Decentralised.
- Partially decentralised.
- Operatively decentralised.
- Mostly centralised.
- Centralised.

The above terminology is clarified in Box 2. Table 2 characterises the five types.

Box 2 – The terminology used in the governance-based classification

Several forms and definitions of decentralisation exist in literature. A simplified terminology which focuses on the level of transfer of power (or authority), responsibility and functions to LRAs is used in this study to distinguish among three types of decentralisation.

- Decentralised: with the exception of some main framing conditions, the power, responsibility and functions for health are not with the central government but with lower, elected levels of government.

- Partially decentralised: some of the power, responsibility and functions for health are transferred/devolved from the central government to lower, elected levels of government. The central government still has a role within the health management system, the importance of this role varying depending on the level of devolution.
- Operatively decentralised: the central government has an important role within the health management system but some operative functions are held by lower levels of elected government.

With regard to centralised health management systems, a distinction is made on the basis of a funding criterion.

- Mostly centralised: most of the power, responsibility and functions are with the central government (or are deconcentrated – see below), but lower levels of elected government still have a minor role including in relation to health expenditure.
- Centralised: all of the power, responsibility and functions are with the central government or are deconcentrated, i.e. are given to entities at the territorial level which represent the central level.

Source: elaborated by the Contractor.

Type 1 ‘decentralised’ includes five countries: **Italy, Spain, Austria, Germany and the United Kingdom.**

- In these countries regional authorities have legislative power with respect to health – or to some specific segments of health, such as inpatient care in Austria.
- They are usually responsible for the management (from policy to planning to organisation) and operation of the health system within their administrations.
- With the exception of the UK, funding through subnational budgets (as % of GDP) is well above the national share.
- Furthermore, regional authorities (and often local authorities as well) have revenue-raising power, mainly through taxation, and own healthcare facilities.
- In all cases, regional authorities are also responsible for public health, whose implementation is often devolved to local authorities (e.g. in Germany).

Two distinct tendencies are found in decentralised systems.

- The first relates to the strengthening of the cooperation and coordination mechanisms among the various actors of the system. This is the case of Italy and its State-Regions Conference, and of Austria, where new organisational and steering commissions have been established to pursue cooperative governance.
- The second tendency is to strengthen competition in the health system, hence also emphasising the privatization of health services. This is the case of Germany and of England (UK).

Table 2 – Characterising the types

Type	DECENTRALISED	PARTIALLY DECENTRALISED	OPERATIVELY DECENTRALISED	MOSTLY CENTRALISED	CENTRALISED
LRA's role					
Revenue-raising capacity	Yes	Yes	Yes	Yes	No
Funding level	Above the central level (exception: UK)	Above the central level (equal in BE)	Below the central level	Below the central level	Nil
Legislative power	Yes	No	No	No	No
Policy power	Yes	No	No	No	No
Planning responsibility	Yes	Yes	No (exceptions: LT, CZ)	Yes, for specific segments	No
Delivery responsibility (organisation/implementation)	Yes	Yes	Yes		No
Facilities ownership & management	Yes	Yes	Yes	No	No
Countries	Italy, Spain, Austria, Germany, United Kingdom	Sweden, Finland, Denmark, Croatia Poland, Belgium	Lithuania, Slovenia, Latvia Czech Republic, Hungary, Estonia, Bulgaria, Romania, Slovakia	the Netherlands, France, Portugal	Cyprus, Greece, Ireland, Luxembourg, Malta

Source: elaborated by the Contractor.

Decentralisation implies a level of autonomy of subnational authorities which may result in disparities in the way healthcare is delivered across the country. This problem is noted in Spain and Italy, the two systems which stand out in the group for the level of power, responsibilities and functions that LRAs have. Other concerns in decentralised systems may relate to funding autonomy. In

Austria, the funding autonomy of regional authorities is limited in terms of revenue-raising capacity when compared to the responsibilities they hold. In Spain, the regions' autonomy in spending decisions limits the central government's capacity to control the financial sustainability of the systems.

Type 2 'partially decentralised' includes six countries: **Sweden, Finland, Denmark, Croatia, Belgium and Poland.**

- In these countries, some of the responsibility and functions of the health management system are devolved to local and/or regional authorities. In Sweden, Finland and Denmark, for example, subnational authorities are in charge of organising and/or delivering primary and secondary care.
- In all countries, health funding through subnational budgets (as % of GDP) is well above the national share, with the exception of Belgium where the national and subnational shares are equivalent.
- In the partially decentralised systems, subnational authorities own and/or manage healthcare facilities, have revenue-raising power and funding responsibility, and are involved in health promotion and prevention activities.

Countries belonging to this type have different levels of decentralisation and – apart from Belgium where the 2014 state reform gave regional authorities more spending responsibility and competences – they still experience an evolving situation. In Croatia, for example, evolution is expected in terms of reorganisation of competences and fiscal relations while in Sweden and Denmark a strengthened coordination and cooperation among relevant government levels of the system is envisaged. In Finland, a health, social services and regional government reform is expected to enter into force in 2020, which will transfer the responsibility of healthcare from the local level to newly established regional authorities.

Similarly to the decentralised systems, differences in access and quality of healthcare services may occur (e.g. in Sweden and Finland) in the partially decentralised systems as a consequence of the high level of autonomy of subnational authorities.

Type 3 ‘operatively decentralised’ includes nine countries: **Lithuania, Bulgaria, Slovakia, Slovenia, Romania, Estonia, Hungary, Czech Republic and Latvia.**

Central authorities have an important and leading role within the health management systems of these countries. However, subnational authorities own and manage healthcare facilities and as a consequence have an operational function in the provision of healthcare services. The relevance of this operative role varies across countries. For example, it is high in Lithuania and the Czech Republic and modest in Hungary and Latvia. In the operatively decentralised systems, the funding from subnational budgets is limited and lower than the national share. The tendency of these systems is variable, although evolution towards lesser decentralisation is common. Among the most common concerns is the low cost-effectiveness of the systems.

Type 4 ‘mostly centralised’ includes three countries: **France, Portugal and the Netherlands.**

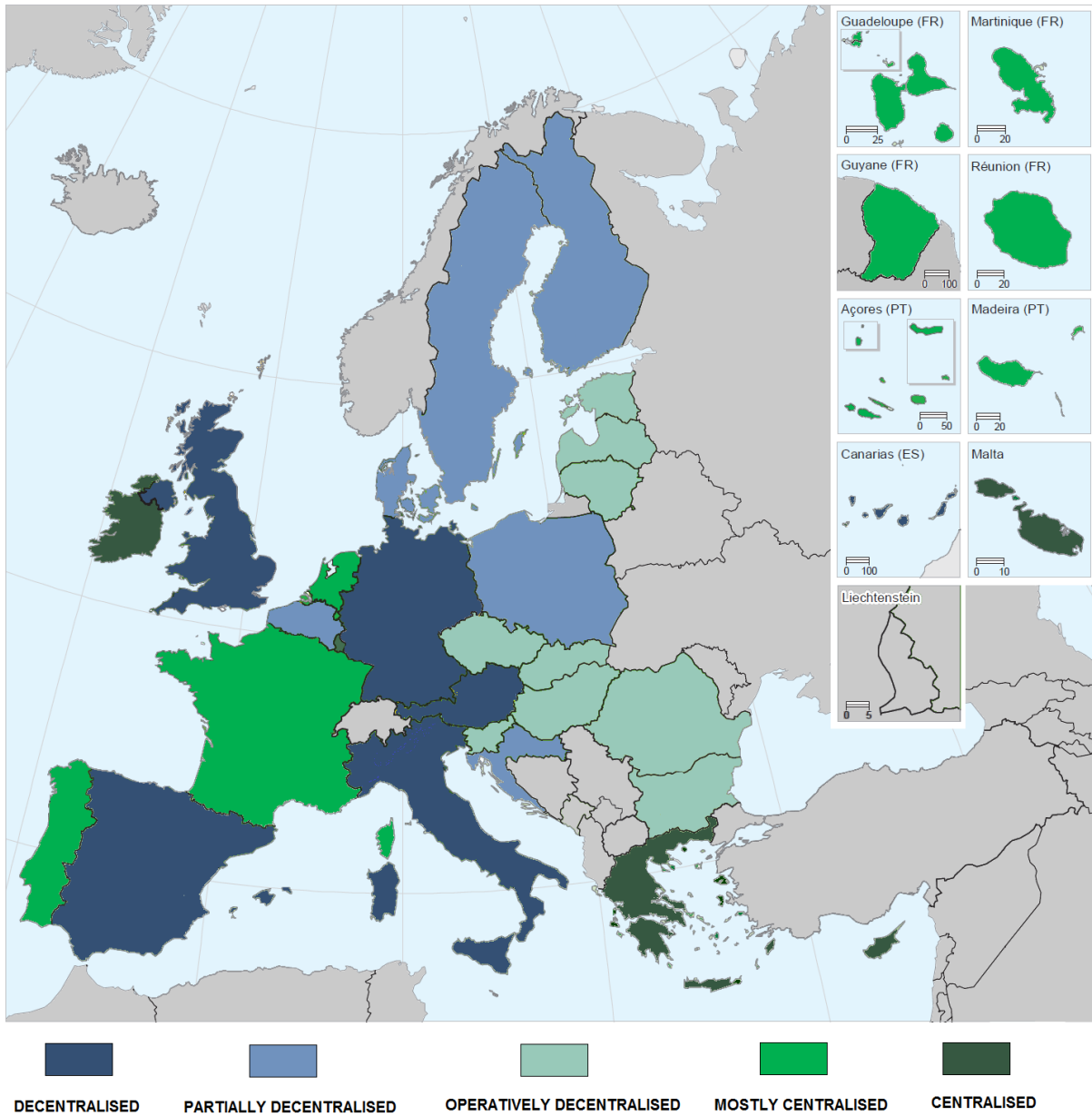
In these countries, the power and most of the responsibilities for the health management system lie with the central government but subnational authorities are given specific functions, including those related to public health. Subnational authorities also contribute, although with a small share, to the funding of health and have the capacity of raising their own revenues. In France and Portugal, the system is structured at the territorial level through entities representing the central administration, while in the Netherlands it is market-based.

Type 5 ‘centralised’ includes five countries: **Cyprus, Greece, Ireland, Luxembourg and Malta.**

In these countries the central level holds the power and responsibility for health as well as for the functioning of the health management system. Health funding is only from the central level. Planning and delivery is also a central task, and healthcare facilities are owned and managed by the state. In Ireland and Greece, the system is structured at the territorial level through entities representing the central administration. Within this group, Malta is an exception in that local authorities have a small role in the management of small clinics and in the delivery of some services, especially in peripheral areas.

The five types of health management systems across the EU are visualised in Map 1.

Map 1 – Governance-based classification of health management systems



Source: elaborated by the Contractor.

2. Country profiles

This section describes the role local and regional authorities (LRAs) have within health management systems with respect to health policymaking, legislation, planning, implementation and funding. This is done through the development of 28 country profiles, one for each EU Member State. The length of each profile is maximum three pages. Profiles outline:

- Synthesis of key characteristics.
- Structure of the health management system and main responsibilities.
- Service delivery, health prevention and promotion.
- Financing.
- Synopsis and evolution of the structure of the system.

The section on evolution reports on important structural reforms which have taken place since the publishing of the 2011 study and on whether these reforms resulted in greater or lesser involvement of LRAs in the management of the health systems.

2.1 Main data sources

Profiles have been developed on the basis of desk research. Among the most relevant sources are:

- The Health Systems in Transition (HiT) series of reports and online country profiles by the European Observatory on Health Systems and Policies. Online profiles are kept up-to-date and are accessible from the Health Systems and Policy Monitor (HSPM) platform (<http://www.hspm.org/>).
- The country documents of the 2016 Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability prepared by the European Commission's Directorate-General for Economic and Financial Affairs and the Economic Policy Committee (Ageing Working Group).
- The 2014 country updates of the 'Analytical support on social protection reforms and their socio-economic impact' (ASISP), providing relevant syntheses of healthcare systems and of recent reforms.

In a number of cases, reference was directly to the website of relevant ministries and/or of bodies/agencies dealing with health within individual countries and to the information made publicly available there. Hospital governance-related information was gathered through various sources while statistics on private and public hospitals were downloaded from the OECD.stat dataset online ‘Healthcare Resources’. The online version of the ‘Health at a glance: Europe 2016’ report (EU/OECD, 2016) and related datasets were the main reference for data on health expenditure. Finally, the 2017 European Semester Country Reports and the Country Specific Recommendations (CSR) issued by the Council on 11 July 2017 were used to highlight major areas of concerns, if any, related to the financing of health systems in the frame of existing reform processes.

2.2 On the infographics

Country profiles are by nature descriptive but efforts have been made to provide immediate, visual information on important characteristics of the health systems. The infographics used towards this scope are illustrated in Box 3.

Box 3 – Infographics used in the country profiles
 Besides charts, other infographics are used in the profiles to visually provide key messages. The level of devolution of the management systems to LRAs is indicated using simple target illustrations.

central management **prevailing central management** **partially decentralised management** **decentralised management**

Icons with centrifugal and centripetal arrows indicate the tendency of the structure of a system according to recent reforms. In particular, the icon with centrifugal arrows indicates a tendency towards decentralisation. The icon with centripetal arrows indicates a tendency towards centralisation.

tendency to decentralisation **stable, no tendency** **tendency to centralisation**

Where LRAs hold competences within the system, these are summarised into blue boxes. If LRAs are the owners of healthcare facilities, this is indicated using yellow boxes.

Within boxes, L stands for ‘local’ authorities and R for ‘regional’ authorities.

COMPETENCES	OWNERSHIP
<ul style="list-style-type: none"> • planning: R, L • funding : R, L • public health: L 	<ul style="list-style-type: none"> • polyclinics: L

Source: elaborated by the Contractor.

2.3 Country profiles

The main findings outlined in the profiles on the role of LRAs within their national health management systems are summarised by country in Table 3.

Table 3 – Overview of the role of LRAs within health management systems, by country

	legislative	planning	implemen tation	funding		legislative	planning	implemen tation	funding
AT	●	●	●	●	IE	⊘	⊘	⊘	⊘
BE	⊘	●	●	●	IT	●	●	●	●
BG	⊘	⊘	●	●	LT	⊘	●	●	●
CY	⊘	⊘	⊘	⊘	LU	⊘	⊘	⊘	⊘
CZ	⊘	●	●	●	LV	⊘	⊘	●	●
DE	●	●	●	●	MT	⊘	⊘	⊘	⊘
DK	⊘	●	●	●	NL*	⊘	●	●	●
EE	⊘	⊘	●	●	PL	⊘	●	●	●
EL	⊘	⊘	⊘	⊘	PT	⊘	⊘	●	●
ES	●	●	●	●	RO	⊘	⊘	●	●
FI	⊘	●	●	●	SE	⊘	●	●	●
FR *	⊘	●	●	●	SI	⊘	⊘	●	●
HR	⊘	●	●	●	SK	⊘	⊘	●	●
HU	⊘	⊘	●	●	UK	●	●	●	●

Legend: ● = LRAs have a role; ⊘ = LRAs do not have a role

Notes: * the decentralisation indicated for France is solely determined by the functions of subnational governments in the so called ‘third sector’ which relates to the health and social care of the elderly and the disabled. In this sector, general councils at the departmental level have planning, implementation and funding responsibilities (see country profile of France for more details). Nevertheless, the French health management system classifies as mostly centralised. The same applies to the Netherlands, where municipalities have planning and delivery functions for specific groups (e.g. the youth). Also the Dutch health management system classifies as mostly centralised.

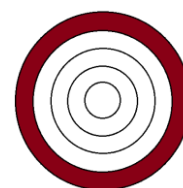
AUSTRIA

Key characteristics

- ▶ Decentralised: important competencies are devolved to regional authorities (Provinces) as well as to social security institutions
- ▶ Provides universal coverage through statutory social health insurance
- ▶ Health expenditure is mostly funded through public funds – out of social insurance contributions and taxation
- ▶ Mixed service provision – public and private

Structure of the health management system and main responsibilities

The Federal Government is responsible for overall health policy and legislation. It also has a supervisory and facilitating role among the numerous actors involved in healthcare, with several functions being shared with, or devolved to, the nine regional authorities and the social security institutions. Regional authorities are responsible for enforcement legislation, policies, and implementation of inpatient care while the social security institutions, as self-governing bodies, have regulatory functions with respect to outpatient health services (Fink, 2014; ÖBIG, 2013). Cooperation among the various stakeholders within the health sector is regulated by law. Planning of the sector is through a national Health Care Structure Plan and Regional Health Care Structure Plans (ÖBIG, 2013).



Main institutional actors include: (i) at the national level, the Federal Health Agency and its executive body, managed by the Federal Ministry of Health and composed of representatives from all government levels as well as from social security institutions, the Austrian Medical Chamber, church-owned hospitals, and patient representatives; (ii) at the regional level, the Regional Health Funds (RHF). RHF are the implementation branches of the Federal Health Agency and include in their executive bodies (i.e. the Regional Health Platforms) representatives of the respective regions, of the Federal Government, of the umbrella organisation of the 22 social security institutions (i.e. the Main Association of Austrian Social Security Institutions), of the Austrian Medical Chamber, of local governments, and of hospital organisations. RHF pool and distribute funds to public and private non-profit hospitals (ÖBIG, 2013).

In order to make decisions, broad consensus is required both at the national and regional levels (Hofmarcher, 2013). The health reform approved in 2012 aimed, among other goals, at improving the governance structure of this articulated system. The reform implied institutional strengthening for the delivery of the so

called ‘governance by objectives’ approach, and improvement of cooperation among the various stakeholders through the establishment in 2013 of additional organisational and steering commissions at the federal and regional levels. The new commissions include representatives from the Federal Government, the regions and the insurance funds. They coordinate cooperative governance and planning of service delivery against contractually set objectives and budget caps (Hofmarcher, 2013; Fink, 2014).

Service delivery, health prevention and promotion

The social insurance system is based on statutory insurance regulated by law. Health insurance may be provided by various health insurance funds. People may not choose their social security institution as affiliation depends on profession, place of work, or place of residence (EC, 2016). Insurance provides free access to a benefits package. User charges may apply in the form of out-of-pocket (OOP) payments or co-payments (Hofmarcher, 2013). Access to health services is not regulated, in that patients are not obliged to enrol with one specific physician and physicians do not play a gate-keeping role. Primary care is mostly provided by self-employed physicians working in individual practices (EC, 2016). Outpatient care is provided through physicians, outpatient clinics – privately owned or belonging to the insurance funds – other specialists, and outpatient departments of hospitals. Physicians usually have a contract with the insurance funds (EC, 2016; ÖBIG, 2013).

Regional authorities are responsible for the implementation of hospital care and the maintenance of public hospitals’ infrastructure (ÖBIG, 2013). The ownership of hospitals is 55% public (the owners being regional authorities, local authorities, or social insurance institutions, directly or through companies) and for the remaining share, private (the owners being, for example, religious orders and associations) (OECD.stat online). The management of public hospitals is given to private service providers (companies) in all regions but Vienna (Hofmarcher, 2013). As owners of hospitals, regional authorities have funding responsibility for current expenditure, maintenance and investment costs.

Health promotion and prevention services are cooperatively implemented by the Federal Government, the regions and social insurance institutions (ÖBIG, 2013).

Financing

In 2014, 75.9% of total health expenditure was from public sources and the remaining 24.1% from private sources (EU/OECD, 2016). Thus, the healthcare system is primarily financed through public funds, the main sources of revenue for which are (income-based) social insurance contributions (44.7% in 2014) and government schemes (31.1% in 2014) (EU/OECD, 2016).

Public income is from the Federal Government and the regional and local governments. However, regions have limited taxation power and their revenues are for the most part represented by shares of general taxation (Hofmarcher, 2013).

Private financing within total health expenditure is sourced from OOP payments (17.7% in 2014) and, to a lesser extent, from voluntary health insurance (4.9% in 2014) (EU/OECD, 2016).

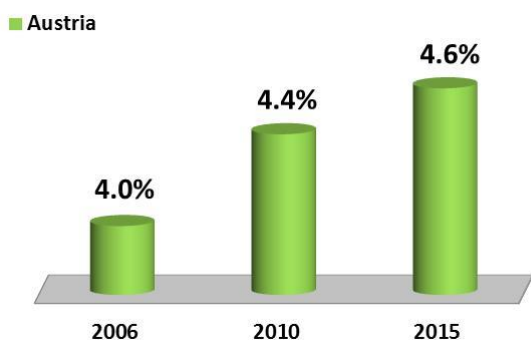
Synopsis and evolution of the structure

In the Austrian health system some tasks are devolved to regions by constitution. The 2012/2013 reform further consolidated this institutional setting as it left main responsibilities and power unchanged while fostering (i) the improved coordination of the actors involved and (ii) the sharing of common quality, efficiency and budgetary goals among these actors.



Austria has underutilised outpatient care and high levels of hospitalisation which are reflected in one of the highest proportion of spending for this area in the EU. Already in 2016, the EC noted that the spending responsibility of the subnational governments for healthcare as well as for investments and maintenance costs of public hospitals was not counterbalanced by a proportional revenue-raising power (EC, 2016a). This mismatch was also outlined, although in more general terms, in the 2017 European Semester Country Report (EC, 2017). The first 2017 Country Specific Recommendation (CSR 1) advocates a more rational and streamlined allocation of competences across the various levels of government, fiscal decentralisation, and the sustainability of the healthcare system. The latter is considered to be at risk in the medium to long term because of projected increase of healthcare spending driven by ageing population (CONS, 2017).

LRAs' spending for health as % of GDP



LRAs' competences and owned facilities

COMPETENCES	OWNERSHIP
<ul style="list-style-type: none"> • legislation: R • policy: R • planning : R, L • delivery: R, L • funding: R, L • public health: R 	<ul style="list-style-type: none"> • hospitals: R, L

R = Regional L = Local

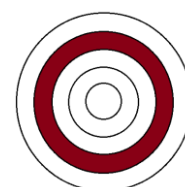
BELGIUM

Key characteristics

- ▶ Partially decentralised: some responsibilities are shared between the federal government and the federated authorities (communities, regions)
- ▶ Provides universal coverage through compulsory insurance
- ▶ Health expenditure is mostly funded through public funds – out of social security contributions and taxation
- ▶ Mixed service provision – public and private, with an important role of the private sector

Structure of the health management system and main responsibilities

Reflecting the institutional setting and devolution of the country, responsibility for the health system is at two levels of government: the central (federal government) and the regional one (the federated authorities, including three regions and three communities – Flemish, French, and German). The central level, through the Ministry of Social Affairs and Public Health, retains the most important power and is responsible for proposing health legislation, for health budgeting, and for the regulation and financing of the compulsory health insurance. Accountable to the Minister, the National Institute for Health and Disability Insurance is a public institution that manages the compulsory health insurance through six private, non-profit national associations of sickness funds and one public sickness fund (EC, 2016). Sickness funds negotiate with healthcare providers and pay for services. The central level also regulates the pharmaceutical sector and controls the hospital sector (EC, 2016), for example in terms of accreditation criteria.



At the regional level, federated authorities were given more health-related competences by the 6th state reform agreed in 2011 and entered into force in July 2014. Their competences include: health prevention and promotion; investments in hospital infrastructure and in heavy medical equipment; responsibility for isolated geriatric and specialised hospitals; care for the elderly and for the disabled (and long-term care); mental healthcare; and support to the organisation of primary care (HiT online; Van de Voorde *et al.*, 2014; Segaert, 2014).

Both the central and the regional levels are responsible for health policy. Cooperation between the different levels is through inter-ministerial conferences, composed of ministers responsible for health policy from the respective governments. These conferences may produce protocol agreements on specific areas such as long-term and elderly care, vaccination programmes, and cancer screening.

At the local level, healthcare responsibility is limited. In particular, municipalities are responsible for organisational tasks (e.g. in emergency care) (HiT online).

Service delivery, health prevention and promotion

The compulsory insurance coverage provides access to a wide benefits package. Health insurance membership is based on current or previous professional activity and provides for the universal coverage of the population. Outpatient care is usually delivered upon up-front payment by patients that will be reimbursed later through their sickness funds. For inpatient care and medicines, patients only pay user charges, as the sickness funds pay the providers directly (third party payer system).

Primary care is mainly provided through general practitioners (GPs) working in solo or group practices. GPs do not function as gate-keepers and generally operate from their premises as independent professionals (EC, 2016). Patients are free to choose their doctor and can access both specialists and hospitals directly. Outpatient care is provided mainly in hospital outpatient departments. Secondary care – comprising inpatient care and day care – is provided in hospitals (EC, 2016). Hospitals are classified into general (acute, geriatric and specialised) and psychiatric. In 2013, there were 127 general hospitals and 65 psychiatric hospitals. The majority (56%) of hospitals are non-profit private and are mostly owned by religious orders or, to a lesser extent, by sickness funds and universities. The remaining 44% of the hospitals are public institutions, owned by public municipal welfare centres or inter-municipal associations (Van de Voorde *et al.*, 2014).

Each regional authority has its own policy and objectives for health prevention and promotion but some initiatives are undertaken on a cooperative basis with the central level (e.g. some vaccinations).

