

HEALTH CARE DEVOLUTION IN EUROPE

Trends and prospects

Ana Rico, Institute of Health Management and Health Economics,
University of Oslo

Sandra León, The Institute for Quantitative Social Science,
Harvard University

HEALTH ORGANIZATION RESEARCH NORWAY - HORN

Working paper 2005: 1



UNIVERSITY OF OSLO
Institute of Health Management
and Health Economics



HEALTH CARE DEVOLUTION IN EUROPE:

Trends and prospects

Ana Rico^{a, c} and Sandra León^{b, c}

^a Institute of Health Management and Economics, University of Oslo

^b The Institute for Quantitative Social Science, Harvard University

^c European Observatory on Health Care Systems and Policies

* The authors are grateful to the European Observatory of Health Systems and Policies, which partly funded data collection. An earlier version of this paper was presented in the Spanish Conference on Health Economics, Pamplona, May 2002.

1. Introduction

Devolution is in vogue. Over the second half of the 20th century, several Western European countries witnessed major processes of institutional change leading to profound changes in the territorial distribution of government power¹. However, little topics in political science and health systems research have proven as resistant to conceptualization as devolution has. This explains the scarce advances made in assessing its dynamics, causes and impact.

Although devolution constitutes one of the most relevant transformations in the governance of modern health care since its inception, little is known about (1) what does it mean in different countries and how it is related to neighboring concepts such as federalism; (2) where (=in which countries and sectors) it prevails, and how it has evolved in time; (3) which are its causes; (4) which factors contribute to its success or failure; (5) and which effects has on health care.

These questions make up a comprehensive research agenda on which more theoretical and empirical analysis is needed. But the basic elements required to build sound analysis on the topic are still missing: namely a clear and simple definition of devolved systems and the policy instruments and institutional tools involved in the dynamics of health care devolution. Tackling these unresolved questions would assist us in overcoming conceptual complexity and empirical diversity and to better describe and compare the main trends of devolution across countries and historical periods. The present paper aims at laying the ground for further systematic debate and investigation on the pending research agenda of health care devolution by addressing the most basic research topics (questions 1 and 2 above) and tracing their relationships with other, more complex issues (questions 3, 4 and 5). We deal with the second question (how devolution has evolved over time) by presenting an analytical overview of the process of health care devolution in countries that have long experienced devolution (the Nordic countries -Denmark, Finland, Norway, Sweden - and the two devolved Southern European countries - Italy and Spain). The main purpose of the empirical analysis is to investigate whether different types of devolved government evolve differently. All those countries share a very important common characteristic, namely a tax-funded National Health System (NHS) that guarantees universal

¹ The process of institutional change has given raise to new regional elected governments with ample executive and sometimes legislative powers (UK, Spain, Italy, France, Belgium and Portugal), or to strengthened county or municipal local governments (Denmark, Finland, Norway or Sweden) (Sharpe, 1993). From the mid 1990s, Central and Eastern Europe joined in, and undertook a deep devolution of executive and fiscal powers to local or regional governments, following the recommendations of the World Bank. Outside Europe, 63 out of the 75 countries with more than five million inhabitants were engaged in some form of devolution by the late 1990s (Tanzi, 1995).

access to health care², although they differ in the way they structure devolution. This allows us to compare the dynamics of health care devolution in different devolved systems under a relatively controlled research design³.

The analysis is structured as follows. First, we delve into what devolution means and how it is related to other forms of local self-rule and present the dimensions according to which we believe devolved systems should be classified. The second section structures the empirical work by introducing the hypotheses on the dynamics of institutional change. It also conceptualizes the variable of analysis through the classification of devolution reform policies in three different groups, according to the substantive policy goals and institutional tools involved in the dynamics of devolved governments. We complete this section with a detailed analysis of recent reforms in the devolved European NHS. In the last (third) section, we summarize the main findings and discuss them in the light of the relative small available evidence on causes, consequences and prospects of devolution in health care.

2. The puzzle of devolution: what is it? Devolution as local self-rule

Devolution is seen by many as a process rather than an end state. For some it is a transfer of powers across democratically elected governments (Mills, 1990). For others is an ever-changing balance of powers across government levels. We use the term *devolution* to refer to an end state (*devolved, multilevel government*), that is, a governance system characterized by subcentral, democratically elected governments having independent political powers over one or more policy fields⁴. Devolution is intimately related to (but cannot be reduced to) the two key political processes outlined above. First, devolved government result from powers being transferred downwards. Second, and as remarked for the case of federations (Schmitt, 2004), devolved government often brings about a process of continuous revision of power-sharing arrangements; and therefore can be considered a more unstable (and flexible!) governance

² In health care, devolution constitutes *the* key governance mechanism mainly in tax-funded countries where the public sector performs the roles of financing, purchasing and providing care; while in Social Health Insurance countries delegation to mutual funds and providers' associations became the main governance mechanism instead.

³ In all European tax-funded health care systems devolution has been a key reform issue. But in Greece, Portugal and the UK, it entered the political agenda only in the last years of the 20th century. Those late developments lay outside the scope of this paper, which focuses in the subset of tax-funded countries that have a longer experience with health care devolution.

mechanism than centralized rule. Both processes are key determinants of the sustainability of devolution; but they should be clearly differentiated from it: the former is a cause of devolved government, the latter a consequence of it.

An important cause for the scarce progress made on assessing devolution is that it tended to be grouped together with other types of decentralization with which it shares little in common, such as delegation to independent agencies, deconcentration to central government's local branches, and privatization via transfer of ownership to public or private enterprises (see, for instance, Mills, 1990; Hagen and Kaarbøe, 2003; Vrangbæk and Christiansen 2005; Vrangbaek, 2004; Saltman and Bankauskaite, 2004). Conceptually, this has created a confusion on what devolution truly means; empirically, it has precluded the in depth analysis of each of these options⁵.

A second category of problems emerges from reversing the argument above, that is, from the failure to trace connections between the three main types of local self-rule, namely devolution, federalism and strong local government. The relative wealth of research on federalism and local government has often been ignored within the field of devolution; and devolved countries (which constitute the bulk of the world nowadays) have failed to benefit from the knowledge accumulated through the relatively long historical experience with multilevel governance and local self-rule under federalism or strong local government.

In the three types of local self-rule, independent political powers are in the hands of subcentral, democratically elected governments; democratic accountability prevails; and a dynamic search for a balance between self-rule and shared-rule applies. It is true, however, that the route towards local self-rule differs: in federalism powers are transferred upwards (from member states to the centre) rather than downwards as in devolution; while local government rule sometimes pre-dated central one in Europe, and therefore required no previous transfers of powers. However, there is little reason to assume that the (frequently mystified) historical processes from which local self-rule originated would help us to better understand the dynamics

⁴ Our definition of devolution is partly based on Riker's classic definition of the essence of federalism (McKay, 2004). As we discuss below; this is consistent with our view, which stresses the similarities between both types of governance.

