EUROPEAN HEALTH LEADERSHIP PROGRAMME

REPORT OF A VISIT TO BARCELONA

10th - 21st MAY 1998

1. Introduction

The European Health Leadership Programme 1998 visit to Barcelona was hosted by Sr Andres de Kelety, Chief Executive of the Hospital Materno-Infantil, Vall D'Hebron.

A wide range of visits had been organised for the four participants to significant hospitals, independent sector providers, education and training organisations and the headquarters of the Catalan Health Institute, the main public sector provider.

We are extremely grateful to Sr de Kelety and his colleagues who gave us such a warm and hospitable welcome and gave so generously of their time to meet and discuss with us and for their tolerance of our many questions.

2. Learning Objectives

The principal learning objectives for this visit were:

1. To investigate the system for the planning and delivery of health care in Catalonia.

2. To identify approaches to meeting the training needs of health care professionals.

3. To identify innovative working practices.

4. To explore the potential for mutual exchanges of key staff.

5. To establish if the organisations visited were evidencing an interest in learning across Europe.

3. Background Research in the UK

Participants in the European Health Leadership Programme (EHLP) spent a day in London in April to meet each other and discuss issues affecting the provision of health care in Europe. This included an overview of health systems, a UK perspective on workforce and training issues, a presentation about the "Time Care Project", and general guidance on working in another country.

Five key models of health care in Europe were described (see Appendix 1):

- state and society model (1) - as in the UK
- state and society model (2) - as in Spain and Italy
- social model, as in Scandinavia
- professional model, as in Germany
- unique hybrid model in France

4. An over view of the Catalan Health System

4.1 Catalonia is one of seventeen autonomic regions within the Spanish state. The devolved responsibilities of the seventeen autonomic regions vary and are negotiated between the regions and the national government. The government of Catalonia has devolved responsibilities for health, education, social services, infrastructures, public safety and the environment. Catalonia was the first autonomous region in Spain to take over devolved responsibility for health.

4.2 Catalonia makes a significant contribution to the Spanish economy, accounting for 25% of the total manufacturing industry in Spain, most notably within the chemical and textiles industries and the mechanical engineering sector. Catalonia has a diverse and well developed service sector, within which commerce and tourism play a major role. The table below gives a brief profile of Catalonia. (Source: *Catalonia, A Model for Public Health Care* June 1997, pub. Servei Catalia de la Salut)

Population	6,059,494
Territory	31,895.3 square km
Population density	191 inhabitants per sq.km
Life expectancy [1]	men: 74.8 years women: 82.0 years
Birth rate (per 1000 pop)	8.9
Death rate (per 1000 pop)	8.6
Doctors (per 1000 pop)	4.3
Employment by sectors • service • industrial • construction • agriculture	 59.4% 28.8% 8.3% 3.5%
GDP in pesetas (thousands of millions)	13,276.1
Per capita income	1, 484, 900 ptas
Foreign visitors per annum	16, 420,506

[1] 1994 data. Source: Health Plan for Catalonia 1996 - 1998.

4.3 Health as a constitutional right

The protection of health, as a fundamental right of the individual, is enshrined in the Spanish constitution. The constitution explicitly recognises:

- the 1948 Universal Declaration of Human Rights
- the 1966 International Pact on Economic, Social and Cultural Rights
- the 1961 European Social Charter

The Spanish Constitution of 1978 guarantees public social security provision for all citizens. It establishes good public health as a constitutional right, together with an explicit level of health care provision to which all citizens are entitled, set out in the 1986 General Health Care Act. This Act also established the purchaser/provider split as one of the basic principles of the Spanish health system. Although responsibility for health is delegated to the Catalan autonomous region, this takes place within the overall framework of the Spanish Constitution.

The Spanish national health system includes primary care, specialised hospital based care and long term "social" health care. The health system is based on explicit values of :

- health promotion and disease prevention
- equity, efficiency and quality of services
- users satisfaction

The users of health care services do not pay directly for treatment, except in the case of pharmaceutical products, for which they pay a percentage of the cost. The Spanish health system is funded by a combination of general taxation (94%) and the compulsory social security contribution made by all workers. (6%). A population based formula is used as the basis for devolution of the budget to the autonomous regions.