Financing

Healthcare expenditure is mainly publicly funded (77.6% in 2014), with the main sources being social security contributions and taxation (EU/OECD, 2016). Taxation is both general and earmarked with regard to taxes derived from VAT income (EC, 2016). In 2014, the private share of total healthcare expenditure was 22.4%, out of which 17.8% came from out-of-pocket payments and 4.4% from voluntary health insurance (EU/OECD, 2016).

Regional and local expenditure for health is made up of regional and local taxes plus transfers from the federal taxes (HiT online). In 2014, total general expenditure for health was equally borne by the central and the subnational levels (Eurostat data online).

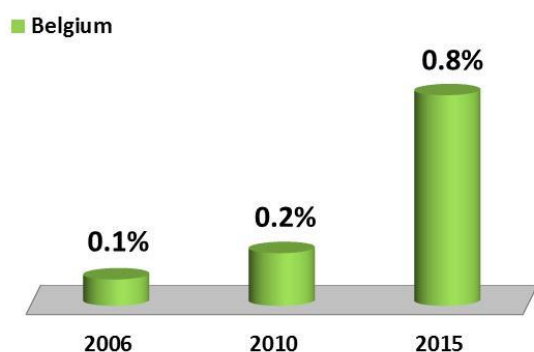
Synopsis and evolution of the structure

The Belgian health system is partly devolved to regional authorities in terms of policymaking, planning and organisation while delivery relies importantly on the private sector. Regional authorities also have a role in inpatient care and in funding. Furthermore, by means of inter-municipal associations, local governments participate in the ownership of healthcare infrastructures.

The autonomy and spending responsibility of regions was increased with the Special Finance Act which accompanied the 6th state reform and entered into force in January 2015. The reform itself, establishing a new repartition of competences among the levels of government, gave regional authorities more supporting and organisational competences in the policy area of health (Segaert, 2014).



LRAs' spending for health as % of GDP



LRAs' competences and owned facilities

COMPETENCES	OWNERSHIP
<ul style="list-style-type: none"> • policy: R • planning : R • organisation: R • funding: R, L • public health: R, L 	<ul style="list-style-type: none"> • hospitals: L

R = Regional L = Local

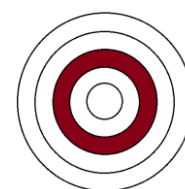
BULGARIA

Key characteristics

- ▶ Operatively decentralised: important role of the central level but local authorities (municipalities) have some implementation functions for healthcare delivery
- ▶ Provides coverage through compulsory insurance
- ▶ Mixed funding of health expenditure: through public revenues – out of statutory health insurance contributions and taxation, and private sources
- ▶ Mixed service provision – public and private

Structure of the health management system and main responsibilities

Main actors in the health system are at the central level and include: i) the National Assembly, responsible for health policy and budgetary matters; ii) the Ministry of Health (MoH), administering the budget and managing the national health system through a public health network of Regional Health Inspectorates (RHIs) and national centres; iii) the High Medical Council, an advisory body to the MoH, gathering together representatives of several stakeholders at the government, professional and civil society levels, among which is one representative of the National Association of Municipalities; and iv) the National Health Insurance Fund (NHIF), under the MoH, a public non-profit organisation administering the compulsory health insurance and financing the health system. The NHIF has branches at the regional level (28 regional health insurance funds - RHIFs) and offices at the municipal level. It establishes contracts with healthcare providers (e.g. physicians, institutions) for guaranteeing access to outpatient and inpatient care by the insured (HiT online; NHIF website).



Municipalities own local hospitals and other outpatient healthcare facilities, hence they hold operative functions as healthcare providers. Municipalities may also have a share in the ownership of inter-regional and regional hospitals, for example in the form of joint-stock companies. Finally, municipal healthcare offices organise healthcare at the municipal level, contributing to its financing through locally levied taxes (HiT online).

Service delivery, health prevention and promotion

The health insurance system is based on compulsory insurance and on payments from employees based on wages. Some social groups are covered by state and municipal budgets (e.g. pensioners and children). Insurance is based on citizenship and residence. The system is regulated by the Health Insurance Act and is designed as a state monopoly. The undertaking of voluntary health insurance is possible but limited. In 2014, 7% of the population was not covered but some categories of people have access to healthcare regardless of their insurance status (e.g. pregnant women), while some other categories started being covered in the second half of 2015 further to amendments made to the Health Insurance Act (EC, 2016). Insurance provides free access to a benefits package and free choice of any service provider who has concluded a contract with the RHIFs. Co-payments and user charges may apply. Primary and outpatient care have been mostly privatised and are provided through individual and group practices. General practitioners function as gate-keepers to specialised and secondary care. Inpatient care is provided by general and specialised healthcare facilities and hospitals. Hospitals may be public (owned by the state and/or municipalities) or private. If the hospital is private and does not have a contract with the NHIF, patients must pay in full for the services.

Health prevention and promotion is centrally planned, organised and implemented through the state-controlled RHIs and with the support of several national centres such as the National Centre of Public Health Protection (Dimova *et al.*, 2012). At the local level, municipalities implement and finance local programmes (HiT online).

Financing

Private healthcare expenditure in Bulgaria is the second highest across the EU after Cyprus. In 2014, out-of-pocket (OOP) payments for user charges and co-payments accounted for 45.8% of total health expenditure (EU/OECD, 2016). Private revenues from voluntary health insurance have a minor role. In the same year, public funding accounted for 53.0% of total health expenditure, mostly out

of compulsory payroll-based health insurance contributions (44.2%) and state and municipal budgets (8.8%) (EU/OECD, 2016). The central budget revenue allocated to health is from general taxation (VAT, income tax, corporate tax).

Municipalities receive transfers from the state to carry out health-related activities and in addition raise financial resources locally through local levies such as waste charges and building tax (Dimova *et al.*, 2012).

Synopsis and evolution of the structure

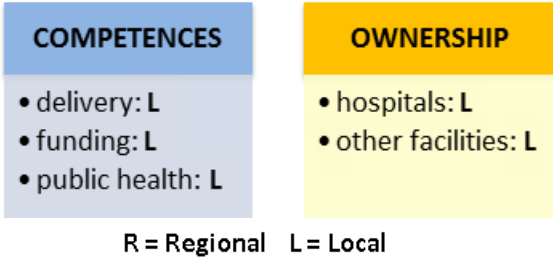
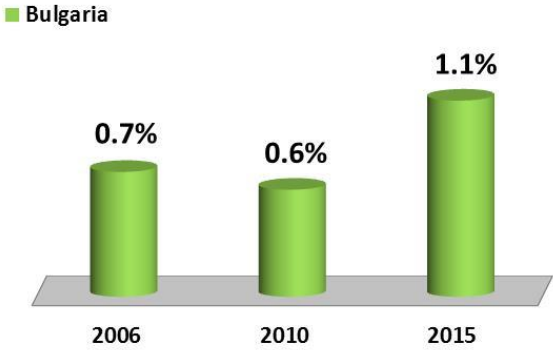
The role of local governments in the Bulgarian system is relevant at the delivery level where they qualify as owners of hospitals and of other healthcare facilities. Apart from this operational function, the power and responsibility for health remain with the central level. Last reforms did not change or influence the structure of the system from the point of view of governance.



In general, on-going reform attempts are aimed at addressing identified problems of the system which include, among other aspects, limited accessibility to healthcare, low funding, low insurance coverage, and high OOP payments (EC, 2017). The increase of health insurance coverage and the reduction of OOP payments are also included in 2017 CSR 3 (CONS, 2017).

LRAs’ spending for health as % of GDP

LRAs’ competences and owned facilities



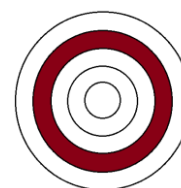
CROATIA

Key characteristics

- ▶ Partially decentralised: several responsibilities for health lie with the regional level (counties), especially with regard to the delivery and funding of healthcare
- ▶ Provides universal coverage through statutory insurance
- ▶ The majority of health expenditure is funded through public funds – for the most part out of social insurance contributions and taxation
- ▶ Mixed service provision – public and private

Structure of the health management system and main responsibilities

At the central level, the Ministry of Health (MoH) is responsible for health policy, planning, regulation and, together with the Ministry of Finance, budgeting. It also evaluates public health and manages health prevention and promotion activities. Among other national institutions dealing with health aspects, the Croatian Health Insurance Fund (CHIF) has a central role as it is the public body responsible, since 1993, for the implementation of the compulsory health insurance. Although independent, the CHIF is accountable to the Ministries of Health and of Finance. It centrally purchases the services to be delivered under the insurance scheme and administers the contracts with public or private healthcare providers (e.g. general practitioners – GPs, hospitals) through a network of regional offices and branches (Džakula *et al.*, 2014).



Regional governments (counties and the city of Zagreb) own and operate healthcare facilities for the provision of primary and secondary care (Džakula *et al.*, 2014; Bodiroga-Vukobrat, 2014). Since 2008, they are responsible for the preparation and implementation of regional health plans – which must be in line with the National Health Plan – and for the programming of investments in the infrastructure they own (Džakula *et al.*, 2014).

Service delivery, health prevention and promotion

Compulsory health insurance is based on citizenship and residence and provides free access to a benefits package. However, co-payments are common as some services are not fully covered and others are not included in the package. Exemptions to co-payments apply to certain categories of people (e.g. those with low income) while others (e.g. disabled) are given free supplementary health insurance with contributions paid by the state (Džakula *et al.*, 2014).

Primary care is usually accessed through GPs, or nurses, who function as gate-keepers. GPs practice individually, in larger units, or in regional health centres where other services (e.g. dental care) are also made available (Džakula *et al.*, 2014). There were 49 of these centres in 2014 (CIPH, 2016). Healthcare facilities at secondary level include polyclinics and hospitals, where the latter are distinguished into general and specialist. There were 73 facilities in 2014, out of which 15 were privately owned (CIPH, 2016). Health centres, all general, and most of the specialist hospitals are owned by the regional authorities (Džakula *et al.*, 2014). Specialised care at tertiary level is delivered in clinics, clinical hospitals and clinical hospital centres which are owned by the state (Bodiroga-Vukobrat, 2014).

Regional authorities also own pharmacies and institutes for emergency medical aid, home care and public health (CIPH, 2016). In fact, emergency care is provided through a network of regional institutes for emergency medicine which are controlled by the Croatian Institute for Emergency Medicine. Similarly, public health services are delivered through a network of 21 public institutes at the regional level – owned by the regions – and one supervisory and coordinating institute at the national level under the MoH (Džakula *et al.*, 2014).

Financing

In 2014, 75.2% of total health expenditure was from public sources, the main one being the contributions paid to the compulsory social insurance (72.7%). In the same year, private expenditure for health was 24.8% of total health expenditure, out of which 16.7% related to out-of-pocket payments and 8.1% to voluntary health insurance (EU/OECD, 2016). Voluntary health insurance may be provided by the CHIF or by commercial insurers (Džakula *et al.*, 2014).

Since 2015, all primary healthcare providers and hospitals are paid/financed by the CHIF (EC, 2016). Main revenues of the CHIF include (i) contributions from the employees, the self-employed and farmers (76% in 2013), and (ii) state budget taxation which pools national, regional and local taxes (15% in 2013). The remaining 9% is made up by co-payments, revenues from supplemental health insurance and other types of contributions (e.g. from car insurance) (Džakula *et al.*, 2014).

While some of the national taxes are earmarked for health, those generated at the regional (county) and local (municipality) levels are freely allocated by subnational governments according to their priorities. Local taxes include revenues from income surtax and real estate tax. Capital investments are funded by the state budget. Regional budgets may be used for additional investments in hospitals owned by the regions (Džakula *et al.*, 2014).

Synopsis and evolution of the structure

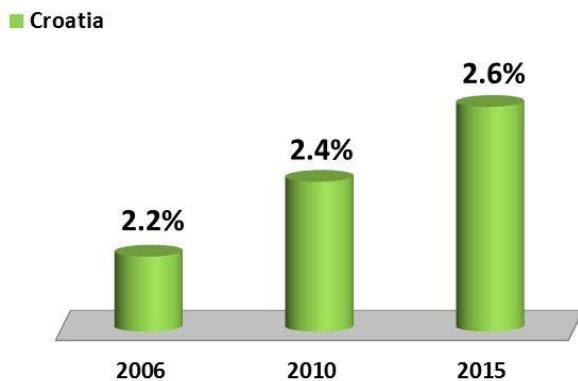
The Croatian health management system is devolved to regional authorities in terms of planning and organisation as well as delivery of several services (including primary, secondary and emergency care) in the light of the fact that regions are the owners of principal healthcare facilities. Still, the central government retains a supervisory and coordinating role, not to mention the relevance of the financing of decentralised activities through a centralised mechanism.

Since 2008, most of the implemented and/or envisaged reforms in the health sector have attempted to stabilise the system financially, in some cases reducing the autonomy of subnational authorities. An example for that is the Act on Sanation (i.e. healing) of Public Institutions adopted in 2012, which aimed to stabilise heavily indebted hospitals owned by regional governments by transferring the management rights of these hospitals to the central level (Bodiroga-Vukobrat, 2014). The accumulation of health sector arrears is one of the concerns expressed in the 2017 European Semester Country Report. Among other issues raised in the report are access inequalities and the fiscal sustainability of the health system, related also to its high dependence on social security contributions which in practice are only due from one third of the population. Hence, there is a need to reorganise competences at the territorial level as well as fiscal relations (e.g. fiscal capacity, financing mechanisms) across levels of government in order to tackle efficiency and fair delivery of public services (EC, 2017; CONS, 2017).

Overall, the tendency of the system towards a greater or lesser involvement of subnational governments seems to be part of a wider evolution of the country's decentralisation process.



LRAs' spending for health as % of GDP



LRAs' competences and owned facilities

COMPETENCES	OWNERSHIP
<ul style="list-style-type: none"> • planning: R • delivery: R • funding: R, L • public health: R 	<ul style="list-style-type: none"> • hospitals: R • health centres: R

R = Regional L = Local

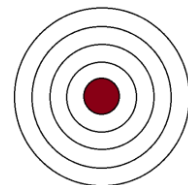
CYPRUS

Key characteristics

- ▶ Centralised: all power and responsibilities are held by the national government
- ▶ Only 85% of the population is currently entitled to healthcare coverage
- ▶ Public healthcare financing is through general taxation but private financing share of health is the highest across the EU
- ▶ Mixed service provision – public and private

Structure of the health management system and main responsibilities

Cyprus has been planning the reform of its national health system since 2001. To date, the reform is still unimplemented although it has come to a crucial point with the parliamentary scrutiny of the draft legislation having started in November 2016 (Presidency Unit for Administrative Reform, 2017). The reform programme is expected, among other aspects, to base the funding of the system on compulsory health insurance contributions, to restructure the provision of primary healthcare, and to reform the hospital sector giving more autonomy to public hospitals (EC, 2017). The (still) draft General Health System (GHS) is planned to be fully implemented by June 2020 (Presidency Unit for Administrative Reform, 2017).



Established by Law 89(I)/2001, the Health Insurance Organisation is the public legal entity in charge of implementing the new GHS. Currently, under the Council of Ministers, the Ministry of Health is responsible for health-related planning, management, budgeting, decision making and proposition of legislation. Through the Department of Medical and Public Health Services, it governs the medical institutions and is responsible for the

organisation and provision of healthcare and public health services (HiT online). Services are provided through Government Medical Services governed by Government Medical Institutions (Amitsis and Phellas, 2014). Private provision of services is important, to such an extent that the country is considered to have a dual delivery system, a public and a private one (HiT online).

Service delivery, health prevention and promotion

Coverage by the public healthcare system gives access to a comprehensive benefits package (EC, 2016). About 85% of the population is covered (EC, 2017) but only 70% is entitled to benefit from the services for free (EC, 2016). In fact, since August 2013, the number of the several existing exemptions was reduced and minimal fees for some specific services were introduced (Amitsis and Phellas, 2014). Patients are free to choose their service provider and there is no gate-keeping system in place (EC, 2016). Delivery of public services is through a network of hospitals, specialist centres, health centres, and sub-centres. Namely, primary healthcare is provided by 38 health centres (30 rural and 8 urban), and the outpatient departments of five district hospitals and two specialised hospitals (districts are administrative units under the Ministry of Interior), in addition to private providers. Secondary and tertiary healthcare are provided through both public and private hospitals. Public hospitals are owned by the government and their funding, administration, organisation, management and coordination is centralised (HiT online). The responsibility for the organisation and delivery of public health is at the central level. Municipalities are responsible for the maintenance of the public health centres belonging to their jurisdiction but their role in implementation is minor (HiT online).


The forthcoming reform is expected to make service provision more efficient and sustainable, with both private and public providers working on a competitive basis, thus the need to make hospitals independently managed units. Provision of public primary care is also expected to improve as a consequence of the introduction of a referral system, the grouping of small healthcare facilities, and the improved coordination with the private sector (EC, 2017).

Financing

In 2014, public expenditure represented 44.2% of total health expenditure. It is the lowest share across the EU, making the share of private expenditure in the same year (58.8%) the highest (EU/OECD, 2016). Public health expenditure is financed by general taxation through the budget. Private expenditure is made up for the most part by out-of-pocket payments (49.8% in 2014) and, to a lesser

extent, by payments for voluntary health insurance (3.8% in 2014) (EU/OECD, 2016). Upon approval of the reform, the public health system will be funded through compulsory health insurance contributions, therefore fostering a shift to universal coverage. The pending bill setting the level of contributions to be paid into a single fund was adopted by the parliament in June 2017 (HiT online).

Synopsis and evolution of the structure

All health-related competences and spending are with the national government. Local authorities have a minor role which is not expected to be substantially changed by the forthcoming reform. 

Lack of universal coverage, various levels of inefficiency, and the limited progress made so far in advancing the reform of the system are among the concerns outlined in the 2017 European Semester Country Report (EC, 2017). Concerns are reflected in CSR 5 which recommends the adoption of the long-awaited legislation for the reform of the health system by the end of 2017 (CONS, 2017).

CZECH REPUBLIC

Key characteristics
▶ Operatively decentralised: important role of the central government but some healthcare responsibilities are devolved to the regions
▶ Provides universal coverage through a mandatory health insurance system
▶ Mainly public financing of healthcare – contributions from the insurance system
▶ Mixed service provision – public and private

Structure of the health management system and main responsibilities

At the central level, the Ministry of Health (MoH) is responsible for health policy and legislation and, together with the Ministry of Finance, budgeting and supervision of the Health Insurance Funds (HIFs). The MoH has also a supervisory role and the direct administration of some care institutions and bodies, among which are several hospitals and the Regional Public Health Authorities, mandated with the responsibility of carrying out a range of public health services (Alexa *et al.*, 2015).

A number of healthcare responsibilities have been devolved to the 14 self-governing regions, including the registering of inpatient healthcare facilities, and of ambulatory care providers in private practice and polyclinics. In addition to this regulatory role, in 2003, the ownership of several of the hospitals and healthcare facilities (e.g. emergency units and long-term care institutions) owned by the state was transferred to them. Several of these hospitals were transformed into joint stock companies owned by the regions, while the others remained public non-profit organisations. As part of this decentralisation process of care facilities, some small hospitals were also transferred to municipalities (Alexa *et al.*, 2015).



The health system is based on mandatory health insurance through membership in one of the seven (as at 2014) HIFs. These funds are quasi-public, self-governing bodies which are not allowed to make a profit and are in charge of contracting healthcare providers and of paying them for their care services. Individuals are free to choose the fund and funds may not refuse applicants, therefore a risk-adjustment scheme applies which redistributes collected resources among them on the basis of specific criteria (Alexa *et al.*, 2015; HiT online).

Service delivery, health prevention and promotion

Insurance provides access to a wide range of services (benefits package), from inpatient to outpatient care, medicines (upon prescription), rehabilitation, spa treatment and some dental care. Coverage is generally bound to permanent residence. The choice of the doctor by patients is free. There is no gate-keeping system and thus specialist care may also be accessed freely. Most (95%) of the services provided at primary care level are from professionals working in private practice, although they occasionally rent facilities in health centres or polyclinics. Secondary care is provided through health centres (generally owned by municipalities), polyclinics, hospitals, specialised centres or private professionals.

The ownership and management of hospitals is by a different range of actors, from the state to regions and municipalities, private entities and, to a lesser extent, churches. Capital investments in healthcare facilities are usually the responsibility of the owner. In 2012, out of the 188 existing hospitals, regional or local authorities owned 40 hospitals and had a majority in the share of other 50 hospitals (Alexa *et al.*, 2015).

The recently published ‘National Strategy for Health Protection and Promotion and Disease Prevention’ (MoH, 2014) envisages the strengthening of the role of both regions and local authorities in health prevention, protection and promotion and calls for the necessary amendment of existing legislation.

Financing

Public expenditure represents the major part of total health expenditure (83.5% in 2014 (EU/OECD, 2016). Its main sources are contributions to the statutory health insurance (71.9%), distinguished into i) mandatory contributions from payroll tax (split between employees and employers) and from the self-employed (on the basis of their profit); and ii) state contribution on behalf of the economically inactive categories of people. The other sources of public expenditure for health are from state, regional and municipal budgets which in 2014 totalled 11.6% of total health expenditure (EU/OECD, 2016). These budgets are financed through general taxation (VAT, income and wealth taxes, and excise duties), levied at the national and local levels, mainly for capital investments in facilities.

In 2014, private expenditure accounted for 16.5% of total health expenditure, for the most part represented by out-of-pocket payments (13.2%) for co-payments on services and medicines or for the purchasing of over-the-counter pharmaceuticals. Voluntary health insurance has a small market.

Synopsis and evolution of the structure

The Czech health system is characterised by a level of devolution of delivery responsibilities to subnational governments and both local and regional authorities own and operate hospitals and other healthcare facilities.

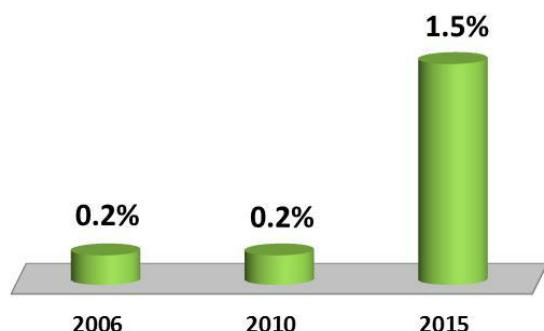


The concerns included in the 2017 European Semester Country Report (EC, 2017) relate to the projected impact on the sustainability of public finances of age-related spending for health. Therefore an improvement of the cost effectiveness of the sector is called for, in particular through the improvement of primary and hospital care, and the reduction of the more costly and over-used inpatient care (EC, 2017; CONS, 2017).

LRAs' spending for health as % of GDP

LRAs' competences and owned facilities

■ Czech Republic



COMPETENCES

- planning: R
- delivery: R, L
- funding: R, L

OWNERSHIP

- hospitals: R, L
- health centres: L
- other facilities: R

R = Regional L = Local

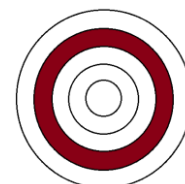
DENMARK

Key characteristics

- ▶ Partially decentralised: several functions in the system are the responsibility of regional and local (municipalities) authorities, including the delivery of primary and secondary care
- ▶ Provides universal coverage free of charge at the point of service
- ▶ Mainly public financing of healthcare – out of national and local taxation
- ▶ Mostly public service provision

Structure of the health management system and main responsibilities

At the central level, the Ministry of Health (MoH) is responsible for health policy and legislation. It also has planning and supervisory roles. Under the Ministry, the Danish Health Authority develops guidelines for uniform healthcare provision across the country (MoH, 2017). The central level administers state funding and activity-based payments to regions and municipalities (Mossialos *et al.*, 2016). Within the national budget, the annual level of public expenditure for healthcare is set through annual financial agreements between the central government and the representatives of regions and municipalities. Regions and municipalities are then autonomous in managing the agreed resources for the provision of healthcare services (MoH, 2017).



The (five) regions are responsible for the running (ownership, management, funding) of hospitals and the administration of primary healthcare (supervision and payment of general practitioners and specialists), with the possibility to plan

and arrange service provision according to regional requirements and facilities, although always within an overall, centrally-set framework (MoH, 2017). Regions are also responsible for ambulance services which they usually contract out (MoH, 2017). The (98) municipalities have an important role in home care, rehabilitation, and public health. They are also responsible for most of the social services, including support to the elderly (Mossialos *et al.*, 2016). Coordination between the regions and the municipalities for the provision of integrated services is through formal agreements which are made mandatory by the central government and must be approved by the Danish Health Authority. These agreements are finalised every four years and cover key topics (Mossialos *et al.*, 2016).

Service delivery, health prevention and promotion

All residents are entitled to freely access publicly financed healthcare (Mossialos *et al.*, 2016). There is no benefits package defined (EC, 2016). Any citizen belongs to health insurance ‘Group 1’ or ‘Group 2’. The default group to which most of the population belongs (99% in 2016) is ‘Group 1’ (MoH, 2017). In Group 1, individuals may choose a general practitioner (GP) who acts as gate-keeper. Belonging to Group 2 enables an individual to consult any GP and any specialist without referral but incurred expenses usually imply a co-payment. No referral is needed for emergency care while hospital treatment always requires a referral. Primary care is provided through GPs and other professionals (e.g. dentists). Most health professionals are self-employed and paid by the regions according to national agreements (Mossialos *et al.*, 2016). Outpatient specialist care is provided by private professionals or hospital-based ambulatory clinics. Secondary care is delivered through hospitals, most of which are owned and operated by the regions. Psychiatric hospital services and local psychiatry centres are also under the regions.

