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THE USE OF GOVERNANCE INSTRUMENTS IN HEALTH POLICIES OF DEVELOPED COUNTRIES[1]

INTRODUCTION

The health care system is sometimes characterised on the basis of how it fulfils three basic functions: financing, provision of services and regulations. These three dimensions allow you to capture the fundamental role of the state and the direction of its policies in individual models. Studies show, however, that over the last 40 years the models have become similar to one another. As a result, today it is hard to speak of pure – model – solutions because these are in fact hybrids based in varying degrees on individual basic versions[2].

According to OECD, health systems in the world are subjected to similar pressure but the response to this pressure is varied because in each country public policy makers and stakeholders conduct various debates concerning the organisation and financing. Sometimes they adopt the perspective of deliberation on the amount of expenditure for this purpose (as in the US), the government's role in co-financing of costs (as in Sweden or Canada), or the issue of restrictions in health care (Germany, the Netherlands). It is, however, only a certain cutting of very complex reality. Solving real problems must be preceded by an analysis of institutional issues in the context of the historical trajectory of development.

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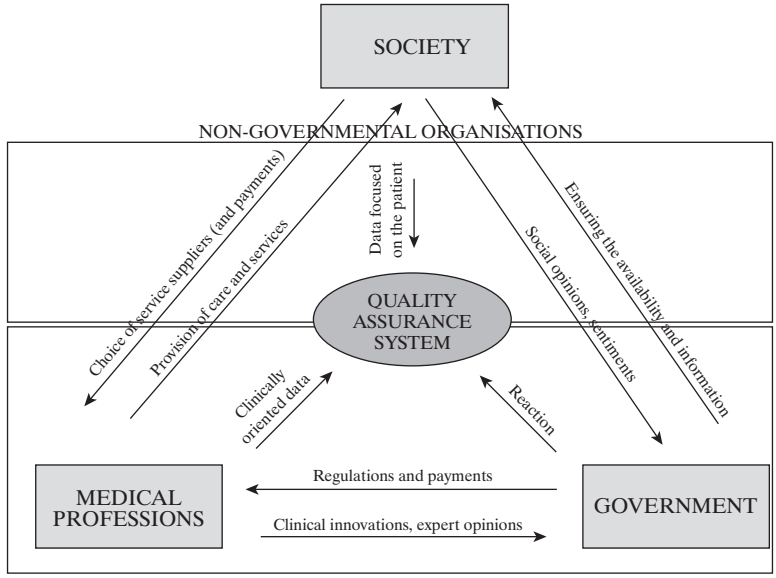
1 The text is based on the material developed during the realisation of the project of the National Science Centre 'Application of the interactive governance method in shaping social policy of the state'.

2 Rothgang, H. 2010. The converging role of the state in OECD healthcare systems. In Rothgang, H. et al. *The state and healthcare, comparing OECD countries*. London, p. 237.

As the OECD research shows[3], citizens living in a centralised health care system or a model of national health systems are more likely to support greater government involvement in health care. Those who live in an insurance system are more sceptical in this respect. It seems that this can be explained by reluctance of societies to experiment in the field of such important public policies. Hence the commitment to the existing model and the consent to deepening it, which is seen as less risky than the introduction of elements of a foreign system. In the literature[4] it is stressed that health care systems are complex adaptive systems (CAS), which results in their significant unpredictability and resistance to changes introduced by means of classic authoritarian tools.

Figure 1

Interactions in the process of building a quality assurance system in health care



Source: own study – expansion on the basis of Kodat, *op. cit.*, p. 266.

[3] Kikuzawa, S., Olafsdottir, S., Pescosolido, B. 2008. Similar pressures, different context: public attitudes toward government intervention for health care in 21 nations. *Journal of Health and Social Behavior*, vol. 49, no. 4, December 2008, p. 386.

[4] Brest, A., Greenhalgh, T., Lewis, S., Saul, J., Carroll, S., Bitz, J. 2012. Large-system transformation in health care: a realist review. *The Milbank Quarterly*, vol. 90, no. 3, September 2012, p. 423.

