

DECENTRALIZATION AND MANAGEMENT AUTONOMY? EVIDENCE FROM THE CATALONIAN HOSPITAL SECTOR IN A DECENTRALIZED SPAIN

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ABSTRACT

The organization of inpatient care provision has undergone significant reform in many southern European countries although the success of the underlying incentives relies on the institutional design with respect to achieving efficiency and promoting policy innovation without harming the essential principle of 'equal access for equal need' that grounds National Health Systems (NHS). This article explores some of the specific organizational developments of decentralizations structures drawing from the Catalanian experiences. We find that the coincidence of both managerial and political decentralization is associated with the mergence of organization and policy innovation resulting from policy experimentation at the regional level might be an additional feature to take into account when examining the benefits of decentralization.

INTRODUCTION

The world in which public managers function is rapidly changing and vastly different. Recent policy developments in the organization of publicly funded health care services indicate a shift towards more decentralization at an organizational level, whilst promoting more management flexibility and autonomy. This shift is reliant on a new set of tools derived from principle-agent theories for the transformation of public sector management (Gray and Jenkins, 1995) being applicable to the health care arena in those countries where the health system is publicly financed and organized. Decentralization and deregulation are increasingly highlighted as instruments for providing more accountable governance arrangements, and ultimately in attempting to obtain efficiency improvements¹. Indeed, decentralized organizations are theoretically able to take advantage of organizational efficiencies and as a result promote internal competition and greater transparency (Saltman and Bankaukaite, 2006). Yet, decentralization alone will not necessarily succeed if it does not encompass a set of underlying incentives for efficiency, and that it is these administrative incentives which may determine whether intended goals are in fact achieved².

¹ Decentralization—including here 'devolution' as the transfer of authority and responsibility for public functions from the central government- to subordinate or quasi-independent government organizations and/or the private sector—is a complex multi-faceted concept and here we refer to the political dimension at the regional level and administrative dimension at the organizational level.

² For instance routine activities might not improve in performance with decentralization given that they are not sensible to the proximity of incentive control and might be relatively homogenous. On the other hand, decentralization in setting where there is limited scope to influence performance can result in the loss of economies of scale and a reduction of the governmental control over scarce financial resources by the central government.

One way to understand administrative decentralization in particular is to envisage it as an institutional reform that affects public policy accountability³ by means of replacing “top-down rules” with less restrictive contracts that grant varying degrees of autonomy to public service providers. Higher organizational flexibility – and discretion in decision making – are consequences of the introduction of incentives into health care organizations (Hood, 1991). According to this framework, decentralization would be expected to reduce direct control (Friedman and Friedman, 1990), smooth out hierarchical structures and arguably to increase capacity to identify the performance of each agent within specific institutional structures. The move towards organizational reform has been intensive in those public policy areas that touch upon welfare policy given their marked impact on local constituents who benefit from the performance of services such as health care. On the other hand, this makes coordination more complex as while there will be greater autonomy at the same time there is a need to improve coordination between different agents.

In the health care arena, there have been progressive moves towards the decentralization of responsibility to smaller units of management (e.g., at the hospital level), with a view in particular to improving performance management. The notion behind this is that by increasing provider autonomy, the performance of providers becomes transparent and open to the introduction of performance management tools, and accordingly prone to the implementation of adequate “checks and balances”. Therefore, greater management autonomy is expected to improve provider responsiveness to local needs, facilitate local community involvement and hence, improve local accountability to better identify outcome improvements (Wilmot, 2004). The examination of the effects of current moves towards decentralization and provider flexibility and autonomy are especially relevant in those countries such as Spain that have not only decentralized the management but also the governance arrangements of their public services organizations. Indeed, decentralization encompasses superior choice and arguably a better chance for providers to introduce organizational innovations within specific geographical areas to adapt policy to fit regional needs and preferences.

The shift towards greater management independence and responsibility from the financial payers has been particularly marked in the health care arena and especially in those countries with integrated systems such as Spain which are progressively decentralised tighter budget limits. This implies fiscal devolution, diversification of strategies in health care, drawing heavily on higher managerial discretion. Some examples are those of the Private Finance Initiative (in some Autonomous Communities in Spain such as Madrid or Valencia, as in the United Kingdom)⁴, contracting out strategies in the Basque regions or in Catalonia (as in Portugal hospital staff have been moved onto private sector contracts). Both suggest that some efficiency gains from

³ Accountability is understood in a broad sense as “answerability” , that is captures the idea of being accountable is expressed almost exclusively in terms of being answerable or responsive to some entity, namely the government either in a centralized or decentralized structure, yet we do not attempt to discuss this issue further in this article. For a discussion of the moral elements being see Dubnick,(2003).