Health prevention and promotion services are provided by municipalities. Municipalities also provide other services such as rehabilitation outside the hospitals, services for children (e.g. child nursing), services for the elderly (e.g. home nursing), and psychiatric-related services (e.g. alcohol and drug abuse).

Financing

Overall, public healthcare is financed through taxation raised by the central government and the municipalities. A national healthcare contribution tax corresponding to 8% of the taxable income applies (Mossialos *et al.*, 2016, 2016). Municipalities source funds for healthcare financing from the collection

of taxes and state block grants (MoH, 2017). At the regional level, most of the finance (some 75% of the total) is from a state block grant. The central level also contributes with a state activity-related subsidy (3% of the total). Furthermore, regions receive an activity-related contribution from municipalities which depends on the level of use by citizens of the regional health services (HiT online).

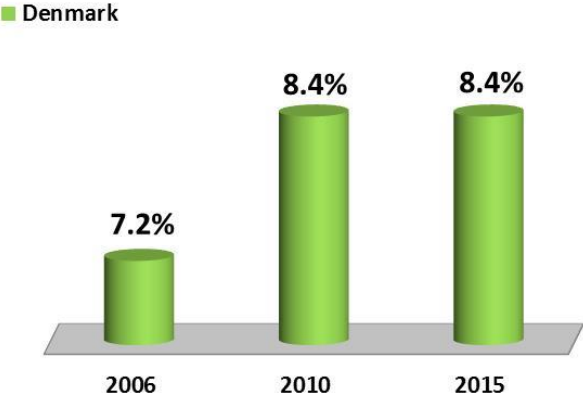
In 2014, public health expenditure represented 84.2% of total health expenditure (EU/OECD, 2016). This is the highest level, after Germany, of public financing of healthcare across the EU. The rest is private expenditure as out-of-pocket payments (13.8%) and voluntary health insurance (2.0%) (EU/OECD, 2016), covering dental care, medicines, glasses and those services which are not fully covered by the public system (Mossialos *et al.*, 2016).

Synopsis and evolution of the structure

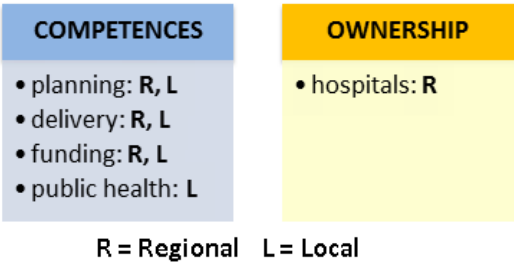
The Danish system is importantly devolved to regional and local governments in terms of planning, administration, and healthcare delivery. Municipalities also bear responsibility for funding while regions own healthcare facilities.

Nevertheless, the role of the central level remains important. The whole system is based on negotiation and coordination mechanisms between the three levels of governments involved. Overall, an increasing trend of formalisation of cooperation and a stronger control by the central level is noted, for example as a consequence of the planned reorganisation and modernisation of the hospital infrastructure (HiT online). This is reflected in the on-going debate on the merging by 2018 of the associations of the Danish regions and of the Danish municipalities in order to strengthen the subnational level’s representativeness in the health system.

LRAs’ spending for health as % of GDP



LRAs’ competences and owned facilities



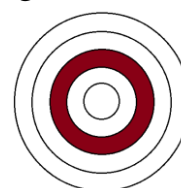
ESTONIA

Key characteristics

- ▶ Operatively decentralised: important role of the central government but local authorities (municipalities) hold operative functions related to secondary care
- ▶ Wide coverage (95.7%) through a mandatory insurance scheme
- ▶ Mainly public financing – out of earmarked taxation through mandatory health insurance contributions
- ▶ Service provision has been mostly privatised, i.e. delegated to autonomous individuals or private legal entities such as limited liability (profit-making) companies or (non-profit) foundations

Structure of the health management system and main responsibilities

The main actors responsible for the planning, administration, regulation, and financing of the health system are at the central level. The Ministry of Social Affairs and its agencies develop health policies and legislation, have supervisory and monitoring functions, and hold the responsibility for the registration of health professionals and the licensing of health facilities (EHIF website). In 2013, the national Health Board, under the Ministry of Social Affairs, took the responsibility from county governors (representing the state regionally) for the management of primary healthcare (Lai *et al.*, 2013). The Estonian Health Insurance Fund (EHIF), also accountable to the Ministry of Social Affairs through the chair of its Supervisory Board, is an independent, public legal entity operating the national health insurance scheme. It collects and pools funds, contracts the health service providers (as the single purchaser), pays for health services, and checks the quality of the services provided (EHIF website). Healthcare provision has been almost entirely privatised and delegated to autonomous providers such as individuals, private profit-making and non-profit legal entities. All healthcare providers have a contract with EHIF (HiT online).



As from 2001 local authorities no longer have the obligation to fund or provide healthcare services but in practice they do so as owners of healthcare facilities. In fact, both the state and municipalities may own and manage facilities for healthcare provision. In this case, such facilities are considered to be public but, as all the other providers do, they have to operate under private law. Additionally, since 2008, an amendment to the Health Services Organisation Act allows municipalities to establish or own primary healthcare companies. Some

municipalities may also provide primary care services to uninsured people on a voluntary basis.

Service delivery, health prevention and promotion

The health insurance system is mandatory for all residents and in 2013 covered 95.7% of the population (Võrk and Paat-Ahi, 2014). Contributions are in the form of earmarked social payroll tax paid by salaried and self-employed workers. Since recently, the other categories were subsidised by the active workforce and the system was considered to be based on a strong component of solidarity. However, since April 2017, a contribution by the central government made on behalf of the non-active population has been introduced (HiT profile).

Primary care is delivered through family doctors who often practice together with a nurse. The service area of each family doctor is determined by the Health Board. Citizens are free to change the family doctor with whom they are registered. Family doctors are private entrepreneurs or shareholders of a company and function as entry points to secondary care, although some specialist care can be accessed without referral (HiT online). Specialist and hospital care (both secondary and tertiary care) is provided through 65 public and private hospitals and outpatient centres organised at different levels (e.g. regional, local) and distinguished into different types (e.g. general) (EHIF website). All services are made available in the 'regional hospitals' and most of the services are delivered in the 'central hospitals'. General and local hospitals provide emergency care and lesser services. Other hospitals are specialised in nursing or rehabilitation care (EHIF website). Most of the hospitals are managed or owned by public authorities (state or local authorities) usually as limited companies owned by local governments, or as foundations, established by the state or local governments (Võrk and Paat-Ahi, 2014; EHIF website).

The 2009-2020 national health plan (amended in 2012) addresses, among other areas, health promotion and disease prevention and indicates actions to be implemented at several levels, including the subnational one.

Financing

In 2014, 75.6% of total health expenditure was from public sources and the remaining 24.4% from private sources (EU/OECD, 2016). Private expenditure is for the most part composed of out-of-pocket payments (in 2014, 22.7% of the total expenditure) including for medicines and nursing care (HiT online). Public expenditure is mainly funded through EHIF contributions (65.6% in 2014) and

the general budget (from state and municipal taxes) (HiT online; EU/OECD, 2016).

Healthcare facilities are financially independent and cover all operating and investment costs individually (HiT online). Hence, capital costs are included in the prices paid by the EHIF to service providers (Lai *et al.*, 2013).

Synopsis and evolution of the structure

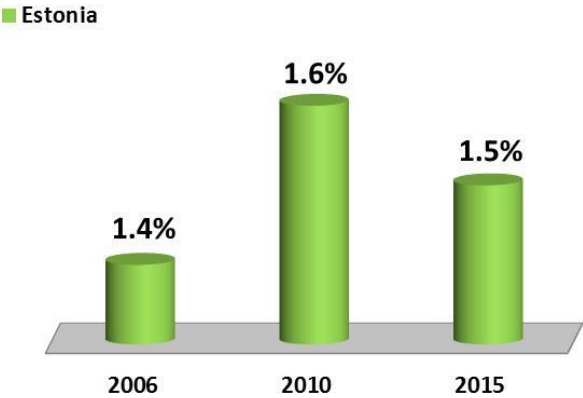
Since 2012/2013, primary healthcare and other management functions were centralised. The absence of statutory responsibility for subnational governments in the area of health does not prevent municipalities from having a role in the delivery and funding of healthcare as well as in the ownership of healthcare facilities.



An on-going (2015-2018) administrative reform focussing on the merging of small local governments to reach a minimum size of 5,000 residents per municipality will further change the territorial organisation of public services as well as tasks and funding mechanisms. Additional legislative acts are awaited in the near future to define responsibilities among the different governance levels in areas such as education, health and transport (EC, 2017).

LRAs’ spending for health as % of GDP

LRAs’ competences and owned facilities



COMPETENCES	OWNERSHIP
<ul style="list-style-type: none"> • delivery: L • funding: L • public health: L 	<ul style="list-style-type: none"> • hospitals: L • other facilities: L
R = Regional L = Local	

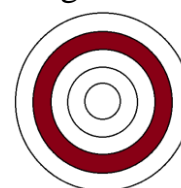
FINLAND

Key characteristics

- ▶ Partially decentralised: local authorities (municipalities) are responsible for the provision and co-funding of healthcare
- ▶ Provides coverage through a compulsory health insurance for all citizens
- ▶ Prevailing public financing of healthcare – out of general taxation and National Health Insurance
- ▶ Mixed service provision because of different arrangements pursued by municipalities in purchasing/providing the services

Structure of the health management system and main responsibilities

At the central level, the Ministry of Social Affairs and Health is responsible for healthcare policy and for providing direction and guidance for its implementation. In particular, the Regional State Administrative Agencies monitor and evaluate the services organised by municipalities and private providers (MSAH website). Also the legislative framework is set at the national level, even if the Act on the Autonomy of Åland gives the self-governing province of the Åland Islands the power to legislate on health and medical care (in Åland, the regional government bears the responsibility for the provision of healthcare) (Ministry for Foreign Affairs website).



Local authorities (313 in 2016) are given the responsibility for the provision of primary and specialised healthcare. While primary care is provided by individual municipalities or federations of municipalities, specialised services are organised by 20 federations of municipalities corresponding to 20 Hospital Districts (HiT online). Hospital Districts are managed by the member municipalities and are further grouped around universities having a medical school (university hospitals) into five tertiary care regions (Vidlund and Preusker, 2014). Since 2011, healthcare is regulated by an additional act, the Comprehensive Health Care Act, which strengthens the role of tertiary care regions, and the possibility of merging of services and of cooperation between primary and specialised care (Vidlund and Preusker, 2014).

Besides the municipal healthcare system, a private and an occupational system exist. The private healthcare system is common in urban areas and is paid for by users and public funds, through the national statutory insurance which provides medical coverage to the whole population. The occupational healthcare system, derived from the obligation of employers to provide employees with first-aid

and preventive health services, is financially supported through the compulsory payments of employers and employees into the statutory insurance pool (Vidlund and Preusker, 2014). The statutory insurance scheme is therefore financed by income-based taxation and contributions (EC, 2016).

Service delivery, health prevention and promotion

In the municipal system, patients have to refer to the health centre of the municipality they belong to. There are 160 health centres providing primary care services (MSAH website). No benefits package exists and available services range from outpatient medical care, to inpatient care, dental care, maternity care, and emergency care. Some of these services are free of charge while others require the payment of user charges. Modalities for delivery are determined by each municipality and may include the direct employment of health specialists in the health centres, and the outsourcing of service provision to other municipalities or to private providers/non-profit organisations.

Secondary care is provided in hospitals, the majority of which are publicly owned (MSAH website). In particular, hospitals are jointly owned and run by the federations of municipalities forming the hospital districts (EC, 2016). Access to care at the hospital districts requires a referral by a licensed physician, either working in the health centre, being private or providing occupational health services (HiT online). Specific treatments are provided centrally through the university hospitals.

Health prevention and promotion are also implemented locally within the framework of centrally-set policies and programmes.

Financing

In 2014, 75.4% of total health expenditure was from public sources and the remaining 24.6% from private sources (EU/OECD, 2016). In the same year, private expenditure was mainly composed of out-of-pocket payments (19.1% of the total expenditure) and voluntary health insurance expenditure (2.5%) (EU/OECD, 2016). Public funding mainly comes from local and national taxes (62.2% of total expenditure in 2014) and, to a lesser extent, from compulsory health insurance contributions (13.2% in 2014) (EU/OECD, 2016).

Besides the revenue from taxes, municipalities rely on state subsidies which are determined according to a series of criteria, including some related to the

number and age structure of citizens; and user charges for care provided in health centres, hospitals, and/or at home (e.g. for the elderly) (HiT online).

Synopsis and evolution of the structure

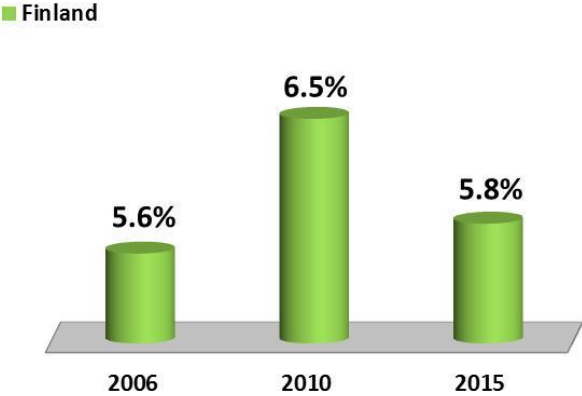
The Finnish health management system is importantly devolved to local authorities (municipalities and/or their federations) in terms of health planning, healthcare delivery and funding. Furthermore, local authorities also own healthcare facilities. Since, overall, the system is based on a high level of autonomy of municipalities with respect to the way healthcare services are organised and delivered, geographical inequities in healthcare access and quality, as well as inefficiencies, exist across the country (Vidlund and Preusker, 2014; EC, 2017).

A health, social services and regional government reform is currently under finalisation. According to its planned entry into force in January 2020, the system will evolve towards a more centralised structure where the responsibility for healthcare will be passed from municipalities to 18 newly elected counties (MSAH website; EC, 2017). This reform will also impact on the administrative organisation and on the distribution of resources.



The sustainability of the health system is one of the concerns discussed in the 2017 European Semester Country Report and afterwards addressed in 2017 SCR 1 (CONS, 2017). In particular, the recommendation invites a timely adoption of the administrative reform as it is expected to improve the cost-effectiveness of both the social and healthcare systems.

LRAs’ spending for health as % of GDP



LRAs’ competences and owned facilities

COMPETENCES	OWNERSHIP
<ul style="list-style-type: none"> • planning: L • delivery: L • funding: L • public health: L 	<ul style="list-style-type: none"> • hospitals: L • health centres: L

R = Regional L = Local

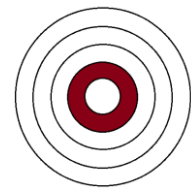
FRANCE

Key characteristics

- ▶ Mostly centralised: centrally managed and structured at the territorial level with a few functions held by local authorities (departments and municipalities)
- ▶ Provides universal coverage on the basis of resident status through statutory health insurance
- ▶ Mainly public financing of healthcare – out of income-based contributions and taxation
- ▶ Mixed service provision – public and private

Structure of the health management system and main responsibilities

Health policy, regulation and financing are mainly under the responsibility of the state and of the health insurance system or Statutory Health Insurance (SHI). At the national level, several ministries hold responsibility for health and social affairs. In particular, the Ministry of Solidarity and Health is responsible for health policy and management of resources for healthcare supply, while responsibility for financial matters and supervision of the SHI is shared with the Ministry of Economy. Among other responsibilities held at the central level are: public health, organisation of the healthcare system, quality of care regulation, allocation of budgeted expenditure, medical education and price setting of drugs (Chevreul *et al.*, 2015).



The healthcare system is organised at the regional level through regional health agencies (*agences régionales de santé* - ARS). The 2009 Hospital, Patients, Health and Territories Act grouped all those public bodies which were in charge of health matters over the territory into the ARS. This act also made the ARS responsible for, among other functions, health planning, coordination and regulation as well as for the allocation of funds at the regional and departmental level (where they work through local delegations). These agencies are subsidiaries of the state, while retaining their autonomy. They are meant to implement national policies while adapting such policies to territorial characteristics and needs. This is tackled through the development of regional health programmes (*projets régionaux de santé* – PRS). ARS have a supervisory board, or Surveillance Council, including representatives of the state, health insurance, local authorities, users and experts. This board approves their budget and expenses and may also comment on the PRS. Furthermore, commissions including representatives of the local governments play an advisory role to the ARS (Chevreul *et al.*, 2015).

The French system is characterised by the presence of a third sector, in addition to health and social care, which deals with the health and social care of the elderly and the disabled. It is in this sector that the departmental councils (*Conseil départemental*) at the department level are involved in the planning of health and social care services as well as in the funding of some facilities. In particular, the following services are under their responsibility: (i) health and social care institutions and services for elderly and disabled people; (ii) financial support of those with low income or fragile categories, including with regard to the funding of home assistance and long-term care; (iii) child protection through the management of mother and child health centres; (iv) disease prevention; and (v) public health and hygiene, in liaison with municipalities (Chevreul *et al.*, 2015).

Service delivery, health prevention and promotion

The health insurance system comprises several schemes, and each individual may belong to only one of these schemes. The main scheme relates to employees in industry and commerce and their families. This scheme is referred to as ‘general scheme’ and covers most of the population (some 89%) including the poorest, regardless of their employment status. All the schemes are represented by the National Union of Health Insurance Funds (HiT online). Insurance coverage gives access to a wide benefits package which nevertheless does not cover the full cost of several services. For these services, contributions are paid directly as out-of-pocket payments or are covered by voluntary health insurance (Chevreul *et al.*, 2015). Some 96% of the population is reported to have a voluntary (complementary or supplementary) insurance (EC, 2016).

Patients have freedom of choice as regards physicians and facilities. The delivery of healthcare is through public and private providers. Primary care is mainly delivered in ambulatory settings where self-employed professionals often practice in a group. These professionals do not necessarily play a gate-keeping function, although a referral system was introduced in 2004 and incentives were created in order to try to encourage this practice (EU/OECD, 2016). Secondary care can be delivered both at the ambulatory level by specialists or in hospitals. Hospitals may be publicly owned (45% in 2015) or may belong to private non-profit or profit-making organisations (the remaining 55% in 2015) (OECD.stat online). Public hospitals are autonomous entities, independently managing their budget. In 2016, further to the modernisation of the sector envisaged by the recently approved reform, public hospitals were grouped by ARS into Territorial Hospitals Groups according to a geographical criterion (HiT online).

Health prevention and promotion is a responsibility shared at the national and local levels.

Financing

The SHI funded 74.5% of total health expenditure in 2014 (EU/OECD, 2016). SHI resources come mainly from income-based contributions by employers and employees (64%), a national tax earmarked for health (16%), other levies (e.g. on tobacco), and contributions of the pharmaceutical industry and of the voluntary health insurance companies (Mossialos *et al.*, 2016).

In 2014, the rest of total health expenditure was covered through complementary sources such as government schemes (4.1%), voluntary health insurance (13.7%) and out-of-pocket payments (7.0%) (EU/OECD, 2016). Local authorities have revenue raising power through direct (e.g. residential tax) and, to a lesser extent, indirect taxation.

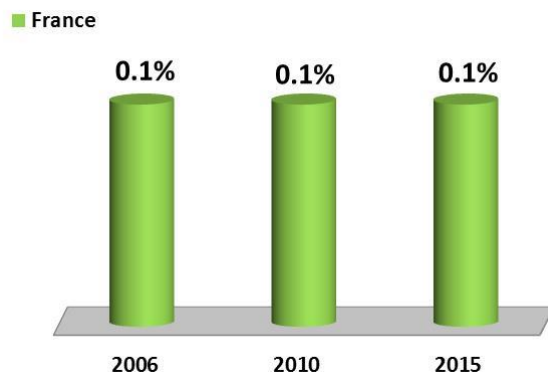
Synopsis and evolution of the structure

The French healthcare system is centralised and relies on territorially organised state entities in order to coordinate the implementation of national policies at the local level. With the exception of the ‘third sector’, local governments are part of the system mainly with a consultative role.



A major reform of the health system entered into force at the beginning of 2016. Among the various measures put forward by the reform (e.g. to strengthen the sustainability of the system, modernise hospitals, provide equal access to care), is the establishment of the *Conseils territorial de santé* (CTS). These are consultative bodies at the regional level whose members are representatives of local authorities, state and professionals and whose aim is to identify territorial needs and enhance the territorial dimension of the PRS. Unlike the previous territorial conferences, CTS are expected to contribute more effectively to actions undertaken within the PRS (MSS, 2016).

LRAs' spending for health as % of GDP



LRAs' competences

COMPETENCES
• planning: L
• delivery (elderly and disabled): L
• funding (elderly and disabled): L
• public health: L

R = Regional L = Local

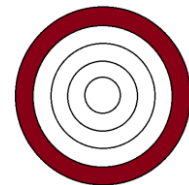
GERMANY

Key characteristics

- ▶ Decentralised: responsibilities and competencies are shared between the national, regional (*Länder*) and corporatist levels
- ▶ Provides universal coverage through statutory and private health insurance
- ▶ Health expenditure is mostly funded through public resources – out of social insurance contributions and taxation
- ▶ Mixed service provision – public and private

Structure of the health management system and main responsibilities

At the central level, the Federal Assembly (elected), the Federal Council (composed by representatives of the regions) and the Federal Ministry of Health are responsible for legislative and supervisory functions. The legal framework is usually set at the federal level but regions have legislative responsibility on licensing of inpatient care and on public health (Busse and Blümel, 2014). Policymaking for healthcare is shared between the federal government, the regions, and a large number of self-governing bodies representing the various existing sickness funds and the physicians' associations, i.e. the healthcare payers and the healthcare providers. These institutions are non-profit, quasi-public corporations, in that their legal status is private but their responsibilities and liabilities are public. They negotiate with each other directly or through joint committees which are governed at the federal level by the Federal Joint Committee (FJC) (Busse and Blümel, 2014). The FJC decisions relate to the services paid for by the statutory health insurance on the basis of the broad benefits package defined by law, and the standard requirements in terms of service provision and quality. If these decisions are not objected to by the



Federal Ministry of Health, they become binding for all actors involved in the statutory system (Busse and Blümel, 2014).

The 16 regions are mainly responsible for capital investments in hospitals (independently from the ownership), planning of inpatient capacity, medical education, emergency aid and public health services. In most cases, organisation and delivery of rescue services and public health services have been devolved to local authorities (Busse and Blümel, 2014; EC, 2016).

Service delivery, health prevention and promotion

Since 2009, health insurance has been mandatory, either as Statutory Health Insurance (SHI) or through private coverage. SHI is provided by 116 (in 2016) sickness funds (EC, 2016). Income-based contributions are centrally pooled, redistributed to the funds by the Federal Insurance Authority, and then used for the payment of healthcare providers. The two most important categories of providers are hospitals and physicians (Busse and Blümel, 2014). In 2012, 85% of the population was covered by SHI. High earners (according to a defined opt-out threshold) may choose to be covered by Private Health Insurance (PHI), which also applies to civil servants and the self-employed (some 11% of the population was covered by PHI in 2012). Special regimes apply to other categories (e.g. soldiers) which make up the remaining 4% of coverage (Busse and Blümel, 2014). The SHI provides for a comprehensive benefits package but cost-sharing or co-payments may apply (Busse and Blümel, 2014).

Individuals are free to choose the sickness fund and the physician (family doctor or specialist). There is no gate-keeping system in place but a referral by a doctor is necessary to access reimbursed care. Primary care is provided through individual private practice or interdisciplinary treatment centres and includes both generalist and specialist care. Inpatient care is provided in public, private non-profit and private profit-making hospitals. Private hospitals prevail and overall have a higher share of beds than public ones. The ownership of public hospitals (601 out of 2017, excluding facilities for prevention and rehabilitation) is usually with local governments (Busse and Blümel, 2014). The operating costs of hospitals are financed by payments from the sickness funds and the private insurers, while capital expenditure is financed by state budget funds.

Public health is the responsibility of regions but its implementation has been devolved to municipalities in 14 out of the 16 regions (Busse and Blümel, 2014).

Financing

In 2014, public sources equalled 84.6% of total health expenditure, the rest being private sources (EU/OECD, 2016). Public sources include statutory health insurance contributions (contributions from employers and employees, unemployment entitlements for the unemployed, and government flat rate per capita for long-term unemployed people) and, to a lesser extent, taxation. Social health insurance contributions (inclusive of tax-financed subsidies from the federal budget) represented 78% of total health expenditure in 2014. Taxes are levied at the federal, regional and local levels. The contribution of taxes to healthcare financing decreased in the last years due to the introduction of statutory health insurance for long-term care which was previously financed through local authorities' budgets.

Private sources include private health insurance contributions and out-of-pocket payments, which in 2014 represented 13% and 1.5% of total health expenditure, respectively (EU/OECD, 2016).

