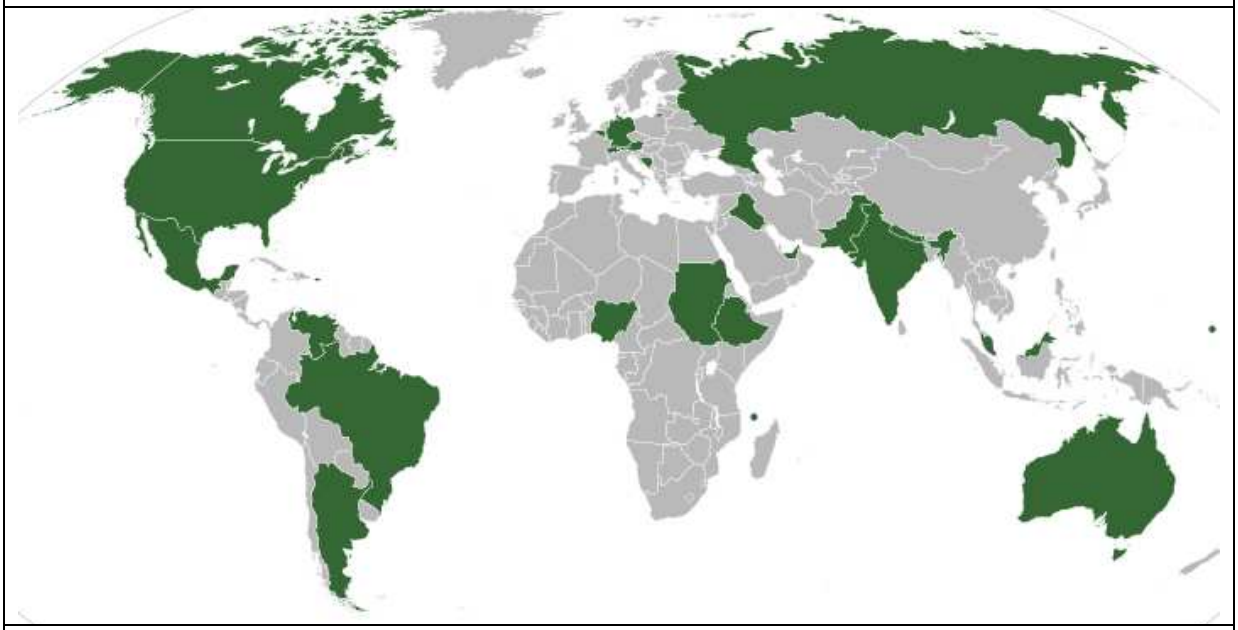
# Health care in federal countries

Background, organization, financing and stewardship

Detlef Schwefel [1]

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

Federal countries of the world



[Wikipedia: Federal countries marked in green]

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

Some countries are federal but do not prefer this label, like Spain. Some are quite centralized, like Malaysia. In some countries the federal level can override the lower level of government. Some non-federal countries are more decentralised than federal countries; they can have rather strong regional

[1] I appreciate the partnership and advice of Friedeger Stierle and Sudip Pokhrel, German Technical Cooperation, Nepal. This article is a synthesis of the knowledge collage on health care organization and financing in eleven federal countries – see [Schwefel 2009] – www.detlef-schwefel.de / detlef.schwefel@berlin.de

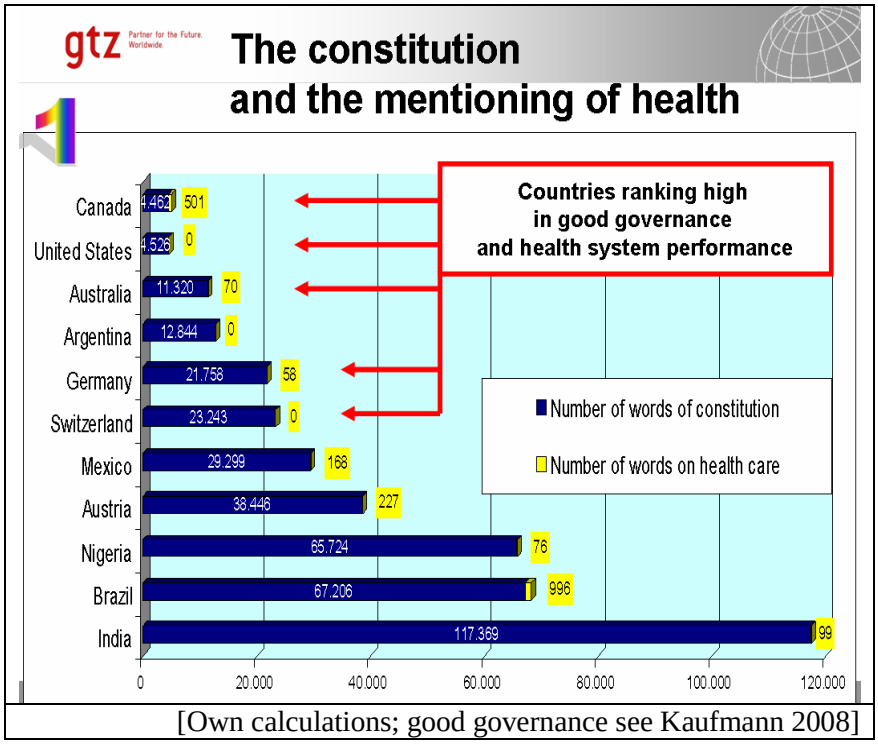
governments like Colombia, Italy and Japan. In the United Kingdom a region – Scotland – achieved considerable power on education, health and local affairs, more than Wales and Northern Ireland. [Anderson 2008] In some countries – like USA – power shifted somehow from the states to the national government with the approval of the Supreme Court. In Belgium there are only two constituent parts of the federation, the Dutch and the French speaking populations. There is a de-facto-federation in China. The same applies to the European Union.

