THE DEVOLUTION OF HEALTH CARE TO THE SPANISH REGIONS REACHES THE END POINT

Even the most optimistic among us did not believe that a Conservative Spanish Government would decentralise health services management to all of the Spanish regions (Autonomous Communities, AC from now on). Nevertheless, the central Government, led by Mr Aznar surprised everyone in July 2001 by reaching new fiscal agreements with the AC (some of them represented by socialist regional Governments) which included placing health care under regional responsibility for them all.

It came as a surprise …

The completeness and speed of the transfer came as a surprise firstly, because past decentralisation (of seven regions accounting for 60% of the overall expenditure) was argued by some to have eroded social cohesion. This view was even supported by some central trade unions in a recent Spanish Social and Economic Council publication. Secondly, the opposition party was divided in its views, representing on the one hand a regional partisan view and on the other the view of an alternative central Government keen not to weaken central powers. Thirdly, the speed of implementation was a surprise because some areas still lacked detailed agreement, notably on finance (for instance, on costing services and redistribution parameters) and the basic central regulation of health planning and co-ordination. The latter is not a trivial issue given that in Spain 10 AC have a population less than two million.

Why then has this happened? A political interpretation is that politicians may think that health care is unmanageable in public hands (because of complaints, demands for extra resources, resistance to administrative change etc) and that decentralisation is a first step towards privatisation. Additionally, by limiting central finance commitments the central Government may protect its own purse while leaving the political costs to be faced by the regions.

There exists some caveats on this interpretation, as the Conservative Party is involved in a number of regional Governments – Madrid, Galícia, Castilla – Leon and Cantabria – and there is only anecdotal evidence to support the view that the Conservatives favour privatisation of public facilities and finance. It may be the case that at present other arrangements looked extremely complex. For example, organising health care for 40% of the population, with high disparities between the INSALUD centrally managed regions (because of the impact of the generous treatment of the Madrid AC) by consortia agreements, regulated cross boundary flows and other mechanisms proved to be very complicated. In addition, there was an expectation on the part of partisan politicians that transfer of health powers would change political powers both between Nationalist/Socialist and Conservative administrations and even within Conservative areas of influence.

It is likely that if the process had not started already, decentralisation would not have been started now, but given its progress any movement back to centralisation looked worse than further devolution.

A further consideration is that the extension of devolution has been a way of weakening the search for a differential power position by the more nationalistic AC (Catalonia, Basque country and Navarre) in favour of the so called “café para todos” (coffee for all).

The new fiscal agreement

Some key features of the new arrangements are summarised below:

1. For the first time, regional health care finance is included into the general financial AC agreements. Up to this moment, health finance was decided in a separate negotiation framework between the Minister of Health and their corresponding Regional Ministers. Given the importance of the health care budgets (around 40% of regional expenses), the results of this bargaining might seriously affect regional finance. Now it is not going to be determined by political bargaining between the central and the regional Departments of Health, but between Finance Ministers first and secondly, at the regional internal level, between the regional expenditure ministers within each AC. The regional parliaments will now have a more decisive ultimate word on heath policy issues.

2. The bottom line of health expenditure is estimated as a minimum amount to be spent. For this, (i) the effective cost at the moment of the transfer or (ii) the share of the overall central expenditure funds according to population (weighted by 75%), age structure (by 24.5%) and the 'insularity factor' (just for the Balearic and Canary Islands, at 0.5%), are on the table. If the former is above the latter, the central government is committed for three years only to maintain finance for the basic figures increased by the GDP growth in nominal terms and at factor costs. However, above the basic amounts, each AC will be able in the future to spend whatever it wishes if financed by its own budgets.

3. Since 2002, general revenues for the regions to finance all the AC services (not just health) will come out of revenue sharing Personal Income Tax (at 33%), VAT (35%), Petrol, Tobacco and Alcohol Taxes (40%), and 100% of the revenues collected in the region of some other minor taxes (car registration, energy tax, inherited and donated dwellings, property transfer, gambling...). Initially, everything, including the equalisation central transfer, will be computed in order to guarantee that all the basic needs (health, estimated as described, and education – in per capita terms) will be covered. Similarly for some pre-set increases over time. But if revenue sharing capability increases, due for instance to the fact regional consumption indicators increase in percentage terms, or that a surcharge on personal income tax is applied ($^{+}$/- 20%), no restriction will apply to this additional expenditure.

