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Varieties of Health Care Devolution: 'Systems or Federacies'?

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Varieties of Health Care Devolution: "Systems or Federacies"?

Joan Costa-Font and Laurie Perdakis

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Varieties of Health Care Devolution: “Systems or Federacies”?

Joan Costa-Font* and Laurie Perdikis**

Abstract

Some European countries have devolved health care services to subnational units. This is especially the case in unitary states that are organised as a national health service, where choice is not ‘built into’ the health care system. We argue that there are different models of devolving authority to subnational jurisdictions which have repercussions for regional health care inequalities and the amount of policy interdependence across regions. We examine broad trends in two institutional models of devolution: a ‘federacy model’, where only a few territories obtain health care responsibilities (such as in the United Kingdom), and a ‘systems model’, where the whole health system is devolved to a full set of subnational units (such as in Spain). This paper briefly discusses the impact of these two models of devolution on the regional diversity of the health system. Our findings suggest that a ‘systems model’ of decentralisation, unlike a ‘federacy model’, gives rise to significant policy interdependence. Another finding indicates that geographical dispersion of health care activity is larger in the ‘federacy model’.

Keywords: regional dispersion, models of devolution, federacy, policy interdependence, systems model, Spain, UK.

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Table of Contents

1. Introduction	1
1.1 Models of devolution	1
1.2 Devolution and Regional Inequality, Spain and the UK	3
1.3 Paper aim	5
2. Background: the devolution puzzle	6
3. Models of Devolution: The UK and Spain	9
4. Regional Disparities	12
5. Discussion	13
6. Conclusion.....	16
References	18

Varieties of Health Care Devolution: “Systems or Federacies”?

1. Introduction

The devolution of public service responsibility in unitary states is a common phenomenon throughout European countries. This is especially the case in specific welfare services such as health. Some European nations have devolved health care services to subnational units (Costa-Font and Greer, 2013). This has been largely a response to various pressures including demands for the expansion of government responsiveness and accountability, efficiency and competition, and the enhancement of policy innovation and transfers. However, whether these outcomes efficiently take place depends on the specific model of health care devolution design. Indeed, the devolution of government responsibilities does not follow a standard trend. One can identify at least two devolution models: a ‘federacy model’ and a ‘system model’.

1.1 Models of devolution

A ‘federacy model’ of devolution is typically one based on the transfer of government responsibilities only to certain specific territories while the bulk of the country remains centrally managed. Typically, territories that qualify as ‘federacies’ can be identified by some distinctive characteristics such as historical rights (e.g., Scotland in the UK), or an implicit demand by the citizenry. We do not purposefully focus on identifying distinctive features, but on examining the impact on two relevant policy outcomes, bearing in mind that

both countries considered could have adopted either model of devolution. However, for the sake of this study it is not essential what determined the setup of a federacy, but the impact and effect of adopting a federacy model rather than an alternative.

The alternative model one can devise sits at the other end of the institutional spectrum and consists of a model where *all territorial* units are held responsible for a specific policy domain, e.g., health care policy. This is irrespective of the existence of a pre-existing demand for self-governance or historical rights. We define such a model as a ‘system of regional governments’, or simply, a ‘systems model’.

In order to spell out the relevant institutional difference between the two models, we examine evidence from two countries where health care is tax-funded, and funds are allocated to regions in a similar way (e.g., capitated block grants such as the Barnett formula in the UK or an equivalent transfer mechanism in Spain). Similarly, in both the UK and Spain, government activity is limited by some framework legislation set out at the time of the transfer of government responsibilities. However, those devolution models are mutually exclusive (e.g., either all regions hold health care responsibilities, or a few do). Nonetheless, countries that have implemented one model of devolution could well have set up an alternative one (e.g., Spain could have devolved health responsibilities only to Catalonia and the Basque Country, and the UK could have allocated the same health care responsibilities devolved to Scotland to all English regions). However, whether one model or the other performs better is not trivial but this has not been examined previously in the literature. This paper will focus on providing a tentative answer to such a question by examining at one dimension the extent of divergence and regional inequality that both models of devolution produce. This is a relevant dimension in the

context of a unitary state where regional cohesion in the delivery of public services is argued to be important.