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

"Decentralization involves a central power possessing authority to decentralize or devolve functional and administrative responsibilities to lower levels of government. The authority to decentralize, however, also includes the authority to recentralize power. Decentralization is concerned with administrative efficiency and functional efficacy in an otherwise unitary system." [Kincaid 2008

## 1 Explicit mentioning of health in the constitution of federal countries

Constitutions of federal countries vary considerably. Some are very short like those of Canada and the United States of America. With close to 500 pages the constitution of India is the longest of the world. Some constitutions give many details on health care – like the constitution of Brazil – other constitutions do not even mention the word health or synonyms like for example hospitals or medical care.



[Own calculations; good governance see Kaufmann 2008]

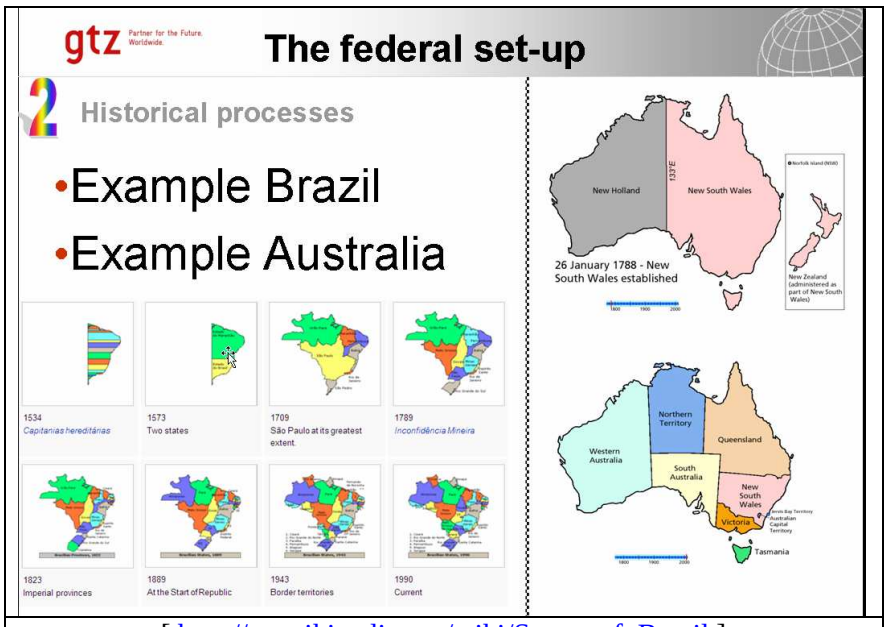
A short constitution or not to mention health in it does not mean that a country is poor in terms of good governance, as measured by an index proposed and used by the World Bank. Changing a constitution is a very difficult task. Therefore it might be wise not to go into too many details of health care organization and financing but rather include general issues in implementing rules, regulations and bylaws. The basic values, nevertheless, deserve to be underscored: human dignity and rights, no-discrimination of social groups, communities and territories – for example.

## 2 Federal history and set-up

Most federal countries developed over long periods of time. Brazil was first split into stretches of land given by the Portuguese king to noblemen or merchants. During 475 years and step by step it developed into the current shape of 26 states and one Federal District. States collect their own taxes and

receive shares of federal taxes but have much less autonomy than the States of the United States of America for example. Adding, splitting and joining of states or territories was also quite usual in the history of Australia.

In federal countries with different cultures, ethnic groups and languages the territorial and power mapping is usually criss-crossing such unities, like in Switzerland. Internal migrations and economically attractive development centres contribute to this. In Belgium the federation is split essentially into two language groups; a very small German speaking community is given a certain degree of autonomy. Such groupings within federal countries are changing over time and can give rise to conflicts and even contribute to the break up of federal republics. One of those cases is Yugoslavia where the former Kingdom was converted 1945 into a Socialist Republic which disintegrated since 1991 to fall apart into seven new countries with still existing separation movements, mostly along religious and linguistic divisions.