4.4 The Catalan Health System

The Catalan health system was reorganized in 1990. The basic elements of the current system are :

A single purchaser: in the form of the Catalan Health Service (Servei Catala de la Salut - SCS) with overall responsibility for maintaining and improving the health of the population. The SCS is the strategic body responsible for developing the Health Plan for Catalonia, which establishes priorities for health improvement based on the health needs of the population. Planning is undertaken on a sub-regional basis, with the SCS being structured into eight Regional Health Authorities covering Catalonia. The Health Plan for Catalonia is the main strategic planning vehicle for the purchaser, setting out targets for health improvement in key areas, and forming the basis of the Service Plan which is then agreed with all primary and secondary care providers.

The SCS agrees block contracts with hospitals and primary care organisations on the basis of the Health Plan targets which are continually evaluated. Ultimately, failure on the part of providers to deliver the targets in the Health Plan results in financial penalties.

- *A "mixed economy" of providers:* There are three groups of secondary care providers, those belonging to the directly managed sector, (Catalan Health Institute - ICS) those belonging to the Unio Catalana d'Hospitals and thirdly, those belonging to the Consorci Hospitalari de Catalunya. The ICS sector is directly managed by the Catalan Health Service and is part of the civil service. However, only 30% of acute beds are in the public sector, the remaining 70% of acute beds are in the independent, not-for-profit, sector. All provider organisations are funded entirely by public monies, i.e. via the purchaser, and all operate within the framework of the Health Plan for Catalonia.

The independent provider sector is particularly strong in Catalonia compared with the rest of Spain. This is attributable to a strong historical tradition in Catalonia dating back to the 16th century in which social welfare services were organised by guilds of craftsmen. The Church has historically been an important provider within this sector, which nowadays includes consortia of autonomous bodies including local business interests and the municipal councils. New hospitals are now usually built and owned by consortia of not-for-profit organisations, with capital provided either by the Catalan Health Service, (SCS) or from banks with the backing of SCS.

Although only 30% of acute beds are found in the public sector, this includes 75% of intensive care facilities in Catalonia. High technology, high cost specialised services are concentrated in the public sector, general hospitals providing treatment which is less reliant on high technology are more typically located in the independent sector, as are most mental health services, rehabilitation services and facilities for the continuing care of the elderly and people with disabilities.

In total there are 68 hospitals within Catalonia competing for the SCS health budget, 11 of which are in the public, directly managed sector. There is a very small insurance based private sector, outside SCS funding arrangements. 20% of the population have "double coverage", i.e. they have private health insurance. This has reduced in recent years.

4.5 Primary Care

Primary Care in Catalonia was reorganised in 1985 but the strategy for implementation is one of gradual evolution. The reform is now effective in 60% of primary care. Catalonia is now organised geographically into 338 *basic health areas*, (ABS) covering neighbourhoods or districts in urban areas, or of one or more municipalities in rural areas, each with a population of anywhere between 5,000 in rural areas and 25,000 in urban areas. 95% of

primary care is directly managed by ICS and all primary care organisations are required to operate within the framework of the Health Plan for Catalonia and the Service Plan. Primary Care is said to be less good in the cities than in rural areas.

Each ABS comprises one GP per 2000 adults over the age of 14 years, and one paediatrician per 1500 children under the age of 14. There is one nurse for each GP, one community dentist per 11,000 population and one social worker per 25,000 population. In addition, there is one administrative assistant per ABS plus nursing assistants. The ratio of professional staff to populations is part of the regulatory framework and applies across Catalonia. All GPs and professional staff comprising the primary health care team are salaried civil servants. GPs are contracted to work a minimum of 36 hours per week in the surgery, including provision of telephone advice and home visits. Out of hours "on call" hours are restricted by agreement with the doctors union to a maximum of 120 hours per month, making the average working week 66 hours.

