ARCHIVIO ISTITUZIONALE
DELLA RICERCA

Alma Mater Studiorum Università di Bologna
Archivio istituzionale della ricerca

How policy tools evolve in the healthcare sector. Five countries compared

This is the final peer-reviewed author's accepted manuscript (postprint) of the following publication:

Published Version:
How policy tools evolve in the healthcare sector. Five countries compared / F. Toth. - In: POLICY STUDIES. - ISSN 0144-2872. - STAMPA. - 42:3(2021), pp. 232-251. [10.1080/01442872.2019.1656182]

Availability:
This version is available at: https://hdl.handle.net/11585/819237 since: 2021-04-23

Published:

DOI: http://doi.org/10.1080/01442872.2019.1656182

Terms of use:

Some rights reserved. The terms and conditions for the reuse of this version of the manuscript are specified in the publishing policy. For all terms of use and more information see the publisher's website.

This item was downloaded from IRIS Università di Bologna (https://cris.unibo.it/).
When citing, please refer to the published version.

(Article begins on next page)

20 April 2024

This is the final peer-reviewed accepted manuscript of:

Federico Toth (2021): How policy tools evolve in the healthcare sector. Five countries compared, Policy Studies, 42 (3): 232-251

The final published version is available online at:

https://doi.org/10.1080/01442872.2019.1656182

Terms of use:

Some rights reserved. The terms and conditions for the reuse of this version of the manuscript are specified in the publishing policy. For all terms of use and more information see the publisher's website.

This item was downloaded from IRIS Università di Bologna (https://cris.unibo.it)

When citing, please refer to the publisher version.

How Policy Tools Evolve in the Healthcare Sector.

Five Countries Compared

Federico Toth

Abstract

The aim of this work is to investigate which policy tools are used in the governance of the healthcare sector. In particular, we compare the healthcare systems of five OECD countries: Australia, Canada, Germany, England and the Netherlands. The analysis intends to reconstruct the healthcare governance methods implemented in these countries, and understand how they have evolved over the last thirty years.
Throughout this work, policy tools are subdivided into four categories: direct provision, regulation, financing and information.
Direct provision remains the prevailing mode of governance in the English healthcare system.
All of the five countries studied in this work make extensive use of regulation. Insurer regulation is particularly stringent in Germany, the Netherlands and Australia.
Of the countries examined, those that make the greatest use of financial leverage seem to be Australia and Canada.
England and the Netherlands are the two countries that focus most on informative policy tools.

Keywords: Policy tools; Health policy; Governance modes; Policy mix; Australia; Canada; England; Germany; Netherlands.

1. Introduction

Policy makers may opt for a vast array of tools to pursue their objectives. Some authors suggest to group policy tools under four ample categories: organization, regulation, financing and information (Hood 1983; Doern and Phidd 1983; Howlett 2011).

By organization, we refer to the principle by which the State acts first hand, directly providing services and – in some cases – also goods (Howlett 2011).

As an alternative to direct management, the State can intervene authoritatively through regulation, namely by enforcing obligations or prohibitions on third parties (Howlett and Ramesh 1995). Public regulation therefore restricts the freedom of choice of individuals, imposing upon them the obligation to behave (or not to behave) in a given way (Bemelmans-Videc et al. 1998).

The State may decide to take a less coercive approach: a specific behaviour is not the object of a formal imposition or prohibition, but is either financially incentivized or discouraged. Unlike regulatory measures, financial tools formally leave subjects free to act as they deem fit: if they comply with the recommendations by the public authority, they will enjoy economic benefits; otherwise, they will not receive incentives and/or will incur additional costs.

Policy makers have a fourth strategy at their disposal: circulating information aimed at influencing individual behaviour (Howlett and Ramesh 1995). Of the four governance strategies, the latter is the least intrusive. Citizens are neither subject to obligations nor do they receive material incentives (or sanctions); they are provided with information and models to follow (Bemelmans-Videc et al. 1998; Howlett 2011).

Evidently, tool selection and policy mix composition are not ideologically and politically neutral decisions (Hood 1983). The choice of policy tools is, in actual fact, embedded in the political culture and policy style of individual countries (Peters 2002; Lascoumes and Le Gales 2007), and is often conditioned by the peculiarities of the individual policy sector (Linder and Peters 1989; Howlett 2005).

The aim of this work is to investigate which policy tools are used in the governance of the healthcare sector.

For this purpose, we shall analyse and compare healthcare policies in five countries: Australia, Canada, Germany, England and the Netherlands. These 5 are among the few countries for which there is a rich literature in English on healthcare policies and politics. The 5 selected cases are

rather similar in many respects, as they all refer to relatively wealthy, democratic and industrialized OECD states. We had, however, the adroitness to select countries which have evolved starting from different models of healthcare governance: in the late 1980s, the United Kingdom had long implemented the National Health Service model; Germany relied on a traditional Social Health Insurance system; the Netherlands had a hybrid system of Bismarckian inspiration; Australia and Canada (albeit the differences that will be commented later) had just recently established a single-payer universal system. Despite their being limited in number, the 5 selected cases offer a sufficiently varied field of observation, which allows for comparisons not only between countries with similar healthcare models, but also between those where the models differ.

The analysis intends to reconstruct the healthcare governance methods implemented in these countries, and understand how they have evolved over the last thirty years. As observed by some authors (Wilsford 1994; Tuohy 1999; Oliver and Mossialos 2005), the choice of this time frame results from the tendency of national healthcare systems to change slowly. Assessing the evolutionary trajectories that unfold within the governance models therefore requires considering a time span that covers a few decades. Given that the 1990s were years of intense reformist activity in the field of healthcare (Jacobs 1998; Saltman and Figueras 1998; Freeman and Moran 2000; Toth 2010), it seems reasonable to start our diachronic analysis from the late 1980s.

The 5 national cases were reconstructed on the basis of secondary sources (Stewart and Kamins 1993).

The article is organized as follows: Section 2 includes a first, general presentation of the policy tools that are most frequently adopted to govern the healthcare system.

The following sections are dedicated to the analysis of the five national systems selected for this study. The description of each individual national system will be divided into three parts.

