

THE CATALAN HEALTH CARE MODEL

Lessons for Canada from Spain

Executive Summary

- Spain has decentralized its publicly funded health care system. In the Catalonia region, public authorities have split the provision of health services from their financing, contracting with private sector providers for their delivery.
- The principles that guide Spanish health care are similar to Canada's, with two exceptions. They do not mandate a strict adherence to public ownership of facilities, and they include a focus that favours preventative medicine.
- These principles also require a decentralized and distributed business-style management of publicly owned health institutions.
- Although Catalonia requires co-payments for a variety of health services, citizens pay less out-of-pocket than Canadians do. It has fewer hospital beds and medical personnel.
- Although public funding is national, provinces have autonomy in designing their local health care systems. Catalonia's Ministry of Health funds the system and sets standards, while the Health Service monitors the performance of providers, the majority of whom are contracted. About 70% of facilities are privately owned.
- The World Health Organization reports that an increasing number of countries contract for health service delivery, as an alternative to traditional publicly administered and publicly financed systems.
- Catalonia's health care system contains a strong emphasis on preventative public involvement through the promotion of healthier lifestyles.

BACKGROUND - COMPETITIVE DELIVERY IN CATALONIA'S PUBLICLY FUNDED HEALTH MODEL



Canadian governments have been notoriously averse to exploring alternative delivery systems for health care, and seem to be ideologically opposed to giving citizens options. They should familiarize themselves with the benefits of the decentralized model of health care in Catalonia, Spain.

Nowadays more than Don Quixote's imaginary windmills are under construction in Spain. Far from ancient, fanciful dreams, the new concepts offer a solid opportunity for the public to live healthier lives. The six million people in the region of Catalonia are enjoying an effective and efficient health care system that is publicly funded, a valuable and frustratingly elusive goal for Canadians..

Catalonia has been so successful in developing a strong health care system that current health literature refers to it as "the Catalan model". It features a separation between the financing of services and their provision. The Catalan Health Service regulates, plans, programs, evaluates and inspects everything related to public sector health services, and both hospitals and the primary care system run by means of agreements and contracts with providers.

This pragmatic approach, which allows public funders to hire private service providers, is both practical and workable.

HOW WAS CATALONIA ABLE TO CREATE ITS MODEL?

For the delivery of health care, Catalonia and sixteen other provinces function as autonomous communities within the Spanish National Health Service (NHS). As in Canada, a set of basic principles guides their system.

Spain is the third largest country in Europe in area, with a population of 40 million people. The population's growth rate is slow, largely due to a low fertility rate, while the percentage of people over the age of 65 is increasing, partially due to increasing life expectancy.

Since the death of dictator Francisco Franco in 1975, the nation's health care system has improved significantly and with it, the quality of life. Change was achieved by constant and consistent attention from Spanish parliaments at both the national and the provincial levels. The system that emerged is a well-organized primary care infrastructure that is publicly financed and offers free services to all.

The system is decentralized, with local organizations in each of the seventeen autonomous communities which make up the Spanish state. The general principles of the NHS as defined by the Spanish General Health Act of 1986 are:

- Universal coverage with free access to health care for all citizens;
- Public financing, mainly through general taxation;
- Integration of different health service networks under the NHS structure;
- Political devolution to autonomous communities, along with region-based organization of health services into health areas and basic health zones; and
- Development of a new model of primary health care, emphasizing promotion and prevention activities.

Spaniards may choose a general practitioner (GP) among those working in the area where they are registered as users. Usually, all doctors working in a given geographical area use the same primary health care centres or polyclinics. Health care centres are also staffed by pediatricians, nurses and sometimes by dentists and social workers. Polyclinics also provide specialist services.

Spain has fewer acute care hospital beds than Canada (3.2 per 1,000 vs. 5.1 per 1,000) and the average length of stay in acute care is greater in Spain than in Canada (8.8 days in Spain vs. 7.5 days in Canada)¹. Spain has 424 physicians per 100,000 citizens, compared to Canada's 229 per 100,000, and 458 nurses per 100,000, compared to Canada's 897 per 100,000. Spain also includes midwives and pharmacists in its health system².