Synopsis and evolution of the structure

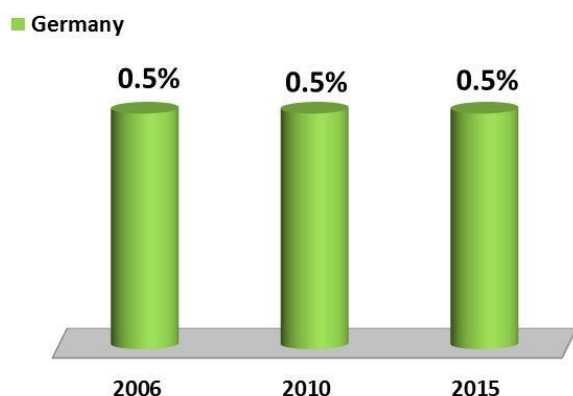
The German system is structured at three main levels: the central level, the regional level and the corporatist level. In specific health-related areas the power and responsibility of regions range from legislative to funding functions as well as delivery of services (i.e. emergency care and public health).

The most evident trends in the country are delegation to corporatist institutions, and privatization. In fact, recent reforms, although some were of a structural nature, did not substantially change the share of power and responsibility of subnational authorities and were mainly aimed at strengthening competition in the system (EC, 2016).



Two of the most recent reforms are expected to impact on the areas of competence of the regions: in 2015, a law for the strengthening of health prevention and promotion entered into force, implying a substantial increase of the expenditure in this field; in 2016, a law to increase the efficiency of the hospital care came into force, implying also in this case the establishment of a structural fund to implement specific measures.

LRAs' spending for health as % of GDP



LRAs' competences and owned facilities

COMPETENCES	OWNERSHIP
<ul style="list-style-type: none"> • legislation: R • health policy: R • planning: R • delivery: R, L • funding: R, L • public health: R, L 	<ul style="list-style-type: none"> • hospitals: L

R = Regional L = Local

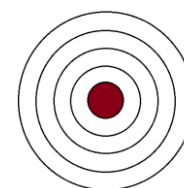
GREECE

Key characteristics

- ▶ Centralised: regulated at the central level and structured at the territorial level
- ▶ Theoretically universal through compulsory health insurance
- ▶ Healthcare financing is public and private
- ▶ Mixed service provision – a combination of public and private systems (i.e. the national health system, a health insurance system and a private system)

Structure of the health management system and main responsibilities

At the central level, the Ministry of Health and Social Solidarity is responsible for the regulation, planning and management of the National Health Service (NHS) as well as for the allocation of resources and funds to the priorities set at the national level. It also regulates the private sector. The Ministry of Labour, Social Insurance and Social Solidarity is responsible for the insurance system. The insurance system was reformed in 2011 to merge the several existing social and health (occupational-based) funds into one organisation, the National Organisation for Healthcare Services Provision – EOPYY (Polyzos *et al.*, 2014; Petmesidou, 2014). EOPYY currently performs de-facto as the only insurer and purchaser of healthcare services, with private insurances mainly having a supplementary role. Under the Ministry of Health and Social Solidarity are several directorates, departments, organisations and institutions as well as the health administrations at the regional level or Regional Health Authorities – RHAs.



In 2012, the geographical boundaries of the seven RHAs were aligned to the boundaries of the seven state administrations. Further, in 2014, the RHAs were given the control of the healthcare service providers which originally fell under the control of the old insurance funds. This circumstance made the RHAs the main public service provider of healthcare at the regional level. RHAs are therefore responsible for the management, coordination, and supervision of hospitals, health centres, peripheral surgeries and centres for mental health. The Central Council of RHAs coordinates the policies of the regional health administrations and ensures their cooperation with the central level (HiT online).

Service delivery, health prevention and promotion

With coverage being based on the occupational status, the government has passed laws in the last years to give uninsured people access to healthcare. The latest Social Bill of 2016 tackles universal coverage (EC, 2016) and the system provides for universal access to primary healthcare (Petmesidou, 2014). Delivery of primary healthcare is through public and private health service providers. Patients are free to choose the provider. Primary care is intended to have a gate-keeping function but in practice patients may decide to access secondary care facilities directly. In urban areas, primary care is delivered through the outpatient departments of public and private hospitals, while in rural areas it is mainly delivered through the health centres of the NHS (Polyzos *et al.*, 2014). Primary care is also provided by private units and self-employed health professionals contracted by the EOPYY. All of these providers represent the National Primary Healthcare Network (Petmesidou, 2014). Secondary and tertiary care is provided through public and private hospitals. In 2011, the hospital sector was also reformed in the attempt to rationalise resources and costs. Out of the existing 131 public hospitals, 82 units were retained; the remaining 49 were connected to 80 of the retained hospitals (the other two non-profit entities remained autonomous) and were managed by means of NHS Trusts. Five hospitals originally under the insurance funds were transferred to corresponding main public hospitals, while a few small hospitals became urban health centres (Nikolentzos *et al.*, 2015). In addition to public hospitals, there were 155 private profit-making hospitals in 2015 (OECD.stat online). Public health is a prerogative of the central level from planning to implementation.

Financing

Healthcare is funded through public and private resources, representing in 2014 a share of 59.7% and 40.3% of total health expenditure, respectively (EU/OECD, 2016). Public resources come from social insurance (contributions

paid by employers and employees) and taxation (direct and indirect tax revenues). Private funding is mainly in the form of out-of-pocket payments which represented 35.4% of total health expenditure in 2014. The role of private health insurance is still minor with just a 3.6% contribution to total health expenditure in 2014 (EU/OECD, 2016).

Synopsis and evolution of the structure

Funding and delivery of services are provided through the combination of a tax-based NHS, a health insurance system financed by contributions, and a private insurance/delivery system financed by private payments (Polyzos *et al.*, 2014).

Notwithstanding several attempts towards decentralisation, the public health management system in Greece is still centralised and structured at the territorial level by means of the RHAs. Therefore, the provisions of Law 3852/2010 (*Kallikratis* plan), enacted in June 2010, on the transfer of healthcare competences from the RHAs to the new, elected, regional and local authorities still have to be implemented (Athanasiadis *et al.*, 2015).

HUNGARY

Key characteristics

- ▶ Operatively decentralised: centrally coordinated, supervised and partially managed, but local authorities are responsible for the provision of primary care
- ▶ Provides universal coverage through statutory social health insurance
- ▶ Mainly public financing of healthcare – out of contributions as well as state and local budgets
- ▶ Mixed service provision – public and private, the latter especially at primary care level

Structure of the health management system and main responsibilities

The central level holds responsibility for health legislation and policy. With the 2011 ‘*Semmelweis* Plan’, the State Secretariat for Health Care of the Ministry of Human Resources and related institutions became responsible for the management and administration of health (Gal, 2014). Among the related institutions is the National Healthcare Service Centre which owns, supervises and manages



state hospitals. In 2012, the state took over all hospitals previously owned and managed by regional and local authorities. In this way, it became the most important provider of inpatient care (i.e. 80% of the country's inpatient capacity) as well as the major provider of outpatient specialist care, as a consequence of the fact that about 70% of these specialist services were delivered within units of hospitals (National Healthcare Service Centre website; HiT online). Polyclinics were to be nationalised under the same regulation, although on a voluntary basis, but apparently they partially remained with local governments (WHO, 2017). Still at the central level is the National Health Insurance Fund Administration (NHIFA), an agency responsible for administering insurance contributions made to the mandatory national health insurance scheme. Besides funding and reimbursing, the agency establishes contracts with healthcare providers (NHIFA website).

Since 2013, the central government has been strengthening its presence over the territory by means of administrative government offices which were given some health-related responsibilities. However, municipalities maintain responsibility for the provision of primary care which may be delivered directly by them or through private providers. Secondary and tertiary care is the responsibility of the central government but municipalities may be responsible for outpatient care in polyclinics and dispensaries and for secondary inpatient care in state-owned hospitals (EC, 2016).

Service delivery, health prevention and promotion

The social health insurance scheme is compulsory for all citizens and provides nearly universal coverage. Employers and employees pay contributions to the Health Insurance Fund through a payroll tax. For some categories of people the contribution is paid by the state through the central budget. The insurance provides access to a benefits package, including, among other services, preventive examinations, primary, specialised and dental care (NHIFA website).

Primary care is delivered through general practitioners working mostly in private practice or being salaried by the municipalities. Patients are free to choose their doctor. A referral is needed for accessing specialist care and secondary care in hospitals. Outpatient care is mostly delivered in polyclinics, dispensaries, and outpatient units of hospitals which are managed by municipalities. Inpatient care is delivered in state-owned hospitals under the responsibility of municipalities. The central government takes direct management responsibility, through various ministries, for a number of acute and chronic hospitals (EC, 2016).

Public health is managed centrally through the National Public Health and Medical Officer Service which includes the Office of the Chief Medical Officer (OCMO) and other national centres and institutes. Under the coordination and supervision of the OCMO are government offices at regional and sub-regional levels charged with public health delivery functions (NPHMOS website; EC, 2016).

Financing

Total health expenditure is mainly funded through public sources (67.1% in 2014), the rest being private expenditure, most of which is represented by out-of-pocket payments (28.4% of total health expenditure in 2014). Public expenditure is financed by income-based contributions paid to the National Health Insurance Fund, earmarked taxes, other levies and government transfers from the central budget (EC, 2016). Other resources for health derive from local government budgets, which in turn are sourced through local taxes and subsidies from the central government.

Recurrent and operational costs of hospitals and other facilities are financed through the National Health Insurance Fund, while capital investment costs are funded by the owners of the facilities (EC, 2016).

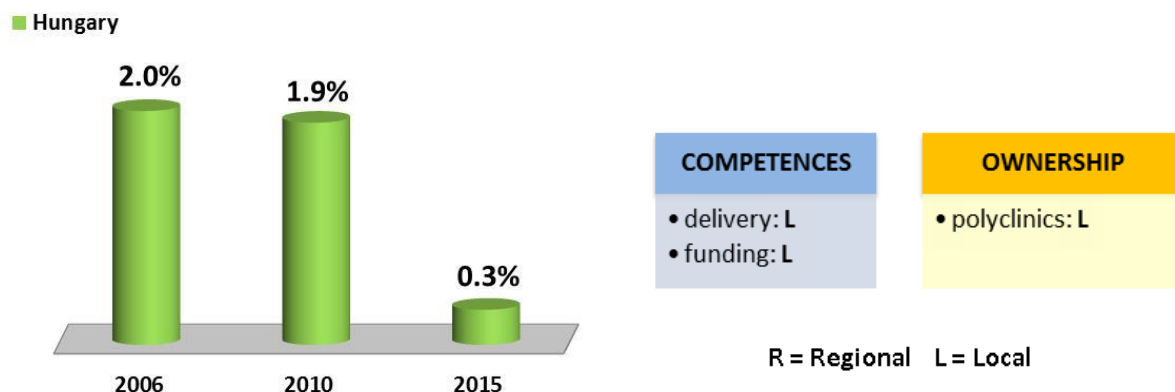
Synopsis and evolution of the structure

Further to some major reforms and as part of an overall centralisation of the governance system, health management has been importantly transformed in the last years. The 2011 Local Government Act which came into force in 2013 reduced the responsibility of subnational authorities in several areas, including health. The centralisation process in the health sector was further emphasised in 2012 with the transfer of ownership of hospitals from the local and regional authorities to the state. The tendency of the system is therefore towards lesser decentralisation.



LRA's spending for health as % of GDP

LRA's competences and owned facilities



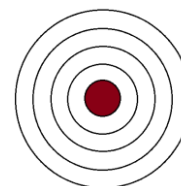
IRELAND

Key characteristics

- ▶ Centralised: power and responsibilities are held at the central level, with the Health Service Executive being responsible for management and delivery of health services
- ▶ Coverage depends on residency, income levels and belonging to specific groups
- ▶ Mainly public financing of healthcare – out of general taxation
- ▶ Mixed service provision – public, voluntary and private

Structure of the health management system and main responsibilities

Overall responsibility for the healthcare system lies with the Government. It is exercised through the Department of Health (DoH) under the direction of the Minister for Health. The Department supports the Minister (and four other Ministers of State having responsibilities for disabilities, communities and national drug strategy, health promotion, mental health and older people) in the strategic development and overall organisation of the health services, including legislation, regulation and planning (DoH website). The single statutory body for the management and delivery of health (and social) services is the Health Service Executive (HSE), also accountable to the Minister for Health.



The HSE is structured into a number of National Service Delivery Divisions including, since July 2013 (Burke and Considine, 2014), those related to acute hospitals, social care, health & wellbeing, mental health and primary

care. Seven Hospitals Groups and nine Community Healthcare Organisations are responsible for the delivery of acute and primary/community-based services, respectively. Each Hospital Group has a defined catchment area and includes from six to eleven public hospitals. Administratively, the HSE has 32 Local Health Offices at the territorial level. Together with the Health Centres – 99 completed and 81 under development according to EC (2017) – these offices give access locally to primary care, nursing care, child health and other services. The HSE is entitled to enter into agreements with other voluntary/non-statutory service providers which range from acute hospitals to local community-based organisations (HSE website). Since January 2015, as a consequence of the reorganisation of the central administration of health management, the budgeting of health and hence the most important source of HSE’s funding is controlled by the Minister for Health (HSE website).

Service delivery, health prevention and promotion

Those ‘ordinarily resident’ (i.e. living, have lived or intend to live in the country for at least one year) citizens with a Medical Card granted according to income levels are entitled to most services free of charge. Other categories may be eligible for the general practitioner (GP) Visit Card granting free access to family doctors, which is given for example to people aged over 70 years (regardless of their income) and children aged below 6 years. Those without such cards must make out-of-pocket (OOP) payments for both hospital and primary care services, unless they have the right to benefit from other exemption schemes. Some of these OOP costs may be covered by private health insurance. In 2015, 2.17 million of people had a card, equalling approximately 47% of the population (HSE, 2016). Primary care is usually provided through GPs. GPs are the gate-keepers to secondary care as they provide referrals to specialist physicians or publicly-funded acute hospitals. However, since registration with a GP is not mandatory, secondary care may be accessed directly upon the payment of a fee. Most of the GPs are self-employed and treat both private and public patients, often in group practice, with Primary Care Teams comprising GPs, nurses, physiotherapists and other professionals (HSE website).

The hospital sector incorporates HSE, voluntary and private hospitals. Beds within the first two categories may be designated for either public or private use. HSE hospitals are publicly funded. Voluntary public hospitals may be controlled by the Minister for Health through centrally appointed boards or be owned by private entities such as religious orders. In any case, they are also for the most part funded by the public sector. Public hospitals provide inpatient, emergency and outpatient care, and diagnostic services (HSE website). Private hospitals have an important role in providing acute and mental healthcare services. The

Private Hospital Association counts 19 members, representing one third of the acute hospitals in the country (PHA website).

Public health is a national task under the Health & Wellbeing Division of HSE.

Financing

The healthcare system is predominantly tax-funded (69.0% in 2014), the remaining components of total health expenditure being from private sources such as OOP payments for services (15.4% of all healthcare costs in 2014) and payments to private health insurance providers (12.7% in 2014) (EU/OECD, 2016). Private health insurance covered 43.7% of the population in 2014 (EU/OECD, 2016). Taxation is non-earmarked and collected at the national level. In 2014, inpatient care accounted for 30% of health expenditure which is among the highest levels in the EU (EU/OECD, 2016).

Synopsis and evolution of the structure

All health-related competences and health-related spending are with the national government, hence the Irish system classifies as centralised. Since 2012, the government has planned or implemented several reforms in the health sector (the Parliamentary Committee on the ‘Future of Healthcare’ released a final report on 30 May 2017 with a set of recommendations and a ten year plan for reform). Among such reforms are the introduction of universal health insurance, the strengthening of primary care in order to move away from a hospital-centric model, the free access to GPs, and the re-structuring of the organisation of the system (Burke and Considine, 2014). In particular, the strengthening of primary care is also suggested in the 2017 European Semester Country Report to enhance the cost-effectiveness of healthcare and the fiscal sustainability of the sector (EC, 2017).

However, notwithstanding another reform which in 2014 implied a reorganisation of local governments and an increase of their responsibilities in several areas (Local Government Reform Act), health and healthcare remain a prerogative of the central level.



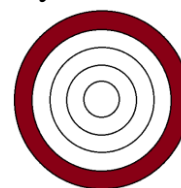
ITALY

Key characteristics

- ▶ Decentralised: the responsibility for the governance and organisation of healthcare and health service delivery is devolved to regional authorities (regions and autonomous provinces)
- ▶ Provides universal coverage mostly free of charge at the point of service
- ▶ Mainly public financing of healthcare – out of national and regional taxation
- ▶ Mixed service provision – public and private

Structure of the health management system and main responsibilities

The health system is organised at two main levels: national and regional. At the national level, the Ministry of Health is responsible for ensuring the right to health of the citizens as defined in article 32 of the Constitution. The legislative competence is shared between the state and the 22 regional authorities. Subnational legislation must comply with the fundamental principles established by national law. The Ministry of Health (MoH), supported by agencies and national bodies, guarantees equity, quality and efficiency of the system and, along with a monitoring role, promotes improvement actions, innovation and change. The central government is also responsible for setting the ‘minimum level of health assistance’, i.e. the services the health system is obliged to deliver to all citizens for free or upon the payment of a contribution (MoH website). Main planning instruments for health are the 3-year ‘Health Pacts’ agreed upon by the government and the regional authorities in an intergovernmental State-Regions Conference. The resources to be allocated to regional governments for healthcare are set within the pacts (HiT online).



Regional authorities bear responsibility for the governance and organisation of all activities related to healthcare and health service delivery. The regional level has legislative, administrative, planning, financing and monitoring functions. Executive functions are based on 3-year regional health plans. Organisation and delivery of services (preventive medicine, primary care, secondary care) at the territorial level is through a network of Local Health Authorities (*Aziende Sanitarie Locali* – ASLs) and of public and private hospitals. The ASLs are public entities with an autonomous entrepreneurship role for their organisation, administration, accountancy and management. Each network of ASLs is under the corresponding regional government and is organised into districts on the basis of a population catchment criteria (Ferrè *et al.*, 2014).

Regional authorities are responsible, among other things, for: defining the regulatory framework of operation of ASLs and public hospitals; allocating (financial) resources to ASLs and public hospitals and defining the technical and management guidelines for their provision of services; appointing general managers of ASLs and public hospitals; and defining the criteria for accreditation of private and public healthcare entities. Since regions independently set their health policy, their level of involvement in the direct management of health services and the organisation of the system at the local level vary greatly from region to region (Ferrè *et al.*, 2014).

Service delivery, health prevention and promotion

The health system provides universal coverage. In addition to the minimum level of assistance centrally set, regions can provide extra services to citizens using their own resources (Ferrè *et al.*, 2014). Primary care is mostly provided through general practitioners/paediatricians who have a gate-keeping function and are self-employed and working in solo or group practice. Registration with a GP is compulsory. Secondary care is provided either by the ASLs using their own resources (e.g. the hospitals they administer) or by accredited public and private providers/facilities with which ASLs have agreements and contracts. Among these facilities are public hospital enterprises and independent entities, usually with a regional or interregional catchment population, with autonomous management and purchasing power, such as teaching or university hospitals (Ferrè *et al.*, 2014). In 2016, there were 733 public hospitals/inpatient facilities and 651 private ones. The number of ASLs in 2017 (101) is much lower than in 2010 (146) due to reorganisation processes undertaken by the regions and aimed at reducing administrative and management costs (MoH website).


Specialist care is accessed through referrals by GPs or, for some services, directly through a centralised booking system. Emergency care is provided for free to everyone and is organised at the regional level (HiT online). Regional authorities are also responsible for health prevention and promotion, which is carried out within a general framework agreed with and monitored by the central level. The national Prevention Plan 2014-2018 is implemented by means of regional prevention plans (State-Regions-Autonomous Provinces Permanent Conference, 2014).

Financing

In 2014, public funding accounted for 75.8% of total healthcare expenditure, almost all of which (75.5%) is financed by earmarked taxes levied at the national and regional levels. Direct taxes include (i) IRAP, a regional tax pooled nationally but mostly allocated back to the regions where it is levied, imposed on companies' value added and on the salaries of public sector employees, and (ii) 'additional IRPEF', a regional tax imposed on top of the national personal income tax. Indirect taxes include a share on VAT and petrol excise. Additionally, ASLs rely on revenues from the purchase of services and over-the-counter drugs and from co-payments by patients for pharmaceuticals, diagnostic procedures and specialist visits. Overall, the system allows for regional variation of taxes (Ferrè *et al.*, 2014).

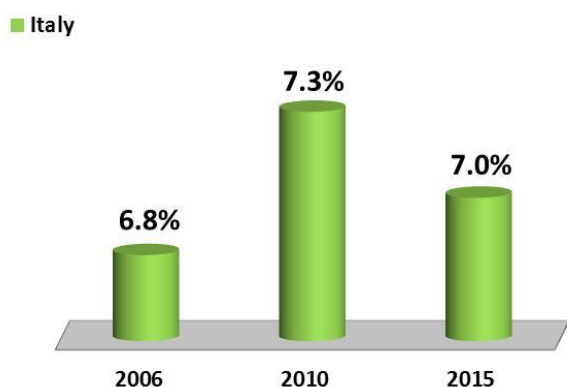
Most of the private expenditure (equalling 24.2% of total health expenditure in 2014) is in the form of out-of-pocket payments and co-payments (22.0% in 2014) (EU/OECD, 2016). Voluntary health insurance does not play a significant role in funding.

Synopsis and evolution of the structure

The Italian health management system is regionally organised. Regional authorities hold main power and functions from health legislation to healthcare delivery and funding. The decentralisation of healthcare achieved over the last twenty years is structural and has given regions increasing autonomy on how to organise the delivery of services. 

However, this circumstance has led to a certain level of disparities across the country in terms of tax base, cost-efficiency, access to care and quality of services (Ferrè *et al.* 2014; EC, 2017). Re-organisation measures are regularly undertaken at the regional level. In addition, in recent years, budgetary constraints have resulted in a stricter control at the central level on regional healthcare expenditure (Ferrè *et al.* 2014; HiT online). This control is directly and indirectly exercised through annual budget laws, urgent decrees and/or cost-containment measures which are agreed within the intergovernmental State-Regions Conference. The latter institutional mechanism has consequently gained in importance as a framework for agreement and coordination between the two levels of government.

LRAs' spending for health as % of GDP



LRAs' competences and owned facilities

COMPETENCES	OWNERSHIP
<ul style="list-style-type: none"> • legislation: R • planning: R • delivery: R • funding: R • public health: R 	<ul style="list-style-type: none"> • hospitals: R

R = Regional L = Local

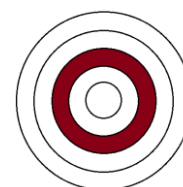
LATVIA

Key characteristics

- ▶ Operatively decentralised: an important role is played centrally by the newly established National Health Service but local authorities hold operative functions
- ▶ Provides universal coverage through a statutory healthcare system
- ▶ Mainly public and private financing of healthcare – out of general taxation and out-of-pocket payments
- ▶ Mixed service provision – public and private

Structure of the health management system and main responsibilities

At the central level, the Ministry of Health (MoH) bears the main responsibility for the development of national health policies and regulation. It also has a planning, organisation, and supervisory role. Since 2011, the financing and implementation of healthcare is the responsibility of the National Health Service (NHS), a central, public institution subordinated to the MoH. The NHS, among other tasks, contracts public and private service providers and determines the content of the benefits package. It is structured into five regional branches (Zilvere, 2014; HiT online). The state also owns some specialised and tertiary hospitals, and is responsible for public health activities (HiT online). Other institutions under the MoH are responsible for the provision of specific services such as the State Emergency Medical Service for emergency care.



Local governments are responsible by law for ensuring access to healthcare services and share the responsibility for the provision of long-term care,

including the care of the elderly and the disabled, with the central level (EC, 2016; HiT online). Furthermore, they own hospitals and primary care facilities (health centres) (HiT online).

Service delivery, health prevention and promotion

Healthcare is provided on the basis of residence, according to a list of benefits, upon the payment of a contribution, and through state, local and private inpatient and outpatient healthcare facilities (MoH website). Healthcare services are in fact delivered in a variety of institutional settings and legal forms. Providers may be independent or employed by, among others, local governments. The condition for patients to receive services is that providers have an agreement in place with the NHS.

General practitioners (GPs), usually working together with a nurse and an assistant, provide primary healthcare and function as gate-keepers to secondary healthcare. Most of the GPs are in private practice, with only a small share employed by health centres or hospitals. Secondary healthcare is provided at ambulatory (outpatient) level, emergency medical care level, through day-patient facilities or in hospitals. Since the 2010 reform of the hospital sector, the number of facilities has been reduced. In 2015 there were 67 hospitals out of which 46 (i.e. 69%) were publicly owned (OECD. Stat online) by the state (the larger ones) and local authorities. Hospitals' owners are in charge of financing investments (HiT online). Tertiary care is provided in specialised medical institutions.

Public health is provided by the central level and funded through the national budget. However, municipalities implement and finance health promotion and prevention activities locally (HiT online).

Financing

Healthcare is mainly financed through general taxation, the other main source being out-of-pocket payments by patients that include user charges for all statutorily financed services and direct payments for those services that are not financed by the state. Limited exemptions apply.

Tax revenues are not earmarked, and each year the Parliament approves the budget for health. In 2014, public expenditure on health was 59.9% of total health expenditure, the rest (40.1%) being private and for the most part (with one of the highest shares across the EU of 38.9%) being contributed by out-of-

pocket payments (EU/OECD, 2016). Local governments do not raise revenues independently and rely on the central government transfers to fund their activities (HiT online).

