A New Model of Primary Health Care in Catalonia

Xavier Ballart

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Introduction

Research into the processes of policy change or policy shift has centred in recent years on the combination of systemic elements with contingent or contextual ones. The theoretical basis of such studies lies in the search for patterns within the processes and in the identification of elements that relate context with a specific situation located in time and space. This is an interesting issue in that it focuses on decisions that neither follow an incremental logic nor respond to past and accepted forms of action (Lindblom, 1959) but rather take into consideration new values and make the decision making process more volatile. This kind of analysis can be can be carried out based on the study of cases in which actors take advantage of a temporary opportunity – policy windows - in order to introduce radical, or at least significant, policy changes.

John Kingdon, influenced by the literature on the social construction of problems and to a large extent, ahead of his time, presented in 1984 his theoretical model for the study of public agendas based on the distinction between three streams: problems that capture the attention of the society, specification of solutions or policy alternatives and opportunities offered by the political context. Kingdon's work shows how new ideas – policy alternatives – enter the political system and may become formal policies in some conditions under which the three streams coincide in time. This separate analysis of problems and solutions allows understanding better the decision-making process, although subsequent interpretations that place emphasis on the dynamics of each of the categories mentioned (problems, solutions and opportunities) tend to simplify the analysis as they lose sight of the elements and the causal relationships between the specific situation and the wider context.

This article proposes the reconstruction of a case of a new policy – Mayntz (2004) talks of the "causal reconstruction of policy making episodes" – with the aim of going deeper

in the analysis of some of the elements that explain policy change. In the terms laid out by Baumgartner and Jones, the case allows to illustrate how we go from a situation of partial equilibrium to a new one of equilibrium in which perceptions over the public monopoly on the provision of primary healthcare enjoyed by a large public bureaucratic structure change. The case reconstructs the dynamic of the process along the lines laid down by Kingdom, but centres on the role of the entrepreneur – "policy entrepreneurship" – that is at the root of policy change, and on the context in which the perceptions held by social and political actors – "issue images" – change. The case is also interesting in that we see "spill over effects" for the public organisation that originally controlled the provision of services due to changes in the environment. As Levitt and March highlighted (1988), we could speak of organisational learning as the public health organisation staffed by public civil servants is forced to adapt its behaviour to new parameters of action, which has a direct effect on its working routines.

Theoretical framework

Several approaches within Political Science deal with the impact of institutions on political and social outcomes. From a number of perspectives, institutionalisms – whether historical, economic, close to rational choice, or sociological – seek to explain the relationship between institutional mechanisms and behaviour. The major approaches to the study of politics have been the subject of a great deal of comment (Hall and Taylor, 1996) that need not be reproduced here.

In the context of institutionalism, some contributions refer to the importance of processes and pay greater attention to the flows of interaction and to the relationship between people and groups with their environment/. The main tool of this new "processualism" (Barzelay 2001, 2003; Barzelay and Gallego, 2006) are narratives based on experiences that are used to try to reconstruct social reality based on an approach that gives a great deal of importance to the temporal context and to the mechanisms of the relationship between certain ways of thinking, specific situations and particular actions (Abell, 2004). Given the importance attached to the reconstruction of narratives, this approach is directly related to historical and comparative analyses of the social sciences, although the theoretical framework is closer to theories of agenda

setting, the specification of alternative policies and decision making along the lines of Kingdom or Baumgartner and Jones mentioned above.

Such theories concerning the formulation of policies are essentially “processual”, which is what makes them interesting when what we seek to explain are the dynamics of change, although Baumgartner and Jones offer a more static vision, since they use the key concept of “policy monopoly” as a means of understanding the solution to a problem.

For such authors, all groups or policy entrepreneurs have an interest in convincing others that their policy represents the solution to a long-standing social problem. The construction of a “positive image” is closely related to the creation of such “monopolies” of ideas that lend stability and avoid having to continually redefine problems and their possible solutions. The image of a policy structures the terms within which it is debated and understood. The combination of “policy monopolies” supported by powerful images produces a situation of stable equilibrium.

