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Contents

The complexities of decentralization

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A common challenge across the majority of countries in Europe is finding the appropriate level for the making and implementation of policy and administration, particularly in health care. Many countries have decentralized, recentralized and then decentralized again in an ongoing cycle, searching the right balance of efficiency and responsiveness in their health care system. Looking at the arguments for and against, in many cases the same reasons are used to justify movement in opposite directions. So is decentralization purely a politically driven phenomenon or is it the wrong instrument used for the right objective?

Arguments for and against decentralization have been put forward for many years. In the later part of the 19th century John Stuart Mill stated that "local provision is able to put to use local goodwill, enthusiasm and knowledge. Services can be more easily tailored to the requirements of local people which can vary greatly from one place to another". Countering this approach, most commonly, are arguments that have at their heart the belief that greater efficiency and cost effectiveness is possible in more centralized systems.

These debates are still current and decentralization is a highly contested process across Europe. In most countries you will find passionate proponents either for or against it. At its most straightforward, decentralization refers to the transfer of powers and responsibilities from the national to the local level, with centralization being movement in the opposite direction.

Decentralization and health care

The evidence to support arguments for or against decentralization in health care are ambiguous.[1] Given the complex multi-dimensional nature of decentralization this is not surprising and indeed, the lack of evidence is due in large part to the difficulties of attributing outcomes to decentralization as opposed to other health system features or changes. In reviewing the evidence Saltman et al[2] report some positive outcomes, including increased capacity to innovate, greater cost consciousness and greater local accountability; however, they also point to studies that do not find clear benefits and some that show greater inequities. The varying rationales are summarised in Table 1.

Dimensions of decentralization

Decentralization can be used to refer to different dimensions: devolution, delegation, deconcentration and privatization.[2]

Devolution is the transfer of political power from a higher to a lower level, be that national to regional, regional to local or indeed national to local.

Delegation is the transfer of administrative or policy initiation power to a lower organizational level.

De-concentration is where administration, rather than decision-making power, is transferred to a lower level.

A final but potentially more contentious assertion is that the privatization of public services, with the transfer from public to private ownership, can be seen as a form of decentralization. Arguments that some privatizations are a form of decentralization hinge on the smaller scale of the private provider, particularly if this is a transfer from state ownership.

The multiplicity of the different tiers and dimensions of decentralization placed into

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Table 1 Objectives, rationales and controversies of health decentralization

Objectives	Rationales	Issues and controversies
To improve technical efficiency	Fewer levels of bureaucracy and greater cost consciousness at local level. Separation of purchaser and provider functions in market-type relations.	May require certain contextual conditions to achieve it. Incentives are needed for managers. Market-type relations may lead to some negative outcomes.
To increase allocative efficiency	Better matching of public services to local preferences. Improved patient responsiveness.	Increased inequalities among administrative units. Tensions between central and local governments and between different local governments.
To empower local governments	More active local participation. Improved capacities of local administration.	Concept of local participation is not completely clear. The needs of local governments may still be perceived as local needs.
To increase innovation of service delivery	Experimentation and adaptation to local conditions. Through increased autonomy of local governments and institutions.	Increased inequalities.
To increase accountability	Through public participation. Transformation of the role of central government.	Concept of public participation is not completely clear. Accountability needs to be clearly defined in terms of who is accountable for what and to whom.
To increase quality of health services	Through integration of health services and improved information systems. Through improved access to health care services for vulnerable groups.	
To increase equity	Through allocating resources according to local needs. Through enabling local organizations to better meet the needs of particular groups. Through distribution of resources towards marginalized regions and groups (through cross-subsidy mechanism).	Reduces local autonomy. Decentralization may improve some equity measures but may worsen others.

Source: Saltman et al.[2]

different cultural contexts results in a complex multi-dimensional picture. Added to this are a variety of intermediate bodies that may not have a specific legal or administrative function, (for example groups of regions or local authorities which form geographically based associations) but can be highly influential in policy both regionally, nationally and on a European level. Whatever the nature of the decentralization, it is highly context-specific and relative in scope and dimension. This is particularly true for health care, where funding, purchasing and provision may be provided at different levels of the system by a diverse range of public and private bodies.

The importance of country context

Germany and Spain have strong regional governments with decentralized political, fiscal and administrative powers. However, although many see Spain as a highly decentralized country, some commentators within Spain argue that decentralization stops at the level of the regional governments – the *Autonomous Communities*. In fact it has been suggested that decentralization not only stops at the level of the region, but in some of the Autonomous Communities, powers have been centralized upwards from local government to the regional level (see case study in this issue of *Euro Observer*).

Spain is not alone in having different expressions of decentralization within one country. Historically, the United Kingdom has had very centralized political and fiscal powers; however, the greater independence of Wales, Scotland and Northern Ireland has led to varying degrees of decentralization within those countries (see case study in this issue). Looking across Europe there is a complex picture of decentralization of different scopes and scales, supported by different historical and cultural contexts.

Going in the opposite direction, Finland is a country that has recently moved to more centralization. However, in the Finnish context, this merging of local authorities transferred powers upwards to a new local government administrative level serving, on average, a population of 12 000 people within regional areas covering on average 850 000 people. By way of comparison, in Germany, the regional states (*Länder*) covers an average population of over five million people, equivalent to the whole population of Finland. Norway, too, a decade ago, decided to recentralize responsibility for hospital services away from the 19 counties to the central state, which then operated through five regional health structures (see case study in this issue). Further exploration of the arrangement of health care in other European countries reveals similar and other cultural and contextual nuances making generalizations about centralization or decentralization difficult.

