ORGANISATIONAL INNOVATIONS AND HEALTH CARE DECENTRALISATION: A CATALAN AND SPANISH PERSPECTIVE

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Abstract

Recent policy developments in public health care systems lead to a greater diversity in health care. Decentralisation, either geographically or at an institutional level, is the key force, because it encourages innovation and local initiatives in health care provision. The devolution of responsibilities allows for a sort of 'de-construction' of the status quo by changing both organizational forms and service provision. The new organizations enjoy greater freedom in the way they pay their staff, and are judged according to their results. These organizations may retain financial surpluses, develop 'spin-off' companies and commission a range of specialised services (such as Diagnostic and Treatment Centres in UK) from providers outside the institutional setting in order to have more access to capital markets.

However this diversity may generate a feeling of lack of commitment to a national health service and ultimately a loss of social cohesion. By fiscal decentralisation to regional authorities or planned delegation of financial agreements to the providers, financial incentives are more explicit and may seem to place profit-making above a commitment to better health care.

An evaluation of the 'myths and realities' of the decentralization process is needed. Here, I offer an assessment 'pros' and 'cons'of the decentralization process of health care in Spain, drawing on the experience of regional reforms from the pioneering organisational innovations implemented in Catalonia in 1981, up to the observed dispersion of health care spending per capita among regions at present.

Key words: fiscal decentralisation, management autonomy, hospital innovation, National Health system, Spain, regional health service, Catalonia.

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Introduction: the strength and weakness of the decentralisation in health care in Spain

For the Spanish health system, with rather poor micro-clinical performance in terms of user satisfaction, excessive clinical practice variation, waiting lists and waiting times, it is understandable that a desire exists for improvements in efficiency. Opportunities for this are considerable: physicians are civil servants with salaries specified across the board in annual budgets, and have protected employment for life. At the same time, they have considerable clinical autonomy leading to important variations in clinical practice (Moya et al. 2002 and Atlas VPM 2005, 1). Health care administrators have to manage resources under restrictive rules that hinder efficient management, without clear and objective budget constraints, and under strong political pressures. Moreover, the fear of change from the public and patient groups, and the political "games" of the opposition parties mean that any measure that may result in changing financial arrangements or any new regulation that may look like to limit access to care, is resisted. Under these circumstances, health care problems at the central state level are big problems and it proves to be very difficult to manage change: inefficiency is institutionalised in the health care sector and *status quo* interests are well protected. Agreement among the parts has been only reached on proposals that require increased public expenditure, accompanied sometimes with the claim of 'structural' organizational changes to reduce 'waste' (in abstract terms) in order to legitimate the increase of public money. This has neither changed by itself clinical practices nor physicians and consumers responsibilities in the utilisation of resources. Indeed, health professionals have reacted negatively to those proposals when they have discovered that improving productivity and reinforcing clinical management might be behind some of those innovations: when they have seen a potential threat to their current status. They have been able to build a coalition with patient groups and some opposition political parties, and have called for the 'privatization' of the system, with the result that these changes have been sent into the limbo of unimplemented health care reforms

The efforts (and past failures) to modify this situation include the introduction into physicians' salaries of a variable component related to productivity (ultimately incorporated into the basic salary on an uniform basis); a purchase-provider split with Program Budget Contracts (which have proved to be illusory as providers and purchasers are in most cases both public bodies under

centralized budgets); free choice of doctors by patients, under salaried primary care physicians (which has usually meant a smaller work load, effectively without a pay reduction); or the search for 'accurate' payment systems to hospitals on the basis of 'need'-registered activity (thus creating the effect that 'worse' i.e. more activity, is 'better' i.e. brings more money to the institution).

In this context, politicians that were initially reluctant to fully transfer health care expenditure to the regional authorities (Autonomous Communities, AC from now) have finally decentralised health care to all the regions. ACs in Spain range from close to eight million people in Andalusia to less that three hundred thousand in La Rioja. Under this new setting, policy makers at the regional level have put a lot of their faith in 'structural' innovation and re-organization at the 'mezzo' level of management in a rather diverse way: from contracting out health care services up to public-private partnerships for new equipments. Innovation at the local level may have been seen by the authorities as a way to show commitment to improve regional health care without risking too much with more drastic reforms. To rely on macro-structural rather than on micro-level management changes can be certainly explained by the difficulty to change clinical practices (Allen, 2002). Therefore professionals seem to have gone along with these changes, as it has not harmed their working conditions and has in fact helped to push their salaries up.