⁴ Allowing the private sector to build hospitals which are then leased to the NHS typically under 30 year contracts

greater flexibility can be achieved (Docteur and Oxley, 2003) perhaps at the cost of diversity and the sense of loose social cohesion. Indeed, in the health care arena there is little comprehensive theoretical grounds on the specific mechanisms that explain the extent to which decentralization in health care promotes desirable policy outcomes. One of the limitations is that desirable outcomes are highly difficult to identify and measure and often performance indicators depend on their institutional setting. Hence, it is important to look at actual s in those countries that have undertaken steps towards fiscal devolution and/or the introduction management autonomy and decentralization, in order to empirically identify likely factors that may influence the generation of desirable outcomes (Pool et al, 2000).

Spain stands as a highly heterogeneous country in both needs and preferences. Accordingly, a fiscal and therefore functional decentralized health care system was implemented after the country passed its democratic constitution in 1978. This came together with the implementation of a British style NHS (with the 1986 Spanish General Health Act) at a time that Britain was starting to prepare the NHS to the next century. However, in Spain fiscal decentralization led to a higher support for greater managerial freedom against many public complaints that the central system suffered from ‘excessive bureaucratization’ and was in need of modernization. As a result, a new NHS management ‘culture’, arguably more consistent with current values than those of the mid 1980s, was introduced across the country (Ormrod, 2003) hand by hand with regional devolution. To fulfill an implicit demand for NHS modernization, different institutional reforms were developed to improve the managerial flexibility and autonomy in health care provision including the development of (i) private health care profit making bodies, that is private bodies that devote private funds to specific health care activities, (ii) foundation hospitals, that is public hospitals that work as autonomous accountable institutions, and finally (iii) consortia, referring to bodies that manage a combination of several – public and private - units or departments. Some of these new institutions were influenced by institutions that had already developed in those autonomous communities where some political responsibility for health care had been present since the 1980s, most notably Catalonia. It is not a coincidence that Catalonia, as the first autonomous community to have responsibility for health care, would also be the first region to implement the new health care organization reforms. Given that two thirds of hospitals are privately owned - although under specific contracts with the NHS- it can be expected that inherent preferences with respect to the governance of organizations would be expected to deviate from the Spanish norm. Given the prominence of some “first mover” advantage within public service organizations, the experience of the Catalan health services should be expected to be innovative relative to other regions, despite the fact that a comparatively dense network of associations and groups might to an extent make certain flexible structures more feasible there than elsewhere in the country.

This article has three main purposes. First, to provide a descriptive overview of the organization of inpatient care in Spain and Catalonia – the first region-state (Autonomous Community - *Comunidad Autonoma*) within Spain to obtain health care responsibilities- in order to ascertain the extent of organizational innovation. Furthermore, we provide a comprehensive description of the incentives facing doctors in foundations, cooperatives and consortia vis a vis those doctors employed on permanent state contracts in hospitals with a traditional hierarchical structure. Second,

we explore current evidence from some regional health services on the expansion of decentralization and management flexibility. Third, we highlight some practical lessons for those undertaking institutional change in other countries, and especially those subject to a similar health system environment. All three examples of new institutional hospital structures in Spain are self-governing, enjoying freedom over how they manage their budgets; treating patients free of charge, and remaining publicly financed. Contrary to what might have been feared, on the basis of these experiences we argue that decentralization and diversity in itself does not threaten the public nature of health care and might, under certain circumstances produce successful results.

The article is structured as follows. In the next section we provide a brief summary of the theoretical background underlying organizational innovation in health care. Then we describe different organizational models of health care provision in Catalonia and elsewhere in Spain. Section four provides qualitative evidence on current findings and organization structures while section five concludes with a discussion pinpointing some key lessons from the Spanish and Catalan experience.