[ http://en.wikipedia.org/wiki/States_of_Brazil ]
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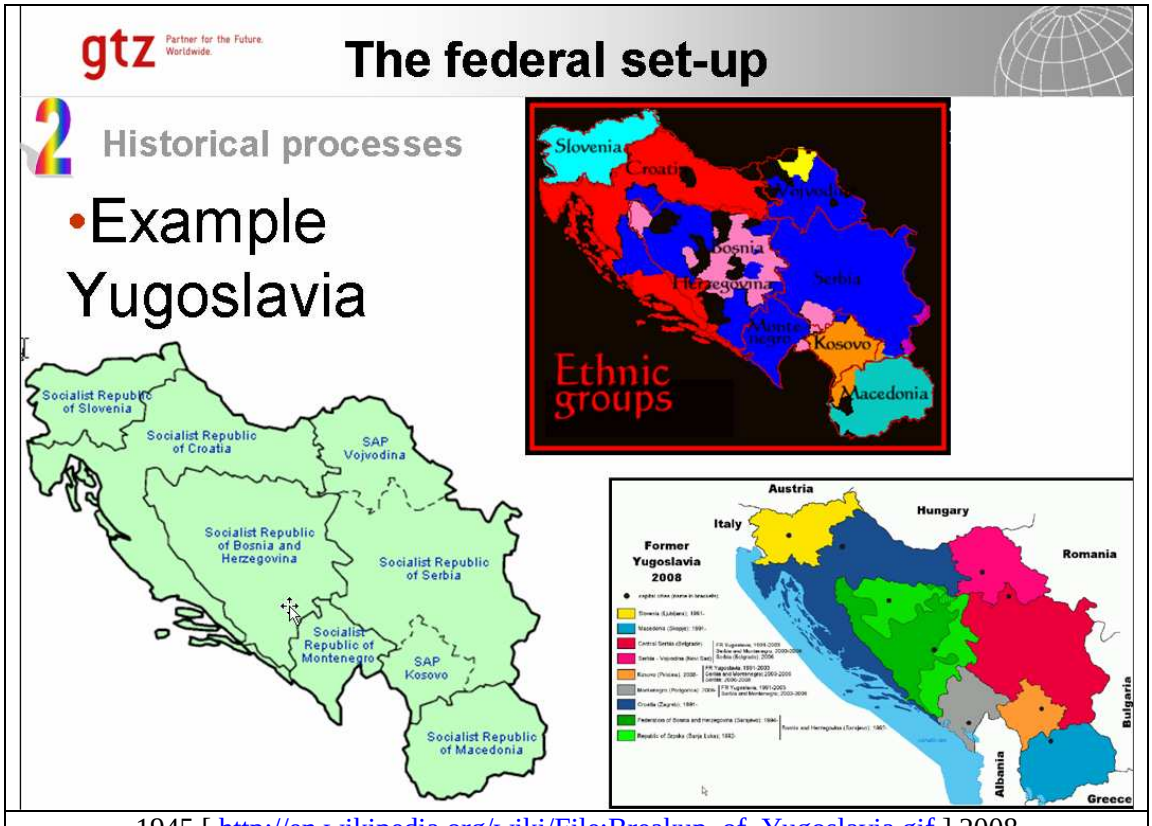
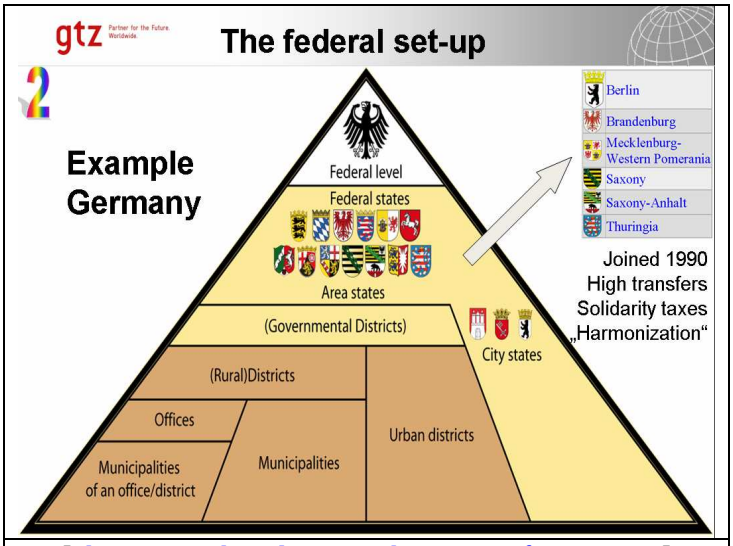



1945 [ http://en.wikipedia.org/wiki/File:Breakup_of_Yugoslavia.gif ] 2008

History influences heavily the set-up of many federal countries – some shrink, some collapse, some grow. After the economic collapse of the German Democratic Republic and a peaceful revolution of its people six new states joined the Federal Republic of Germany in the year 1990. All new states were much poorer than the federal states in the West of Germany. High financial transfers based on debts and solidarity taxes levied to the Western tax payers contributed to a long-term and gradual harmonization of the living conditions which now – after 20 years is not yet done fully. Such measures towards harmonization create quite some conflicts. Federal states develop and change over time. They are not enduring per se. Harmonization mechanisms are needed to create and maintain solidarity among economically, ethnically and otherwise different units.

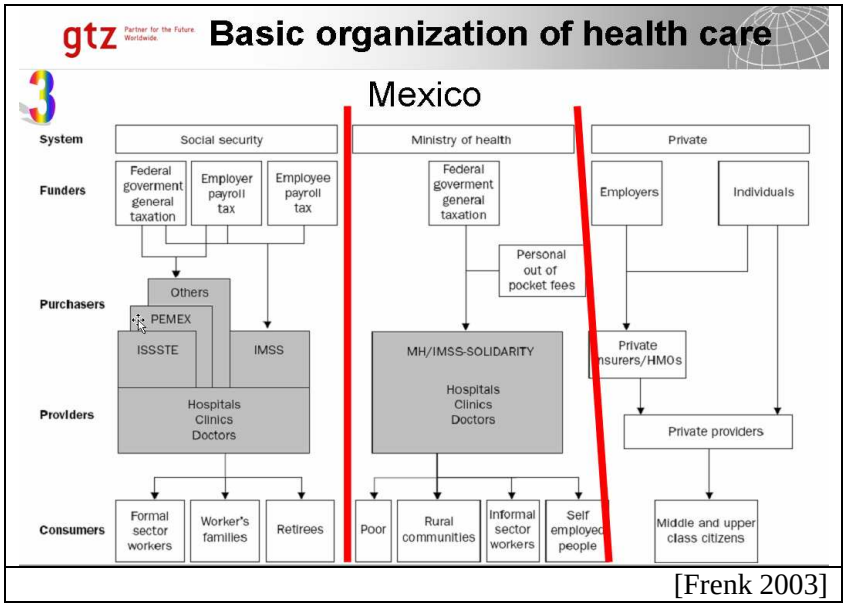



[ http://en.wikipedia.org/wiki/States_of_Germany ]