Other contingent factors

Adding to this complexity, it is not sufficient to only understand the organizational and political arrangements of decentralization but it is essential to also understand the legislative and legal frameworks – and how those are implanted in relation to decentralized political and administrative powers. How much freedom has the region (or other sub-national unit) to initiate policy and changes in administration and how much immunity does it have from the national government in making those changes?

Spanish regions have very high levels of policy and administrative immunity and initiation whilst regions in England and the Netherlands operate at a much lower level. In some countries the style and content of the regulatory framework can have a greater impact on the level of local initiation than the legislative framework. For example, in the Netherlands, the strong system of health care regulation pushes against the freedom of the commissioners and providers, creating a higher level of uniformity within a market system than in many other parts of Europe.

Underpinning some of this variation might be the differing perceptions of the legitimacy and competence of local government. For political devolution, the legitimacy of the local or regional tier is essential and for administrative devolution a solid infrastructure is helpful. Page and Goldsmith[3] have equated this challenge with determining what should be the powers and capabilities of local or regional government in modern states. The strength of legitimacy claims can be seen in Europe, for example; many Scandinavian countries with a strong history of powerful regional and local government have devolved responsibility for healthcare to the regional or local level.

Arguments for and against

Comparison across Europe is difficult given the complex nature of the arrangements, the importance of the underlying historical context and the lack of strong evidence. However, across Europe there is some consistency in the arguments put forward by the centralizers and decentralizers which tend to follow familiar themes.

Ironically, it seems that the key arguments of enhancing efficiency and bolstering democracy are used by both sides of the debate. Achieving allocative efficiency is cited as a reason to centralize in order to allow for the distribution of funds across a national population according to need. However, it is also often argued that decentralization, which would bring the planning and prioritization of services to a lower level, allows for a more sensitive local mechanism to target populations in greatest need.

Cost efficiency is also a contested rationale used by both sides of the debate, with economies of scale cited as a reason to centralize while decentralizers point to savings achieved through less duplication and better targetting of services. Greater local democratic control and greater control by local people can be a strong argument for decentralization but centralizers contest this, citing the low turnout at local elections in many countries and positing other mechanisms for effective involvement of patients and citizens.

If nothing else, the ferocity of some of the arguments for and against decentralization highlights the political nature of the decisions. What is probably more interesting than the arguments for and against decentralization is developing an understanding of the problems that it is trying to solve. In many countries this is about how a range of services can be appropriate and accessible to local populations, effectively working together to meet the local needs of citizens and patients. Meeting this challenge might be about decentralization but it is in large part also about how we manage our health and social care services and our systems.

The freedom and flexibility we give to our front line staff and managers to adapt and tailor services to meet needs and the requirements we place upon them to engage with their broader communities is crucial. Moving power up and down geographical or organizational levels may be one way of addressing these challenges but every country (centralized or decentralized) can point to areas where this is done well, suggesting that while some of the answers might lie in the system structure, many of them lie in broader issues of culture and management.

References

1. De Vries MS. The rise and fall of decentralization: A comparative analysis of arguments and practices in European countries. *European Journal of Political Research*, 2000;38(2):193–224.

2. Saltman RB, V Bankauskaite, Vrangbaek K (eds). *Decentralization in health care. Strategies and Outcomes*. Maidenhead: Open University Press, 2007.

3. Page EC, Goldsmith M. *Central and Local Government Relations*. London: Sage, 1987.

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Centralizing England and decentralizing the United Kingdom: The paradox of power in British health services

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Health policy in the United Kingdom is a paradox of simultaneous centralization and decentralization. On one hand, since the 1998 creation of devolved governments for Northern Ireland, Scotland, and Wales, their and England's health policy worlds have drifted further apart, with little interest or coordination across borders. On the other hand, within each jurisdiction, and particularly England, every minister has made greater and greater claims to control the system, at the expense of intermediate organizations such as the medical profession or NHS boards.

The two movements might seem contradictory, but they are not. They merely reflect the geography of national identity in a multinational state. To put it simply, it turns out that voters anywhere in the UK seem to care much more about equality within England, Northern Ireland, Scotland and Wales than about equality within the UK. Whichever politicians are responsible for a system forge ever more invasive and specific, if not necessarily effective, tools to intervene in the system's priorities and processes and care ever less about what other politicians do in other systems.

Constitutional and political structure

The UK has four component units: England, Northern Ireland, Scotland, and Wales. Since 1998, there have been elected legislatures and governments in Northern Ireland, Scotland, and Wales; their creation is known as "devolution" and they are referred to as "devolved administrations". The three devolved administrations have responsibility for health and most personal social services, which are all national health service (NHS) models with universal access paid for out of general taxation and organized around gatekeeper models. The UK central government retains responsibility for the tax, income replacement and cash benefit systems. The devolved administrations are financed out of UK general taxation, with new funds allocated on a per-capita basis (per the "Barnett formula") and existing funding giving them slightly higher levels of per-capita expenditure than England.

England is the anomaly. It makes up 84–85% of voters, population, and the UK economy, and has significant divergence in economic fortunes, health status, and overall per capita government spending between its regions. It is also directly ruled by the UK government. So English health policy is made by a UK government, elected by the whole UK electorate, while Scottish or Welsh health policy is made by Scottish or Welsh governments.

It is unlikely that a policy analyst would design such a country with a clean sheet of paper, but then again the allocation of authority is never a technocratic process. It reflects the map of nationalisms in the UK. The English, however diverse they may be, show no interest in a decentralized England. A referendum on a regional government for the most apparently pro-autonomy region, the Northeast, failed spectacularly.

The Scots and Welsh do have a consensus on the importance of their autonomy, and the structure of devolution serves that. Northern Ireland's devolution is part of its peace process; while its policy issues and political culture are certainly distinctive, the main reason for devolution is that it is a compromise between the two unsustainable alternatives of integration in the UK and integration into Ireland.

