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A Principal-agent approach to locating the politically decisive coalitions on health in countries worldwide, pre-COVID 19 Pandemic: Who is primarily accountable for the financing and delivery of health care, and who do they answer to?

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Citizenship, Rights, and Cultural Belonging

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A PRINCIPAL-AGENT APPROACH TO LOCATING THE POLITICALLY DECISIVE COALITIONS ON HEALTH IN COUNTRIES WORLDWIDE, PRE-COVID 19 PANDEMIC: WHO IS PRIMARILY ACCOUNTABLE FOR THE FINANCING AND DELIVERY OF HEALTH CARE, AND WHO DO THEY ANSWER TO?

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Abstract:

We examined decision making in health using the Decision Space approach, which is rooted in the principal-agent theory. Countries analyzed were Algeria, Argentina, Australia, Austria, Bangladesh, Belgium, Finland, Guatemala, Hungary, Israel, Nigeria, Spain, Thailand, and Turkey. Researchers sought to analyze who was the de facto decision maker of health related decisions in each state. We have accomplished this through looking at government structures and the financing of health, which gave significant insight into who the primary authority on health is. Furthermore, we examined who holds this de facto decision maker accountable. In some cases it was the executive that did so, while in others it was a political coalition. We find that poorer countries tend to have increased expenditure by NGOs, and have a high presence of private health providers, driving up out of pocket spending and making those countries more accountable to private or external interests than to any domestic political coalitions.

Keywords: Decision Space, Pandemic, COVID-19, Public Health, Healthcare, Finance, Principal-Agent, Accountability, Electoral Support, Political Coalitions, Decentralization, Health expenditure, Health Policy, Political Parties, Algeria, Argentina, Australia, Austria, Bangladesh, Belgium, Finland, Guatemala, Hungary, Israel, Nigeria, Spain, Thailand, and Turkey.

A Principal-agent approach to locating the politically decisive coalitions on health in countries worldwide, pre-COVID 19 Pandemic: Who is primarily accountable for the financing and delivery of health care, and who do they answer to?

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1 - Introduction

Decision space methodology seeks to identify the authority in charge of decision making in health. It is the de facto, as opposed to de jure approach of assessing institutions. In this context, decision space is about finding the agent that is most responsible for the health system, and who that agent is accountable to. This conceptual framework was introduced by Peter Bossert in 1998, and is based on principal agent theory.[1] Principal-Agent theory posits that principals delegate authority to agents to make decisions on their behalf.[1] An agent in this case is someone who directs the bulk of resources in health, enacting health specific policies, as well as running, organizing, and regulating health provision.[1] Agents can be accountable to constituents, politicians, political parties, coalitions, private actors, or a blend of these together. A process called agency loss occurs when the agent's preferences differ from the principal's, and they begin to carry out their duties in a way that does not reflect the principal's original intentions for the agent. A general example of agency loss in this sphere would be a health department either at the federal, state, or local level enacting policies that differ greatly from the preferences of the head of the executive who appointed the department.

We have applied Bossert's principal-agent approach to multiple different healthcare systems around the world, creating a comprehensive analysis of the decision space environment

in a variety of states. We have analyzed Algeria, Argentina, Australia, Austria, Bangladesh, Belgium, Finland, Guatemala, Hungary, Israel, Nigeria, Spain, Thailand, and Turkey. In each we identified the main agent or agents in charge of health decision making, and the main principal they are accountable to. Additionally, we examined the finance of health in each country, as that is another key indicator for accountability, as following the money is often telling for who wields decision making authority. We also briefly discussed the nationalization and integration of the political parties in each country, as it further gives insight into how the decision making in health in each country is either separated from or linked with principals at multiple levels. Lastly, we hope that our research advances the existing literature on the topic of decision space in health policy, and that the conclusions we draw from our research can be applied to other areas of health policy research.

References

1 Bossert, Thomas J., and Joel C. Beauvais. "Decentralization of health systems in Ghana, Zambia, Uganda and the Philippines: a comparative analysis of decision space." *Health policy and planning* 17.1 (2002): 14-31.

2 - Methodology

In general, most recent pre COVID-19 pandemic information was collected from the accessible sources available online to the general public. Pandemic era information and sources were excluded, as the decision space environment that unfolded during the pandemic was not a regular slice of history. Many times individuals making the decisions during this period differed from the usual authorities, due to the extreme risk that COVID posed to the welfare of states, and to the new political and financial pressures that emerged. Aside from the information collected being recent, we also took great care to ensure the highest quality sources were used. Each

researcher will delve into how they selected their sources, and where they gathered their information.

Country-level decision space information is summarized in the tables at the end of this article, and forms the basis of our analysis and conclusions. More specifically, we gathered information about the involvement of all forms & levels of government in health decision making, the role of national & sub-national executives, and the role of national and subnational legislatures. We codified these on a scale of Low (L), Medium (M), and High (H), based on how much the actor was involved in *government's* health decision-making. Low meant that an actor essentially had no say, to marginal say in making decisions over health policy, whereas Medium generally meant that the actor had decision making authority over some select aspects of health decision making, but other actors carried decision making authority over the vast majority of health responsibilities. A codification of High indicated that the actor had dominant decision making authority and was considered responsible for essentially all areas of health decision making.

In terms of financing health, we examined the share of financing of health across 3 areas: government funded, private funded, and non-government public funded (NGOs). These three areas each were measured on a percentage scale, and when summed add up to 100%. We also made note of how much government funding came from the federal government, as opposed to state/provincial governments. Finally, we reported if the country's federal and or state constitutions took responsibility for health, as well as if political parties in the state were integrated, and nationalized. These metrics were codified along a simple yes or no scale, as these tend to be more black and white, and are found in countries' constitutions. We also assessed the

condition of party systems, in particular, the nature of the linkages among state and local parties in government.

Research for each country followed a similar pattern. County's constitutions, and government websites were consulted to gain a general overview of the political system, and party landscape. Knowing how each country's government worked was crucial to giving further insight into their health decision making. National, regional, state, and local health ministry websites were critical sources, as comparing and contrasting between each level gave clear sight into what health responsibilities were assigned to each. This allowed us to discern which level of government had authority over what, and which level of government was more dominant. Additionally, government or NGO studies into country health systems proved useful if ministry of health sources were not available or unclear. The WHO was a key source, as they have an extremely detailed and reliable database of health finance for each country by year. Country budget reports were also referenced often, and gave excellent breakdowns of health finance. In the absence of official government or WHO reports, peer reviewed articles, NGO reports, and other reliable web sources filled in any gaps.

3 - Algeria

Key Points

- Despite facing continuous economic hardships, Algeria still provides its citizens with free healthcare.
- Though Algeria guarantees free healthcare, the standards of their healthcare remain poor.
- Many citizens have been opting to private healthcare sectors of higher standards.
- Both the federal and state governments share responsibility for health, with the states taking on a larger role.

Accountability

Algeria, the largest nation in Africa, continues to face economic hardships. Despite its fiscal challenges, Algeria still emphasizes health for all of its citizens. Algeria provides free public healthcare, and article 65 of the Algerian constitution guarantees healthcare as a fundamental right.[1] The Algerian Ministry of Health, Population and Hospital Reform is granted the fourth largest portion of the country's national budget and this public healthcare system is financed by the government of Algeria.[2] Therefore, in regards to the principal-agent theory, the principals are the citizens of Algeria and the agent is The Algerian Ministry of Health.

Though Algeria guarantees free healthcare, the standards of its healthcare remain poor.[3] This is largely due to budgeting and bureaucratic issues.[3] The healthcare sector relies heavily on imported goods, and there is a considerable demand for quality medical equipment and disposables.[2] In analyst's opinion, "Algeria's ineffective licensing of generic pharmaceuticals and lack of clear coordination between the Ministry of Health and the Algerian patent office creates an uncertain environment regarding the registration and sale of brand-name health products."[2] Though no private health insurance scheme currently exists in Algeria, many citizens have been opting for private healthcare, which generally hold themselves to a higher standard than the flawed public healthcare.[3]

Financing

As of 2018, the total share of the national budget allocated to health reached 7.3%. The government holds a high share of the financing of health with the dominant level being the subnational level. The total health expenditure in Algeria is around 10.8 million which is 6.2% of the GDP. The government's share of health funding is around 3.7 million (65%), with the remaining 7.1 million (35%) coming from the contributions of private healthcare funding.[4]

References

1 *Algeria's Constitution of 2020 - Constituteproject.org*. https://www.constituteproject.org/constitution/Algeria_2020.pdf?lang=en.
2 "Algeria - Healthcarealgeria - Healthcare." *Algeria - Healthcare | Privacy Shield*, https://www.privacyshield.gov/article?id=Algeria-healthcare.
3 "Healthcare in Algeria." *Healthcare and Health Insurance for Expats in Algeria | Expat Arrivals*, https://www.expatarrivals.com/africa/algeria/healthcare-algeria.
4 "Algeria Real Expenditure on Health, 2000-2021." *Knoema*, https://knoema.com/atlas/Algeria/topics/Health/Health-Expenditure/Real-expenditure-on-health.

4 - Argentina

Key Points

- Argentina is a federation, where health is handled at the subnational and municipal level.
- Sub-national executives known as Ministers of Health take primary responsibility for health.
- Argentina hosts three different health sectors. These are the public sector, the social security sector, and the private sector.
- Overall, Argentina hosts one of the best healthcare systems in South America.

Accountability

Argentina has adopted a federal form of government in which sovereignty is passed to lower provincial and municipal governments. "Each Province shall adopt for itself a constitution under the republican, representative system, in accordance with the principles, declarations, and guarantees of the National Constitution, ensuring its administration of justice, municipal government, and elementary education. Under these conditions, the Federal Government guarantees to each Province the enjoyment and exercise of its institutions".[1] The Argentine constitution makes clear that provinces are guaranteed the freedom of exercising their own institutions as long as they are operating in accordance with the principles and declarations of the national constitution.

Due to Argentina being a federation, health care institutions are decentralized, run by provinces, and managed at the municipal level. “The health system is decentralized, meaning public health is administered at a municipal level. Primary health care is often independently managed by each city”.[2] The decentralization of Argentina’s health system leaves accountability in the hands of sub-national provincial governments. It is here that decisions regarding health are made. “The provinces and municipalities are responsible for financing and delivering healthcare. Each province has its own Ministry of Health managing healthcare delivery”.[2] Sub-national executive positions are primarily accountable for their province’s healthcare. The decision space of political accountability for health outcomes in Argentina is most significantly found in sub-national executives in the form of Ministries of Health. These ministries hold far more responsibility for health outcomes than the national government. Legislative branch in Argentina’s national and sub-national governments are not given the authority to make substantial health-related decisions and for this reason, are less responsible than the executive branch, the Ministries of Health. In regards to Principal-Agent Theory, Argentinian citizens are the principal, and the agents are the Ministries of Health found at the provincial level. Ministries of Health are held accountable by Argentinian citizens through provincial elections.[3] Currently, Argentina’s government is dominated by two major parties that are nationalized and integrated. These two parties are found at the national and provincial levels of government. However, there are some small local parties that are influential in their regions.[4]

Financing

Argentina’s three different health sectors are separately financed. The first is the public sector which services around half of Argentina’s population. This sector is entirely free, funded by the government, with the exception of small payments for prescription drugs. However, the

downside of the public sector is that although treatment quality is high, wait times can be extremely long. This is why the other half of Argentina's population opts for the other two sectors. The social security sector consists of around 300 union-run health insurance schemes that are financed by fees paid by employers. This scheme's quality of treatment varies from one to the next. However, minimum coverages must be met. Finally, the private sector provides traditional private health insurance coverages that must offer at least the minimum level of coverage required of the social security sector.[5] All three sectors are monitored and regulated by the Ministries of Health in each province.