The area of social policies is very little susceptible to quantification, or even measurement of the quality of services because, for instance, there is no unified method for measuring the results of clinical procedures, or even widely accepted definition of their quality. What is more, universal social and health security is a rule in developed countries. The government must, therefore, on the one hand, enforce cost control and thinking oriented towards economic efficiency. On the other hand, it must take into account a key group – doctors – who passionately defend their professional autonomy. Then there are patients – often represented by their attorneys – who demand maximum space to make decisions about the treatment and often in the areas that require professional competence[5].

The above diagram illustrates interactions that occur between the main actors in building a health care system ensuring the quality of services, albeit implemented with respect to economic efficiency. In order to obtain satisfactory results, it is therefore necessary to find a balance of power between the three entities mentioned above.

Reforms implemented in the spirit of governance focus primarily on strengthening the position of society which usually has been a too weak partner, in particular in relations with the administration acting in the field of the empire. This convention emphasises, however, also the participation of NGOs in co-management, which in the above diagram fit in the regions of its central point – a little closer to the public or the medical profession depending on the profile. They can primarily play the role of a relay of information, an aggregate of public sentiment, a support system, or an arbitrator in emerging disputes. Their place would be, however, in principle outside the area defined as a formal management structure. Depending on the intensity of the stimuli – the health care system in the given country is more oriented to the needs of the patient or general notions of clinical effectiveness.

At this point we should note that the above diagram shows that formal structures do not cover the entire space of interaction in this field. They leave a lot of space for non-formal interactions which affect the quality of the system to a similar extent. *Ergo*: it is impossible to build an effective health care system only on the basis of formal actions. It is necessary to perceive real interactions in their whole complexity and to use methods of soft law or informal channels of communication and decision-making. This, in turn,

[5] Kodate, N. 2010. Events, public discourses and responsive government: quality assurance in health care in England, Sweden and Japan. *Journal of Public Policy*, no. 30, p. 264.

fits into the purpose of this article – i.e. into the search for manifestations of solutions using co-management in deciding about public issues in the area of social policies.

METHODOLOGY

This study is a legal analysis taking into account a broad economic context. Thus, an economic analysis of the law is a research perspective which was adopted here. This interdisciplinary convention assumes the treatment of the law just like any other object of research, which economics deals with, while recognizing its whole juridical complexity. The reference of the above assumptions to the thematic scope of the text implies its purpose – i.e. search for such solutions in the creation and application of the law, that will enhance the effectiveness (in terms of Kaldor-Hicks), and more generally contribute to the maximisation of social welfare.

It should be emphasised, however, that the limitation to only such assumptions would be insufficient, because this study concerns the protection of human health and life and a decent existence, which often escape the economic quantification. Hence the need to supplement the discussion with the context of non-economic values, allowing us to take into account the impact of public policies that are analysed here on wider social reality.

The preparation of this text was preceded by conducting comparative research in the field of the law system (normative acts, soft law) in the area of health policy in selected developed countries in terms of the level of implementation of the demands of the concept of governance in a dynamic perspective, taking into account the current direction of changes and projected trends.

The conducted analysis of public policies will focus on those elements that allow for the fullest realisation of interactive management. In order to show the context, the discussed practices will be also assessed from the perspective of implementation of the demands of New Public Management, understood as a modern form of managerial approach to administration. The central place in the analysis, however, will be occupied by the concept of governance (good governing), the essence of which is to make decisions and take actions which are characterised by engaging all stakeholders, the rule of law, transparency, responding to social needs, striving for consensus, taking into account voices of minorities, efficiency, as well as broad responsibility towards society. Eight countries characterised by high socio-economic

development were chosen for the analysis: Australia, France, Japan, Canada, Germany, the United States, Sweden and the United Kingdom. The group chosen in this way allows us to observe differences between various traditions, to indicate characteristic solutions, compare the operation of the most important mechanisms in order to evaluate individual institutions in order to identify good practices. Only on this basis it is possible to correctly propose postulates *de lege ferenda*. Proposing such conclusions will be possible also because the analysis of health care and social systems of the above countries concerns not only the current state, but is made in a dynamic perspective, allowing us to observe the basic directions of reforms.