Health system organization

All four systems are NHS systems, with hospitals owned by the government and primary care doctors contracting with the government. They are funded out of direct taxation (allocated to the devolved administrations as part of their block grants).

In each of the four jurisdictions, we have seen greater claims to authority by the center – the devolved administration or, in England, the UK government. Ministers, charged with providing equal access at a reasonable cost, have invented more and more mechanisms for cost containment and, latterly, quality improvement. The list of these mechanisms is long; the UK is both an early adopter and major global innovator in health policy ideas. Their common denominator is that they erode the power of intermediate bodies such as territorial boards and organized professions, replacing them with regulators, management initiatives, and precisely orchestrated market systems designed to balance cost and quality in a government's preferred manner.

Centralizing Northern Ireland, Scotland, and Wales is not that hard. Scotland has an integrated NHS with 22 boards, 14 of them territorial units that provide a full range of health care and the rest specialist organizations responsible for issues such as health promotion or ambulances. That means the key executives of NHS Scotland can (and do) fit around a table, leaving metaphorical and sometimes literal room for other important players in Scottish health care. Wales is reorganizing into ten boards, similar to those in Scotland, with seven integrated territorial boards and three specialist ones. Northern Ireland is formally keeping a purchaser-provider split, but its reorganization also reduces the number

of organizations and lodges planning responsibilities in a single "commissioning" body.

England is far larger and more fragmented, so it generates and absorbs more policy ideas intended to fine-tune the NHS's balance of cost and access concerns. Margaret Thatcher found an extraordinarily decentralized health system in 1979; for many issues (such as procurement of high-technology equipment) it was difficult to find any responsible person in Whitehall. Appointed territorial boards and professionals basically ran the NHS.

Thatcher began the secular trend of centralization and policy development by creating a general management function from 1983 to 1989, headed by a Chief Executive of the NHS and some boards, whose makeup varied. In 1989, the UK government famously introduced a purchaser-provider split, allowing general practitioners (GPs) to choose where to buy care for their patients.

Labour, in 1998, focused first on management and money, massively increasing spending and target-based "performance management". This had the compelling advantage of delivering electorally salient targets, such as reduced waiting times for elective surgery and primary care appointments. It then followed the Conservatives in trying to engineer a market-based system that would produce efficiency and quality through market incentives, DRG-style tariffs, and (a Labour addition) much tighter regulation. It also struck a blow against territorial inequality ("postcode prescribing") with NICE, the National Institute for Health and Clinical Excellence, which enunciates general standards of care and recommends different procedures and medicines.

The result was that by 2010, when Labour lost office, the NHS had three separate kinds of central control. One was direct management, in which the government gave targets to NHS organizations. Another was regulation, in which the government created a specialist regulator charged with ensuring quality (such as the Care Quality Commission) or financial stability (such as Monitor, which oversees Foundation Trusts). The third was finely designed market mechanisms, which are supposed to ensure efficiency through carefully calibrated incentives.

The new Conservative-Liberal Democrats coalition government has taken the logic to an extreme, proposing to abolish all the territorial commissioners. Should the extraordinarily large reorganization happen, tightly regulated groups of doctors subject to a central Commissioning Board will negotiate care with regulated autonomous hospitals. The simplest and most time-consuming form of management, direct performance management, will have given way, but the government will have sculpted the system and be able to intervene through the Commissioning Board or regulators.

The big losers since 1983 have been the formerly autonomous intermediate groups. Territorial boards were more and more tightly controlled and lost more and more power to the market mechanisms, until the final announcement of their abolition in 2010. Professionals, especially doctors, had formally run much of the NHS until the mid-1980s, but have lost most of that role. More and more aspects of their practice are regulated by the new quality regulators, in which they have less and less say.

The driving force, spanning governments of different colors and ministers of different styles, is the endless difficulty of controlling costs without damaging quality in a system that tries to provide universal access. They put their energy into designing systems to make it happen. What we do not know is how effective these mechanisms are on the ground. Eliminating territorial units or particular professional roles is one thing, but eliminating the effects of territory or professionals is another. Governments since Thatcher shouldered the doctors and territorial boards aside and took the controls. It is not clear just what those controls actually control.

Finance

Finance tells the same story: the increasing centralization of England, in the name of access, efficiency and quality; and the increasing decentralization of the UK, in the name of national autonomy.

The NHS system, when created in 1948, inherited a highly unequal landscape of services that was deeply marked by the caprice of donors. Rich towns and London had more hospitals and doctors; rural areas and poor areas were underserved. The postwar history has been of policymakers awakening to this reality and trying to change it, replacing local initiative and inequity with national expenditures.[1]

In 1968, a Hospital Plan set out to build new infrastructure. The next step was to reallocate spending to underserved areas, through a formula developed by the "Resource Allocation Working Party" (RAWP). Over decades RAWP has narrowed the gaps. Likewise, the new financial formulae adopted by the Scottish and Welsh governments after devolution also rebalanced spending towards areas of greater need. The structure of finance after the new coalition government's reform attempt remains to be seen, but presumably will allocate money to GP consortia on an adjusted per-patient basis.

The diminishing intra-regional inequalities were accompanied by only small reductions in inter-regional inequalities. Spending in England, which started with the lowest per-capita expenditure, went up 55% while spending in Scotland, which started with the highest per-capita expenditure, went up only 45%. The result was a slight narrowing of the gap in expenditure between the systems.

The current government has also committed to pass a law that would transfer responsibility for about 20% of Scottish revenue to the Scottish Parliament; this would come from a share of income tax, which could thence vary in Scotland, and a number of small taxes. This will allow Scotland greater financial responsibility but does not change the underlying Barnett formula, which continues to fund Scottish government overall at a higher per-capita rate than the rest of the UK.