The first one describes the healthcare system as it was in the late 1980s (these descriptions will constitute the "starting point" for our longitudinal analysis). The second part will ascertain whether, over the last thirty years, major health reforms have taken place, radically changing the governance modes of the system. Thirdly, we shall try to reconstruct the current governance modes of the healthcare system under study.

Sections 8 and 9 serve to draw conclusions and highlight how each of the five countries analysed uses a different combination of policy tools to govern its healthcare system.

2. Policy Tools in Healthcare

It may prove useful to start with a general overview of the most commonly used policy tools in the governance of healthcare systems, taking into account the four categories of policy tools presented in the introduction. For each category, we shall give only some significant examples, as it would be impossible to draw up a comprehensive list of all the potentially usable tools in the healthcare field.

Organization

As we shall see in the following sections, in some countries the State directly provides healthcare *in kind* to its residents, through its own facilities and personnel. This is what happens, for example, in England (and, more generally, in all countries with a National health Service). In other countries, the State abstains from direct provision of healthcare, which is entrusted to external providers.

Regulation

In all Western countries, the government – at either national or decentralized level – plays a central role in regulating healthcare services. Public regulatory policies may take on different forms (rules, standards, permits, prohibitions, etc.) and usually involve sanctions in case of non-compliance with the rules (Howlett and Ramesh 1995; Howlett, 2011). Within a healthcare system, many aspects may be subject to detailed public regulation (Rothgang et al. 2005). The State can oblige individuals (all residents or only certain categories) to take out mandatory insurance, decides how insurers and providers are financed, defines which requirements must be met by providers in order to operate, determines the composition of the package of essential care, establishes how much freedom users have in choosing providers and accessing specialist care.

Financial Incentives and Disincentives

In addition to regulatory tools, financial incentives and sanctions also serve to influence the behaviour of insurers, healthcare providers and users.

A typical incentive and sanction mechanism for insurers is found in countries where a risk equalization system is in place: insurers receive more transfers (hence an incentive) if they grant coverage to high-risk patients, whereas they are required to contribute more to the common fund (sanction) insofar as they only accept low-risk individuals as subscribers.

All the forms of remuneration of providers tend to either incentivize or discourage certain behaviours (Kutzin 2011). The payment of family doctors by capitation[1], for example, should favour continuity of care. Conversely, fee-for-service remuneration schemes should encourage provider productivity.

Incentives or additional costs are also liable to influence user behaviour. As we shall see later in this work, the governments of some countries grant financial incentives for the purchase of

voluntary healthcare insurance. In addition, to encourage voluntary insurance, some countries provide for sanctions for high-income citizens who decide not to insure themselves.

Information

Finally, we come to the topic of "informative" tools. Many governments invest in information and awareness campaigns: advertising campaigns to promote a healthy lifestyle, vaccination or the screening of certain diseases are just few examples of the implementation of the "informative" approach.

There are some informative tools that have greater impact than others on the governance of the healthcare sector (Kutzin 2001). An example can be found in countries where a ranking (or, in any event, a systematic and comparative assessment) of healthcare providers is published. These rankings are public and easily accessible by users, who can therefore refer to them to choose providers based on enhanced information and awareness. These assessments do not necessarily involve direct material incentives, and are in no way binding on patients; however, information of public domain may somehow influence the free choice of users, hence also the strategies of the subjects included in the assessment process.

When formulating policy interventions, public decision makers can hence draw from a well-equipped toolbox (Hood 1983). Policy makers often do not adopt only one of the four governance modes described above, but mix them together (Salamon 2002; Howlett 2005; Howlett 2011): a single policy initiative can therefore combine organizational, regulatory, financial and informative tools.

In the following sections five national healthcare systems will be analysed. For each country, the main policy instruments adopted in the health sector will be identified over the last three

decades. The policy tools (and the respective policy mixes) will be labelled according to the four categories described above.

3. England

The UK NHS: Public, Unitary, Integrated

The United Kingdom was the first large country to adopt the National Health Service model, established in 1946. Despite the devolution (the NHS is now subdivided into four distinct administrations, for Northern Ireland, Scotland, Wales and England), and other radical reforms introduced over the years, the National Health Service has always retained some distinctive features: it continues to be financed through tax revenue and provides care to all residents of the United Kingdom.

More than 70 years ago, the United Kingdom therefore decided to manage the healthcare sector through internal organization. The NHS owns and operates its own hospitals and outpatient clinics. Most healthcare personnel are employed by the NHS. In short, the National Health Service embodied – at least until the conservative reform of 1990 – the prototype of the public, unitary and integrated healthcare service (Helderman et al. 2012).

From the Thatcher to the Cameron Reform

Over the past 30 years, the English NHS has undergone at least three major reforms.

The first turning point was produced by the 1990 Conservative reform. The *NHS and Community Care Act*, approved in 1990 by the Thatcher government, was meant to promote a radical change in the governance of the English healthcare service, switching from an integrated system to an "internal market" model (Enthoven 1985). To this end, the split between buyers

and providers plays a major role. The buyers would be the District Health Authorities (DHAs). The latter would receive a budget, based upon the number of residents, with which to purchase necessary services from a vast array of providers. 'Fund holding' general practitioners (GPs) represented a second category of purchasers (Oliver 2005): family doctors were given the opportunity to associate and were allotted a budget to purchase some services on behalf of their patients. The provision of services, on the other hand, was the responsibility of the hospitals, which were transformed into autonomous 'trusts' that would then be obliged to compete to win contracts. The split promised efficiency by introducing a system of provider competition in which money would follow the patient (Klein 1998).

We ought to stress that such a reform did not entail the strengthening of the private sector. The rationale behind the reform was, in actual fact, to spur competition only among public providers, introducing incentives for their productivity. Nothing really changed for NHS users: providers could not be selected by the single patient, but by district authorities and general practitioners; therefore, there was no enhancement of the citizens' freedom of choice.

One of the first measures taken by the Blair government – elected in 1997 following 18 consecutive years of conservative rule – was to undertake a counter-reform in the field of healthcare. Abandoning the rhetoric of competition, the Labour reforms instead focused upon 'co-operation' and 'collaboration' (Klein 1998). Even though the split between local health services and hospitals was maintained, Primary Care Trusts constituted in fact the framework of a tightly co-ordinated system, which encouraged the integration of primary, secondary and community care (Ham 2009). The Primary Care Act (1997) decreed that all healthcare workers were to work in unison at local level, adhering to triennial programmes, which would be co-ordinated by the local health authorities. Fund holding was abolished, and all GPs, as well as all providers of primary care, were to form part of the Primary Care Trusts (PCTs).