## 3 Organization of health care in federal countries

The organization of health care is quite different in federal countries. Federalism does not prevent the existence and persistence of outdated models of health care provision. Mexico is an example of a highly fragmented health system:

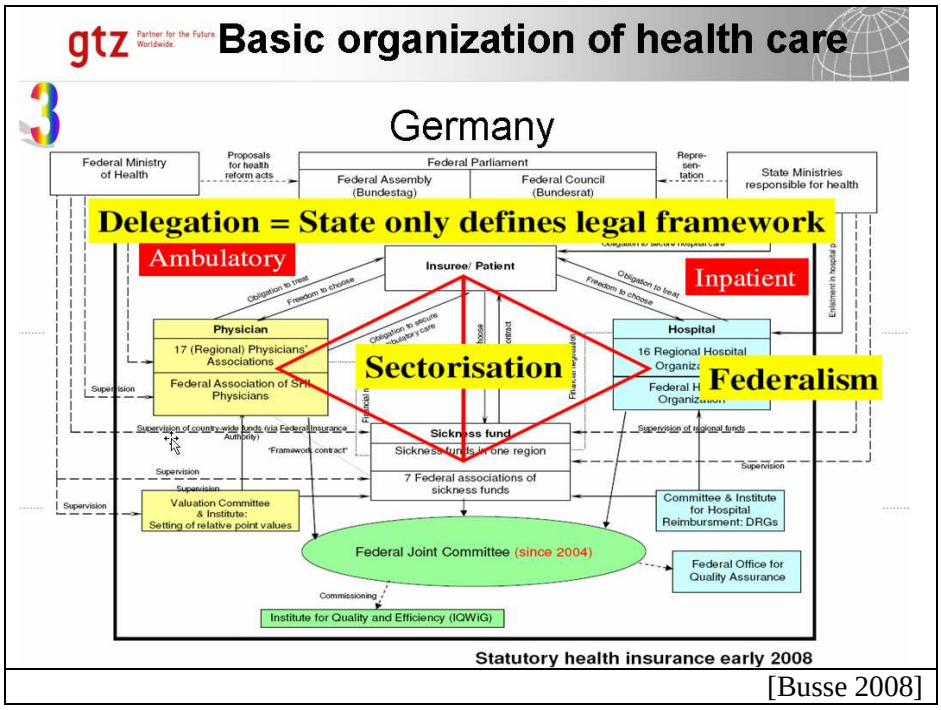
- The private sector caters for the better-off population who pay out-of-pocket or through private health insurances and they purchase good quality health care.
- Mandatory health insurances exist since long for the employees in the formal public and private sectors and they offer health care at an intermediate quality level.
- The Ministry of Health is responsible for those not covered by one of the two other systems, i.e. especially the poor and vulnerable at a rather low level of quality.




[Frenk 2003]

There are nearly no interactions between these three rather isolated subsystems and current national reform endeavours have brilliant strategies but a very slow trickling down of real impacts.

Germany's health care system is not perfect either. The federal government defines the legal framework of health care provision and consults with the federal states which approve or reject reform laws. The federal government does not provide health care – it is just the regulator and has supervisory powers. Federal states let municipalities engage only in those health programmes which are not included in the mandate for private and social health insurances which cover 100% of the population.

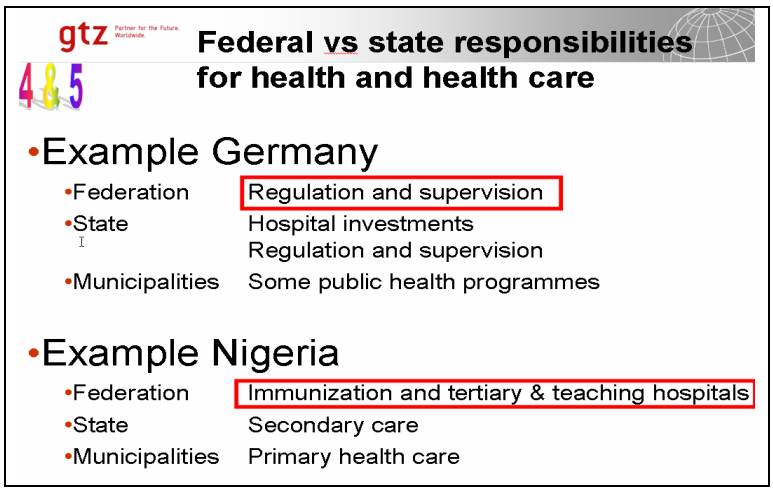


[Busse 2008]

Health insurances are organized at different levels than the states – some nationally, others regionally, others locally or even at the level of individual companies. Equalisation mechanisms are nationally mandated. They level off differences in the clientele of the legal health insurances. Legal insurances cover about 90% of the population. Insurances are run democratically by employers and employees, i.e. those who finance health insurances. Providers affiliated with legal health insurance have a mandate to guarantee outpatient and inpatient care economically at a high quality level. They are organized and elected democratically. There is a rather strict split between outpatient care and inpatient care. This system is quite old already. It is being reformed continuously and incrementally. The basic principle of organizing health care in Germany is the subsidiarity principle: the federation should not do what others can do and the federal states should follow this principle, too.