The UK is currently engaged in an extraordinary series of government

cutbacks, more or less unprecedented for a country without a currency crisis. Health is a protected expenditure category in England and will mathematically become a larger part of the welfare state as a result, although that is unlikely to be much consolation to a service whose costs increase substantially each year and that is about to undergo its most radical reorganization. The devolved administrations will feel the cuts though changes to their bloc budgets. They are less committed to protecting health. In each case, the result should be more efficiency as the four health systems draw back from activities that are past the point of maximal marginal productivity (no matter how socially useful). It should also mean an unpredictable environment; whether the UK government loses credibility depends on whether it can deliver such a successful retrenchment that voters forgive it the cutbacks.

Future

The decentralization of the UK is likely to continue. It is always possible that the differential expenditure in the UK could become politicized. The conservative press, which sells very few copies outside England, has long cultivated an English sense of injustice at higher per-capita funding in Scotland. Such issues become politicized, however, when political elites choose to politicize them, and it is not clear which party's leadership would choose to make an issue of it. The Conservatives have the most incentive to do so: they do best in England, face a Labour party with strong devolved support, and can reasonably view their voters as subsidizing a Scottish welfare state. On the other hand, they are committed to the Union and are not presently interested in breaking it up.

So devolution might not make sense, but it continues to work. The clean-ness of its division of powers means that coordination is mostly a problem for issues that cross borders, and the fact that no government has tried hard to coordinate can be criticized but at least means that there have been no crises. And it means that, in the absence of cross-border debate, the ideational worlds of health policymaking in the four capitals of the UK diverge-even if there are scraps of evidence that they might also compete for the better.[2,3]

The centralization of English health policy will also continue for the time being; the current reforms, should they go ahead, would be the apotheosis of centralizing policies that replace intermediate territorial and professional groups with agents of the state. Such centralization, pulverizing old centers of power in the NHS, is a powerful trend that spans political lifetimes. So long as the government is responsible for access, cost, and quality, it seems that it will continue to develop more and more ways to make the NHS produce some combination of the three that suits it.

But health policy has a long history of costly misfires; even policies that substantially increase the effectiveness of the state (for example targets) can produce unintended results (for example gaming). The longer-term question is whether greater state power over health services is worth the price in reorganization, management, and regulation.

Lessons

What does the UK experience teach the rest of the world about the allocation of authority in health care? First, the allocation of authority has health policy effects but is not always a health policy. Devolution in the United Kingdom happened because of pressure from Scottish and Welsh activists and political elites. It did not happen in England because only a few people sought it. The logic of nations, not technocracy, is at work here.

The second and most important is that decentralization can mean centralization. It is a commonplace of comparative political economy that the introduction of regulated markets can mean a more effective central state.[4,5] In fact, the insight dates back to Alexis de Tocqueville's work on the French Revolution: destroying old intermediate bodies such as territorial boards can put the government in more direct contact with its citizens, to the benefit of the government's power. So eliminating territorial boards allows GPs and regulators to be the government's presumably more effective agents in running the English NHS. By contrast, the strong territorial governments of devolution are, if anything, increasingly divergent in style.

In other words, the key issue is power. The UK relinquished much central power over the devolved administrations and seems prepared to relinquish more. But in England, and in the devolved administrations, governments take their responsibilities very seriously and are centralizing power unto themselves. How else, ministers might ask, are they to balance cost, quality, and access in a time of cuts?

References

1. Gorsky M.Sheard S. Introduction. In: Gorsky M, Sheard S (eds). *Financing Medicine: The British Experience Since 1750*. Abingdon: Routledge, 2006.

2. Greer SL. Devolution and health: structure, process and outcome since 1998. In: Lodge G, Schmuecker K (eds). *Devolution in Practice 3*. Newcastle-upon-Tyne: IPPR North, 2010.

3. Greer SL. United Kingdom. In: Costa i Font J, Greer SL (eds). *Federalism and Decentralization in Heath Policy*. Basingstoke: Palgrave Macmillan, 2011.

4. Vogel SK. *Freer Markets, More Rules: Regulatory Reform in Advanced Industrial Countries*. Ithaca: Cornell University Press, 1996.

5. Giaimo S, Manow P. Adapting the welfare state: the case of health reform in Britain, Germany, and the United States. *Comparative Political Studies* 1999;32(8): 967–1000.

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Health system decentralization in Spain: a complex balance

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In the brief time-span of a decade (from the mid-1970s to the mid-1980s), Spain was transformed from an authoritarian, centralist regime to a democratic, quasi-federalist state. The complex intertwining of these processes explains the dynamics and results of health system decentralization.[1] This article takes a look at the division of competencies between national and regional health authorities, how it works in practice and the main outcomes.

Institutional change

Political power in Spain was substantially devolved by the 1978 Constitution to 17 regions (*Comunidades Autónomas*, CAs) and two autonomous cities in northern Africa (Ceuta and Melilla), giving them wide-ranging autonomy – although some CAs have more powers than others. The agreement was that a two-chamber Parliament, elected by direct vote, and a National Government would be at the centre of a 'federal-like system without federation'. Central government would control certain policy areas (for example, defence, foreign affairs), while CAs, through their own elected regional parliaments and governments would exercise their own legislative and executive authority over an increasing number of policy fields, including health (the protection of which was recognized as a Constitutional right).

The division of responsibilities in health care was designed as follows:

- Central government is expected to provide a common basic framework for health and health care in order to ensure equity, cohesion and common quality standards;
- Implementation is the responsibility of CAs, which spend 89.81% of public funds – which are mostly (not earmarked) budget transfers from the state;
- Each CA has a regional health department and health minister responsible for health policy within the region plus a health service which manages service delivery; jointly they handle around 30% of each CA's total budget.
- Health policy coordination between central government and CAs is ensured though an Inter-Territorial Council (*Consejo Interterritorial*) without executive power (it only provides "consensus recommendations to promote cooperation and exchange of information towards equity") with representatives from the central and each regional health department.