⁵ What devolution shares with other forms of decentralization is only the process that directly causes it: namely the transfer of powers from the central government downwards to smaller units. However, delegation, deconcentration and privatization are very different from devolution. First, the nature of the powers transferred is administrative or managerial rather than political, what has important analytical and empirical implications. Second, the type of accountability mechanisms is radically different too: while administrative decentralization relies on top-down hierarchical or contractual mechanisms, devolution mainly relies on bottom-up citizens' control through voting and other forms of political participation.

and consequences of devolved government nowadays. In fact, marked differences between existing federations emphasize that there is no such a thing as a federal model (Rico and Costa, 2005)⁶. In addition, the comparison between federal and devolved systems stresses that the main differences are apparently across specific country models, rather than between devolved and federal countries⁷. Following these considerations we believe that government mechanisms should be conceptualized according to other dimensions, an idea we further develop in the next section.

2.1 Types of devolved government

Our main proposal is therefore that different *types of devolved government* should be classified according to the following dimensions:

1. Distribution of powers across government levels
2. Prevailing accountability mechanisms
3. Size of constituent units

As far as the distribution of power is concerned, there are three main aspects that help to classify power allocation in multi-level governance. The first is to what extent each level of government has independent versus shared regulatory and decision-making powers in each sphere of intervention and policy field. A distinction has been drawn between layer-cake and marble-cake federalism, which can be directly applied to devolved government. The former involves that independent powers prevail, the latter that powers tend to be shared in each policy field. A related aspect is the number of government levels involved in each policy field. Finally, the third dimension is the extent to which financial risk is coupled with political decision-making; or in other words, whether fiscal powers are transferred alongside political decision-making and expenditure powers⁸.

⁶ In fact, marked differences between existing federations emphasize that there is no such a thing as a federal model (Rico and Costa, 2005). For instance, regarding the issue of historical origins, federalism was in some cases imposed by the central government (e.g. India), an external power (Switzerland), or by the strongest member states upon the weakest (Canada).

⁷ In some devolved countries subnational units' enjoy more political and fiscal powers than the member states in many federations (e.g. Spain versus Germany in health care). As for the institutional differences, although subnational governments' powers tend to be more protected under federal constitutions, second chambers elected along territorial lines in practice do not represent territorial interests and, most importantly, in some federations the central state can suppress local self-rule or re-draw territorial boundaries (McKay, 2004). By contrast, some devolved governments (like Navarra and the Basque Country) enjoy almost full tax freedoms, what does not occur in none of the existing federations. Hence, the main differences are apparently across specific country models, rather than between devolved and federal countries.

⁸ A relevant aspect of power distribution refers to the distinction between formal power and effective political autonomy (Vrangbæk and Christiansen 2005). The former depends on the constitutional design

Table 1 below summarizes the main dimensions of formal power distribution in the health care field. While governance tasks at the *meso* and *micro* level are in the hands of subnational governments in most devolved countries, the more critical macro-level functions are shared to different degrees with the central government in all devolved countries. The degree of power sharing at the macro level is the main feature that differentiates devolved health care systems across countries.

Table 1. Distribution of power in health care systems

GOVERNANCE TASKS	DECISION-MAKING	FINANCING
MACRO – Government	Regulation, oversight	Budget & tax powers, audit
MESO – Purchasing	Organization, contracting	Resource allocation
MICRO – Delivery	Management of provision	Payment systems

Source: Adapted from Vrangbæk 2004

The second dimension that defines devolved governments is the prevailing accountability mechanisms. We identify three main types of accountability mechanisms in multilevel governance. The first is vertical bottom-up accountability. This is the key mechanism in federations and devolved government. It includes both democratic accountability - which operates through voting and direct political participation of citizens; and financial accountability – which operates through taxation and other revenue raising mechanisms. The second is horizontal accountability, which depends on the extent of competition and mutual oversight among units within each level of government (that is, among regions or municipalities)⁹. The third is vertical top-down accountability, a remnant from centralized rule, but more restrictively targeted under local self-rule to guarantee that citizens’ rights are preserved, and intense majority preferences are not overruled by territorial minorities.

Finally, the size of subnational governments is also an important characteristic of multilevel governance. It determines both the economies of scale in the provision of devolved public

of political and financial government institutions. In our view, the later depends not only on constitutional design, but also on the relative government capacity of each level of government and other supporting political factors. Government capacity depends on the availability of informal political power resources such as policy expertise, social and political support, or ownership rights (Rico and Costa, 2005). Local governments with sufficient informal power resources would enjoy some degree of political autonomy, independently of the constitutional framework; while central governments with enough knowledge, support and market power can achieve considerable influence upon local governments, even if the constitution prescribes maximum local self-rule.

⁹ Horizontal accountability mechanisms work among peers. It resembles a “checks and balances” system based on units of government having similar *insider* information on common governance task. It brings about the advantages of oligopolistic competition (in contrast to the effective monopoly that prevails under centralized governance).

policies and subnational jurisdictions' (technical) capacity to raise their own taxes, which in turn affects both the scope of policy devolution and the financial accountability mechanisms.

In the next section we present the main differences and similarities among the devolved European National Health Systems according to the three dimensions we described above.

2.2. The different devolved National Health Services

Devolved countries in Europe differ considerably in terms of the size of the subnational governments which are in charge of health care, and also, if less markedly, in terms of distribution of powers. Finland stands out as the only country in Europe in which most health care powers are in the hands of municipalities. Norway is also unique in that health care is split up between two local government tiers: until 2002, counties are in charge of hospitals; while municipalities are responsible for primary and community care. Sweden and Denmark have concentrated power over health on the county council level. In Italy and Spain, relatively large regions are in charge of health care. This amounts to marked differences in the average size of the relevant health care governments. Municipalities in Finland have an average size of 5000 inhabitants, while in Spain the seven special regions had all populations above 2 million inhabitants.

In terms of distribution of powers, the main differences are across European regions: while in the Nordic countries the functions and powers of local governments are not listed or protected in detail by the constitution, the Spanish and also (if to less extent) the Italian constitutions are quasi-federal in this sense. Also, regional parliaments in Southern Europe are explicitly allowed to issue legislation independently from the central state; while in the Nordic countries, local governments are in principle only in charge of applying central laws. In spite of that, until recently, Nordic local governments' effective powers in health care were ample, at a similar level than their Southern counterparts. This resulted from the unwillingness of central governments to issue legislation in a field that had been transferred down. In both groups of countries, the central state only retains the powers to frame legislation; to coordinate personnel, training, research, and pharmaceutical policies; and to manage a few tertiary national hospitals. The rest of powers are under devolved government¹⁰.