General practitioners, who are mainly salaried but may be paid by fee for service, act as gatekeepers to the rest of the public health care system. Nurses have been integrated into primary health care teams supplying care to individuals, families and community through programs for children, adults and at-risk groups. Pharmaceuticals are provided by independent pharmacies. Patients pay 40% of the cost of a prescription, except for pensioners, who pay nothing.

SPAIN PROVIDES UNIVERSAL FREE HEALTH CARE AT THE POINT OF DELIVERY

The Spanish health care system has been set up as an integrated National Health Service (NHS) which provides, with only a few exceptions, universal free health care at the point of delivery.

While the bulk of health service funding is public, about 22% of the country's total health expenditure in 1992 was financed privately, compared to 30% in Canada. Private health expenditure qualifies for tax relief at a deductible rate of 15%.

Out-of-pocket payments constitute 19.6% of total health expenditure, which breaks down as follows:

- 6.1% co-payments by patients for pharmaceuticals and orthotic-prosthetic products that are not fully covered by the public system;
- 6.3% charges for dental; and
- 7.2% for private care.

An increasing percentage of gross domestic product is devoted to Spanish health care. The actual and projected total expenditures on health care as a percentage of GDP for the period 1992 to 2000, including the private sector, are:

Year	1992	1993	1994	1995	1996	1997	1998	1999	2000
GDP	7.1	7.2	7.4	7.5	7.6	7.8	8.0	8.1	8.3

Public expenditures constitute almost 80% of the total, while private spending accounts for only 20%. This ratio is expected to continue in the future.

Many Spaniards opt for a private policy in addition to their public coverage. These arrangements vary from region to region. In Catalonia, 20% of the population holds private insurance. These premiums cover primary and specialized hospital care, excluding pharmaceuticals.

LOCAL AUTONOMY PROVIDES FLEXIBILITY TO MEET LOCAL NEEDS

Catalonia has its own health model that is integrated into Spain's national health system. A Parliamentary Act created the Catalan Health Service (SCS), an organization which is responsible for providing a public health service and controls all public health resources. The model is based on the separation of two functions: first, the planning and purchasing of health services and second, the management of the resources available. Purchasing is based on the population's defined needs in the Health Plan, and the public resources available.

Responsibility for developing the health care plan falls to the autonomous government of Catalonia. It sets the targets, the guidelines and the actions needed to implement the right to health protection guaranteed by the Spanish

¹ OECD Data File 1998

² Source WHO 1998

constitution. However, it is not responsible for the delivery of services. Critically, the payer and the provider are separated.

A MIXED HEALTH CARE SYSTEM ALLOWS FURTHER FLEXIBILITY

Catalonia relies on a mixed health care system, where the main emphasis lies not in the nature of the ownership of facilities, but rather on public financing to meet the population's needs. The ownership of health centres and entities may lie within the public sector (the Catalan Health Institute, municipal governments, or autonomous governments), with charitable institutions (religious orders, the Red Cross and foundations) or private institutions (private foundations and corporations). The formula of diverse ownership allows fast and flexible adaptation to innovations in the health care sector.

This new structure has led to the shaping of a health care system where one body, the SCS, is in charge of the contractual engagement of services with sets of suppliers who are responsible for delivering the services. The suppliers can be either publicly or privately owned.

Ultimately, the government ceased to have a hierarchical relationship with service providers, and now follows contracts based on the goals set forth in the Catalan Health Care Plan.

70 % OF HOSPITAL BEDS IN THE CATALANIAN HEALTH CARE NETWORK BELONG TO AUTONOMOUS HOSPITALS, WHILE ONLY 30% BELONG TO THE MINISTRY

The difference between the Catalan health care network and that in the rest of Spain is noteworthy. In the country as a whole, 70% of severe-case hospital beds are the property of the Ministry and 30% are owned by other entities. In Catalonia, that the ratio is reversed, with 70% of beds belonging to autonomous hospitals (public and private, for profit and not for profit).

As a result, Catalonia offers a natural ground for comparison between the network made up of 30% of beds belonging to and directly managed by the Catalan Health Institute, and the 70% of beds that belong to autonomous centres contracted by the Institute. In other words, the model existing in many countries can be compared to the one that most countries want to implement in the future, since both coexist in Spain.