DECENTRALIZATION AND AUTONOMY OF HOSPITAL ORGANIZATIONS

One of the dominant assumptions in the organizational change literature is the need for the transformation of hierarchical structures in order for organizations to prosper. Decentralization represents one way to deal with the increasing bureaucratization, potential entrenchment and limited innovative capacity and lack of local autonomy to deal with community specific problems that may be seen in highly centralized structures. Hence, decentralization can be seen as an institutional reform that may facilitate policy innovation and better suit the needs of consumers of public services such as health care users. However, there are a number of ambiguities surrounding the rationale for the organization of power arrangements. This is particularly seen in the case of public sector organizations that have historically relied on power elites to perpetuate established hierarchy schemes (Kraemer et al 1989). It is quite well known that public sector political constraints do not allow at the central level high powered incentives schemes. The hypothetical trade-off between efficiency and flexibility is perhaps the most enduring idea in organizational theory (Thompson, 1967, Hannan and Freeman, 1989) whereby flexibility can only be achieved at the cost of efficiency. However, some approaches (Galbraith, 1977) indicate that under certain circumstances specific organizational designs can improve efficiency and flexibility at the same time. Holmstrom and Milgrom (1994) recognize that incentives within organizations might enhance cooperation and coordination mechanisms that ensure the attainment of both efficiency and autonomy (Horn, 1995 and Gibbons, 1998). Whether this purpose can be served by decentralizing health care management to service providers or is better guaranteed by a rigid hierarchical supervisory structure is an open discussion in management theory literature (Williamson, 1996, Allen, 2002).

In addition to fiscal devolution, decentralization implies an arrangement between a principal and an agent hired to accomplish some specific task. As principal-agent theory has long argued, appropriate incentives must be provided for the agent to deliver desired outcomes. As the principal cannot directly measure the effort level of the agent,

incentives need to be provided by making the agent's pay partially contingent on performance. Still, some limitations might arise when it is not possible to specify clear performance measures in advance or, as in the case of health care, when there are measurement problems in identifying efficiency in the provision of services and whether they lead to system fragmentation and some equity concerns. The solution prescribed by agency theory calls for a comprehensive contract that considers the marginal value of all possible activities of agents and the marginal cost to agents in all possible states of the world, and the ability of the principal to commit to pay the appropriate level of compensation for each outcome (Hart and Holmstrom, 1987). Nonetheless real world contracts are incomplete; there are inevitably some circumstances or contingencies that are left out of the contract, because they were either unforeseen or simply too expensive to enumerate in sufficient detail (e.g., the level of intangible quality of care). Therefore, opportunities for improving flexibility in health care are likely to depend on the specific organizational design as well as on the prevailing management culture and legal constraints.

It is possible to distinguish three broad models of decentralization, which differ in the (i) level of private sector involvement, (ii) the presence of fiscal and regulatory mechanisms at the political local-state level, (iii) accountability frameworks and the extent of autonomy of both organizational and financial institutions in the provision of health care and (iv) management capacity and the transparency of the financial allocation system is. Decentralization following Rondinelli (1983), can take the form of devolution, deconcentration, delegation and privatization. The extent to which a country can restructure the provision of health care will of course also be constrained by political and social values.

THE MOTIVATION AND CONSTRAINTS OF ORGANIZATIONAL INNOVATION IN SPAIN

Health care expenditure accounted for 7.7 per cent of gross domestic product (GDP), of which approximately 72% (5.5 per cent of GDP) was for public expenditure according to the latest Spanish Ministry of Health. From a functional perspective 52% of total funding is inpatient and specialized care. Furthermore, 42% of expenditures refer to salary and payments to providers and 12% to contracting out arrangements implying that potential reform in this area would be expected to exert an important impact on expenditure. Health care is fully financed by general taxation since 1999; and patients only make modest out of pocket contribution towards some minor procedures as well as paying 40% of the costs of prescription drugs, though still there are exemptions from charges for some groups including those over retirement age and reduced charges for others including people with certain chronic conditions and disabilities. Three quarters of the population believe that all health care services should be fully funded through taxation, while 15% (20% in Catalonia) are in favor of some sort of personal contribution towards health care costs, while just a tiny minority (around 3% both in the whole Spanish state and Catalonia alone) believes that the patient should cover all the costs of health care (Barometro Sanitario, 2005).