¹⁰Against what it is sometime assumed, in the formally federal countries of Europe (such as Germany and Switzerland, as well as Austria and Belgium), the health care powers of subnational governments are very weak, what is consistent with the critical role that insurers' and providers' associations play in health system governance in Social Health Insurance (or Bismarck) countries. For instance, the German *länder* or the French regions have only relevant powers in the field of public health, and hospital capacity planning and development.

3. Do different types of devolved systems evolve different?

So far we discussed the main types of devolved government. In order to understand the dynamics of health care devolution, we need to advance two further steps. The main research objective is to compare and assess the dynamics and paths of devolution reforms across different types of devolved systems that share a common characteristic: a tax-funded National Health System.

3.1 Hypotheses

Our point of departure comes from the debates around the causes and dynamics of institutional change in comparative social research. The two main alternative hypotheses in the field are as follows. On the one hand, *path dependency theory* defends that (H_0) each country tends to follow specific reform paths that are dependent on the initial institutional set-up chosen. Ultimately, this involves that most institutional change is endogenous, derived from a process of internal trial and error; and incremental, as the initial set-up precludes more radical change. On the other hand, *convergence theory* defends that (H_1) radical policy change can result from external shocks; and that, as global shocks are increasingly felt in all countries, their reform trajectories would converge around some shared policy solutions or *best practice* models.

As Bouguet (2003) remarks, a more adequate view of institutional and policy change most probably lies somewhat in the middle of the road. An interesting proposal is the idea of *club convergence*, which expects countries with similar institutional features to adopt the same policy solutions when faced with shared external shocks, through a process of transfer of experiences and mutual learning. A relevant empirical question here is to know how and along which lines are such *country clubs* formed, if at all, in the evolution of devolving health care policies. Do the Nordic countries form a distinctive club, and Italy and Spain a separate one (on account of similar historical trajectories)? Are policy solutions more widely and increasingly shared across Nordic and Southern European countries (on account of a shared –if not homogeneous, devolved National Health System)? Or is institutional change incremental and endogenous?. All these questions require empirical investigation, which follows in the next section.

3.2 *Categorizing devolution reforms*

Before testing the hypotheses it is necessary to clearly define the variable of analysis (health care devolution reforms). As there is a great deal of policy instruments and institutional tools involved in the dynamics of devolved governments, it is a difficult task to choose and conceptualize some of them so that they can conform to a categorical variable of health care devolution reforms. We address this issue by classifying policy instrument and reform moves according to their stated policy goals¹¹. More specifically, we identify three different groups of health care devolution policies, characterized by different types of policy goals and instruments:

In the first group, the main policy goal of devolution is to *strengthen local democracy*. Most policy instruments are directed towards transferring powers and building government capacity at the local level. Financially, the reform aims at guaranteeing the sustainability of the newly (often re)born subcentral governments, which often takes precedence over macroeconomic stability. Local democracy is expected by most to increase the responsiveness of government to citizens' preferences (therefore improving *allocative efficiency*); and by some to expand also the opportunities for citizens' participation in politics, strengthening democratic accountability.

In the second group the policy goal is *microeconomic (productive) efficiency*, and policy instruments focus on transferring financial risk to local governments (such as fiscal federalism); expanding economies of scale through voluntary cooperation among local governments; creating incentives; or promoting competition among them (e.g. via patient choice). The idea is that financial accountability should be closely coupled to local democratic accountability; and more generally that those who decide should bear the financial consequences of it.

In the third group *equity and macroeconomic control* are the main policy goals. Local self-rule is regarded as an obstacle to fulfill them, so that most policy instruments are directed towards recentralizing powers and capacity at the central level, intensifying macroeconomic controls on local governments' financial freedoms, promoting integration across and within government levels, and guaranteeing equality of rights across the territory. Shared rule can be expanded in parallel with re-centralization, so that local governments see their participation in central

¹¹ The explicit policy goals guiding reform and informing policy instruments do not need to be coincident with the actual political goals of the groups who launch and support territorial re-structuring. The former constitute the reform blueprints, while the latter can be conceived as more direct causes of change. Often, political goals are not made explicit at the time of reform, but remain hidden. They are usually defined in terms of achieving *political resources* such as public opinion and voting support, safeguarding revenues and financial resources, or acquiring strategic knowledge so as to improve actors' power positions in negotiations and decision-making processes.

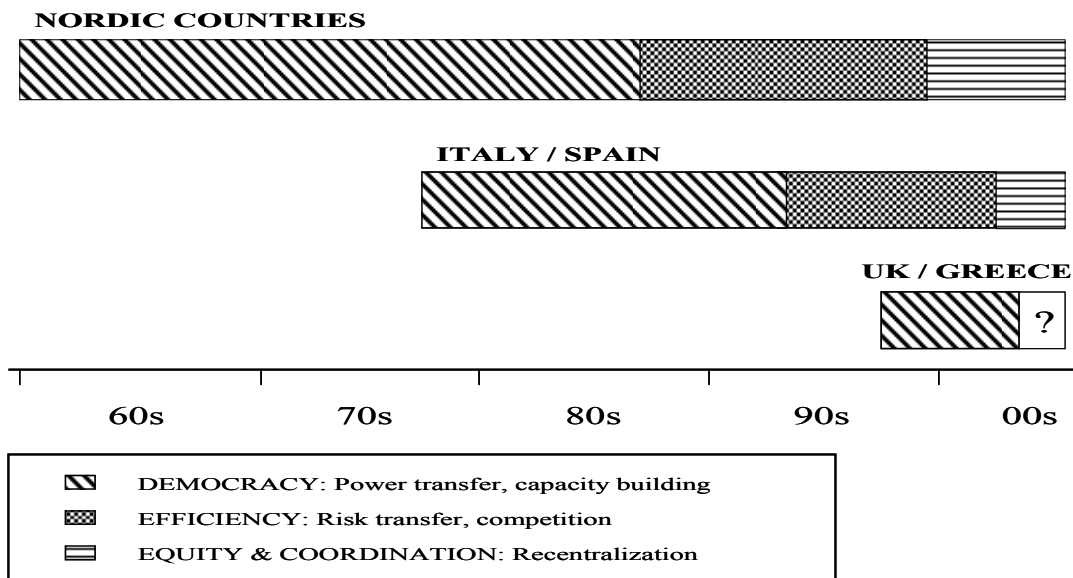
government decisions increase (at least formally), to compensate for the decrease in local self-rule¹².

In the next section we analyze whether devolving policies in each country conform to any of these categories of policy goals and instruments; and compare the path of devolution reforms over time and across countries.