In 1986 the country's social health insurance system was transformed into a tax funded national health system (*Sistema Nacional de Salud*, SNS)* with decentralized governance offering universal coverage to all residents, including immigrants.** The principles of universal provision, equity in access to services, system integration and decentralization were ratified as founding principles of the health system by the SNS Cohesion and Quality Act (2003), which shaped the current decentralization. Today, primary health care is provided by publicly salaried professionals (one doctor and nurse for every 1500 inhabitants with numerous prevention programs) and 71.2% of all available hospital beds are in the hands of the public sector (with 40% directly owned and the remainder subcontracted from the private sector), including 80% of acute care beds, 36% of psychiatric beds and 30% of long-term care beds. According to national surveys there is generally a high level of user satisfaction and system legitimacy. For example, a combined total of 69.2% of respondents agreed that "the SNS works quite well" and "works well yet needs changes".[2]

Positive effects

Decentralization has certainly coincided with and most likely contributed to positive effects in Spain, particularly in terms of improvements in health outcomes. For example, average life expectancy at birth rose from 72.88 in 1970 to 81.24 in 2008 while the infant mortality rate fell substantially from 20.78 per 1000 live births to 3.35 over the same period.[3,4]

Spain now enjoys a high position in most world health outcomes rankings. It is 4th in average life expectancy at birth (3rd for females), 4th in life expectancy at age 65 and occupies 4th best place in rankings for female potential years of life lost. It has below-average infant mortality compared to other EU countries (ranking sixth in the average annual rate of decline since 1970) and among the lowest mortality rates for top causes (cardiovascular diseases, cancer and respiratory diseases) in Europe since 1970. The only area in which Spain shows clearly worse outcomes is in diabetes-related lower-limb amputations, with 26.5 amputations per 100,000 in 2006, compared with the OECD average of 14.9 amputations.[5]

Moreover, reductions in avoidable mortality[6] during the period 1991–2005 suggest that there is substantial health care access, quality and safety of services. A similar picture of improvement emerges for the five-year relative survival rates for selected cancers (breast, colorectal and lung) from 1990 to 2002, which are comparable to the advances made in France, Germany, Italy and the United Kingdom.[7]

Importantly, such results have been achieved with what seems to be a very efficient level of expenditure in terms of international comparisons – in 2007 Spain

*Between 1948 and 1985 the social health insurance system was financed by compulsory contributions (covering first workers and later their families).

** Only 0.5% of the population, consisting of high-income, non-salaried individuals refuse to be registered.

spent US$2671 per person, or 8.5% of its GDP on health care, versus 16% in the United States.[5] Looking at the percentage of revenue by source, public sector funding represents 71% of the total*, out-of-pocket direct expenses (mostly for pharmaceuticals) is 22.5% and private insurance 5.5%. As a percentage of public funds spent, specialist care represents 54% of the total, pharmaceuticals 19.8%, primary health care accounts for approximately 16%, and prevention and public health some 1.4% (with the remaining 8.8% in the 'other' category).[8]

In summary, there is consensus that the decentralized health system in Spain (coinciding with a period of sustained economic growth in the country before the financial crisis began in 2008) has stimulated investment in health care, encouraged flexibility and innovation in the delivery of health services and fostered approaches that are attuned to local preferences.[9]

Tensions and challenges

Despite these successes, some tensions and challenges that were always there have become increasingly visible. Firstly, regions have tended to over-spend their allocated budgets, with Parliament and central government having virtually no control over such expenditure.** Because of this, for some commentators, the financial sustainability of the SNS is under threat.[10]

Secondly, the Ministry of Health and Inter-territorial Council have encountered serious obstacles to effectively coordinating health and (especially) health service policies due to partisan struggles between national and regional political parties. As a result, geographical differences in health outcomes and financing as well as intra-region inequities arguably have changed little; average life expectancy at birth for both sexes ranges from 82.5 in Navarra to 79.8 in Andalucia.[11] Since differences in health status reflect income and wealth differences, it would be unfair to blame the health system decentralization process entirely, yet as pointed out by Montero-Granados et al 'healthcare decentralization in Spain seems to show no positive effect on convergence in health, as measured by life expectancy at birth and infant mortality between provinces… Some provinces improved their situation overtaking others but the final result is one of greater dispersion than at the start".[12]

The real issue is that decentralization has kept per capita expenditure uneven. The SNS Cohesion and Quality Law (2003) created the National Cohesion Fund to promote policies addressing geographic inequalities but it has primarily been used to pay for costs generated by patients being treated in health care facilities in regions other than their own, failing to promote the expected degree of national cohesion and reductions in inequality. Furthermore, in the period 1992–2009 the variation coefficient of expenses among regions increased – and changes in population- protected volume fail to explain such variability.[8]

Legislation was passed in December 2009 to create a new regional financial system around a Guarantee Fund for Fundamental Public Services which integrated the Cohesion Fund, and holds 80% of the resources for key public services such as education, social services and health care. Monies for the Fund are collected centrally from tax revenues and then dispersed. However, critics argue that arrangements disproportionately reflect the demands of some regions (namely Cataluña) in the context of electoral politics. Publicly funded health care expenses (budgeted) per person in 2010 still differed by €557 (ie. 40.73% of the average of €1343) between the Balearic Islands (79.37% of the average) and the Basque Country (120.84%).[14]

There is little wonder then that the Spanish health care system shows unwarranted variability in access, quality, safety and efficiency, across regions, health care areas and hospitals[6], including:

- 5-fold variation in the use of percutaneous transluminal coronary angioplasty (PTCA) between areas and 2-fold variation in mortality after PTCA (hospitals);
- 7.7-fold variability in prostatectomy rates across health care areas;
- 28 times more frequent admissions to acute care hospitals due to affective psychosis between health areas;
- 26% of hospitals with between 501 and 1000 beds are at least 15% more inefficient than the average;
- 12% of hospitals with between 201 and 500 beds are at least 25% less efficient than the standard for treating similar patients.