Analysis of selected good practices in developed countries

Table 1

Overview of good practices in the context of the concept of New Public Management and Governance, own study

Dimension	Governance	NPM	Examples of good practice
Marketisation		+	**Australia** – a system of incentives for taking out additional health insurance (1) **Germany** – a wide range of private insurance – alternative, supplementary and complementary (2) **USA** – a system of incentives for small entrepreneurs to take out health insurance policy for employees (3) **United Kingdom** – reforms that paved the way to outsourcing of non-core elements of hospital operation (feeding, cleaning) (4)
Empowerment / participation of recipients of public policies	+		**Australia** – e-health, remote consultations (5) **France** – the institution of a 'preferred doctor' which rewards the best doctors, and is not based only on the mechanical system of premiums per capita (6)

Co-creation of public policies by external entities	+		**France** – broad inclusion of representatives of all relevant stakeholder groups already in the early stages of work on reforms (7) **Canada** –inclusion of representatives of the medical community in preparing healthcare system reforms – including the implementation of changes also through formal agreements between public authorities and this professional group (8) **Sweden** – multidimensional and far-reaching decentralisation leaving Swedish local government units a lot of flexibility, while maintaining effective – albeit non-invasive – national coordination mechanisms (9)
Responsiveness	+	+	**France** – widely implemented programme of surveys of recipients of public policies, the aggregate results of which are publicly available (10) **United Kingdom** – Healthwatch, which constitutes a genuine opening to feedback from recipients of public policies and provides a convenient channel to communicate demands (11)
Conducting public policies based on evidence	+	+	Japan – Japanese Council of Health Care Quality and use of independent entities for broadly delineated evaluation of health care services and granting of certificates to distinctive entities on the basis of methodology developed by independent scientific communities (12) **Canada** – the project Knowledge to Action for System Transformation (KAST) providing fast and systematic information about the effects of healthcare system reforms (13) **Germany** – the quality management system implemented at the providers of public services, covering, among others, professional training of doctors, improving procedures, or the obligation to publish the results of 182 indicators defined at the federal level (14) **Sweden** – entities providing guidelines based on scientific evidence which share the responsibility for the realisation of public policies (15)

/1/ According to the **Australian** government the private sector providing and funding medical services is a very important element of the health care system. Therefore, the government subsidises 30% of private health insurance to people who want to buy such insurance. Moreover, a number of other

incentives for people using private health care have been implemented. The majority of issues relating to private health insurance are regulated by the law on private health insurance of 2007. When the number of private insurance began to decrease local authorities introduced far-reaching financial incentives under the banner of lifetime health care which were particularly beneficial for person choosing private health protection at a young age – at the beginning of their career. It effectively restored the attractiveness of private insurance policies.

/2/ In connection with numerous **German** healthcare system reforms, which, among others, have introduced a wider range of patients' co-payment, a significant increase in the number of people opting for alternative insurance, or private insurance can be observed. The private insurance sector also includes supplementary insurance, under which the insured persons are guaranteed the right to choose a doctor and a higher standard of accommodation during hospitalisation (single or twin rooms). The third private insurance sector consists of complementary policies, in which the scope of protection covers surcharges to the services offered by the public sector. The rapid development of this sector began in 1996 when prosthetic treatment was excluded from the scope of services (re-added to the medical service basket in 1999) and surcharges for other areas of dental treatment were significantly increased[6].

/3/ According to the assumptions of the Patient Protection and Affordable Care Act (Obamacare) adopted in the **US**, the law is designed to encourage employers to insure their employees. According to the reform entities that employ 50 people or more mandatorily have to insure their full-time employees, or they will be fined. This provision caused a lot of excitement and discussion among low-paid workers in the United States. They feared that employers in order to avoid paying health insurance could reduce their working time. Small enterprises employing less than 50 people, according to the law, are not required to provide health insurance for employees. However, the law provides substantial tax relief for employers in this respect. Since 2010, in the United States we can talk about the real sharing of responsibility for health care between the government, employers and individual entities. The aim is to provide all Americans with access to 'affordable and high-quality' health insurance. This system, however, is fragmented. There are still significant problems, for example, related to the issue of its universality.

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[6] Kruszewska, X. 2009. Niemcy – systemy opieki zdrowotnej na świecie. [Germany – health care systems in the world.] *Świat Lekarza*, no. 5.

/4/ Undoubtedly, the creation of space for the existence of business mechanisms on the **British** grounds were Griffiths' reforms, which outsourced some services from hospitals – initially cleaning and feeding, but it has led to significant functional privatisation.