3.3 Empirical analysis: The Dynamics of Health Care Devolution in Europe

Figure 1 displays graphically the *timing* of health care devolution reforms in the European NHS according to the three groups of devolution policies defined in section 2. The Nordic countries follow closely parallel development paths (with Finland often lagging somewhat behind the three Scandinavian countries); and that the two Southern European countries also evolve hand in hand. Despite differences in timing, and clear country-specific features, the phases are apparently similar across North South boundaries, in that similar packages of policy instruments linked to specific policy goals are introduced sequentially in all countries. In what follows, we describe the shared and distinctive reform elements in each group of devolution policy and country.

Figure 1. Health Care Devolution Trends in Europe



¹² This has been the trend in classic federations such as Switzerland, USA or Canada during the last decades (Schmitt, 2004).

3.3.1 Local democracy

In the Nordic countries there is a long tradition of local autonomy and local service provision in health care. For instance, in Finland the origins of the local public health care system can be traced back to the 17th century, when the municipalities started to hire primary care physicians to attend the health needs of their populations; in Sweden county councils (that assumed the provision of health care as their principal task) were established in 1862; in Norway independent general practitioners (GPs) became employees of municipalities (district physicians) in 1836; and in Denmark responsibilities for poor relief and health care assumed by the towns and counties during the 18th and 19th centuries (Jarvelin, 2002; Vallgård, Krasnik and Vrangbæk, 2001; Hjortsberg and Gatnekar, 2001; Furuholmen and Magnussen, 2000)

After the II World War, Nordic local government structures underwent profound reorganization, through parallel reforms expanding their size and increasing local self-rule. In Sweden and Norway, the expansion in size was achieved during the 1950s and 1960s through a two-wave process of amalgamation after which the former 2500 Swedish municipalities were reduced to 280. In Norway, the whole process of amalgamation was not as drastic as in Sweden. In both countries, amalgamation was guided by the *integration model* advocated by the left (the Social Democrats in Sweden and the Labour Party in Norway), emphasizing equal access and integrated planning of public services, which in turn required an increase in the scale of local governments. In Denmark, the reapportionment of the municipal structure was completed almost one decade later, and took place in one go. The amalgamation process was completed in 1974 and reduced the number of county councils from 25 to 14, and the number of municipalities from over 1300 to 275. The strong liberal tradition in Danish society and politics was reflected in a model of devolution which gave more emphasis to strong local self-rule than to integration concerns such as guaranteeing equal access across the territory (Kjellberg, 1988).

In Sweden, the county councils assumed responsibilities for the provision of somatic outpatient care in 1963, and took over private outpatient care in 1970, in addition to hospital inpatient services, which were in the hands of county councils since 1928. In 1985, the *Dagmar* reforms transferred the regulation and oversight of private, contracted-out primary care to county councils. Municipalities were responsible of social welfare services such as child care and school health services since the 1950s. In Norway the counties become responsible for hospitals through the 1969 Hospital Act; while the municipal role in service provision remained in the background until the mid-1980s. In 1984, the Local Authority Health Care Act gave municipalities responsibility over primary health care services, and in 1988 county councils decentralized the management of nursing homes to municipalities. In Denmark, hospitals were

historically owned by municipalities and counties. The National Board of Health had proposed to centralize hospitals since the 1930s; and a key reason for reducing the number of counties in the 1970s was to enable hospital governance to operate at a larger scale. In 1976 counties were also given responsibility for psychiatric hospitals (previously under state control) and in 1977 for non-profit private hospitals. Municipalities took over important powers in health and social care of the children, the elderly, and the disabled starting in the mid 1970s, including community psychiatric care, nursing homes, home nurses, health visitors, municipal dentists and school health services (Jarvelin, 2002; Vallgård, Krasnik and Vrangbæk, 2001; Hjortsberg and Gatnekar, 2001; Furuholmen and Magnussen, 2000).

Among the Nordic countries, Finland is usually considered as the latecomer in welfare state development. In fact, industrial development and urbanization occurred late so that the country long remained predominantly agrarian and rural (Kettunen, 2001). In fact, the great expansion of welfare benefits took place in the early 1970s, when in other countries welfare state policies were being put into question. The process of health care devolution in Finland started however earlier on, and focused on the municipal level since the county level authority is much weaker. During the 1950s municipalities assumed responsibilities in hospital care while in the 1960s hospital districts were built in some areas under the initiative of municipalities. In 1972 the Primary Health Act brought all primary and public health care services that had previously been provided separately under locally integrated health centres, which were subordinated to municipalities.

In Italy and Spain, devolution focused on the regional level of government, and arose much more political tensions than in the Nordic countries. A political history of authoritarian states trying to impose centralized rule upon dynamic, ancient reigns and cities brought about a deeply felt political divide on the issue of devolution. In consequence, political debates were protracted and implementation was difficult. The Italian Constitution of 1948 foresaw the institution of elected regional governments, and detailed the functions to be transferred to them. However, implementation remained blocked in the Parliament due to intense political resistance (Hine 1996; Putnam et al.; 1983; Dente, 1997). With the exception of the five “special” regions (Sardinia, Sicily, Valle d’Aosta, Trentino Alto-Adige and Friuli-Venezia-Giulia), the creation of the remaining “ordinary” regions was delayed until 1970, and the first power transfers did not become viable until the late 1970s. The quasi-federal constitution was the result of intense pressure by special regions. The breakthrough in the 1970s is to a great extent explained by the leftward drift in national politics that took place since the end of the 1960s, characterized by frequent episodes of mass mobilization and political strikes led by the communist party and the trade unions. The initial steps of devolution in Italy were therefore the result of a new political

equilibrium at the national level and of the strong pressures for regional government coming from the periphery, which threatened to secede.

The Spanish State under Franco's dictatorship had imposed centralized rule by force against open (and increasingly violent) opposition from powerful, dynamic regions with long historical traditions of self-government. Unsurprisingly, democracy was only considered feasible provided that it implied some form of devolution to regional governments (Aja, 1999). The Constitution established two initial levels of regional autonomy that resulted in two groups of regions with different powers. Catalonia, the Basque Country, Galicia, Navarra, Canary Islands and Comunidad Valenciana (comprising 60% of the population) formed the group of "special" regions with fully devolved powers while the remaining ten "ordinary" regions assumed a lower level of powers. Although political pressure in favour of devolution was initially only coming from some of the special regions, the extension of regional autonomy throughout all the territory was regarded as a way of diluting the secession demands coming from the periphery. The health care devolution process started in 1978, shortly before the approval of the Constitution, when pre-social security health networks were transferred to the pre-Autonomous Communities. By 1983, all regional governments, parliaments and constitutions were in place.