The system has worked on the basis of a regionally decentralized structure since the early 1980s, when Catalonia became the first Autonomous Community responsible for

health care policy, culminating in the complete transfer of such responsibilities to all 17 Autonomous Communities (AC) by 2002⁵. In the last two decades, and thanks to the decentralized nature of the health system, there has been an increase in government responsiveness and policy innovation in the organization of health services, which has had some impact on the efficiency of health care provision. During the 1990s, the new vogue in health care management was the introduction of a contract system (pseudo purchaser-provider split) at the hospital and service level. Catalonia and the Basque country established independent public agencies to coordinate the purchasing function, while a specific measure was introduced by the Catalan system to measure and reimburse hospital activity; this was later extended to all AC's (López Casasnovas, 1993). During the mid-1990s, Andalusia, Catalonia and the Basque Country introduced a prospective payment system based on Diagnosis Related Groups case-mix adjustment for complexity that has evolved to a mixed system that includes retrospective global budgets. Currently, the vast majority of Spanish ACs are introducing some form of prospective payment system based on performance management indicators, which have as a benchmark the experiences of Catalonia. Prospective payment or forward-looking budgets provide incentives to keep costs down –not to overspend - and avoid inefficiencies by stating ex-ante any contract conditions with providers (Chalkley and Malcomson, 2000).

Spain ranks highly in aggregate performance, as measured through health indicators such as mortality and health expenditure⁶. However, this situation contrasts markedly with a rather poor micro-clinical performance as measured by user satisfaction (Blendon *et al.* 2002), clinical practice variation (VPM *The Dartmouth Atlas* for Spain, several years), waiting lists and organization climate (Docteur and Oxley, 2003). Interestingly, some evidence suggests that whilst about 72% of the Spanish population (80.1% in Catalonia) believes that the public health care system has improved markedly during the last ten years (Barometro Sanitario, 2005)⁷, barely 48% (41% in Catalonia) believe that public services in general have improved. Yet, given that health care, along with education, is one of the few responsibilities that have been decentralised to the regions this might suggest that either decentralization improves the visibility of health system actions that would perhaps have happened in any case, and also or, alternatively it may have indeed improved individual perceptions of the provision of health care services in Spain.

The Spanish health care system relies on doctors who enjoy civil servant status, meaning that their salaries are defined centrally in annual central budgets, and they are guaranteed employment for life. There is evidence that the medical profession does though retain has a sense of clinical autonomy that is evidenced by 'unjustifiable'

⁵ The transfers to Catalonia were completed in 1981, followed by Andalusia (1984), the Basque country and Valencia (1988), Galicia and Navarra (1991) and the Canary Islands (1994). Along with the timing, *health care financing remained an exclusive central power*, with the exception of two regions (the Basque country and Navarra), which enjoyed almost full fiscal autonomy in accordance with their historical statutes.

⁶ - The Spanish Health System exhibits a fifth place in the WHO ranking, with good health standards and low public expenditure in terms of GDP (5.4% in 2001).

⁷ <http://www.msc.es/estadEstudios/estadisticas/docs/BS2005CCAAv3.pdf>

variations in clinical practice (Moya *et al.* 2002). Furthermore, health care administrators are compelled to manage their resources under a common budget constraint, and are subject to restrictive administrative rules; arguably in place to prevent fraud but that reduce significantly the scope for management flexibility. In this setting, a health care manager use tentative budgets for efficiency improvements, but the practice suggests that they end up being retrospectively adjusted and strongly subject to political influence given that the medical profession has a strong political voice (Rico *et al.*, 1998). Finally, as noted above, evidence from opinion polls indicates that the public opposes measures that would result in the introduction of co-payments (Barometro Sanitario, 2005), arguably because they view them as a restriction to access to care which might in turn be used to justify further welfare state cuts.

The efforts (and failures) to change the present situation include the introduction of a variable component into doctors salaries based on productivity (ultimately incorporated into basic salary); a purchase-provider split with Programme Budget Contracts (which have proved illusory as both providers and purchasers are public agents under a centralised retrospective budget); free choice of salaried primary care doctors by patients - which has meant a lower work load without losing remuneration; or the search for 'accurate' payment systems for hospitals on the basis of 'needed' activity and thus the illusion that 'worse' (more activity) is 'better' for the institution. Finally, in this context and in absence of some more radical changes at the micro level clinical practice, policy makers have put a lot of faith in innovation and organizational change. To this end professionals seem to have also played the game as this has not impacted on their working conditions, and may in fact have even helped to push up their salaries. In addition, organizational change may have been seen by the *status quo* as a way to avoid more drastic reforms by relying on macro structural rather than micro level management changes. Finally, health professionals seem to have reacted negatively when they have discovered that in fact the goal of improving productivity and reinforcing clinical management was behind these innovations. This has been the Spanish experience so far when corporations have seen the potential dangers of reforms that shift the current status quo. Namely, they have been able to build a coalition with patient groups and some political parties, in opposition to the so called 'privatization' of the system, and thus have consigned past institutional change to the 'Limbo' of health care reforms (see Lopez Casasnovas, 2007).