Currently, Argentina spends 9.51%[6] of its gross domestic product on health. As of 2019, Argentina spends $945.99 USD per capita[7]. This has decreased by nearly $600 USD per capita since 2017. However, in comparison to other South American countries, this is quite high.[5] Argentina hosts one of the best healthcare systems in its region.

References

1. *Argentina's Constitution of 1853, Reinstated in ... - Constituteproject.org*. Translated by Johnathan Miller and Fang-Lian Liao, Oxford University, https://www.constituteproject.org/constitution/Argentina_1994.pdf?lang=en&lang=en.
2. "Healthcare and Expat Health Insurance in Argentina." *Expat Assure*, 26 June 2020, https://www.expatassure.com/argentina/.
3. "Argentina." *Argentina* -, AceProject, https://aceproject.org/main/english/es/esy_ar.htm.
4. Leandro, Av. "ELECCIONES 2021 - ACTAS DE ESCRUTINIO DEFINITIVO." *Cámara Nacional Electoral*, https://www.electoral.gob.ar/nuevo/paginas/btn/escrutinio2021.php.
5. "Health Insurance in Argentina." *International Citizens Insurance*, International Citizens Insurance, 14 Oct. 2020, https://www.internationalinsurance.com/health/south-america/argentina.php.
6. "Current Health Expenditure (% of GDP) - Argentina." *Data*, The World Bank, https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=AR.
7. "Current Health Expenditure per Capita (Current US$) - Argentina." *Data*, The World Bank, https://data.worldbank.org/indicator/SH.XPD.CHEX.PC.CD?locations=AR.

5 - Australia

Key Points

- Federal government plays a large role in funding healthcare, namely through the national insurance plan, pharmaceutical schemes, and research
- State governments preside over the management and organization of health services, such as primary care centers or hospitals, which they generally fund with their own revenues.
- State ministers of health have immense influence over the health policy formation process.
- Despite heavy federal and state involvement, private expenditures still add up to make up 31% of total health expenditure, mainly coming from OOP costs.

Accountability

In Australia, The federal government plays a large role in anything related to funding (national insurance, benefits programs, grants for research etc.), whereas the state and local governments have discretion over the formation of health policy, and the actual deployment of more direct health initiatives (management and administration of public health infrastructure, delivery of preventative health programs, immunization programs, and regulatory standards).[1] Due to these differing responsibilities between the federal and state government, Australia's federal government has a very low level of accountability when it comes to health outcomes.

Australia is divided into six separate states, each governed by bicameral parliament with the exception of Queensland, which has a unicameral parliament.[2] Each territory's governor (appointed by the monarch), selects the formateur of the cabinet, the individual to be the premier after parliamentary elections happen.[3] The premier is the prime minister figure in each state, and comes from the winning party, or coalition of parties in the legislature.[4] They are responsible for selecting the ministers who will make up the executive council to the governor– which is the supreme executive authority of the states, and serves as key advisors to the governor.[5] The role of these ministers become very important during the policy making process, making them the main agents in Australian healthcare.

If the parliament decides that there is a need for policy, then the minister whose area the issue falls under is responsible for drawing up the legislative proposal for the new policy.[6] This

gives the minister a great deal of power, as they determine what the new policy will look like. The policy is drafted up by a parliamentary counsel or legislative counsel, taking instruction on the details and specificities that the policy should entail from the minister, and members of the minister's department.[6] This again shows the high degree of power that the executive branches of Australian states have in policy making, as the ministers and their departments have the most direct role in shaping the policies that affect health outcomes in the states. After it is drawn up, the policy goes to the parliament floor for readings and potential revisions, then to the second chamber of parliament for the same process.[7]

In theory, when the ministers writing the bills are from the same party or coalition that holds the majority in the legislature, there are not too many obstacles left for the minister's policy to be shot down. The policy at its core is likely to remain largely unchanged, and specificities might be tampered with in some way or another in order to satisfy coalition squabbles, but for the most part holding a majority in parliament makes it much more convenient to pass legislation that the minister sees fit. The legislature, premier, and ministers all come from the same party or coalition of parties, as a rule, in Australian states. Whichever party is at the helm, their ministers have immense power to shape policy, and the legislature makes it easier for them to pass policies given the party ties.

In terms of political parties, the parties that participate in state politics are largely the same as in national politics, with the main three being the Liberals, The Nationals, and Labor.[8] Therefore , the voters who voted for the winning party or coalition are the principal, and they are in practice the ones to whom the regional ministers of health have to answer, as they owe their positions and future reelection to the voters who put them and their party in office. Due to the same political parties being important at the federal and state level, there is an intertwining

accountability of parties at different government levels, as federal politicians can leverage party ties with local politicians to affect electoral outcomes, and vice versa.

Financing

Australia's federal government does not take responsibility for health, yet it plays the largest role in funding healthcare in the country. Before the pandemic, in the 2018-2019 fiscal year, total health spending on health goods and services totaled $195.7 billion, which averaged to be around $7,772 per person, and made up 10% of overall economic activity in the country during this period.[9] Of the total spending, 41.2% came from the federal government (80.6 Billion/ 195.7 Billion), with most of this going towards the Medicare Benefits Scheme, the Pharmaceutical Benefits Scheme, and general health research.[9] State governments spent $53 billion on health, with most of that spending going towards hospitals, and primary health care services.[9] As is shown in Table 2, between these two, health spending in the country was 68.3% funded by state or federal governments.[9]

Table 2 also highlights non-government spending, the remaining 31.7% ($62.1 billion) in the equation, this is mostly private non-government spending. Individuals spent $31.8 billion on things such as non-subsidised medications, dental services, and other medical services.[9] Spending on private insurance was $17.2 billion, and other non-government private sources such as private funding, private hospitals, private research, and workers compensation insurers made up $13 billion.[9] There was very little public non-government spending; NGOs only spent about 1.6 billion, giving them less than 1% of spending in the overall pie.[10] This share is small, because it seems that things that NGOs usually cover, such as research, or distributive services are already covered by the government, as the welfare/social provision in Australia is very good.

References

1 "Health in Australia: A Quick Guide – Parliament of Australia." Aph.gov.au, 2013, www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp1314/QG/HealthAust. Accessed 23 Feb. 2022.

2 "Three Levels of Government: Governing Australia - Parliamentary Education Office." Peo.gov.au, 2022, peo.gov.au/understand-our-parliament/how-parliament-works/three-levels-of-government/three-levels-of-government-governing-australia/. Accessed 23 Feb. 2022.

3 Wikipedia Contributors. "Governor of New South Wales." Wikipedia, Wikimedia Foundation, 5 Feb. 2022, en.wikipedia.org/wiki/Governor_of_New_South_Wales. Accessed 23 Feb. 2022.

4 Wikipedia Contributors. "Premiers and Chief Ministers of the Australian States and Territories." Wikipedia, Wikimedia Foundation, 14 Dec. 2021, en.wikipedia.org/wiki/Premiers_and_chief_ministers_of_the_Australian_states_and_territories#:~:text=Following%20a%20general%20election%2C%20the,head%20of%20government%20%2D%20the%20premier.. Accessed 23 Feb. 2022.

5 "The Governor of NSW." Nsw.gov.au, 2019, www.parliament.nsw.gov.au/about/Pages/The-Governor-of-NSW.aspx. Accessed 23 Feb. 2022.

6 "Legislative Process Explained." Nsw.gov.au, 2019, www.parliament.nsw.gov.au/bills/Pages/Legislative-process-explained.aspx. Accessed 23 Feb.

7 "Factsheet No. 6 - Making Laws." Nsw.gov.au, 2019, www.parliament.nsw.gov.au/la/proceduralpublications/Pages/Factsheet-6---Making-Laws.aspx#:~:text=In%20a%20bicameral%20Parliament%2C%20such,implement%20Government%20policy%3B&text=give%20effect%20to%20inter%2Dgovernment%20agreements.. Accessed 23 Feb. 2022.

8 Wikipedia Contributors. "Premiers and Chief Ministers of the Australian States and Territories." Wikipedia, Wikimedia Foundation, 14 Dec. 2021, en.wikipedia.org/wiki/Premiers_and_chief_ministers_of_the_Australian_states_and_territories. Accessed 23 Feb. 2022.

9 Australian Institute of Health and Welfare. Health expenditure Australia 2018-19. AIHW, 2020.

10 "Global Health Expenditure Database." Who.int, 2014, apps.who.int/nha/database/ViewData/Indicators/en. Accessed 3 Mar. 2022.

6 - Austria

Key Points

- According to the Constitution of Austria, the federal government is responsible for the regulation of health care, with hospitals being an exception.
- Accountability for health in Austria is complex, divided among multiple levels of government.
- No Public Health Act exists in Austria and the term public health is only mentioned in one of Austria's legal documents.
- Experts regard legislation related to public health in Austria as "outdated or even non-existent".

Accountability

Political accountability for health in Austria is complex, divided among multiple levels of government. The federal government is responsible for the legislative frameworks regarding health, for instance the regulation of social health insurance.[1] Social health insurance is responsible for ambulatory and rehabilitative care, outpatient medicines, as well as negotiating contracts with providers. At the state level, responsibilities include regulating hospital care within the framework defined by federal legislation, and the responsibility for the organizing and financing of inpatient and outpatient care in hospitals.[1] With ample legislative oversight powers the executive branch holds the bulk of the accountability for health both nationally and sub-nationally.[1]

In 2005 the Federal Health Agency was established at the national level with the Federal Health Commision as an executive body,[2] with responsibilities, "for promoting further development by defining principles for planning, budgeting and reimbursement, and by applying steering mechanisms".[2] At the regional level, Regional Health Funds were established with the Regional Health Platforms as executive bodies.[2] In comparison to the executive, much less accountability is found with the legislature.[2] When you apply the principal-agent theory to the Austrian healthsystem, you find that the principals are the citizens that pay for healthcare, and the agent is The Federal Health Agency, which is a body that is not directly politically accountable to the citizens, as it is a permanent professional bureaucracy.

No Public Health Act exists and the term public health is only mentioned in one of Austrias legal documents.[2] "The only legal documents addressing specific public health functions are the Health Promotion Act , the draft of the new Federal Act on Health Promotion and Prevention, the Imperial Sanitary Act and the acts related to infectious diseases and epidemics"[2]. There are gaps in several areas, including organizational structures and

responsibilities, funding, education, health promotion, prevention structures, and the management of chronic diseases.[2]

Many experts regard legislation related to public health in Austria as "outdated or even non-existent".[2] Along with the executive and legislature, political parties share accountability for health as well. According to Austrian health legislation the contracting parties agree to incorporate the principles of public health when implementing any measures stipulated in the agreement[2]. "These principles include systematic health reporting, the acknowledgement of a comprehensive notion of health, the undertaking of health services research to ensure needs-oriented planning, development and evaluation, the promotion of multidisciplinary working in care or research, the development of health targets"[2]. Experts believe it is essential that a clear strategy with precise allocation of resources is agreed, across the political parties[2].

Financing

The healthcare expenditure in Austria hovers around 45 million which is 10.4% of the GDP. The health system in Austria is financed through a combination of tax revenues and compulsory SHI contributions.[1] These non-government, income-related SHI contributions account for the majority of publicly financed health expenditures at around 60%, with general taxation accounting for the remaining 40%[1]. The contributions are pooled together by the Main Association of Austrian Social Security Institutions (HVB), before being allocated to SHI funds to pay the health care providers.[1]

The federal government finances less than 2% of the health budget.[1] This puts the location of government authority in health at the provincial level The funding of healthcare is distributed across government, public non-government, and private corporations, with the most dominant level being the public non-government at about 43%.[1]

References

1. "Austria." World Health Organization, World Health Organization, https://eurohealthobservatory.who.int/countries/austria.
2. Ladurner, Joy. "Public Health in Austria." *Public Health in Austria: An Analysis of the Status of Public Health*, https://doi.org/Observatory Studies Series.