Catalonia's General Principles

The general principles of the health care system are as follows:

- Health care as a publicly-financed public service;
- A comprehensive concept, integrated within the health care system, with special emphasis on primary health care;
- Health care services universal for all citizens residing in Catalonia;
- The health care plan as a governing backbone of public health and welfare service policies;
- A service plan that governs planning;
- Community participation in the formulation of health care policy and in the control of its implementation;
- Rationalization, efficacy, simplification and efficiency in the health care organization;
- To equate and overcome geographical or social inequities in the provision of health care services;
- Sector-based health care service;
- Decentralized, distributed management; and
- Business-style management of publicly owned health institutions.

This framework is more nuanced and flexible compared to the Canada Health Act of 1984, which sets out five principles that apply only to hospital and physician services:

- Public administration;
- Comprehensiveness (pay for all insured services);
- Universality of coverage;
- Portability; and
- Accessibility.

CATALONIA DEVELOPED MANAGEMENT TOOLS TO ATTAIN ITS PRINCIPLES

In Catalonia, the administration of health care is organized in accordance with its differing functions, to ensure that appropriate services are delivered to the general public. These organizations are:

1) The Department of Health and Social Security (the Catalanian Autonomous Government Ministry of Health), which is in charge of political leadership, health care financing, health care planning, system regulation, authorization and accreditation and evaluation.

2) The Catalanian Health Care Service, the sole public insurer, which is responsible for resource management and planning (the health service plan). It provides organization, planning, programming, assessment and inspections of system organizations and facilities. It is also responsible for the distribution of financial resources and the establishment of agreements, covenants and contracts with entities directly and indirectly managed by the autonomous government.

The Catalanian Health Care Service is geographically organized into eight health care regions that facilitate the appraisal of health status, health care needs and operational priorities.

The Department of Health produces the Catalanian Health Care Plan, which is the main analysis tool of the population's health status, and which sets the goals that must be reached in a three-year period.

The Health Care Plan is a basic tool for the definition of autonomous government health care policies for the short and mid-term. It is a government policy assessment and action tool.

THE PROVIDER NETWORK AND CONTRACTS ARE IMPORTANT FOR SUCCESS

Catalonia features a stable network of health care service providers. This network is made up of centres and facilities of diverse ownership that are contracted by the Catalanian Health Care Service, with the purpose of meeting the population's health care needs by way of public financing.

The relationship between the Catalanian Health Care Service and its different providers is formalized by a contract that establishes yearly the nature of contracted services, the cost of services, the payment system, and the assessment and penalization mechanisms among the contracting parties.

CATALAN HEALTH SERVICE PLAYED A BIG ROLE IN CATALONIAN HEALTH CARE REFORM

The health care reform carried out in Catalonia has incorporated into the health care system some characteristics now being considered by most of its neighbouring countries:

- Separation of purchasing and financing functions from the provision of health care services;
- Creation of contracts to regulate the relationship between buyer and service provider;
- Autonomy of health care centre management;
- Ensuring that professions manage hospital, primary health care services and health care centres;
- Contract-based hiring for health care centre staff;
- Health care goal-based planning;
- Incorporation of health care goals into contracts;
- Design of incentive formulas for professionals that tie them to the entity's achievements; and
- Design of organizational formulas for public networks that may allow the latter's development of labour relationship plans protected under private law, while sustaining the public nature of the facilities.

THE WORLD HEALTH ORGANIZATION REPORTS THAT EUROPEAN HEALTH REFORM IS TIED TO SUCCESSFUL CONTRACTING

The World Health Organization (WHO) has completed an analysis of current strategies in European health care reform. It found that an increasing number of European countries are using contracting as an instrument to implement health policy objectives, as an alternative to traditional publicly administered and publicly financed systems. Contracting mechanisms bind providers to explicit commitments and generate the economic motivation to fulfill these commitments.

In current reforms, particularly in tax-based health systems, contracting has become a device for negotiations on prices and quality, as well as to ensure compliance by the provider. Proponents of contracting cite four major reasons for introducing contractual relationships into tax-based, command-and-control health systems: to encourage decentralization of management, to improve the performance of providers, to improve planning of health care development and to improve management of care.

WHAT'S NEXT IN CATALONIA?