Other authors, notably Kingdon and, in general, new institutional processualism as defined by Barzelay (2003) centre their attention on the change in the situation of equilibrium. This can be disturbed by groups with different preferences entering the process of agenda setting. Arguments and the construction of a new image can play a key role in changing the general and background references of a policy, as Majone (1989) has pointed out. The media can also play an important role, since negative or positive coverage can question a given way of understanding policies in relation to a problem. Hence the narrative pays attention to the change in the policy image, to the relationships between the entrepreneur, the media, the current political context and to the possible effects for those who participated in the previous policy structure.

The narrative: precedents*

The origins of the Spanish health system can be traced back to the 1940s when the National Institute for Health (Instituto Nacional de Previsión) was created in a social and political context that was very different from the current one, with an under-developed hospital system in which the doctor was a liberal professional who received the support of nurses paid by the public administration.

In the 1970s important changes were introduced into hospitals when a business structure was adopted that rested power from doctors, who became responsible for only medical services, while managers were brought in order to make the running of hospitals more professional.

However, it was not until the beginning of the 1980s until real changes were introduced in primary care, when doctors were employed as civil servants and the levels of equipment and personnel (doctors, dentists, midwives, nurses, administrative staff and social workers) were improved in the primary healthcare centres (CAP in Spanish).

The 1980s also saw the beginnings of a process whereby healthcare was transferred from central administration responsibility to that of the regions or autonomous communities. Catalonia was the first community to receive such policy powers, and as such the Catalan Institute for Healthcare (ICS) was set up, managing 40% of hospital beds (the rest belonging to the private and non-profit sector) and all of public primary healthcare.

The status of healthcare on the public agenda

Since its inception the ICS was one of the largest firms in Catalonia with approximately 35,000 employees, while its budget represented 45% of the regional government's total budget. However, for historical reasons, there existed in Catalonia a large network of hospitals belonging to the third sector, that is local and district hospitals created, given

* This case study is based on interviews with the protagonists. Margarita Martínez wrote a case which was published in a book coordinated by Xavier Ballart in 2001. That first version deals with the first phase of the development of this initiative in the town of Vic. For an overall account of health policy in Catalonia, see the work of Gallego.

the limitations of public health provision, by Catalan society as foundations or consortia in which local authorities could participate. Public contracts represented an important part of the overall turnover of these hospitals, which gave them a great deal of influence, in general, over the government of Convergència i Unió (CiU) – the centre-right nationalist coalition headed by Jordi Pujol – and in particular over its strategic decision to take advantage of the existing network of hospitals instead of creating new public hospitals.

In 1991, within the framework of state-wide legislation, the Catalan government passed the Law of the Regulation of Healthcare in Catalonia (Llei d'Ordenciació Sanitària de Catalunya), the result of consensus between the main parliamentary parties. The Law created CatSalut, the public agency to which the department of Health transferred the management of public funds for healthcare together with the functions of planning, the purchase of services and evaluation. With this reform, the ICS was reduced to a service provider. The Catalan political parties were in agreement on the question of increasing the budget of the ICS given its deficit, and on transforming it into a competitive firm specialised in the provision of both hospital care and primary care.

Availability of new ideas

The main mission of the CatSalut agency was to ensure high levels of performance in terms of health, efficiency and cost control along with user satisfaction. In the area of primary care, the main problems related to the relatively poor functioning of certain CAPs, in terms of long waiting times and high rates of hospital referrals. In addition, there was the more urgent problem of a lack of control over costs, especially spending on medicines, since in the Spanish system the regional administration pays for 60% of prescription drugs, with the figure rising to 100% in the case of the over sixty-fives.

In the light of the experience of outside firms managing certain CAPs, some health sector professionals had raised the possibility of taking over the management of a CAP by creating a company. Their intuition was that they could obtain better value for money by changing present arrangements wherever necessary. The Catalan government was receptive to such ideas since it was also interested in diversifying the provision of primary healthcare. The main hurdle for the civil-servant doctors of the ICS was the

prospect of losing their civil service post, for which they had studied for at least ten years and had passed highly competitive exams, and which represented job stability and above-average income.