ORGANIZATION MODELS FOR HOSPITAL CARE

Organizational innovation

Given the departure point of the organization of health services in Spain, a large array of different provider structures have been developed. Table 1 describes the different types of organizations within the Spanish public sector. We distinguish five different types of organizations on the basis of their legal status, which may be subject to rules governing private or public sector institutions. Indeed, the public section can decentralize from direct state control using various legal approaches. For instance, certain specialized activities might be undertaken within newly established foundation a organization, that is non-profit status that manages an endowment or budget to pursue some defined goals (e.g., foundation hospitals). The creation of foundations implied conferring some assets

to certain activities (e.g., hospital care) and setting up an activity based on labor or external contracts. These, unlike administrative contracts, allowed wider flexibility, with decision making accountable to an administration body - so called '*patronato*' -, composed of members of relevant civil society organizations as well as the public sector and employees. Alternatively, public sector bodies might set up a consortium, which might be subject to private, or public sector law and governed by an administrative council. Other alternative organizations include co-operatives and limited liability companies; they differ in that whilst the first is a private mutual organization the second refers to a publicly owned company. Finally, it is important to list autonomous organization bodies that undertake specialist public sector functions though subject to public sector law e.g., specific units which deal with the needs of older people.

Table 1. Legal bodies in the Spanish public sector bodies

Institutions	Autonomous organization bodies	Public companies	Foundations	Consortium	Cooperatives
Legal subjection	Public Law	Private Law	Private Law	Public/Private Law	Private Law
Aim	Functional decentralization	Public asset ownership	Assets devoted to a general interest	Association of public sector bodies	Mercantile society
Personnel management	Administrative and labour contracts	Labour contracts	Labour contracts	Labour contracts	Labour contracts
Funding	Public grant*	Public grant *	Contract	Contract	Contract
Decision making	Depends on statutory law	Council	Patronage	Council	Council

* In addition to own resources.

The evidence in Catalonia compared to the rest of Spain comes on the stability of the organizational reform that involves public-private Consortia and private foundations in hospital care, and more recently Cooperatives and private companies of doctors in primary care, which are not part of the public sector though operate within the system. These are, commonly, private sector organizations. Foundations are regulated by the Law for the Creation of Private Foundations (1994) operating under private sector rules to try and 'escape' from the constraints of public administration. In similar terms public-private non for profit Consortia. New rules allow the employment of staff according to general labour legislation, purchasing supplies under private law, and less intervention by allowing ex-post control of expenditure, private accountancy rules, etc. However, in practice, sometimes public and private are mixed and confused. For instance, the supervisory body – the so called '*protectorado*'- and the administration body (*patronato*) are both in the same hands (on a majority basis, the regional health authority). With some few exceptions, there is not a separate endowment for Foundation expenses and in deciding current revenues, the financier sits on all management boards, often appointing managers and representatives in the administration body.

Despite criticisms, these Foundations have already survived within different regional and political climates. Initially they raised expectations for change amongst highly motivated, and then better-paid doctors in these Foundations, reducing the incentive for supplementing income through private practice and providing better access to new equipment. This shaped a new type of public management culture which went beyond the organizational change. However, this is today under threat since payment and different working conditions tend to disappear, since doctors in the 'old' public hospitals have recently had their salaries raised, without any incentive to change in working practices, in the interest of having a uniform wage under the argument of the single-payer regime.

Besides private foundations, another type of foundation institution refers to public foundation hospitals introduced by the Spanish Law for Hospital Foundations in 1999. These are subject to a common legislation for the existing Public Hospitals and affected hospitals in both regions with (then) centralized and non-centralized responsibilities. The anticipated changes are minor (for purchasing inputs, new employment and formal accountancy) since they could not affect, in any case, pre-existing employment rights and had to be accepted on a voluntary basis by health professionals. Even in this case, the potential thread of a general change in current affairs created strong political disagreement with medical trade unions and opposition parties. After a long and sordid political debate, the efforts of the Spanish Ministry of Health were put in a closed box with no policy change at the national level.