In Italy, the implementation of regional devolution in health care was launched in parallel with the transfer of management powers to Local Health Units (LHUs) in 1978, but took longer to implement. LHUs constituted as semi-independent local agencies, with their boards made of political parties' delegates chosen by the municipalities. Although in 1974 and 1975 the central government transferred hospital management to regions, these lacked real legislative autonomy yet, and were heavily dependent on earmarked funds from the centre. Unlike the Scandinavian countries, where local government development went hand-in-hand with the decentralization process, Italian localism contributed in a way to undermine the weakness of the regions at the onset of the devolution process. By the time a regional tier of elected governments had been established nation-wide in the early 1980s, LHUs leaders had formed a strong and entrenched class of political entrepreneurs with the monopoly of information resources at the local level and a strong and autonomous bureaucracy (Hine, 1997). Corruption practices and frequent overspending (around 10% of the budget during the 1980s) had undermined the initial popularity of LHUs. Since 1978, regions were formally responsible for LHUs (even if they still lacked real effective powers) and they had to fight for recovering citizens' support for devolved government (France, 2002).

During the 1980s, the decentralization of the Spanish health care system was implemented gradually according to the two-tier system of regional autonomy that had been established in the

Constitution. Between 1981 and 1994 the social health insurance network (which became National Health System from 1986 on) was devolved to the seven special regions with full constitutional self-government rights. In the remaining ten “ordinary” regions the INSALUD - National Health Institute - managed most health care services. In 1987 the Interterritorial Council of the National Health System was created as a deliberative and advisory board, with half of its members coming from the central government, and the other half from the regions. During its early years there was a predominance of the central governmental role and some of the special regions that obtained power transfers earlier on. Until the early 1990s, reforms of the health care system skirted the idea of introducing cost containment measures. In fact, until 1994 the regional resource allocation system – based on historical criteria and bilateral negotiations – gradually eroded the credibility of central government on cost containment and introduced disincentives for regions to diminish their debt, which represented some 10% of the total budget from the mid 1980s to the mid 1990s (Rico and Sabés, 2000).

3.3.2 Micro-economic efficiency

The second phase of reforms in the territorial distribution of health care powers was directed towards containing costs and rationalizing public provision, but still worked within the logic of strengthening local self-rule. The idea that devolved government should resemble well-behaved markets, developed by the US school of public choice school, increasingly influenced the design of reforms, specially from the late 1980s. Reorganization was in general linked to two factors who gained attention at different times depending on the country. First, the large magnitude that the public sector had reached in some countries raised concern about the need to coordinate and re-allocate the multiplying public programs more rationally. The idea of promoting better use of economies of scale through the voluntary cooperation of local governments was seen as a solution to this problem. Also, some re-allocation of tasks took place to facilitate integrated management of different health care programmes. Second, costs were rising rapidly, generating not only fiscal problems, but also political ones derived from the *blame avoidance* strategies of local governments (Pierson, 1996), who accused the central government of under funding local health care and therefore being responsible for most of its faults. Strengthening fiscal federalism emerged as a potential solution, but was not seen as equally politically acceptable in all countries. In all Nordic countries (although to a lesser extent in Norway), local taxes were the predominant source of financing since the inception of local public health care. However, local tax freedoms were heavily regulated by the central state to avoid differences in tax levels across countries.

A first wave of reforms directed to expand micro-economic efficiency took place between the mid 1970s and the mid 1980s in the Scandinavian countries. For instance, in Sweden the Health Care Act (1982) clarified and expanded county councils' powers by explicitly placing financial responsibility and capacity planning in their hands. In addition, the *Dagmar* reform (1985) changed the financing of counties from retrospective reimbursement to prospective, weighted capitation; and established that any deviation from the capitation allocations should be financed by counties themselves. It also transferred cost liability for private, contracted-out services to county councils, who gained the power of deciding which services could be reimbursed by the public system. The instrument used by the county councils to contain expenditure was to decentralize financial responsibilities to health districts through the establishment of global budgets. The districts also decentralized with the same method financial responsibility for the management of clinical and other departments. Since 1988 county councils were grouped into six medical care regions, which were established to facilitate cooperation in tertiary care (Anell, and Svarvar 1999; Diderichsen, 1999).

In Norway, five health regions (an administrative tier managed by associations of counties) were created in 1974 to manage teaching hospitals and highly specialized tertiary hospital care. In addition to that, the financial system based on earmarked grants for each type of service was replaced in 1986 by a block grant scheme under which municipalities were allowed to prioritize resources to different services, while at the same time they received responsibility for keeping actual costs within the specified budget (Hagen and Kaarboe, 2002).

The stronger support for local self-rule in Denmark was illustrated by the early adoption of block grants around 1970. This reform replaced a transfer system based on earn-marked reimbursement grants, which restricted the freedom of local governments to decide on the re-allocation of funds among health care and other policy sectors. Also, since the early 1980s the county councils allocate a global budget to each hospital and this may in turn allocate budgets to separate departments. However, the decentralization of financial responsibility over health care took place together with an increasing central government's control on expenditure. Since the 1980s the central government has increased its role through annual budgetary negotiations with the counties and municipalities in which they establish growth rates of expenditure and average taxation rates. Every year the central government agrees maximum rates of county and municipal taxation with the Association of County Councils and the Association of Local Authorities, a decision that represents the strongest instrument of economic control.

In Finland, reforms directed to increase micro-economic efficiency started to be discussed in 1987, but some of them were delayed until 1993 due to the severe economic depression that hit

the country in the early 1990s. Early moves were taken in 1984, when state subsidies to municipalities were rationalized, and the integration of health care and social services at the municipal level started. In 1990, a new hospital act transferred the ownership and management of hospitals to 21 districts, which were constituted as federations of municipalities. In 1993, a reform of state subsidies was introduced which aimed at generating economic incentives for municipalities by dismantling the heavily centralized planning and financing system of the past. Financial responsibility was handed over to the municipalities, and the average proportion of state subsidies over local taxes was decreased from 40 to 25% during 1993-98. Central regulation regarding organization, personnel and user fees were suppressed; and the municipalities received new freedoms to contract-out provision to private or informal providers. As a result of the reforms, expenditure dropped markedly; little advances were made, though, in relatively resource-consuming options such as contracting-out private providers. One of the main effects of the radical federalization proposals was taking the blame for cost containment away from the central government.

The second wave of micro-economic efficiency reforms took place during the 1990s both in Scandinavia and in Southern Europe. The most innovative moves were made in Finland (see above) and Sweden. As it happened in the rest of Scandinavian countries, improved cooperation among government levels was a salient political issue in Sweden at the start of the 1990s. Specially problematic were the prolonged hospital stays of elderly and disabled patients, who remained in the hospital due to the weaknesses of the municipal social care network, which lacked in capacity and medical staffing. To address such problems, the Care of the Elderly (or Ädel) reform was approved in 1992, which transferred responsibility upon nursing homes and home care to the municipalities. They were also made financially responsible for the hospital costs of 'bed-blockers'. This meant that the costs of the additional bed days following hospital discharge were to be paid by municipalities. The Ädel reforms were considerable successful in reaching their objective of promoting increased efficiency. It provided incentives for county councils to report patients as having completed medical treatment in an early stage, and at the same time it gave municipalities the incentive to urge on discharge of patients from hospital care to nursing homes and special housing. Average hospital stays as well as the number of bed-blockers were drastically reduced as nursing home beds expanded from 7% to 24% of total hospital capacity. The Ädel reforms did also have the effect of increasing the level of co-operation among counties and municipalities in the field of training and special health care programs for the elderly and the disabled (Harrison and Calltorp, 2000).