Starting in 2001, at the beginning of the second mandate, the Blair government aimed at changing the direction of its healthcare policy. The «second phase» of the New Labour administration (Bevan and Robinson 2005) insisted particularly on the issues of freedom of choice of patients and quality of providers. From 2008 onwards, English patients were allowed to choose from any provider meeting the Healthcare Commission's standards and charging the NHS rates (Klein 2013). In order to facilitate patients' choice, the Blair government focused on typically "informative" policy instruments. Indeed, the assumption was that it was not sufficient to give patients the freedom to choose, if they did not have the means to judge which providers were better than others. Therefore, a system was set up for the periodic evaluation of all the healthcare facilities within the country, giving citizens the possibility to compare the performance of the different facilities and choose accordingly (Oliver 2005).

The last reform in order of time is that passed in 2012 by the coalition government led by David Cameron. With the implementation of the 2012 Health and Social Act, the NHS is presently subdivided into about 200 territorial districts called Clinical Commissioning Groups (CCG). The CCGs are largely managed by general practitioners and receive a budget commensurate with the population residing in the district; they have the task of providing primary care with their own personnel, whereas they act as buyers for home and specialist care. The provision of the latter is the responsibility of the NHS trusts, namely public companies providing healthcare services, remunerated according to the volume of services actually provided. Depending on the case, the NHS trusts may be hospital facilities, mental health centres, or community health services. Clearly, the 2012 Cameron reform recalls the internal market rationale initially proposed by the 1990 conservative reform (Klein 2013).

The Current Governance Modes

Organization. Over the past three decades, the English NHS has been subjected to major reforms, aimed primarily at enhancing efficiency and patient-orientated approach. However, these reform measures have not undermined the founding principles of the NHS: financing through taxation, universal coverage, and the eminently public provision of care. The 2012 Cameron reform was accused of wanting to privatize the NHS, as it allows Clinical Commissioning Groups to buy specialist care not only from NHS trusts but also from licensed private providers. The drift towards privatization does not, however, seem particularly evident, at least for the time being: the NHS outsources less than 8% of its budget to private providers (Department of Health and Social Care 2018).

Regulation. The assignment of important regulatory activities to independent agencies is a peculiarity of the English healthcare system (Ham et al. 2015). These agencies in part have regulatory powers, and in part carry out informative and advice functions. The main independent health agencies are: NICE, the Care Quality Commission and Monitor. The National Institute for Health and Care Excellence (NICE) provides recommendations and publishes guidelines on clinical practice, technology assessment and health promotion. The Care Quality Commission performs important regulatory functions, and is committed to monitoring and evaluating the quality of the services offered by the individual NHS providers. Monitor (merged in 2016 in NHS Improvement) has the task of authorizing, regulating and monitoring all NHS providers, from a financial and administrative point of view.

Financing. From the citizens' perspective, NHS financing has remained unchanged: citizens continue to finance the public healthcare service through taxation. Users mostly benefit from NHS services free of charge: the only forms of cost-sharing involve pharmaceuticals and dental care (Cylus et al. 2015). What has changed over the last few decades is the providers' remuneration system. Providers are now paid based on a payment-by-results system, which should serve as a quality and efficiency incentive (Helderman et al. 2012).

Information. If we focus on the typically "informative" tools, a significant innovation as from the early 2000s was the adoption of performance rating systems for NHS providers, based on a typical "naming and shaming" strategy (Helderman et al. 2012). In the early years, assessments on the different facilities (hospitals, outpatient clinics, primary care and mental health centres) were expressed using a scale from zero to three stars, as in tourist guides (Klein 2013). Assessment was entrusted to an independent agency, the Healthcare Commission (later transformed into the Care Quality Commission). The star rating was later replaced by other performance rating methods and citizens can easily view the results on the Care Quality Commission website.

4. Germany

The Legacy of the Bismarckian system

In the late 1980s, West Germany relied on a classic social health insurance (SHI) system. In 1990, with the German unification, the SHI system was extended also to the Länder of former East Germany.

The Bismarckian system obliged most workers to make regular contributions to a sickness fund. Some categories of workers were exempt from this obligation and excluded from the mandatory SHI scheme: those belonging to the latter categories could have taken out a private insurance policy. The majority of those enrolled in the mandatory SHI scheme could not choose the sickness insurance fund: enrolment was automatic depending on profession. Healthcare providers were independent of the sickness funds (and still are today), and patients had ample freedom of choice with respect to both physicians and hospital facilities.

The Great Reforms of 1993 and 2007

Over the last thirty years, the German parliament has approved at least twenty healthcare reforms (Busse and Blümel 2014). The major reforms, which have significantly changed the architecture of the system, are essentially two: the 1993 *Health Care Structure Act*, approved by the fourth Kohl government; and the 2007 reform, launched by the first Merkel government.

The 1993 Healthcare Structure Act was to open up the system to greater competition between sickness funds. This reform guaranteed the majority of German citizens the freedom to choose which health fund to subscribe to. The new arrangement was put into practice in 1996. In order to discourage insurers from discriminating patients on the basis of risk, sickness funds were required to accept all subscribers. A new risk equalization scheme, which would operate between the various sickness funds, was established in 1994.

The 2007 reform (called *Act to Strengthen Competition in SHI*) comprises a wide range of measures that, as a whole, have significantly modified the way the German healthcare system is regulated and financed. The most relevant change is the introduction of a universal insurance obligation: starting in 2009, the obligation to take out insurance is no longer limited to some professional categories, but includes all German residents. Non-SHI subscribers are required to have a private healthcare insurance policy. Private insurers are obliged to offer their policyholders basic tariff for coverage of a benefit basket similar to the one guaranteed by the SHI (Busse and Blümel 2014). A Central Reallocation Pool has been established for the purpose of making the financing of sickness funds even more equitable and transparent. All mandatory contributions paid by SHI subscribers are now collected by this central fund, which in turn allocates them to individual sickness funds according to a morbidity-based risk-adjustment scheme (Kifmann 2017).