Remarkably, the population does seem to perceive the lack of geographical equity in financing: only 42% of respondents in the *Health Barometer* survey believe that the same health services are offered to all citizens despite region of residence, compared with around 87% who assess treatment is equal despite patient's gender and around 70% who assess treatment is equal despite a patient's social class and wealth.[2]

Other problematic aspects of decentralization in Spain include the very limited connectivity across the country and between regional health systems in terms of health information, which is based too much on resource or activity data (to the detriment of outcomes information). In spite of considerable financial investment, no systematic assessment of SNS performance, whatever the level of disaggregation, is currently feasible. In addition, there is little information on the health workforce; in the absence of any central registry, numbers of public sector staff are uncertain and whole time equivalents need to be estimated from different partial registers.

Paradoxically, devolution has had little effect on SNS staff and patients'/citizens' voice on how health services are managed. While decision-making at the national level has been clearly decentralized, processes at regional level have been rather over-centralized, copying the

* Of which taxation is 94.07%, professional mutuality schemes 2.53% and civil servants mutual funds 3.4%.

** For example, there was over 130% growth in capital expenditure in 2000–2008.[5,14]

centre, with plenty of duplication of the chain of delegation and accountability.[15] In addition, remarkably "[CAs] … have been belligerent against municipal powers … and have tried to grab their competences".[16]

Decentralization patterns have been quoted as the cause behind the complex relationships between regional administrations and the medical profession. One assessment is worth quoting at length: "Health services management in Spain was born in an unfavourable context: obsolete public administration, bureaucratic inheritance, lack of qualified human resources… In spite of it all, a modernizing wave gave birth to a spectacular improvement… But while this generation of enthusiastic managers improved facility and service management, they did so at the expense of enforcing a centralist model tainted with enlightened despotism, sidelining away from power – especially in big hospitals – even the influential medical leaders who rather informally but effectively led life in the big public institutions for decades".[17]

Future developments

Perhaps the best way to signal the hopes and limitations of the current situation is through the proposal of a National Healthcare Agreement (*Pacto por la Sanidad*) involving all regions and political parties in the context of the Inter-Territorial Council. Originally proposed in June 2008 by former Minister of Health, Bernat Soria, the draft proposal covered no less than "human resources policy, common services, budget sustainability, common health policies, quality and innovation and prevention of drug addiction".[18]

When the next Minister of Health and Social Policy, Trinidad Jimenez, was appointed in April 2009 in the context of the financial crisis, she enthusiastically embraced the initiative, establishing six working committees whose membership included the national ministry of health, regional health authorities, professional associations and patient groups. However, her latest statement on the matter in April 2010 suggests that any agreement will not be signed before 2013.

References

1. Colino C. The Spanish model of devolution and regional governance: evolution, motivations and effects on policy making, *Policy & Politics* 2008;36(4): 573–86.

2. Agencia de Calidad del SNS. Instituto de Información Sanitaria. *Barómetro Sanitario 2009*. Madrid, 2010.

3. WHO. European Health for All Database, May, 2010

4. Instituto Nacional de Estadística. May 2010.

5. OECD. Health Care Quality Indicators, OECD Health Data 2009, Paris www.ecosante.org

6. INEBASE, Social Indicators 2006. INE, June 2008.

7. KantarHealth. *Oncology Market Access, Europe*, Data from EUROCARE-4, 2010.

8. García-Armesto S et al. Spain: Health system review. *Health Systems in Transition* 2010;12(4):1–295.

9. Borkan J et al. Renewing primary care: lessons learned from the Spanish health care system, *Health Affairs* 29, 8, 2010:1432–41.

10. Martín JJ. Crisis económica y s ostenibilidad del Sistema Nacional de Salud, *El Médico* 2010;1109:16–19.

11. Ministerio de Sanidad y Politica Social. *Indicadores de salud 2009. Evolución de los indicadores y el estado de salud en España y su magnitud en el contexto de la Union Europea*, 2009. www.msc.es/estadEstudios/estadisticas/inforRecopilaciones/docs/Indicadores2009.pdf

12. Montero-Granados R et al. Decentralization and convergence in health among the provinces of Spain (1980–2001), *Social Science & Medicine* 2007;64,:1253–64.

13. Federación de Asociaciones para la Defensa de la Sanidad Pública. *Diferencias notorias en el presupuesto per cápita entre CC.AA*, January, 2010. www.medicosypacientes.com/noticias/2010/01/10_10_05_ccaa

14. WHO. National Health Accounts – Country Information, Spain. www.who.int/nha/country/esp.pdf

15. Flores Juberías C. Spain: delegation and accountability in a newly established democracy. In: Strøm K, Müller W, Bergman T (eds). *Delegation and Accountability in Parliamentary Democracies*. Oxford: OUP Press, 2003.

16. Ramió C. Las Administraciones Públicas. In: Alcántara M, Martínez A (eds). *Política y Gobierno en España*, Valencia: Tirant lo Blanch, 1997:381–404.

17. Belenes R. Un balance personal de 25 años de gestión sanitaria moderna en el Sistema Nacional de Salud, *Gaceta Sanitaria* 2003;17(2):150–6.