In general there exists a certain contrast between the situation elsewhere in Spain and Catalonia, being the Catalan a more successful image of health innovation. This is partly the result of the past tradition of an active presence of civil society. Catalonia with about seven million inhabitants, a strong sense of community identity and aspirations for self-governance, has long had a different experience with health care innovations. There is a longstanding tradition of community involvement in health and social care. In fact, local authorities, the Church, and private endowments, historically complemented the initially poor and basic Spanish health care coverage. As a result, to this day a publicly financed network of not for profit organizations provide about two thirds of inpatient care. Most of these hospitals are 'public consortia', open to private not for profit participation, pure private foundations and Mutual Funds. They are licensed to provide public services and a contract is set up with the Catalan Health Service Authority on the basis of hospital activity. Thus, hospital managers autonomously decide on salaries and working conditions for their professionals. So far, lower rates of remuneration and more flexible (private compatible) time schedules are the norm. At any rate, no discrimination between patients is formally possible within the public network and in practice for acute care; risk selection has never been an issue to date.

Consortia and foundations work therefore under their own management practices. They differ by the rules on which they are created: Consortia develop under common public law while foundations are created from specific private legislation. However, in both cases, employment policies, managerial charts and internal operating rules differ from older Social Security Hospitals. In the case of 16 important hospital consortia, this is

reflected in (i) the way they purchase inputs (following private law); (ii) how they contract professionals (outside the civil servant regime) and set their working conditions (more flexibility and greater compatibility, combining public and private practices); (iii) the capacity to deal with provision of care for private insurers only. With more autonomy, they own their assets, although their finances are publicly controlled ex – post, and they are governed by representatives of the community subject to a lower degree of political influence. So far, their management has proved to be robust to political change. A member of the local community chairs an ‘associated group of interests’ usually with no direct involvement either in politics or in the health care business.

Eight important hospital foundations are private organizations given the rules under which they operate, but remain under a public protectorate. Their governing body is commonly open to representatives of the civil society who risk their reputation and assume legal responsibilities for the privilege of leadership. Foundations own their assets and operate under the private law in all aspects of their activity. They may borrow freely in the private market. Once they enter into contracts with the Catalan Department of Health, given their non-profit status, they are licensed and monitored by the public regulator in a similar way as consortia.

As aforementioned, historical reasons are behind this particular Catalonian Hospital structure, since in the past, local provision of health care came to complement central provision, through a diversity of institutions, that today are integrated under a single publicly financed network.

In primary care innovation is shorter but still alive, with a dozen of new initiatives of health professionals, owners of coops and private companies and working under publicly set contracts for well defined geographical areas. As a result, in primary care services Catalonia has also avoided opening new Health Area Teams under the old administrative rules and salary employment. These new experiments are run currently with self- employed doctors, either under ‘Co-operative’ organizational forms or Limited Responsibility Corporations. They are financed by capitation, with not much elective inpatient care usually being included, and with notional agreements on drug prescription costs. This means in reality that primary care in these new areas is ‘indirectly’ publicly managed since they decide on working conditions, budget surplus applications, incentives on peer controls and salaries. They offer more extended working hours and some offer additional payments for some minor procedures not financed publicly such as some dental treatment, podiatry, etc.

These new organizations are at least 51% owned by their professionals and no one individually may own more than 25%, and share holding is disallowed. Doctors who accept a change in status from the former social security primary care teams to the new structure do not initially lose their job in the public system for a certain period but they do not have their particular post ‘reserved.’ These organizations are subject to private law, they own their own assets, sometimes financially supported indirectly by the Royal College of Physicians, which offers a sort of leasing contract for equipments to

professionals willing to assume some financial risk and managerial autonomy. Needless to say those doctors who have left the old regime are a biased sample, since they are usually more committed to the public provision of health care (no private practice exists), have greater motivation (they are younger) and are probably tired of the old rules in which ‘someone from outside tells you what to do, and you get the same payment irrespective of the effort you put into the team’.

Evidence

Given that evidence of organizational reforms is diverse, it is important to provide an overview of how Catalonia compares to the rest of Spain at an aggregate level. The Catalonian population accounts for 15% of total Spanish population. Table 2 reveals that 24% of all Spanish hospitals are in Catalonia including 53% of all hospitals for chronic patients. Given both the historical tradition and the fact that it is a relatively affluent region-state, about 31% of all Spanish private hospitals (35% of non-for profit hospitals) are found in Catalonia. Only 40 (22%) of hospitals are publicly owned compared with 140 privately owned institutions. This figure is markedly smaller in Spain as a whole where 47% of all hospitals are publicly owned. Yet, the average size of hospitals elsewhere in Spain is larger than in Catalonia. However, the caveats of decentralised structures come to place when examining the staff composition as *Catalonia exhibits a larger share of part time and occasional personal, but especially a higher proportion of managers. On the other hand looking at the combination of doctors versus other health professionals is not significantly different to that of Spain.* Finally, Catalonia and all Spain exhibits similar level of hospital activity. For instance, activity and quality indicators including the percentage of caesarean sections are similar. The main differences are that Catalonia seems to treat more patients, and have a slightly longer length of stay possibly due to significantly more intensive use of both surgery and ambulatory care.