An analysis of details of organization and financing of health systems in federal countries and its synthesis shows that there are good and poor health systems all over the world, not only in federal settings. We can learn from their failures and successes. Comparative health system analysis is a very important tool for preparing reforms.

## 4 Responsibilities of federal level

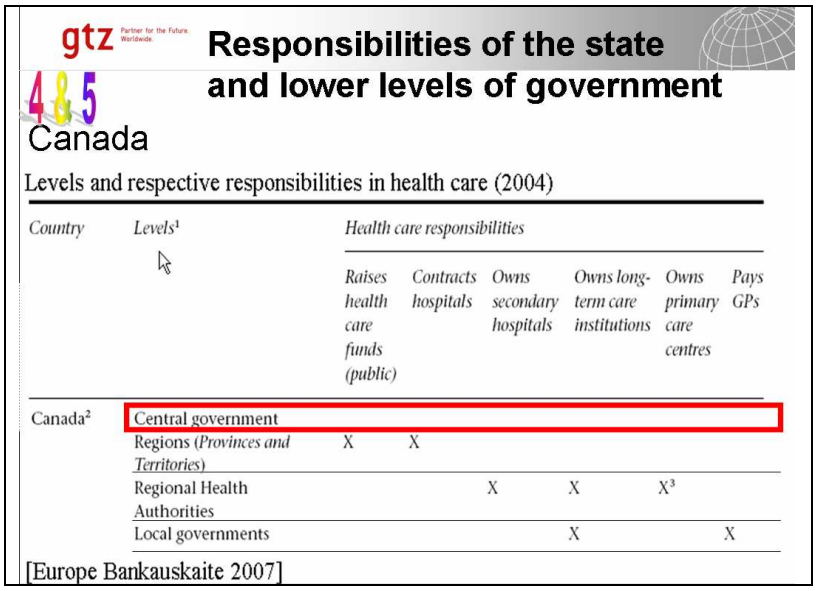



Germany's health care system shows that this very country is following the 'modern' advice of health economics: split regulation, financing and provision of health care and assure that federal states are not too strong to interfere into equalisation measures across patients, people, populations and territories. Regulation and supervision is the task of the federal government. Federal states contribute to this and have to act as back-up for what other agents, e.g. legal health insurances can not do. Nowhere in the world can contributions of employers and employees fully finance a health system. Therefore the state has to finance the investment costs whereas the insurances pay the current costs. Federal governments delegate responsibilities and assume them if they can not be followed by lower levels or entrusted agents. This principle is implemented in many poor countries, like for example

Nigeria – even if it is questionable if immunization campaigns, tertiary health care and teaching hospitals could not be commissioned cost-effectively to other agents.

## 5 Responsibilities of state and lower levels

Canada is the example of a country where the central government has nearly no health care responsibilities. In a clearly structured division of labour federal provinces / territories, regional health authorities and local governments are made responsible for certain essential functions and tasks to be done. This assumes of course the capability of lower level agents to stand to their obligations. This principle can not be applied all over the world.

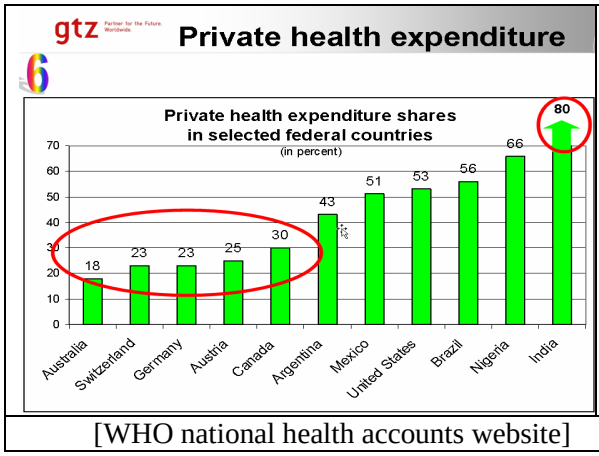


[Europe Bankauskaite 2007]

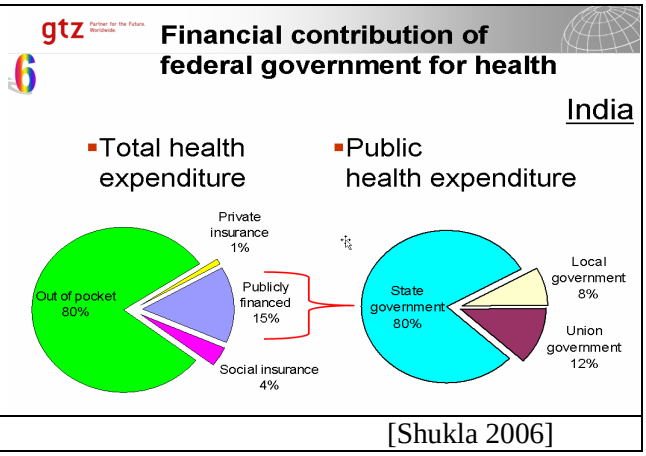
Some federal governments entrust the main health care responsibilities to lower government levels and some do have a clear division of labour between different layers of government and between government and health care provision. What matters most is that health care provision and health care financing are not mixed up and that there is no fragmentation of the health system.

