CONTRACTING ARRANGEMENTS IN THE HEALTH STRATEGY CONTEXT. A REGIONAL APPROACH FOR SPAIN

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Abstract

Background. Several different proposals have been made recently to reform the organisation, financing and management of the health care system in Spain. The aim is to obtain improved efficiency, without prejudicing the equity level already achieved, by creating a more competitive framework. However, current health strategies seem not to be in accord with these proposals.

This paper approaches the issue of matching these two main components of the health systems, health strategy and contracts, and emphasises the need to develop contracting arrangements within the general health policy framework.

Design: Case studies, analysis of published and unpublished documents, and semi-structured interviews with key informants.

Results and discussion. A review of regional health strategies and regional contracts developed in the 1990s is presented, followed by an analysis of the degree of incoherence between them. Then we discuss whether the programme contract can be an instrument guided by the health plan, commenting on its potential and limitations.

Conclusion. The relationship between health strategy and health care management is practically non-existent in Spain. The need to insert the contract cycle within the broader framework of the planning cycle has led to proposals to adapt contracts and health plans to guarantee their coherence. This will require changes in the structure of both of these instruments and, probably, deeper structural modifications of the context within which both have been developed. To this aim, we make some recommendations for policy making.

Key words: Health strategy, contracting, and regional, Spain

During the past two decades, Spain has undergone fundamental political and social change[1-3]. This has been the case within the health care sector as well. The NHS has evolved over the last fifty years, in parallel with the economic, social and political development of the country. In 1978, the new democratic constitution established the right of all Spanish citizens to health protection and recognised the devolution of powers, health care included, to the Autonomous Communities. At present, central government is responsible for the provision of health services to only 38% of the Spanish population and this remaining responsibility will be devolved to the regions in full in the short run. In 1986, the General Health Law created the National Health System, consisting of the regional health services of the Autonomous Communities, and integrating all previous health care networks (those of Social Security, the regions and local authorities).

Health services devolution made the governments of the Autonomous Communities responsible for the management of the health services before their respective regional parliaments, which pass and control the regional health care budgets. The main source of regional health services financing is a block grant, transferred by the central government according to an unadjusted capitation criteria. However, decentralisation has resulted in different levels of per capita financing, with a rank of 20% above or below the Spanish average, and in different health care systems. [1]

In order to co-ordinate the system, the Interterritorial Council of the NHS was established as a consultative body, composed of the 17 regional health ministers of the Autonomous Communities and an equal number from different ministries of the central government, and chaired by the Spanish Minister of Health. It has, so far, had a political co-ordinating function but has not been very much involved in the practical aspects of co-ordinating the management of the NHS. Its main role of co-ordinating health policy has never been developed.

Within the framework of the recent health care reforms, it is highly probable that the contract will become the only link between health planning and health management, between the

purchasers and the providers: hence the importance of analysing the feasibility of inserting the contract cycle within the broader framework of the planning cycle.[4]

This paper approaches the issue of matching these two main components of the health systems, health strategy and contracts, and emphasises the need to develop contracting arrangements within the general health policy framework in Spain.

To this aim, a review of regional health strategies, and regional contracts developed in the 1990s is presented, followed by an analysis of the degree of (in)coherence between them. Then, we discuss whether the programme contract can be an instrument guided by the health plan, commenting on its potential and limitations, to provide suggestions for policy making.

Objectives and methods

The general aim of the study is to provide practical and relevant recommendations to policy makers regarding the implementation of health targets through contracts with health care providers, organisations, hospitals and health service units. The study addresses the issue through qualitative techniques. First, an analytical review has been made of all the documents published under the heading "health strategy" or health plan in each of the 17 Spanish Autonomous Communities. All the modalities of purchasing contracts within the Spanish Health Care System have also been reviewed. Extensive interviewing with several key actors across the institutions involved in the process has been carried out. The authors themselves were involved in the design and implementation of health plans.

Health strategies in Spain

Health plans are considered by Spanish law as the key tools for The Global Health Care

Co-ordination design at central level; and each of the 17 Autonomous Communities has the obligation -by law- to draw up a Regional Health Plan. For this reason, health plans have to be formulated according to general co-ordination criteria laid down by the Central Government[5]. In 1989 a Royal Decree was approved stating the procedures and terms for the elaboration of the so-called Health Integrated Plan, described as the sum of the different Regional Plans as well as

government ones (i.e. Aids, Transplants). Health plans are defined as 'the sum of different health care actions to be implemented in a time and a space already determined, with defined costs, in order to fulfil targets already established by the Health Services'. Moreover, the decree establishes the content of each Regional Plan under six headings: Analysis and diagnosis of health care problems; Targets; Programmes to be implemented; Finance; Implementation; and Evaluation.[6]

Although a model for developing a health plan existed, each Autonomous Community produced its own conceptualisation of it. Two general trends could be seen: first, one based on the underlying idea of the need for an intersectoral health policy and, second, a tendency towards a health services plan inside the health care sector.