The Catalan Agency for Health Technology Assessment and Research believes that finance and bioethics must be considered to ensure that progress on health issues will continue indefinitely. *"Catalonia believes that making improvements to health or maintaining the standard that we already have achieved will only come from directly involving the population. More important than adequate health care are our lifestyle habits, environmental factors and our genes."*

A document produced by the Catalan Agency for Health Technology Assessment and Research (CAHTA) analyzes the current situation and provides indicators that let the agency set objectives and make recommendations on health matters for the next 25 years. The document's five sections are:

1. Promotion of health and healthy life styles.

Promoting health and preventing disease are vital to improving the health of the population. Improvements to health are the responsibility of the individual and of society as a whole. Decision-makers have agreed upon a package of preventive interventions that can be applied gradually to asymptomatic adults targeted according to age and sex. Currently Spaniards spend less of their lives suffering from disabilities than Canadians. (A Canadian female will live with disability for approximately 7.2 years of her life; a Canadian male will experience disability for 6.5 years of his life. Compare this to 7 years for Spanish females and 5.8 years for Spanish males). Quality of life is important to the Catalonia Health System. Source: OECD data File 1998

2. Continued improvement in the health system

The ethical principles by which health professionals and institutions work need continued strengthening. Ongoing improvements to the functioning of health services focus on making them as effective and efficient as possible and on maximizing the quality of service. The system seeks improved relationships between resources and care needs.

3. Rehabilitation is an integral part of the healing process

Rehabilitation needs to be considered as an integral process that covers physical, motor and other aspects. It should include the emotional and social well-being not just of patients but also of their families or other care givers.

4. Life science education and training and the health professions future require continued evolution.

The skill profiles of health professionals need to be redefined to adapt them to the needs of society. This requires changes in course content and teaching methodology. The number of students admitted to life science faculties should be determined in accordance with the needs predicted by experts in the field. A further fundamental issue is the development of continuing medical training. New technologies and scientific discoveries place demands on the system that must be met.

5. Life science research & evaluation give direction for action.

The Agency recommends moving towards a multidisciplinary and interdisciplinary method of organizing research in the life sciences, overcoming the traditional fragmentation and divisions between the various biomedical disciplines. Support should be given to teams working in areas of life science research that are highly competitive at an international level.

WHY SHOULD WE BE INTERESTED IN CATALONIA?

Manitobans and Canadians should take a close look at health care reforms in other countries. France and Spain are providing better care at lower cost, despite the fact that they allow private providers a share of the health care system. In Stockholm, Sweden, and Catalonia, Spain, the provision of services is separated conceptually from their financing, and the split is improving the efficiency of all aspects of their health care systems.

Suggested Readings

The health care system in Catalonia can be further reviewed at www.chc.scs.es

Notes

(1) Several government documents were used in researching this paper including a framework document for the elaboration of the health plan for Catalonia (1991), and the health plan for Catalonia for 1991-1993, 1993-1995 and 1996-1998 (Barcelona, Department of Health and Social Security).

(2) Several documents were reviewed with Dr. Luis Oppenheimer, the Medical Director of Surgical Programs in Winnipeg. Dr. Oppenheimer is from Catalonia and continues to have regular contact with key people there. These documents included the health care plans, a summary document called *Health Care System in Catalonia*, and a presentation prepared for him and presented in March 2000 entitled *The Health-Care System and Service Providers — A View from a Contract Provider*.

(3) Two World Health Organization documents provided much information and references for other documents: *Development of a Policy for Health for All in Catalonia* and *Highlights on Health in Spain*.

(4) McGraw-Hill Ryerson Ltd. 2002 recently published a new book entitled "Trends and Issues in Health Care" by Linda West, R.N., M.B.A., PhD. Chapter nine of this book covers the Catalan Model in depth and was referred to extensively in preparing this article.

The Frontier Centre for Public Policy is an independent public policy think tank whose mission is to explore options for the future by undertaking research and education that supports economic growth and opportunity. You can reach us at: 201-63 Albert Street • Winnipeg, Manitoba CANADA R3B 1G4 • Tel: (204) 957-1567 Fax: (204) 957-1570 • E-mail: newideas@fcpp.org • Website: www.fcpp.org