Synopsis and evolution of the structure

The governance of the health system is under the state’s control and last reforms confirm the tendency to merge institutions and centralise.

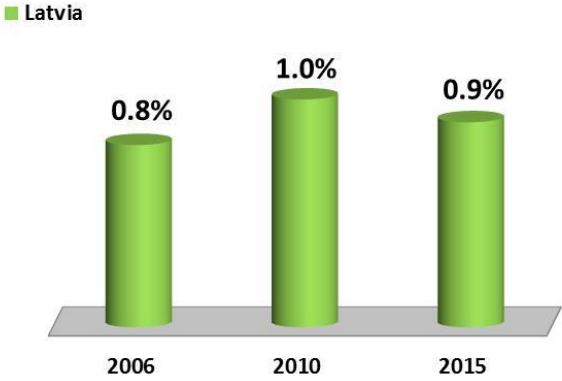


For example, in 2009, emergency care services were reorganised and put under the coordination of the State Emergency Medical Service. In 2011, successive merging led to the establishment of the NHS, as a single purchaser of services in charge of centralised financing and implementation of healthcare (HiT online). Local authorities only hold some operative functions as owners of healthcare facilities.

Among the concerns related to the funding of healthcare and outlined in the 2017 European Semester country report is the improvement of the cost-effectiveness of the healthcare system which is also reflected in 2017 CSR 2 (EC, 2017; CONS, 2017).

LRAs’ spending for health as % of GDP

LRAs’ competences and owned facilities



COMPETENCES	OWNERSHIP
<ul style="list-style-type: none"> • delivery: L • funding: L • public health: L 	<ul style="list-style-type: none"> • hospitals: L • health centres: L

R = Regional L = Local

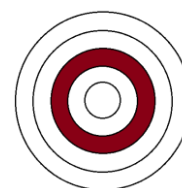
LITHUANIA

Key characteristics

- ▶ Operatively decentralised: centrally regulated but with responsibilities devolved to local authorities for primary healthcare and public health
- ▶ Provides universal coverage based on compulsory health insurance
- ▶ Mainly public financing of healthcare – out of insurance contributions and taxation
- ▶ Mixed service provision – public and private

Structure of the health management system and main responsibilities

The state holds the responsibility for health legislation and policy. Among the main stakeholders at the central level is the Ministry of Health (MoH) which is responsible for drafting laws; developing health policies, strategies and programmes; issuing regulations; licensing healthcare providers and professionals; and approving capital investments in the health sector. It is also the owner of some healthcare facilities. The National Health Insurance Fund (NHIF) – under the MoH but also accountable to the Ministry of Finance – is a state authority which implements the compulsory health insurance scheme and hence looks after financial flows and purchase of services. It is structured into five territorial branches (Territorial Health Insurance Funds) which administer the scheme by contracting healthcare providers and pharmacies for the provision to the insured of, respectively, services and medicines (NHIF website). NHIF branches also monitor service provision and finance municipal public health activities. Representatives of the municipalities sit in their supervisory boards together with representatives of the MoH and of the central NHIF office (Murauskiene *et al.*, 2013).



The governance structure of healthcare has changed since July 2010, when the county administrations were abolished and their responsibilities taken back by the Ministry or delegated to municipalities. Municipalities are currently responsible for primary (and social) care. Municipal health boards are responsible for the implementation of health policy locally. Their representatives sit in the National Health Board, which is under the Parliament and is responsible for the implementation of health policy at the national level. Furthermore, municipalities own and run some healthcare facilities (polyclinics and small and medium-sized hospitals), and bear responsibility for the implementation of public health activities.

Service delivery, health prevention and promotion

The publicly financed health system theoretically covers all residents but coverage is subject to the payment of contributions or to belonging to a group under the responsibility of the state (about 60% of the population is covered by the state). Emergency care is provided free of charge to all (Murauskiene *et al.*, 2013). Insured individuals have access to a standard benefits package. Some services and some medicines require cost-sharing. Patients have to register with a general practitioner but are free to choose the doctor, the specialist and the institution.

Primary care has a gate-keeping function to secondary care and is provided through a network administered by municipalities. Facilities include polyclinics and primary care health centres or smaller units such as ambulatories and medical posts. It is delivered by a general practitioner or a primary care team, in solo or group practices, as public or private providers. Access to specialists requires a referral or is otherwise possible with the payment of a fee (which also applies in order to consult private health professionals). Secondary care is provided through general and specialised facilities. Specialist outpatient care is provided in polyclinics, in outpatient departments of hospitals and in private clinics. Inpatient care is provided in hospitals, distinguished into general, nursing, specialised and rehabilitation hospitals. In 2015, there were 95 hospitals in the country, most of which (88) were publicly owned, the rest being profit-making privately owned (OECD.stat). Both the state and municipalities own and run healthcare facilities.

Public health is a shared task between the central and the local levels. There are ten public health centres distributed over the country which, since 2012, are under the MoH. Additionally, there are a number of municipal public health bureaus carrying out public health monitoring and other locally-based activities. These bureaus are financed by state and local budgets (Murauskiene *et al.*, 2013).

Financing

The health system is mainly funded through the contributions paid into the NHIF (57.5% of total health expenditure in 2014). However, a share of these contributions is in fact represented by transfers from the national budget for those categories of people insured by the state (e.g. children). In practice this means that taxes (national and, to a lesser extent, local) are the main source of

public funding (Murauskiene *et al.*, 2013) although they directly contribute only 10.1% to total health expenditure (EU/OECD, 2016).

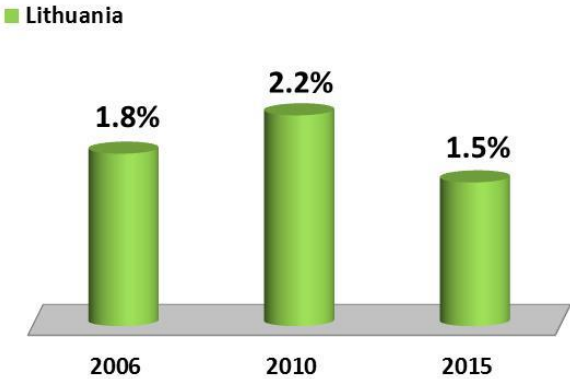
In 2014, 67.6% of total health expenditure was public. Private expenditure share (32.4%) was almost exclusively represented by out-of-pocket payments (31.5%) (EU/OECD, 2016).

Synopsis and evolution of the structure

The Lithuanian health system is organised at two levels: national and local. Municipalities hold important competences with regard to management, administration and delivery of care and public health. Recent reforms do not substantially modify this situation, apart from the fact that municipalities’ institutional and financial strengthening may be expected to more properly handle these responsibilities in the future.

Among the concerns related to the funding of healthcare and outlined in the 2017 European Semester country report are the projected raise of expenditure caused by both declining population and population ageing, and the low performance of the health system driven, among other factors, by the high reliance on inpatient care and the low expenditure on public health. The latter concern is reflected in 2017 CSR 2 which calls for a better performance of the system through the strengthening of outpatient care and of disease prevention (EC, 2017; CONS, 2017).

LRAs’ spending for health as % of GDP



LRAs’ competences and owned facilities

COMPETENCES	OWNERSHIP
<ul style="list-style-type: none"> • planning: L • delivery: L • funding: L • public health: L 	<ul style="list-style-type: none"> • hospitals: L • other facilities: L

R = Regional L = Local

LUXEMBOURG

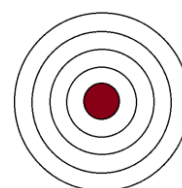
Key characteristics

- ▶ Centralised: power and responsibilities are held by the national government
- ▶ Provides universal coverage, by means of a compulsory social health insurance (SHI) system
- ▶ Mainly public financing of healthcare – out of national insurance
- ▶ Mostly public service provision

Structure of the health management system and main responsibilities

The Ministry of Health is responsible for health policy and legislation. Additionally, it takes responsibility for regulation, planning, organisation and funding of the national healthcare system. Health services are provided according to a social health insurance system, led by the Ministry of Social Security, which includes three schemes, one on healthcare, one on long-term care and an accident insurance.

The health insurance scheme and the long-term care insurance scheme are managed by the National Health Insurance (CNS - *Caisse Nationale de Santé*) which functions as a single payer of service providers. Fees for the provision of services are negotiated between professional groups and employers (in case of secondary care settings such as hospitals) or the national health insurance, in the case of primary care (Berthet *et al.*, 2015).



Service delivery, health prevention and promotion

Insurance provides patients with access to a package of services. Patients usually make up-front payments and are later reimbursed in the range of 80% to 100% of the cost. Some services (e.g. in hospitals) are rendered in kind (Spruit, 2014). Provision of primary care is not regulated. Patients may consult any service provider and directly access specialists and hospitals. There is no referral system in place but all health providers have to be authorised by the Ministry of Health in order to practice, and be accredited to the CNS in order to be reimbursed for the services rendered.

Secondary care is delivered through hospitals (private and non-profit), long-term care settings and specialists. Hospital care is centrally regulated. The number and standards of hospitals are set in the National Hospital Plan (NHP). In 2016, there were 12 hospitals (OECD.stat online) distributed over the country on the

basis of three planning regions (Berthet *et al.*, 2015). The NHP regulates the hospital sector (both public and private facilities) also taking into account the global budget for hospitals' costs set by the CNS.

The Ministry of Health is in charge of health prevention and promotion, including its co-financing. To this end, national plans are adopted to address specific preventive objectives and support promotion campaigns.

Financing

Public expenditure contributes most of the total health expenditure (82.4% in 2014), in particular in the form of compulsory insurance contributions (73.9%) (EU/OECD, 2016). The healthcare scheme is contributed to by employers and employees (60%) and by the state (40%) (Berthet *et al.*, 2015). Contributions to insurance schemes are mandatory for all economically active persons and for those who receive a subsidised income (Berthet *et al.*, 2015). The rest of total health expenditure is from private sources mainly represented by out-of-pocket payments (10.7%) and, to a lesser extent, payments for private insurance schemes (5.5%) (EU/OECD, 2016).

Funding of hospitals is through the national health insurance on the basis of agreements negotiated by the CNS with individual hospitals.

Synopsis and evolution of the structure

All health-related competences and health-related spending are with the national government, hence the health system of Luxembourg classifies as centralised. Reforms undertaken since 2010 principally aimed at improving quality of health, promoting equal access, and ensuring the financial sustainability of the system.



None of the structural changes which occurred implied transfer of competences at the subnational level. Rather, the reduction of the number of hospitals in the last decade and the on-going modernisation process of the sector tend to increase its regulation and planning. The draft law on hospitals, tabled by the government to the Chamber of Deputies in September 2016, envisages, among other aspects, new provisions related to hospital governance (MoH, 2017).

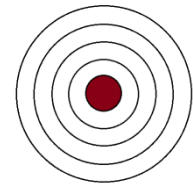
MALTA

Key characteristics

- ▶ Centralised: power and responsibilities are held by the national government
- ▶ Provides universal coverage free of charge at the point of service
- ▶ Mainly public financing of healthcare – out of general taxation and national insurance
- ▶ Mixed service provision – public and private

Structure of the health management system and main responsibilities

Health policy, legislation, planning, implementation, licensing, monitoring and funding are a state responsibility. Among the main actors are the Ministry for Health and various regulatory and advisory bodies. Healthcare is tightly regulated, the 2013 Health Act being the most relevant piece of legislation currently framing the whole system (Azzopardi-Muscat *et al.*, 2017).



The Health Act also rules the organisation of the Ministry for Health. Within the ministry, there are three Departments, for (i) Policy in Health, (ii) Health Services, and (iii) Health Regulation. The Department for Health Services is responsible for the operation and delivery of healthcare services. The Department for Health Regulation is responsible for health promotion, prevention, licensing and control (Azzopardi-Muscat *et al.*, 2017).

Service delivery, health prevention and promotion

Statutory healthcare services are free of charge at the point of use for those individuals covered by the Social Security Act. Coverage provides access to a comprehensive benefits package set by the government, without user charges or co-payments (EC, 2016). Primary care is provided through nine public health centres (eight in Malta and one in Gozo) as well as local health clinics. General practitioner and nursing services, some ambulatory care, and specialist services are provided through the public system. Patients do not have the choice of the GP. Public GPs have a gate-keeping role (EC, 2016). At the level of primary and community care, there are cases of involvement of local authorities in the provision of services, especially in the peripheral areas, through small clinics and primary health centres (Azzopardi-Muscat *et al.*, 2017). Secondary care and tertiary care are mainly provided through four public hospitals, two of which are acute and two specialised.

The private sector continues to gain importance in the delivery of health-related services and is significant in primary care where it accounts for two-thirds of the workload. There are private GPs and specialists as well as six private hospitals, and other clinics and facilities providing private healthcare. In the future, private involvement will also increase in the delivery of secondary care as a consequence of the recent 30-year concession granted by the government to a private provider for the management of three hospitals (Azzopardi-Muscat *et al.*, 2017).

Public health services are a prerogative of the central level.

Financing

The public healthcare system is funded through general taxation and national insurance (i.e. social security contribution) paid by workers and employees, although these revenues are not earmarked for health. A fixed budget is allocated annually to the Ministry for Health which then finances, among other areas, primary care and acute public hospitals. The central government is both a purchaser and a provider of services. Public funding represented 69.2% of total health expenditure in 2014 (EU/OECD, 2016).

Care in private facilities is for the most part funded through out-of-pocket payments and, to a lesser extent, private insurance purchased on a voluntary basis. Those individuals joining a private scheme are, nevertheless, not allowed to exit the public system. Although no user charges or co-payments apply for public healthcare, private health spending accounted for 30.8% of total health expenditure in 2014 (1.7% from private insurance and 28.9% from out-of-pocket payments) (EU/OECD, 2016).

Synopsis and evolution of the structure

All health-related competences and health-related spending are with the national government, hence the Maltese system classifies as centralised. However, the 2013 Health Act provides for regulated decentralisation and for an increased involvement of local authorities, especially in the provision of community healthcare (Azzopardi-Muscat *et al.*, 2017).



In parallel, the private sector is also gaining in importance as service provider, originally in ambulatory and primary care and in the near future in hospital care.

Among the concerns noted in the 2017 European Semester country report is the long-term sustainability of the system. A steep increase in public expenditure in general is expected, and healthcare is among the driving sectors of this increase as it is sensitive to population ageing (EC, 2017).

NETHERLANDS

Key characteristics

- ▶ Mostly centralised: centrally monitored market-based system, with a role for local authorities (municipalities) in specific service areas
- ▶ Provides universal coverage through compulsory health insurance
- ▶ Mainly funded through income-related contributions and premiums
- ▶ Service provision is private, on the basis of a regulated competitive market

Structure of the health management system and main responsibilities

Since the 2006 Health Insurance Act and the introduction of a compulsory health insurance scheme, one of the main tasks of the central government in healthcare is to ensure the functioning of a regulated competitive insurance market. The central level is responsible for controlling the quality, accessibility and affordability of healthcare. It defines health policies and sets health budgets. Among the most relevant ministries are the Ministry of Health, Welfare and Sport and the Ministry of Finance. Still at the central level, supervision and inspection roles are delegated to independent bodies such as the Health Care Inspectorate (with regard to quality and accessibility of healthcare) and the Dutch Health Care Authority (with regard to health insurers). Other entities have an advisory role (e.g. the Health Council) or deal with different health-related issues such as public health, knowledge and research (Kroneman *et al.*, 2016).



Insurers and providers are responsible for the provision of healthcare services. In particular, private health insurers (26 in 2014, although merged into only nine groups) are responsible for mobilising healthcare providers with whom they negotiate the quality, quantity and cost of care. Insurers are for the most part non-profit, i.e. mutual or cooperatives whose members are the insured. For-profit and non-profit insurers cannot charge applicants differently based on different risk factors and are regulated by a series of state acts. Healthcare providers are independent, non-profit entrepreneurs and need to be licensed under the Health Care Institutions Admission Act. Insurers and providers cannot

spend more than the budget set by the government for healthcare (Kroneman *et al.*, 2016).

The responsibility for public health services is shared between the central level and the local authorities. Additionally, since 2007, according to the Social Support Act, which was extended in 2015, local authorities are also partly responsible for the provision of long-term care (e.g. home nursing) and youth care (e.g. mental health) (Kroneman *et al.*, 2016).

Service delivery, health prevention and promotion

The Health Insurance Act refers to a basic health insurance scheme covering, among other benefits, primary care, home nursing care and hospital care. Patients are free to select their health insurer and providers, unless some restrictions are applied by the insurance package they join. There are two main types of arrangement between the insurer and the applicant: the ‘in-kind arrangement’, where services are paid in full but the choice of providers is restricted; and the ‘restitution arrangement’, where there is a free choice of providers but if the cost of services is above a certain maximum level of reimbursement, the difference is paid by the patient. Insurers are obliged to provide a basic benefits package defined by the government. Citizens may decide to complement this package with voluntary health insurance schemes (Kroneman *et al.*, 2016).

With regard to primary care, all citizens are registered with a general practitioner (GP). A very high percentage (93%) of contacts is handled within the general practice that is part of the basic health package provided by insurers. A gate-keeping system through the GPs is in place for accessing specialist and hospital care as well as emergencies, although emergencies may be also accessed without referral. Secondary care is for the most part provided in hospitals which usually have inpatient and outpatient facilities and are distinguished into general, academic and specialised as well as in different types of ‘centres’ (independent treatment centres, top clinical centres and trauma centres). Most hospitals are foundations and all hospitals are non-profit as profit-making is not allowed. Investments (construction, reconstruction, equipment) are the responsibility of the hospitals themselves in that a contribution towards this type of expenditure is built into the care tariffs applied (Kroneman *et al.*, 2016).

The Public Health Act establishes that the main targets for prevention are set by the central government while implementation activities are the responsibility of municipalities. To this end, municipalities have established 25 municipal health

services (*Gemeentelijk Gezondheidsdiensten – GGDs*) that are involved in health prevention and promotion activities. GGDs' tasks, as specified in the Public Health Act, include: preventive youth healthcare; environmental health; socio-medical advice; periodic sanitary inspections; public health for asylum seekers; preventive screening; epidemiology; health education; vaccinations; and preventive community mental health (Kroneman *et al.*, 2016).

Financing

The statutory insurance is funded through a combination of income-related contributions (which are transferred to the Health Insurance Fund for further redistribution to health insurers according to a risk-adjustment system), premiums (paid directly to the insurers), and government contributions for those aged below 18 years (Kroneman *et al.*, 2016). Funding of the health system is mainly through public sources (80.6%), in particular from compulsory contributions and premiums (75.8% in 2014) and, to a lesser extent, government schemes (4.8% in 2014) (EU/OECD, 2016). Taxation is not earmarked for healthcare. Private expenditure accounted for 19.4% of total health expenditure in 2014, of which 12.3% was for out-of-pocket payments and 5.9% for voluntary insurance schemes (EU/OECD, 2016).

Municipalities are funded out of the state budget through a tax-based municipality fund. Allocations to municipalities are determined at the central level on the basis of a number of criteria, but are not earmarked. Furthermore, municipalities may raise their own funds through local taxes and contributions. Municipalities purchase care from providers and may independently spend the resources allocated to them for home and youth care as well as public health services (Kroneman *et al.*, 2016).

Synopsis and evolution of the structure

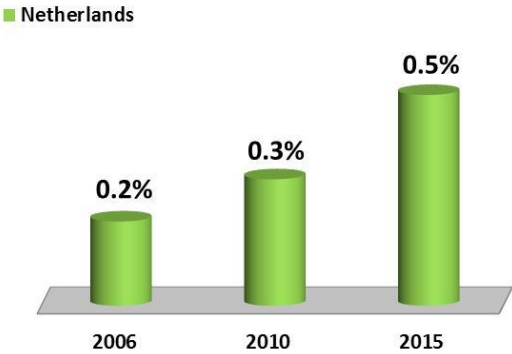
Local governments are among the several actors which are delegated responsibility for healthcare provision within a market-based system regulated and controlled by the central level. The reforms implemented in the last decade have progressively increased the involvement of local authorities in the delivery and organisation of some types of care, including in the long-term care sector.



The 2017 European Semester country report mentions the importance of evaluating the impact of the 2015 shift of responsibility reform (Social Support Act) in the light of the projected increase of long-term care expenditure (EC,

2017). In fact, such an increase may lead to sustainability problems of the system and hence have implications for municipalities. An evaluation of the reform is awaited for 2018.

LRAs’ spending for health as % of GDP



LRAs’ competences

COMPETENCES
• planning (youth): L
• delivery (youth): L
• funding: L
• public health: L

R = Regional L = Local

POLAND

Key characteristics

- ▶ Partially decentralised: important role of the central level, with regional (voivodeship) and local (*gmina, powiat*) authorities having health-related responsibility by law
- ▶ Provides coverage through mandatory health insurance
- ▶ Mostly public funding – out of health insurance contributions and taxation
- ▶ Mixed service provision – public and private

Structure of the health management system and main responsibilities

At the national level, the Parliament enacts health laws while the Ministry of Health is responsible for health policy, for proposing regulations, and for the financing of some specialised services and of health programmes (Nieszporska, 2017; HiT online). It also has, among other functions, a supervisory and sometimes managing role for a wide range of institutions. One of these entities, jointly supervised with the Ministry of Finance, is the National Health Fund (NHF). The NHF is directly accountable to the government and is the public insurer responsible for the pooling of resources raised through the mandatory national insurance scheme, for contracting private and public healthcare providers, and for payments and reimbursements. The fund has branches in all the 16 regions.



Regional and local authorities hold health responsibility at their

administration level with respect to health needs assessment for services and infrastructure. Regional authorities also perform strategic, planning and supervisory functions and are responsible for emergency care (HiT online). Since most of the healthcare facilities are owned by territorial authorities, these authorities also bear funding and capital investments responsibilities and may be involved in the delivery of services (Nieszporska, 2017; EC, 2016).

Service delivery, health prevention and promotion

The mandatory health insurance covers 91.6% of the population (EC, 2016). It provides access to a range of services defined by law. Some services may require co-payment. There is free choice of doctors and of healthcare facilities, as far as providers have contractual arrangements with the regional branches of the NHF. Apart from some specific cases, a referral by a physician is needed to access both specialist and inpatient care (Żukowski, 2013). Healthcare providers are contracted by the NHF and may be public or private. Providers include physicians, public and non-public healthcare facilities (hospitals and surgeries). All providers are independent with respect to their organisation and finances (EC, 2016).

Primary care is through a general practitioner. Secondary care is delivered in facilities that may be owned by the state, regional or local authorities or private actors. A structural reform of public healthcare facilities came into force in July 2011. The conversion of public units into corporations was encouraged while those subnational authorities owning facilities with debts and refusing to change their organisational structure had to either cover the debts or sell the facility. As a consequence of this reform, 191 public hospitals – 70% of which owned by local authorities – were transformed into corporations (EC, 2016).

A new law on public health entered into force in 2015. The law introduced a National Health Programme 2016-2020, which is allocated its own budget, and established some central functions related to monitoring, consultation and advice. Provision of public health services is the responsibility of local and regional authorities (HiT online).

Financing

The healthcare system is funded mainly from (income-based) health insurance contributions and, to a lesser extent, from taxes levied at the national and local levels (Żukowski, 2013; EC, 2016). In 2014, social insurance contributions

accounted for 62.4% of total health expenditure, while public contribution in the form of taxation equalled 9.1% (EU/OECD, 2106).

Private revenue was 28.5% of total health expenditure in 2014, mainly from out-of-pocket payments (22.5%).

Synopsis and evolution of the structure

Since the 2004 law on healthcare services financed from public funds, the management structure of healthcare has not changed (Żukowski, 2013). A further decentralisation of the system has been discussed in the last years but legislation was never drafted in that sense.

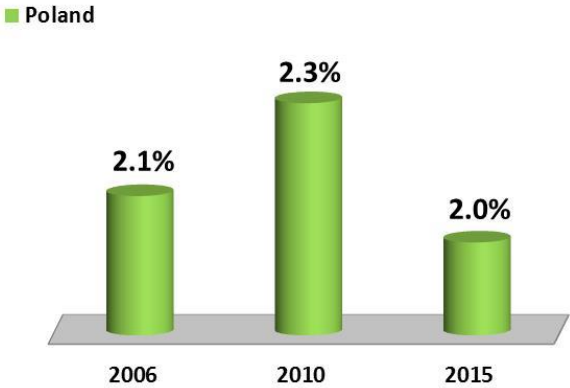


The central government still holds important power and responsibility, primarily through the Ministry of Health and the National Health Fund, while local and regional authorities have a role in planning, supervision and delivery of services, the latter function as owners of healthcare facilities.

The 2017 European Semester country report points to the need to improve the cost-effectiveness of healthcare spending, for example by strengthening primary care versus secondary inpatient and specialist care. However, the remark is only generally reflected in CSR 1, where the necessity to improve the efficiency of public spending is mentioned (CONS, 2017; EC, 2017).