1.2 Devolution and Regional Inequality, Spain and the UK

Among the main reasons for advocating one model of governance over another, it is essential to consider the effect of regional inequality (Costa-Font and Turati, 2018). Regional 'equality' in health care provision is an important policy goal of unitary states. For instance, medical trade unions in the UK have, at times, called for the centralisation of the working conditions of professionals working for the NHS on the grounds of a possible fragmentation of the NHS, and the need to strengthen the stewardship of the ministry of health. However, the spread of devolution in Spain shows that devolution instead opens up a game of 'follow-the-leader' where regions implementing new reforms which give rise to policy innovation (e.g., the Basque Country, Navarra and Catalonia developed new dental care for children and coordination between health and social care), which have eventually spread to the entire country, hence reducing regional inequality (Costa-Font and Rico, 2006).

It is a factual and empirical question whether keeping health services centralised does indeed manage to reduce the diversity of the health system. This is especially the case when health care activity and, more generally, the demand for public services is often beyond government control; such as the health care preferences of patients and doctors about what they value the most from health system benefits. These are at least partly driven by differences and needs (e.g., a higher concentration of elderly people might lead to a demand of rehabilitation, etc.).

A 'systems model' such as the one we observe in Spain, can give rise to some significant policy interdependence where some regions adopt policies that have already been implemented in other regions and have shown evidence of

Varieties of Health Care Devolution

success. However, in the absence of such policy interdependence, one would expect to see diversity in the system. In contrast, the ‘federacies’ model is designed to develop ‘distinct’ health services and hence policy interdependence is not what it seeks to promote, and it rarely leads to policy transfer. However, given that some regions remain centrally run (e.g. the NHS in England), one would expect to find that uniform policies and regulation would limit diversity, even though that does not necessarily imply outcome uniformity. Whether the dynamics of interdependence are different across governance models, and more specifically, whether they impact outcome diversity differently is a question on which we can garner some evidence. Costa-Font and Turati (2018) show that in Italy and Spain, regional inequalities in both quality and output (measured by health care expenditure per capita) decline after devolution. However, so far comparative policy evidence has not featured countries that fit a ‘federacy model’.

The UK stands out as a typical example of a ‘federacy model’ where English regions remain governed by Whitehall, but the three other countries of the UK – Wales, Scotland and N. Ireland – were governed from their territories after 2001. In contrast, but at the same time, Spain transferred health care responsibilities to all the Spanish regions or Autonomous Communities (ACs). Originally, health care decentralisation was asymmetric, but after 2001 a more symmetrical system was achieved. Hence, Spain qualifies as a ‘systems model’.

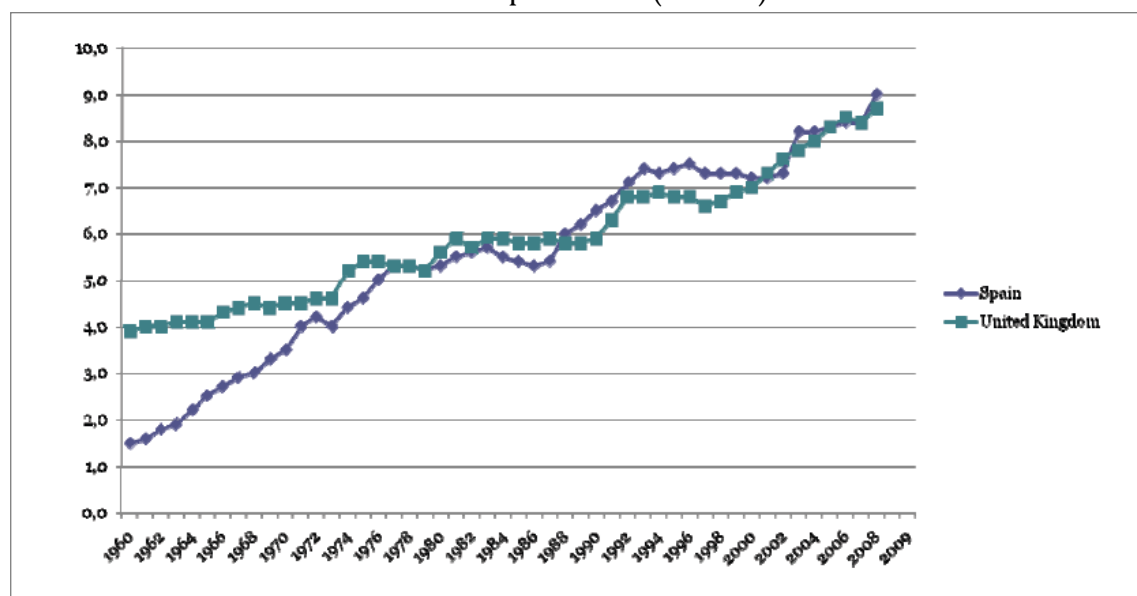
Note that a systems model can be asymmetric in its funding (e.g., Basque Country or Navarra in Spain), and a ‘federacy model’ can be symmetric in its funding (e.g., Barnett’s formula in the UK). The difference between the models lies in two different strategies of devolution, one based on dividing the entire territory into governance units (systems model) and the other, in keeping most of the country centralised and only devolving health care to some states within the UK (federacy model).