However, the financial decentralization of the health care system, though imperfect, has changed how things are done. Now, diversity is common in health care delivery; more fiscal responsibility underpins most decisions on health spending, and the regional health authorities are controlled by different political ideologies. Consequently, each AC has introduced changes in health care provision based on their party's policies and their vision of how the Spanish health system should develop. Today, Spain has a NHS composed of 17 independent health care regions, which have a great deal of autonomy on health care provision, their own revenue to add to central government financing, and hold full responsibility for any overspending on budget (López-Casasnovas et al. 2005). As a result, the observed dispersion of health care spending per capita among regions has increased (pooled data at the central state level did no allow in the past to observe regional differences). This diversity generates a feeling of lack of commitment to a national health service and ultimately a loss of social cohesion and some authors (Rey, Gimeno, Sevilla... for Fundación Alternativas, 2005) have started to question the price of efficiency in equity terms.

An evaluation of the 'myths and realities' of the decentralization process is needed, drawing on the experience of regional reforms from the pioneering organisational innovations implemented in Catalonia in 1981, up to the present.

The Organisational Innovation reforms: the Spanish and Catalan experiences

Most of the organisational innovation has so far have turned its efforts to the hospital sector by extending the Private Foundations Bill (to newly built hospitals) and by issuing a new Public Hospital Foundations Bill (for already existing hospitals). Both are pieces of the central state legislation to be implemented at the regional level and adopted on a voluntary basis by professionals.

The first case (new status for new hospitals) comes under the 1994 Law for the creation of Private Foundations (not just for hospitals) and its extension in 1996 to cover new hospitals (up to now, half a dozen small to medium sized hospitals). These are all publicly-owned, but managed privately, employing staff according to general labour laws, purchasing supplies on the open market, and using private accountancy rules and with ex-post control of their expenses. However, in practice, public and private interests are far from clear in the new legal status. For instance, the '*Protectorado'* (the supervisory board) and '*Patronato'* (the administrative board) are both in the same hands (today the regional health authority). There is no separate capital endowment for expenses (other than equipment, which is bought in fact from public funding). In deciding current revenues, the financer sits on the management boards, often appointing managers and representatives in the '*Patronato'*. Having said this, it is interesting to note that despite criticisms; these Foundations (in Andalusia, Madrid, Valencia, Galicia, the Balearic Islands) have so far survived political changes, although we do not yet have a full appraisal of their performance. At first they raised expectations for change with the highly motivated and, at that time, better-paid doctors in these Foundations, with less private practice and better access to new equipment. This shaped a new type of public management culture beyond the organizational change, which today has almost disappeared as doctors in the old public hospitals have been able since to recoup former salary differences without changes in their working conditions. This has been done to ensure equity of the public interest[1].

The Public Hospital Foundations Bill introduced in the Budget Law of 1999 for public hospitals allows for minor changes in existing hospital management: for purchasing goods, contracting new

staff and for book keeping. However, they could not change pre-existing employment entitlements without the voluntary acceptance of health professionals. Even then, the threat of political change created strong disagreements between the medical trade unions and the political parties in opposition. Under the central management of health care and after a long and sordid political debate, the efforts of the Minister of Health did result in no changes in hospital status.

In contrast to the Spanish situation, the Catalan experience on health innovation after the decentralisation has proved more successful. Catalonia (with almost 7 million residents, a strong sense of community, and desire for self-governance) shows rather different attitudes to the innovations which have occurred since health care devolution in 1981. These changes are largely the result of the importance in the past of community involvement in social care. In fact, local authorities, the church, and private wealth endowments had complemented the initially poor services of a Bismarck's model of basic health care coverage in Catalonia. And at the point of transfer, instead of adopting a new status uniformly for all the existing facilities, diversity has been fostered. As a result, most in-patient care today is provided by a publicly financed network of non-profit making private hospitals. Only 40% of the beds are under traditional social security management. Most of these hospitals are "public consortia" of regional interests (local and provincial authorities), open to private non-profit-making participation. In addition, some private Foundations are also licensed for public provision. This allows health authorities to contract out health care on the basis of hospital activity, instead of just reimbursing actual expenses, and allowing greater autonomy to hospital managers when deciding on salaries and working conditions for their professionals. So far, lower pay scales and more flexible timetables compatible with private practice are the norm. At any rate, within the public network no discrimination between patients is formally possible, and in practice risk selection has never been an issue to date, despite the fact that the four largest and most complex hospitals are Social Security hospitals capable of dealing with severely ill patients.

Consortia and private Foundations work under their own management rules. They differ in the rules under which they are created: Consortia, from common public law and Foundations from specific private legislation. However, in both cases, employment policies, managerial charts and internal management are different from the, older, social security hospitals

In the case of Catalan Hospital Consortia (16 important ones), differences are reflected in (i) the way they purchase goods (on the open market); (ii) how they contract professionals (outside the

civil servant regime) and set their working conditions (more flexibility and greater compatibility, between public and private practices in and out of the hospital if convenient); and (iii) the capacity to create purely private organizations to achieve the consortia interests (provision of care for private insurers). They enjoy more managerial autonomy and own the assets, although their finances are still publicly controlled ex–post, and their policies are overseen by representatives of the community, although subject to a lower degree of political influence. So far, their management policies and manager teams have proved to be robust in the face of political changes. The 'associated group of interests' is usually chaired by a member of the local community with no direct involvement either in politics or in the health care business as such.