7 - Bangladesh

Key Points

- Bangladesh is a unitary state, where the government takes responsibility for health.
- Bangladesh's national health executive is the Minister of Health and Family Welfare. Although this position takes responsibility for health, they are not the de facto decision maker for health outcomes.
- Bangladesh's de facto health care decision makers can be found in four different sectors, all of which are extremely ineffective.
- In comparison to the rest of the world, Bangladesh has one of the worst healthcare systems.

Accountability

Bangladesh is an independent, sovereign, and unitary Republic known as the People's Republic of Bangladesh. Bangladesh is a parliamentary democracy where the winning party or coalition elects a President for a five-year term. The President then appoints the leader of the winning party or coalition as Prime Minister and head of government.[1] In regards to health, the PrimeMinister appoints a Minister of Health and Family Welfare who is responsible for health outcomes in Bangladesh.[2] This position is held accountable by the winning coalition as they can be removed and replaced as seen fit.

Bangladesh claims in its constitution that they are responsible for "the provision of the basic necessities of life, including food, clothing, shelter, education and medical care".[1] One would expect that Bangladesh would have a universal health care system. However, in reality, Bangladesh's de facto healthcare system is pluralistic. This system is largely unregulated and

dominated by four major actors: the government, the for-profit private sector, international development organizations, and the not-for-profit private sector.[3] This creates confusion when analyzing who is perceived as accountable for healthcare in Bangladesh. Although the constitution states the government is responsible for healthcare, they hold little influence. NGOs, for-profit private institutions, and non-profit institutions hold significant influence on health decisions in Bangladesh even with the presence of the Minister of Health and Family Welfare. In regards to Principal-Agent Theory, Bangladesh is an interesting case. The Bangladeshi citizens are the principal only for the government as an agent: the Minister of Health and Family Welfare. While the other three actors, the for-profit private sector, international development organizations, and the not-for-profit private sector are not the agents of Bangladeshi electorate. Currently, Banladesh's political parties are nationalized and intertwined: the same parties are found both at the federal and local levels.[4]

Financing

Health in Bangladesh is extremely underfunded as 2.64% of the gross domestic product is spent on health.[5] This lack of funding is most notably seen in Bangladesh's leading causes of death; cardiovascular diseases, cancers, diabetes, chronic respiratory diseases, and malnutrition.[6] This is because citizens more often than not have to either forego medical care or go into serious debt. This is primarily because of the out-of-pocket payments that are required to receive treatment in Bangladesh. Even in the public sector, Bangladeshi citizens must pay 63.3% of their treatment cost leaving the rest of the cost to the government. Wait times and the quality of treatment in the public sector is so abysmal many citizens are forced to find medical treatment in the private sector where 93% of their treatment cost must be out of pocket.[3] Financially, this is

unsustainable for many citizens causing them to either forego treatment altogether or enter into debt.

This situation has led to “nine percent of households face catastrophic health payment, 5.6 percent face impoverishment, and seven percent face distress financing (borrowing or selling household assets to finance healthcare costs)”.[3] Further, health insurance is non-existent in both the public and private sectors making healthcare expenses even more detrimental. Bangladesh only spends 1.4 billion dollars on health.[7] This lack of funding also leads to the understaffing of its medical facilities. Currently, “only 35% of health and clinical facilities in the country have more than 75% of sanctioned staff working and there is a 36% vacancy in sanctioned healthcare workers. There is also a 50% vacancy in alternative medicine providers”.[3] This lack of staffing contributes to the failures of Bangladesh's public health sector and raises the costs of medical treatment. In comparison to other countries, Bangladesh’s out-of-pocket payments are some of the highest in the world, and the percentage of GDP spent on healthcare is ranked the lowest in Southern Asia.[3]

References

1. “The Constitution of the People’s Republic of Bangladesh.” *Bdlaws.minlaw.gov.bd*, People’s Republic of Bangladesh, http://bdlaws.minlaw.gov.bd/act-367.html.
2. “Transmenu Powered by Joomlart.com - Mambo Joomla Professional Templates Club.” *Welcome to Ministry of Health and Family Welfare*, People’s Republic of Bangladesh, http://www.mohfw.gov.bd/.
3. Joarder, Taufique, et al. “Universal Health Coverage in Bangladesh: Activities, Challenges, and Suggestions.” *Advances in Public Health*, Hindawi, 3 Mar. 2019, https://www.hindawi.com/journals/aph/2019/4954095/.
4. “2018 Bangladeshi General Election.” *Wikipedia*, Wikimedia Foundation, 10 May 2022, https://en.wikipedia.org/wiki/2018_Bangladeshi_general_election.
5. “Current Health Expenditure (% of GDP) - Bangladesh.” *Data*, The World Bank, https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=BD.
6. Thelwell, Kim. “7 Facts about Healthcare in Bangladesh.” *The Borgen Project*, Kim Thelwell Https://Borgenproject.org/Wp-Content/Uploads/The_Borgen_Project_Logo_small.Jpg, 3 Nov. 2020, https://borgenproject.org/healthcare-in-bangladesh/.

7. Huq, Nazmul M, et al. "Paying out of Pocket for Healthcare in Bangladesh - a Burden on Poor?" *Iranian Journal of Public Health*, Tehran University of Medical Sciences, July 2015, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4645756/.

8 - Belgium

Key Points

- The Government has been becoming more decentralized
- Different languages across the country give much more power to local governments
- Social Security funds over half of the costs

Accountability

Accountability for healthcare policy is divided between the federal state and the 9 federal entities across the country. Each federal entity has their own legislative process, government, and budget. Each entity also has an executive in charge of healthcare policy. This resulted in nine ministers of health being responsible for healthcare in 2020[1]. These nine are: The Flemish Community which is overseen by the Flemish ministry of Public Health. The French Speaking Community is governed in the Walloon region and overseen by their minister of health while the French community has a minister that oversees the child, from birth and babies to medical prevention for children all the way up to students. Brussels has its own regional government and it has three ministers that oversee health in some way. Two of them are responsible for people with a disability, hospital care policy and the eldery care[2]. As does the German speaking part of the country. There are two types of federal entities in Belgium: Regions and Communities. Communities were formed when Dutch speakers in the country wanted their own cultural autonomy. They formed the Fleming community, the French speaking community, and the German speaking community. Regions are responsible for more economic decisions while communities are responsible for cultural policies linked to a person's language. Although in the

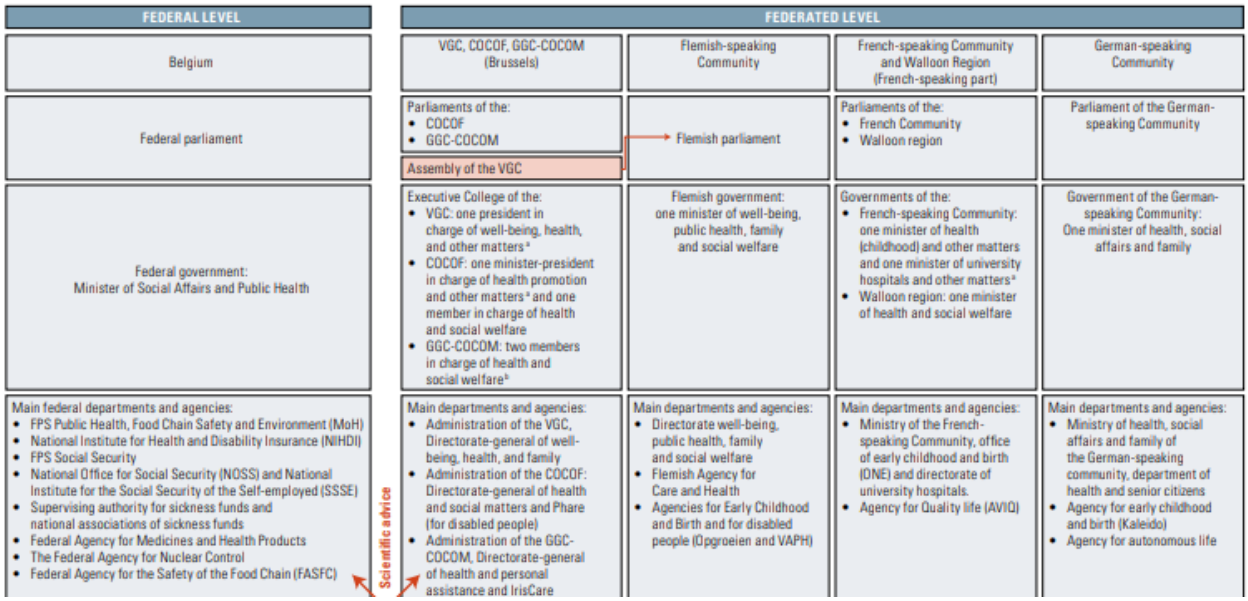
northern Fleming region both the region and the community overlap into one parliament that makes all decisions. The Federal parliament is the legislative body. The Federal government is the executive body and it includes the post of the Minister of Social Affairs and Public Health[1]. This minister is appointed by the prime minister after a coalition government has been settled upon. The previous minister of health, Maggie De Block, described the position as more of a bridge connector for all of the regions and communities in Belgium; rather than a political decision-making figure, Deblco described herself as a crisis manager.[3]

The communities and regions have decision-making autonomy although they work with the federal government on reimbursement of costs. Health care responsibilities of the provinces and municipalities are limited to matters of local interests and they act under the supervision of the regions[8]. Municipalities are mainly responsible for organizing social support for low-income groups and if applicable manage public hospitals or health care settings they have created[1]. Provinces exercise certain powers that go beyond municipal boundaries and interests, such as health screening and coordination of mental health programs. Ever since the 2011 sixth major reform even more power has been delegated to the regions and communities. This has led Fleming to implement a more patient based approach to healthcare as opposed to other regions.

Finance

The Belgium constitution takes responsibility for healthcare and a healthy environment[4]. It also takes responsibility for medical and social assistance . Public healthcare is funded through social security and health care payments from the government. These payments are proportional to income. Residents have to pay for the remainder of unsubsidized care. Health insurance funds will cover: around 50-75% of the costs for doctors, hospitals, and clinics; around 20% of prescription costs;basic dental costs; maternity costs[5]. Those who do not have public healthcare must take out private insurance for any costs they may have but this is a rare occurrence.

Unemployed people, pensioners, students, and those with disabilities are given the same subsidies as the working population. Health insurance contributions are 7.35% of gross salary (3.55% as payroll deduction and 3.8% paid by employer). Self-employed workers pay the full 7.35% themselves[5].



Source: Belgium+ health system review 2020
https://eurohealthobservatory.who.int/publications/i/belgium-health-system-review-2020

Sickness funds are non-profit, private players that operate the reimbursement system of health care services covered by the compulsory health insurance for their members and the payment of a replacement income in case of long-term illness. All Belgian residents must be affiliated to a sickness fund of their choice or to the public auxiliary fund. In 1995, a procedure was introduced to make sickness funds more accountable for the health expenditure of their members. At the end of the year, the National Health for Disability Insurance (NIDHI) calculates the difference between the actual health expenditure of their members and their so-called normative (risk-adjusted) expenditures, and sickness funds are held financially responsible for a proportion of this difference. More than three quarters of current health expenditure is financed

by the public sector (77.25% in 2017). Voluntary health insurance represents a small share (5.12% in 2017) of healthcare costs. Patients' out-of-pocket payments was 17.63% in 2017[5].

Social security is the main contribution of funding for public healthcare providing 52% of the funds. For most health services Belgium has the federal government finance and reimburse the local governments for costs and let them organize how they want their system to work[5].