Another important change concerns the standardization of the contribution rate for SHI subscribers. Prior to the reform, contributions could have varied depending on the sickness

fund. Following the 2007 reform, all sickness funds are financed through the same contribution rate. The latter was subsequently set at 14.6% of the worker's salary, to be paid in equal shares by employer and employee.

The Current Governance Modes

In Germany, the various reforms introduced over the last three decades seem to have followed an all-in-all coherent design. Overall, this thirty-year process has resulted in changing the system's financing model. Health insurance is no longer mandatory only for given professions but applies to all residents. Coverage has therefore become universal. The mandatory contributions that were once collected by individual sickness funds are now collected and then allocated by a single national fund. The financing of the system has therefore become more centralized and equitable. Also, starting in the mid-1990s, SHI subscribers are entitled to choose the sickness fund they wish to register with, whereas in the past this was not possible. To date, the German system is based on competition between insurers, which are nonetheless subject to stringent public regulation.

Regulation. National laws determine a general framework of reference but, in actual fact, the daily regulation of insurers and providers takes place at a decentralized level (Giaimo 2016). Despite the abandonment of the classic Bismarckian model, none of the recent governments has questioned the corporatist mode of regulating the healthcare sector (Busse and Blümel 2014), based on the involvement of associations representing sickness funds, hospitals and practitioners. In this scenario, the Federal Joint Committee plays an important linking role. This body consists of ten representatives of the associations of providers and sickness funds, plus three neutral members (Kifmann 2017). The Federal Joint Committee performs important quality assurance duties for the entire system, and has the authority to determine which treatments should be covered under Social Health Insurance (Giaimo 2016).

Financing. Compared with the early 1990s, the federal government has presently put in place – through the Central Reallocation Pool – a more stringent monitoring of sickness fund financing. Hospitals are remunerated according to a DRG system[2], introduced in 2004 (Busse et al. 2017).

Organization and Information. If we consider the policy tools used in the healthcare sector, we can conclude that Germany mainly relies on the financing and regulation levers, while recourse to organization (the German State does not directly provide healthcare through its own facilities and employees) and information are rather scarce. One of the few examples of an "informative" tool is the Institute for Quality and Efficiency: this body – established following the model of the English NICE (Busse et al. 2017) – has no regulatory powers but performs an informative function for the public and the Federal Joint Committee (it publishes guidelines and assessments on the clinical effectiveness of treatments).

5. The Netherlands

The Bismarckian Imprint and the AWBZ Scheme

Up until the end of the 1980s, a Bismarckian system was also implemented in the Netherlands, where it was established in 1941 during the German occupation. About two thirds of the population were subject to a typical social health insurance scheme, while the remaining part of the population was free to take out private insurance. For those enrolled in the mandatory scheme, the benefit package was uniform, and contributions were paid in equal shares by employers and employees (Vonk and Schut 2019).

In addition to basic insurance (mandatory or voluntary), from the second half of the 1960s, all Dutch residents could rely on additional insurance coverage, called AWBZ. This scheme, unique

and uniform for all residents, was financed through mandatory income-related contributions, and covered long-term care expenses.

Healthcare providers were – and still are – independent of insurance companies and sickness funds, and were reimbursed by the latter.

The 2006 Reform and Mandatory Insurance for all Residents

In the last three decades, the Dutch healthcare system has experienced various reform initiatives (Kroneman et al. 2016). The most important reform is the one implemented in 2006, supported by the centre-right coalition led by Balkenende. It is largely inspired by the recommendations contained in the 1987 Dekker Report (Maarse et al. 2016; Vonk and Schut 2019), and has introduced a unified mandatory insurance scheme and provided for a regulated competition system, which should promote the efficiency of the system and increase citizens' freedom of choice.

Following the 2006 reform, all Dutch residents are obliged to purchase an insurance policy covering a standard, basic benefits package. Citizens are free to choose their insurer, which may be changed every year. Insurers (both for-profit and non-profit) are in competition with each other, and are obliged to accept each person who applies for an insurance plan (the so-called "open enrolment"). Adults are required to pay an annual premium directly to their insurer. These premiums vary depending on the insurer, but cannot be calculated based on individual risk, as they must be community-rated [3] (Stolper et al. 2019). The government pays the premium due for minors through tax revenue. In addition to the fixed premium, subscribers pay an income-dependent contribution to a single national fund. The contributions collected by this fund are redistributed among all insurers on a risk-adjusted basis. Low-income families can apply for fiscal subsidy to purchase basic health insurance (Okma and Crivelli 2013).

The Current Governance Modes

Organization. Although not directly involved in the provision of health services, the Dutch government monitors the financing system and performs important regulatory functions.

Regulation. Starting in 2006, the State requires all residents to take out basic health insurance. Both insurers and healthcare providers are strictly regulated. The basic insurance benefit package is uniform and determined by the national government (Stolper et al. 2019); it includes outpatient and hospital care, prescription drugs and dental care for children under 18 (Maarse et al. 2016). Healthcare services excluded from the basic package may be covered by private insurance. Four out of five Dutch citizens subscribe to complementary[4] private insurance (Kroneman et al. 2016). With regard to complementary coverage, insurers are allowed to refuse applicants and calculate premiums based on individual risk.

The regulation of the healthcare system is in part delegated to some independent agencies, the most important of which are the Dutch Healthcare Authority, the Health Care Inspectorate and the antitrust authority (Schut and Varkevisser 2017). The Dutch Healthcare Authority (NZa) has the task of monitoring both insurers and healthcare providers and, for this purpose, is empowered to impose sanctions and obligations that the actors are required to comply with. The Health Care Inspectorate (IGZ) is responsible for monitoring quality and accessibility of healthcare. The objective of the Authority for Consumers and Market (ACM) is to protect consumers' interests by preventing the formation of cartels and the abuse of a dominant position. The regulatory powers of the ACM also extend to insurers and providers operating in the healthcare field.

Financing. With respect to financing, the national government plans and allocates the national healthcare budget. Through taxation, it also finances the long-term care fund for the entire population and pays basic healthcare for minors. Moreover, the risk-adjustment criteria among

insurers are also the responsibility of the State. At present, hospitals are financed through an adapted type of DRG system.