Primary Care is managed by 36 ICS directorates, who provide management and clinical support services and co-ordinate certain health promotion activities, such as the current women's health programme.

Prior to the 1985 reorganisation, Primary Care in Catalonia had two levels in Catalonia, a second tier of specialists in such areas as trauma, ophthalmology, general medicine, renal medicine and many other smaller specialties. This was found to be clinically and financially non viable and is gradually being phased out as part of the 1985 reforms.

4.6 The interface between primary and secondary care

Each primary care directorate will agree protocols with their main secondary care providers, although this is not compulsory and the coverage varies. In the case of ante natal care, there is a well developed joint primary/secondary care protocol, implemented nationally, which specifies the number and frequency of hospital visits, the diagnostic tests which should first be undertaken in primary care, which professionals can order which tests, etc. Each woman has a single health record for the pregnancy, which covers both primary and secondary care.

Communication between primary and secondary care is a perennial problem. There is a strategy to develop a fully integrated hospital and primary care information system, but progress is limited by the complexity of the "mixed market" of provision and by resources.

Primary care teams have direct access to hospital out patient booking systems, either by computer or by block booking appointment slots which they then allocate. This is not yet universal throughout Catalonia but progress is being made towards this.

4.7 New models of management

The traditional style of public administration throughout Spain is rigid, highly bureaucratic and widely seen throughout the health care sector as being inappropriate for the challenges of the future. The Catalan Health Service is keen to promote a more modern, decentralised management model as a means of increasing efficiency within the ICS provider sector. Human resources management is seen as a key area requiring modernisation, as the terms and conditions of professional employment in the ICS providers are effectively, those of the national civil service and are extremely inflexible. Unionisation is strong in the Catalan health workforce at all levels.

The independent sector is characterised by a less rigid regulatory framework and more management innovation to which the ICS providers now openly aspire. In the independent sector, key appointments are increasingly on the basis of three or five year rolling contracts, as opposed to the "job for life" model traditional in ICS providers.

4.8 The role of the media

It would appear that in Spain generally, the relationships between politicians, the health service and the media are different from the UK. In Spain, the relationship between individual politicians and the electorate is different from the UK, there is no direct representational relationship with a local community of constituents as a basis for local political campaigns on health issues in the media. This is not to say that the media do not engage in debate about health policy from a populist perspective, but rather that the role of politicians in this is different.

4.9 Workforce Planning and Training

Undergraduate professional education is provided by the Universities and is funded from within the higher education budget. There is no analogy to the UK system where the NHS commissions professional education from the higher education sector. Spain as a whole produces a surplus of doctors and nurses, and is a net exporter of these professions to other Spanish speaking countries, particularly in South America.

Post graduate professional education for doctors is well developed and is rapidly developing within the nursing profession. Access to different levels of continuing professional education is now subject to a national agreement between employers and the doctor's unions, with the intention of encouraging doctors to stay in the clinical field rather than moving into administrative posts to boost their salaries. There is evidence of good integration of doctors into management, several of the high profile chief executive posts are held by doctors.

In nursing, grade mix is not well developed. There are three levels, the nursing auxiliary, the qualified nurse and the supervisory grade with responsibility for a team and/or a clinical area. In Spain, nurse salaries have more purchasing power than in any other EU country. The ratio of nurses to hospital beds is currently the subject for debate as there is an awareness that current ratios are based on out of date service models.

In "The Health Plan for Catalonia", the Catalan Health Service state that the system inherited by the Catalan Government in the early 1980's was one based firmly on the medical model. The role of the nurse as a practitioner appears to be developing more rapidly than with any other health care discipline. The Institute of Health Studies (IES), which is part of the Catalan Health Service, has been instrumental in developing nursing competences and frameworks for multi-disciplinary post basic education. IES has also been influential in developing training and development resources for quality improvement programmes.