/5/ **Australia** is one of the pioneers in the use of electronics in health assistance. E-health tools are mainly accessories recording medical parameters of the patient cooperating with the patient's smart phone. The data obtained in this way are much richer – measurements can be carried out very often – and they enable doctors quick and remote access. What is more, in cases of emergency the system can quickly and independently call for help. Australia is also a country in which the use of consultation using video conferencing was particularly needed as many people in fact live in rural areas far away from larger centres.

/6/ In 2004, a new approach to the management of public insurer liability was presented in **France** – mainly in the context of the financial condition of the health care system. Also the basket of medical services was defined, a framework for the amount of paid services was introduced and a space for collective negotiations with providers of health services was created. Moreover, a model of a 'preferred doctor' was introduced. A system of financial incentives was provided for physicians indicated by a greater number of patients, while limiting the simple principle of payment per capita. However, these reforms have failed to improve the efficiency of the system by reducing the number of unnecessary visits to specialists[7].

/7/ The **French** Ministry of Social Affairs, Health and Women's Rights, which is responsible for the coordination of the local health care strategy, precedes the majority of its planning and regulatory activities with wide negotiations to which service providers, insurers, representatives of employees are invited. As a rule, a consensus worked out in such a group becomes the subject of legislation passed by the parliament. And although over the last two decades we have seen a rather expansive state policy in this area, its main purpose is to control the balance of revenues and expenses associated with health care[8].

/8/ The **Canadian** primary health care reforms seem to be of particular interest. They were held on the basis of the deeply rooted tradition of autonomy and self-governance of the medical community, as well as strong

[7] Naiditch, M., Dourgnon, P. 2009. *The preferred doctor scheme: a political reading of a French experiment of gate-keeping*. Working paper. March 2009, p. 11.

[8] Mossialos, E., Wenzl, M., Osborn, R., Anderson, C. eds. 2015. *International profiles of health care systems 2014*. London, p. 53.

powers conferred to the authorities of each province. Hence, the fact that in principle all entities got involved in the reform process on a voluntary basis must be considered a major success. Key innovations in public policies were often built into a formal agreement between medical associations and the government or the minister of health. The scope of the activities covered therefore systems with various methods of payment, remuneration of doctors and functioning on the basis of non-uniform organisational models[9].

/9/ The **Swedish** Law of 1982 on health and medical services specifies that the responsibility for providing adequate care to everyone who lives in this country is assigned to regional and municipal level authorities. This act also gives a relatively high degree of freedom to local government units in how to realise this task. This corresponds to the firmly established tradition of extensive local and regional government in this country. The Ministry of Health and Social Affairs is responsible only in general terms for health policy. It is also worth mentioning that in this area a supportive role is played by eight government agencies involved in specific aspects of public policies related to health and social care. Most reforms in Sweden, however, have a regional or local character, and are implemented by local authorities. It is a natural implication of far-reaching decentralisation. The majority of reforms focus on improving primary health care and on better coordination of benefits for seniors[10].

/10/ One of the most visible manifestations of the implementation of the model of public co-management in the field of health and social policy in **France** are programmes of nationwide surveys of patients conducted since 1998. They are organised twice a year and pertain to public perception of the availability and assessment of the quality of services. The aggregated results are public. The French model creates a large space to make choices by individual actors. Patients have considerable freedom in the choice of doctors and – within the limits of rationality – methods of treatment. Also, doctors and other staff can move freely between jobs, which opens the way for the flow of human resources on the basis of market mechanisms.

/11/ The **English** reform of 2012 played an important role from the point of view of principles of public co-management. It established the authority called HealthWatch England, whose task is to take care of patients' interests. This is done through local representatives who collect complaints on services and prepare reports submitted to the headquarters. As a result, it is possible

[9] Hutchison, B., Strumpf, E., Coyle, N. 2011. Primary health care in Canada: systems in motion. *The Milbank Quarterly*, vol. 89, no. 2 (June 2011), pp. 262–263.

[10] Anell A., Glenngard, A., Merkur, S. 2012. Sweden. Health system review. *Health Systems in Transition,* vol. 14, no. 5, pp. XIX–XX.

to initiate control measures and legislative changes. It is therefore a genuine opening to feedback from recipients of public policies and the creation of a suitable channel for the transfer of demands, and thus in effect also – indirectly – the inclusion in decision-making processes. From the perspective of the model approach, there is, however, the lack of the division of responsibilities, which does not let us regard this reform as complete.