In the case of Catalan Hospital Foundations (8 important hospitals), they are currently private organizations according to the rules under which they operate, but under a public protectorate. Their governing body is commonly open to representatives of civil society, people who risk their reputation and assume legal responsibilities for the privilege of leadership. Foundations own their assets and operate under private law in all aspects of their activity. They may borrow freely in the private market. Once they are contracted out by the Catalan authority, given their non-profit status, they need to be licensed and monitored by the regulator in a similar way to the public sector.

As stated, this Catalonian hospital structure exists for historical reasons, since in the past, local provision of health care came to complement central provision, through a range of organisations, today integrated in a single public-financed network. At any rate, the Government of Catalonia has taken advantage of this, continuously favouring organizational changes and avoiding the administrative constraints which are imposed otherwise on a purely public health care system.

Away from hospital care, in Primary Care services, Catalonia has also avoided replicating the old model of salaried physicians working in Area Health Teams under the old administrative rules. Fourteen experiments are currently running with self-employed physicians, either under "Co-operative" organizational forms or "Limited Responsibility Corporations" for well-defined geographical areas. Following on from this, some of The Catalan Health Institute health centres have begun to compete with and emulate some of the innovations being made, such as paperless records, better-adapted work schedules, the offer of complementary services and so on. New teams are financed on capitation grounds, with some elective in-patient care usually being included, and with notional agreements on drug prescription costs. This means in reality that

primary care in these areas is “indirectly” publicly managed. They are awarded a license and they decide on their own working conditions and salaries, the application of any budget surplus (within limits), incentives on peer controls, etc. They offer more extended working hours and some of them have started to take on offering community premia or direct prices for some additional, so far minor, services out of the public ‘catalogue’ (such as some dental treatments, or chiropody).
At least 51% of the assets of these organizations have to be in the hands of their professionals. None of them may own more than a 25%, and share holding is prohibited for Co-operatives. Physicians who accept a change in status from the former Social Security primary care teams to the new forms do not lose their job in the public system for a certain period, although they do not have their particular post ‘reserved’. These organizations are subject to private law. They own the assets, and are sometimes (indirectly) supported financially by the Royal College of Physicians, a professional corporation which offers a sort of leasing contract to professionals willing to assume financial risk and managerial autonomy. In judging their performance, it has to be said that those physicians 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 is allowed there), 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”[2].

Finally, for the last five years, in order to improve the co-ordination of health services at a local level, the Catalan Health Authority has offered a new scheme of financing to regional associations of health providers, on a voluntary basis, paying the new ‘holder’ under a new, virtually all-inclusive, capitation regime. This has so far been accepted by 5 larger regions (just below 10% of the Catalan population), which include diverse providers. It has allowed the creation of Health Consortia on a virtual (rather than vertical) common ownership (see Horn, 1995 and Williamson, 1975). It has created new organizational incentives for health system integration in a geographical area. In this context, several providers with diversified status, different organizational forms and positions in primary, hospital and long-term care, integrate their equipment and facilities and co-ordinate strategies for fulfilling the Catalan Health Plan objectives with a greater sense of autonomy. No loss of finance comes out of reducing activity, and it puts in place a more efficient co-ordination of primary and hospital care. Also, it can control the costs of drugs, since they are financed on a kind of risk-adjusted (still preliminary) population formula. Despite the fact that extending the system to the large metropolitan area of

Barcelona seems difficult, the first evaluation results recently published by the Generalitat of Catalonia are encouraging (see footnote 2). At any rate, this new Catalan pilot scheme based on capitation follows the strategy of (i) not creating hierarchically-uniform health providers, (ii) awarding greater autonomy to their professionals (extended internally within their institutions) and (iii) pushing in this way for a better co-ordination of health care facilities and health strategies in focussing not so much on "who they are or what do they do, but on what they finally achieve in terms of health outcomes."

Diversity in the organisational structures of regional health care provision has opened the discussion on how far ACs can go in reforming on their own the Spanish National Health Service. Moreover regional health finance is today open ended with a central transfer that may be completed by ACs with their own resources, either new taxes or surcharges, or the rebalance of the previous expenditure priorities. Per capita expenditure is today greater and so its variation among regions (being differences more explicit now than in the past under central management). However, this diversity is not so much due to differences in central finance of regional health care as it is in expenditure (once the ACs have added up the central transfer) and this is consubstantial with the theory of fiscal decentralisation. At any rate the sense of loss of social cohesion is under political discussion.

