Comment on decentralization, re-centralization and future health policy

Dr Saltman has tried with his article to forecast a trend for the future development of health policy in Europe, a very difficult task. His analysis concludes that there is a new re-centralization in countries where decentralization has been the paradigm in healthcare policy. Although this is very interesting, I do not totally agree.

In my comment to this article, I will review the evidence of the article about what happens in the countries analysed by the author: the Nordic group (Finland, Norway, Sweden), the UK and Germany. Then I would like to express my own view on this situation, and I will end by discussing the Spanish situation.

The healthcare systems of Nordic countries are undertaking several changes that the author interprets as a re-centralization. In my opinion this is the other way around, since bringing together several local units into bigger units is rather a mechanism to reinforce decentralization than a re-centralization, as the new units will have more strength to manage the healthcare institutions.

In the analysis of the United Kingdom the article describes only what is going on in England. The article does not take into account what is happening in the other countries of the United Kingdom: Wales, Scotland and Northern Ireland. The decentralization of the National Health Service is not affected by what happens inside England.

The creation of a social security fund in Germany is clearly not a decentralization process since this only affects the funding, not the delivery of services, and the social security has never been decentralized to the Länder.

My own conclusions therefore differ from that of Dr Saltman. The magnitude and complexity of the healthcare institutions are too big to be managed by local administrations. Hospitals and health centres are in many places the biggest enterprise in the city. The changes in Nordic countries result from the fact that bigger local authorities are required to manage the healthcare system. Local authorities may have difficulties to make these changes by themselves, and therefore states are better placed to make them.

Healthcare costs have a big share in the budgets of the decentralized units and they try to control these costs by closely controlling the expenditure. This is what happens in England by centralizing decisions at the level of the decentralized units, but not touching the basic decentralized system.

The equalization of rates paid to a social security fund in Germany may be understood in a Social Security system but it is unthinkable in a National Health Service financed by taxes where everyone pays differently according to their income.

In the last part of my discussion I will analyse if in Spain we can apply the recentralization predictions made by professor Saltman, as the Spanish Health System is the one I know best.

Spain approved a new constitution in 1978. This constitution allowed the creation of new regions. It was not until 1986 that the Spanish National Health System was created and subsequently most of the responsibilities for the health services management were decentralized to the regions.

However, the central state maintained some responsibilities such as drugs policy, research policy and it was also responsible for determining the necessary number of specialists and their competences. It kept the coordination role.

This coordination role is currently under discussion as it has only been focused in defining what kind of health services can be provided to the Spanish population in order to achieve the same portfolio in all regional communities. This portfolio is very large and most of the services are free at the point of delivery.

As I already said, each region is responsible for managing its own health services and therefore it takes its own decisions in prioritizing the services to be provided. Consequently each region has a different budget devoted to the provision of health services. These differences have created a debate on equity and equality among citizens that live in different regions. But the differences I am mentioning are different to the ones professor Saltman has described for Nordic countries. In these countries the objective of their policies is to improve the efficiency of the system, while in Spain the argument is focused on equity and so far has just been a debate with no policy concretion.

The differences between the regions in Spain are the consequence of a democratic system and therefore, we have to deal politically with them. People who argue that the central state must intervene to readdress these differences should remember that Spain has a large tradition as a centralized state and that on those days the differences were even worse.

The tension between centralization and decentralization is always permanent in a sector as complex as public health. Probably there will be periods of time where one situation will predominate over the other but I cannot see big trends on this subject. I rather think that the time of ‘megatrends’ in terms of Health has already gone and that we are now in a ‘microtrends’ period where the analysis has to be a very local one.

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