## 6 Health financing in federal countries

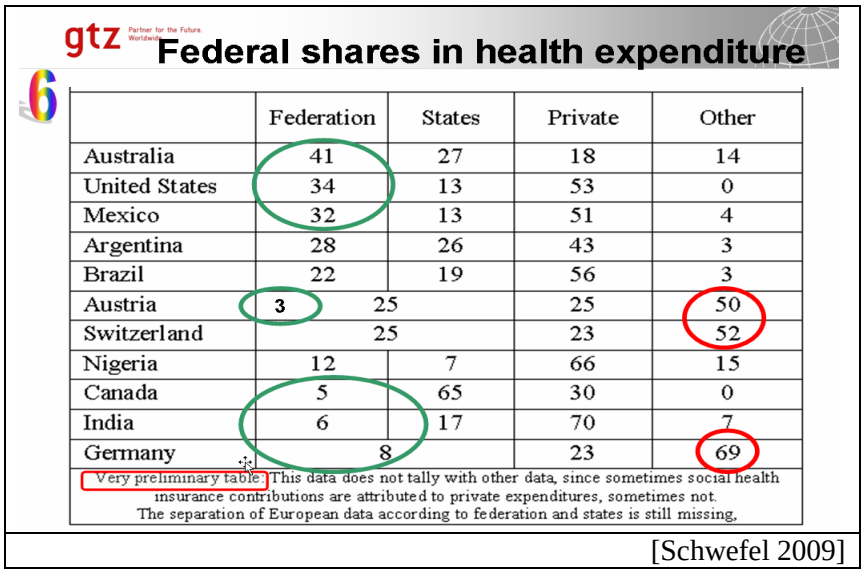
Federal countries differ considerably in health care financing. Less than 2% of the national health expenditure is given by the Union government in India whereas out-of-pocket payments of the people account for 80% of all what is spent for health and health care. A high share of private health expenditure – this is 'voluntary' spending of households, non-governmental organizations and companies – is typical for least developed countries; the share of households ranges typically between 80% and 95% in private health expenditures. A high out-of-pocket payment of the poor and medically rather uneducated can be considered to be a failure of the government – it is an irrational allocation and waste of scarce resources.



[WHO national health accounts website]



[Shukla 2006]




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

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

[Schwefel 2009]

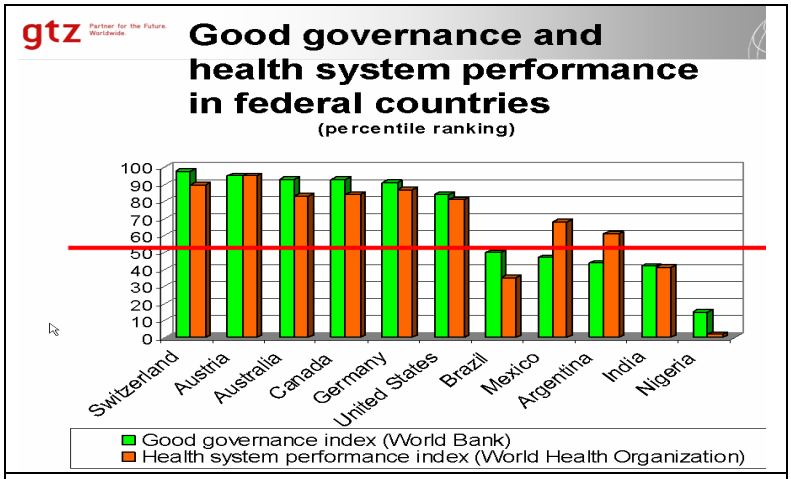
A rather high private expenditure[2] for health characterizes the national health accounts in underdeveloped countries. In most Latin American countries this share is close to 50% because of the long-rooted existence of health insurances for the formal employment sector which covers relatively small parts of the population. In the United States this share is shrinking and the share of the federal government increasing. In Australia and Europe it is essentially the existence of mandatory health insurances for the majority of the population which keeps the private shares in health expenditure quite low.

The allocative power of spending for healthcare is quite different between the federal and the state levels in the eleven countries under study. The federal shares are high in Australia, United States and Mexico, whereas the federal states of Canada are much more empowered to allocate resources. In Central European countries with high developed social health insurance systems the share of central and local governments for health care financing is much lower.

Developed federal countries keep out-of-pocket payments (at the point of delivery) for health quite low and mobilize other sources of health care financing, especially through pre-payments for health insurance. Health financing is a key issue of health systems' management and good governance.

## 7 Stewardship and governance

This assumption is based on the very principle of 'subsidiarity'. It means that higher levels of government should be active only if lower levels can not do. It refers not only to two levels of government but to all instances between people and government, i.e. families, communities, and any kind of institutions. Federalism is trying to be closely linked up with or even subordinated to lower level governance.