The variability of the products is impressive. Ten years after enacting the Royal Decree on Health Plans, 14 out of the 17 Autonomous Communities have written down and published their own health plan. Eight of them have published a second document. Three Autonomous Communities have not published a proper health strategy but have done something about it, mainly green papers or drafts. In 11 of the 17 Autonomous Communities, there are Acts with references to the elaboration, structure and relevance of health plans. There are two without a single reference to it. The content of the laws is based mainly on the above mentioned Royal Decree on Integrated Health Plans. Eight of the Autonomous Communities establish that the 'health plan is to be passed by the regional government, and then sent to the Regional Parliament'. Although the structure of the legislation is quite similar, there are two Autonomous Communities that establish the time horizon of the health plans: 'the timing of the health plan is three years' (table 1).[7]

It must be mentioned that none of them has become a government strategy. Even though some of them are highly intersectoral documents, with intersectoral strategies, the truth is that all of them have been confined to the health care sector: after all, that is the responsibility of the Regional Health Minister. In general, Spanish health plans are very good technical documents, excellent epidemiological exercises. They represented the first explicit attempt by local governments to provide a strategic approach to improving the overall health of the population.

Another point to be considered is the horizon proposed: plans that were intended to become government strategies did not have a proper end point. The underlying idea was to mark out a course towards health, in the sense suggested by the WHO.[8, 9] For other Autonomous Communities, the health plans are closely related to the political cycle. In table 1 it is seen that at least six of them have periods associated with electoral processes. This is probably one of the key elements for analysing Spanish health plans. Could health be transformed in four-year periods? Does it depend on the political colour of the health minister in office? One explanation for this being the case can be found in the rapid transformations within the Spanish political system over the last 15 years. As Maxwell (1998) states: 'Too much managerial effort has been absorbed by politically inspired organisational changes, and too little by the sustained drive to improve health. It is high time to recognise that health gains ought to be above party political ideologies, and that they call for sustained action beyond the lifetime of most administrations'.[10]

There is one view that the Health Ministries (regional and central) should concern themselves with health care, i.e. health services, and that health policy is the responsibility of a variety of government departments and organisations. This is the idea underlying most documents that try to reconcile their responsibility with the health care system, and attempt to deal with health problems.

As some of the persons originally involved in the process in different Autonomous Communities have stated, even though some regional plans have not been implemented, they would do the same thing again, if only because of the dynamics involved in designing and building up a strategy. 'It was a real boost for most of us. We started thinking about something much more important than visits, consultations, hospital beds. It made us think in terms of health, which is much more than could be expected at the time. I do not regret the effort and the time spent on it' –at least three years for most teams. In fact it was suggested that the process was much more important than the plan.

A good corollary ten years after was stated by a person formerly in charge: 'Most of them –although not all of them- were born as an obligation: Something that the Ministry made it

obligatory to do; they merely reflected what was being done, or could be done, around and within the health care sector; and thirdly, plans should not disturb political peace. Their role is not to vex anyone'.

Contracting health care services in Spain

Contracts are becoming more relevant to the current discussions and proposals of health care management and policy reforms within Spain, a process moving from vertically integrated public provision towards a quasimarket structure *à la* Enthoven,[11] moving from hierarchy towards hybrid models, as described by Williamson[12]. The process was considered explicitly for the first time in Spain in the strategic green paper on reform proposals for the health care system agreed by Parliament and submitted to the government as the Abril Report (1991).

This strategy has been developed on two parallel mechanisms of reform: the introduction of the programme contract in all public health care organisations, hospitals and primary health care centres, and the creation of public health care companies (ruled by private law) as pilot experiences. We shall concentrate here on contracting inside the public health care organisation, the so-called programme contract.

A typical annual programme contract of the central services (INSALUD) with its centres, establishes: (1) services' objective: volume of activity, with a loose reference to health targets; (2) financing, usually a block contract with specification of volume; (3) quantity of other financing sources the centre may have; (4) incentive mechanism, usually based on distribution of budget savings; and (5) sanctions for excess or defect provision.