5. Comparisons with the UK

5.1 Key similarities:

- similarity in terms of core values of equity, efficiency and effectiveness
- national health service publicly funded through taxation
- significant and sustained downwards pressures on costs and expenditure
- pressures to reallocate resources across population groups, eg. urban/rural in pursuit of greater equity
- sustained pressure to shift resources away from acute care into primary and community care
- a widespread belief that the public sector is "inefficient" and therefore relatively ineffective in service delivery (ie. the traditional "employment" role of the welfare state is no longer seen as legitimate)
- pressures to deliver a more "personalised" service (ie. the hospital, clinic or practice as "factory" is no longer an acceptable mode of delivery - patients must now be treated as individuals with clear rights)
- pressures arising from more sophisticated, better informed consumers with higher expectations
- the need to "account" for costs resulting in pressures to separate service delivery activities from teaching, research and anything else which is paid for from a different budget.

5.2 Key Differences:

In this section, the criteria for comparison are :

- finance
- power
- organisation
- managerial/professional interface

- values

5.2.1 Finance

- mixed economy of providers all receiving public funding from SCS, on a much larger scale than in the UK
- directly managed providers do not have access to private capital as in the case of the private finance initiative in the UK
- independent sector have access to capital from the banks, with the backing of SCS
- independent sector hospitals appear to raise funds through income generation in partnership with private corporations (eg. computer companies) on a larger scale than in the UK

5.2.2 Power

- mixed economy of providers with not for profit sector a major provider of hospital services (mainly in the continuing care sector) makes the independent sector more powerful than in the UK
- independent sector hospitals are well organised into two influential employers organisations
- trade unions are strong in Spain as a whole and a well accepted part of the system
- European legislation (eg. Social Chapter, equal opportunities targets for women; disability discrimination) is more integrated into employment policies than in the UK
- rights to health and health care are enshrined in the Spanish constitution
- increasing user involvement is an explicit goal in the Health Plan for Catalonia but we were unable to ascertain the extent to which this is implemented in practice.
- in the ICS sector, there is no involvement of non executive directors on the board.

5.2.3 Organisation

- tensions exist between the directly managed (ICS) sector and autonomous bodies managing the not for profit sector
- wider acceptance and take up of information and communications technology in both clinical and managerial areas
- rigid civil service terms and conditions for employees in the ICS providers including primary care
- human resources management not well developed generally- now a growing trend and focus on developing HRM particularly in the independent sector
- general practitioners do not have independent contractor status - salaried GPs on civil service terms and conditions
- national agreements on working hours for GPs
- more commitment to management structures in primary care

- long term care of older people integral part of health system

5.2.4 Managerial/Professional Interface

- good evidence of medical involvement in management
- rapid pace of development in the role and skills of nurses compared with other professions
- relatively "flat" structures in nursing in terms of grade/skill mix

5.2.5 Values

- medical salaries appear relatively modest but these are usually supplemented by private practice
- well informed about other European systems eg. GPFH in the UK, recent White Paper read on the internet as soon as published
- more emphasis throughout the economy on occupational health

6. Key Learning Points

6.1 A mixed economy of provision in Catalonia has led to innovation in the independent sector through greater management freedoms and is influencing cultural change in the directly managed sector.

6.2 Primary care practitioners are salaried civil servants and there is no analogy to the UK "independent contractor" status. The implications of this are significant in terms of primary care being a more managed sector than in the UK with more defined organisational structures. This appears to have led to greater equity of access to primary care services.

6.3 Overall, human resources management (HRM) is a developing discipline within the Catalan health system. There is a distinct lack of centralised workforce planning, however, there is evidence of leading edge practice which recognises staff development as being critical to the success of the business. In one independent hospital visited, the Chief Executive demonstrated an explicit commitment to HRM as a means of

> *"promoting research, promoting knowledge, promoting professional development and promoting organisational values."*

7. Recommendations

The following general recommendations for leadership development in the UK are:

7.1 To continue encouraging greater exposure and openness to alternative models and health systems;

7.2 To learn from the experiences of other countries in the field of primary care development;

7.3 To quicken the pace of implementation of the national strategy for information and communications technology as a means of increasing efficiency and effectiveness;

7.4 To continue to encourage the involvement of doctors at the highest levels of management.