Assessing the changes

Of course all the above-mentioned changes involve potential risks for day-to day practice. A full assessment of results has not yet been backed up by data: some transaction costs, degree of financial responsibility, possible violation of some minimum pools for a credible transfer of risks, and the still prevailing culture against too much talk on money in health care may still create serious problems, though as time passes this looks more unlikely. From time to time, those caveats create a hostile political response from those who prefer the old system and they accuse some regional politicians and policy makers of privatizing the NHS. However, we believe that if public finance and public regulation are maintained, these claims are difficult to sustain. For instance, on the profit incentives is clear that their denial does not mean that they are not there in terms of bureaucratic fringe benefits, nor that patient welfare will not be exploited by producers, particularly when no free choice and local monopolies are established. Furthermore, some authors doubt the ability of the public authorities at the regional level in their new role: in this new context, the regulator needs to be more responsive and alert to any of the undesired

consequences of those changes, because in these new frameworks any mistakes will be more apparent than those made within the hierarchical rule of public organizations. Moreover, learning to live with diversity is needed in a regionally decentralised, quasi-federal state as the Spanish one. This allows for emulating best practices, some forms of benchmarking and regional ideologically led health reforms. It certainly makes for a more complex society but to several extents for a more democratic one too.

In brief, in public health systems the confluence of incentives of the participants always favours the status quo under well-known working rules (Gibbons, 1998). A fully centralised health care system seems to better protect them. From this premise it is relatively easy to relate existing conflicts of revenue allocation and prioritisation in health care to the need for more resources and changes in the organizational structure of care. More resources may indeed protect against changes at the clinical managerial level with a larger dose of self-governance and financial risk-transfer to providers. Changing structures at the macro level is thought to avoid more drastic reforms at a micro level i.e. the way that health care is delivered. But if the organizational reform is to be successful it needs to change clinical management at the local level (preferment at the level of the professionals). Regional devolution, decentralisation and planned delegation of responsibilities have favoured in Spain the innovation strategies. The final test even for the apparently more successful Catalan experience is changes at the clinical level. Organisational innovations may not be sufficient conditions for this. It is easy for the conservative status quo to build a coalition with some patients' groups and political parties to effectively halt the institutional changes. This has been clearly the case of the central state Spanish Public Foundations. In the Catalan case, the diversity of hospital providers is an asset from the past which has so far proved resistant under decentralisation management to the efforts to bring uniformity (rigid working conditions and wages), although it is far from safe. Pressures for equality in salaries and working conditions appear from time to time. More encouraging are the reforms in primary care and on territorial integration. The key to success here is the potential for self-governance and at least an attempt to transfer financial risk to the management teams.

The experience shows the fact that organizational change on a radical basis makes for a very limited strategy for health care reforms, particularly in public systems where working conditions, providers' autonomy, responsibility and financial risks remain unchanged. It may be better to innovate on a local basis. It cannot be ignored that in the NHS, organizational changes do not per se accommodate stakeholders' interests. In this sense is easy to build on radical but selective –

not general - changes, offering continuity as the Catalan experience shows. It is much more difficult to reform ex-novo at the general level, as the Spanish experience proves. At any rate, decentralisation and organizational change do not prove to be either surrogate for direct measures to improve clinical practice. If this is not considered, there is a greater chance that any innovative proposal, taken in isolation, will be consigned to limbo.

Footnotes:

[1] -See on this Le Grand J (2005), op.cit.
[2] -The Donabedian Foundation for Quality Assessment and the Royal College of Physicians of Barcelona have offered the first evaluations of the experiments with rather satisfactory results both in health care access, and efficiency, and public satisfaction. With respect to those units managed by the Catalan Health Institute (the majority of primary care teams), this is basically linked to greater access to the medical teams (available after five o'clock) and the sense of membership of an innovative group with new equipment. More specifically, new organisational innovations in Catalonia, against the old civil servant regime show there were better indicators in the New Teams of GPs: the average waiting time for a visit (less than one day in 40% of cases, 68% in 2 days), better access to paediatric care after 5 pm (children leave school at this time), more continuity in health care (by overlapping working schedules during the day) with indicators of satisfaction for this three times higher for the new teams than for the traditional forms. Similar good indicators for the new organisational forms against the old ones relate to a lower use of antibiotics for some common viral flus (11% of cases against 31%) and for gastroenteritis (6% against 17%). Some adjustment is needed before assessing the significance of lower prescription costs, despite similar total costs per capita per year, of lower referrals (22% of cases against 33%) and a lower number of visits per inhabitant year (5.3% against 6.8%).
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