	2000*	2005	2010	2015	2016	2017
Current health expenditure per capita in international US$ (purchasing power parity)	2 225.5	3 011.7	4 015.6	4 702.4	4 873.9	5 119.1
Current health expenditure as a % of GDP	7.9	9.0	10.0	10.3	10.3	10.3
Public expenditure on health as % of current expenditure on health	74.6	76.8	77.8	77.6	77.1	77.2
Public expenditure on health per capita in purchasing power parity	1 660.3	2 313.8	3 122.7	3 649.1	3 758.8	3 954.2
Private expenditure on health as % of current expenditure on health	25.4	23.2	22.2	22.4	22.9	22.8
Public expenditure on health as % of general government expenditure	12.1	13.4	14.5	14.8	15.0	15.3
Government health spending as % of GDP	5.9	6.9	7.8	8.0	7.9	8.0
OOP payments as % of current expenditure on health	20.2	17.9	18.2	17.5	17.9	17.6
OOP payments as % of private expenditure on health	79.6	77.4	81.7	78.3	78.1	77.5
Private insurance as % of private expenditure on health	20.4	22.6	18.3	21.7	21.9	22.5

Source: Belgium+ health system review 2020
https://eurohealthobservatory.who.int/publications/i/belgium-health-system-review-2020

	LEGISLATION	PLANNING	LICENSING	PRICING/ TARIFF SETTING	QUALITY/ ASSURANCE	PURCHASING/ FINANCING
Dental care	• Mainly Federal authorities	• Federal authorities (quota)	• Federal authorities (visa) • Federated entities (recognition)	• Federal authorities (national fee schedule) • Providers for extra-billings and non-reimbursed care (see Section 3.4.1)	• Mainly Federal authorities (quality law)	• Sickness funds (Compulsory health insurance) • Households OOP payments • Voluntary health insurance
Pharmaceuticals (ambulatory)	• Federal authorities	• Federal authorities (e.g. planning of community pharmacies)	• Federal authorities (e.g. licensing of community pharmacies)	• Federal authorities (for both reimbursed and non-reimbursed pharmaceuticals)	• Federal authorities (feedback, monitoring)	• Sickness funds (Compulsory health insurance) • Households OOP payments • Voluntary health insurance
Long-term care	• Mainly Federated entities	• Mainly Federated entities	• Federated entities	• Federal authorities (e.g. nursing care at home: national fee schedule) • Federated entities (e.g. accommodation price in residential care infrastructure and community services)	• Federated entities	• Mainly Federated entities • Federal authorities: – Sickness funds (compulsory health insurance) – Households OOP payments – Voluntary health insurance
University education of personnel	• Federated entities	• Federated entities	• Federated entities	• Federated entities	• Federated entities but Federal authorities for continuing education	• Federated entities • Households

Source: Belgium+ health system review 2020
https://eurohealthobservatory.who.int/publications/i/belgium-health-system-review-2020

References

1 Belgium+ health system review 2020 https://eurohealthobservatory.who.int/publications/i/belgium-health-system-review-2020

2 Hope, Alan. 2020. "Here's why Belgium has nine health ministers." *The Brussels Times*, 08 05, 2020. https://www.brusselstimes.com/98588/heres-why-belgium-has-nine-health-ministers-regions-communities-powers-responsibilities-coronavirus.

3Moens, Barbara. 2020. "De Block out as health minister in new Belgian government." POLITICO. https://www.politico.eu/article/maggie-de-block-out-as-health-minister-in-new-belgian-government/.

4 *The Belgian Constitution* . (n.d.). Retrieved February 28, 2022, from https://www.dekamer.be/kvvcr/pdf_sections/publications/constitution/GrondwetUK.pdf

5 "Healthcare in Belgium: a guide to Belgian healthcare." 2022. Expatica. https://www.expatica.com/be/healthcare/healthcare-basics/the-belgian-healthcare-system-100097/

6 *Creating 21st Century Care in Flanders and Beyond*. World Health Organization . (2019). Retrieved May 29, 2022, from https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/20191026-h1155-flanders-report-web.pdf

9 - Finland

Key Points

- The national government has a heavy hand in directing health policy through the Ministry of Social Affairs & Health
- This ministry has two ministers whose combined responsibilities oversee all areas of health policy within the country
- While the federal government is responsible for policy direction, the municipality councils have extreme independence in deciding how to meet these policy objectives and deliver health services in their district
- This autonomy gives municipalities the ability to fulfill their obligations in a way that best suits their population
- The government is highly involved in funding health, making up 75.2% of all health expenditure in 2019
- The national government has a smaller share in funding health than municipalities, as municipalities can raise their own taxes to cover the costs of health services.

Accountability

Finland is a state that provides a rich array of social & welfare services to its citizens, including healthcare. The Finnish constitution takes direct responsibility for health, declaring that public authorities have a duty to provide sufficient health care services to everyone, and promote the health of the population.[1] Despite the national constitution taking responsibility for health, the national government plays a very minor role when it comes to the provision of health services. Rather, the national government has a heavy hand in steering the ship when it comes to health policy direction. This national power comes in the form of the Ministry of Social Affairs and Health, which is responsible for directing health policy, proposing legislation to parliament related to health, introducing regulations & reforms to the health system, and ensuring the implementation of their decisions regarding these matters.[2]

There are two ministers at the helm of the Ministry of Social Affairs and Health. One is responsible for Social Affairs and Health, while the other is responsible for Family Affairs and Social Services.[3] Together, their respective responsibilities add up to encompass the totality of health policy affairs in Finland, covering areas such as: health insurance, pharmaceutical services, health services, prevention of disease, immunization programs, public health, and preventative health.[3] Additionally, as I mentioned before, these two ministers (and the bureaucracy below them) are responsible for forming health policy, and presenting legislation to parliament regarding health, giving them and their organization extreme decision making power & influence, making them the main agent in the Finnish health system. These ministers are selected by the new prime minister after parliamentary elections, which occur every four years, and as it happens in most parliamentary systems, the freshly selected ministers come from the same party/coalition of the prime minister.[4,5] Therefore, the principal counterparts to these influential ministers are their party or coalition in parliament, and the population of Finland who

voted said party or coalition into office. Political parties are intertwined and nationalized, as the same parties tend to predominate national and local politics, leading to interplay between the politicians at the two levels in order to influence electoral outcomes.[4,6]

While the federal executive has significant decision making power over health policy, the core health system is actually quite decentralized, giving municipalities extreme autonomy in organizing their health systems, and deciding how best to reach policy objectives that the Ministry of Social Affairs & Health has set.[2] In addition, it is these municipalities who are responsible for providing primary care centers, hospitals, and the provision of other health goods & services to their populations.[1] This decentralized system of delivery enables municipalities to tailor health service provision to the needs of their population, allowing for much more flexibility and enabling the municipality council to better serve their constituents.[2] This approach, in conjunction with the bulk of funding coming from the municipal level, also makes municipal incumbents the main authorities in health. The municipality council is elected every four years by the citizens of the municipality, and there is usually a committee within the municipality council that presides over health.[1] These committees are staffed proportionally by party, so each party generally has a guaranteed voice in their respective committee, including on health.[2] As these committees are making decisions about how best to deliver health, and have extreme autonomy in doing so, they are also key agents in Finnish health.

Financing

Shown in Table 2, the government plays a reasonable role in financing health in Finland, with total government contribution making up 75.2% of all health expenditures in 2019.[2] Compared to other European countries with similar levels of social & welfare provision, Finland's national contribution to health was on the lower side, with only 35.1% of government

health expenditure coming from the national level.[2] This comparatively lower figure can be explained by the fact that municipalities have the right to direct and raise their own taxes, allowing them to generate the funds they need to fulfill the delivery of healthcare in their municipality on their own; as a result, 50%> of government health expenditure comes from municipalities.[2] These funds go towards things such as primary care centers, hospitals, diagnostic services, student and occupational health services and mental health services within the municipality. The tax rate can vary by municipality, and the taxes they have a right to set can take many forms, however the most important one by revenue volume has proven to be the municipality income tax, which can range from 16.5%-22.5% of taxable income.[2]

The national portion of government expenditure, a figure around 35.1% in 2019, comes from an income & wealth tax, and a value added tax.[2] Revenues raised are mainly directed to subsidies for municipalities, and national contributions to NHI funding (Finland's national health insurance plan for all citizens).[2] The subsidies from the national government to municipalities are in order to correct natural socioeconomic differences that exist between municipalities, so that a great inequity in health services does not develop in the country based on the municipality you are in.[2] As for the NHI, it is mainly funded through income tax from employees and employers, giving Finns excellent coverage at a sharply reduced cost.[2] However as shown in Table 2, in recent years private health expenditures have jumped up to 25.4% of total health expenditure, with most of this (20.4%) being attributed to out of pocket spending (OOP).[2] OOP has doubled since the year 2000, as fees for municipal health services have been on the rise, largely due to a desire for more revenue in municipalities.[2] The remainder of private expenditures comes from private insurance (2.2%), employers (2%), and less than 1% coming from NGOs, as Finland's strong welfare capacity takes care of issues that NGOs typically aim to tackle.[2]

References

1 Vuorenkoski, Lauri, Mladovsky, Philipa & Mossialos, Elias. (2008). "Finland: health system review." World Health Organization. Regional Office for Europe. https://apps.who.int/iris/handle/10665/330342

2 Keskimaki, Ilmo & Tynkkynen, Liina-Kaisa & Reissell, Eeva & Koivusalo, Meri & Syrja, Vesa & Vuorenkoski, Lauri & Rechel, Bernd & Karanikolos, Marina. (2019). Finland: Health System Review. Health systems in transition. 21. 1-166.

3 "Minister of Social Affairs and Health - Minister of Family Affairs and Social Services - Ministry of Social Affairs and Health." Ministry of Social Affairs and Health, 2018, stm.fi/en/ministers. Accessed 18 Apr. 2022.

4 Wikipedia Contributors. "Parliament of Finland." Wikipedia, Wikimedia Foundation, 7 Apr. 2022, en.wikipedia.org/wiki/Parliament_of_Finland. Accessed 18 Apr. 2022.

5 Wikipedia Contributors. "Prime Minister of Finland." Wikipedia, Wikimedia Foundation, 13 Apr. 2022, en.wikipedia.org/wiki/Prime_Minister_of_Finland#:~:text=Under%20the%20provisions%20of%20the,cabinet%20and%20the%20government's%20programme.. Accessed 18 Apr. 2022.

6 Helsinki City Councillors. "Helsinki City Councillors." Helsingin Kaupunki, 2021, www.hel.fi/helsinki/en/administration/decision/council/members/. Accessed 18 Apr. 2022.

10 - Guatemala

Key Points

- Fragmented Coverage
- Public Sector underfunded
- Over 50% of Costs are out of pocket

The Constitution declares healthcare a universal right in Guatemala. The Ministry of Public Health and Welfare was created to ensure this, however with just 1% of the GDP at its disposal, it is hard to provide resources for over 80% of the country,which results in a deficient system[1].The Guatemalan health system is characterized by high levels of fragmentation among various public institutions, as well as by a private sector that, despite interacting with the public health system on many levels, operates largely independently, with minimal regulation[2]. On the public side, the main actors are the Ministry of Health and Public Welfare (MSPAS) , which is responsible for governance as well as providing services, and the Guatemalan Institute of Social

Security , a social health insurance system that covers workers. Members of the armed forces are covered through Sanidad Militar. Despite low levels of private health insurance coverage (less than 5 percent), there are many diverse actors in the private sector.