1.3 Paper aim

This paper sets out to contribute to answering the question of ‘what impact does devolution (understood as the regional decentralisation of government activity) have on regional inequality in government activity, and to what extent does the model of devolution make a difference in this regard.’ Specifically, given that both Spain and the UK could have adopted either model, we examine whether there are significant differences regarding regional disparities. To do so, we draw on evidence from the UK and Spanish health care devolution. We distinguish the period before and after the onset of the financial crises to examine the potential effect of heterogeneity resulting from spending cuts across the territory. Given that Spain and the UK have a similar health care financing (tax) system, they are reasonably comparable. Adding more countries to the analysis would increase the variation on other features.

Health funding in both the UK and Spain is comparable in that both are tax-funded and have expended the same proportion of their GDP to health care (see Figure 1). Finally, both are unitary states subject to comparable contexts.

Figure 1.
Relative Expenditure (%GDP)



Source: OECD, 2012.

We put forward the claim that there are different models of devolving authority to subnational jurisdictions, and these are consequential. We examine the extent of the impact of the 'devolution model' on two health system outcomes, specifically regional disparities and the degree of policy interdependence. Our findings suggest a systems model of devolution is shown to increase policy interdependence and does not worsen regional inequality (unlike the federacy model). Indeed, evidence from the UK shows that even when emulation might take place, there is no cognition of the process for political reasons, and instead, diversity results from the setting of explicitly different, and often, non-comparable policy goals. Regional inequalities exhibit a declining pattern in Spain and the trends are much weaker.

We organise the rest of paper as follows. Section two sets out some theoretical background. Section three provides a literature review in the context of 'varieties of devolution' and the relationship between devolution and regional inequality. Sections four and five will present this paper's results and discussion.

2. Background: the devolution puzzle

The process of devolution and its impact upon regional inequality has gained credence within the literature. Some theory suggests that decentralisation may, in fact, increase regional disparities because as resources are passed to sub-central governments or regions, it consequently weakens inter-regional distribution intended for regional convergence (Prud'homme, 1995). In contrast, some work argues that devolution helps to reduce regional inequality (Oates, 1972; 1993). However, this literature does not distinguish between different models of devolution and does not explicitly examine a homogenous sector of policy activity. Indeed, some public services are more likely to be

devolved to sub-central governments across countries than others. Health care is the most common public service responsibility that has been devolved among European Union member states, and hence it has been compared across countries. The focus on one welfare service (health care) is essential as health care is comparable across the two countries under examination in both how it is funded and the principles in which it is grounded. However, in what follows we do not attempt to describe the institutional differences and historical legacies between Spain and the UK. Instead, we point out the observed regularities in policy outcomes after devolution bearing in mind that health care was centrally managed before devolution was implemented. We assume that both countries could have adopted either model of devolution described (e.g., Spain could have devolved health care only to Catalonia, Basque Country and Galicia, or the UK could have devolved health care to all English regions too).