In a parallel fashion, other market-oriented reforms in Sweden launched in the early 1990s, such as the introduction of patient choice and the purchaser/provider split, had the effects of

promoting closer collaboration among county councils, between primary and specialized care, and across health care districts. Building on this renewed networking capacities, and as a result of broader political and financial reasons, district purchasing agencies were integrated into unified county agencies, and several county hospitals passed to be managed by a single managerial team in several counties during the period 1997-1998. Recent moves include agreements among counties within each health region to move to integrated regional purchasing and management of secondary and tertiary care (Johansson and Borrell, 1999). The Swedish reforms were very influential in Norway and Denmark, which introduced patient choice in the mid 1990s, as well as new activity-based financing systems directed to give incentives to councils to increase their productivity.

In Southern Europe, a series of similar reform moves took place since the early 1990s, which started to materialize and get more radical by the end of the decade. In both countries, a high level of vertical imbalance (separation between central financing responsibility and local and regional spending powers) prevented any attempt to enforce regional and local financial responsibility. In Italy, this resulted in mounted deficits mainly in the affluent northeastern and central regions. The fact that the government financed deficit *expost* meant that the redistributive effect was the opposite than expected. In addition, demands for greater regional financial autonomy were opposed by the government, which wanted to keep the financial control of the system. Instead, market-based reforms similar to the Swedish and British internal markets were introduced starting in 1994. Management autonomy is delegated to LHUs and tertiary hospitals, while the regions are let free to purchase services from them, or from private, contracted-out providers. Regions are made responsible for their own deficits, but heavily constrained to raise new resources due to fiscal centralization, and already high levels of taxation and co-payments. In 1997 and 2000, new acts were launched which expand financial autonomy of regions through the transfer of some percentage over central taxes, within the framework of an explicit transition towards federalism in Italian health care.

In Spain, fiscal federalism reforms started in 1997 with the transfer of 30% of income taxes to all regions except the Basque Country and Navarra, which enjoyed full fiscal freedoms since the early 1980s (a power they had hold historically, up to the late 19th century). In July 2001, further transfer of financial powers were made to all regions, including 33% of income tax, 35% of VAT, and a varying percentage (ranging between 40% and 100%) of special taxes on alcohol, tobacco and petrol. Also, central transfers, previously earmarked to health care, are integrated within the general capitated block grants to regions, thus allowing regions to decide on intersectoral allocations. In January 2002, health care powers were transferred to the 10 ordinary regions, what required a reform of regional constitutions.

3.3.3 Equity and coordination

The reforms introduced by the Nordic countries since the mid to late 1990 open a new phase in the process of territorial restructuring in Europe. On the one hand, for the first time there is a clear shift in the reform path, from expanding local autonomy to strengthening central powers. On the other hand, reforms focus this time in several policy goals (equity, macroeconomic control, service integration) subject to trade-offs, while in previous phases a single, clear-cut goal was prioritized instead. Formally, they also tend to become less visible. Manipulating the political visibility of reforms by resorting to highly technical instruments or micro-regulations (e.g. ordinances versus laws) is a strategy chosen by governments to promote reforms which are not popular with the public, so that accountability is blurred, allowing for the political costs of reforms to remain low. The use of equity (a popular policy goal in Europe) alongside macroeconomic stability helped decreasing the political costs of re-centralization reforms (Pierson, 1996).

Recentralization reforms have been particularly forceful in Norway since the late 1990s. An outstanding example is the reform of the hospital financing system in 1997. The main motivation for the reforms was a relative decrease in the amount of resources dedicated to specialized care during the late 1980s and early 1990s, which led to drops in activity levels and expanded waiting times. The central government responded by decreasing block grants to county councils, and allocating these free funds to counties on a fee-for-service basis instead. This means that 60% of each county budget directly depends on its hospital and outpatient specialized activity levels. By 1999, all counties had shifted to activity-based financing for hospitals (although they were not forced to do so). This has brought about moderate increases in hospital capacity and utilization, and a sharp decrease in waiting lists (which are centrally regulated and monitored through a system of waiting-times guarantees). The 1997 financing reforms in fact mixed elements of the previous phase (transferring financial incentives to counties), and elements of re-centralization (as the changes were centrally imposed and the resource allocation freedoms of regions decreased).

A combination of increasingly detailed framework legislation by the central state and frequent use of earmarked funds targeted to the first stages of development of particular reform packages also worked towards recentralization, even if under lower political visibility. During the 1990s some examples of that are: capacity developments in nursing homes; the psychiatric reform; the new network of care for the mentally handicapped; and the creation of a list system in primary care. In addition to that, the introduction of regional planning in 1999 involved a further attempt

by the central state to foster cooperation and continuity of care across subnational governments. Under the new regulation, though, regions were not conceived as voluntary associations of local governments, but rather as centrally managed and controlled bodies. And the central government for the first time can modify regional/county planning on its own if it is not adjusted to national priorities.

But the more radical move towards re-centralization is undoubtedly the transfer of ownership and management of hospitals from the counties to the central government in 2002. The reform was the initiative of a minority labor government, in office only for a few months after a crisis in the previous coalition government; and was rapidly passed in Parliament with the support of the conservatives, who saw the move as an opportunity to strengthen market-based reforms in Norway. The recentralization of hospitals was preceded by an expansion of patient choice; and followed by a transfer of the management over hospitals to the new regional agencies, instituted as administrative bodies, with their board members appointed by the central state. Both regions and hospitals were constituted as public enterprises, and 70-80 hospitals were merged into 45 health enterprises. In general, the shift to tighter central control tried to address growing discontent with the problems of insufficient scale of local governments; weak coordination among levels of governments; duplication of resources; growing tensions between the central state and the counties on who was to be blamed for financing problems in health care; differences in utilization and accessibility rates across local and regional governments; and increasing dissatisfaction among the population due to growing waiting lists.