Table 2. Catalan and Spanish Hospitals

	Spain	Catalonia	
		number	%
Number			
Total	764	180	23.6%
General	447	80	17.9%
Acute	119	23	19.3%
Chronic	116	62	53.4%
Psychiatric	86	15	17.4%
Entitlement			
NHS hospital	190	10	5.3%
Other public	123	30	24.4%
Total Public	313	40	12.8%
Private non-for-profit	147	52	35.4%
Private for-profit	308	88	28.6%
Total Private	455	140	30.8%
Resources			
Beds per hospital	208	167	80.3%
Operating rooms	4.9	3.5	71.4%
Personnel			

>36 hours	346312	49341	14%
<36 hours	50669	10643	21%
Permanent	396981	59984	15%
Occasional	20069	4348	22%
Total employee	417050	64332	15%
Health professionals	302992	48473	16%
Doctors	77527	13481	17%
Nurses	113767	17772	16%
Managers	5334	1188	22%
Doctors/Health professionals	26%	28%	109%
Health/Total	73%	75%	104%
Nurses/Doctors	68%	76%	111%
Managers/Doctors	7%	9%	128%
Manager/Total	1%	2%	144%
Activity			
LOS	9	10.2	113%
Patients	146369	28871	20%
Surgical in Hospitals	2132810	702484	33%
Ambulatory Surgery	389021	140200	36%
% Caesarean Section	23.1%	22.5%	97%
% Urgent Interventions	84%	88%	104%

Encuesta de Morbilidad Hospitalaria, 2007

However, examining aggregate evidence is unavoidably missing some micro perspective. Therefore other sources of data come from ex-post assessments of managerial experiences directly. The Donabedian Foundation for Quality Assessment and the Royal College of Physicians of Barcelona have offered initial evaluations of these experience of the Catalan case with rather satisfactory results in terms of access to health care access, efficiency and public satisfaction. This is basically linked to more continuous access to teams (open after five pm) and the sense of membership of an innovative group with access to modern equipment, in respect of those units managed by the Catalan Health Institute (the majority of primary care teams). More specifically, new organizational innovations in Catalonia, compared against the old civil servant regime demonstrate that there are were better indicators in the new GP teams: average waiting time for a visit (less than one day in 40% of cases, 68% in 2 days), better access to pediatric care after 5 pm (children leave the school at this hour), more continuity in health care (by overlapping working schedules along the day) with indicators of satisfaction being three times higher for these new teams than for the traditional primary care institutions. Equally, good indicators for these new organizational arrangements compared with the older institutional structures can be seen in terms of the lower utilization of antibiotics for common viral flu (11% versus 31% of cases) and for gastroenteritis (6% versus 17%). Some adjustment is however needed before assessing the significance of lower prescription costs. Indeed, despite similar total costs per capita/year were identified this refers to lower referrals (22% of the cases against 33%) and a lower number of visits per inhabitant year (5.3% against 6.8) (Fundacion Avedis Donabedian, 2003).

Finally, during the last three years, the Catalan Health Authority has offered, on a voluntary association basis, a capitation regime to 5 internal areas (7% of the Catalan

population). This constitutes a new organizational framework for health care integration on a territorial basis. In this context, providers with diverse legal status in several health system spheres such as primary, hospital and long term care have integrated -so far virtually- their equipment and structures to co-ordinate on a more autonomous basis, their strategies towards fulfilling the objectives of the Catalan Health Plan. No loss of finance comes from a reduction in activity, and incentives for more efficient co-ordination of primary and hospital care are provided, changing the balance of inpatient versus outpatient or ambulatory care, or by reducing the costs of prescription drugs, since they are financed on a risk-adjusted population basis. Despite the fact that extending the system to the large metropolitan area of Barcelona seems extremely difficult (two and half million people), the initial results of evaluation recently published by the government of Catalonia are again encouraging. At any rate, this new Catalan pilot capitation experiment follows the strategy of not creating hierarchically-uniform health providers; awards greater autonomy to providers (extended internally within their institutions); and pushes for a better co-ordination of health care facilities and health strategies to achieve improvements in health outcomes.