Data taken from [World Health Organization 2000] and [Kaufmann 2008]

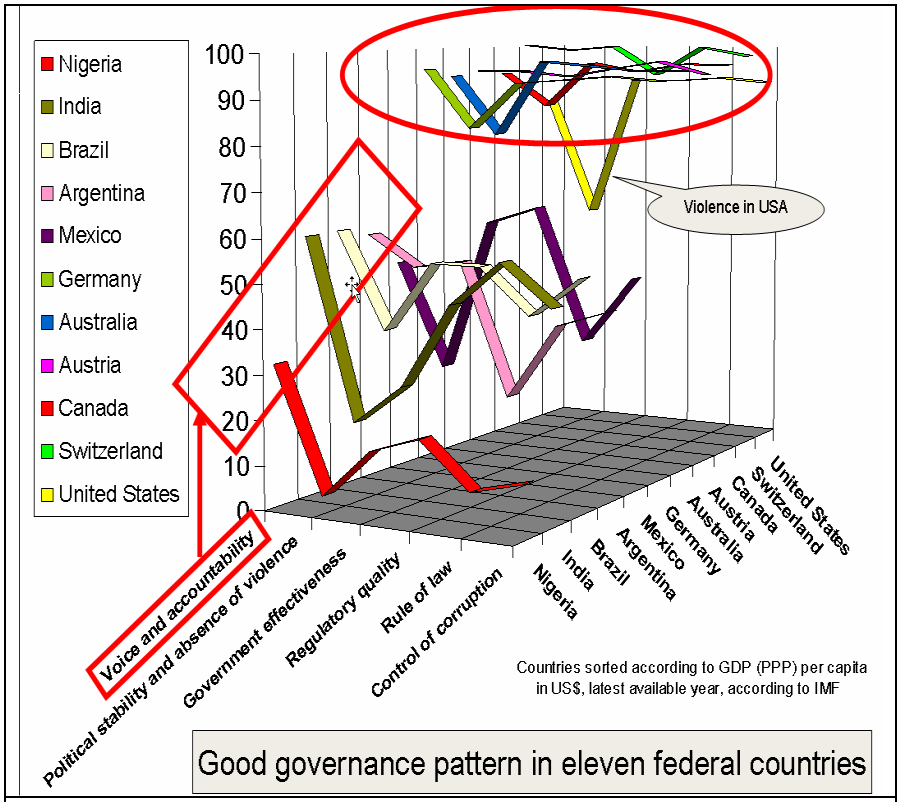
The World Bank developed and

[2] To avoid misunderstandings: nearly all health expenditure originates in private households which pay taxes to the local and national governments and contributions to insurances. Here we speak about the allocative powers and capabilities. Mandated contributions to health insurances are not private health expenditure.

uses a general index of good governance. The World Health Organization compared all its member countries according to goodness and fairness of their health systems. Except for Nigeria all highly developed federal countries under observation rank high in general good governance and the Latin American transition countries are close to the average of the world. In terms of health system performance two Latin American countries – Mexico and Argentina – are considered quite okay. Countries with very large populations – Brazil and India – did not perform that well. Good governance and health system performance in Nigeria are a disaster.

The World Bank index on good governance is composed of six components:

1. Voice and Accountability – measuring political, civil and human rights
2. Political Instability and Violence – measuring the likelihood of violent threats to, or changes in, government, including terrorism
3. Government Effectiveness – measuring the competence of the bureaucracy and the quality of public service delivery
4. Regulatory Burden – measuring the incidence of market-unfriendly policies
5. Rule of Law – measuring the quality of contract enforcement, the police, and the courts, as well as the likelihood of crime and violence
6. Control of Corruption – measuring the exercise of public power for private gain, including both petty and grand corruption and state capture

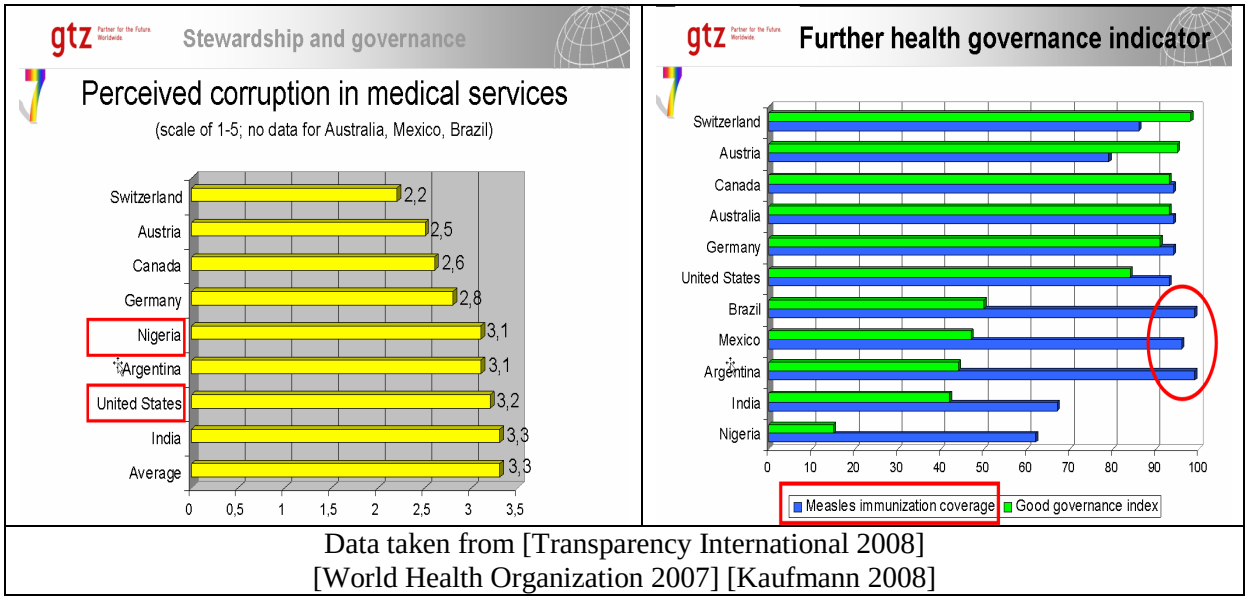



Data taken from [Kaufmann 2008] and [Wikipedia 2009]

The following graph compares eleven federal countries according to these six criteria.[3] The countries are sorted according to economic development. High developed countries are scoring high with regard of most of the good governance indicators, except absence of violence in the United States. All underdeveloped and transitional federal countries rank relatively high in 'voice and accountability', i.e. in political, civil and human rights.