Information. The Dutch system avails itself of some important advisory bodies, which do not have regulatory and sanctioning powers, but are required to provide policy makers and citizens with "advice and evidence". The most relevant advisory body is the National Healthcare Institute. It publishes periodic reports assessing the performance of the healthcare system, based on quality indicators, accessibility and costs (Stolper et al. 2019).

The Dutch healthcare system generally places great emphasis on information at all levels of the system (Kroneman et al. 2016). As a tool for patient empowerment, the Dutch government is committed to providing all citizens with the information required to make a conscious choice of the healthcare provider. A website hosted by the National Healthcare Institute is available for users who wish to find information on performance, prices, waiting times, specific providers or a specific condition (Kroneman et al. 2016).

6. Canada

Medicare and the 1984 Canada Health Act

The vast majority of healthcare services in Canada are financed by a public single-payer insurance scheme known as Medicare, which acts as a public insurer for the entire population. The Medicare scheme - established by legislation passed in 1957, 1966 and 1984 - is financed through tax revenue. The provision of healthcare services is not guaranteed by facilities and personnel directly employed by Medicare, but by independent providers. Hospitals in Canada are, to a large extent, non-profit voluntary organizations, while doctors are mainly either self-employed or employees of non-profit voluntary organizations (Martin et al. 2018)

The structure of the Canadian healthcare system is highly decentralized (Gray 1998; Geva-May and Maslove 2000; Fierlbeck 2011), except for certain population groups such as members of the Canadian armed forces, Indigenous peoples and veterans. Although the federal government imposes a regulatory framework common throughout the country, Medicare is managed at provincial/territorial level (in this work, we shall use the "provinces" to mean both the 10 provinces and the 3 territories).

The overall governance of the system is based on financial leverage: since the Constitution guarantees the autonomy of the provinces insofar as healthcare matters are concerned, the Ottawa government uses financial transfers to "convince" the provinces to implement the federal objectives (Evans 2000). In addition to financial leverage, governance of the Canadian healthcare system is reinforced by social control: the majority of Canadians considers Medicare as a national pride. This strengthens an implicit social contract among government, healthcare providers and citizens, guaranteeing that the public financing scheme will remain fair and supportive (Martin et al. 2018).

The Canada Health Act, approved in 1984, sets out the five basic criteria that the provinces are required to comply with to receive federal transfers (Geva-May and Maslove 2000; Fierlbeck 2011). The five conditions are: 1) *universality* (coverage of all residents, who are entitled to uniform conditions); 2) *accessibility* (services provided free of charge, without user fees); 3) *comprehensiveness* (all care classified as medically necessary must be guaranteed); 4) *portability* (insured residents moving from one province to another, must continue to be covered for insured health services); 5) *public administration* (provincial health insurance plans must be administered and operated on a non-profit basis by a public authority).

No Major Pan-Canadian Reform

Unlike the countries analysed in the foregoing, over the last three decades, no major federal health reforms have been approved in Canada (Geva-May and Maslove 2000; Fierlbeck 2011; Marchildon 2013). The Canadian system evolved by incremental advances (Martin et al. 2018). Relevant organizational changes took place at a decentralized level. The innovations introduced at a provincial level were aimed at boosting the overall efficiency of the healthcare provision system, improving the quality of services, reducing waiting times, dehospitalizing patient care and enhancing home care services (Marchildon 2013).

From the end of the 1980s till today, the major novelty in the organization of the Canadian healthcare system lies in the process of regionalization (Fierlbeck 2011; Segatto et al. 2019), namely the introduction of the Regional Health Authorities (RHAs). These agencies were not introduced through a federal reform, but were established at different times, and in different ways, by the individual provinces.

RHAs have been delegated by provincial ministers of health to oversee hospitals, long-term facilities, home care and public health services within defined geographical areas. The RHAs are entitled to provide these services directly, or by contracting with other healthcare organizations and providers (Marchildon 2013). The main purpose of the RHAs is to make the system more integrated.

The Current Governance Modes

Organization. In Canada, the State finances and regulates its healthcare services, but does not provide them directly. The regionalization process that began in the early 1990s has led to a greater integration of the system. In the provinces where the RHAs own and manage first-hand most of the healthcare facilities, the organizational model approaches that of the NHS.

Regulation. The provinces and the federal government share the regulation of the healthcare system. The primary policy responsibility of financing, managing and regulating healthcare and

hospital services falls upon the provincial governments (Fierlbeck 2011; Segatto et al. 2019). The federal government may determine some general planning principles (Gray 1998; Evans 2000), which it seeks to impose on the provinces mainly through the use of financial leverage.

The Medicare scheme guarantees "medically necessary" care to all Canadian residents, without deductibles or co-payments (Evans 2000). There is no official list of services guaranteed by Medicare, established at federal level. The benefit baskets are defined at the provincial level. Coverage includes inpatient care, outpatient and day surgery care, emergency room care, primary care, and public health. For services that are not included in the Medicare package (such as outpatient prescription drugs, home care, long-term care, dental care, and outpatient physiotherapy), two-thirds of Canadians prefer to subscribe to private complementary insurance, mostly through their employers (Martin et al. 2018). Voluntary health policies that attempt to provide a private alternative to Medicare or faster access to Medicare services are prohibited or in any case discouraged by provincial laws and regulations (Flood and Haugan 2010; Marchildon 2013). Conversely, the purchase of a complementary private policy is incentivized through tax exemption on insurance premiums.

Financing. The Medicare scheme is financed through general taxation. The provinces raise the majority of funds through own-source revenues and receive approximately 20% of their healthcare budget from federal transfers (Martin et al. 2018; Segatto et al. 2019). Transfers are conditional on compliance by the individual provinces with the five provisions set forth by the Canada Health Act. Most hospitals are financed through global budgets, although in the last few years alternative methods have been tested at provincial level (Marchildon 2013).

Information. To date, typically informative tools do not play a particularly important role in the overall governance of the Canadian healthcare system (Fierlbeck 2011). Among the bodies responsible for data collection in the healthcare sector, the most relevant is the Canadian Institute for Health Information (CIHI). This institute is responsible for collecting and

processing administrative and financial data that enable the provincial governments to assess the effectiveness and efficiency of their respective healthcare systems (Marchildon 2013).