While the devolution process in the UK was indeed accelerated under the 'New' Labour government, a centre-left party, between 1997-2010, the Conservative government of 2015 has also taken a 'pro-devolution' stance and it too has begun to speed up the process.¹ The second caveat concerns innovation in welfare systems. Experimentation can lead to enhancements in welfare at the regional levels and support of this, Costa-Font and Rico (2006a) found that, more prominently, innovation in one region can spread to others and thus create a 'race to the top' as opposed to the argument of a 'race to the bottom'. Moreover, in a further study Costa-Font and Rico (2006b) argue that if successful policies are copied by neighbouring and other regions, i.e. via lesson drawings, regional inequality would decrease and not increase. They

¹ As can be seen in the example of the devolution of health care spending to Manchester. Moreover, in the Chancellor George Osborne's budget in July 2015, he also put forward the devolution of expenditure to Cornwall and set out on a so called 'devolution revolution'.

Varieties of Health Care Devolution

conclude that devolution decreases regional disparities (see also McEwen, 2005; Shaw et al. 2009).

The explanation of policy diffusion and divergence for the reduction in inequalities and the reasons behind different politico-economic systems have been put forward by various scholars. MacKinnon (2015) argues that devolution has had a significant impact upon public policy both in Wales and Scotland. Another long-term effect put forward in the literature refers to the political influence upon a reform which has produced divergence for example in Wales and Scotland, less market-orientated changes, with more social democratic approaches to policy (MacKinnon, 2015; Greer 2003; Birrell, 2010). Indeed, given that latter governance model (localism and public health in Wales vs professionalism and cooperation in Scotland) are chosen policy options, they were intended models of governance which could have been adopted by other countries in the UK.

The models of governance within the UK are not absent of comparison, emulation or policy learning, although the strategy was instead not to acknowledge similar improvements in other countries and set diverging policy goals instead. For example, there is little doubt that longer waiting times in Wales compared with England spurred the Welsh Assembly government to give waiting time reduction a higher priority. Scotland similarly took waiting times more seriously when its government saw the performance in England. However, there was no explicit recognition of the process for obvious political reasons, and instead, they focused on diverging policy goals to avoid being compared.

Undoubtedly, it is these political games per se that have a bearing upon policy and thus, make up the types of devolution seen in Spain and the UK. Therefore, within a federacy, the politics of difference is a central characteristic.

3. Models of Devolution: The UK and Spain

Both the UK and Spain embarked on their process of devolution for similar reasons and can be defined as unitary states that share some aspects of federal states ('quasi-federal states'). Both the UK and Spain differ significantly regarding the transfer of powers to their regional governments. Therefore, we can argue that both the UK and Spain exhibit different 'varieties of devolution' and that devolution is indeed highly variegated in these two examples (Peck and Theodore, 2007). Devolution in the UK is based upon the separation of political and fiscal powers between the devolved parliaments of Scotland, Wales and N. Ireland, and the UK parliament (Keating, 2002; Mackinnon, 2015). Therefore, some leeway is given to these devolved governments in the development of their particular policies. Nevertheless, the UK Parliament can still legislate under the law, in theory, and in practice, for Scotland, Wales and N. Ireland.

In the UK, the three devolved administrations receive a block allocation from the UK Parliament in Westminster out of which they have to decide what proportion should be allocated to the NHS, social care, and education and so on. This contrasts with the Spanish case where block grants are received from the Spanish government except for the Basque Country and Navarra which are fully fiscally accountable. However, it is important to point out that the Barnett formula that determines these block allocations in the UK predates political devolution.

An essential difference between the UK and Spain lies in that the post-devolution UK lacks any UK-wide, federal governance institutions. However, this is not the case in Spain where the Ministry of Health does exist and exerts some critical coordination roles alongside the provision of information. The only exception where the UK and Spain are comparable is the fact that the

Varieties of Health Care Devolution

English Department of Health undertakes some UK-wide functions on behalf of the other three devolved administrations regarding international relations affecting the NHS.