Status of corruption and control of corruption are other indicators of governance or stewardship. In terms of corruption in the medical services there are no extreme differences perceived to exist. The graph demonstrates that federal countries do not automatically have very high scores – Nigeria and the United States are not that far apart. When a specific indicator of good governance in public health is used – the measles immunization coverage – than Latin American federal countries are doing better than the countries in old Europe.

[3] It would be revealing to compare all federal countries with all other countries regarding stewardship performance and all the other indicators. This is a task for the future.




Data taken from [Transparency International 2008]
[World Health Organization 2007] [Kaufmann 2008]

Good health system performance is an asset of many federal countries, except India and Nigeria but even developed countries still have to work hard, especially USA. Voice and accountability are relatively high in federal countries. Good governance drives socioeconomic development and good health is the best driver of development. High development is concurrent to good governance. Good governance reduces private and especially out-of-pocket payment for health and converts it into regular rather small prepayments for health insurance for (nearly) all citizens. Good governance and social health insurance are partners.

## One tentative result

### Relation between

- Good governance
- Health financing

| | Federation | States | Private | Other |
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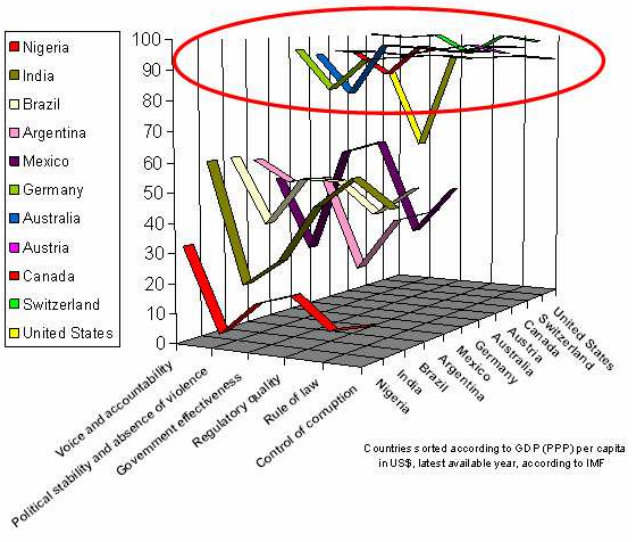


**First hypothesis: Development ⇔ good governance**
**= low private payments for health = good social health protection**

[Schwefel 2009]

## 8 Federalism and welfare

Theoretically there is a dilemma in the relationship between federalism and welfare. Multiple veto powers of the federal states can easily block reforms and the competition of jurisdictions tends to prefer cheap solutions. Both problems lead to reduced welfare[4]. In this context it seems important to distinguish between a cooperative versus a competitive federalism. A competitive federalism can be overcome by superimposing nationwide tax and transfer systems and equalisation mechanisms as they exist in Old Europe but not in Anglo-Saxon federations. Social insurance schemes for pensions, work injuries, health, unemployment and long-term care contribute to a certain sustainability of the welfare state. Such social insurance schemes are overwhelmingly national schemes. Often they are organized at territorial levels that do not correspond to federal delineations. They are less influenced by 'vested interests' of municipalities, states and the federal level. Another important smoothening factor would be if the Constitution assigns the main responsibility to the national federal government in regard to the harmonization or equalization of living conditions. Besides defining individual human rights the constitution would have to guarantee a certain uniformity of living conditions and a non-discrimination of social groups, communities and territories. Welfare and redistribution should not be handed over to competitive battles between territories and battles. Welfare needs and deserves sustainability.

## 9 Conclusion

There are many forms of federalism. What matters are the basic and universally shared values of people and politics being shaped by the history, the democratic traditions, and the political culture. Popular participation contributes a lot. Voice and accountability are symptoms and drivers of good governance. Good governance shapes good health systems, which drive – through an evolving social health protection system – towards a sustainable fair and good health care for all, opposing discriminatory practices against the poor and the vulnerable. The basic principles and values behind are: subsidiarity and solidarity.

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[4] "Conventional wisdom strongly suggests that federalism is inimical to high levels of social spending. Two arguments are prominent in this context: a veto-point thesis and a 'competition of jurisdictions' thesis. The veto-point thesis is quite straightforward: federal systems have more veto points than unitary systems ceteris paribus. This increases the probability that groups opposed to welfare state expansion can exert some influence in the legislative process. Veto points would then give these groups the opportunity to block or substantially water down redistributive legislation. 'Competition of jurisdiction' arguments hold that welfare redistribution is limited in federal systems because those who would pay more than they would gain in a given jurisdiction (high income earners, 'capital') can credibly threat to exit highly redistributive and join less égaliste jurisdictions. At the same time, those who gain more than they would pay (e.g. low income earners) are attracted to regions with higher level of redistribution and these would therefore develop into 'welfare magnets'. Thus, a re-distributional policy stance is self-defeating in a federal context." [Manow 2005]

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