The list of problems that the programme contract aimed to solve may be summarised as follows: (1) financial undiscipline and unrealistic budgets; (2) poor information systems; (3) low productivity of the resources and lack of technical and allocative efficiency of health care processes; (4) chronic persistence of waiting lists, especially in surgery.

The programme contracts in hospitals began as a pilot scheme in 1992. By 1996, programme contracts had become an annual routine. There were some changes in 1998, putting emphasis on

waiting times and quality, strengthening links between primary and specialised care, and reinforcing incentives and professional participation.

An evaluation of the reform strategy based on the programme contracts developed in Spain results in the following conclusions. (1) No activity is contracted on a health targets basis. Budgets rely upon measures of intermediate output (albeit sophisticated). (2) The program-contract is a legal fiction, being simply management by objectives, the hierarchy principle remaining unchanged. (3) It has had a positive effect in changing the organisational culture, improving information systems, and allowing efficiency measurement. (4) It has made possible some marginal improvements in management efficiency, particularly when it has incorporated important incentive systems. (5) Budgeting continues to be retrospective and altering this is beyond the scope of the programme contract. Prospective budgets are not viable given the impossibility of reducing resources in those health care organisations identified as inefficient. (6) There is no effective risk transfer, either to the organisations or to the managers and the health care professionals.

Discussion

The origin of programme contracts lies in the logic of the internal needs of the health care system and not so much in those of the instruments development for the achievement of the objectives of the health plan. Up to now, internal purchasing of services strategies have been aimed towards rationalisation in the utilisation of resources and frequently towards improving the satisfaction of citizens, in particular with a reduction in waiting lists. Table 2 shows a self-explanatory comparative analysis of both instruments. Health plans and programme contracts emerge in very different contexts with well-differentiated motivations and pursue very different strategic objectives.

Most health plans avoid responses to the daily questions raised in the management of health care services. However, the health plan should be the strategic document in which the limits and priorities of the services are determined, establishing the services that should be financed and those not considered cost effective enough (or not fulfilling other desired criteria) to be

financed. It should determine the strategic priorities not only in health but also in the quality of health care and citizens´ rights and guarantees concerning the services, such as waiting lists or geographical equity in access to services. Moreover, it should direct the purchasing process.

In spite of their current limitations, health plans could provide better orientation to the contracts. Needless to say that underlying our health care system there are important power conflicts between managers and planners, which are reproduced at both central and regional levels.

In the light of what has already been said, one can ask whether it is not naive to expect two such radically different instruments to come together in the current social context of pragmatism and short-term direction. This would not only be desirable but also turns out to be feasible, as shown by existing limited experience in the Basque Country[14,15] and Catalonia[16]. To some extent, the new health plans attempt to respond to current requirements.

It should not be forgotten, however, that the rational of programme contracts is based on the objective and measurable production of services, which justifies financial assignment through a transparent and previously established evaluation system.

Recommendations

From this review and analysis of health strategy (defined through the health plans in the regions of Spain) and of programme contracts with health agencies, we conclude that the relationship between health strategy and health care management is practically non-existent. Nonetheless, in the framework of the recent health reforms, it is highly probable that the contract will become the only link between planning and health management, between purchaser and provider. Hence the importance of analysing the feasibility of inserting the contract cycle within the broader framework of the planning cycle, and of making proposals to adapt contracts and health plans to guarantee their coherence. This will require changes in the structure of both of these instruments and, probably, deeper structural modifications to the context within which both have been developed. We shall start with the latter:

A. Changes needed in the structural framework.

Guaranteeing that the financial flow takes place correctly. This means budgeting allowances to the purchasers and from them to the providers, and not directly to the latter as is currently approved by regional parliaments.

Guaranteeing the autonomy of the agents. The relationship between the financing, purchasing and supplying agents should be established in context of sufficient autonomy between them to make possible the fulfilment of their functions. The hierarchical scheme that is usually found in the public health system reduces the autonomy of the contracting parties when it comes to negotiation. The recently initiated personification of the health centres in Spain (trusts) might contribute to widen the capacity for negotiation.

Guaranteeing integration between strategic planning and the central function of purchasing. The design and formulation of contracts must be carried out by the planning agency, breaking with the tradition that separates planning activity from that of management.