The Catalan government proposed a pilot programme to five civil-servant doctors: in a town in the interior of Catalonia that, given its population size, was due to have a new CAP, an experiment would be undertaken whereby the centre would be managed by the medical staff. Of the five to receive the proposal, only one, Dr. Ledesma, accepted. From the beginning of the debate on the subject, he had defended the viability of autonomous management by medical professionals as a means of avoiding both public bureaucracy (the ICS) and private bureaucracy in the case of hospital firms that had entered the market for primary care.

Dr. Ledesma accepted the challenge of creating a firm, a limited company, and of managing a centre along with a certain degree of financial risk. He imposed three conditions: a free hand to hire personnel; not to have to use the ICS information system; and the possibility to return to his previous post within a three-year period. Once such conditions had been accepted by the administration, he began work on the organisation of his own firm, with his only experience being that of a civil-servant doctor of the Spanish and Catalan health system.

The temporal and political context

The decision to carry out the experiment in Vic, a town of approximately 35,000 inhabitants about 50 kilometres from Barcelona, was not welcomed by the population. The cause of the negative reaction to the project was that it was presented as a ‘private management’ project for the new CAP.

The movement against the project ranged from traditional trade unions such as the General Workers’ Union (UGT) and left-wing parties to part of the civil-servant doctors of the ICS that worked in the existing CAP in the town, whose main representative even stood as a candidate in the local elections as head of an independent platform against the project, subsequently winning a seat on the local government.

Given the reaction of the town's population, the regional health minister put the pilot project on hold. For his part, the mayor of Vic, also from the CiU coalition and who had lost his overall majority within the local council, conditioned the eventual development of the project on the freedom of choice of CAP for all citizens of the town, in contrast to the normal policy of assigning patients to CAPs based on geographical proximity. In this way no-one was forced to go to a privately-run centre.

While the regional government was deciding what to do with the project, Dr. Ledesma was encouraged to continue with the setting up of the business. One of the main problems faced by Dr. Ledesma was the difficulty in finding and paying for suitable premises in the centre of town. The Official College of Doctors of Barcelona (COMB), interested in an experience with the potential to return decision-making power to doctors in the ambit of primary healthcare, decided to participate in the firm with the intention of facilitating the purchase of premises.

The people count

At that time, the secretary of the COMB was Dr. Soler, who was also a member of the regional parliament for the ruling CiU. President Pujol named a new health minister who proved to be most receptive to Dr. Ledesma's project, but preferred changes in current legislation before continuing, given the scale of the social conflict that the project had generated. Ledesma and Soler set to work on an amendment to the Catalan law on health and came up with the "Associative-Based Entity" (EBA), that is, a limited company controlled (with 51% of capital) by a minimum of three partners who at the same time had to be practicing doctors at the centre that they managed. At the same time, each member could not own more than 25% of the firm's capital, and as such the door was opened for other partners to participate in these small companies, be they private partners from the health sector or public ones such as the regional or local administration.

Ledesma realised that political parties on the left might oppose the privatisation of primary healthcare given their preference for a public institution that they felt able to reform. The design of the EBAs, by allowing the participation of the ICS itself or of

local authorities in the running of the CAPs, made the legislative proposal more politically acceptable.

In 1995 the Catalan parliament passed the law that legalised the EBAs, and a year later the running of the new CAP in the town of Vic was put out to tender, with the only bid coming from the firm founded by Ledesma with the support of the COMB. Thus came into being the first centre for primary healthcare run by professionals, who in this case were ten healthcare workers (five general practitioners, one paediatrician, one dentist and three nurses) and four administrative staff. The citizens of Vic could chose between a CAP located in the northern part of the town run by the ICS and the new CAP that covered the southern part. In theory each centre had a patient base of around 17,000, although Ledesma and his team would have to win over their share of the market. At the opening of the centre, the regional health minister, Eduard Rius, said that: “the opening of this centre represents a turning point for the Catalan health service”.