18. Ministerio de Sanidad y Politica Social (MSPS). Bernat Soria ofrece a las CCAA un gran Pacto por la Sanidad para garantizar el futuro del Sistema Nacional de Salud, (2 June) 2008. www.msc.es/gabinetePrensa/notaPrensa/desarrolloNotaPrensa.jsp?id=1206

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New HiT on United Kingdom/England

The Health System in Transition report on England is the most comprehensive overview of the health and social care system in England produced this century. It provides a wealth of detail about all aspects of the health care system, as well as developments in the health of the population.

Drawing on a detailed analysis of the changes to health care introduced by a series of Labour governments between 1997 and 2010, the report's author Seán Boyle gives his assessment of the impact that these changes have had in terms of access, equity, efficiency, quality and health outcomes. This definitive report on one of Europe's largest and complex health care systems will be a valuable resource for policy analysts and health system researchers for years to come.

Available online in March 2011 at www.healthobservatory.eu

Recentralization 10 years later – success or failure in Norway?

Jon Magnussen

In 2002, after a political process that was unusually swift, the responsibility for hospital services in Norway was transferred from 19 counties to the state. The hospital reform was marketed as a "responsibility and leadership reform".[1] Now, almost ten years later, the organizational model in Norway is more controversial than ever, drawing support only from one of the three parties in the coalition government (Labor). This article briefly describes the background for, the contents of and the results of the recentralization reform. It discusses why the reform has been controversial, and briefly sketches some future options for the organization and governance of the Norwegian health care sector.

Why the 2002 reform?

The Norwegian health care system is part of what is termed the Nordic health care model.[2] This model is characterized by a strong focus on equity, decentralized political governance and dominantly public ownership and control. Norway differs, however, in two areas. First, there is no tradition in Norway of discretionary local taxation. Thus, local political governance is executed under strict fiscal centralism. Second, the responsibility for primary and specialist care was divided between two levels of local government; the municipal and the county level.

For specialist care a principle of regionalization, established in 1974, meant that while (19) counties were responsible for both providing specialist health care to their inhabitants and running hospitals, they cooperated closely within five regions. Thus, highly specialized services were provided in one (teaching) hospital within the region. The period of county ownership is described elsewhere;[3] suffice it to say that a combination of blame games over budget deficits, geographical differences in access to and utilization of services, and duplication of services both within counties and regions eventually led to the 2002 state takeover of hospitals.

The state takeover meant moving ownership and responsibility from 19 counties to the state, who exercised its governance through five regional health authorities (RHAs). These regional authorities were organized as trusts and governed by a board of trustees (with only appointed and no elected members, and no politicians). The RHAs, in turn, owned the hospitals (named health authorities) which were also made into trusts. Thus, a model of devolution was replaced by a model of administrative decentralization.

Another important element of the reform was to include the financing of capital costs in the budgets of the regional health authorities. Previously, investments had been financed separately and depreciation was not considered a cost. Finally, the "leadership" element of the reform was followed up through a national training program for mid-level hospital managers.

Main issues

Geographical equity was one of the main motivations for the reform. Counties were responsible for other services than health care, and hence prioritized differently. Thus, the state takeover also meant that unconditional grants to counties were replaced by specific health care budgets to the health authorities. The distribution of funds between the five RHAs soon became one of the major political issues. A capitation based model recommended by a government-appointed committee was rejected by the Ministry of Health, mainly because it was felt that it would lead to a too large redistribution of income relative to the county model. It took six years, and the work of a second government-appointed committee, before a universally accepted capitation-based model could be implemented in 2009.

Hospital payment in Norway has been a mixture of fixed budgets and activity-based payment (using DRGs) since 1997; i.e. well before the state takeover. The share of activity-based financing was initially set as low as 30%, but increased steadily to 60 % in 2003. This initiated concern that the incentives to cream skim, both by incorrect coding and by selection of 'profitable' patients, were too strong.[4] Following a few years where the share of activity-based financing fluctuated between 40 and 60%, it has now been stable at 40% since 2006. There is still, however, an ongoing discussion about whether this share is too high. Interestingly, while Norway was one of the first countries to implement activity-based financing on a national level, it is now moving in the opposite direction of other countries such as Denmark, Germany and England, where the share of activity-based financing is substantially higher.

One of the main motivations for the state takeover was to end the *economic blame game*[3] between hospitals, counties and the state. Hospitals would run deficits and look to the counties – in their capacity as owners – for help. As noted, counties in Norway cannot set tax levels at their own discretion, and thus would regularly turn to the state to bail them out. Deficits thus became a natural consequence of a model with decentralized ownership but (essentially) centralized financing. In this context, a state takeover seemed like a good idea, with total responsibility now at one level. Nevertheless, four out of the five RHAs ran substantial deficits. Changing governments would all respond with extra funding, while at the same time trying to send a message that this deficit funding was a "once only" occurrence. In fact, it would take the RHAs eight years (in 2009) before they collectively ran a small surplus.

The fact that the boards of trustees had no politicians as members raised some concern about the reform creating a "democratic deficit". Thus, from 2006 the boards were reorganized with government appointed politicians constituting the majority of the RHA boards, and

Table 1 Health reform issues and policy options

Issue	Policy Today	Alternative Policy	Probability of Change/Reform
Size of health care budget	Parliament sets budget and activity goals, but budget is partly open ended through activity based financing	Decentralize to regions or counties, combine with local tax discretion	No
Geographical distribution of funds	Capitation based model and an additional activity based part	Decentralize fund raising to regions or counties, combine with some income equalizing grants, but open up for geographical variations Or Abolish RHAs and distribute funds directly to hospitals based on the population in their catchment area.	Decentralized fund raising unlikely. RHAs may very well be abolished. Either a central health directorate will take their place or downsized regional offices will remain.
Hospital structure	This is the responsibility of the RHA, but need approval from owner (i.e. Ministry of Health)	Devolve to elected regional or county boards/councils. Or Centralize to Ministry of Health as part of a national health plan	Centralization likely, but it is unclear how detailed the political governance would be. Most likely a central directorate of health would do much of what is today done in the RHAs
Capital financing	RHAs fund investments, but can get state loans for 50% of costs for larger projects	Capital financing of large projects (i.e. new hospitals) is done through a national plan with central funding	Only likely in the case of a centralization of hospital structural decisions (see above)
Hospital payment	RHAs decide. All RHAs use a mixture of capitation and activity- based financing.	Cost-volume contracts, using DRGs in budget setting rather in an open ended activity-based financing.	Unlikely. The rhetoric attached to "money following the patient" is too strong.