7. Australia

The Establishment of Medicare in 1984

The overall organization of the Australian healthcare system resembles the Canadian set-up in many respects (Gray 1998; Duckett 2018). Australia also has a single public insurance scheme, financed through taxation. As in Canada, this scheme is referred to as Medicare. It was established in 1984, and guarantees a basic benefit package to all Australian residents. Providers are separate from Medicare and are reimbursed by the latter. Another similarity lies in the fact that in Australia, too, the federal government (Commonwealth) and the State and Territory governments (from now on, when referring to Australia, the term "States" will also include the mainland territories) share both the financing of the system and the healthcare competencies (Hall 2015).

Unlike Canada, coverage provided by the Australian Medicare does not grant access to all hospitals, but only to public hospitals. Public hospitals account for about two-thirds of all beds (Duckett 2018), and citizens have to pay out of pocket to access private hospitals.

Another difference between the Australian and the Canadian systems concerns private insurance: in Canada, supplementary private health insurance is either prohibited, or in any case strongly disincentivized; conversely, in Australia, private insurance – including insurance covering the same services as the Medicare package – is encouraged through tax incentives (Connelly et al. 2010).

Finally, we ought to point out that the overall governance of the Australian healthcare system is less decentralized than the Canadian one (Gray 1998; Duckett 2018). The Australian federal government indeed has greater regulatory powers, and takes on a greater share of the system financing: this means that Australian Medicare – unlike the Canadian one – guarantees a greater degree of uniformity across the nation (Gray 1998).

The Regulation of Private Healthcare Insurance

A traditionally divisive issue in the Australian political debate concerns the ways in which private health insurance is regulated, and the role this insurance must play with respect to the Medicare public scheme (Willcox 2001; Hall 2015).

In 1997, the Howard government decided to incentivize the purchase of voluntary insurance using the "stick and carrot" approach (Hall 1999). On the one hand, tax rebates commensurate with income were granted for the purchase of private health insurance. On the other, tax penalties were introduced for taxpayers with medium-high income who had not taken out a private policy (Gray 1998; Hall 1999; Connelly et al. 2010).

Ten years later, in 2007, the Private Health Insurance Act introduced further changes in the regulation of the private insurance market. The Act provided for a risk equalization scheme among the different insurers. The system requires consumers to pay a community-rated premium to the insurer of their choice, with solidarity transfers then being made between a central equalization fund and the insurers (Connelly et al. 2010).

In addition to the changes involving private insurance, over the last 20 years several reform interventions have focused on the integration of primary care and the management of public hospitals (Hall 2010; Duckett 2018). Starting in 2015, the Primary Health Networks (PHNs) were established for the purpose of making the primary care network more integrated, with

particular attention to the treatment of chronic diseases (Hall 2015). About thirty PHNs are currently operative in Australia.

As concerns specialist care, from 2011 onwards Local Hospital Networks (LHNs) have been established. These networks are separate statutory authorities (each with its own Council, appointed by the State Minister) to which state governments delegate the management and financing of public hospitals (Hall 2010). At present, about 140 LHNs are operative throughout the Australian territory.

The Current Governance Modes

Organization. The Australian federal government is not directly involved in the provision of healthcare services. The individual States are instead responsible for the management of public hospitals, delegated to the Local Hospital Networks. Outpatient care is provided by independent practitioners (i.e., not employed by the government), paid mainly on a fee-for-service basis.

Regulation. Healthcare is formally divided between Commonwealth and State governments (Duckett 2018); this notwithstanding, the Australian healthcare policy is strongly shaped by the preferences of the federal government, which exerts a considerable leverage through its funding role (Gray 1998; Hall 1999). The federal government defines Medicare benefits, which include hospital care, medical services, and pharmaceuticals.

Private health insurance is highly regulated, and insurers are required to comply with the constraints imposed by both open enrolment and community rating (Hall 1999; Connelly et al. 2010). The role played by private insurers is both supplementary and complementary to Medicare, and currently around 50% of Australians have private insurance (Duckett 2018).

Financing. Medicare funding is shared by the federal government and the individual States. The Commonwealth transfers to the States the resources required to cover primary and outpatient

care, pharmaceuticals and about 40% of public hospital funding (Duckett 2018). With respect to the public hospital funding system, all States use some form of "activity-based" payment, subject to budget caps (Hall 2010; Duckett 2018).

The Commonwealth encourages enrolment in private health insurance through a tax rebate and, above a certain income, a penalty payment for not having a private insurance policy.

Information. In the Australian system, the typically "informative" policy tools do not seem to play a crucial role. The two main agencies with information functions are the Australian Institute of Health and Welfare (which collects and publishes information on a wide range of health topics) and the Commission on Safety and Quality in Health Care (which, in addition to data dissemination, has the task of developing clinical standards).

8. Discussion: The Trajectories of Healthcare Governance

On concluding this work, we ought to recap the trajectories followed by the five healthcare systems analysed in the previous sections. Over the past three decades, all the countries we have focused on have indeed modified – at least in part – their model of healthcare governance. At the end of the 1980s, England adopted, and still adopt, the National Health Service model. However, starting in the early 1990s, England have promoted a shift in governance mode: without disrupting the basic principles of the NHS (universal coverage, financing through taxation, mainly public service provision), the integrated model was left behind, moving on towards an internal market system. The internal market rationale was first introduced in 1990 by the Thatcher government. It was later softened by the Blair government, and was finally implemented again in 2012 by the Cameron government, with new operational tools.

Over the last three decades, Germany and the Netherlands have followed a similar trajectory. Indeed, both countries are progressively moving from a classic Bismarckian system of SHI to a system that is approaching mandatory national health insurance (Toth 2016). While the classical SHI does not grant the freedom to choose the sickness fund and imposes the obligation to take out health insurance only to some professional categories, the mandatory national insurance model is instead based on the obligation for all residents to subscribe to an insurance and on the "regulated competition" of insurers.

In the late 1980s, Canada and Australia had, and still have, a universal single-payer system in which the state finances healthcare for the entire population, but does not provide it directly. An important innovation lies in the introduction of Local Hospital Networks in Australia, and of Regional Health Authorities in Canada (especially in the provinces where the RHAs manage hospitals first-hand). These models indicate a tendency towards vertical integration and direct management of hospitals (similarly to the NHS).