During the late 1990s, the regulations and recommendations issued by the central state to local governments within the annual budgetary agreements became more specific and detailed in Denmark, also in the direction of expanding central control and decreasing financial and regulatory local freedoms. Also, earmarked financing to promote the advancement of central priorities was more extensively used. The approach was however initially more subtle than in Norway. For instance, waiting times guarantees were not compulsory for counties, but in practice, as considerable resources were geared towards waiting times reduction, the need to obtain more resources restricted local autonomy to decide on the priority to be given to waiting lists (Vrangbæk and Christiansen, 2002). In 2004, a new liberal-conservative government in Denmark decided to follow the Norwegian example and launched a package of reforms (to be implemented by 2007), which were openly in the direction of re-centralization. The reforms passed in 2004 included: the suppression of county councils, replaced by 5 new health regions with democratically elected boards but without tax powers; a further reduction in the number of municipalities from 275 down to approximately 150; a transfer of most municipal health care powers (child and elderly care, some primary care) to the regions, together with an expansion of

their responsibilities in the fields of health prevention and promotion; and a modest shift towards activity-based financing (which will go up to 15% of total financing). An interesting innovation is that municipalities will keep on funding 20% of total regional health care costs, so that they have incentives to develop efficient prevention programmes which will reduce their populations' need for treatment (Vrangbæk, 2004).

In Finland, the de-regulation accomplished during the 1990s is accompanied by new *soft regulation* by the central state, which focus on improving information and statistical systems so as to evaluate the results obtained by municipalities; expanding national priority projects under earmarked financing; assessing and deciding on the introduction of new technologies, and issuing recommendations and clinical guidelines for health care personnel. An example has been the development of mental health care services through central subsidies and quality regulation. In addition, in 2000 new central government regulations introduce constraints in municipal freedoms to establish co-payments, what involves a return to the pre-1993 situation in this field (Koivusalo, 1999).

In Sweden, as in Finland, the main trend during the 1990s is towards strengthening financial self-rule; in 1992 the Ädel reforms strengthen the powers of municipalities, while in 1997, the financial responsibility for prescription drugs is transferred to counties. But, as in Finland too, from the late 1990s some less visible re-centralization trends emerge. The stronger move in this direction was a new act approved in 2001 by the social democratic government, banning the privatization of acute hospital care which had advanced rapidly in Stockholm and other county councils in the hands of the conservatives during the late 1990s. Other initiatives had been: the 1998 central action plans trying to push county councils to rely more on primary care; the attempts made at controlling deficits and new taxes in the privatizing county councils; and the debate opened at the start of the 2000s around the desirability of recentralizing research and training, technology assessment, tertiary care, co-payments and clinical guidelines (Anell, 2002).

In Southern Europe, there are also some attempts at expanding equity and coordination in health care through reinforcing the powers of central government. In Italy, the 1998-2000 National Health Plan as well as the 111 Health Care Act represents a monumental (if partially failed) effort at regulating centrally health care benefits, patient mobility, and other aspects of the system, so that the new regional autonomy could not run counter to equal rights across the territory. A central independent agency (the ASSR) in charge of generating comparative research and evaluation on regional health care governance, which was successfully re-founded in 2001, had healthy supporting evidence. In Spain, the 2003 Decree of Cohesion and Quality of

the National Health System was directed toward similar objectives; and rapidly implemented by a particularly efficient ministerial team. However, the electoral swing in March 2004, which replaced the centre-right government launching the reforms, with a new social democratic executive, will apparently block further development of the reforms in the years to come.

4. Assessing devolution: trends and prospects

The process of devolution in European health care has proceeded through several comparable stages in all countries with devolved health care systems. Apparently, therefore, policy learning and transfers have not been confined to neighboring countries, but rather operated at a Europe-wide scale. Our analysis identifies three main groups of devolution reforms that all European countries with a devolved health care system have apparently followed. Among the National Health Systems the Nordic countries consistently pioneered all the phases of the devolution process in Europe; lately followed by Southern Europe; and more recently, by Central and Eastern Europe and the UK¹³. However, against the logic suggested by this timing, devolution reforms were less radical in the Nordic countries than among the latecomers. Also, the perceived outcomes of devolution in the Nordic countries appear to be more negative than in the rest of European countries, what could be due to the smaller scale of devolved government in these countries. Hence, the re-centralization backlash experimented at the turn of the century was also stronger in some of the Nordic countries, and especially in Norway and (to less extent) Denmark.

The evidence examined points to a process of convergence between Nordic and Southern European countries in the field of devolution policies during the last decades. This suggests that, among the alternative hypotheses examined in section 2, club convergence seems to be best fitted to our empirical data. Until now, however, the concept of club convergence has been used in the literature in a much more restricted sense than the one suggested by our research. Usually it is applied only to countries with markedly similar historical traditions and political institutions (the typical example are precisely the Scandinavian ones). Our research results suggest that it is necessary to redefine the concept, and to investigate in detail which type of institutional similarities favor the transfer of experiences and reform paths across countries.

¹³ In the UK health care was devolved to Scotland and Wales starting in 1998. In Greece, a package of reform proposals elaborated from 1999 onwards initiated devolution in health care. In Central and Eastern Europe, the countries of the former Yugoslavia, together with Hungary, Poland and the Czech Republic, started from the mid 1990s to transfer primary and social care (and sometimes some specialized care also), to local governments. By contrast, in Portugal a referendum on the desirability of instituting democratically elected regions in health care and other sectors took place in 1996; but the majority of citizens stood against it.

Causes, consequences and prospects

Issues around the causes, consequences, or factors that promote the sustainability of devolved government lay outside the scope of the analysis. In spite of that, our empirical evidence suggests that each phase in the devolution process has different, specific causes; brings about distinctive effects; and requires different supporting mechanisms to become self-sustained. Moreover, the different phases could be causally linked among them, so that if the first phase is perceived as failing to achieve its policy and political goals, it leads to the second phase; and likewise, when the second is perceived as unsuccessful, the third follows through¹⁴. An open question is thus whether there is circularity on top of causality across phases; or in other words whether a failing third stage would lead to re-starting the first one all over again.

The reforms analyzed in this article show that devolution is an unfinished and ongoing process that involves the constant search for a more efficient balance between central steering and local self-rule. Re-centralizing reforms in Norway and Denmark also emphasize that, against the established wisdom in this sector, devolution can be a reversible process. Further research on the evolution of those recent reforms in the future should focus on casting light on the degree to which devolution can be reversed, and therefore, on the potential existence of a cycle of concentration/deconcentration of powers in devolved countries. It is still too soon to elucidate in which direction will Nordic and Southern European countries evolve in the next coming decades. On the one hand, and following the profound political and fiscal devolution fostered during the last 30 years, will re-centralizing reforms take over in Southern Europe as in some of the Nordic countries? On the other hand, we currently ignore if the recent developments in some of the Nordic countries will lead them towards further re-centralization, or rather towards the re-founding of local democratic self-rule at the regional level. The latter option will represent a clear convergence towards the Southern European model of devolved government; the former, a critical turning point, away from historically entrenched local self-rule. The future evolution of devolution in Greece, the UK and Central and Eastern Europe should also be investigated further, to elucidate whether devolution policies in these countries proceed through a similar sequence of policy goals and reform instruments than the Nordic and Southern European countries.