/12/ In **Japan**, the Health Care Quality Council was established in 1995 and has functioned since then. The idea of the use of evaluations made by third parties was born there as a result of good experience with the activities of the group of volunteers – scientists who evaluated the quality of care in individual hospitals. They did it in over 100 categories, in order to grant the final evaluation in a five-point scale. In some environments the venture was accompanied by scepticism arising from contesting the methodology, or only partial availability of the results because this group published only the list of the best hospitals – to which they granted accreditation. The lack of experience in making peer reviews, typical for the Japanese medical community, also caused difficulties[11].

/13/ The realisation of the concept of co-management in the conduct of public policies undoubtedly requires properly organised knowledge resources. Hence, a very interesting **Canadian** project Knowledge to Action for System Transformation (KAST), which was to provide quick and systematic information about the effects of the reform of the Canadian health care system on the example of Saskatchewan province. The aim was to investigate four strategic initiatives: health care oriented towards an individual patient and family, the improvement of primary health care, the reduction of health administration and shorter waiting times for surgery. Four operational objectives were set up in this project:

1. The identification of the scope of successes and failures of the large system transformation (LST) in the context of the role of provincial authorities with regard to the implementation of national policies.
2. Deeper understanding of the mechanisms which determine the success of the reforms and their relation to different contexts.
3. The identification of barriers and challenges which should be solved by the government.
4. The determination of the possibility of monitoring and evaluation of processes and the effect of large systemic transformations[12].

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11 Kodate, N. *op. cit.,* pp. 279–280.

12 Cf. Brest, A., et al., *op. cit.*

/14/ In **German** health care policy, quality in structural terms is guaranteed as a result of the requirement that each service provider has implemented a quality management system. In this framework, among other things, professional training of doctors, and improvement of procedures take place. Each new method must be thoroughly verified and approved in the formal procedure. Each hospital is obliged to publish the results of 182 indicators defined at the federal level, which is intended to make it easier for patients to compare these institutions[13].

/15/ In **Sweden**, there are both public and private service providers in the field of health protection. Public funding is, however, the rule. The law of that country constitutes an obligation to apply the latest scientific knowledge, and formally accepted standards of conduct by medical personnel. National Board of Health and Welfare provides in this area evidence-based guidelines. It shares responsibility with other entities, in particular the Swedish Council on Technology Assessment in Health Care. This is undoubtedly an interesting manifestation of cooperation of entities which are not non hierarchically subordinated[14]. It is a model use of co-determination and co-sharing of responsibility.

Summary and recommendations

A key aspect of reforms of the social and health security system is to seek a balance of power among stakeholder groups because if one wants to include into co-management entities standing outside the administrative structures, one is naturally exposed to excessive susceptibility to certain well-organised pressure groups. It is also easy to lead to a situation where the active minority will prejudge the fate of the silent majority. Naturally it is not possible to realise full egalitarianism and some stakeholders must be treated as a priority. The pathology begins where they have a dominant role and use it for serious undermining of the public interest.

It seems that in the area of health care efficient co-management can be introduced only where advocates of patients and their associations are well organised and if the government has already built some positive experience in cooperating with them. Associations representing the medical profession are in fact relatively strong in all the analyzed countries and without coun-

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13 Mossialos, E. red. et al., *op. cit.,* pp. 68–69.

14 Anell, A., et al., *op. cit.,* p. XVI.

terweight in the form of lobbying of patients' representatives there is a significant risk of distorting the system.

We can put forward the thesis that reforms introducing privatisation of certain areas or outsourcing of services traditionally performed by the state in the area of health care may find fertile ground after breaking the mental resistance connected with risks of too far-reaching commercialisation moving the dignity of the human person out of sight. It is evidenced by the growing number of additional insurance, or deciding on treatment in private, commercially operating facilities. Thus, this type of reform would use the already occurring processes to build a coherent and effective model, in which public and private components are conducive to the maximisation of social welfare.