B. Reformulation of the traditional health plans.

Broadening the scope of priority specifications to include targets other than those of health. This means recognising that the health strategy encompasses not only health targets but also process targets, such as satisfaction with the services received and waiting times, as well as procedural rights, such as second opinion, informed consent, freedom of choice of general practitioner, consultant and centre, information on one's health record, board and lodging aspects, and others. There is an opportunity cost in achieving any of them. Consequently, the traditional content of health plans should be expanded and priorities established to allow combination of the two types of target. The specification of targets and priorities must be carried out with the involvement of all agents that might be affected, namely, health care professionals, planners, managers and the citizens.

The health strategy must be a strategy of the whole government, not only of the health department. Formally, there should be wide support for the health plan involving, at least, the departments of health, environment, education and social services, as well as global support from the government and parliament.

The plan should define the purchasing strategies that are most suitable for the strategic targets pursued. The health strategy must cease to be a statement of aims and priorities (good intentions) and come to have an assignment function, specifying those services under the responsibility of the health care system and those belonging to other sectors. The requirements for the financial viability of the proposals should be stated.

C. Re-adaptation of contracts to the health strategy.

Contracts must contain explicit targets linked to the health strategy. Contracting based on health targets should replace contracting solely on an activity basis. The relationship between health targets and contracted activity should be made explicit in order to make evaluation of the results possible. Contracts should involve benefits or penalties.

Contracts should be relational, not sporadic and must be drawn up paying due attention to the time horizon indicated by the health strategy. To this end, it is necessary that the contractual relationship is a stable one and contracts should be of a pluriannual character to enable incorporation of the health targets in a coherent way.

In terms of services, contracts should consider not only health care services but also preventive and health promoting services on an equal basis.

Targets should be specified in terms of quality performance targets as well as in-service targets. Financing mechanisms must take into account not only quantifiable targets (i.e. occupancy rates, number of outpatient consultations, etc.) but also achievements in terms of quality performance. Qualitative targets include such areas as informed consent, standards of practice, etc. that should also be considered when assigning budgets and establishing specific funding.

The use of proxy indicators of the health targets. Once having established the causal relationship between process indicators and health results (for example, vaccinations and incidence of diseases), the former can be used to evaluate the output and the performance of the contract.

Table 1: Health plans by Autonomous Communities in Spain, legal basis and date of publication.

Autonomous Community	**First health plan**	**Second health plan**	**Legal basis**	**Health care system devolved**
Andalucía	1993	1998	Act 98	Yes 1984
Aragón	1992		Act 2/89	No
Asturias	1997		Act 1/92	No
Baleares	1998		Act 4/92	No
Canarias	1992-1994	1997-2001	Act 11/94	Yes 1994
Cantabria	1996-2000			No
Castilla la Mancha	1993 (1995)	1995-2000		No
Castilla León	1991-2000	1998 (2^{nd})	Act 1/93	No
Cataluña	1993-1995	1996-1998	Act 15/90	Yes 1981
C. Valenciana	1992-1995?		Res. 15/2/91	Yes 1988
Extremadura	1997-2000		Decree 53/96	No
Galicia	1993-1997	1998-2000	Act 8/91	Yes 1991
Madrid	1992?	1995-2004	Order 20/7/92	No
Murcia	1993-1996	1998-2000	Act 4/94	No
Navarra	1991		Act 10/90	Yes 1991
País Vasco	1988	1994	Res. 23/6/93	Yes 1988
Rioja	1998		Act 4/91	No

Table 2. Comparative analysis of the context and initial strategic orientation of the health plans and of the programme contracts in Spain.

	Health plan	**Programme contracts**
Social context in which emerge Dominant values	Social awareness Idealism Community participation	Pervasive economic approach Pragmatism Individualism Short-term results
Health care context in which emerge	System in expansion toward the universality Uncovered needs	Containment need of the System The health care services as 'consumption goods'
Prevailing model of organisation	Centralised planning Centralised public management Predominance of public health official in charge	Freedom of choice to the user Regulated market laws Predominance of managers and economists
Strategic priorities	Health outcomes orientation Economic efficiency Preventive orientation Need orientated Community orientated Long-term objectives Needs satisfaction	Financial results orientation Management efficiency Services approach Orientation towards demand Orientation towards the individual Short-term objectives Users´satisfaction
Objectives and goals	Explicit health priorities Health goals, no action plans.	Financial results Waiting lists and services provided

	Insufficient definition of strategies and priorities concerning services	Insufficient definition of priorities concerning services with the exception of Primary care
Responsibilities assignment	By programmes	By management areas
Specific financial and resources assignment	By programmes Undetermined frequency	By centres and services Specific

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