Of course, all of these changes involve some potential risk for day-to day practice although no evidence on this is as yet available. There may be a risk of increasing the administrative costs of the system, a potential violation of some minimum risk pools, while hostile attitudes towards reforms which may be seen as privatizing the health system may also hamper performance. However, we believe that if public finance and public regulation are maintained, these claims are difficult to sustain. The role of the regulator is of critical importance as any mistakes made will be much more visible than those occurring under more centrally controlled hierarchal public organizations.

ANALYSIS

In this article we have sought to provide some insights from the experience across the whole of Spain and within one Autonomous Community, Catalonia, in particular. We suggest that in the absence of a real transfer of responsibilities and financial risk to providers, the organizational change is not itself the remedy for improving efficiency in health care. The Spanish example suggests that although it is straightforward for health system stakeholders to acknowledge the need for change to the organizational 'structure' of care, generally stakeholders are reluctant to change and only accept some reforms in order to avoid more drastic measures. Short term mild reforms are then accepted in exchange of not modifying significantly the status quo. A successful health care reform would require a significant change in the management at the *professional level* in addition to those reforms that already take place at the *organizational arena* to avoid the protection of the 'status quo' and overcome institutional constraints to institutional change. In this sense, the Catalan experience does seem to prove that political stability of those reforms over time, together with greater decentralization at the provider's level and on a geographical basis may help to reduce these constraints.

Evidence from Catalonia, indicates that the whole set of organizational reforms can lead to the expansion of more flexible terms of employment for health system professionals

and the introduction of incentives to encourage health system managers to better control the performance of new institutional structures for hospitals. Indeed, the Catalan experience suggests that for reforms to be accepted incentives may need to be offered to those stakeholders. Without such incentives while policies may be launched, this may not be translated into effective action on the ground.

Although the Catalonian Health Service has only a moderate record in terms of the evaluation of institutional innovation, Spain as a whole has benefited from observing the array of reforms that have taken place in Catalonia. Nonetheless despite this, the health care system as a whole in Spain remains largely unchanged. In this context, regional decentralization (for all the ACs after 2002) may be a first step to fostering the development of organizational innovation to counteract existing vested interests. As a result, political decentralization may lead to greater heterogeneity in health care, but this does not necessarily have to lead to institutional fragmentation if funding for new institutions follows transparent rules and regulation and if coordination of the system takes place at the health service level. Moreover policy innovation is not welfare improving for the whole system if it is accompanied by policy diffusion to that all agents benefit. For the latter to take place it is important the development of information systems within the system to share evidence on the outputs and outcomes of certain experience as to encourage “evidence based decision making”.

Nevertheless, the Spanish experience also indicates that only limited reforms – in the form of changes to the status quo - take place unless key working conditions, namely organizational autonomy and responsibility as well as financial risk bearing are changed. There is a need for higher accountability for newly independent hospitals as well as incentives to foster desired outcomes, since coordination problems might still persist. It is also an increasingly complex task to overcome potential “ratchet effects” that often go unobserved in decentralized organizations that are subject to incentives.

CONCLUSIONS

Organizational decentralization is a potential mechanism for facilitating change in the activity level of organizations including those in health care, which could in turn enhance improvements in their efficiency. This may take place through improvements in the degree of policy innovation and dynamism seen in the system, as well as greater levels of transparency. However, there may also be additional transaction costs associated with a looser level of central control (and greater need for voluntary coordination and cooperation) and there may also be initial inception costs that would be expected to smooth over time.

The extent to which there has been any implementation of organizational innovation significantly differs among sectors. In terms of health it may potentially have most impact in those cases which historically have had a high degree of central control over the financing and provision of services. However some evidence suggests that performance levels might not necessarily correlate with the level of activity and functional desegregation of semi-autonomous organizations (Pollit *et al*, 2004)

In NHS style health systems in particular, the uniformity of care and organizational changes do not in themselves accommodate stakeholders' interests. The Spanish case suggests that policy changes might require transitional costs to reduce resistance to change and promote high level political support. Organizational change is neither a surrogate for the necessary clarification of the extent of private sector involvement in public health care, nor a substitute for a frank discussion on the balance between public and private funding. As with all policy reform, ensuring the involvement of all stakeholders from an early stage can help facilitate change and create a sense of ownership over proposed changes. Without such early involvement proposed innovative reform are likely to be unsuccessful.

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