4- However, in order to preserve cohesion by avoiding 'excessive' deviation in per capita health spending amongst regions, central transfers will help those AC that shows increases in public health coverage (say due to legal immigration) three points above the Spanish average. In addition, as commented, all the AC will have to finance at least some (increased) basic health care. However, no maximum is defined and then a mobile average according to the effective regional revenue raising capacity may result. The chances of devoting larger amounts to health care may come out of the open possibility to impose a petrol tax at the final retail level (as a surcharge) just to finance health care. This is not however a real earmarked tax, but a way to build a more politically acceptable tax on the former premises. So far, the Central Administration has already approved a central tax on petrol to finance health expenses already committed. AC strongly complain that this makes more difficult to impose their own taxes as stated on the fiscal aggreements.

5- A Cohesion Fund to be funded by the central budget will devote resources to compensate for cross boundary flows of patients amongst regions. The central state is proposing to create an homogeneous information system and a close to DRG type of billing, which needs, however, to be negotiated with the regional health authorities. Some regions seem to be prepared to co-

ordinate themselves to avoid those adjustments without central intervention, as, for instance, in the case of the extended central (Madrid and both Castillas) health region. Some caveats exist on how the central state will compensate for new central regulations or pricing policies (new drugs to be reimbursed, centrally authorised new health technologies...)that affect regional expenses. Without compensation, regional acceptance is less likely.

6- A defined basic entitlement package will become a necessity if patients are not to exploit differences. Diversity itself should not be a cause for concern (so legal precedent suggests) provided the basic minimum package is covered and any additions are financed from regional sources. Handling other variations in policy, such as those applied to drugs, may not be straightforward. Although regions will not negotiate drug prices themselves, they may well influence the prescribing habits of their professionals. This will pose new challenges to the marketing departments of drug companies.

The future: fewer taboos about geographical equity and more fiscal accountability

The integration of health care finance under the general financing system for all the AC for an indefinite period should end a political process that has been very contentious. The present system has promoted little consensus amongst health authorities, with the only point of commonality being the claim of more resources from central Government. There have been endless disputes on the shares each region should have relative to the rest and as a result all health problems have been presented as due to lack of resources, with little discussion of evidence based new policies.

Under the new arrangement complaints about central under finance of regional health care will have to cease. This is appropriate because, despite common perception, Spain is not an unequal country in terms of health delivery and finance. This is borne out by a recent study (BBVA Foundation and the Institute of AC Studies, 2001) that evaluated the impact of regional health policies since the first health transfers for Catalonia in 1981. Indeed the coefficient of variation in regional health care finance per capita is one of the lowest amongst health care systems for which territorial health care expenditure may be identified. By contrast, France and England are among those countries which have most uneven distribution of health care resources. This probably reflects the fact that in those countries health regions are a geographical artefact with no parallel in regional Government. Therefore, these differences are not readily translated into the political arena as happens in Spain or Italy. This means that the central Government is under little political pressure to justify the differences that exist.

Additionally, the differences that are observed between regions in Spain relate to relatively few programs that have little practical relevance to health status. For example, Andalusia finances from the public purse certain low therapeutic value drugs which are exempted in most of the other regions; only a few regions will finance sex change operations or the "morning after" contraceptive pill.

These differences should cause little concern in equity terms as they reflect different political views on public preferences. They should be self financed as there seems little basis for interregional transfers to support them. Indeed, where conducted, regional opinion polls seem to favour keeping such decisions close to the citizenry affected.

Having said this, we should also recognise that we know relatively little about health differences which derive from variations in quality of care and variations in clinical practice. It is probably not the case that there is a fundamental regional pattern in such disparities. The main equity concern probably relates to intra regional differences rather than interregional differences. Those who have

spoken loudest against the dangers of interterritorial inequities have not usually made most effort to redress imbalances between local areas within the regions.

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