The Government of Wales Act 1998 was the impetus for devolution in Wales, creating the Welsh Assembly and devolving powers in areas such as health care provision. The Scotland Act 1998 in contrast, granted powers to the Scottish Parliament on a reserved basis while in Northern Ireland, the Good Friday Agreement 1998 paved the way for the devolution of powers under the Northern Ireland Act 1998. It is also important to note that the devolved parliaments have narrow revenue-raising powers (MacKinnon, 2015). Importantly, and similar to the Spanish case, the devolved assemblies and Scottish Parliament in the UK are elected on a wholly different basis from the Westminster Parliament. They use variant forms of proportional representation which may well affect the nature of the policies adopted in the devolved administrations. Hence, the political majorities in the devolved assemblies do not necessarily reproduce the electoral results of nation-wide elections.

In 2014, Wales received some limited tax-raising powers in the form of stamp duty and landfill tax. Absent from devolution is England, which has one government and legislature, namely the UK Government and UK parliament respectively, compared to two each for Scotland, Wales and N. Ireland. The UK, therefore, can be best described as a state categorised by the 'federacy model' (Rokan and Unwin, 1983; Rhodes, 1997; Keating, 1998; Cooke and Clifton, 2005).

In contrast to the UK, Spain has a different devolutionary arrangement. Paradoxically, Spain began as a highly centralised, unitary state which has undertaken asymmetric devolution, passing power to the 17 'autonomous

communities' (ACs), (Carbonell and Alcalde, 2008; Maiz et al. 2008). However, Spanish devolution has evolved a 'systems model', especially in the area of health care. Since 2002, all ACs have had the same responsibilities except for two; the Basque Country and Navarra, which collect their taxes and are thus, fiscally independent and politically accountable for running health care provision (Prieto and Lago-Penas, 2012).

The concept of 'varieties of devolution' is directly applicable to health care because unlike the UK where health care is devolved to Scotland, Wales and N. Ireland, although not yet to England and its regions (apart from Manchester as of 2015), Spanish health care management is devolved to its 17 ACs.

The size of the devolved administration is consistent with the federacy in the UK v system model of devolution in Spain. Although the total population of the UK is larger than that of Spain, the UK model has kept an English centralised NHS that provides care to 53 million individuals. In contrast, the population of the devolved administrations amount only to one-fifth of-of such figure (Scotland 5.2 million, 3 million and Northern Ireland 1.8 million). In contrast to Spain, where the 47 million inhabitants receive decentralised health care, and where regional population size ranges from 8 million in Andalusia, 7.5 million in Catalonia to 0.3 million in La Rioja.

Finally, it has been argued that four health care models characterise the UK. Wales adopted a system based on localism, a bottom-up approach to health care. In comparison, Scotland exhibits a model of medical professionalism, Northern Ireland a model of permissive managerialism; while the English model, unsurprisingly, is focused on a market and performance management approach (Greer, 2004). The notion of the 'politics of difference' is a central character in the type of devolution associated with the UK, and is directly reflected in the approach to health care. This approach can be attributed to the

permissive nature of the type of devolution, which facilitates policy divergence (Mackinnon, 2015; Greer, 2007, Jeffery, 2007). Spain, in contrast with its devolved health care systems and autonomous fiscal regions, is more akin to the 'systems' model of devolution.