Guatemala's health sector includes three major components: MSPAS (Their ministry of health), which plays the dual role of overall senior authority of the country's health system, and provider of publicly financed health services including the largest network of local, regional, and national health service providers[1]. IGSS, which provides health services to its affiliates and is financed through employee and employer contributions. The IGSs as previously mentioned funds workers healthcare through social security. The private health sector provides fee-based services to all segments of Guatemalan society, including many who are least able to pay but lack access to public health services. The Private health sector attempts to close this coverage gap. In addition to MSPAS and IGSS, publicly funded health services are also provided to the Armed Forces through a separate health system managed by the Ministry of Defense[1]. A fourth subcomponent, frequently overlooked, includes national and international nonprofit organizations which until 2013 provided minimal health services on contract with the MSPAS to population groups – generally indigenous – that were not reached directly by MSPAS, as well as organizations that receive financing from international public and private sector donors to provide services to underserved populations and that frequently have no direct relationship with the government. However,in 2013 Guatemala passed a law that NGOs could not receive federal funding after a series of corruption scandals with non profit organizations. They have since made it so the government must approve of NGOs and know their stated purpose before they grant them permission to operate[3]. This has made NGOs accountable to the federal government much more than they were before[4].

Starting in 2017 Guatemala has been moving more towards a decentralization route with their national Decentralization agenda[4]. Municipal governments are now charged with formulating the insurance schemes to provide to their residents. However there is little financial flexibility held by municipal governments. In addition to this there is concern on how to implement a long term agenda in healthcare due to the fact that each municipality leader is appointed by the president at the beginning of his or her term. The health minister in Guatemala is accountable to the president who appoints the health minister at the beginning of his or her term. They can also decide to remove a health minister if they do not like how they are doing at any time. There is no coalition process in Guatemala and no one else who the health minister is accountable to. Municipalities in Guatemala are formally accorded autonomy and a broad mandate under the country's constitution and laws, and can provide services that "improve the quality of life of the inhabitants," including "preventive health[4].

Finance

Spending in the overall health sector represented 6.3 percent of the country's GDP, which is average for the region. (Within Central America, total health care spending ranges from a low of 5.4 percent in Belize to a high of 9.9 percent in Costa Rica.) However, health spending is dominated by the private sector (4 percent of GDP), mostly (83 percent) household out-of-pocket spending[1]. Public sector expenditures constitute the remaining 2.3 percent of GDP going to health: 1.1 percent of GDP was spent by IGSS, financed primarily by contributions from employers and employees, to cover an estimated 17 percent of the population[1]. All other government agencies combined spent 1.2 percent of GDP: MSPAS expenditures were equal to 1.0 percent of GDP, to cover 83 percent of the population18. From 2010-2019 out of pocket spending nearly doubled in Guatemala. It was at 1.5 billion in 2010 and increased to 2.67 billion

in 2019. The Healthcare system in Guatemala is 63% privately financed with 52% of that coming from out of pocket payments[1].

The MSPAS is funded by general government revenue while the IGSS is funded through the payment of its enrollees. There has been a push recently for a municipal insurance scheme. In which local municipalities would be responsible for providing their citizens with health insurance. This was tried out in 2015 by Villeneuve. The goal was to create a sustainable cost recovery mechanism for health services provided by the municipality. Existing and upgraded infrastructure and services would be used to create a primary healthcare package for municipal residents, who would access services through a collective health insurance policy. Community leaders hired by the municipality would offer the optional, low-cost policy to Villa Nueva residents. The ideal scenario would have seen the generation of a large enough pool of beneficiaries to work ideally generating a large enough pool of beneficiaries for a substantial impact to be made.A contracted insurance provider would reimburse the municipality at pre-established rates. The Villa Nueva public health company , which was to be established to operate the system, planned to generate additional revenue by keeping service costs low. The public health company was also seen as an opportunity to generate income for the municipality by offering services for insurance reimbursement under the systems operated by the MSPASand the IGSS. Ultimately, Villa Nueva was unable to secure the necessary authorization from the Ministry of Finance to proceed[4]. However I still felt it important to include as it shows the potential for decentralization that exists today within Guatemala.

References

1 Rodriguez, Michael P. 2015. “GUATEMALA HEALTH SYSTEM ASSESSMENT 2015 EXECUTIVE SUMMARY.” US Agency for International Development. https://www.usaid.gov/sites/default/files/documents/1862/Guatemala-HSA%20_ES_ENG_4-25-16_MCDV.PDF.

2Health and Education Policy Plus: Guatemala." n.d. Health Policy Plus. Accessed May 15, 2022. http://www.healthpolicyplus.com/ns/pubs/8210-8370_GuatemalaCountryBrief.pdf.

3 Ruiz, Esther P. 2019. "Attaining Selected Sustainable Development Goals in Guatemala: Spending, Provision, and Financing Needs." IMF eLibrary. https://www.elibrary.imf.org/view/journals/001/2019/060/article-A001-en.xml.

4 Improving Access to Quality Healthcare: A Political Economy Analysis of the Prospects for Municipal Health Insurance Schemes in." n.d. Health Policy Plus. Accessed May 10, 2022. http://www.healthpolicyplus.com/ns/pubs/7148-7263_GuatemalaPEABriefJune.pdf.

11 - Hungary

Key Points

- Over the past decade, Hungary has shifted its government power in health to the center. This can be seen in their highly centralized healthcare system.
- Responsibility for health is placed in the hands of the National Healthcare Service Center. The NHSC is administered by The Ministry of Human Capacities.
- Hungary's healthcare system is significantly worse than other European countries. Out of pocket payments are nearly double that of the European average and funding as a whole is below the regional average.
- Power has been centralized so heavily that political accountability is lacking.

Accountability

Hungary is a sovereign, unitary, parliamentary republic that was founded in 1989. In the recent decade, Prime Minister Victor Orban's centralized power is also evident in Hungary's government. This shift towards centralized power can be seen in Hungary's health care system. As of reforms enacted by Orban in 2012, "The Hungarian health system has become highly centralized. The national government is now responsible for setting strategic direction, controlling financing and issuing and enforcing regulations, as well as delivering most outpatient specialist and inpatient care".[1] Hungary is dominated by Orban's political party known as Fidesz. Fidesz makes up a majority of the legislature and is both nationalized and integrated throughout Hungary's national and local governments.[2] Hungary's central government takes responsibility for its citizen's health. In regards to Principal-Agent Theory, this makes the central government,

or in particular, The Ministry of Human Capacities, the agent in this relationship. While the national head of the executive, and possibly eventually the Hungarian citizens are the principal.

The quality of Hungary's healthcare system is in question for a multitude of reasons. In comparison to its neighboring EU nations, Hungary does not prioritize health for its citizens. As of 2017, only a mere 10% of all government spending is allocated toward health while other European countries allocate over 16% on average[3]. Hungary's chronically underfunded health sector can best be seen in the amount of out-of-pocket payments Hungarian citizens have to make for health treatments. Currently, Hungarian citizens average 27% out-of-pocket payments for treatments while the average for other European countries is only 16%.[3] Indicative is the number of preventable deaths that happen in Hungary. Hungary's preventable deaths are double that of Europe's average. In 2017, 46,000 deaths could have been prevented had more funded, timely, and effective healthcare been in place.[3] In comparison to other European countries, Hungary lags far behind in the quality of its health sector.

Responsibility for health is placed in the hands of the National Healthcare Service Center. The NHSC is administered by The Ministry of Human Capacities, and is responsible for care coordination, hospital planning/management, and medical licensing, while simultaneously serving as the umbrella organization for the regional and local health system agencies.[1] The single health insurance fund, which will be discussed later, is administered by the National Institute of Health Insurance Fund Management.[1] Though the public-health system in Hungary is highly centralized, it still grants authorities to regional branches and offices of the National Public Health and Medical Officer Service, National Health Insurance Administration and Special Hospitals and Polyclinics, as well as local authorities.[5] There is currently no non-government authorities responsible for health in Hungary.

Hungary is severely lacking in terms of accountability. Hungary's Prime Minister Viktor Orban is leading his country down a path towards authoritarianism. Orban has implemented many governmental reforms both legislative and judicial that have threatened Hungary's rule of law.[2] Many have begun to question the integrity of Hungary's elections as there is also evidence of fraud.[2] This has left Hungarian citizens unable to hold their government, who controls health, accountable. Unfortunately, citizens's voices can no longer be heard at the polls and much of democratic accountability is lost. Hungarian citizens have to hope that the government themselves will hold The Ministry of Human Capacities accountable.

Finance

The Hungarian health system is currently organized around a single health insurance fund providing health coverage for nearly all residents.[1] This is funded by a combined effort of citizen taxes and the National Health Insurance Fund.[3] This fund consists of 3% of an employee's income and an additional 15% that is covered by employers. Patients should also expect co-pay costs for pharmaceuticals, dental care, rehabilitation services, and other treatments.[4] Though health is covered for nearly all residents, this benefit package is relatively limited in comparison to other EU countries. Currently, Hungary spends 6.4% of its gross domestic product on health expenditures which is significantly lower than other European countries.[3] Hungary's health sector is underfunded, lacking in quality, and ineffective.

References

1. "Hungary - European Observatory on Health Systems and Policies." https://eurohealthobservatory.who.int/countries/hungary. Accessed 25 Apr. 2022.
2. "OSCE Monitors Hungarian Elections Amid Voter Fraud Fears." 3 Apr. 2022, https://www.rferl.org/a/hungary-elections-osce-orban-fraud/31783927.html. Accessed 10 May. 2022.
3. "Hungary - Country Health Profiles 2019: Launch presentation - OECD." https://www.oecd.org/hungary/Hungary-Country-Health-Profiles-2019-Launch-presentation.pdf. Accessed 25 Apr. 2022.

4. "Hungary's Healthcare System - International Citizens Insurance." https://www.internationalinsurance.com/health/systems/hungary.php. Accessed 25 Apr. 2022.
5.*Division of Powers*, https://portal.cor.europa.eu/divisionpowers/Pages/default.aspx.

12 - Israel

Key Points

- All Israelis are entitled to basic healthcare as a fundamental right.
- Residents get to choose between four competing non-profit health plans.
- Despite spending a relatively low percentage of the GDP on healthcare, the Israeli health care system runs efficiently.
- Their healthcare system is financed primarily through a health-specific payroll tax and general taxation.

Accountability

Though Israel has no written constitution, all residents are entitled to basic healthcare as a fundamental right. As a part of its national health insurance law, Israel provides universal coverage to all citizens.[1] Residents get to choose between four competing non-profit health plans.[1] These plans provide citizens with mandated benefit packages, including hospital, primary, specialty, mental health, and maternity care, as well as prescription drugs and other services.[1] The national government is responsible for population health and the overall functioning of the healthcare system through the Ministry of Health.[1] Almost all governmental health functions are organized by the Ministry of Health, which has regional and district health offices.[1] When you apply The Principal Agent Theory to the health system of Israel, you find that the principal is the Israelin citizens and the agent is the national government and the ministries of health.

The Ministry of Health bears the national responsibility for ensuring the health of Israel's population.[2] The ministry develops policies on matters of health and medical services, and is

tasked with the planning, supervision and control, licensing and coordination of the health system's services.[2] The ministry also deals with the organization, operation and provision of preventive, diagnostic, treatment, rehabilitation and research services either directly or via medical institutions.[2] "The ministry provides health services in the fields of hospitalization and preventive medicine, and insures the population on matters of mental health, geriatrics, public health and rehabilitation devices.[2]"

Despite spending a relatively low percentage of the GDP on healthcare, the Israeli health care system is quite efficient. "Factors contributing to system efficiency include regulated competition among the health plans, tight regulatory controls on the supply of hospital beds, accessible and professional primary care and a well-developed system of electronic health records.[3]" Israeli health continues to demonstrate their willingness to innovate, improve, establish goals, be tenacious and prioritize.[3]

Financing

Israel spends less than 8% of its gross domestic product on healthcare at about 28.5 Million. Their healthcare system is financed primarily via a health-specific payroll tax and general taxation through the national government.[4] Thanks to a sharp increase in spending on voluntary health insurance, the share of private financing has also been increasing in recent years, reaching nearly 40% by 2015.[4]

References

1 Roosa Tikkanen, et al. "Israel." *Home*, 5 June 2020, https://www.commonwealthfund.org/international-health-policy-center/countries/israel.