Table 1 – The evolution of policy tools in the healthcare sector

	Main policy tools used in the late 80s	Policy tools introduced since the early 90s
Australia	Contribution through general taxation Free choice of provider Medicare benefits defined by the federal government	Tax incentives to take out private insurance Tax penalties for not having private insurance Highly regulated private insurance market: risk equalization scheme; community-rated premiums; open enrolment Regulation through Local Hospital Networks
Canada	Contribution through general taxation Free choice of provider Transfers to provinces based on a reward system Prohibition of supplementary private insurance	Regional Health Authorities Performance-based funding CIHI: information dissemination
England	Public provision of care Contribution through general taxation	Internal market Purchaser-provider split Budget holding

		Contracts NICE: standards and guidelines Free choice of provider Payment by results Assessment of providers' performance
Germany	Obligation for most workers to register with a sickness fund Free choice of provider	Free choice of sickness fund Open enrolment Risk equalization scheme Obligation for all residents to take out insurance Standardisation of the SHI contribution rate
Netherlands	Obligation for some categories to register with the Social Health Insurance AWBZ scheme financed through mandatory contributions Free choice of provider	Obligation for all residents to take out basic insurance Free choice of insurer Open enrolment Community-rated premiums Public subsidies Risk equalization scheme Regulation through independent agencies National Healthcare Institute: performance assessment and information dissemination

9. Conclusions

Throughout this work, we have subdivided the policy tools into four broad categories: organization, regulation, financing and information. In the previous sections, we have discussed the different ways in which the individual countries combine these four governance modes.

Organization. Direct management remains the prevailing mode of governance in the English healthcare system: most healthcare services are provided by personnel and facilities belonging to the National Health Service. As regards hospital care alone, Australia and some Canadian provinces are also shifting towards government-led models similar to those of the NHS.

Regulation. All of the five countries studied in this work make extensive use of regulation. Often this regulation is shared between the national and sub-national governments, and is in part delegated to agencies and external actors.

In all five countries, governments require that residents have basic coverage and regulate healthcare providers. Insurer regulation is particularly stringent in Germany, the Netherlands and Australia. Insurers in these three countries must comply with three major constraints if they want to provide the basic package in Germany and the Netherlands, and if they want to enjoy tax incentives in Australia. These constraints are: open enrolment, community rating and acceptance of risk-equalisation mechanisms. Compliance with these three constraints should prevent (or in any case discourage) the selection of policyholders and the calculation of premiums based on individual risk.

Financing. Of the countries examined in the foregoing, those that make the greatest use of financial leverage to influence the behaviour of the different actors (insurers, providers, users) seem to be Australia and Canada. In Australia, for example, private health insurance is incentivized either through an award (positive) or through a penalty (negative). In Canada, the entire Medicare scheme is based on financial incentives. The individual provinces are formally free not to comply with the directives of the federal government, but in this case they do not receive financial transfers from the latter.

Information. Among the five countries under consideration, the two that focus most on genuinely informative policy tools are England and the Netherlands, where systems for the evaluation of provider performance have been put in place. These evaluation systems are very convenient for users (who can decide where to be treated in a more informed and conscious manner) and motivate providers to keep quality high.

Disclosure statement

No conflict of interest was reported by the authors

References

Bemelmans-Videc, M.L., R.C. Rist, and E. Vedung, eds. 1998. *Carrots, Sticks and Sermons: Policy Instruments and Their Evaluation*. London: Routledge.

Bevan, G., and R. Robinson. 2005. "The Interplay between Economic and Political Logics: Path Dependency in Health Care in England." *Journal of Health Politics, Policy and Law* 30: 53-78.

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

Busse, R., M. Blümel, F. Knieps, and T. Bärnighausen. 2017. "Statutory health insurance in Germany: a health system shaped by 135 year of solidarity, self-governance, and competition." *Lancet* 390: 882–897.

Connelly, L.B., F. Paolucci, J. Butler, and P. Collins. 2010. "Risk equalisation and voluntary health insurance markets: The case of Australia." *Health Policy* 98: 3-14.

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

Department of Health and Social Care. 2018. *Annual Reports and Accounts 2017-18*. London: Department of Health and Social Care.

Doern, G.B., and R.W. Phidd. 1983. *Canadian Public Policy: Ideas, Structure, Process*. Toronto: Methuen.

Duckett, S. 2018. "Expanding the breadth of Medicare: learning from Australia." *Health Economics, Policy and Law* 13(3-4):344-368.

Enthoven, A.C. 1985. *Reflections on the Management of the National Health Service*. London: Nuffield Provincial Hospital Trust.

Evans, R.G. 2000. "Canada." *Journal of Health Politics, Policy and Law* 25: 889-897.

Fierlbeck, K. 2011. *Health Care in Canada*. Toronto: University of Toronto Press.

Flood, C.M., and A. Haugan. 2010. "Is Canada odd? A comparison of European and Canadian approaches to choice and regulation of the public/private divide in health care." *Health Economics, Policy and Law* 5: 319–341.

Freeman, R., and M. Moran. 2000. "Reforming health care in Europe", *West European Politics* 23(2): 35-58.

Geva-May, I., and A. Maslove. 2000. "What prompts health care policy change? On political power contest and reform of health care systems (the case of Canada and Israel)." *Journal of Health Politics, Policy and Law* 25: 717-741.

Giaimo, S. 2016. *Reforming Health Care in the United States, Germany, and South Africa*. Basingstoke: Palgrave-Macmillan.

Gray, G. 1998. "Access to Medical Care under Strain: New Pressures in Canada and Australia." *Journal of Health Politics, Policy and Law* 23: 905-947.

Hall, J. 1999. "Incremental Change In The Australian Health Care System." *Health Affairs* 18: 95-110.

Hall, J. 2010. "Health-care reform in Australia: advancing or side-stepping?" *Health Economics* 19: 1259-1263.

Hall, J. 2015. "Australian Health Care – The Challenge of Reform in a Fragmented System." *The New England Journal of Medicine* 373(6): 493-497.

Ham, C. 2009. *Health Policy in Britain* (6th ed.). Basingstoke: Palgrave-Macmillan.

Ham, C., Baird, B., Gregory, S., Jabbal, J., and Alderwick, H. (2015). *The NHS under the coalition government. Part 1: NHS reform.* London: The King's Fund.

Helderman, J.K., G. Bevan, and G. France. 2012. "The rise of the regulatory state in health care: a comparative analysis of the Netherlands, England and Italy." *Health Economics, Policy and Law* 7: 103-124.