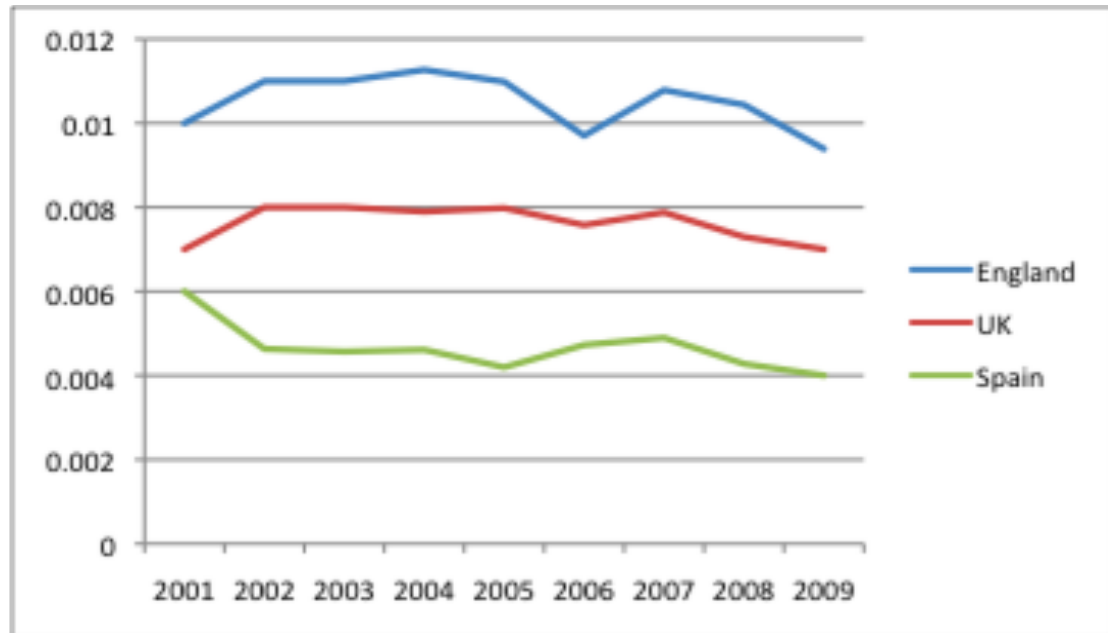
4. Regional Disparities

To examine the effects of devolution on convergence, a simple and commonly accepted strategy is to identify a measure of health care output (unadjusted health expenditure per capita) and examine an inequality index. Consistently with previous studies, we employ the coefficient of variation as it is simple to interpret and it facilitates comparisons with some previous studies (Costa-Font, 2010a, Costa-Font and Turati, 2018). Figure 2, provides the evidence of the trends in unadjusted per capita health expenditure in Spain, England and the UK as a whole.

We limit the analysis of 2000-2009 to avoid our analysis being affected by the economic downturn post 2009. Figure 2, suggests a reduction in the coefficient of variation of unadjusted public expenditure per capita over the period 2000-2009, highlighting a downward trend regarding regional disparities. For example, decreasing from 0.006 to 0.004 in the same period. In contrast, there is more of a discrepancy when analysing the UK as a whole, which has seen a more turbulent movement in the level of regional disparities, which is significantly larger when we examine England than the UK as a whole. As such, in the short term, it can be argued that in the cases of both Spain and the UK, both show a decrease in regional inequality which happens to be speedier in the Spanish 'system model'. Similar results are found when Italy is included in the analysis as suggested by Costa-Font and Turati (2018). The latter, results

are consistent with our argument as Italy qualifies as a system model along the lines of Spain.

Figure 2.
Regional Inequalities on Unadjusted Health Care Output (expenditure per capita)



Source: MT Treasury and Spanish Ministry of Health, 2012. Note: Inequalities are measures as the coefficient of variation of the unadjusted per capita health care spending in each of the units examined. The coefficient of variation is defined as the ration between the standard deviation and the mean of the variable.

5. Discussion

In the previous section we have identified some evidence that suggests that both in Spain or the UK, devolution has not increased regional inequalities, and in Spain, we see a significant reduction of regional disparities consistently with other previous studies (Costa-Font and Rico, 2006 and Costa-Font and Turati, 2018). In line with Pollock (1999) and Morgan (2002), we find that devolution has helped to address regional preferences in health care, as is evident from the decrease in inequality in Spain and the UK. Devolution has helped to overcome veto points in health care reform. For instance, in the case of the UK, decentralization has by allowing health care in Wales, Scotland and Northern

Varieties of Health Care Devolution

Ireland to be tailored to its preferences (e.g., elimination of prescription charges, free long-term care in Scotland). Hence, overcoming the potential veto in a centralised UK-wide health system. Similarly, in Spain it has allowed the Basque Country and Navarra to introduce free dental care for children under 15, Catalonia to design a health technology agency and coordinate further health and social care and the Canaries to provide funding for a second medical opinion when needed. The difference between the UK and Spain is that many of the reform we identify in Spain have been transferred to other regional states, while there is more limited policy transfer within the countries of the UK.