Demographic reasons are undoubtedly an aspect which increases negative effects of the existing dysfunctions of public policies in the social area. The process of aging of societies – typical of developed countries – highlights the need to reach for the most effective tools because even the richest countries are not able to increase the financing of this sector at such a rapid pace.

There is no denying that the implementation of reforms, an essential component of which are cuts in the availability and funding of services is very difficult. What is more, if we bring the theory of public choice to the fore, such changes are impossible to carry out in democratic systems. For example, it is difficult to expect that any Polish government in the next few years would decide to implement even small co-financing of certain benefits, although most commentators believe it is a much needed procedure for the Polish system. Due to the enormous social reluctance and the fact that a large part of citizens treat this area of public policy as a priority, you cannot expect to see such reforms unless politicians, in fact, are deprived of any other choice.

It seems, therefore, that skilfully introduced reforms based on the principles of New Public Management and governance are a reasonable alternative here because they make it possible to increase the efficiency of the system also by using other tools than just limiting the availability and lowering the quality of services. Some of these best practices have the character of general recommendations, the aim of which is to outline the general direction of changes. Most, however, are *de lege ferenda* postulates that after taking into account local contexts could be implemented to legal systems of other countries. Their general tone seems to affirm the methods of interactive public management and inclusion of a wide range of stakeholders in the decision-making process, which should, however, be carried out with simultaneous sharing of responsibility because health policy, which is one of the areas so

crucial to the community, cannot be effectively managed in a centralised, bureaucratic and authoritative way.

Finally, the implementation of proposals of governance is an opportunity to build effective policies in the social area. As the experiences of the countries analysed in this text show, this approach favours the creation of a system giving society high satisfaction with rendered services without the destruction of public finances. Naturally, this is not a sufficient condition as there are examples of countries which despite the relatively high level of use of the concept of governance have a system of social and health care distant from efficiency and high quality. The question whether the implementation of these principles is a necessary prerequisite remains open.

The question of the possibility of establishing a system of public policies in the social area without the use of the concept of governance, however, remains outside the scope of this study. The analyses carried out in this report, however, entitle us to articulate the conclusion that reforms using interactive management solutions are conducive to the efficiency of health care systems in developed countries and are, therefore, worth a recommendation for other countries.

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THE USE OF GOVERNANCE INSTRUMENTS IN HEALTH POLICIES OF DEVELOPED COUNTRIES

Summary

This text is an analysis of selected aspects of public policies in the field of health care in developed countries. They are tested for implementation of the Governance concept. The aim of the study is to show the results of this analysis as a catalogue of good practices, which can provide recommendations for other countries, because implementation of governance is an opportunity to create effective policies in the social area.

WYKORZYSTYWANIE INSTRUMENTARIUM WSPÓŁZARZĄDZANIA PUBLICZNEGO W POLITYCE OCHRONY ZDROWIA W KRAJACH ROZWINIĘTYCH

Streszczenie

Niniejszy tekst jest analizą wybranych aspektów polityk publicznych w obszarze ochrony zdrowia w krajach rozwiniętych. Są one badane pod kątem realizacji postulatów koncepcji *Governance*. Celem opracowania jest także ukazanie wyników ww. analizy w formie katalogu dobrych praktyk, które mogą stanowić rekomendacje dla innych państw. Realizacja postulatów *Governance* jest bowiem szansą na zbudowanie efektywnych polityk w obszarze społecznym. Jak pokazują doświadczenia państw analizowanych w niniejszym tekście, takie podejście sprzyja kreowaniu systemu dającego społeczeństwu wysoką satysfakcję ze świadczonych usług bez destrukcji finansów publicznych.

Использование инструментов совместного публичного управления в области здравоохранения в развитых странах

Резюме

Предлагаемый текст содержит анализ некоторых аспектов государственной политики в области здравоохранения в развитых государствах. Они рассматриваются с точки зрения постулатов Governance *(управления)*. Целью исследования является также представление результатов вышеупомянутого анализа в форме каталога передовой практики, которая может быть использована в качестве рекомендации для других государств. Реализация постулатов Governance представляет собой, в связи с этим, шанс для создания эффективной политики в социальной сфере. Как показывает опыт государств, анализируемых в данном тексте, такой подход благоприятствует формированию системы, обеспечивающей обществу высокую степень удовлетворённости оказываемыми услугами без разрушительных последствий для государственных финансов.