2 *Health.gov.il*, https://www.health.gov.il/English/About/Pages/default.aspx.

3 Rosen B;Waitzberg R;Merkur. "Israel: Health System Review." *Health Systems in Transition*, U.S. National Library of Medicine, https://pubmed.ncbi.nlm.nih.gov/27050102/.

4 "Israel." *World Health Organization*, World Health Organization, https://eurohealthobservatory.who.int/countries/israel.

13 - Nigeria

Key Points

- Nigeria has a bustling private health sector, driving up private out-of-pocket health expenditure.
- This private sector arose out of a need to fill gaps in state capacity in providing healthcare
- There is a lot of jurisdictional entanglement going on in Nigerian health policy decision space, as local, state, and federal governments assume overlapping roles.
- As a result of this, the executives at both the state and federal levels have a lot of decision making power.
- Out of the amount of health expenditure in the country that is covered by the government, at least 75% of the funding is provided by the federal government.

Accountability

The Nigerian government aims to be the dominant player in healthcare, and their constitution takes responsibility for health, however when it comes to putting this objective into action, the Nigerian government fails to fully realize its promise. When it comes to the actual deployment of health services (primary care, hospitals, specialty hospitals) by the public sector (which accounts for only 60% of facilities in the countries), Nigeria follows a three tier structure.[1] The local governments are responsible for primary healthcare provision, the state governments handle the next step up, providing hospitals, and the federal government controls specialty hospitals.[1] However when it comes to who actually makes decisions on health policy, it becomes a bit of a mess.

The constitution puts health on the concurrent legislative list, meaning that local, state, and federal governments assume overlapping roles in terms of the provision, regulation and designs of policy.[1] This has created extreme ambiguity, as there are no specific divisions of responsibility, leading to an entanglement when it comes to policy making and administration.[1] Due to this, there is technically a high level of decision making authority vested in both the national executive, and the state executives when it comes to health policy. At the state level, the

Minister/Counselor of Health are the dominant agents. These ministers are appointed by the governor of their state, pending legislative approval, and among other things, are responsible for health policy/plan/strategy formulation and legislation.[2] This makes the executive branch at the state level a significant decision maker when it comes to formulating health policy. Being the agent, this state executive's principal is their party, and the coalition of voters who voted in support of the governor.

At the federal level, we see a similar pattern. The Federal Ministry of Health is responsible for the formulation and implementation of all policies related to health, much like state health departments are, with there being little established boundaries between them.[3,4] This makes the federal ministers of health a dominant agent in health policy decision making as well. There are two federal ministers of health, appointed by the president of Nigeria, and their principal is their party, and the winning coalition of voters that elected the president of Nigeria. In both the state and federal cases, ministers/councilors of health are selected from the same party as the president/governor. Two political parties predominate at both the state and national level, the All Progressives Congress, and the People's Democratic party.[5] Political parties therefore are nationalized, and intertwined.

It is important to note however, that Nigeria has a bustling private healthcare sector, which aims to fill gaps in each of the three tiers of the Nigerian health system.[6] The state and federal governments have a weak regulatory capacity to actively set rigorous standards and compliance, so there is an entire private sector of health that is largely unregulated, and decisions are left to the private actors who run them.[1]

Financing

Due to the prominent private healthcare sector discussed in the accountability section, most of Nigeria's healthcare expenditure comes from private sources, mainly out of pocket payment for services.[7] This is because private health care facilities at each level of the three tier systems are patronized far more than public ones, as there is weak government capacity in many areas that prevents the establishment of public healthcare facilities.[6] With a 71% private sector expenditure as shown in Table 2, it is not uncommon for households to spend more than 10% of their household consumption on health.[7,8] The types of actors behind these private health facilities can be faith based providers (which tend to offer services at a lower cost), or private-for profit corporations, which tend to be based in urban areas, where there is a much higher willingness to pay, and ability to meet prices.[6]

As for public spending, Table 2 shows that Nigeria's government makes up 16% (55% of all public) of healthcare expenditure, while the remaining 13% (45% of all public) is covered by external sources.[8] These external sources are revenues introduced from foreign sources (donors) to the Nigerian government to use for healthcare.[9] As for public spending, the Nigerian federal government provides funding to state governments. Nigeria's revenues stream to two accounts, one from the value-added tax pool account, and an oil and other non-oil revenue related account, which then is distributed across the three levels of government based on allocation formulas.[7] State access to funding is contingent upon a 25% contribution matched by states, so out of government funding, the federal government funds 75% of things, and the remaining quarter is covered by states.[7] However the state contribution match requirement has been very relaxed since it began, so it is very likely that the federal government is funding more than 75% of healthcare in Nigeria.[7]

References

1 Olaniyan, Toyib. (2012). The Health Status of Nigeria and the Nigerian Health System.

2 “Responsibilities - Ministry of Health.” Ministry of Health, 2022, health.lagosstate.gov.ng/responsibilities/. Accessed 30 Mar. 2022.
3 “Federal Ministry of Health - Department of Health Planning, Research & Statistics.” Fmohconnect.gov.ng, 2013, fmohconnect.gov.ng/policy_planning.html. Accessed 30 Mar. 2022.
4 Wikipedia Contributors. “Federal Ministry of Health (Nigeria).” Wikipedia, Wikimedia Foundation, 26 Oct. 2021, en.wikipedia.org/wiki/Federal_Ministry_of_Health_(Nigeria). Accessed 30 Mar. 2022.
5 Wikipedia Contributors. “List of Political Parties in Nigeria.” Wikipedia, Wikimedia Foundation, 25 Apr. 2022, en.wikipedia.org/wiki/List_of_political_parties_in_Nigeria. Accessed 25 Apr. 2022.
6 SHOPS Project • Nigeria Private Health Sector Assessment Nigeria Private Health Sector Assessment BRIEF.
7 Hafez, Reem. “NIGERIA HEALTH FINANCING SYSTEM ASSESSMENT.”
8 “Global Health Expenditure Database.” Who.int, 2014, apps.who.int/nha/database/ViewData/Indicators/en. Accessed 30 Mar. 2022.
9 “Indicator Metadata Registry Details.” Who.int, 2021, www.who.int/data/gho/indicator-metadata-registry/imr-details/4955#:~:text=The%20share%20of%20external%20sources,sources%20relative%20to%20domestic%20sources.. Accessed 30 Mar. 2022.

14 - Spain

Key Points

- The Spanish constitution guarantees the right to healthcare for all citizens, but the national government only plays a marginal role in health decision making
- Autonomous community and regional governments are the main decision making bodies when it comes to public health, specifically the ministers/councilors of health in each
- The Spanish government plays a miniscule role in public health financing; governments of the autonomous communities and regions are the key bankrollers of the healthcare system
- With the autonomous and regional governments handling the financing and decision making over health, the federal government is left to play the role of an overseer, managing the national health system, and ensuring equality.

In Spain, the government in general plays a very large role in healthcare, with the national government guaranteeing in their constitution a right to healthcare for all Spanish citizens.[1] Despite this, the national government takes a very minor role in public health decision making. The national government's main role is overseeing and managing the health system across the country, as in 2002 there was a complete transfer of healthcare responsibility from the

national to regional level, giving the 17 autonomous community (AC) and regional governments prime decision making power over designing their health system, doing research, and most importantly establishing public health policy.[2,3] Additionally, the sub-national governments can add extended coverage, or add things that may not be included in the SNS's basic coverage plan, by having additional taxes in their provinces, further showing how regional governments are the main power source here.[3] The national government also plays a quality assurance role, and equity role, ensuring that each regional government is performing adequately, and that systems are up to standard.[2]

Due to this, the national government's legislative and executive branch do little in terms of actual health policy decision making. Instead the ministers or councilors of health, and their departments at the regional level have a lot of control over what policy will be in their regions.[2] This makes the executive branch at the regional level the prime decision maker, and the main agent. The 17 regions each use a parliamentary form of government, where the winning party or coalition selects a prime minister/president figure to lead the government, who in turn selects a cabinet of ministers/councilors for various departments, including health.[4] The voters who supported the winning party or coalition in each region are the base principal, as they elected the party responsible for selecting the minister of health, so at the core of the matter they are who the agent is serving.

The ministries/departments of health and the bureaucratic ladder within them each presumably have a big role in developing policy if the legislative or other decides there is a need for policy relating to their issue area.[5] Given the nature of parliamentary systems like those in the 17 regions, it in theory is relatively easy for health policies designed by the ministries or departments of health to be passed, as they are of the same party, and have control of the

legislature. In terms of political parties, the 3 predominant parties that are present across the national and AC governments are the Spanish Socialist Workers Party (PSOE), Vox, and Peoples Party.[6] There is integration, and nationalization, as voters and parties are likely to behave along similar lines at both levels, and local influence can be used to influence national political outcomes, and vice versa.

Financing

Shifting towards numbers, Spain has a €115 billion health expenditure for the year of 2019, with 70.5% of this being covered by the government at all levels, and 29.2% by the private sector as seen in Table 2.[7,8] There are very few public-non government sources of funding, with non-profits and patient organizations making up less than 1% of total healthcare expenditure.[2] The lion's share of public funding comes from the governments of the 17 regions from their own tax revenues, which made up 92.3% of all public health expenditure in 2019.[8] Looking into the individual expenditures of AC's, we are able to get a more detailed perspective on this. In 2019, Andalucia, one of the largest regions in the country, spent €10 billion on health, out of the some €80 billion total public health spending in the country.[8,9] This reiterates that out of government financing of health, the regional governments are the main bankroller, and the amount funded by the national government is microscopic in comparison.

References

1 https://www.constituteproject.org/constitution/Spain_2011.pdf?lang=en
2 García, Sandra, et al. Spain Health System Review. Vol. 12, no. 4, 2010, www.euro.who.int/__data/assets/pdf_file/0004/128830/e94549.pdf.
3 Bernal, Enrique, et al. Health Systems in Transition Spain Health System Review. Vol. 20, no. 2, 2018, www.euro.who.int/__data/assets/pdf_file/0008/378620/hit-spain-eng.pdf.
4 Wikipedia Contributors. "Regional Government of Andalusia." Wikipedia, Wikimedia Foundation, 5 Mar. 2022, en.wikipedia.org/wiki/Regional_Government_of_Andalusia. Accessed 13 Mar. 2022.
5 de, Colaboradores. "Institución de Gobierno de Catalunya." Wikipedia.org, Wikimedia Foundation, Inc., 15 June 2003, es.wikipedia.org/wiki/Generalidad_de_Catalu%C3%B1a#:~:text=El%20Consejo%20Ejecutivo%

20o%20Gobierno%20de%20Catalu%C3%B1a%20es%20el%20%C3%B3rgano,y%20de%20la%20potestad%20reglamentaria. Accessed 13 Mar. 2022.

6 Wikipedia Contributors. "List of Political Parties in Spain." *Wikipedia*, Wikimedia Foundation, 4 Mar. 2022, en.wikipedia.org/wiki/List_of_political_parties_in_Spain. Accessed 13 Mar. 2022.

7 diariofarma. "El Gasto Sanitario de España En 2019 Alcanzó Los 115.000 Millones de Euros | @Diariofarma." Diariofarma, 8 July 2021, www.diariofarma.com/2021/07/08/el-gasto-sanitario-en-espana-alcanza-los-115-000-millones-de-euros#:~:text=El%20gasto%20sanitario%20de%20Espa%C3%B1a%20en%202019%20alcanz%C3%B3%20los%20115.000%20millones%20de%20euros,-Comparte%20esta%20noticia. Accessed 25 Apr. 2022.