In addition, our evidence indicates a higher regional inequality in the UK and England, than in Spain, which can be explained by some factors including the historical distribution of teaching hospitals, different political legacies and dynamics. However, these have not been radically modified over the period observed, and hence they are unlikely to explain the patterns of regional health inequality. Instead, explanations for the reduction of regional health care inequality in Spain and a more moderate one in the UK lie within the politico-economic makeup of each country, which is highly 'variegated' (Peck and Theodore, 2007). In essence, the political economy of the 'federacy' and 'federation' models have had a positive impact on the relationship between regional inequality and devolution in the UK and Spain. For example, Spain is categorised by significant policy diffusion and innovation. In the Spanish ACs, particular policies have been 'lesson drawn' and implemented by other ACs. For example, there has been significant diffusion in health and ageing services, second opinions and dental care for children (Costa-Font and Rico, 2006). As such, the type of devolution in Spain has encouraged policy diffusion and innovation to take place and could hold explanations for the decrease in regional inequality.

A central characteristic to highlight are the political differences between the 'regions' in the UK, which are important when analysing the relationship between devolution and regional inequality. As Andrews and Martin (2010, p.929) note 'the creation of new devolved political institutions in 1999 placed the pursuit of distinctive policy agendas on a far firmer constitutional footing... unleashing much more forceful and explicit expressions of the ideological and cultural differences between different parts of Britain'. The pursuit of policy divergence, therefore, plays a key role in debates such as the relationship between regional inequality in health care provision and devolution. Interestingly, in their study on public service outcomes, Andrews and Martin (2010) find that differences in health care and education are attributable to some extent to policy divergence since devolution began. Regarding the performance of public services, including health, the differences in public service outcome widened following devolution. Nevertheless, regional inequality in health care provision in the UK as a whole has experienced a slow but downwards trend. Moreover, Bevan et al. (2014) finds 'that the increasing divergence of policies since devolution has been associated with a matching divergence of performance'. This would be consistent with limited pro-efficiency policy transfer. The findings in the UK are directly related to the effects of a lack of devolution in England. Indeed, a centre-region dynamic might come when each level has some stake in the health policy domain in the Spanish Case (Costa-Font and Rico, 2006 a).

From our findings, one can argue that should health policy be devolved to England as a whole -and that level of government made distinct from the UK level, a centre region dynamic might emerge. In other words, the UK has four 'little worlds' of health care, which do not interact in ways that could deliver a 'race to the top' as in Spain (Costa-Font, 2006b). One needs to acknowledge some level of policy comparison over health policy does in the UK, for example

as between Wales and England does exist when it comes to the adoption of some policies like ambulance time target in England (Bevan, 2014). However, so far it has not produced significant policy changes in the policy priorities of each country.

Finally, in comparing Spain and the UK, the model of devolution does indeed impact upon regional inequalities as a result of the politico-economic makeup of these models. Both models of devolution have helped to reduce regional disparities and therefore the myth surrounding standard arguments against devolution by increased inequality should be dispelled.

6. Conclusion

We have broadly discussed whether different models of devolution enhance policy diversity. General trends indicate different patterns of inequality in health care expenditure per capita and policy interdependence Spain and the UK after devolution. In the Spanish NHS, we find considerable policy interdependence and stark decreasing regional disparities, while in the UK we see policy divergence and hardly any change in territorial inequality patterns. Hence, these results shed light on a central feature of the devolution debate, namely that reducing central government role in health care policymaking does not encompass the expansion of regional inequalities and can lead to spontaneous policy interdependence. However, for obvious reasons the results do not establish a causal association. They are consistent with similar studies comparing devolution in Italy and Spain, which suggest that in both countries devolution did not increase regional inequalities (Costa-Font and Turati, 2017).

In February 2015, the UK government devolved control of NHS spending to the Greater Manchester region. Budget responsibility will be devolved to a

partnership of councils and local NHS commissioning groups and providers. Our results would suggest that if devolution is extended to other English regions it has the potential to reduce regional inequality in health care. A policy that has hitherto not been adopted. Hence, there is a chance that existing regional diversity in the British NHS could be corrected by further devolution of health care responsibilities to regional authorities.

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