Hood, C. 1983. *The Tools of Government*. London: Macmillan.

Howlett, M. 2005. "What Is a Policy Instrument? Tools, Mixes, and Implementation Styles." In *Designing Government. From Instruments to Governance*, edited by P. Eliadis, M. Hill and M. Howlett, 31-50. Montreal: McGill-Queens University Press.

Howlett, M. 2011. *Designing Public Policies. Principles and Instruments*. London: Routledge.

Howlett, M., and M. Ramesh. 1995. *Studying Public Policy: Policy Cycles and Policy Subsystem*s. Toronto: Oxford University Press.

Jacobs, A. 1998. "Seeing difference: market health reform in Europe". *Journal of Health Politics, Policy and Law* 23(1): 1-33.

Kifmann, M. 2017. "Competition policy for health care provision in Germany." *Health Policy* 121: 119-125.

Klein, R. 1998. "Why Britain is Reorganizing its National Health Service – Yet Again." *Health Affairs* 17: 115-126.

Klein, R. 2013. *The New Politics of NHS* (7th ed.). Oxford: Radcliffe.

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

Kutzin, J. 2001. "A descriptive framework for country-level analysis of health care financing arrangements." *Health Policy* 56 (3): 171-204.

Lascoumes, P., and P. Le Gales. 2007. “Introduction: Understanding Public Policy through Its Instruments – From the Nature of Instruments to the Sociology of Public Policy Instrumentation.” *Governance* 20: 1-21.

Linder, S., and G. Peters. 1989. “Instruments of Government: Perceptions and Contexts.” *Journal of Public Policy* 9: 35-58.

Maarse, H., P. Jeurissen, and D. Ruwaard. 2016. “Results of the market-oriented reform in the Netherlands: a review.” *Health Economics, Policy and Law* 11: 161-178.

Marchildon, G.P. 2013. Canada: Health system review. *Health Systems in Transition, 15(1)*, 1-179.

Martin, D., A.P. Miller, A. Quesnel-Vallée, N.R. Caron, B. Vissandiée, and G.P. Marchildon. 2018. Canada’s universal health-care system: achieving its potential. *Lancet* 391: 1718-1735.

Mossialos, E. and S. Thomson. 2004. *Voluntary health insurance in the European Union*. Copenhagen: WHO Regional Office for Europe.

Okma, K., and L. Crivelli. 2013. “Swiss and Dutch consumer-driven health care: Ideal model or reality?” *Health Policy* 109: 105-112.

Oliver, A. 2005. The English National Health Service: 1979-2005. *Health Economics, 14 (S1)*, 75-99.

Oliver, A., and E. Mossialos. 2005. “European Health Systems Reforms: Looking Backward to See Forward?”. *Journal of Health Politics, Policy and Law* 30(1-2): 7-28.

Peters, G. 2002. “The Politics of Tool Choice.” In *The Tools of Government. A Guide to New Governance*, edited by L. Salamon, 552-564. Oxford: Oxford University Press.

Rothgang, H., M. Cacace, S. Grimmeisen, and C. Wendt. 2005. “The changing role of the state in healthcare systems.” *European Review* 13: 187-212.

Salamon, L. 2002. “The New Governance and the Tools of Public Action: An Introduction.” In *The Tools of Government. A Guide to New Governance*, edited by L. Salamon, 1-47. Oxford: Oxford University Press.

Saltman, R.B., and J. Figueras. 1998. “Analyzing The Evidence On European Health Care Reforms”. *Health Affairs* 17(2): 85-108.

Schut, F., and M. Varkevisser. 2017. “Competition policy for health care provision in the Netherlands.” *Health Policy* 121: 126-133.

Segatto, C.I., D. Béland, and G.P. Marchildon. 2019. Federalism, Physicians, and Public Policy: A Comparison of Health Care Reform in Canada and Brazil. *Journal of Comparative Policy Analysi*s. https://doi.org/10.1080/13876988.2019.1603357

Stewart, D.W., and M.A. Kamins. 1993. *Secondary research: Information sources and methods*. Newbury Park: Sage.

Stolper, K., L. Boonen, F. Schut, and M. Varkenvisser. 2019. "Managed competition in the Netherlands: Do insurers have incentives to steer on quality?" *Health Policy* 123 (3): 293-299.

Toth, F. 2010. "Healthcare policies over the last 20 years: Reforms and counter-reforms." *Health Policy* 95: 82-89.

Toth, F. 2016. "Classification of healthcare systems: Can we go further?" *Health Policy* 120: 535-543.

Tuohy, C. H. 1999. *Accidental logics: The dynamics of change in the health care arena in the United States, Britain, and Canada*. New York: Oxford University Press.

Vonk, R., and F. Schut. 2019. "Can universal access be achieved in a voluntary private health insurance market? Dutch private insurers caught between competing logics." Health Economics, Policy and Law 14(3): 315-336.

Willcox, S. 2001. "Promoting Private Health Insurance In Australia." *Health Affairs* 20: 152-161.

Wilsford, D. 1994. "Path Dependency, or Why History Makes It Difficult but Not Impossible to Reform Health Care Systems in a Big Way". *Journal of Public Policy* 14(3): 251-283.

Wörz, M., and R. Busse 2005. "Analysing the impact of health-care system change in the EU member states – Germany." *Health Economics* 14(S1): 133-149.

Endnotes

[1] Under the capitation payment model, health care providers receive a fixed amount for each patient assigned to them. This is paid in advance, for a defined time, whether the patient seeks care or not.

[2] The DRG (Diagnosis-Related Group) system categorizes patients with similar diagnoses, and assigns a reimbursement rate to each DRG. Hospitals are paid a fixed fee for each case within a given category, regardless of the actual costs incurred.

[3] Premiums are defined as *community-rated* when they are uniform for all residents within a given geographical area.

[4] Voluntary healthcare insurance can be of three types (Mossialos and Thomson 2004): 1) substitutive; 2) complementary; 3) supplementary. Substitutive insurance replaces a mandatory healthcare policy with a voluntary private policy. Complementary insurance involves a private policy that covers procedures and/or services that are excluded or not fully covered by mandatory insurance. Supplementary insurance covers procedures and/or services already covered by mandatory insurance.