Ten years later

Ten years later the Vic South CAP had gone from employing fourteen to forty five people and from a notional population base of 17,000 to 24,000. In Catalonia, approximately 25% of the population has a double insurance system: the obligatory public one and a voluntary private one. This sector of the population seeks better treatment in the private sector, while using the public sector to cover the cost of medicines and for serious illness. Such patterns of behaviour are less likely in Vic South given the socio-economic characteristics of the area, the high levels of immigration over the last ten years and the quality of public healthcare.

The evaluation by the CatSalud agency of the primary healthcare services was highly positive for the centre managed by Ledesma, as can be seen in the following indicators:

- An increasing “market share”;
- Above-average in clinical practice controlled by CatSalud (clinical practice includes aspects such as the level of diagnosis and the treatment of specific illnesses);
- Below-average use of the local hospital accident and emergency services;

- Below-average spending on medicines compared to other CAPs;
- Below-average referral of patients to hospital consultancies;
- Prompt payment of suppliers.

On the other hand, the public success of Vic South might be found in the qualitative aspects promoted by the team formed over the period:

- More patient-friendly opening hours;
- Personalised treatment by a doctor of choice;
- Good management of waiting lists;
- Pleasant and clean environment;
- Good working environment, involvement in the project and, if necessary, the substitution of those failing to fit into the team;
- Performance-related pay of between 30 and 50% of total salary.

Vic South and the other EBAs (15 have been subsequently created) have been subjected to thorough control mechanisms, which in turn have been applied to the public provider and to the third-sector hospitals that have contracts with CatSalud. The new rules have laid bare the problems associated with "large" providers, the solutions to which are difficult given that their unwieldy administrative structures have difficulties with:

- Keeping within the agreed spending limits per patient, particularly in terms of spending on medicines;
- Completing the process of computerising individual medical records;
- Managing labour disputes, mainly the pressure from civil-servant doctors to increase pay and reduce the volume of work and from doctors from third-sector companies seeking to enjoy the same pay and conditions as civil-servant doctors.

<u>Change in the way of understanding policy and the new institutional rules</u>

In the light of this situation and of the influence that such reforms may have had in the relations between the CatSalud public-sector agency and the dominant public sector

provider, ICS, the Catalan government has raised the issue of whether more CAPs should be put out to tender to be run by EBAs or hospital-sector firms. Or, whether they should go further in the transformation of the ICS into a more efficient public sector company, while maintaining its dominant position in the provision of primary healthcare. It will probably opt for both, although the "monopoly" in the form in which the policy is understood has changed, as has the "image" that political representatives have of this policy.

The policy of diversifying provision was promoted by a coalition of centre-right nationalist parties that did not have a clearly-defined model but that was open to new ideas from the healthcare sector. At the same time, the further one goes to the left of the political centre the more one finds political parties that are reluctant to accept any reform that might be related to the privatisation of universal public services such as healthcare. However, even those political parties with greater levels of confidence in their capacity to transform large and inefficient public institutions are today receptive to reforms that may lead to greater efficiency with the condition that existing levels of provision and quality are maintained.

This underlines the importance of the "feel" of the reforms, their public or private ethos and the images which support the new monopoly or structure of dominant policies in a given sector.

In the terms used by Kingdon (1984), the window of opportunity can be explained by indicators highlighting a problem (health spending, de-motivation and conflict with healthcare workers); by the availability of ideas as the basis for new interventions (new tools such as management by EBAs); and by people in key posts (the secretary of the COMB member of parliament for the governing coalition, the new regional health minister was prepared to accept the risk, as were Ledesma and his team).

However, in this specific context it must be pointed out that the policy of partial privatisation of the provision of healthcare services is not like those experiences from the English-speaking world that public administration studies would label as "new public management" (Hood, 1991). Rather the contrary, in that the process in which Dr. Ledesma has played such a prominent role reflects a neo-public vision of public service,

far removed from any proposal to roll back the state or to reduce public spending on health. At the extreme, the success of the reform would mean that those who opted for a double system of health insurance - public and private –left the private sector given the quality of public primary healthcare.