8 del Carmen Rodriguez Blas, Maria. "Principales Resultados Sistema de Cuentas de Salud." 2019.

9 Datosmacro. "Presupuestos de Andalucía 2019." Datosmacro.com, 2019, datosmacro.expansion.com/estado/presupuestos/espana-comunidades-autonomas/andalucia?anio=2019. Accessed 13 Mar. 2022.

15 - Thailand

Key Points

- Thailand is a unitary state whose central government takes responsibility for health.
- Thailand has a national executive known as the Minister of Health who is responsible for health.
- Thailand has a universal healthcare system for which all citizens are eligible. This covers around 80% of Thailand's population while the other 20% opt for the private sector.
- Both sectors provide excellent care which is a major reason why Thailand boasts an enormous amount of medical tourism.

Accountability

Thailand is a unitary state that has a written constitution outlining its monarchy and parliamentary system. Power is concentrated in Thailand's central legislative authority known as the House of Representatives. It is here where lawmaking and the day-to-day running of government take place. In regards to decision space, governmental decisions are made in the House of Representatives rather than lower municipal governments. Local administrations "Have the duties and powers to regulate and provide public services and public activities for the benefits of the people in the … locality, as provided by law".[1] Sub-national governments are

only responsible for ensuring that laws made by the central government are carried out and followed. They are not given the jurisdiction to create laws at the local level as seen in the earlier excerpt from Thailand's constitution "as provided by law".

This is an important factor to take into consideration when analyzing the decision space of Thailand's healthcare system. The House of Representatives, Thailand's national legislative authority, is where health policies are determined. The Minister of Health is usually selected from the winning coalition. This position is primarily responsible for health policies as "Carrying out acts provided by the law to be the duties or powers of the Minister".[1] In terms of accountability, the Minister of Health is appointed by the winning coalition that is in control of The House of Representatives and can be removed if seen fit. In regards to Principal-Agent Theory, Thailand's citizens are the principal and the Minister of Health is the agent. Thailand has 25 parties that are represented in its legislature.[2] Many of these parties only hold significant influence in their regional areas, making political parties not nationalized or integrated.

Thailand has a universal health care system in which all citizens are covered. This system was created in 2002 and has been considered one of the best public health services in the world.[3] This system is laid out within Thailand's constitution and guaranteed by the state. "A person shall have the right to receive public health services provided by the State. An indigent person shall have the right to receive public health services provided by the State free of charge as provided by law".[1] As written in its constitution, Thailand does not restrict healthcare from any citizen within its borders making it universal.

Finance

In regards to funding, as of 2019, Thailand's healthcare expenditure reached 25.3 Billion USD which is equivalent to 6.6% of the gross domestic product. Thailand's government

allocated 13.3% of its total budget towards health expenditures as their health care system is universal and in high demand.[4] Thailand primarily funds its healthcare system through tax revenues. Prices of medical procedures in Thailand are significantly cheaper than in countries such as the United States, making medical tourism a very large industry and a large contributor to Thailand's GDP.[5] Thailand also hosts a private health sector that provides similar health care quality as the public sector with shorter wait times. This sector covers around 20% of Thailand's population and consists of traditional private insurance companies.

References

1. "Thailand 2017 Constitution." *Constitute*, Constitute Project, https://www.constituteproject.org/constitution/Thailand_2017?lang=en.
2. "ค ะ แ น น ผ ส ู้มคั ร ร า ย เ ข ต." Ect.go.th, ขอม้ลูณ วนั ท, https://www.ect.go.th/ect_th/ewt_dl_link.php?nid=5481.
3. "Healthcare Resource Guide - Thailand." *International Trade Administration | Trade.gov*, International Trade Administration, https://www.trade.gov/healthcare-resource-guide-thailand.
4. "Understanding the Healthcare System in Thailand." *International Citizens Insurance*, International Insurance, 19 Jan. 2022, https://www.internationalinsurance.com/health/systems/thailand.php.
5. Tantisaeree, Kornluck. "Healthcare Resource Guide: Thailand." *Export.gov*, https://2016.export.gov/industry/health/healthcareresourceguide/eg_main_108623.asp.

16 - Turkey

Key Points

- Authority in health has been more centralized since 2017
- HTP program centralized health funds and improved access for everyone in the country
- Social Security Funds

Accountability

In Turkey the national government takes responsibility for providing healthcare in the constitution and in practice1. The government focus on healthcare at the national level increased starting in 2002, when the Justice and Development Party, led by Tayyip Erdogan won power. In

2003 Turkey established the Health Transformation Program (HTP) which aimed to improve the services provided by the government[2], and established Universal Health Coverage which consolidated enrollees under a single system which made healthcare accessible to all people through a single package[2]. The HTP expanded the capacity of the ministry of health and therefore the authority of the national government as a whole when it comes to health care and made the system much more centralized. The Turkey Ministry of Health carries out the HTP. The key actor in this system is the minister of health who is appointed by the president. The healthcare system in Turkey is very centralized and rigid as a result (see Figures 1, 2).

Turkey created a single purchaser model through which the Social Security institution assumed full responsibility for all health financing functions, including collecting revenues, pooling resources and expenditures and purchasing relevant goods and services. This was the main impact of the overhaul of the health sector. The impact that this had on financing accountability of healthcare is displayed in figure 1 below. In 2010 Turkey continued to move towards a private-public partnership in regards to healthcare. In this model, investment is realized by the private sector and risks are shared among related parties. The fund needed for investment can be raised through syndicated loans with the contribution of the domestic banking system[3].

A major political institutional change took place in Turkey's government structure in 2017 when the constitution was amended to allow the president to assume all executive powers and appoint his own cabinet[1]. This continues the trend of President Erdagan centralizing the power of the executive branch in Turkey.

From: The experiences of merging health insurance funds in South Korea, Turkey, Thailand, and Indonesia: a cross-country comparative study

		Scheme	Population eligibility	Benefit package	Financing	Affiliation
Turkey	**Before**	SSK (the Social Insurance Organisation), 1945	blue collar workers (49.49%)	Pre-paid short-term medical and maternal benefits, employment related accident and occupational disease benefits; long-term benefits for old age, disability and survivor pensions; did not provide or pay for preventive services	Employees (5% of salary), employers (6%), state subsidized (8.5% employer share 5% employee share)	Attached to the Ministry of Labour and Social Security until May 2006, transferred to the Social Security Institution
		Bağ-Kur, 1971	self-employed people, artisans, and organised groups (23.43%)	All outpatient and inpatient diagnosis and treatment. The insured were required to pay health insurance premiums for at least 8months and have no record of default of health insurance and long term insurance premiums	20% premiums collected from beneficiaries. The scheme worked on a reimbursement system	Attached to the Ministry of Labour and Social Security until May 2006, transferred to the Social Security Institution
		Emekli Sandigi (the Government Employees Retirement Fund), 1949	Retired civil servants and their dependents (13%)	Diagnosis and treatment	20% of the deduction of the Government Employees Retirement Fund (State share as employer), 16% of the deduction of the Government Employees Retirement Fund (participant share) for both health and pension; funded through the contributions of the active civil servants and their employers (general budget revenues)	Attached to the Ministry of Labour and Social Security until May 2006, transferred to the Social Security Institution
		the Active Civil Servants Insurance Fund, 1965	civil servants in work and their dependents	Diagnosis and treatment	Benefits were financed by general tax revenues; no premiums were assessed for active civil servants while they were covered directly through their employers	Attached to the Ministry of Finance through their institutions until 2010, transferred to the Social Security Institution in January 2010
		the Green Card, 1992	Uninsured poor individuals (15%)	Inpatient and ambulatory care, pharmaceuticals	General budget (100%)	Attached to the Ministry of Finance through the Ministry of Health, will be transferred to the Social Security Institution by the end of 2012
	After merging	General Health Insurance scheme, 2006	Turkish citizens, refugees, foreigners residing in Turkey for more than 1 year	(1) Primary care, rehabilitation, preventive services; (2) ambulatory and inpatient care; (3) maternal benefits as well as in vitro fertilization treatment; (4) partial general oral and dental care; (5) blood and blood products, bone marrow, vaccination, medicine, medical devices and equipment	12.5% of a person's gross income, and employee (5%), and employer (7.5%) salary deductions. The rate for people who are only dependent on General Health Insurance Scheme is 12% of their earnings. The contribution of the state will be 3% of insured earnings as the basis for premiums	Attached to the Ministry of Labour and Social Security through the Social Security Institution

(Figure 1) Bazyar, M., Yazdi-Feyzabadi, V., Rashidian, A. *et al.* The experiences of merging health insurance funds in South Korea, Turkey, Thailand, and Indonesia: a cross-country comparative study. *Int J Equity Health* 20, 66 (2021).

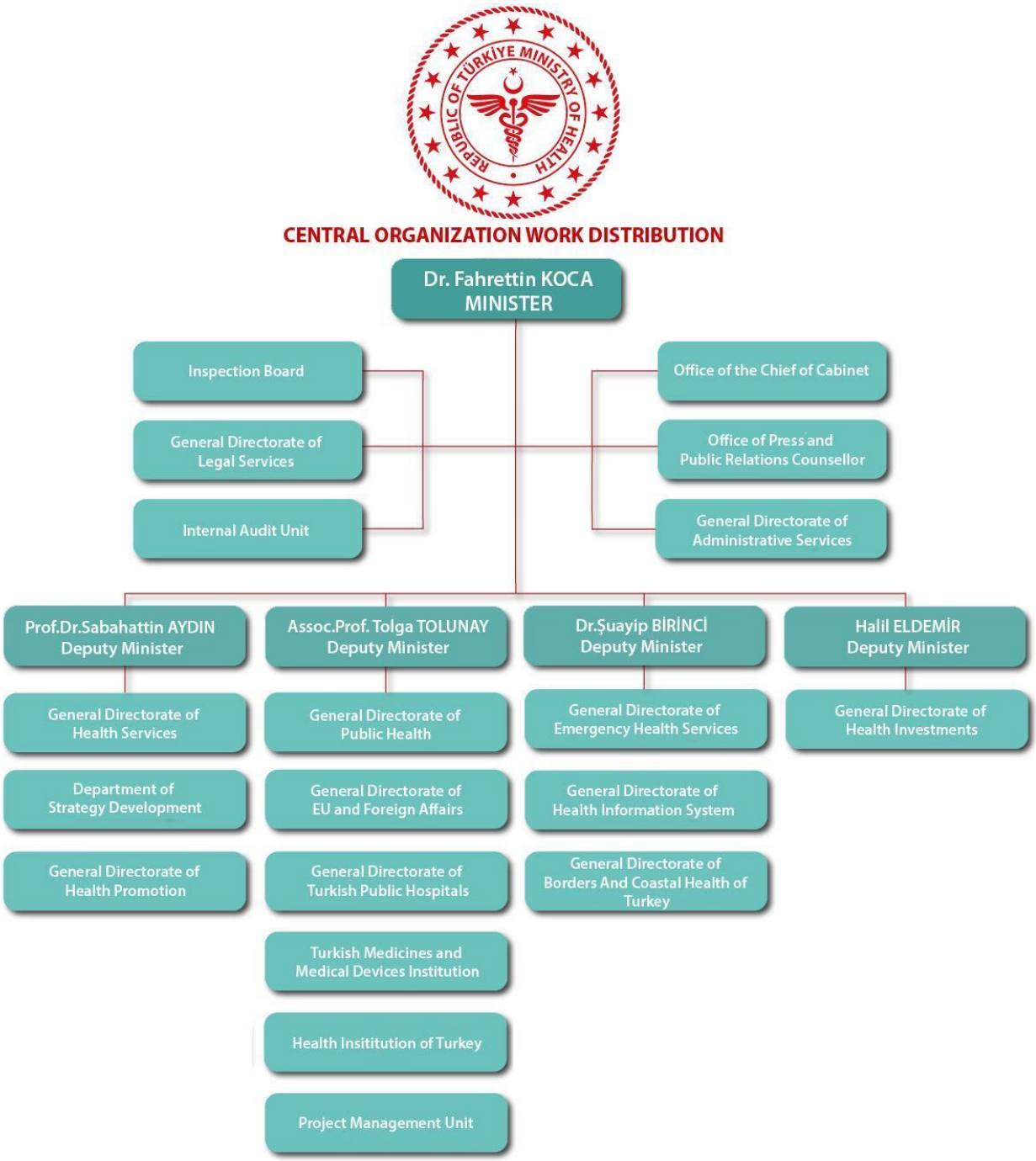
Financing Health in Turkey

The HTP was financed by the World Bank which issued loans to the Turkish government to implement the program[3] . The Bank also provided technical assistance in the preparation of the Social Security and Universal Health Insurance Law of 2008, which unified the country's social security system and made health services available to all. Turkey created a single purchaser model through which the Social Security institution assumed full responsibility for all health financing functions, including collecting revenues, pooling resources and expenditures and purchasing relevant goods and services [4].