RHA appointed politicians constituting the majority of the local boards. It is notable that these politicians are not elected, but there was still the belief that appointed politicians would make the boards more receptive to local needs than professional board members.

Strategic and operational governance

The basic governance idea in the present model is that parliament should focus on the larger policy issues, creating a framework under which the Ministry of Health should execute strategic governance and regional health authorities focus on operational governance (which at local level also would include strategic governance of that particular geographical area).

Parliament, however, is populated by members who every four years need to go back to their constituency (county) and ask for renewed confidence. As a consequence the focus of many MPs tends to be centered around local issues; the location of a maternity ward, the waiting lists for a particular group of patients, the choice of local providers for services that are contracted out, and – it would sometimes seem – generally any issue that the local MP thinks may raise his or her credibility with voters.

The major policy issues – what types of services should be decentralized and what types should be centralized; what types of services should be included and what types should be excluded from the public benefit package; how should government distribute scarce resources between health care and other public services (and avoid deficit funding) – these are questions conspicuously played down in the national health policy debate. Occasionally, they may be raised by policy experts or researchers, often resulting in angry responses from politicians who find it way easier to propose budget increases than to "put value on human life". When ultimately confronted by the boundaries of a governance and financing system that they have themselves put in place, with regularity they turn to 'health care reform' as the viable exit.

Further change – what are the options?

As noted above, the only political party defending the current model is the Labor party. It is therefore not unlikely that we will see some kind of change in the not too distant future. The question then is – where will health care in Norway go?

Before considering the alternatives it is useful to briefly recapitulate the major issues that need to be dealt with, regardless of the model. In broad terms they are:

(i) How large a share of the public budget should be allocated to health care?*

(ii) How should these funds be distributed evenly among geographical areas?

(iii) How should the delivery of hospital services be structured; that is, what types of services should be offered where?**

(iv) Is capital special, in the sense that capital financing needs to be more centralized?

(v) How should hospitals be paid, capitation, cost-volume contracts, global budgets or activity based financing? (Table 1)

In this setting, the choice of governance model implies choosing a degree of political centralization, choosing the types of issues that should be politicized and those that could be handled administratively, and finally choosing the degree of administrative decentralization.

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* Private supplementary funding is not an issue in Norway, so we'll leave that be.

** Remember that Norway is a large, but sparsely populated country.

The most likely scenario, given the present political landscape, is that the regional health authorities will be abolished. Some argue that these are merely an unnecessary bureaucratic level between the state and the local health authorities (hospitals). Others are critical of the power that lies in these (essentially administrative) organizations to determine issues that are felt to be more political than administrative. With the structural changes that have taken place since the state takeover the number of local health authorities has been reduced substantially, and now closely resembles the number of counties (22 health authorities versus 19 counties). Thus, an administrative decentralization directly from the state to the local health authorities is now a more feasible option than it was in 2002. Notably, local health authorities all receive their budgets through the same capitation model that sets the distribution of funds to the RHAs so removing the RHAs would not lead to the need for a new model of resource allocation.

This leads us to the dilemma of the present Norwegian debate: which decisions should be taken at what political level. Or put differently, how devolved should the system be? A return to the devolved model of county councils owning and running hospitals seems unlikely; even among critics of the present model it is hard to find people who express nostalgic feelings about the period of county ownership. Therefore, the most likely solution is to strengthen the central political governance of the sector; i.e. the role of parliament. Proponents of this solution point in the direction of using a national health plan as a more detailed policy instrument. Under the general (and presumably specific) framework laid out by such a plan the administrative burdens would be reduced, there would be no need for the RHAs and local health authorities could be governed directly from the Ministry of Health (or a directorate).

This model hinges on the ability of parliament to design a health plan that actually is detailed enough to provide policy guidance for whatever is left of the bureaucracy. History does not make us optimistic, but nevertheless, one should perhaps give the idea some serious consideration. However, for those who today are concerned about the "democratic deficit" in the RHAs, it may be worthwhile spending some time contemplating the possibility that parliament may remain rather impotent in its ability to make tough local level policy decisions, and thus will need to rely on the new (centralized?) administrative unit. Therefore, rather than having five RHAs with local boards we may end up with a centrally located directorate of health. Presumably, the effects of this structure may be the theme for an article in *EuroObserver* in 2020.

References

1. Ministry of Health and Social Affairs. *Parliamentary proposition No. 66: Om lov om helseforetak mv [On the law of health authorities etc].* Oslo, 2000–2001.

2. Magnussen J et al. The Nordic model of health care. In: Magnussen J, Vrangbæk K, Saltman R (eds). *Nordic Health Care Systems. Recent Reforms and Current Policy Challenges.* London: OUP, 2009.

3. Hagen, TP, Kaarbøe O. The Norwegian hospital reform of 2002: Central government takes over ownership of public hospitals. *Health Policy* 2006;76(3).

4. Directorate of Health. *Activity-based Funding of Health Services in Norway. An Assessment and Suggested Measures*. Oslo: 2007. www.helsedirektoratet.no/publikasjoner/rapporter/activity_based_funding_of_health_services_in_norway___an_assessment_and_suggested_measures___84034

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