¹⁴ The relative success or failure of each devolution phase is expected to depend not only on institutional design and effective government capacity, but also on cultural and political factors linked to the diverse historical experiences with devolution in different countries and sectors

REFERENCES

- Aja, Eliseo. *El Estado Autonómico. Federalismo Y Hechos Diferenciales*. Madrid: Alianza Editorial, 1999.
- Anell, A. and P Svarvar. "Health Care Reforms and Costs Containment: The Swedish Experience." In *Health Care and Costs Containment in the European Union*, eds. E. Mossialos and J. Le Grand. Ashgate: Aldershot, 1999.
- Anell, A (2002), Decentralization in Swedish health care, paper presented in the XXII Congress of the Spanish Association of Health Economics, Pamplona, May 2002, available from URL: www.aes.es, /Jornadas, /XXII Jornadas, /Programa /Anders Anell
- Blom-Hansen, Jens and Thomas Pallesen. "The Fiscal Manipulation of a Decentralized Public Sector: Macroeconomic Policy in Denmark." *Environment and Planning C: Government and Policy* 19 (2001): 607-23.
- Bouguet, D. Convergence in social welfare systems: What are we talking about?, Social Policy and Administration, in press. "Convergence in Social Welfare Systems: What Are We Talking About?. Comparing Dynamics of Transformation of Social Protection Systems in Context of Globalization and European Construction", April 2002 [Welfare Reforms for the 21st Century - Second Conference - Oslo].
- Dente, Bruno. "Los Gobiernos Subnacionales En La Larga Transición Italiana." In *Federalismo Y Subsidiariedad En Italia*. Barcelona: Fundació Carles Pi i Sunyer d'Estudis Autonòmics i Locals, 1998.
- Diderichsen, F. "Devolution in Swedish Health Care." *British Medical Journal* 318 (May 1999): 1156 - 1157.
- France, G. "Compatibility Between the National Health Service Model And Decentralised Government: The Case of Italy", Pamplona, 29-31 Mayo 2002 [XXII Jornadas Asociación Economistas de la Salud].
- Furuholmen, C., J. Magnussen and A. Rico. *Norway. Health Care in Transition Profiles Series*. Copenhagen: European Observatory on Health Care Systems, 2000.
- Hagen, Terje P. and Odvar M. Kaarboe. *The Norwegian Hospital Reform of 2002: Central Government Takes Over Ownership of Public Hospitals*. , Working Paper 2004:1.
- Häkkinen, Unto and Juhani Lehto. "Health Care Reforms of the 1990s in Finland", n.d. A paper to be presented a LSE, 21-22 February 2002
- Harrison, M. and J. Calltorp. "The Reorientation of Market-Oriented Reforms in Swedish Health Care." *Health Policy* 50 (2001): 219 - 240.
- Hine, D. "Regionalism in the Italian Republic: Centre and Periphery Under Strain." In *Italian Regionalism. History, Identity and Politics*. Oxford: Berg, 1996.
- Hjortsberg, C. et al. *Sweden. Health Care Systems in Transition Profiles Series*. Copenhagen: European Observatory on Health Care Systems, 2001.

- Jarvelin, H. *Finland*. Health Care Systems in Transition Profiles Series. Copenhagen: European Observatory on Health Care Systems, 2002.
- Johansson, R. and K. Borell. "Central Steering and Local Networks: Old-Age Care in Sweden." *Public Administration* 77, no. 3 (1999): 585 - 598.
- Kettunen, P. "The Nordic Welfare State in Finland." *Scandinavian Journal of History* 26, no. 3 (2001): 225 - 247.
- Kjellberg, F. "Local Government and the Welfare State: Reorganisation in Scandinavia." In *The Dynamics of Institutional Change. Local Government Reorganisation in Western Democracies*, eds. B. Dente and F. Kjellberg. London: Sage, 1988.
- Koivusalo, M. "Decentralization and Equity of Healthcare Provision in Finland." *British Medical Journal* 318 (May 1999): 1198 - 1200.
- McKay, David. "William Riker on Federalism: Sometimes Wrong But More Right Than Anyone Else?" *Regional and Federal Studies* 14, no. 2 (Summer 2004): 167 - 186.
- Mills, A., P.J. Vaughan, D.L. Smith, I. Tabibzadeh and (eds.). "Health System Decentralization. Concepts, Issues and Country Experience.", 1990. World Health Organization
- Pierson, Paul. "The New Politics of the Welfare State." *World Politics* 48 (1996): 1996143 -179.
- Putnam, R. et al. *Making Democracy Work. Civic Traditions in Modern Italy*. Princeton: Princeton University Press, 1993.
- Rico, A. and J. Costa. "Power Rather Than Path Dependency? The Dynamics of Institutional Change Under Health Care Federalism." *Journal of Health Politics, Policy and Law* 30, no. 1 (February 2005).
- Rico, A. and R. Sabes. *Spain*. Health Care in Transition Profiles Series. Copenhagen: European Observatory on Health Care Systems, 2000.
- Saltman R.B., V. Bankauskaite and K. Vrangbaek. "The Role of Decentralization of European Health Care Systems", February 2004 [Report to IPPR].
- Schmitt, N (2004) The diminishing autonomy of subnational entities in federal countries, New trends in federalism working paper #1, Institute of Federalism, Granges-Paccot, Switzerland, available from URL:
http://www.federalism.ch/attachment/8427b695bb71c1559997a9c9b489ce1d/94f1a8a9326d4dfe17e2f0bc10c1b727/New_trends_in_federalism_WP1.pdf
- Tanzi, Vito. "Fiscal Federalism and Decentralization: A Review of Some Efficiency and Macroeconomic Aspects." In *Annual World Bank Conference on Development Economics*, eds. Michael Bruno and Boris Pleskovic. Washington, D.C.: World Bank, 1995.
- Vallagarda, S., A. Krasnik and K. Vrangbaek. *Denmark*. Health Care Systems in Transition Profiles Series. Copenhagen: European Observatory on Health Systems, 2001.
- Vrangbæk, K (2004), Decentralization and recentralization in Scandinavian health care, paper presented to the European Conference in Health Economics, London September 2004, available from URL:
<http://www.lse.ac.uk/collections/LSEHealthAndSocialCare/europeanConferenceOnHea>

lthEconomics2004/EHPGPAPERS/EHPG6aVrangbaeck.doc.
Vrangbaek, K. and T. Christiansen. "Transformation and Stability in Danish Health Care",
February 2002 [[Paper for EHSDG LSE]].

Vrangbæk, Karsten and Terkel Christiansen. "Health Policy in Denmark, Leaving the
Decentralized Welfare Path?" *Journal of Health Policy, Politics and Law* 30, no. 1
(February 2005).