LRAs’ spending for health as % of GDP

LRAs’ competences and owned facilities



COMPETENCES	OWNERSHIP
<ul style="list-style-type: none"> • planning: R • organisation: R, L • funding: R, L • public health: R, L 	<ul style="list-style-type: none"> • hospitals: R, L • other facilities: L

R = Regional L = Local

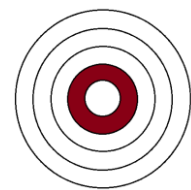
PORTUGAL

Key characteristics

- ▶ Mostly centralised: regulated, planned and managed at the central level with local authorities (municipalities) having a minimal role
- ▶ Provides universal coverage mostly free of charge at the point of service
- ▶ Mainly public financing of healthcare – out of general taxation
- ▶ Mixed service provision – a combination of public and private systems (i.e. the national health system, health insurance schemes and private voluntary health insurance)

Structure of the health management system and main responsibilities

At the central level, the Ministry of Health (MoH) is responsible for defining health policy and for the regulation, planning and management of the National Health Service (NHS). It also regulates and controls private health service providers. Several institutions are under the MoH's direct or indirect administration, among which are the Directorate-General of Health, responsible for health promotion and prevention, and five Regional Health Administrations (RHAs). Each RHA is governed by a board that is accountable to the Minister of Health. RHAs are responsible for managing the health system at the regional level coherently with regional plans and national policies. They coordinate healthcare provision, supervise hospitals, and manage public primary healthcare. They also contract hospitals and private service providers, and negotiate the delivery of primary care with groups of primary care centres (*Agrupamentos de Centros de Saúde*, ACES) (Simões *et al.*, 2017). A few hospitals are under the direct control of the government while other entities are still under the MoH but with public enterprise status, which gives some autonomy. These entities include local health units (originally aimed at integrating hospital and primary care units in one organisation), hospital centres (grouping hospitals of a same geographical area) and hospitals.



Other public sub-systems and private schemes are complementary to the NHS for the provision of healthcare and cover some 25% of the population (Simões *et al.*, 2017). These include occupational-based health insurance schemes and private voluntary health insurance.

Municipalities' role in healthcare is minimal and often related to health promotion activities. They are part of the National Network for Long-term Care for the provision of long-term, social and palliative care. In some regions, they

may contribute to the development of infrastructure for the care of the elderly. In addition, they participate in the National Health Council, an independent consultative body for the MoH established in 2016 (Simões *et al.*, 2017). On the other hand, the two autonomous regions of Azores and Madeira have a certain level of power for the planning and management of healthcare (Simões *et al.*, 2017). According to OECD (2012), local authorities have a limited capacity of raising independent revenues but receive transfers from the central level, some of which are earmarked for health.

Service delivery, health prevention and promotion

The NHS provides universal coverage and access to a basic benefits package which is determined by the Ministry of Health. Co-payments apply according to income thresholds (EC, 2016). Registration with a general practitioner is statutory and GPs have a gate-keeping role to secondary care (Simões *et al.*, 2017). Primary care is provided through a network of public and private providers, including professionals working in private practice. Within the NHS, primary care is mainly provided through 459 (as at October 2016) family health units (*Unidades de Saúde Familiares - USFs*). These USFs are teams of GPs and nurses and are located in the ACES together with other units (e.g. public health, long-term care). In fact, ACES also provide some specialist care, with the double aim of improving access to healthcare and reducing the referrals to secondary care (Simões *et al.*, 2017).

Secondary and tertiary care is mainly provided in hospitals. As at 2015, there were 114 public and 111 private hospitals (OECD.stat online). Private hospitals may be for-profit or not-for-profit. The management of hospitals belonging to the NHS may be given to private actors on a contractual basis (e.g. public-private partnerships). Private providers have contracts with the national health system or with other sub-systems to provide care services (Simões *et al.*, 2017). According to the 1990 Basic Law on Health, the state promotes the involvement of the private sector in the management of public healthcare facilities, in the provision of healthcare, and in the development of alternative health financing schemes such as voluntary insurances (Simões *et al.*, 2017). This has been leading to a growing role of the private sector in healthcare.

Provision of public health services is a shared responsibility between RHAs, local public health teams based in ACES, and individual doctors (Simões *et al.*, 2017).

Financing

Public healthcare is mainly financed through general taxation, with an important share coming from indirect taxes. In 2014, public health expenditure represented 66.2% of total health expenditure. Private expenditure accounted for the remaining 33.8% of total expenditure in the same year, for the most part from out-of-pocket payments (27.5%) and, to a lesser extent (5.4%), from premiums paid to private insurance schemes (EU/OECD, 2016).

The Ministry of Finance allocates funds to the Ministry of Health that, in turn, allocates budgets to the RHAs. These have some spending autonomy for primary care while hospitals are remunerated directly by the Ministry of Health on the basis of contracts and through global budgets. Public and private health sub-systems are funded through employer and employee contributions.

Synopsis and evolution of the structure

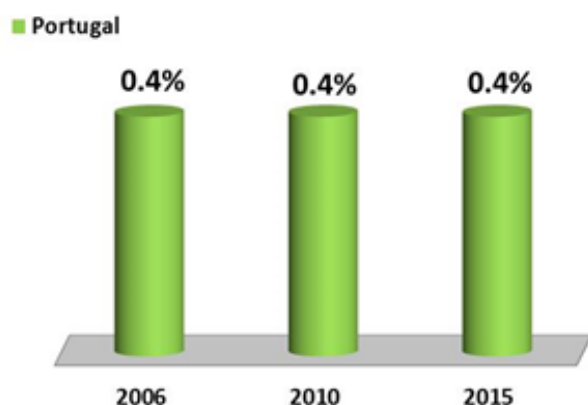
With the exception of the two autonomous regions of Azores and Madeira, the Portuguese health system is centralised, with policy, legislative, planning, implementing and financing competences held at the state level. The system is regionalised through the RHAs and structurally decentralised over the country. Local authorities' involvement is limited to some health prevention activities and activities related to social and long-term care.

Recent reforms, including the 2016 'Strategic Plan for Primary Healthcare Reform', do not encompass decentralisation aspects. Rather, it is noted that the latest measures taken within the framework of the Economic and Financial Adjustment Programme agreed in May 2011 implied greater control by the central level (Simões *et al.*, 2017).



Notwithstanding the progress made towards 2016 CSR 1 on the long-term sustainability of the health sector and access to primary healthcare, 2017 CSR 1 still calls for greater control on expenditure. It refers in particular to the accumulated delayed payments in the hospital sector which cause indebtedness of the state-owned hospitals and undermine the short-term sustainability of the system (EC, 2017; CONS, 2017).

LRAs' spending for health as % of GDP



LRAs' competences

COMPETENCES
• funding: L
• public health: L

R = Regional L = Local

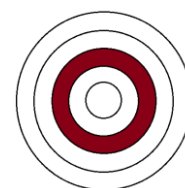
ROMANIA

Key characteristics

- ▶ Operatively decentralised: main role of the central government but local (municipalities) and regional (*judet* or district councils) authorities hold some operative functions derived from the ownership of hospitals
- ▶ Provides coverage through compulsory social health insurance
- ▶ Mainly public financing of healthcare – contributions from national insurance system and general taxation at national and local levels
- ▶ Mainly public service provision

Structure of the health management system and main responsibilities

The central level holds the responsibility for health legislation and policy. Among the main national institutional actors are the Ministry of Public Health, responsible for defining health policies, developing secondary legislation, issuing regulations – including for the pharmaceutical sector and public health –, setting standards, and monitoring and evaluating healthcare provision and the organisation of healthcare providers; the Ministry of Public Finance, for healthcare financing issues and financial control; and the National Health Insurance House (NHIH), as an autonomous public institution administering and regulating the social health insurance system. Every two years, the NHIH develops the 'Framework Contract' which is then approved by the Ministry of Public Health and the government. This contract defines the benefits package for the insured people and the terms and conditions of the contractual relationship between public and private service providers and the insurance system (Vladescu *et al.*, 2016). Both the Ministry of Public Health and the NHIH are



represented at the district level by 42 District Public Health Authorities (DPHAs) and 42 District Health Insurance Houses (DHIHs), respectively. Locally, the DHIHs contract health service providers and monitor service provision.

It is only since 2010 that regional and local authorities started taking some responsibilities for the hospitals they own, in particular in terms of administration and management (Vladescu *et al.*, 2016).

Service delivery, health prevention and promotion

In principle, the mandatory health insurance scheme covers the whole population but, in fact, only 86% of the people are insured. These individuals have access to a comprehensive benefits package that includes, among other things, ambulatory care, hospital care, pharmaceuticals, health materials and devices, dentistry services, and home care nursing. Cost-sharing, introduced in 2013, applies to some services. The uninsured (e.g. those working in agriculture) have access to some basic services only (Vladescu *et al.*, 2016).

Primary healthcare services are provided through family doctors working as independent practitioners. Patients have to register with a GP who acts as gate-keeper for secondary care. Patients have free choice of the provider. Almost all health providers are independent practitioners contracted by DHIHs. Ambulatory secondary care is delivered through a network of outpatient departments within hospitals, centres for diagnosis and treatment, and specialists. Inpatient care is provided through a wide network of hospitals including a variety of types (e.g. regional, district and local hospitals but also specialty hospitals and health centres). The public hospital sector has gone through a series of reforms and a substantial reduction of hospital units in last years. After the take up of administrative and management functions in 2010 by regional and local authorities, a national strategy for hospital rationalisation was approved in 2011 which led to the closure of some units and the transformation of others into facilities for the elderly and long-term care. According to the 2014–2020 Health Strategy, a further reduction in the number of hospitals is envisaged with a view to promote more integrated services, reduce inpatient care and strengthen primary and community care. In 2014, there were 527 hospitals in the country, over two thirds of which were public. Some 80% of the public hospitals are owned by regional and local authorities (Vladescu *et al.*, 2016).

Public health is coordinated and supervised at the central level while services are delivered by the DPHAs (Vladescu *et al.*, 2016).

Financing

According to 2014 data, funding of the health system is mainly through public sources (79.3%), in particular from compulsory contributions and premiums (64.4%) and government schemes (14.9%) (EU/OECD, 2016). There are categories of people who are exempted from the payment of contributions and for which payments are made through state funds. Taxes represent the second most important source of revenue for public health expenditure and are levied at the national and local levels. Taxes are not earmarked for health, with the exception of those related to tobacco and alcohol.

Private health expenditure accounted for 20.7% of total health expenditure in 2014 (EU/OECD, 2016) most of which (19.9%) was sourced through out-of-pocket payments. OOP payments refer to co-payments for services included in the benefits package, direct payments for services purchased from private providers, or payments from uninsured patients (Vladescu *et al.*, 2016). Voluntary health insurance and the private market have marginal roles (Zaman, 2014).

The budget for health is approved yearly by the government. It is allocated for two thirds to the Ministry of Public Health and other central ministries, and for one third to subnational governments. Distribution of funds to DPHAs and DHIHs is done according to allocations specified in the budget. Capital investments are also made according to the budgets specified in annual programmes developed by the Ministry of Public Health. Capital investments in healthcare facilities are mainly from the state budget but local budgets may also be used. In addition, since 2014, hospitals are allowed to cover investments costs out of the payments they receive but only after having covered their operating expenses in full (Vladescu *et al.*, 2016).

Synopsis and evolution of the structure

The Romanian health system is still mostly controlled and regulated at the central level, although in the last years regional and local authorities have been able to take up an operative role which was previously constrained by the lack of financial and human resources. Their main input is in terms of administration and management of healthcare facilities as well as in revenue raising and financing of the facilities they own, including capital investments. The impact on the role of subnational authorities in health management further to the restructuring of the hospital

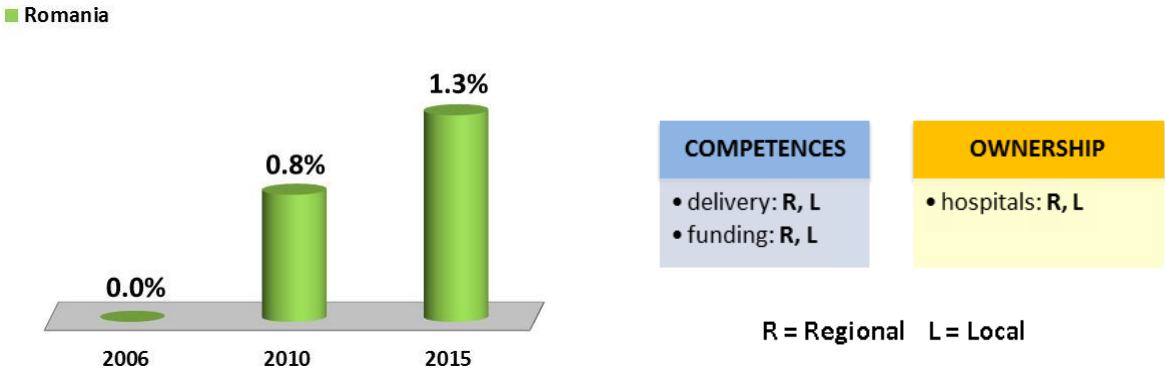


network as envisaged in the 2014–2020 Health Strategy is unclear.

Most recent reforms focus on cost-saving measures and control of healthcare expenditure. Nevertheless, there are several areas of concerns highlighted in the 2017 European Semester Country Report which include, among other aspects, unequal access to healthcare, under-funding, excessive reliance on inpatient care, and prevalence of informal payments. In particular, the shift to outpatient care and the need to limit informal payments are part of 2017 CSR 2 (EC, 2017; CONS, 2017).

LRAs’ spending for health as % of GDP

LRAs’ competences and owned facilities



SLOVAKIA

Key characteristics
▶ Operatively decentralised: main responsibilities are at the central level but regional and local authorities (municipalities) hold some functions with respect to the healthcare facilities they own
▶ Provides universal coverage through a mandatory health insurance system
▶ Mainly public financing of healthcare – contributions from the insurance system
▶ Mixed service provision – public and private

Structure of the health management system and main responsibilities

Under the central government, the Ministry of Health (MoH) is responsible for drafting health policy and legislation as well as for the regulation of healthcare and pricing, the managing of national health programmes, and the determination of quality criteria and of the basic benefits package. In addition, the state is the owner



(and operator) of what are usually the largest and most specialised healthcare facilities, and of the most important health insurance company. Since 2004, monitoring and supervisory functions have been passed to the Health Care Surveillance Authority. The authority supervises health insurance, the purchasing and provision of services, and the risk adjustment mechanism for redistributing contributions collected with the insurance schemes. Its members are appointed by the Parliament while the central government appoints its chair (Smatana *et al.*, 2016).

Some tasks have been decentralised to the eight self-governing regions, in particular with regard to monitoring, issuing of permits to providers, and securing healthcare provision in specific circumstances such as the temporary withdrawal of a provider or upon detection of poor accessibility of services by patients. Regions also own and manage some healthcare facilities. In particular, in 2003, regions received the so called ‘type II’ hospitals providing secondary care, while ‘type I’ hospitals with facilities for primary care were transferred to municipalities. Some of the facilities received by the regions were afterwards privatised or transformed into joint stock companies (Smatana *et al.*, 2016).

Insurers are profit-making joint stock companies in charge of contracting public and private healthcare providers on a competitive basis. An exception to this rule relates to state-owned facilities which have to be contracted because it is considered necessary in order to reach a fair geographical distribution of services. Hence, all but the state hospitals compete to win contracts with the insurers. The MoH owns the largest of the three existing insurance companies, with a market share of 64% in 2015, while the other two insurers are private. Insurance companies also operate according to market mechanisms (Smatana *et al.*, 2016).

Service delivery, health prevention and promotion

The compulsory insurance provides universal coverage and access to a basic benefits package which is sometimes subject to co-payments or small user fees. Patients are free to choose their insurer and general practitioner (GP) as well as their specialist and hospital. Since 2013, GPs have a gate-keeping role to specialist (outpatient) care and to hospital (inpatient) care. Primary care and outpatient facilities are for the most part privately owned. Secondary care is provided in general hospitals (including university hospitals) and specialised hospitals, owned publicly or privately. In 2014, out of the 174 inpatient facilities, 27 were owned by regions or municipalities while 73 were private or with mixed ownership (Smatana *et al.*, 2016). Each hospital is managed by its owners.

Emergency care is state-controlled through the National Emergency Centre of Slovakia. Emergency care services are provided by private or public providers and create a network of some 274 units all over the country. Also health prevention and promotion is centralised, with the Slovak Public Health Authority taking responsibility for it (Smatana *et al.*, 2016).

Financing

In 2014, public sector expenditure was 80.2% of total health expenditure. The health system is mainly financed through contributions collected in the form of health insurance payments (76.2% in 2014) (EU/OECD, 2016). Contributors include the employed population, the voluntarily unemployed and non-employed people, for whom the state pays out from tax revenues (Smatana *et al.*, 2016). A governmental financing system also exists, based on general taxation at the national, regional and municipal levels (equalling 4.0% of total health expenditure in 2014). Regions and municipalities are responsible for covering the investments costs of the facilities they own but corresponding amounts are relatively small. Private contributions equalled 19.8% of total health expenditure in 2014 and were mostly sourced through out-of-pocket payments (18.0%) (EU/OECD, 2016). Voluntary insurance schemes are not commonly undertaken (Smatana *et al.*, 2016).

Synopsis and evolution of the structure

The Slovak health system is importantly controlled by the central level, institutionally (e.g. at the legislative, policy and planning levels) and operatively, through the ownership of the most important insurance company and of the largest healthcare facilities.

None of the recent reforms imply evolution towards greater decentralisation, and the role of regions and municipalities in the health system remains related to the ownership of healthcare facilities.

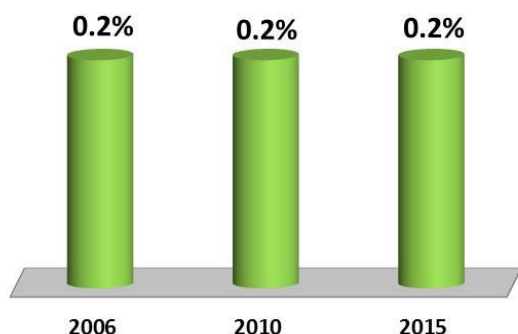


Since 2008, the focus of undertaken reforms has been on cost containment measures. Making the health system more cost-effective was one of the Council's country-specific recommendations in 2016, a recommendation that was reiterated in 2017 (CSR 1) due to the limited progress made until now (EC, 2017; CONS, 2017).

LRAs' spending for health as % of GDP

LRAs' competences and owned facilities

■ Slovakia



COMPETENCES	OWNERSHIP
<ul style="list-style-type: none"> • delivery: R, L • funding: R, L 	<ul style="list-style-type: none"> • hospitals: R, L

R = Regional L = Local

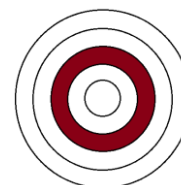
SLOVENIA

Key characteristics

- ▶ Operatively decentralised: several functions are held centrally but municipalities are responsible for primary care
- ▶ Provides universal coverage through a mandatory health insurance system
- ▶ Mainly public financing of healthcare – income-based contributions from the national insurance system and, to a much lesser extent, general taxation at national and municipal levels
- ▶ Mixed service provision – public and private

Structure of the health management system and main responsibilities

The central level is responsible for administrative and regulatory functions in the health sector as well as for health policy and planning. The Ministry of Health (MoH) prepares health legislation and monitors its implementation, deals with licensing matters, health financing, and public health. The Health Insurance Institute of Slovenia (HIIS) is a public independent body supervised by the government in charge of administering the universal compulsory health insurance on which the system is based. It is structured at regional and local levels with 10 and 45 branches, respectively, and is in charge of purchasing services and contracting providers such as individual professionals, hospitals and primary care centres (Albrecht *et al.*, 2016). Apart from the compulsory insurance, there are three private providers of voluntary health insurance. The state also owns public health facilities at the secondary and tertiary care levels while public primary healthcare centres and pharmacies are owned by municipalities.



Municipalities are responsible for managing and maintaining the primary care network. At primary care level, local authorities grant concessions to private healthcare providers and are responsible for capital investments in the facilities they own. Their role is mostly operative because in practice their planning functions related to primary healthcare are non-exerted (Albreht *et al.*, 2016). Municipalities also own pharmacies, generate revenues (non-earmarked for health) through local taxation, and contribute to other activities related, for example, to public health and long-term care.

Service delivery, health prevention and promotion

Compulsory health insurance covers those individuals with an employment status and those with a dependency status, as is the case, for example, for minors or registered unemployed persons. The insurance gives access to a wide package which includes, among other benefits, primary, secondary and tertiary services. Co-payments may apply. Patients may choose their primary care doctor. Referral by the doctor for accessing specialist care is required (gate-keeping system) (Albreht *et al.*, 2016).

Service providers are mainly public but the number of private providers is increasing. Primary care is delivered through public primary healthcare centres (65 in 2014) and private general practitioners having a contract with HIIS. Primary healthcare centres provide, among other services, diagnostic services, general practice, community nursing and emergency aid. Emergency care services are in fact integrated within the primary and secondary care structures. At secondary care level, services are provided through hospitals and private facilities. Almost all hospitals (27 out of a total of 30 in 2014) are public. Private hospitals are profit-making. As is the case with all the other private providers, they first must receive concession from the MoH and then obtain a contract from HIIS. Tertiary care is provided in clinics and specialized institutes (Albreht *et al.*, 2016).

Since 2012, public health services are provided centrally by the National Institute of Public Health and by the National Laboratory for Health, Environment and Food (Albreht *et al.*, 2016).

Financing

The system is mainly funded through public sources but there is a significant share of private funding (29.0% in 2014) through co-payments (13.0%) and complementary voluntary insurance (14.8%) (EU/OECD, 2016).

Most of the public expenditure (71% in 2014) is out of the public insurance system (67.6%) which is contributed to by employers and employees on the basis of gross incomes (Albreht *et al.*, 2016). Another public source is out of general taxation, at the national and municipal levels. In 2014, this source contributed 3.4% of total health expenditure and was mostly used for governance-related expenses, public health activities, contribution to the co-payments of vulnerable groups and capital investments (Albreht *et al.*, 2016). In particular, the national level is responsible for investing in hospitals and other specialised infrastructure at the national and regional levels, while municipalities finance investments locally, in public health centres and pharmacies. Since taxes are not earmarked for health, decisions on the amounts to be allocated are made annually both at the central and at the local levels. Besides their own revenue, municipalities also receive a contribution for healthcare from the central level (Albreht *et al.*, 2016).

Synopsis and evolution of the structure

Within the Slovenian health system, responsibility for primary care is devolved to local authorities while the rest of the system is mostly under the power and competence of the central level. There is an important on-going healthcare system reform process which is likely to be finalised by the end of 2017/beginning of 2018. At the core of this reform, the draft Healthcare and Health Insurance Act addresses, among other aspects, health funding mechanisms/sources, responsibility of HIIS, and the contracting process of healthcare service providers. Other areas of concern relate to hospital governance/performance, and the gate-keeping function of primary care for inpatient care. Apparently, the envisaged reform does not imply further decentralisation of the system.

Instead, in the light of a recognised problem of fragmentation of service organisation and delivery of primary care – which implies unequal access to healthcare across the country – some standard measures have been recently introduced (e.g. strengthening of nursing support in the healthcare centres, and setting the number of patients per GP or paediatrician).

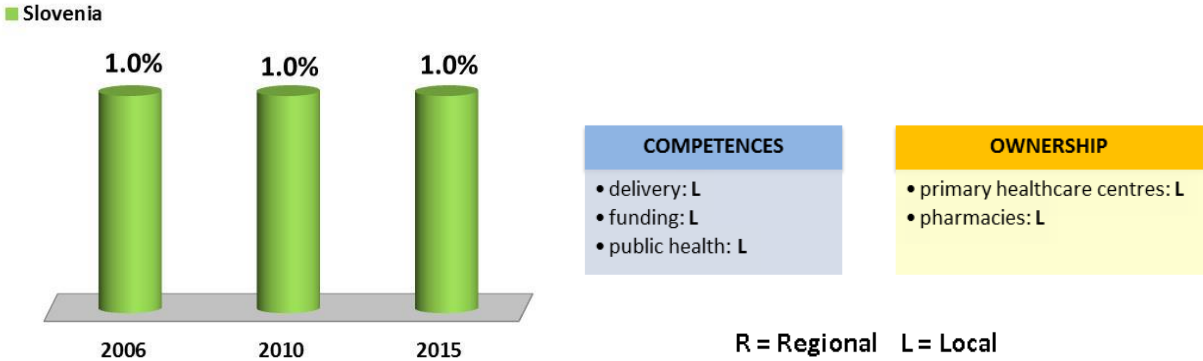


The 2017 European Semester country report highlights the increasing spending in healthcare – especially driven by population ageing –, the need to enhance healthcare access, and the pressure put by health on the long-term sustainability of public finances. These concerns are reflected in 2017 CSR 1 which calls for

the adoption and implementation of the planned health system reform (EC, 2017; CONS, 2017).