The General Health Insurance Scheme is financed by 12.5% of a person's gross income, for the employed it is paid for by 5% employee and 7% of the employer's salary deductions[3]. The rate for people who are only dependent on the Government for their coverage is 12% of their income[3]. Figure 1 below shows the impact of this overhaul had on the healthcare system of Turkey along with the programs it combined to make things more efficient.

The current minister of health is Dr. Fahrettin KOCA. He was appointed by President Erodgan in 2017 as he was in the initial president's cabinet after the consolidation of power mentioned earlier. He is accountable to Erogdan and does not have to face consequences from anyone but the executive in Turkey as is the case with all members of the cabinet. Thus Turkey has a rating of high from the national executive and not anything else in our table. You can see in figure 2 below who is accountable to the minister of health.

		Scheme	Population eligibility	Benefit package	Financing	Affiliation
Turkey	**Before**	SSK (the Social Insurance Organisation), 1945	blue collar workers (49.49%)	Pre-paid short-term medical and maternal benefits, employment related accident and occupational disease benefits; long-term benefits for old age, disability and survivor pensions; did not provide or pay for preventive services	Employees (5% of salary), employers (6%), state subsidized (8.5% employer share 5% employee share)	Attached to the Ministry of Labour and Social Security until May 2006, transferred to the Social Security Institution
		Bağ-Kur, 1971	self-employed people, artisans, and organised groups (23.43%)	All outpatient and inpatient diagnosis and treatment. The insured were required to pay health insurance premiums for at least 8months and have no record of default of health insurance and long term insurance premiums	20% premiums collected from beneficiaries. The scheme worked on a reimbursement system	Attached to the Ministry of Labour and Social Security until May 2006, transferred to the Social Security Institution
		Emekli Sandigi (the Government Employees Retirement Fund), 1949	Retired civil servants and their dependents (13%)	Diagnosis and treatment	20% of the deduction of the Government Employees Retirement Fund (State share as employer), 16% of the deduction of the Government Employees Retirement Fund (participant share) for both health and pension; funded through the contributions of the active civil servants and their employers (general budget revenues)	Attached to the Ministry of Labour and Social Security until May 2006, transferred to the Social Security Institution
		the Active Civil Servants Insurance Fund, 1965	civil servants in work and their dependents	Diagnosis and treatment	Benefits were financed by general tax revenues; no premiums were assessed for active civil servants while they were covered directly through their employers	Attached to the Ministry of Finance through their institutions until 2010, transferred to the Social Security Institution in January 2010
		the Green Card, 1992	Uninsured poor individuals (15%)	Inpatient and ambulatory care, pharmaceuticals	General budget (100%)	Attached to the Ministry of Finance through the Ministry of Health, will be transferred to the Social Security Institution by the end of 2012
	After merging	General Health Insurance scheme, 2006	Turkish citizens, refugees, foreigners residing in Turkey for more than 1 year	(1) Primary care, rehabilitation, preventive services; (2) ambulatory and inpatient care; (3) maternal benefits as well as in vitro fertilization treatment; (4) partial general oral and dental care; (5) blood and blood products, bone marrow, vaccination, medicine, medical devices and equipment	12.5% of a person's gross income, and employee (5%), and employer (7.5%) salary deductions. The rate for people who are only dependent on General Health Insurance Scheme is 12% of their earnings. The contribution of the state will be 3% of insured earnings as the basis for premiums	Attached to the Ministry of Labour and Social Security through the Social Security Institution



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Source: https://www.saglik.gov.tr/EN,15609/ministerial-organization.html

References

1 "Turkey's Constitution of 1982 with Amendments through 2017." 2022. Constitute Project. https://www.constituteproject.org/constitution/Turkey_2017.pdf?lang=en.

2 Bazyar, M., Yazdi-Feyzabadi, V., Rashidian, A. *et al.* The experiences of merging health insurance funds in South Korea, Turkey, Thailand, and Indonesia: a cross-country comparative study. *Int J Equity Health* 20, 66 (2021). https://doi.org/10.1186/s12939-021-01382-w

3 Turkish Health Transformation Program and Beyond." 2018. World Bank Group. https://www.worldbank.org/en/results/2018/04/02/turkish-health-transformation-program-and-beyond.

4 Yıldırım HH, Yıldırım T. Healthcare financing reform in Turkey: context and salient features. Journal of European Social Policy. 2011;21(2):178-193. doi:10.1177/0958928710395045

5 2022. Ministerial Organization. https://www.saglik.gov.tr/EN,15609/ministerial-organization.html.

17 - Conclusions

Our research into the de facto patterns of authority and accountability on health has led us to a number of general observations. Some of these observations were consistent with prior expectations, while others we did not expect. For example, while funding is obviously very important to the quality of a healthcare system it is not everything, as in some countries the lack of coordination and flawed incentives in decision making led to worse systems than those who had less total funding. Countries with very good organization, and clear delegation of responsibilities tend to have much better health systems. Less streamlined systems may have overlapping responsibilities, leading to needless spending, or even mismanagement of funds, raising the possibility of worse health outcomes despite their advantage in having more funds.

Of the countries we have analyzed, national and sub-national legislatures tended to have low involvement in making decisions regarding health. Their executive counterparts held much more decision making authority and responsibility, making them the dominant agents in their country's health decision space. The majority of countries had dedicated executive positions of the Minister/Ministries of Health. These positions are found at both the national and sub-national levels. Whether or not a country's healthcare system was centralized or decentralized,

determined the authority and responsibility balance between the national and local Ministries of Health. Rather than the legislature, it was the Ministries of Health, whether they were found at the national or sub-national level, that held the authority to make decisions regarding health. The principals who these executives were accountable to were mostly political parties or coalitions, as well as the segment of the population responsible for electing said party or coalition. This was so as the voters elected the winning party or coalition, that would then select an executive amongst themselves as their leader, who then selects ministers from their party or coalition to serve in these executive public health positions.

Some of the poorer countries we analyzed such as Nigeria, Bangladesh, and Turkey have received massive funding from NGOs. While such aid benefits recipient countries, not all countries can eventually support themselves without the aid. Turkey is a positive example here. The country received major funding from the World Bank for their overhaul of the health system and used those funds to make their system more efficient. However, with countries like Nigeria and Bangladesh, NGOs provide steady flows of funding and partially run the healthcare system, which is problematic, as they are not accountable to domestic actors and are unable to affect large-scale change to the healthcare system. In addition, these two countries are examples of the heavy involvement of private for-profit healthcare companies. These companies offer better treatment than other national options, but at a very steep cost. Their operation in these countries does expand the range of provided services but generally are unaffordable options for many consumers.

Most countries' constitutions assigned the government the responsibility for health in the country, however when it came to practice, the vast majority passed the torch of health provision to more local levels of authority, such as provinces, states, or municipalities. These local actors

tended to be responsible for the actual provision of health, via things like primary care, hospitals, or specialists, whereas the national governments in many cases tended to play more of an overseer role, regulating the health system, setting standards, and ensuring that state, local, or municipal health systems met certain standards. These findings clarify the fact that a gap exists between the de jure responsibility assignment for health and the actual institutional identity of decision-making authority over health. Generally, responsibility seems to belong to national governments, whereas frequently the more local levels of government have the authority to both make and implement specific health policies.

Overall, countries like Bangladesh and Nigeria were more dependent on private actors, as their weak provisional capacity enabled private markets to thrive. Thus, the role of their governments in health is relatively limited. Other countries in our sample, like Spain, Australia, Finland, Thailand, Hungary, Israel, Austria, and Algeria, had their health systems dominated by the public sector, which was well structured with a clear division of roles. Health decision-makers as a rule were not subject to direct elections, and the vast majority of health agents were appointed by members of the executive branch like a prime minister, governor, or president. Countries like Argentina and Belgium had a more decentralized system where local ministers of health have more authority. There definitely exists a strong advantage of more developed countries having better organized, interconnected, and highly developed health systems, and further research is owed into how to effectively bring less developed health systems like those of Bangladesh or Nigeria up to speed. While research into the decision space of health systems in every country around the globe is needed to improve the accuracy of these findings, for the countries in our current sample we have developed a comprehensive map of their decision space environment.

Appendix

Table 1: Accountability indicators in 14 countries, pre COVID-19 pandemic

Country	Government involvement	Executive - National	Executive - Subnational	Legislature - National	Legislature - Subnational	Political parties are integrated	Nationalization of political parties?
Spain	High	Low	High	Low	Low	Yes	Yes
Australia	High	Low	High	Low	Low	Yes	Yes
Nigeria	High	High	High	Low	Low	Yes	Yes
Finland	High	High	High	Low	Low	Yes	Yes
Belgium	High	Low	High	low	high	No	No
Argentina	High	Low	High	Low	Low	Yes	Yes
Thailand	High	High	Low	Medium	Low	No	No
Hungary	Medium	High	Low	High	Low	No	Yes
Bangladesh	Low	Low	Low	Low	Low	Yes	Yes
Israel	Low	High	Low	High	Low	Yes	Yes
Austria	Low	Low	High	High	High	Yes	Yes
Guatemala	medium	medium	low	low	low	yes	yes
Algeria	High	High	Low	High	Low	Yes	No
Turkey	High	High	Low	Low	Low	Yes	Yes

Table 2: Health finance roles across 14 countries, pre COVID-19 pandemic

Country	Federal constitution responsible for health?	Subnational constitutions responsible for health?	Share of federal government in financing health	Dominant level for primary care provision	Government share of funding healthcare	% public non-governmen t sources in funding healthcare	% private share of funding healthcare
Spain	Yes	No	7.70%	States	71%	>1%	29%
Australia	No	Yes	60.30%	States	68.30%	0.90%	30.80%
Nigeria	Yes	No	<75%	States	16%	13%	71%
Finland	Yes	No	35.10%	Municipality	75.20%	>1%	24.40%
Belgium	Yes	Yes	15%	Commmunites	77.25	>1%	17.25
Argentina	Yes	Yes	~50%	Provinces	50%	40%	10%
Thailand	Yes	No	80%	C. Government	~80%	0%	~20%
Hungary	Yes	No	L ~10%	C. Government	68%	~0%	32%
Bangladesh	Yes	No	L <3%	Pluralistic	36.70%	~31%	~31%
Israel	No	No	4.90%	C. Government	60%	0%	40%
Austria	Yes	No	<2%	Lander	33.40%	43%	23.60%
Guatemala	yes	no	36%	Private OOP	19%	17%	62%
Algeria	Yes	No	7%	States	65%	0%	35%
Turkey	Yes	Yes	37.40%	C.Government/ Executive	75%	37.6	21%