It is precisely this public ethos of the reform that makes it much more acceptable for parties of the left, including the possibility for local authorities to participate as shareholders of the EBAs. At the same time other rules operate that mean that this public ethos has an impact on the day-to-day running, for example the prohibition on EBA partners maintaining control once they no longer are employed as healthcare workers, or the limited profit margins involved (15%) due to the high costs of medical personnel and medicines.

Against the external image of the government as a "marketizer" that some authors consider for NPM countries (Pollit y Bouckaert, 2000) – opposed to centralised planning and distribution of resources in favour of markets and individual decision-making – those promoting the reforms are conscious that the market is a tightly regulated one in which there is very little competition between providers, despite the fact that the freedom to choose of patients has been increased, obliging providers to be more responsive to demand. The reformers of the Catalan health system are aware that their relative advantage lies in fragmentation and not in market arrangements. Against the public or third-sector provider, both with cumbersome bureaucracies, the EBAs allow public money to go directly from a central public treasury to patients. In addition, one of the key features of the relationship with the public agency is the advantageous position of the purchasing agency to resolve possible disputes through internal administrative procedures without the need to turn to the judicial system.

On the contrary, over time there has been an improvement in the public image of the policy of diversification of primary healthcare provision as a balanced way of resolving the problems of, on the one hand, the low levels of motivation of healthcare workers and, on the other, the control of public spending per patient. Initially, the policy provoked opposition as it was perceived as a means of encouraging doctors to seek private gain from public resources. However, this changed as it increasingly came to be

seen as a means of improving the productivity of medical staff that normally feel undervalued within the large public bureaucratic structures.

In all large organisations, part of the staff feel frustrated and tend to voice their complaints: they know how to do their job and see the opportunities for improvement but lack the power to take advantage of them. In the case of the policy analysed here, staff are organised in an efficient way, thus creating public value, since public service providers change their behaviour without increasing spending – even decreasing public spending –. They feel both owners and employees, enjoy their work and discover new opportunities. In addition, pay rises although this should not be a problem if society achieves greater efficiency and quality clinical practice.

Conclusions

The challenge for the promoters of the policy analysed and of any other innovative policy measure necessarily involves explaining to the society at large, political parties and others involved in taking political decision the extent to which the ideas fit into their political points of reference, in the most classical sense of the term 'political'.

In this case, the status of the issue "efficiency in primary healthcare" becomes more relevant due to the flow of ideas coming from third sector providers of hospital services and, above all, from the experiences of small business owned by medical staff in managing CAPs. While the status of the reform declined over a period in which political support wavered in the face of the initial public reaction, it soon recovered due to the greater level of commitment on the part of the new regional minister for health.

The proposal to create EBAs emerged as a specific alternative to the existing provision of services, which, while requiring legislative changes, shows how by finding the right formula at the right time it contributes to maintaining attention on the new policy and to overcoming potential reticence. In this respect, the option of modifying the law allowed the risk-aversion of the previous minister to be overcome and to legitimise the reform by means of a parliamentary agreement that included other aspects and in which the reform became the subject of negotiation.

The entrepreneurial character of Dr. Ledesma and those that supported him is important, as is the way in which the public image of the initiative from the moment in which citizens were given a free choice of CAP and rules were established to guarantee the public ethos of the project. Rather than a project of strategic policy change towards market-based solutions, it became a means of motivating public employees, and as such can be understood as a means of adding value to the system without increasing public investment.

The case presented here is interesting since it allows us to illustrate theoretical ideas about the formation of agendas and about policy change in a situation of partial equilibrium. The use of case narratives allows us to offer a more complete picture of the process through which a policy is adopted by relating the situation in which the promoters of change act with the context. A fundamental element of the context is the trust generated by the rules concerning the real goals and the overall ethos of the reform.

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