LRAs’ spending for health as % of GDP

LRAs’ competences and owned facilities



SPAIN

Key characteristics
▶ Decentralised: responsibility for healthcare is devolved to regional authorities (Autonomous Communities)
▶ Provides coverage to those holding the status of being insured
▶ Mainly public financing of healthcare – out of general taxation, including regional taxes
▶ Mixed service provision – mainly public and only to a lesser extent private

Structure of the health management system and main responsibilities

Since 2002, with the exception of the Autonomous Cities of Ceuta and Melilla, the responsibility for public health and for the provision of healthcare is with the regional governments of the 17 Autonomous Communities. The Ministry of Health, Social Services and Equality (MSSSI) of the central government is responsible for general coordination, financing, and issuing basic health legislation. Additionally, among other functions, it oversees the pharmaceutical sector and defines the benefits packages (EC, 2016). The permanent body in charge of coordinating the central and the regional levels is the Inter-territorial Council of the national health system, whose members include the central Minister for Health, Social Services and Equality and the 17 regional ministers of health (*Ministerio de la Presidencia* website).



Policy, regulatory, planning and organisational responsibilities for the regional health systems are with regional health ministries (HiT online; *Ministerio de la*

Presidencia website). Within the basic benefits package agreed at the national level, regions may define packages tailored to their needs (EC, 2016). They also define the system of healthcare areas and basic health zones for the delivery of healthcare. The regional health service assumes responsibility for operational planning, service network management and coordination of healthcare provision (HiT online). Historically, local authorities have been involved in the management of healthcare but their function is often limited to collaboration. Instead, they have an important role in health promotion activities as well as in community and social care (HiT online).

Service delivery, health prevention and promotion

The coverage status of the health system was modified in 2012 by Royal Decree 16/2012. According to the reform, individuals must meet specific criteria in order to be insured within the system and hence access healthcare. If eligibility conditions are determined centrally, accreditation has to be verified regionally, usually through the social security authorities (EC, 2016). The decree aimed, overall, at enhancing the sustainability of the system and also reformed, among other aspects, the definition of the benefits granted to the insured and the rules on prescription of medicines. In terms of benefits, a fully-covered core benefits package and a complementary package contributed to by patients' co-payments were distinguished (Patxot, 2014).

Services are usually provided at the two distinct levels of primary and secondary care or at an integrated level delivering both types of care. Delivery occurs within a structured territorial framework based on a system of healthcare areas determined according to demographic and geographical criteria (*Ministerio de la Presidencia* website). Primary care is delivered through a public network of medical or primary healthcare centres where multidisciplinary teams of professionals (e.g. general practitioners, nurses and paediatricians) have a gate-keeping function towards specialists. In turn, specialists give referrals for inpatient care, which is thus carefully regulated (EC, 2016). Specialised care is provided in hospitals and specialist clinics in the form of outpatient care, inpatient care and day hospital. In 2015, there were 765 hospitals out of which 343 (i.e. 45%) were publicly owned (OECD.stat online), the others being private for-profit. Public hospitals belong to several stakeholders including regions, the social security system and local authorities (MSSSI website). Their management is the responsibility of regions while the provision of services is based on contracts (EC, 2016). In most cases, the regional ministries allocate the funding to the regional health service, as the main provider, with whom global annual budgets are negotiated. In turn, the regional health service negotiates global

annual contracts with providers of primary care, hospital and specialised care, including private ones (HiT online).

Health prevention and promotion is a shared function. National plans coexist with regional plans and strategies, with Law 33/2011 defining the basis for coordination and cooperation activities among concerned public authorities. Primary healthcare centres are responsible for health prevention and promotion activities (*Ministerio de la Presidencia* website).

Financing

There is no earmarked budget for health. Regions cover health expenditure out of their general budgets which are essentially determined by two financing mechanisms: national and regional taxation and block-grants from the central government state’s budget (HiT online; EC, 2016). Different funds are used to pool resources (i.e. the Fundamental Public Services Guarantee Fund) and to ensure regions have enough (i.e. the Global Sufficiency Fund) and balanced resources to perform their competences (i.e. the Convergence Funds) (EC, 2016). On average, health spending accounts for 30% of the regions’ total budget (*Ministerio de la Presidencia* website). The share of public health expenditure in 2014 was 69.8% (EU/OECD, 2016). It is principally funded through general taxation. Regions are assigned specific shares of national taxes (e.g. 50% of personal income tax and VAT) and in addition may levy their own (EC, 2016). Private financing within total health expenditure (30.2% in 2014) is sourced almost entirely from out-of-pocket payments (24.7% in 2014) and, to a lesser extent (5.2%), from voluntary health insurance (EU/OECD, 2016).

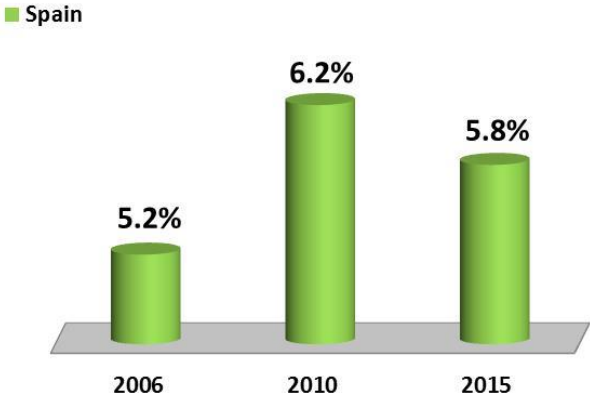
Synopsis and evolution of the structure

As a result of a decentralisation process of healthcare started over twenty years ago, the Spanish health system is structurally decentralised at the regional level. Regions are responsible for legislation, planning, implementation and financing of public health and healthcare services. The last substantial reform of the system (Royal Decree 16/2012) did not result in greater decentralisation.

The 2017 European Semester country report highlights an important increase in interregional inequalities in access to healthcare since 2008 (Patxot, 2014). It also notes the increasing share of regional taxes within the overall revenues of regions. This tax autonomy and the differences in tax capacity of regions is evened out by the equalisation transfers from the Guarantee and Convergence

funds which guarantee the delivery of the minimum level of services by all regions. However, the mechanism does not impact on the quality of services or on the provision of additional services over the statutory ones (EC, 2017). The regions' autonomy in spending decisions on health also limits the impact that the government's decisions may have on financial sustainability as compliance by the regions to the central government's fiscal rules is not mandatory (EC, 2016).

LRAs' spending for health as % of GDP



LRAs' competences and owned facilities

COMPETENCES	OWNERSHIP
<ul style="list-style-type: none"> • legislation: R • planning: R • delivery: R • funding: R • public health: R, L 	<ul style="list-style-type: none"> • hospitals: R, L

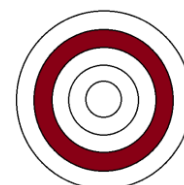
R = Regional L = Local

SWEDEN

Key characteristics
▶ Partially decentralised: regional and local authorities hold important responsibilities with respect to healthcare planning, organisation, delivery and funding
▶ Provides universal coverage through a tax-based National Health Service (NHS) and upon the payment of a nominal fee at the point of use
▶ Mainly public financing of healthcare – mostly out of regional and local taxation
▶ Mixed service provision – public and private

Structure of the health management system and main responsibilities

The state is responsible for overall healthcare legislation and policy but responsibilities for providing and funding health-related services are mostly at the regional and local levels. At the central level, health and medical care is under the Ministry of Health and Social Affairs, supported in its activities by a number of agencies. The Ministry drafts legislation, shapes policy, distributes resources, monitors implementation and negotiates with county councils, regions and municipalities on issues concerning the delivery of services. Negotiation is through the Swedish Association of Local Authorities and Regions.



At the regional level, there are 18 county councils, two regions and one independent island community – each with different organisational and governance structures – in charge of organising primary care, secondary care (specialist outpatient and inpatient) and public health according to the Swedish Health and Medical Services Act of 1982. In addition, county councils have the power to regulate accreditation and payment of private healthcare providers, hence performing a monitoring role of the private sector. Counties are grouped into healthcare regions to encourage mutual cooperation (Mossialos *et al.*, 2016). At the local level, the responsibilities of the 290 municipalities relate to home healthcare. Since municipalities are also responsible for long-term care, their focus is on the care of the elderly and of people with disabilities (EC, 2016; Anderson and Backhans, 2013).

Service delivery, health prevention and promotion

The NHS provides universal coverage. There is no benefits package defined and most of the services usually require a co-payment by the patients (EC, 2016). Services delivered vary across the country and may include primary and secondary care, preventive care, emergency care, dental care, nursing home care, hospice care, mental healthcare and drugs (Mossialos *et al.*, 2016). Primary care is delivered through general practitioners, nurses, and other health professionals either working on a private practice basis or as public employees, for the most part as group practices. Patients are free to choose their doctor, specialist and hospital and there is no compulsory referral system in place (EC, 2016). Primary care is often delivered in primary care centres. Out of some 1,100 primary care practices, about 40% are reported to be privately owned and therefore are contracted by the responsible regional authority (Mossialos *et al.*, 2016; EC, 2016).

Outpatient specialist care is provided in outpatient units of public hospitals and in private clinics (Mossialos *et al.*, 2016). Provision of services by the private sector is increasing in outpatient and primary care, but specialist and inpatient care remain dominated by public providers. Most of the hospitals are public (some 98% of hospitals' beds are public). Out of the 79 hospitals, most are local. Hospitals usually belong to county councils but may be managed by private companies to which county councils transfer all or part of the operational responsibilities (EC, 2016). Hospitals at the regional level usually provide more specialised care as do regional university hospitals (EC, 2016).

In 2014, the Public Health Agency of Sweden was created from the reorganisation of national institutes. The agency holds national responsibility for public health (HiT profile online) while programmes for health promotion and disease prevention are developed and implemented at the regional level (Mossialos *et al.*, 2015; EC, 2016).

Financing

Healthcare expenditure is mainly out of general taxation at the national and subnational levels, accounting for 83.4% of total health expenditure in 2014. In the same year, private funding of healthcare in the form of out-of-pocket payments accounted for 15.5% of total healthcare expenditure (EU/OECD, 2016). The number of those individuals purchasing private health insurance is small (2.3% of the population) and so is voluntary health insurance contribution to total expenditure (0.6% in 2014) (EC, 2016; EU/OECD, 2016).

Allocations of taxes to health are decided at all levels of governance, from central to local. Public budgets for health are determined according to responsibility and by the concerned authority (i.e. counties, regions and municipalities). This decentralised decision-making system is favoured by the lack of a standard benefits package (EC, 2016). A very high (70%) share of county council costs are financed through taxes, where the level of taxation is decided autonomously by the councils. Other revenues are from state grants (16%) and user charges (4%). A similar proportion exists for municipalities since 67% of their costs are financed through local taxes, while state grants contribute by 18 % and user fees by 6 % (Anderson and Backhans, 2013).

Synopsis and evolution of the structure

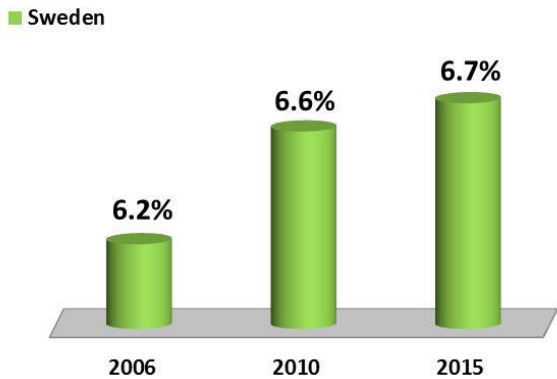
The Swedish healthcare system is organised at three levels: national, regional and local. Responsibility for the provision of health and medical care is devolved to county councils and, for some aspects, municipalities. The councils'

ample autonomy determines the existence of several differences across regions in the way healthcare services are made available as well as in the quality of services. To address this issue, attempts to strengthen governance at the national level have been made in recent years, in particular through the development of national action plans to be implemented by county councils (Anderson and Backhans, 2013).

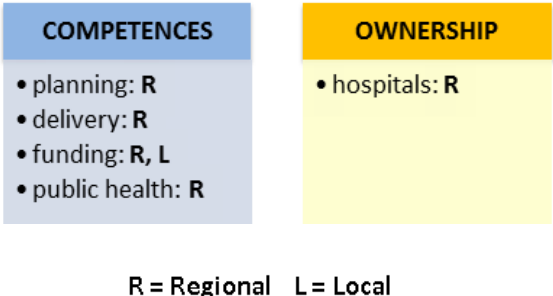
Another aspect which is currently being looked at within the framework of a re-organisation of primary care – and of a move away from hospital-centric care – is the need for better coordination and cooperation between county councils and municipalities (Government of Sweden, 2017). Hence, the system does not appear to evolve towards greater or lesser decentralisation but towards a strengthened coordination of the various decision-making levels.



LRAs’ spending for health as % of GDP



LRAs’ competences and owned facilities



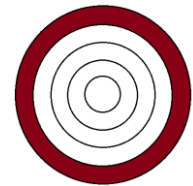
UNITED KINGDOM

- Key characteristics**
- ▶ Decentralised: the power and responsibility for healthcare and public health are devolved to the four constituent countries
 - ▶ Provides coverage to all residents, largely free at the point of service
 - ▶ Mainly public financing of healthcare – out of general taxation and national insurance contributions
 - ▶ Mostly public service provision

Structure of the health management system and main responsibilities

Each of the four nations of the United Kingdom (UK) has its own, publicly-funded, 'National Health Service' (NHS). The health system in England is under the direct responsibility of the UK Parliament while the systems of Scotland, Wales and Northern Ireland are under the responsibility of the corresponding devolved administrations (Cylus *et al.*, 2015).

In England, the UK Department of Health is responsible for health policy and regulation, for central budget disbursement as well as overall guidance and control of the NHS. Further to the Health and Social Care Act of 2012, a new public organisation accountable to the Secretary of State for Health – called NHS England – was charged with the responsibility to deliver healthcare services. NHS England contracts and purchases services and supervises their delivery. It also allocates resources to the 221 clinical commissioning groups introduced by the 2012 Act and led by general practitioners (GPs). These groups are in charge of commissioning necessary services from a range of providers including, for example, public hospitals and the private sector (Cylus *et al.*, 2015). The 2012 Act also established Health and Wellbeing Boards in order to improve the way the population's health needs are addressed and to start integrating health and social care. The boards bring together several stakeholders including local authorities and representatives from the NHS and adult social care (Cylus *et al.*, 2015).



In Scotland, the Scottish Parliament is responsible for health legislation while various actors within the Scottish government decide on budget and resources' allocation, and supervise the NHS. NHS Boards (14 regional and 7 national) are given the responsibility to plan and deliver healthcare services (i.e. there is no purchaser-provider split). They also plan and oversee hospitals. Local partnerships related to health and social care, which bring together local authorities and the public, are structurally linked to these boards as committees. The Scottish system is characterised by the recent integration of healthcare with social care (Cylus *et al.*, 2015; EC, 2016).

In Wales, the National Assembly is responsible for health legislation while the government's Department for Health and Social Services takes overall responsibility for the performance of the NHS, develops health policy, and decides on health funding. Seven Local Health Boards are given the responsibility to plan and deliver healthcare services locally (i.e. there is no purchaser-provider split). They also manage most of the hospitals. Additional

services are delivered by three NHS Trusts (one for emergency services; one for cancer-related specialist services; and the Public Health Wales) (Cylus *et al.*, 2015; EC, 2016).

In Northern Ireland, the Northern Ireland Assembly is responsible for health legislation while, within the government, the Department of Health, Social Services and Public Safety is responsible for health policy and public health. Health and social services are integrated within the system and are commissioned by four Health and Social Services Boards through local commissioning groups. Five Health and Social Care Trusts are the main service providers (Cylus *et al.*, 2015; EC, 2016).

Service delivery, health prevention and promotion

Among the common characteristics of the four systems is the universal coverage provided on the basis of residency. No benefits package is defined and the type of covered services varies across the nations. Some cost-sharing or direct payments may apply. Patients are free to choose which GP to register with, and the hospital. The primary care system, mainly delivered through GPs, has a gate-keeping function to secondary care. Secondary care is provided mostly through state-owned hospitals (called trusts in England and Northern Ireland), or, in more rural areas, specialists clinics. Private sector provision of services is still limited. Emergency care is provided in several forms and structures including hospitals' units (Cylus *et al.*, 2015).

Local authorities are often involved in the provision of social care but apart from Northern Ireland and, more recently, Scotland, social care is not yet integrated with healthcare (reforms in this sense were made in 2013 in England with the establishment of the Better Care Fund, and in 2014 in Wales, with the Social Services and Wellbeing Act) (Cylus *et al.*, 2015). Responsibility for public health is at the government level of each of the four nations. Public health services are delivered through the respective NHS and usually imply the involvement of local authorities. In England, the Health and Social Care Act of 2012 made local authorities responsible for commissioning such services (Cylus *et al.*, 2015).

Financing

The pooling of funds for health occurs centrally. Funds are then distributed by the UK Treasury in the form of allocations for health in England and block grants in the other three nations. These grants cover all the devolved functions and it is up to Scotland, Wales and Northern Ireland to decide autonomously on

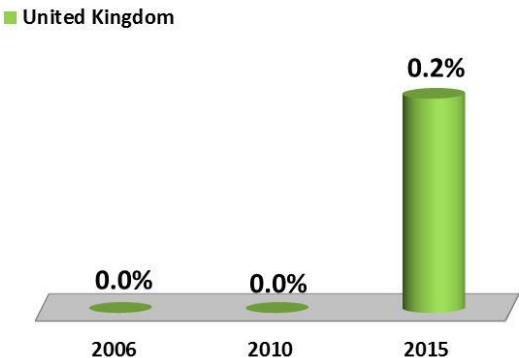
the portion to be dedicated to health. At the UK level, health is mainly financed from public sources, primarily general taxation (income tax, VAT, corporation tax and excise duties) and a small share of the revenues collected through national insurance contributions paid by employers, employees and the self-employed (Cylus *et al.*, 2015). In 2014, public expenditure represented 79.6% of total health expenditure (EU/OECD, 2016), almost entirely represented by government schemes.

Private expenditure is made up of out-of-pocket payments (14.8% of total health expenditure in 2014), and private medical insurance (3.6%). Private insurance is taken by 9.9% of the population (EC, 2016). In England, capital investments are mostly made by the central government. Capital investments related to large infrastructures are also centralised in the other three nations. The capacity to raise funds by the devolved administrations is limited.

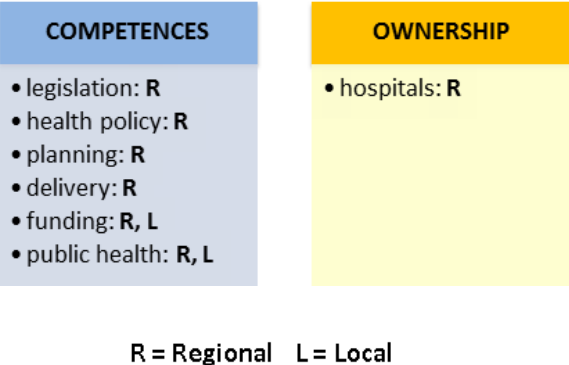
Synopsis and evolution of the structure

The UK healthcare system is devolved to the four constituent countries. Each nation holds the responsibility for its own NHS, from legislative power to planning and implementing functions. The four systems are generally centralised while their tendency varies. In England, the tendency is towards decentralisation, for example in terms of decision-making, increased competition within the internal market, and more autonomy of trusts as in the case of foundation trusts. On the contrary, in Wales and Scotland the tendency is towards centralisation. Northern Ireland, due to its small size, fosters cooperation, not competition (notwithstanding the existence of a purchaser-provider split). According to the 2017 European Semester country report, the UK healthcare system faces sustainability risks in the medium to long term, with ageing population being one of the main drivers. Options for improving the efficiency of the system include strengthening primary care, integrated care, and health prevention and promotion (EC, 2017).

LRAs’ spending for health as % of GDP



LRAs’ competences and owned facilities



3. Conclusions

The compilation of the profiles of the health management systems of the 28 EU Member States provides evidence on the role LRAs have with respect to some relevant policy areas. In particular:

- Effectiveness of health systems, intended as the ability to improve people's health (EC, 2014).

The profiles show that in a number of cases LRAs are directly responsible for public health or share this responsibility with the central level; and are involved in the delivery of public health services. Overall, LRAs are importantly responsible for public health in six (6) MS. In 13 other countries they are involved in health prevention and promotion activities ranging from planning to delivery.

- Accessibility of health systems, intended as availability of services, affordability of services, universality of coverage, and comprehensiveness of the benefits package (EC, 2014).

LRAs from 11 MS are involved in the territorial management of health systems, from a decentralised level where policy and regulatory/legislative aspects are handled by subnational authorities, to a partially decentralised level where LRAs de-facto determine the planning and delivery characteristics of the health systems. As noted in some of the profiles, accessibility may vary across a country as a consequence of the high level of autonomy LRAs have in the shaping of their health systems.

- Resilience of health systems, intended as the systems' capability of addressing changing needs and maintaining accessibility and effectiveness while remaining fiscally sustainable (EC, 2014).

LRAs participate in the funding of healthcare in 23 MS. In nine (9) MS, their contribution to health spending is higher than the national one. They are therefore primarily concerned when considering the cost-effectiveness of the systems.

Furthermore, LRAs are often specifically responsible for the provision of services to the elderly, including social services and long-term care. Having to address evident changing needs of an ageing population they often look for integrated care solutions. Hence, LRAs are evidently the most exposed to

sustainability risks as age-related costs are expected, in general, to rise in the medium to long term.

The opportunity for LRAs' structured contribution to policymaking at the EU level is logically implied by the important role they have in healthcare management and delivery of services across the EU (CdR, 2017). A structured contribution may be achieved through the participation of the Committee of the Regions (or of representative associations of regions) in relevant EU committees and working/expert groups. Such a suggestion for participation is grounded on the evidence gathered in this research work that in some Member States the power and responsibility for healthcare and/or for specific health-related policy areas (e.g. cost-effectiveness, accessibility) are with subnational rather than national authorities.

Explanatory note

This study is a re-make of the work carried out by the Contractor in 2011 for the Committee of the Regions. The conceptual pillars of the 2011 study are maintained but the text is almost thoroughly developed ex-novo.

Conceptually, the study still: • focuses on the role LRAs have in the health management systems of EU countries; • provides evidence of this role through the compilation of tailored country profiles; and • summarises the evidence through the outline of a health systems' governance-based classification.

New elements of this study with respect to the 2011 version include:

- A simpler presentation of the content and a more systematic use of infographics. This is meant to increase the dissemination scope of the research.
- More comprehensive, comparable and relevant country profiles based on recent data and literature, by virtue of improved data opening and reporting mechanisms at the institutional and research community level, with respect to six years ago. This is meant to concretely contribute the LRAs' perspective to the current review of the state of health in the EU.
- Notes on recent reforms, tendencies of governance structures, and relevant 2017 Country Specific Recommendations. This is meant to underline the dynamism of the health systems and the opportunity for policymaking to support their adaptation to changing needs and environments.

Annex I – References

General

European Commission (2014), Communication from the Commission ‘On effective, accessible and resilient health systems’, COM(2014) 215 final, Brussels, 4.4.2014.

European Commission, DG Economic and Financial Affairs (2010), *Projecting future health care expenditure at European level: drivers, methodology and main results*, written by Bartos Przywar, European Economy: Economic Papers 41.

EU/OECD (2016), [*Health at a Glance: Europe 2016 – State of Health in the EU Cycle*](#), OECD Publishing, Paris.

European Committee of the Regions (2017), Opinion ‘Integration, cooperation and performance of health systems’, 122nd plenary session, 22-23 March 2017, NAT-VI/017.

Eurostat (2011), [*Manual on sources and methods for the compilation of COFOG Statistics, Classification of the Functions of Government \(COFOG\)*](#), Theme ‘Economy and finance’, Collection ‘Methodologies & Working papers’.

Hope & Dexia (2009), [*Hospitals in the 27 Member States of the European Union*](#), Dexia Editions.

Joumard, I., André C. and Nicq C. (2010), [*Health Care Systems: Efficiency and Institutions*](#), OECD Economics Department Working Papers, No. 769, OECD Publishing.

Mossialos E. *et al.* (2016), [*2015 International Health Systems Profiles*](#), London School of Economics, The Commonwealth Fund, January 2016.

Paris V., Devaux M., Wei L. (2010), [*Health Systems Institutional Characteristics: A Survey of 29 OECD Countries*](#), OECD Health Working Papers, No. 50, OECD Publishing.

Websites for accessing main data & reports:

OECD.stat online <http://stats.oecd.org/>

OECD.stat online, health statistics, accessed on July 2017
http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT#

The country reports of the EC Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability are available for download at:
https://ec.europa.eu/info/publications/economy-finance/joint-report-health-care-and-long-term-care-systems-fiscal-sustainability-0_en

The 2017 European Semester Country Reports are available for download at:
https://ec.europa.eu/info/publications/2017-european-semester-country-reports_en

The ASISP country documents (update 2014) on Pensions, Health and Long-term Care are available for download at:
<http://ec.europa.eu/social/main.jsp?advSearchKey=Health+and+Long-term+Care&mode=advancedSubmit&catId=22&policyArea=0&policyAreaSub=0&country=0&year=0>

The country HiTs by the European Observatory on Health Systems and Policies are available for download at:
<http://www.euro.who.int/en/about-us/partners/observatory/publications/health-system-reviews-hits/full-list-of-country-hits>

Austria

Council of the European Union (2017), Note from the General Secretariat of the Council to the Permanent Representatives Committee/Council on ‘Recommendation for a COUNCIL RECOMMENDATION on the 2017 National Reform Programme of Austria and delivering a Council opinion on the 2017 Stability Programme of Austria’, Brussels, 12 June 2017, 9282/17.

European Commission (2016), *Austria - Health Care & Long-Term Care Systems*, An excerpt from the Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability, published in October 2016 as Institutional Paper 37 Volume 2 - Country Documents.

European Commission (2016a), *Commission Staff Working Document – Country Report Austria 2016 – Including an In-Depth Review on the prevention and correction of macroeconomic imbalances*, SWD(2016) 88 final, Brussels, 26.2.2016.

European Commission (2017), *Commission Staff Working Document – Country Report Austria 2017*, Accompanying the document COM(2017) 90 final, SWD(2017) 85 final, Brussels, 22.2.2017.

Fink M. (2014), *Country Document, Update 2014 – Pensions, Health and Long-term Care: Austria*, ASISP: Analytical support on social protection reforms and their socio-economic impact.

Hofmarcher M. (2013), *Austria: Health system review*, Health Systems in Transition, 2013; 15(7): 1– 291, European Observatory on Health Systems and Policies.

Österreichisches Bundesministerium für Gesundheit (2013), [*The Austrian Health Care System – Key Facts. Updated version 2013*](#), August 2013

Belgium

European Commission (2016), *Belgium - Health Care & Long-Term Care Systems*, An excerpt from the Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability, published in October 2016 as Institutional Paper 37 Volume 2 - Country Documents.

Segaert S. (2014), *Country Document, Update 2014 – Pensions, Health and Long-term Care: Belgium*, ASISP: Analytical support on social protection reforms and their socio-economic impact.

The European Observatory on Health Systems and Policies, The Health Systems and Policy Monitor, *Online Health Systems in Transition (HiT) profile of Belgium*, accessed on May 2017 .

Van de Voorde C., Van den Heede K., Obyn C., Quentin W., Geissler A., Wittenbecher F., Busse R., Magnussen J., Camaly O., Devriese S., Gerkens S., Misplon S., Neyt M., Mertens R. (2014), *Conceptual framework for the reform of the Belgian hospital payment system*, Health Services Research (HSR) Brussels: [Belgian Health Care Knowledge Centre](#) (KCE), KCE Reports 229. D/2014/10.273/68, published under a “by/nc/nd” Creative Commons Licence

Bulgaria

Council of the European Union (2017), Note from the General Secretariat of the Council to the Permanent Representatives Committee/Council on ‘Recommendation for a COUNCIL RECOMMENDATION on the 2017 National Reform Programme of Bulgaria and delivering a Council opinion on

the 2017 Convergence Programme of Bulgaria’, Brussels, 12 June 2017, 9284/17.

Dimova A., Rohova M., Moutafova E., Atanasova E., Koeva S., Panteli D., van Ginneken E. (2012), *Health Systems in Transition*, Vol.14 No.3, *Bulgaria: Health system review*, European Observatory on Health Systems and Policies.

European Commission (2016), *Bulgaria Health Care & Long-Term Care Systems*, An excerpt from the Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability, published in October 2016 as Institutional Paper 37 Volume 2 - Country Documents.

European Commission (2017), *Commission Staff Working Document – Country Report Bulgaria 2017 – Including an In-Depth Review on the prevention and correction of macroeconomic imbalances*, SWD(2017) 68 final/3, Brussels, 28.2.2017.

National Health Insurance Fund [website](#), accessed on May 2017.

The European Observatory on Health Systems and Policies, The Health Systems and Policy Monitor, *Online Health Systems in Transition (HiT) profile of Bulgaria*, accessed on May 2017.

Croatia

Bodiroga-Vukobrat N. (2014), *Country Document, Update 2014 – Pensions, Health and Long-term Care: Croatia*, ASISP: Analytical support on social protection reforms and their socio-economic impact.

Croatian Institute of Public Health (2016), [Croatian Health Statistics Yearbook 2015](#), web edition, Zagreb 2016.

Council of the European Union (2017), Note from the General Secretariat of the Council to the Permanent Representatives Committee/Council on ‘Recommendation for a COUNCIL RECOMMENDATION on the 2017 National Reform Programme of Croatia and delivering a Council opinion on the 2017 Convergence Programme of Croatia’, Brussels, 12 June 2017, 9286/17.

Džakula A., Sagan A., Pavić N., Lončarek K. and Sekelj-Kauzlarić K. (2014), *Croatia: Health system review*, *Health Systems in Transition*, 16(3): 1–162.

European Commission (2016), *Croatia Health Care & Long-Term Care Systems*, An excerpt from the Joint Report on Health Care and Long-Term Care

Systems & Fiscal Sustainability, published in October 2016 as Institutional Paper 37 Volume 2 - Country Documents.

European Commission (2017), *Commission Staff Working Document – Country Report Croatia 2017 – Including an In-Depth Review on the prevention and correction of macroeconomic imbalances*, SWD(2017) 76 final, Brussels, 22.2.2017.

Cyprus

Amitsis G., Phellas C. (2014), *Country Document, Update 2014 – Pensions, Health and Long-term Care: Cyprus*, ASISP: Analytical support on social protection reforms and their socio-economic impact.

Council of the European Union (2017), Note from the General Secretariat of the Council to the Permanent Representatives Committee/Council on ‘Recommendation for a COUNCIL RECOMMENDATION on the 2017 National Reform Programme of Cyprus and delivering a Council opinion on the 2017 Stability Programme of Cyprus’, Brussels, 12 June 2017, 9287/17.

European Commission (2016), *Cyprus Health Care & Long-Term Care Systems*, An excerpt from the Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability, published in October 2016 as Institutional Paper 37 Volume 2 - Country Documents.

European Commission (2017), *Commission Staff Working Document: Country Report Cyprus 2017, Including an In-Depth Review and the prevention and correction of macroeconomic imbalances*, Accompanying the document COM(2017) 90 final, SWD(2017) 78 final, Brussels, 22.2.2017.

Presidency Unit for Administrative Reform (2017), [*Europe 2020 – Cyprus National Reform Programme 2017*](#), April 2017.

The European Observatory on Health Systems and Policies, The Health Systems and Policy Monitor, *Online Health Systems in Transition (HiT) profile of Cyprus*, accessed on June 2017.

Czech Republic

Alexa J, Rečka L, Votápková J, van Ginneken E, Spranger A, Wittenbecher F. (2015), *Czech Republic: Health system review*, Health Systems in Transition, 17(1):1–165.

Council of the European Union (2017), Note from the General Secretariat of the Council to the Permanent Representatives Committee/Council on 'Recommendation for a COUNCIL RECOMMENDATION on the 2017 National Reform Programme of the Czech Republic and delivering a Council opinion on the 2017 Convergence Programme of the Czech Republic', Brussels, 12 June 2017, 9289/17.

European Commission (2017), *Commission Staff Working Document: Country Report Czech Republic 2017*, Accompanying the document COM(2017) 90 final, SWD(2017) 69 final, Brussels, 22.2.2017.

Ministry of Health (2014), *Health 2020 – National Strategy for Health Protection and Promotion and Disease Prevention*, First edition, Prague 2014.

The European Observatory on Health Systems and Policies, The Health Systems and Policy Monitor, *Online Health Systems in Transition (HiT) profile of Czech Republic*, accessed on May 2017.

Denmark

European Commission (2016), *Denmark Health Care & Long-Term Care Systems*, An excerpt from the Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability, published in October 2016 as Institutional Paper 37 Volume 2 - Country Documents.

Ministry of Health (2017), [Healthcare in Denmark – An Overview](#)

The European Observatory on Health Systems and Policies, The Health Systems and Policy Monitor, *Online Health Systems in Transition (HiT) profile of Denmark*, accessed on June 2017

Estonia

Estonian Health Insurance Fund [website](#), accessed on June 2017.

European Commission (2017), *Commission Staff Working Document: Country Report Estonia 2017*, SWD(2017) 72 final, Brussels, 22.2.2017.

Lai T., Habicht T., Kahur K., Reinap M., Kiiwet R., and van Ginneken E. (2013), *Estonia: health system review*, Health Systems in Transition, 2013; 15(6):1–196.

Ministry of Social Affairs (2008), [National Health Plan 2009–2020 – Amended in 2012](#)

Võrk A. and Paat-Ahi G. (2014), *Country Document, Update 2014 – Pensions, Health and Long-term Care: Estonia*, ASISP: Analytical support on social protection reforms and their socio-economic impact.

The European Observatory on Health Systems and Policies, The Health Systems and Policy Monitor, *Online Health Systems in Transition (HiT) profile of Estonia*, accessed on June 2017.

Finland

Council of the European Union (2017), Note from the General Secretariat of the Council to the Permanent Representatives Committee/Council on ‘Recommendation for a COUNCIL RECOMMENDATION on the 2017 National Reform Programme of Finland and delivering a Council opinion on the 2017 Stability Programme of Finland’, Brussels, 12 June 2017, 9282/17.

European Commission (2016), *Finland Health Care & Long-Term Care Systems*, An excerpt from the Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability, published in October 2016 as Institutional Paper 37 Volume 2 - Country Documents.

European Commission (2017), *Commission Staff Working Document – Country Report Finland 2017 – Including an In-Depth Review on the prevention and correction of macroeconomic imbalances*, SWD(2017) 91 final, Brussels, 22.2.2017.

Ministry of Social Affairs and Health (MSAH) [website](#), accessed on June 2017.

Ministry for Foreign Affairs [website](#), accessed on June 2017.

The European Observatory on Health Systems and Policies, The Health Systems and Policy Monitor, *Online Health Systems in Transition (HiT) profile of Finland*, accessed on June 2017.

Vidlund M. and Preusker U. (2014), *Country Document, Update 2014 – Pensions, Health and Long-term Care: Finland*, ASISP: Analytical support on social protection reforms and their socio-economic impact.

France

Chevreur K, Berg Brigham K, Durand-Zaleski I, Hernández-Quevedo C. France: Health system review. *Health Systems in Transition*, 2015; 17(3): 1–218.

European Commission (2016), *France Health Care & Long-Term Care Systems*, An excerpt from the Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability, published in October 2016 as Institutional Paper 37 Volume 2 – Country Documents.

Ministère des Solidarités et de la Santé (MSS) (2016), [Instruction no SG/2016/348 du 21 octobre 2016 relative à la territorialisation de la politique de santé en application des articles 158 et 162 de la loi no 2016-41 de modernisation de notre système de santé.](#)

The European Observatory on Health Systems and Policies, The Health Systems and Policy Monitor, *Online Health Systems in Transition (HiT) profile of France*, accessed on June 2017.

Germany

Busse R. and Blümel M. (2014), *Germany: health system review*, Health Systems in Transition, 16(2):1–296.

European Commission (2016), *Germany Health Care & Long-Term Care Systems*, An excerpt from the Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability, published in October 2016 as Institutional Paper 37 Volume 2 – Country Documents.

Greece

Athanasiadis A., Kostopoulou S., Philalithis A. (2015), ‘Regional Decentralisation in the Greek Health Care System: Rhetoric and Reality’, *Global Journal of Health Science*, 7(6):55-67 doi:10.5539/gjhs.v7n6p55 - Open Access article distributed under the terms of the [Creative Commons Attribution License](#)

European Commission (2016), *Greece Health Care & Long-Term Care Systems*, An excerpt from the Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability, published in October 2016 as Institutional Paper 37 Volume 2 - Country Documents.

Nikolentzos A., Kontodimopoulos N., Polyzos N., Thireos E., Tountas Y. (2015), ‘Reengineering NHS Hospitals in Greece: Redistribution Leads to Rational Mergers’, *Global Journal of Health Science*, 7(5):272-287, doi:10.5539/gjhs.v7n5p272 - Open Access article distributed under the terms of the [Creative Commons Attribution License](#)

Petmesidou M. (2014), *Country Document, Update 2014 – Pensions, Health and Long-term Care: Greece*, ASISP: Analytical support on social protection reforms and their socio-economic impact.

Polyzos N. *et al.* (2014), *The Introduction of Greek Central Health Fund: Has the Reform Met Its Goal in the Sector of Primary Health Care or Is There a New Model Needed?*, *BMC Health Services Research* 14 (2014): 583, *PMC*, Web. 11 July 2017, <https://doi.org/10.1186/s12913-014-0583-4> - Open Access article distributed under the terms of the [Creative Commons Attribution License](#)

The European Observatory on Health Systems and Policies, The Health Systems and Policy Monitor, *Online Health Systems in Transition (HiT) profile of Greece*, accessed on July 2017.

Hungary

European Commission (2016), *Hungary Health Care & Long-Term Care Systems*, An excerpt from the Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability, published in October 2016 as Institutional Paper 37 Volume 2 - Country Documents.

Gal R.I. (2014), *Country Document, Update 2014 – Pensions, Health and Long-term Care: Hungary*, ASISP: Analytical support on social protection reforms and their socio-economic impact.

National Health Insurance Fund Administration (NHIFA) [website](#), accessed on June 2017.

National Healthcare Service Centre [website](#), accessed on June 2017.

National Public Health and Medical Officer Service (NPHMOS) [website](#), accessed on June 2017.

The European Observatory on Health Systems and Policies, The Health Systems and Policy Monitor, *Online Health Systems in Transition (HiT) profile of Hungary*, accessed on June 2017

WHO (2017), [Hungary – European Region](#), updated February 2017.

Ireland

Burke S. and Considine M (2014), *Country Document, Update 2014 – Pensions, Health and Long-term Care: Ireland*, ASISP: Analytical support on social protection reforms and their socio-economic impact.

Department of Health (DoH) [website](#), accessed on June 2017.

European Commission (2017), *Commission Staff Working Document – Country Report Ireland 2017 – Including an In-Depth Review on the prevention and correction of macroeconomic imbalances*, SWD(2017) 73 final, Brussels, 22.2.2017.

Health Service Executive (HSE) [website](#), accessed on June 2017.

Health Service Executive (2016), [*National Medical Card Unit Strategic Plan 2016-2018*](#)

Private Hospitals Association (PHA) [website](#), accessed on June 2017.

Italy

European Commission (2017), *Commission Staff Working Document – Country Report Italy 2017 – Including an In-Depth Review on the prevention and correction of macroeconomic imbalances*, SWD(2017) 77 final, Brussels, 22.2.2017.

Ferré F., de Belvis AG., Valerio L., Longhi S., Lazzari A., Fattore G., Ricciardi W., Maresso A. (2014), *Italy: Health System Review, Health Systems in Transition*, 16(4):1–168.

Ministry of Health [website](#) (including for statistical [data](#)).

State-Regions-Autonomous Provinces Permanent Conference (2014), [*Agreement of 13th November 2014*](#), National Prevention Plan 2014-2018.

The European Observatory on Health Systems and Policies, The Health Systems and Policy Monitor, *Online Health Systems in Transition (HiT) profile of Italy*, accessed on June 2017.

Latvia

Council of the European Union (2017), Note from the General Secretariat of the Council to the Permanent Representatives Committee/Council on 'Recommendation for a COUNCIL RECOMMENDATION on the 2017 National Reform Programme of Latvia and delivering a Council opinion on the 2017 Stability Programme of Latvia, Brussels, 12 June 2017, 9302/17.

European Commission (2016), *Latvia Health Care & Long-Term Care Systems*, An excerpt from the Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability, published in October 2016 as Institutional Paper 37 Volume 2 - Country Documents.

European Commission (2017), *Commission Staff Working Document – Country Report Latvia 2017*, SWD(2017) 79 final, Brussels, 22.2.2017.

Ministry of Health (MoH) [website](#), accessed on July 2017.

The European Observatory on Health Systems and Policies, The Health Systems and Policy Monitor, *Online Health Systems in Transition (HiT) profile of Latvia*, accessed on July 2017.

Zilvere R. (2014), *Country Document, Update 2014 – Pensions, Health and Long-term Care: Latvia*, ASISP: Analytical support on social protection reforms and their socio-economic impact.

Lithuania

Council of the European Union (2017), Note from the General Secretariat of the Council to the Permanent Representatives Committee/Council on 'Recommendation for a COUNCIL RECOMMENDATION on the 2017 National Reform Programme of Lithuania and delivering a Council opinion on the 2017 Stability Programme of Lithuania', Brussels, 12 June 2017, 9303/17.

European Commission (2017), *Commission Staff Working Document – Country Report Lithuania 2017*, Accompanying the document COM(2017) 90 final, SWD(2017) 80 final, Brussels, 22.2.2017.

Murauskiene L., Janoniene R., Veniute M., van Ginneken E. and Karanikolos M. (2013), *Lithuania: health system review*, Health Systems in Transition, 15(2):1–150.

National Health Insurance Fund (NHIF) [website](#)

Luxembourg

Berthet F. *et al.*, (2015), *HiT in brief – Luxembourg*, European Observatory on Health Systems and Policies.

Ministry of Health (2017), [*Rapport d'activité 2016 du ministère de la Santé*](#), April 2017.

Spruit G. (2014), *Annual National Report 2014 – Pensions, Health and Long-term Care: Luxembourg*, ASISP: Analytical support on the Socio-Economic Impact of Social Protection Reforms.

Malta

Azzopardi-Muscat N., Buttigieg S., Calleja N., and Merkur S. (2017), *Malta: Health system review*, *Health Systems in Transition*, 19(1):1–137.

European Commission (2017), *Commission Staff Working Document – Country Report Malta 2017*, SWD(2017) 83 final, Brussels, 22.2.2017.

European Commission (2016), *Malta Health Care & Long-Term Care Systems*, An excerpt from the Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability, published in October 2016 as Institutional Paper 37 Volume 2 - Country Documents.

The Netherlands

European Commission (2017), *Commission Staff Working Document – Country Report The Netherlands 2017*, SWD(2017) 84 final, Brussels, 22.2.2017.

Kroneman M., Boerma W., van den Berg M., Groenewegen P., de Jong J., van Ginneken E. (2016), *The Netherlands: health system review*, *Health Systems in Transition*, 18(2):1–239.

Poland

Council of the European Union (2017), Note from the General Secretariat of the Council to the Permanent Representatives Committee/Council on 'Recommendation for a COUNCIL RECOMMENDATION on the 2017 National Reform Programme of Poland and delivering a Council opinion on the 2017 Convergence Programme of Poland', Brussels, 14 June 2017, 9307/1/17 REV 1.

European Commission (2016), *Poland Health Care & Long-Term Care Systems*, An excerpt from the Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability, published in October 2016 as Institutional Paper 37 Volume 2 - Country Documents.

European Commission (2017), *Commission Staff Working Document – Country Report Poland 2016*, Accompanying the document COM(2017) 90 final, SWD(2017) 86 final, Brussels, 26.2.2016.

Nieszporska S. (2017), *Priorities in the Polish health care system*, *The European Journal of Health Economics*, 18(1), 1–5 <http://doi.org/10.1007/s10198-016-0831-0>, - Open Access article distributed under the terms of the [Creative Commons Attribution 4.0 International License](#)

The European Observatory on Health Systems and Policies, The Health Systems and Policy Monitor, *Online Health Systems in Transition (HiT) profile of Poland*, accessed on July 2017.

Żukowski M. (2013), *Country Document, Update 2014 – Pensions, Health and Long-term Care: Poland*, ASISP: Analytical support on social protection reforms and their socio-economic impact.

Portugal

Council of the European Union (2017), Note from the General Secretariat of the Council to the Permanent Representatives Committee/Council on ‘Recommendation for a COUNCIL RECOMMENDATION on the 2017 National Reform Programme of Portugal and delivering a Council opinion on the 2017 Stability Programme of Portugal’, Brussels, 12 June 2017, 9308/17.

European Commission (2016), *Portugal Health Care & Long-Term Care Systems*, An excerpt from the Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability, published in October 2016 as Institutional Paper 37 Volume 2 - Country Documents.

European Commission (2017), *Commission Staff Working Document – Country Report Portugal 2017 – Including an In-Depth Review on the prevention and correction of macroeconomic imbalances*, SWD(2017) 87 final, Brussels, 22.2.2017.

Simões J., Augusto GF., Fronteira I., Hernández-Quevedo C. (2017), *Portugal: Health system review*, *Health Systems in Transition*, 19(2):1–184.

OECD (2012), [*OECD Economic Surveys: Portugal 2012*](#), OECD publishing.

Romania

Council of the European Union (2017), Note from the General Secretariat of the Council to the Permanent Representatives Committee/Council on ‘Recommendation for a COUNCIL RECOMMENDATION on the 2017 National Reform Programme of Romania and delivering a Council opinion on the 2017 Convergence Programme of Romania’, Brussels, 12 June 2017, 9309/17.

European Commission (2017), *Commission Staff Working Document – Country Report Romania 2017*, Accompanying the document COM(2017) 90 final, SWD(2017) 88 final, Brussels, 22.2.2017.

Vlădescu C., Scîntee SG., Olsavszky V., Hernández-Quevedo C., Sagan A. (2016), *Romania: Health system review*, Health Systems in Transition, 18(4):1–170.

Zaman C. (2014), *Country Document, Update 2014 – Pensions, Health and Long-term Care: Romania*, ASISP: Analytical support on social protection reforms and their socio-economic impact.

Slovakia

Council of the European Union (2017), Note from the General Secretariat of the Council to the Permanent Representatives Committee/Council on ‘Recommendation for a COUNCIL RECOMMENDATION on the 2017 National Reform Programme of Slovakia and delivering a Council opinion on the 2017 Stability Programme of Slovakia’, Brussels, 12 June 2017, 9310/17.

European Commission (2017), *Commission Staff Working Document – Country Report Slovakia 2017*, Accompanying the document COM(2017) 90 final, SWD(2017) 90 final/2, Brussels, 27.2.2017.

Smatana M., Pažitný P., Kandilaki D., Laktišová M., Sedláková D., Palušková M., van Ginneken E. and Spranger A. (2016), *Slovakia: Health system review*, Health Systems in Transition, 18(6):1–210.

Slovenia

Albrecht T., Pribaković Brinovec R., Jošar D., Poldrugovac M., Kostnapfel T., Zaletel M., Panteli D., Maresso A. (2016), *Slovenia: Health system review*, Health Systems in Transition, 18(3):1–207.

Council of the European Union (2017), Note from the General Secretariat of the Council to the Permanent Representatives Committee/Council on ‘Recommendation for a COUNCIL RECOMMENDATION on the 2017 National Reform Programme of Slovenia and delivering a Council opinion on the 2017 Stability Programme of Slovenia’, Brussels, 12 June 2017, 9311/17.

European Commission (2017), *Commission Staff Working Document – Country Report Slovenia 2017 - Including an In-Depth Review on the prevention and correction of macroeconomic imbalances*, Accompanying the document COM(2017) 90 final, SWD(2017) 89 final, Brussels, 22.2.2017.

Spain

European Commission (2016), *Spain Health Care & Long-Term Care Systems*, An excerpt from the Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability, published in October 2016 as Institutional Paper 37 Volume 2 - Country Documents.

European Commission (2017), *Commission Staff Working Document – Country Report Spain 2017 - Including an In-Depth Review on the prevention and correction of macroeconomic imbalances*, Accompanying the document COM(2017) 90 final, SWD(2017) 74 final, Brussels, 22.2.2017.

Ministerio de la Presidencia website La Moncloa, ‘Health’ [webpage](#) dated 26 January 2017 and accessed on July 2017.

Ministry of Health, Social Services and Equality (MSSSI) [website](#)

Patxot C. (2014), *Country Document, Update 2014 – Pensions, Health and Long-term Care: Spain*, ASISP: Analytical support on social protection reforms and their socio-economic impact.

The European Observatory on Health Systems and Policies, The Health Systems and Policy Monitor, *Online Health Systems in Transition (HiT) profile of Spain*, accessed on June 2017

Sweden

Anderson K. and Backhans M. (2013), *Country Document, Update 2014 – Pensions, Health and Long-term Care: Sweden*, ASISP: Analytical support on social protection reforms and their socio-economic impact.

European Commission (2016), *Sweden Health Care & Long-Term Care Systems*, An excerpt from the Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability, published in October 2016 as Institutional Paper 37 Volume 2 - Country Documents.

Government of Sweden (2017), [*Good quality, local health care – a joint roadmap and vision – Summary*](#)

United Kingdom

Cylus J., Richardson E., Findley L., Longley M., O’Neill C., Steel D. (2015), *United Kingdom: Health system review*, Health Systems in Transition, 17(5): 1–125.

European Commission (2016), *The United Kingdom Health Care & Long-Term Care Systems*, An excerpt from the Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability, published in October 2016 as Institutional Paper 37 Volume 2 - Country Documents.

European Commission (2017), *Commission Staff Working Document – Country Report United Kingdom 2017*, SWD(2017) 93 final, Brussels, 22.2.2017.

EN

ISBN 978-92-895-0943-5
doi:10.2863/514678

QG-02-17-977-EN-N



**European Committee
of the Regions**

Created in 1994 following the signing of the Maastricht Treaty,
the European Committee of the Regions is the EU's assembly of 350 regional and
local representatives from all 28 Member States, representing over 507 million Europeans.

Rue Belliard/Belliardstraat 101 | 1040 Bruxelles/Brussel | BELGIQUE/BELGIË | Tel. +32 22822211
www.cor.europa.eu | [@EU_CoR](https://twitter.com/EU_CoR) | [/european.committee.of.the.regions](https://www.facebook.com/european.committee.of.the.regions)
[/european-committee-of-the-regions](https://www.linkedin.com/company/european-committee-of-the-regions)